WHO COLLABORATIVE PROJECT ON IDENTIFICATION AND MANAGEMENT OF ALCOHOL-RELATED PROBLEMS IN PRIMARY HEALTH CARE

Report on Phase IV

Development of Country-Wide Strategies for Implementing Early Identification and Brief Intervention in Primary Health Care

World Health Organization

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Development of Country-Wide Strategies for Implementing Early Identification and Brief Intervention in Primary Health Care

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CHAPTER 1

INTRODUCTION AND BACKGROUND

Nick Heather

1.1. The WHO Collaborative Project

This Report describes the background, methods and findings of Phase IV of the *WHO Collaborative Project on Detection and Management of Alcohol-related Problems in Primary Health Care.* Phase IV was entitled: *Development of Countrywide Strategies for Implementing Early identification and Brief Intervention in Primary Health Care*. Previous phases of the Collaborative Project were as follows:

Phase I: a reliable and valid screening instrument for detecting hazardous and harmful drinkers in primary health care (PHC) settings was developed (the AUDIT questionnaire)[1-3];

Phase II: a clinical trial of screening and brief intervention in PHC was carried out[4,5];

Phase III: the current practices and perceptions of general medical practitioners (GPs) were assessed (Strand 1)[6], in-depth telephone interviews with GPs and personal interviews with key informants were conducted[7] (Strand 2) and methods for encouraging the uptake and utilization of a screening and brief intervention package by GPs were evaluated in a controlled trial[8-13] (Strand 3).

The aims of the WHO Collaborative Project are fully consistent with the *European Charter on Alcohol*[14] and with the *European Alcohol Action Plan*[15].

1.1.1. Rationale for the Phase IV study

Phase IV follows logically from the previous phases of the Collaborative Project and therefore began with the following question. Given that in previous phases of the WHO Project (i) an effective screening method has been developed for use with brief interventions in PHC, (ii) the effectiveness of a form of brief intervention in PHC has been demonstrated in a cross-cultural randomised controlled trial, and (iii) obstacles to widespread implementation of screening and brief intervention have been identified and methods for their initial dissemination and deployment in PHC have been evaluated, what remains to be done in this programme of research? The answer to this question, which forms the underlying rationale for Phase IV, is that what remains is the *development and application of country-wide strategies for the widespread, routine and enduring implementation of PHC early identification and brief intervention throughout participating countries*.

1.1.2. Comparison with earlier phases of the WHO Collaborative Project

Whereas earlier phases of the WHO Project consisted of a single study design adapted to the situation of each participating country, Phase IV is better described as a collection of similar studies. Thus, while all investigators shared the overall objective of the study, the specific design and procedures to be used were to a large extent flexible and varied among participating countries. This flexibility was necessary in order to take account of the very different systems of PHC to be found among the participating countries, as well as differences in political structures, the organisation of professional groups and other cultural and socio-economic factors influencing the process of practical implementation in PHC. Also countries varied in the extent of their technological sophistication and resources in the scientific disciplines relevant to Phase IV objectives and the methods used had to be adjusted to reflect these differences. It is important to note, however, that this flexibility was contained within clearly defined parameters and that all studies making up Phase IV shared four *common components* (to be described below).

While all these components were practically addressed in somewhat different ways, the most variable aspect of Phase IV study design was the *Demonstration Project* (see below) which was carried out according to a range of methodologies among the participating countries.

Phase IV was also a much more practical and policy-oriented group of studies than seen in previous phases of the WHO Project. Although quasi-experimental methods were used by some investigators, Phase IV as a whole is not an experimental study based on strictly controlled comparisons from which unambiguous conclusions may be drawn. Instead, it was in many ways an example of *action research* in which the central aim was to make a significant difference to the "real world" conditions under which brief interventions are disseminated in a particular country and to establish a programme of action leading to the widespread, country-wide implementation of early identification and brief intervention in PHC.

A further difference from previous phases was that, in terms of research methods, qualitative approaches often assumed equal or greater importance than quantitative methods in Phase IV (see Chapter 2).

Lastly, in contrast to previous phases, there was no natural end-point to Phase IV activities. This is firstly because the iterative nature of action research requires continuous improvements to the methods employed and the outcomes realised (see Chapter 2); there is no obvious point at which the work of the study can said to be finished. Secondly, as will become obvious throughout this Report, the central aim of the Phase IV study of achieving widespread, routine and enduring implementation of screening and brief intervention in PHC, presented formidable difficulties in all the participating countries and, as in other examples of desirable innovations in PHC practice, requires a long-term effort over many years. Thus, without exception, the work initiated in the Phase IV study will continue in all the countries taking part.

1.2. Broad Design Features

The broad design of Phase IV borrows heavily (with permission) from a report prepared by the Alcohol Research Center, University of Connecticut Health Center[16]. This report described a strategy for disseminating screening and brief intervention (SBI) for "risky drinking" in order to contribute towards a significant reduction in alcohol-related harm in the USA. As part of this strategy, four Action Points were described, as follows:

1) Create Customized Materials and Services
2) Reframe Understandings of Alcohol Issues
3) Establish Lead Organizations and Build Strategic Alliances
4) Establish and Evaluate Demonstrations

These headings provided the structure for WHO Phase IV and were addressed in one form or another by all participating centres. In contrast to the American plan, however, Phase IV was confined to PHC and did not include other areas of service delivery. Each of these components of Phase IV will be described in more detail in Chapter 2.

1.3. Definition of Terms

It will be useful here to define and discuss certain key terms employed in the study and in this Report.

a) In the American report[16], the activity it was desired to disseminate in PHC was known as "screening and brief intervention" (SBI). This term made the point that the objective was to develop and popularise the use in PHC settings of methods for identifying targets of intervention as well as the interventions themselves. The term had the further advantage of suggesting that it is complete *systems* of screening, intervention procedures and other components of brief intervention activity that were the focus of research[17].

Unfortunately, the term "screening" in this context was not appropriate for use in some countries participating in WHO Phase IV. This is because the term can be taken to imply population screening, an activity that is unpopular in some quarters. Thus the countries in question preferred the term "early identification and brief intervention" (EIBI). This term will be used in this Report by those investigators who prefer it. However, investigators from other countries taking part in Phase IV found "screening and brief intervention", and the abbreviation SBI, more useful for their purposes and were free to use this term if they wished to do so. It should also be noted that the term, "early identification" does not imply that drinkers' problems would inevitably deteriorate without intervention: "early" here merely refers to symptoms of alcohol dependence and problems having less severity than those found in more advanced alcohol dependence and which may sometimes lead to further deterioration and sometimes not.

b) Following the American report[16], the target behaviour in Phase IV studies was usually referred to as "risky drinking" and the target population as "risky drinkers". This term is similar to the WHO[18] concept of "hazardous drinking" (i.e., drinking above medically recommended levels for low-risk consumption but without current evidence of alcohol-related harm) but includes individuals who would fall into the WHO category of "harmful drinkers" in ICD-10[19] (i.e., those drinking above recommended levels and with evidence of concomitant alcohol-related harm). Risky drinking in this sense could be seen as synonymous with the term "excessive drinking" but is to be preferred for the social marketing purpose of communicating the aims of the research to people outside the study, the objective being to change the understanding of alcohol-related problems to include lesser degrees of severity and the recognition of hazardous consumption as being of concern. It is important to note that, within the general definition of risky drinking given here, individual centres participating in Phase IV showed slight variations in the meaning given to the term – depending, for example, whether or not some experience of alcohol-related harm was considered essential to identification for the purposes of brief intervention in local conditions of PHC.

Again, and in accordance with the flexibility of Phase IV, some investigators used alternative terms to denote the target population. The use of "hazardous drinkers" or "hazardous and harmful drinkers" has the advantage of being consistent with earlier WHO definitions[18,19] but may be less meaningful than "risky drinking" to the general public and professional workers whose understandings of alcohol problems it is hoped to influence. For scientific purposes, however, "hazardous and harmful drinkers" was preferred because of consistency with earlier phases of the WHO Collaborative Project. Whatever terms were used, participating centres were encouraged to provide a clear definition of the target population and a clear description of the identification process.

The target population specifically excluded drinkers showing a significant degree of alcohol dependence (i.e., showing recurrent withdrawal symptoms) and who were therefore deemed to need more than a brief intervention approach to their drinking problem. Although it is now commonly accepted that alcohol dependence exists on a continuum throughout the population of heavy drinkers[20], including low-dependence drinkers who are suitable for brief interventions, the excluded category will be referred to as "alcohol dependent", again for ease of communication with those outside the study. In practical terms, this means those individuals who meet criteria for a diagnosis of *alcohol dependence syndrome* in ICD-10[19].

c) In this study, "primary health care" was defined widely to include, for example, the work of occupational and school physicians. Also, the conditions of PHC varied widely among participating countries and the meaning of the term should therefore be taken to embrace all such variations.

1.4. Co-ordination and Conditions of Membership of Phase IV

The group of studies included in Phase IV was co-ordinated by the *Phase IV Co-ordinating Centre* in Newcastle upon Tyne, UK. At the inception of the study, this was collaboration between the *Centre for Alcohol and Drug Studies*, *Newcastle City Health NHS Trust* (Professor Nick Heather) and the *Department of Primary Health Care, University of Newcastle upon Tyne* (Dr. Eileen Kaner and Professor Brian McAvoy). Professor Heather was *Technical Focal Point* for Phase IV and took the lead in providing advice and assistance to study participants.

In its earlier stages, the Phase IV study was carried out under the auspices of the WHO Regional Office for Europe in Copenhagen and, in particular, by Dr. Peter Anderson and then Mr. Cees Goos. Towards the end of the project, however, support was provided by WHO headquarters in Geneva (Dr Isidore Obot).

A small grant from WHO Copenhagen was obtained to fund attendance at Phase IV meetings (see below) by investigators from eastern Europe and to cover the expenses of the Technical Foal Point when visiting participating countries. Apart from that, all participating centres were required to find their own research funding, including for attendance at Phase IV meetings, usually from institutions in their own countries.

1.4.1. Admission to Phase IV

The first step in the process of collaboration was for investigators from a research centre that desired to join Phase IV to complete the *Proforma* that is shown in condensed form in Appendix 1.1 and send it to the *Phase IV Co-ordinating Centre.* The Co-ordinating Centre then evaluated the Proforma and, if appropriate, recommended to the WHO Regional Office for Europe that the research centre in question be admitted to the study. This step was considered essential precisely because of the greater flexibility of Phase IV compared with earlier phases of the WHO Project; in this situation it was essential to ensure that all participating studies shared the common objective of widespread and enduring implementation of EIBI and also had plans adequately to address the 4 common components of Phase IV described above.

1.4.2. Meetings of investigators

Once a centre was admitted to Phase IV, the investigators in question were invited to attend regular meetings at various locations at which progress in the participating countries was reported and any difficulties experienced discussed. The *Co-ordinating Centre* was also available for consultation and technical assistance between these meetings.

The objectives and design of a study to follow Phase III were discussed between investigators at the later meetings of the Phase III study group. These meetings took place in Copenhagen, Denmark (September 1996), Besançon, France (April 1997) Sofia, Bulgaria (October 1997), Barcelona, Spain (May, 1998) and Udine, Italy (September 1998). The first formal meeting of Phase IV coincided with the final meeting of Phase III investigators in Sydney, Australia in January 1999. At this meeting a Study Protocol[21] for Phase IV was agreed (although this was subsequently modified in relatively minor ways as a result of experience in the study). Thereafter, meetings were held in Europe, initially at roughly 6-monthly intervals but later less frequently, at the following locations:

- Tampere, Finland (June 1999)
- Bled, Slovenia (January 2000)
- Brussels, Belgium (October 2000)
- Pécs, Hungary (September 2001)
- Geneva, Switzerland (May 2002)
- Paris, France (March 2003)
- Leiden, the Netherlands (October 2003)

The last meeting in Leiden was held in conjunction with an early meeting of the PHEPA research group (see below).

1.4.3 Website

To increase communication among investigators between meetings and also to provide information to interested parties outside the study, a website was established in 2001 http://www.who-alcohol-phaseiv.net. As well as giving a background to the study and current research methods, the website also contains individual pages for participating country where the products of each country study could be posted. Investigators were also encouraged to develop their own website for assisting the aim of Phase IV within their countries. The Phase IV international website is now managed by the Public Health Department of the Government of Catalonia in Barcelona.

1.4.4. Definition of "country"

The term "country-wide" rather than "national" was deliberately chosen in connection with Phase IV to allow for the possibility that the geographical region within which it is aimed to implement EIBI could be smaller than a nation state. Thus within the UK, for example, England rather than the United Kingdom as a whole was the geographical region in question. This was because Scotland and Northern Ireland had separate health systems from England and, as with Wales, had developed their own national strategies on alcohol-related harm; it therefore made little sense to attempt to disseminate SBI in the UK as a whole. Similar considerations applied to Catalonia in Spain and to Flanders in Belgium.

The main criterion for deciding what should be the geographical region at which Phase IV was aimed was that this region afforded the best opportunity to affect the widespread dissemination and implementation of EIBI. All that was required beyond this was that the geographical area is a recognized and well-defined region with a unique identity. This has the decided advantage of being able to take into account different administrative and legislative systems and, importantly, different systems of PHC.

1.4.5 Participation of different centres in the same country

It was also possible that two or more centres within the same country could be involved in Phase IV. For example, several areas might wish to carry out separate demonstration projects or might agree to take different roles in the customization process. In this eventuality, however, it was essential that the participating centres worked together in close collaboration and, in particular, that they produced one joint report on their country's combined activities in the Phase IV study.

In the event this applied only to Italy where originally 4 centres took part in Phase IV. However, these separate studies were co-ordinated by the *Istituto Superiore di Sanità* in Rome. Two studies later combined and all collaborated in sharing research methods. This is explained in greater detail in Chapter 11 which is a joint report of the work carried out in Italy as a whole.

1.4.6. Ethical approval

It was expected in Phase IV that participating investigators would be responsible for arranging ethical clearance from appropriate bodies in their own countries.

1.5. Related Projects

During the course of Phase IV, 3 separate projects were established that were relevant to the central aim of the WHO study and were, or still are, extremely useful in the attempt to reach widespread implementation of SBI.

1.5.1. The ECAToD project

In 1998, two Phase IV investigators, Dr. Pierluigi Struzzo (Municipality of Udine, Italy) and Dr. Leo Pas (*Vlaams Instituut,* Belgium) successfully applied for EU funding to enable 7 countries participating in Phase IV (Belgium, Bulgaria, Italy, Hungary, Russian Federation, Latvia and

Slovenia) to create a common methodology for carrying out qualitative research - the ECAToD Project. This was intended to define the essentials of European Community Actions supporting primary health care against Tobacco consumption and hazardous Drinking. It created the basis for a common approach to focus group and Delphi investigations which was especially useful in the customisation component of the Phase IV study in the Phase IV countries in question. ECAToD also aimed to stimulate links between the PHC setting and the local community in each country.

Meetings of the ECAToD researchers were usually held in conjuction with Phase IV meetings and were atteneded by the Phase IV Technical Focal Point and other Phase IV investigators as observers. References to the work of the ECAToD project will be found in the relevant chapters of this Report (Chapters 4, 9, 11, 12 and 13) and full details of work completed in a report to the European Commission[22].

1.5.2. PHEPA

In 2001, two investigators from the Phase IV study in Catalonia (Dr. Joan Colom and Dr. Antoni Gual), together with Dr. Peter Anderson, were successful in obtaining a grant from the European Union to fund a 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). This was funded by the EU as part of the *Community Action Programme on Public Health* and was 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 was completed at the end of June 2005. A total of 16 countries in the EU took part in the project, including the Phase IV countries of Belgium, Bulgaria, Denmark, England, Finland, France, Hungary, Italy and Slovenia, together with Eurocare and the WHO Regional Office for Europe.

The general aim of the project was similar to that of WHO Phase IV: to integrate health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals' daily clinical work. However, the specific aims of PHEPA entailed the development of 4 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;
(iv) *Country-based Strategies* aimed at integrating SBI for hazardous and harmful drinkers in the PHC systems of participating countries.

It is clear that PHEPA and the Phase IV study adopted somewhat different approaches to a common goal. The basic assumption of PHEPA was that standardised documents and materials, adjusted where necessary to the situations of individual countries, can accelerate the practical implementation of SBI in participating countries, whereas the basic assumption of the Phase IV study was that the conditions prevailing in each country, especially the conditions of PHC, were sufficiently distinct that countries needed to develop their own, unique SBI products. It is not obvious which of these two approaches is the more efficient for promoting widespread implementation of SBI. However, it is likely that the two approaches can work in harmony with each other to achieve their common purpose. Certainly, as several chapters in this Report suggest, the PHEPA products and the additional funding provided were and will continue to be of considerable assistance to the furthering the ambitions of Phase IV.

PHEPA has now been completed and the products above may be inspected by visiting the project website at http://www.phepa.net

1.5.3. INEBRIA

Towards the end of the Phase IV study, investigators discussed what should happen when the study finished and what measures at an international level could be taken to continue to pursue the study's aim. The conclusion was the need for an international network of individuals interested in research and practice n the field of alcohol SBI and, with the support of the Programme on Substance Abuse at WHO Geneva, this has now been established under the name of INEBRIA (International Network on Brief Interventions for Alcohol Problems).

The main aim of INEBRIA is: to promote wide implementation of brief interventions in a variety of settings for hazardous and harmful alcohol consumption at local, national and international levels. More specific objectives are:

i) To share information, experiences, research findings and expertise in the area of alcohol brief interventions.
ii) To facilitate training on brief interventions and provide assistance to countries and institutions to adapt and implement brief interventions, particularly with regard to the transfer of knowledge and technology from high income to low income countries.
iii) To promote best practice and develop guidelines for the wide dissemination and implementation of brief interventions.
iv) To identify gaps and needs for research in the field of alcohol brief interventions, promote international research co-operation and set standards for research in this field.
v) To integrate the study of brief interventions with the wider context of measures to prevent and reduce alcohol-related harm.
vi) To pay particular attention to the needs of young people in relation to alcohol brief interventions.

The initial membership of the network was made up of participants in the Phase IV study and PHEPA but membership is open to any individual with demonstrated experience in the area of brief interventions for alcohol problems, either from undertaking research or having implemented interventions in one or more settings.

Since the aim of Phase IV is far from being achieved in all the countries taking part and since ongoing support on an international basis is essential for progress toward this aim to continue to be made, INEBRIA is the ideal vehicle for this to occur. Additional information on INEBRIA is available from the network website http://www.inebria.net

1.6. Preparation of this Report

A total of 14 countries were represented at the beginning of Phase IV. Latvia dropped out roughly halfway through and no chapter for this Report has been received from Hungary. This leaves a total of 12 countries with chapters in the Report. As already pointed out above, the chapter for Italy includes 3 studies.

Investigators were asked to compile a short account of the progress of the Phase IV study in their country, beginning with general information on the country, its health services and its responses to alcohol problems etc., then focussing on the 4 components of the study separately (customisation; reframing; lead organisation and strategic alliance; demonstration project) and lastly stating what conclusions it was possible to draw from the study. It is important to note, however, that it was impossible in this document to provide anything like a full account of the work undertaken in each country simply for reasons of space. As a result, chapter authors were asked to provide references to published articles, other documents and websites where this more detailed information could be found and readers interested in knowing more about the Phase IV work in any particular country should pursue these leads. Information can also be found on the Phase IV international website http://www.who-alcohol-phaseiv.net.

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APPENDIX 1.1

PROFORMA FOR PHASE IV WHO COLLABORATIVE STUDY

IMPLEMENTING COUNTRY-WIDE EARLY IDENTIFICATION AND BRIEF INTERVENTION STRATEGIES IN PRIMARY HEALTH CARE

Aim: To develop and implement a strategy leading to widespread, routine and enduring delivery in primary health care of early identification and brief intervention for hazardous and harmful drinking in each participating country.

GENERAL DESCRIPTION OF PROJECT

Collaborative Centre*:*

Chief Investigators:

Geographical Area in which Implementation
Strategy will be Applied:

Starting Date (i.e. overall Phase IV project):

Completion Date:

Project Strands and Milestones:

Proposed Funding Sources:

Local Support:

CUSTOMIZING MATERIALS AND SERVICES
(participants and methods to be used)

Brief Intervention Package, including delivery systems:
(including method of delivery)

Early Identification (Screening):

Brief Intervention Process

Training of PHC Staff:

Data Analysis:

REFRAMING UNDERSTANDING OF ALCOHOL ISSUES
(Communications Strategy)

General Public:

Health Professionals:

Other Stakeholders:

Media Advocacy:

Control of Communications Strategy:

ESTABLISHING LEAD ORGANIZATION(S) AND BUILDING STRATEGIC ALLIANCES

Lead organization(s):

Building Strategic Alliances:
(list targeted organizations and methods to be used to build alliances)

DEMONSTRATION PROJECT(S)

Location(s):
(including population base & number of PHC facilities)

Projected Start Date:

Projected Completion Date:

Design of Project:
(e.g., randomized trial, quasi-experimental design, before-after study)

Outcome Measures:
(describe variables and how measured)

Process Measures:
(describe variables and how measured)

Economic Analysis:
(describe variables and how measured)

CHAPTER 2

METHODS

Nick Heather

2.1. Principles of Action Research

As stated in Chapter 1, the studies making up Phase IV are best thought of as examples of action research[1,2]. For present purposes, the main principles of action research, and what chiefly distinguished Phase IV research methods from the more conventional research approaches in earlier phases of the WHO Collaborative Project, are as follows:

i) whereas conventional research aims to increase knowledge of the world, action research aims directly to impact real-world conditions, in this case of PHC service delivery, as well as to increase knowledge;

ii) in action research the distinction between "researcher" and "subject" or "participant" breaks down. In Phase IV, PHC professionals were invited actively to collaborate with the research team in making progress towards the goal of the study;

iii) action research involves an iterative process in which research, action and evaluation are interlinked in a cyclical fashion;

iv) in action research qualitative methods are often more important than quantitative methods[3]. In this document, although some quantitative findings are reported, qualitative findings in the form of results of focus groups, interviews and Delphi surveys, form a prominent part of all chapters.

v) action research is especially suited to the goal of filling the gap between research evidence and practice, as in the field of SBI where impressive research evidence of effectiveness in PHC[e.g.,4-6] is accompanied by equally firm evidence of a failure to implement SBI in practice[e.g.,7].

Since an essential element of action research is evaluation of what has been achieved, evaluation formed a central part of the Phase IV study. Investigators were strongly encouraged to evaluate all aspects of their work on components of the Study Protocol in order to provide evidence of the extent to which stated aims had been realised. The Phase IV Co-ordinating Centre provided guidance on all relevant types of evaluation.

2.2. Component 1: Customising Materials and Services

In all countries taking part in Phase III of the WHO Project, the brief intervention package under study was the *Drink-less Programme*[8], used in conjunction with the AUDIT screening instrument[9]. This standardization of materials was necessary to meet the specific aims of the Phase III research programme. However, to meet the aim of Phase IV of achieving a widespread implementation of SBI in the particular PHC setting of each participating country, it was clearly necessary to adjust the SBI package to that country's specific needs and circumstances. An SBI dissemination strategy that did not take such country-wide factors into account would be unlikely to succeed.

In addition, in the course of conducting Phase III of the WHO Project, investigators in many of the participating countries noted various recommendations from GPs and other health care professionals regarding the specific form and contents of the SBI package, comments that stemmed mainly from the varying circumstances in which PHC was organized and delivered in each country. Finally, research findings on SBI had accumulated since the WHO Phases I and II, on which the *AUDIT Questionnaire*

and *the Drink-less Programme* were based, and these new findings provided the opportunity to improve important features of the SBI package.

As well as varying between participating countries, aspects of the SBI package in Phase IV could also vary to some extent *within* countries. For example, different methods of early identification and brief intervention procedures may be appropriate to different health professional groups within a country.

Aspects of the SBI package that could be revised in Phase IV included early identification methods, length of intervention, intervention procedures, intervention materials, responsible personnel, training methods and the strategy used to reframe understandings of alcohol-related issues (see below). There was found to be no reason, however, why the *AUDIT Questionnaire* or the *Drink-less Programme* should not be retained, either in whole or in part and in original or modified form. Whatever form the revised SBI package took, it was as far as possible based on research evidence. When a novel early identification instrument was used, it was supported as far as possible by evidence of reliability and validity.

2.2.1. Focus groups

The main research method used in the customisation process was the focus group[10]. Training in focus group methodology and advice on specific contents and procedures to be used was provided to investigators by the *Phase IV Focus Group Centre.* This centre represented a collaboration between the *Vlaams Huisartsen Instituut* in Belgium (Dr. Leo Pas) and the *Healthy City of Udine Project* in Italy (Dr. Pierluigi Struzzo). As stated in Chapter 1, Drs. Pas and Struzzo also co-ordinated an EU-funded project (ECAToD) in which the focus group was the leading research method. A document entitled, *Guidance Notes on Focus Group Methodology*[11] was prepared by the Phase IV Co-ordinating Centre for use by all Phase IV investigators.

Groups consisted primarily of health care professionals who were asked to discuss barriers to the implementation of SBI in PHC, how these barriers might best be overcome and how an SBI package should be developed to facilitate dissemination and implementation in the conditions of PHC of the country in question. It was not considered necessary to ensure that members of the groups were statistically representative of all PHC professionals in the participating country; rather, group members were selected from convenience samples chosen for the relevance of their knowledge and experience to the aims of the study. If possible, members of focus group worked in the geographical area or areas that later became locations of demonstration projects (see below) in order to prepare the ground for these projects and provide a link between strands of the overall Phase IV investigation.

Groups were composed either of single professional or mixed professional affiliations and both single and mixed groups were sometimes used in a participating country. In the case of single professional groups, there could be separate groups of (i) general practitioners, (ii) practice nurses, (iii) medical receptionists, (iv) practice managers; and (v) other health care professionals. In the case of mixed professional groups, a suitable representation of relevant professions was assembled. The actual professions involved in these groups and the scope of their involvement in SBI depended on the nature of PHC in each participating country.

For countries that took part in Phase III of the WHO Project, focus groups sometimes comprised PHC personnel who were involved in Strand 3 of Phase III. This consisted of randomized controlled trials of dissemination methods and of PHC support conditions in which *the AUDIT Questionnaire* and *the Drink-less Programme* were used. Care was taken to include individuals with varying responses to the early identification method and/or the intervention - for example, those who inspected and rejected the SBI package, those who used it but only to a minor extent and those who used it more extensively. A mixture of positive and negative attitudes to SBI in each group was thought desirable.

For countries that did not take part in the previous Strand 3 study, there was nevertheless an attempt to include PHC professionals with experience of and/or considered attitudes to SBI. Selection of individuals for the focus groups could have been preceded by a short questionnaire asking about attitudes to SBI and willingness to take part in focus groups.

Another type of focus group that was run was with potential recipients of the SBI package, i.e., patients attending PHC facilities or simply members of the general public who sometimes made use of PHC. It was thought important to obtain patients' or potential patients' perspectives on the contents and delivery of SBI. Issues for discussion included ways in which early identification procedures could be carried out to avoid giving offence or making patients defensive about their drinking habits, the conditions in which advice from doctors or nurses would most likely to be effective, the kind of advice and guidance patients would most welcome, problems such as constraints on patients' time and how these might be overcome, and several other issues. Focus groups included patients with hazardous levels of alcohol consumption and those under such levels, either in separate or mixed groups.

2.2.2. One-to-one semi-structured interviews

Information from focus groups was sometimes supplemented by a set of one-to-one interviews with a convenience sample of PHC professionals. These interviews aimed to include the full range of professional affiliations that might be involved in SBI work, a full representation of types of PHC delivery applying in the country in question (e.g. solo and group practices, urban and rural settings), and a mixture of gender, age and experience of PHC workers. If possible, subjects of interviews had some experience of and possessed some knowledge about the delivery of SBI in PHC or, at least, some involvement with health promotion and/or secondary prevention of other behavioural problems. Interviews with Key Informants having a close involvement with and influence on the practice of SBI in a country were considered especially relevant.

2.2.3. Structured questionnaires

In some participating countries, structured questionnaires were used to supplement information obtained from focus groups and semi-structured interviews. This applied particularly to countries that did not take part in the questionnaire study forming part of Phase III (i.e., Strand 1). The contents of these questionnaires were determined by the requirements of the particular country in question but were circulated among the group of investigators for possible use in other countries.

2.2.4. Delphi surveys

A Delphi survey is essentially a series of questionnaires that are sent out to a selected "expert" panel in rounds[12]. At the end of each of these rounds a new questionnaire is developed from the responses to the preceding questionnaire. In a typical Delphi survey, the first questionnaire gathers qualitative data so that the panel are able to freely express their opinions on the topic. The responses to the first questionnaire are then gathered into statements and grouped under headings, forming the basis of the second questionnaire. The second questionnaire asks the respondents to use a Likert scale to indicate how much they agree or disagree with the items generated by the panel as a whole. The third questionnaire contains the same statements as the second, while also including statistics showing the respondents' initial response and the average group rating. The respondents then have the opportunity to re-rank their agreement with each statement in the light of the group's response. This process is then repeated until consensus is achieved.

The Delphi is therefore a multi-stage technique with each stage building on the previous one, generating individual judgements on a particular question and combining them to form a consensus. The Delphi relies on the opinions of an expert panel that is selected for knowledge and experience in a chosen area of study. This method clearly had potential usefulness in the Phase IV study as a method of soliciting the views of, and forming a consensus among, all those with expert knowledge of SBI in a participating country.

2.2.5. Data analysis

Data from both focus groups and one-to-one interviews were analysed using a range of techniques, including content analysis involving both coding of categories and thematic analysis. Once more, the *Phase IV Focus Group Centre* provided guidelines for these analyses. Where possible, output from focus groups and interviews regarding the appropriateness and efficiency of various aspects of the SBI package were combined with information from Strands 1 and 2 of Phase III in participating countries and/or from the results of structured questionnaires in countries that did not take part in Phase III. Findings were also placed in the context of national and international research relevant to the SBI customisation process. The *Phase IV Focus Group Centre* and the *Phase IV Co-ordinating Centre* in Newcastle gave guidance on the conduct and analysis of Delphi studies.

2.2.6. Customisation of SBI training.

A further element of the complete SBI package that required customisation was the training programme that would be used to familiarise PHC staff with the rationale, principles, methods and procedures of SBI. The objective here was for each country to develop an SBI training programme specific to its own PHC requirements. Focus groups (either the same groups as for the customisation of the SBI package itself or different focus groups) were used for this purpose. As before, relevant information from the Phase III study, if it had been carried out in the country in question, were used to structure the themes of the focus groups or to augment the findings from the groups; information from all strands of the Phase III study could have been used here.

There was seen to be no reason why the training model in a particular country should not take full advantage of the extensive international literature that exists on this topic. More specifically, it was possible to make use of, or at least adapt, existing training packages that have been extensively used in the brief interventions field. Examples are the *Helping People Change* package, that was developed by the Health Education Authority in the UK[13] , and the WHO's *Skills for Change*[14]. In these packages, both the Core and Alcohol modules could be used. Other packages were designed to be more appropriate to local needs. Dr. Antoni Gual of the *Departament de Sanitat, Generalitat de Catalunya* provided feedback to other investigators regarding use of the *Skills for Change* package in Catalonia and, more generally, was responsible for providing consultation and advice on training aspects of Phase IV studies.

2.3. Component 2: Reframing Understanding of Alcohol Issues

Parallel with the customisation of the SBI package, and to support the dissemination of SBI in the participating country, communication strategies were developed and applied. The main aim of these strategies was to communicate a better understanding of the concept of "risky drinking" (or whatever term was preferred) among relevant professional groups and, if possible, the general public. Without such an improved understanding of the fundamental rationale for SBI, no attempt at widespread dissemination could be expected to succeed in the long term.

The communications strategy was usually linked to a demonstration project (see below) and was aimed in part at preparing the ground for that project to succeed. The strategy was therefore typically concentrated in the first instance on the local area in which the demonstration project was to take place.

One of the main obstacles to understanding what is meant by risky drinking is the concept of "alcoholism". This is probably the only form of alcohol-related harm that is recognized by most members of the public and by many professionals in participating countries. While no attempt was made to demean the problems and suffering of those with severe alcohol dependence or of their loved-ones, or to seek to diminish the resources that should be devoted to the treatment of severe dependence, one of the chief objectives of the communications strategy was to "reframe" understanding of alcohol-related harm. The idea was to be conveyed that much harm is experienced, and much damage to the social fabric brought about, by people whose alcohol problems are less

severe than those of "alcoholics". Although "early intervention" is by no means the sole aim of PHC brief interventions, it is an aim that is readily understandable by health care professionals and the general public alike and it therefore formed a prominent part of communications strategies.

A great deal of ingenuity and creativity was needed to achieve the aims of the communications strategy in each country. It was also necessary in some countries to employ the services of a *communications specialist*. This specialist was typically someone with communications expertise in the community prevention area and was found at a local university or in the local health system.

Focus groups could once again be used in the development of the communications strategy and information relevant to all aspects of the strategy could be acquired in this way. The focus groups in question were specially arranged for the purposes of the communications strategy or were the same focus groups used in the customisation of the SBI package and the training model.

Communications strategies in each country were able to take advantage of previous work on the communications aspects of various Community Action Projects aimed at reducing alcohol-related harm[15-20]. However, it is important to note that this input from Community Action Projects was confined to the circumscribed objectives of (i) changing the understanding of alcohol issues among the general public and professional groups within a local community to include the concept of "risky drinking", and (ii) encouraging users of PHC to request advice and help regarding risky drinking or, at least, not to resent the offer of such help.

2.3.1. The communications targets

There were 3 targets of the communications strategy: the general public, health professionals and other stakeholders.

The general public

Effective communication of the concept of risky drinking among the general public would almost certainly require a fully-fledged mass media campaign and this was too expensive for Phase IV participating countries, at least during the study itself. For this reason, the general public element of the Phase IV communications strategy was *optional*. It was, however, possible that, in those countries deciding not to implement this element of the strategy, a mass media campaign could be delivered at a later time - for example, following the building of a strategic alliance in which central government agencies and other bodies with the resources necessary to fund a media campaign were fully involved.

When a general public media communications element was implemented, it should, in addition to communicating the concept of risky drinking to the public, also have encouraged members of the public to ask their GP or other PHC worker about drinking and whether or not they should cut down. In an effective media campaign, the public should be informed that, provided dependence and problems have not progressed too far, it is not necessary in most cases to abstain from alcohol completely as a solution to a drinking problem. Although information to the public on limits for "responsible" drinking will already be available in many countries, these limits should be strongly reinforced. It is essential that risky drinkers among the public are given confidence that, if they are motivated to do so, drinking problems can be solved and that the PHC services available to them will provide the assistance they need.

Health professionals

Professionals working in PHC need education on the concept of risky drinking and, where necessary, modification of their understanding of "alcoholism". They also need to understand that they in fact see risky drinkers every day of their working lives, without in most instances being aware of this. It was also essential to communicate that, provided it is done in the right way, raising the issue of drinking will not alienate their patients and that the professional can be instrumental in enabling a risky drinker to cut down to low-risk levels. Above all, PHC professionals need to be convinced of the

widespread damage to public health and welfare of risky drinking. The good evidence on the effectiveness and cost-effectiveness of SBI needs also to be clearly communicated.
Although they varied from country to country to take account of the local cultural context of PHC, messages aimed at health professionals represented the most immediately relevant and affordable element of the communications strategy. Reframed understanding on the part of health professionals should have helped to change the general publics' understanding of alcohol-related issues and vice-versa.

Other stakeholders
A further category of targets for the communication strategy was other people in the local community who clearly had a stake, or could be persuaded to have a stake, in the reduction of risky drinking. These mainly consisted of influential figures in the health services, social services, local government authorities, volunteer groups and other organizations and institutions with the power to affect the dissemination process. The more that different sectors of the community can be involved in the communications strategy, the more likely it will be to succeed.

2.3.2. Methods of communication

As stated above, it was necessary in some participating countries to employ the services of a communications specialist to assist the communications strategy. This person was usually someone with experience in community action projects in the alcohol field or in another field of prevention. This specialist input could be directed to:

(i) developing messages that are most likely to have an impact on their intended audience;
(ii) identifying the best means of delivering these messages (word, graphics, audio, video or multimedia);
(iii) the most appropriate communication vehicles (mail, telephone, TV, radio, Internet, newspapers, billboards, posters in waiting rooms, etc.) for each of the messages, especially with respect to dissemination at a local level.

There was obviously a need for different messages and different means of communication for each of the 3 target groups listed above. Even within one of the target groups, it should have been decided which general approach is best suited to the target group and whether messages needed to be further targeted at specific sub-groups (e.g. different messages for young and older members of the community or for male and female targets.)

2.3.3. Media advocacy

Another aspect of the communications strategy was an attempt to create links with local journalists to increase their interest in alcohol-related issues and persuade them to promote the concept of risky drinking in their work. An attempt at media advocacy during the Lahti project[20] met with only limited success due to the very different agendas of journalists and health professionals. Nevertheless, under the right conditions, media advocacy could assist the communications strategy.

2.3.4. Evaluating the communications strategy

The communications strategy could be evaluated by pre- and post-strategy measures of the extent to which respondents understood and accepted the concept of risky drinking and other related matters. Among the general public this could be done by mailing questionnaires to a random sample of the local community or by face-to-face interviews in community settings. Among health professionals and other stakeholders, mailed questionnaires, telephone or personal interviews could be used to record changes in attitudes to EIBI and risky drinking. These evaluations could either be made part of the evaluation of the demonstration project, assuming that the communications strategy is carried out concurrently with the project, or done independently.

Investigators were encouraged to keep a record of local initiatives carried out as part of the communications strategy, qualitative data on the response to these initiatives and evidence on how they were thought to have impacted on the implementation strategy at a local level.

2.4. Component 3: Establishing Lead Organizations and Building Strategic Alliances

In most country studies, this component began simultaneously with the customisation process and the communications strategy and continued throughout the study. The objective of this component was to build a network of organizations and individuals in the participating country who were willing to work together to promote the widespread implementation of SBI in PHC.

2.4.1. The lead organisation

To begin the process of disseminating SBI in each country, it was necessary to establish a lead organisation. The function of this organization was to take the lead in developing a co-ordinated, country-wide approach to the promotion of SBI in the participating country. Its major objective was to bring together individuals and organizations with an interest in SBI in a spirit of co-operation, mutually expected benefits and effective partnership. It was obviously essential that the lead organization was adequately funded and resourced to achieve these aims.

In those countries that took part previously in the WHO Project, the lead organization was naturally the base(s) of the current or past WHO investigator(s) but other scientists and practitioners with needed expertise and established working relationships with the lead organization could be brought into its ambit. For countries without previous participation in the WHO Project, the lead organization was a centre or a network of centres with a special interest in, understanding of and enthusiasm for the promotion of SBI in PHC. Existing academic or professional involvement in the country's PHC system was a distinct advantage.

The lead organisation could also act as a "laboratory of learning" with regard to SBI in general and PHC-based SBI in particular. This involved:

(i) gathering and converting to user-friendly form the existing research evidence and practical experience bearing on the effectiveness of SBI and its various modes of delivery;
(ii) assembling a collection of SBI materials (e.g. early identification instruments, intervention manuals, self-help publications) with translation to local languages where necessary;
(iii) developing expertise in areas such as SBI training and communication methods.

In short, the lead organization aimed to establish for itself a reputation throughout the country for knowledge and know-how in SBI to which interested parties could turn for expert technical advice and assistance.

It was also thought essential to the success of the strategy that, as it develops, the lead organization should adopt an increasingly low profile. Although strong and active leadership was needed at first, attempted alliances in which one partner is seen as dominant would be unlikely to continue to work. Rather, ways were sought to ensure that the implementation strategy was felt to be "owned" by those joining in and was seen as a broadly-based and equal collaboration with tangible benefits to all.

2.4.2. Building strategic alliances

However skilled and knowledgeable the lead organisation, it would not be able to achieve, or even begin to achieve, a country-wide dissemination of SBI on its own. It therefore had to attempt to bring together into an effective alliance all the many individuals and organizations in the participating country who had an essential role to play in the implementation strategy. The targets for these efforts could have included any of the following:

(i) Central and local government agencies responsible for funding and supporting special initiatives and innovative projects in PHC. Agencies with the power to vary the reward structures and conditions of service in PHC were crucial here. Government departments responsible for public health, if such separate departments existed, were clearly of the utmost importance in this regard.

(ii) Central government and other agencies interested in funding research into the reduction of alcohol-related harm through PHC services.

(iii) Prominent scientists, academics and practitioners with the influence to affect thinking in crucial areas (e.g. PHC, treatment and prevention of alcohol problems, training for PHC professionals).

(iv) Key educational and research institutions with expertise in SBI and/or in the development of intervention and training materials and methods.

(v) Professional associations with the power to set the agenda for particular service sectors, e.g. colleges of general practitioners, nurses, medical social workers, psychologists, etc..

(vi) All agencies in the country that had acquired valuable experience in the delivery of PHC-based SBI.

(vii) Charities, voluntary organizations and community groups that could contribute to the implementation strategy, particularly with respect to communicating the concept of risky drinking among the general public. Elected representatives of the community were key individuals to be included here.

(viii) Health insurance companies that might have a special interest in the aims of the study and could be approached as sponsors.

The exact composition of these key players obviously varied considerably between participating countries. The building of strategic alliances is also an evolving process and will continue after the Phase IV study has formally ended. However, the central thrust of these alliances is the development, refinement and implementation of a workable and widely-supported, country-wide plan or policy for disseminating SBI in PHC. The adoption and promotion of such a plan by central government is clearly one important landmark in this process.

2.5. Component 4: Establishing and Evaluating Demonstrations

The Study Protocol stipulated that, following the customisation of materials and services, the commencement of a communications strategy for reframing understanding of alcohol issues and the formation of collaborative relationships with relevant bodies on local and national levels, each country taking part in Phase IV should then undertake one or more *demonstration projects*. These projects were aimed at showing that widespread dissemination of SBI in PHC in a local area was possible and could served as models for similar applications throughout the country. The demonstration project(s) also aimed to show, within the limitations of what was typically an uncontrolled study, that widespread dissemination of SBI is effective in reducing alcohol-related harm and the burden of costs imposed on the local community by that harm. Lastly, demonstration projects were intended to generate valuable lessons regarding the practicalities of disseminating and delivering SBI that could be fed back to the overall implementation strategy in an iterative process (see below).

In somewhat more detail, these demonstration projects had 3 elements based on the achievements of earlier components of the study, i.e., the customized SBI package, the SBI training programme and the communications strategy. These supported direct efforts to disseminate and maintain the use of the

SBI package in PHC in the local community using the contacts that had begun to be developed during the establishment of the lead organization. The key objective was not to produce "scientific proof" of the effectiveness of widely-disseminated SBI but rather to provide a practical demonstration of how it can be achieved, with if possible some evidence of its impact on alcohol-related harm and its costs to the community. As already suggested, the wider objective of the project(s) was to strengthen the country-wide SBI strategy by providing a practical demonstration of feasibility and benefits.

2.5.1. Design of the demonstration project(s)

The design of demonstration project or projects was again a flexible aspect of Phase IV and is perhaps the main illustration of this flexibility. Some countries could have conducted a formal quasi-experimental study in which an experimental area where the SBI implementation strategy was put into effect was compared to a control area matched on key variables (e.g. population size, socio-economic composition, density of PHC services, previous experience with SBI) where it was not. It was even possible in principle to randomise local areas within a larger geographical region to experimental or control conditions, although this required some geographical and other separation between the local areas in order to avoid "contamination" of control areas by the SBI dissemination.

In the majority of countries taking part in Phase IV, however, such quasi-experimental designs were too expensive to implement and/or infeasible for other reasons. In these cases, a simple "before-after" design (i.e., with baseline and outcome measures) was considered adequate for the Phase IV demonstration project.

2.5.2. Location

Since the demonstration projects envisaged in Phase IV did not necessarily require the selection of a control group, a wide range of communities could be considered as locations. Given that the objective was to demonstrate the expected benefits of SBI, selection could be based on enthusiasm by administrators and policy makers regarding the possible benefits of SBI and the convenience of the location to the investigators. It was obviously necessary, however, that the location(s) could be considered to be a setting for the dissemination of SBI that was in some way "typical" of the country in question.

2.5.3. Evaluating demonstration projects

Outcome measures

The main outcome measures used in the demonstration projects were aimed at measuring the project's success in achieving widespread, routine and enduring implementation of SBI in the PHC setting. Thus there were to be baseline and follow-up measures, at least, of the number of GPs or other health professionals who screened and intervened for risky drinking patients and the extent to which they did so, including rates at which eligible patients were screened and risky drinkers received brief intervention. These rates were to be measured at various intervals between baseline and final follow-up and be taken over a time period sufficiently long to make a reasonable inference about their enduring quality. They were similar in principle to those used in Strand 3 of the Phase III study but applied to the entire population of PHC services within a community.

As additional outcome measures, changes in knowledge of relevant alcohol issues and attitudes towards SBI were also recorded. There was also attention paid to the attitudes and responses of patients to early identification and intervention for risky drinking, although this fell far short of a general test of the effectiveness of SBI since this was considered to have been already firmly established.

A survey of Phase IV investigators was conducted, on behalf of the Phase IV Co-ordinating Centre, by Professor Kaija Seppä of the University of Tampere, Finland. This resulted in the identification of a common set of measurement domains and suggested measurement techniques for use in Phase IV demonstration projects. These were included in a document prepared by the Phase IV Co-ordinating

Centre entitled, *Guidance Notes on Measurement and Evaluation*[21] and distributed to all Phase IV investigators.

Process measures
In order to gather information on process variables (e.g. relating to how and why the SBI package is effective in leading to reduced alcohol consumption and the circumstances in which it is not effective), it was possible to conduct in-depth interviews with a small, representative sample of patients who had received the brief intervention package. This sample should have included both patients who appeared to have benefited from the intervention and those who had not. In-depth interviews could be supplemented by structured or semi-structured questionnaires to gather data on the process of change among patients. Data on the intervention process could also be obtained from PHC personnel, again using a variety of methods.

Quality assurance in demonstration projects
There should also have been some attempt at quality assurance with respect to the delivery of the SBI package, i.e., to ensure that early identification and brief intervention procedures were being delivered as they were intended to be delivered and had not "drifted" to some less effective form in the process of dissemination.

Community-wide measures
Outcome measures could also have included changes in community-wide indices of alcohol-related harm, where these were available, e.g. rates of drink-driving convictions, rates of drunkenness convictions, diagnoses of alcohol-related diseases, alcohol-related health care utilisation data, reports of accidents involving alcohol, alcohol sales figures, requests to laboratories for GGT readings and for other markers of alcohol consumption. The nature of the measures in question depended on the types of data available within each country context.

2.6. Economic evaluation

Of considerable importance to the development of a country-wide dissemination strategy is the demonstration that the widespread implementation of PHC-based SBI in a particular community brings economic benefits to that community in terms of reduced health care and wider costs, if indeed such cost savings can be shown.

For this purpose, an ideal study design would be to follow-up and interview a random sample of patients who have received SBI and measure changes in the costs of their use of health services before and after intervention. Community-wide indices of alcohol-related harm could also be used to estimate savings to the community arising from changes in these variables. The economic evaluation as a whole should obviously take into account the full costs associated with the SBI package and the linked training programme. It might sometimes possible from the data gathered during a demonstration project to develop an economic simulation of the costs and benefits attached to widespread implementation of SBI in a participating country. The expert advice of a *health economist* was needed for all these aspects of economic evaluation.

Advice on this aspect of Phase IV was be provided by the Phase IV Co-ordinating Centre in collaboration with Professor Christine Godfrey of the *Centre for Health Economics, University of York, UK.* Professor Godfrey attended a meeting of Phase IV investigators (in Bled, Slovenia, January 2000) to run a workshop on how an economic evaluation could be carried out within the budget constraints affecting most country studies. She also collaborated with the Phase IV Co-ordinating centre to produce a document on *Costing EIBI*[225] which was distributed among investigators.

2.7. An Iterative process

It has already been made clear that the activities of Phase IV represent an ongoing and iterative process that will continue after the study itself has formally ended. This applies especially to lessons

learned from demonstration projects regarding the best way to deliver SBI and the best way to disseminate it in PHC. There is every reason to expect that the SBI package, the training methods associated with it, the strategy used to reframe understanding of alcohol issues and the means used to disseminate SBI in PHC can be continually refined and improved. It is also likely that materials and methods will need to be periodically revised to adjust to changing circumstances of PHC in participating countries. At the very least, the experience gained from demonstration projects conducted during the Phase IV study itself, in combination with the products of PHEPA and other relevant research, will be used to improve the customisation process and the other elements of the overall strategy.

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CHAPTER 3

AUSTRALIA

Carla Schlesinger, John B. Saunders & Elizabeth Proude

3.1. Introduction

3.1.1. Country description

Australia is an island continent in the Southern Pacific with a large land mass and a relatively small population of 20,012,948[1]. Indigenous Australians number 386,000 (approximately 2% of the population). Like other Western countries, the population is ageing, with a median age of 35.4 years in June 2001, compared with 29.6 years in 1981[1]. The distribution of the population aged 15-64 years has steadily increased, with an added increase in the proportion of those aged 65 years or more. In contrast, the proportion of children 0–14 years has steadily decreased, resulting in a shift in the age structure, and proportionate with the ageing population.

Australia's national health care delivery system covers all permanent residents of Australia and is largely financed by general taxes. In 2000-01 there were 726 public hospitals recorded nationally (excluding psychiatric hospitals). Private hospitals, which once provided uncomplicated non-emergency care, are today providing complex high technology services. The private sector primarily consists of medical and paramedical professionals who are self-employed and provide general practice services and specialist services (such as internal medicine, diagnostic imaging, pathology and physiotherapy). An increasing number of people are covered by private health insurance, particularly following the introduction of Lifetime Health Cover in 2000, which saw a rapid rise from 32% to 46% during 2000. Australia has 123 divisions of general practice, and in June 1995 there were 22,298 general practice and specialist medical businesses.

3.1.2. Alcohol-related problems in Australia

Over 85% of the general population of Australia drink alcohol at least occasionally. Alcohol use is not restricted to specific population groups or geographical areas. Per capita, Australians drink 7.7 litres of pure alcohol per year, comprising 101 litres of beer, 18.6 litres of wine and 1.1 litres of spirits. In 1991, Australia was ranked 17th in the world, and second among English-speaking countries in terms of total alcohol consumption.

Alcohol misuse continues to be a major health and social problem[1]. It remains one of the two major causes of substance-related mortality in Australia, accounting for approximately 5% of all deaths, translating to an average of 15.2 years of life lost per death[2]. It causes 50% of all motor vehicle accidents and is also a significant contributing or exacerbating factor for many health problems, including national health priority areas of injury, mental health, and cancer[3,4]. Australian Hospital episodes attributable to alcohol use can be seen in Table 1.

3.1.3. Brief history of responses to alcohol consumption

Traditionally, national responses to alcohol misuse have concentrated on the treatment of drinkers who are experiencing problems or who meet clinical criteria for alcohol dependence. Today, more treatment is conducted within a primary health care setting. Although general practitioners (GPs) are not highly engaged in this field of work, promising developments include the availability of the alcohol pharmacotherapies, such as acamprosate and naltrexone from 2000, and the establishment of the Australian Chapter of Addiction Medicine in 2002.

TABLE 3.1

Alcohol-Attributable Hospital Episodes in Australia, by Age and Principal Diagnosis (1997-1998)

Principal Diagnosis	Age Group				
	0-14	15-34	35-64	65+	Total
Cancer	-	113	3,078	2,849	6,040
Alcoholism & liver cirrhosis	278	5,864	16,726	2,890	25,758
Cardiovascular disease	-	208	-7,622	-10,541	-17,955
Road injuries	410	3,711	1,442	283	5,846
Other	346	15,311	9,970	-2,284	23,343
Total	1,034	25,207	23,594	-6,803	43,032

Source: Ridolfo & Stevenson (2001)[5]

3.1.4. The place of brief interventions

Brief interventions have been developed for several forms of substance use now, most notably alcohol. There has been support for this approach by the Federal Government of Australia and state health departments.

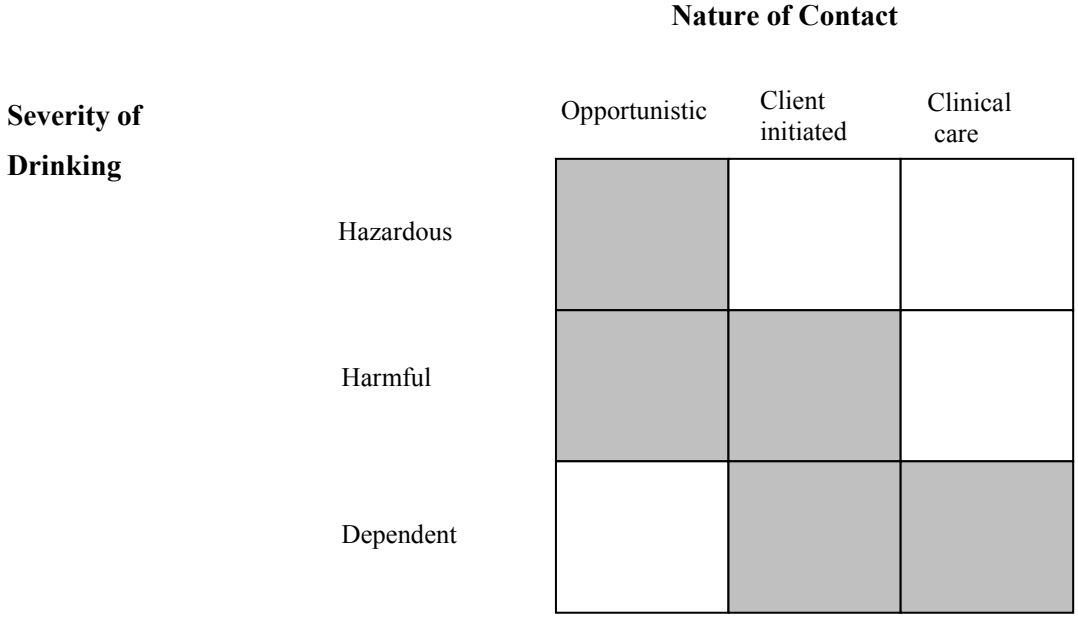
Brief interventions for hazardous and harmful drinking are broadly supported within the framework of the *Smoking, Nutrition, Alcohol and Physical activity* (SNAP) framework of the Commonwealth Department of Health and Ageing. As one of its primary aims, SNAP seeks to reduce the rates of hazardous and harmful alcohol use in Australia. The SNAP implementation group view general practice as being well-placed to act as advocates for health promotion, and achieve change in the risk status of individuals consuming alcohol at unsafe levels.

The concept of brief intervention in Australia is similar to that elsewhere. These interventions are designed to be delivered after hazardous consumption or an alcohol problem has been initiated by the client or identified opportunistically (see Figure 1). Support for this approach corresponds with the national shift towards prevention and early intervention, rather than late-stage treatment[6]. The goal of brief intervention is to help individuals reduce or eliminate hazardous and harmful alcohol use, thereby avoiding or minimising harmful consequences. With an overarching aim of encouraging responsible drinking behaviour, brief interventions incorporate psycho-education on drinking and its consequences, motivational and cognitive-behavioural principles[7], clear targets for reduced drinking and a series of step-by-step strategies to achieve it. Brief interventions have the additional benefit of being delivered in a manner that is personalised and free from judgement. Examples of brief interventions for alcohol developed in Australia include the 'Drinkcheck' and 'Drink-Less'[8], which are derived from those developed for the WHO Phase II trial, and 'AlcoholScreen'[9].

Australian investigators have identified that brief interventions are best implemented within a general medical practice setting, due to a number of advantages over other professional settings.

FIGURE 3.1

3x3 matrix of the interaction between different types of drinkers and the nature of treatment contact. Grey areas indicate the point of contact.



First, GPs are generally the initial and most frequent point of contact between the general community and the health care system. Second, hazardous and harmful drinkers present twice as often to primary health care as other patients[10]. Third, GPs are accepted as an authoritative source of health advice[11], with studies indicating that Australian patients expect and value being asked about alcohol intake during a medical consultation[12], possibly because this setting does not have the stigma associated with specialised treatment facilities. However, there still remains a gulf between the potential and the reality, which will be discussed below.

3.1.5. The evidence-base for screening and brief intervention

Internationally, there is now compelling evidence for the effectiveness of both screening and brief intervention to reduce hazardous and harmful alcohol consumption. Several meta-analyses of brief intervention trials have been published to date[12-14]. The latest study by Moyer et al.[14] showed a significant positive effect of brief intervention compared with control in 29 of 32 randomised controlled trials, with an average reduction in alcohol intake of 20%. There was no significant benefit of extended treatment compared with a brief intervention. In the WHO Brief Intervention trial, conducted in Australia and internationally, a 5-minute intervention reduced hazardous consumption by 27-30% compared with a non-intervention control group[15,16], with corresponding reductions in alcohol problem scores and biochemical abnormalities. In summary, brief interventions for hazardous and harmful alcohol consumption are well supported by the scientific literature and are considered among the most cost-effective internationally[17].

3.1.6. Evidence-base for the training of GPs in providing brief interventions

There is a paucity of studies examining the effectiveness of training for GPs in providing brief interventions. The Australian arm of the Phase III of the WHO Collaborative Project, we examined training and support strategies for GPs. Onsite training, with the provision of attractive and user-friendly resource material, was found to be the most acceptable and achievable approach.

Internationally, best practice methods have been established for training GPs in providing screening and brief intervention. A systematic review of 102 randomised controlled trials of continuing medical education (CME) interventions to improve professional practice was conducted by Oxman and colleagues[18]. Results suggested that onsite training (educational outreach or academic detailing) was an effective educational approach for improving preventive medical approaches and screening. Therefore, onsite training is one of the few educational methods which has continuously demonstrated improved practitioner performance in the prevention and management of alcohol and substance misuse generally[19,20].

The cost-effectiveness of onsite training has been investigated. Wutzke et al.[20] examined the effectiveness of the Drink-Less intervention package as applied to (1) the costs associated with marketing the package to practitioners, (2) training and support costs, and (3) the costs of providing a brief intervention to 'at risk' drinkers. Results indicated that onsite training was cost-effective in promoting the uptake of brief interventions by practitioners, with increased numbers accepting the package, and an increase in number of patients subsequently screened.

3.2. Involvement in the WHO Brief Intervention Collaborative Studies

Australia has been a partner in the WHO collaborative studies since their inception in 1983. Australian investigators took a lead role in Phase I (John B. Saunders, Technical Focal Point 1985-1989) and Phase III (John B Saunders and Michelle Gomel, Technical Focal Points, 1992-1998). Accordingly, the Australian team was well-placed to embark upon Phase IV and engage in the systematic investigation of dissemination of brief interventions. The Australian team contributed to the development of the Phase IV Study Protocol and incorporated it into the local protocol and into several grant applications. Due to a number of factors, including a lack of finding, only partial achievements can be reported for Phase IV.

3.2.1. Formation of a Lead Organisation and Strategic Alliances

The lead organisation in Australia was the Centre for Drug and Alcohol Studies, School of Medicine, University of Queensland, which worked in close association with the Alcohol and Drug Service of Queensland Health within The Prince Charles Hospital and District Health Service, and with colleagues in the University of Sydney. The lead organisation's role was to initiate, organise and oversee the study and it was responsible for preparing intervention projects and establishing co-operative relationships with local organisations and individuals. A research group was established with members co-ordinating the design and implementation of the project. A steering committee was established to co-ordinate, oversee and provide advice about the implementation of the project.
The lead organisation also aimed to become a centre of learning excellence in the field of opportunistic brief interventions by:

- putting the existing research evidence and clinical knowledge about the effectiveness of SBI into a user-friendly form, and
- assembling a collection of brief intervention materials (e.g., early identification instruments, intervention manuals, self-help publications).

Alliances were formed with the following organisations:

- Central and local government agencies responsible for funding and supporting special initiatives and projects in primary health care, particularly government departments responsible for public health policy.
- Government and other agencies interested in funding research into the reduction of alcohol-related harm through primary health care services
- Divisions of General Practice
- The Roads and Traffic Authority of New South Wales

- Prominent scientists, academics and practitioners with the influence to affect thinking in for example, primary health care, treatment and prevention of alcohol problems and primary care training
- Key educational and research institutions with expertise in SBI and/or in the development of intervention and training materials and methods
- Professional associations with the power to set the agenda for particular service sectors, such as colleges of general practitioners, nurses, medical social workers, psychologists
- Charities, volunteer organisations, community groups and local community leaders that could contribute to the implementation strategy, particularly the communications strategy
- Potential sponsors of the implementation strategy

3.3. Customisation

Considerable progress has been made in customising brief intervention materials. The aims of customisation were to adapt the materials, interventions and approaches used in previous phases such that they would be suited to the (i) Australian professional population, (ii) settings where brief interventions could be adopted, and (iii) the patient population. It was also hoped to include a cost-benefit analysis and review of the training methods used.

3.3.1. Customisation of materials, interventions and techniques for delivery

In Phase III a brief intervention package, the Drink-Less Program, was developed and trialled. The package entailed the use of the AUDIT and a standardised set of materials. During Phase III many recommendations of potential variations were put forward by GPs and other health professionals to suit local conditions. This provided an opportunity to improve and fine-tune the materials for Phase IV in order to tailor both the screening and intervention to local needs and circumstances.

Customisation of the screening instrument

For Phase III, the AUDIT screening questionnaire was adapted to Australian needs. The *Aus*AUDIT[21] included modifications to the first two questions of the AUDIT to reflect Australian National Health and Medical Research Council (NHMRC) guidelines for safe levels of consumption. In the Australian derivation, those drinking at hazardous and harmful levels according to the NHMRC consumption guidelines will necessarily be detected as high-risk from the first two questions alone. In a subsequent validation study of the *Aus*AUDIT, it transpired that the modified instrument lacked specificity (too many false positives). AUDIT was re-adopted as the main national screening instrument.

Customisation of the brief intervention

It was anticipated that a modification of adaptation of the Drink-Less approach would form the intervention in Phase IV.

The Drink-Less Package: As mentioned above, the Drink-Less approach was developed for Phase III of the collaborative project. Drink-Less was based on validated techniques for early detection and treatment of hazardous and harmful alcohol use developed in the WHO Phase II trials. The intervention approach and materials were based on the 5-minute intervention technique shown to be effective in the multicentre WHO Phase II trial[15-16]. As well as the AUDIT and scoring template, the package consists of a handy advice card, patient booklet, and instruction brochures for receptionists and GPs. The program has been widely used in general practice since its development.

Revision of the Drink-Less Package: Between 2001 and 2003, the Drink-Less package was revised and updated by the collaborative team in Queensland working with colleagues from the University of Sydney. Revisions incorporated (a) feedback from focus groups; (b) WHO's revision of the AUDIT guidelines; and (c) new NHMRC alcohol guidelines. This work was supported by a grant from the Roads and Traffic Authority (RTA) of New South Wales. A professional graphic design company was engaged to submit new logo designs and new colours and graphics for consideration by the

research group. The components were printed up in draft form and field-tested with local GPs . In response to their feedback, the Drink-Less package was then further refined and finalised. Drink-Less has been endorsed by the Australian Medical Association, the Royal Australian College of General Practitioners and the Royal Australian College of Physicians.

Training medical practitioners
A training program was designed to familiarise GPs with the revised Drink-Less intervention and to train GPs in the use of this approach. This was undertaken in conjunction with the RTA's initiative to combat drink driving using an alcohol ignition interlock device. The whole research team contributed to the training program. A presentation in PowerPoint format was developed and consists of two sections. The first hour (optional) gives a detailed background on alcohol problems and management in general practice; recognition of dependence on alcohol, management of outpatient alcohol detoxification, new pharmacotherapies and relapse prevention. The second hour commences with a brief description of the RTA Interlock program (see below) and continues with a practical session on the use of the Drink-Less package; including scoring the AUDIT, use of the handycard in advising the patient, arranging for ongoing treatment, referral if necessary and follow-up. Case studies further illustrate the use of the package.

Delivering the training program
General Practitioner Liaison Officers at all Divisions of General Practice in New South Wales were invited early in 2003 to ask their members (GPs) to participate in training sessions for Drink-Less. Those Divisions that had time slots available and sufficient interest from their members arranged for the Drink-Less program to be presented at one of their meetings. Continuing professional development (CPD) practice points were applied for from the Royal Australian College of General Practitioners and two points per hour are awarded to GPs who attend the training session (i.e. 4 points for the 2-hour program). Presenters at these sessions were: Prof John Saunders, A/Prof Kate Conigrave, A/Prof Paul Haber, Dr Elizabeth Proude (University of Sydney & Drug Health Services CSAHS), Dr Hester Wilce of Central Sydney Division of GP and Dr Rose Neild of the Drug and Alcohol Unit, Hunter Health.

During 2003, 175 GPs attended these sessions throughout New South Wales. Evaluation forms were given to the participants at each session and 164 were completed. The results show that confidence in identification of alcohol problems and in conducting brief interventions grew after attending the program. For example, doctors feeling 'very confident' in their ability to identify at-risk drinkers rose from 12 (7%) to 82 (51%). Confidence in the ability to conduct brief interventions changed from 54 (33%) feeling 'slightly' or 'fairly' confident at pre-test to 74 (46%) at post-test, while those who stated they felt 'very confident' rose from 10 (6%) to 70 (44%). One hundred and thirty-seven (86%) felt 'fairly' or 'very' confident in understanding the requirements of the brief medical intervention for the RTA Interlock program.

3.4. Reframing Community Understandings of Alcohol Issues

Australian communities have adhered strongly to the concept of 'alcoholism', creating an obstacle to understanding the range of alcohol-related problems. This may be, in part, due to a lack of research into the continuum of recreational to compulsive drinking, particularly with respect to recent Australian research. Furthermore, research into alcohol consumption patterns are generally based on the intensive and compulsive use categories due to greater accessibility. Emphasis on alcoholism has been reflected in Australia's history of disease model-oriented treatment approaches. As a result, many health professionals and members of the community understand this as the sole form of alcohol-related harm and often view all alcohol-related problems exclusively as dependence.
It has been the aim of the Australian investigators to work from a public health perspective and emphasise that harm is also experienced by drinkers whose problems are less severe than those of 'alcoholics', a stance endorsed by the National Health and Medical Research Council since the mid

1980s. Members of the Australian team (John B. Saunders and Brian McAvoy) worked with the NHMRC to develop guidelines and various resource documents. The NHMRC has developed a communication strategy with the aim of promoting the concept and understanding of risky drinking among health professionals and the community. This has been undertaken to support (i) the understanding that drinkers can be categorised according to a continuum, and (ii) the availability of brief interventions in the long term.

3.4.1. Communication targets

Three communication targets were devised for Phase IV of the project: the general public, health professionals and other stakeholders. Each of these strategies is described consecutively.

The general public

The international protocols suggested that a mass media campaign would be ideal to target the general public. In Australia it was decided that communication would be best delivered in local media campaigns and through a network of community activities and centres. As no funding was secured for this strand of the project, local purpose-designed media interviews have been provided by Australian investigators which have:

- communicated the concept of hazardous and harmful drinking and emphasised that abstinence is not the only intervention available for non-dependent drinkers;
- encouraged drinkers to seek advice about their drinking.

Health professionals

At a broad level, formalised links have been established with Divisions of General Practice throughout Australia. Through these links, general practitioners and other health professionals have been educated in seminars and workshops on knowledge and delivery of interventions for hazardous and harmful drinking. Education and training has been undertaken in the following areas:

- introducing the concept of hazardous and harmful drinking, and modifying understanding of 'alcoholism' and dependence
- information that detection rates of hazardous and harmful drinkers are poor and that health professionals encounter them unknowingly regularly during their work
- advice that it is possible to raise the issue of high-risk alcohol consumption without alienating patients
- information that they can have a large impact on reducing the risk from excessive and high-risk consumption with little additional effort
- education on the impact of hazardous and harmful, non-dependent drinking in both individual and public health terms
- information on the good evidence for the effectiveness of brief interventions.

In addition to the training program supported by the RTA grant, several other training workshops have been provided in Queensland, New South Wales and elsewhere in Australia. These workshops have outlined drinking according to a spectrum (where degree of drinking corresponds with degree of harm) and the most appropriate interventions for different drinkers. Workshops have also been conducted with other health professionals, and these have additionally taught the skills for implementing brief opportunistic interventions within a primary health care setting.

Other stakeholders
Other stakeholders are defined as those in the community demonstrating an interest, or potential interest, in reducing high-risk consumption of alcohol, including local government authorities, health and social services personnel, volunteer organisations and other organisations with the ability to influence community attitudes and behaviour. To date, this has varied in each state and community, with links being established with police and court services, Lions associations, Rotary Club and the Department of Veterans Affairs.

3.5. Establishing and Evaluating Demonstration Projects

The Australian arm has been unable to secure major funding for the Phase IV work. The most significant financial support has come from the RTA. The research team has submitted a number of funding applications, each of which was adjusted to the funding body's specific requirements, without losing integrity to the project objectives. The research applications are listed below:

- National Health and Medical Research Council: 1999, 2000, 2001, 2002
- The Alcohol Education and Rehabilitation Foundation: 2002
- The Prince Charles Hospital Foundation: 2001
- Commonwealth Department of Health and Aging: 2000

It was anticipated that, following the customisation process, the communications strategy and the formation of collaborative alliances, an implementation project would take place. The minimum requirement of the international protocol was a demonstration project(s) which would show that widespread dissemination of brief opportunistic interventions in primary health care in a local area is possible and viable. It was anticipated that the project would generate additional feedback about the practicalities and process of dissemination that could be used to feed back into the implementation process in future.

Each project plan submitted included a range of measures of impact (such as awareness of hazardous and harmful use as an issue in both primary health care and the general population and the degree of coverage in the local media), process (such as the availability of alcohol materials used in primary health care, the extent of screening and the extent of brief or other intervention for alcohol use) and outcome (such as self-reported alcohol intake, number of drink driving or drunkenness offences, alcohol-related hospitalisations, children at risk, mortality).

3.6. Concluding Section

The lack of success in obtaining major funding for Phase IV was a great disappointment, particularly as the previous phases had been well supported. In addition, the environment in which brief interventions would be implemented also appears less conducive than previously thought. In an examination of general practice activity in Australia (2000-2001), Britt and colleagues[22] reported that alcohol was rarely addressed within the general practice encounter, even though two of the five most frequently managed problems, namely hypertension and depression, are often alcohol-related. An alcohol intervention (general and specific advice-giving or counselling) comprised only 0.4% of all encounters. Within the study, the AUDIT was administered to 31,543 individuals aged 18+ years. 24.1% of patients reported 'at risk' levels of alcohol use. Thus, despite evidence supporting the effectiveness of brief alcohol interventions, and the large number of hazardous drinkers attending general practice, an appropriate intervention is rarely offered.
During Phase III, Saunders and Wutzke[16] identified several barriers to the provision of screening and brief interventions by GPs which may go towards explaining the lack of uptake in Australia. Barriers included: (1) educational limitations, notably a lack of awareness of the effectiveness of brief alcohol intervention, and of the conditions and problems (excluding physical ones) that could arise from harmful alcohol use; (2) a lack of resource materials, including questionnaires, intervention guidelines

and patient self-instructional materials; (3) logistical barriers, such as a lack of time and heavy workloads; and (4) attitudinal barriers, such as a lack of self-confidence and self-efficacy in delivering an effective intervention, with low expectations of success.

Another possible reason for the limited uptake by GPs may be the large number of preventive medicine interventions available to them. It is estimated that GPs receive an average of 3-4 kilograms of materials per month on the effectiveness and cost-effectiveness of various interventions. As a possible result of this barrage, GPs appear to be engaging in preventive interventions in a highly variable manner and using interventions that do not often correspond with health priority areas[10].

A final barrier to brief interventions in general practice may involve deciphering who owns the consultation. Unlike some other countries, patients are not allocated to a GP in Australia. Instead, patients are somewhat similar to consumers and can pick the GP according to their own needs. With the growth of patient empowerment, GPs may have become somewhat driven by the patient's primary concerns.

Taking into account some of the environmental issues faced by GPs, the following recommendations have been made:

Education Programs

1. Skills development: Suitably designed training courses that are available face-to-face and in electronic form need to be promoted to GPs to impart the knowledge and skills needed for screening and brief intervention for alcohol misuse.
2. Education courses should also address the issue of ownership of the consultation. Perhaps a view that emphasises mutual responsibility and conjoint ownership of the consultation would facilitate that alcohol screening and brief intervention should be a routine part of this role.

National Government and Peak Bodies

3. In light of GP workload and inundation of preventive medicine opportunities, it is recommended that, based on mortality and morbidity statistics, a list of prioritised issues be developed for GPs to manage as part of their core role.
4. National government bodies should carefully assess and monitor trends in alcohol consumption and misuse, and examine the priority given to alcohol interventions.
5. They should examine specifically whether incentives for primary health practitioners to promote brief interventions should be incorporated into relevant policies and practices.
6. To enhance role legitimacy for GPs, the media could be engaged to develop public communication strategies to emphasise the hazards of risky drinking and the role of the GP in discussing these issues.

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CHAPTER 4

BULGARIA

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4.1. Introduction

4.1.1. General information

Since the great political changes in central and eastern Europe in 1989, Bulgaria has been in a period of transition with major transformations at all levels of society – political, economic, social, health care, etc.. The main national priorities during this period were the development of a democratic society, achieving political and economic stabilization, and joining the EU and NATO.

Bulgaria covers a territory of 111,000 sq. km. The population at 31/03/2001 was 7,932,984, of whom 51.3 % were female. The population peak was in 1985 when it reached 8,948,649. Since 1986 the population has consistently decreased with a mean of 0.8% decrease per year. This decrease is due mainly to emigration in the years of transition (more than 680,000) and to natural changes in the population related to a lower birth rate, a slow but constant increase in the mortality rate, and socio-economic and demographic factors.

The majority of the population is urban (68.4 %) with 31.6 % in the rural population. Mean duration of life was 70.5 years (67.1 for men and 74.3 for women) in 1998[1].

4.1.2. Cultural context related to alcohol: professional and public attitudes

Cultural and social beliefs and norms have traditionally strongly affected drinking patterns and tendencies in alcohol consumption in Bulgaria. Social beliefs and cultural stereotypes have formed the dominant public discourse about alcohol and drinking. Bulgarian culture has an extremely permissive attitude to alcohol consumption and, especially for men, it is considered socially expected behavior[2]. In addition to being a beverage, alcohol has culturally symbolic meanings as a part of life-style, rituals and celebrations. Young people view drinking alcohol as a symbol of adulthood and of independence from parents; some beverages are used as an expression of social well-being, personal life-style or masculinity; and serving alcohol is a part of hospitality. Alcohol consumption is considered an irreplaceable part of socializing and having a good time, as well as a means to relax and overcome negative moods. High levels of alcohol consumption are considered the social norm and beliefs about the *macho* drinker as an expression of strength, bravery and strong character are common. Ideas about alcoholic beverages and particular drinking patterns are a common part of national and local identity[3].

Bulgarian health professionals, including GPs and other primary health care workers, reflect this dominant public discourse. In the WHO Phase III, Strand I study, they were shown to be the most permissive in Europe to large amounts of alcohol consumption among their clients[4].

4.1.3. Alcohol consumption

Bulgaria has long-standing traditions in alcoholic beverage production and consumption, especially home production of wine and brandies, and a high level of consumption of mainly wine, beer and brandies. Bulgaria is among the top six countries in spirit consumption in the world and among the top 15 in overall consumption.

Alcohol consumption in Bulgaria has traditionally been carried out in a hedonistic style, with a preference for wines and brandies. A clear tendency towards a change in that style has been observed over the past 20 years, with a substantial rise in the consumption of beer and imported liquor. Traditionally, home produced alcohol has been a significant part of consumption, especially in villages[5].

For the second half of the last century, per capita alcohol consumption substantially increased, the 1990 figure reaching a 3.4 times higher level than 1952. This increase had different rates for different kinds of beverages – 2.5-fold increase for wine and spirits and 12-fold for beer.

Recorded per capita consumption of pure alcohol was 7.8 litres in 1991. This represents a decrease over the figure of 8.7 litres in 1980 and is in fact the lowest consumption recorded for the period 1980-1991, during which the figure tended to be around 9 litres. The 1991 figure is considered to be an underestimate of real consumption since there is no information available on unrecorded consumption[6]. For the same reason, the recorded figure of 2.6 litres per capita of pure alcohol in 1999 is considered underestimated and unreliable.

The overall recorded per capita consumption of alcohol beverages for 2001 was 18.2 litres, of which 8.6 was beer, 6.9 wine and 2.7 liquors and brandies. This figure is also suspect since, for the last 12 years, unrecorded imports, untaxed sales and illegal sales substantially increased and became a significant part of total alcohol consumption[1].

For the last 25 years alcohol consumption has been constantly increasing. The increase seems to be slower among males 20-50 years of age but rapid for women of the same age-range and for adolescents and young people of 15-20 years. The mean age of first alcohol consumption is 12.8 years. Regular alcohol consumers over 15 years of age for the period 1986-1996 increased from 76.4 % to 81.5 % for men and 33.6 % to 49.9 % for women[4].

4.1.4. Alcohol-related problems

Male mortality rates from cirrhosis had more than trebled over a period of 25 years (9.8/100,000 in 1970 to 33.6/100,000 in 1994) and have continued to rise. The standardised mortality rate (SMR) per 100,000 population (all ages) from chronic liver disease and cirrhosis was 23.8 in 2001. The number of people seeking treatment for alcohol dependence showed a steady increase during the period 1980-1992 and was relatively stable for the period 1992-2001.

The SMR from the external causes of injuries and poisoning per 100,000 population increased from 61.1 (93.9 for men and 29.7 for women) in 1980 to 67.2 in 2001 (107.5 and 30.1). The number of road traffic accidents involving alcohol was 13.8/100,000 in 2001. With some minor fluctuations, this figure has been relatively stable since 1989[1].

Alcohol abuse and intoxication are important factors in a major part of fatal road traffic accidents, domestic, recreational, work-related and fatal incidents, public order problems, crime, homicide and violence. Alcohol consumption takes second place (after tobacco smoking) among the behavioral risk factors contributing to morbidity, absenteeism and death due to external causes.

Alcohol-related diseases comprise a heavy problem for the health of the nation and the health care system. The estimated number of alcohol dependents is 350,000 and 30% of the male population are risky drinkers. Bulgaria is at number one in Europe for death rates due to brain stroke (277.6/100,000) and in the top 10 in Europe for death rates due to coronary heart disease (262.3/100,000), both related to alcohol and tobacco consumption. It is also at number two in Europe for death rates due to circulatory diseases and problems (737.1/100,000) in 2000[7].

4.1.5. Responses to alcohol-related problems

Legislation

Advertising of alcohol beverages was banned on television and radio, in newspapers, magazines and cinemas[8]. However, these bans were not at all enforced. Recently these limitations were practically removed by the introduction of regulations allowing advertising under some restrictive conditions, addressing mainly messages to young people. The result is a flooding of TV, magazines, billboards and public places with alcohol advertisings.

A license is required for production, trade and distribution of wine, beer and spirits. Restrictions on sale on hours, days and location of outlets and the age limit of 18 for buying alcohol are not effectively enforced. The use of alcohol is forbidden in specific places, such as institutions, public transport, clubs and discos for teenagers, etc.[9,10].

The BAC limit for driving is 20mg/100ml and is fairly effectively enforced. Conviction for driving above the BAC limit does not usually lead to suspension from driving or imprisonment. Random breath testing is carried out infrequently.

Alcohol policy
Prior to the political changes in 1989, alcohol policy was centralised and predominantly restrictive. It was mainly directed at limiting the production of alcoholic beverages and the prohibition of consumption. These activities were of a propaganda character relevant to the existing social structure, which substantially limited their impact and made them insufficient in terms of time and effectiveness.

Contemporary alcohol policy, relevant to the present situation of the country and the principles of the European Alcohol Action Plan, is in the process of creation. It is confronted by significant difficulties related to unfavourable conditions during the period of transition, the instability of the political, social and economic situation, political and public neglect of alcohol-related problems, and the strong political and economic position of the alcohol trade and alcohol producing industries.

The priorities of recent years have been reducing availability, mass media campaigns to encourage safer drinking, encouraging lighter drinking in particular settings, using price to reduce demand, and addressing specific problems (drinking and driving, alcohol and young people, alcohol and health, alcohol and the family)[5].

Prevention
Bulgaria applies a joint approach to issues related to alcohol, drugs and tobacco. Alcohol prevention programs are developed together with health education programs and drug misuse prevention programs. Such programs are developed at national, community and sectoral levels. Prevention programs are targeted mainly at school populations and much fewer prevention programs address the workplace and the home. Alcohol prevention issues are now incorporated in the newly-developed health education school programs that are to be implemented at a national level[2].

Treatment
Treatment of alcohol-related problems is provided by various treatment facilities depending on locality, the nature of the problem and patient needs. Treatment of acute alcohol intoxication is provided at specialized toxicology services and emergency units. A significant number of patients with alcohol-related problems are treated in specialised medical units (neurology, gastroenterology, cardiology, etc.) relevant to the specific disease. Quite often the alcohol genesis of cases with cardiovascular disturbances is not acknowledged. Patients with alcohol dependence, dual diagnosis and marked behavioral changes are treated at specialised inpatient and outpatient units, generally incorporated in the psychiatric care system. At seven of the major psychiatric hospitals there are specialized wards for treatment of alcohol-related disturbances; 13 of the outpatient psychiatric units in some district centres have consulting rooms for outpatient treatment. In the remaining districts this activity is carried out together with the general psychiatric services offered to the population. The development of a specialized treatment network started in 1994, when the *National Centre for Addictions*, providing short-term and mid-term outpatient and inpatient programs, was established.

A process of establishing a network of specialised centres having broader treatment options is being carried out. The *National Centre for Addictions* is the main research and treatment centre, providing short-term, mid-term, inpatient and outpatient treatment programs, counselling, day-hospital, home detoxification and family counselling. Recently, qualified treatment for alcohol dependence and alcohol-

related problems is provided by emerging medical centers and specialized private treatment centers.
There was some experience of early interventions for alcohol-related problems in the 1970s and 1980s, when research work in Bulgaria was carried out and specialists were trained in implementing screening methods for early detection of alcohol-related problems and early interventions. Since then, this approach has remained within the psychiatric institutions, was transformed and gradually lost its value. Attention to the importance and possibilities of applying early identification and brief intervention was increased recent years in the context of, and due to the activities of, the WHO Phase III and Phase IV projects.

4.1.6. The health care system

At the beginning of 2003 there were 1,423 outpatient health care services, mainly ambulatory services, group practices and medical centres, with 11,092 doctors. The number of GPs was 5,293 (19.1 % of all physicians in the country). Each GP was in charge of a mean of 1, 482 people. The number of hospitals is 251 with 46,929 beds, including 11 psychiatric hospitals with 2,780 beds and 49 dispensaries with 4,101 beds. In the hospitals and dispensaries there were 13,161 doctors, 83.1 % of them with a speciality. There was a mean 76 beds per 10,000 people.

The total number of physicians in the health care system was 27,688, the greater proportion of whom were GPs (6.7 per 10,000) and internists (5.3 per 10,000). There were 45,604 and a mean of 35.3 doctors per 10,000 people for the country as a whole[1].

Organisation of primary health care

Until 2000 the primary health care (PHC) system was based on a district principle (living place and workplace). The medical care system had three levels: national, regional and municipal. One primary care doctor was in charge of an average of 314 people.

There were no specialized GPs. Primary health care (PHC) was provided by district doctors, pediatricians and gynaecologists in cities and towns and general doctors in villages. Referrals to specialist consultations and hospitalization were the responsibility of PHC doctors but they did not act as health care gate-keepers to specialized services. Since 1996 there has been a possibility for patients to choose their permanent PHC doctor.

In June 2000 the National Health Reform had commenced, together with the introduction of the National Health Insurance Fund. That started a process of transformation from a centralized model to privatization and a GP-based system, with radical changes in the structure, organization, functioning, regulation and funding of the health care system, as well as a change in the nomenclature and status of health services. The main focus was on the reform of the PHC and outpatient services and a decrease of inpatient services. The GP system started working with 5,451 GPs. GPs act as gate-keepers to specialized services. Their work is regulated, funded and controlled by the National Health Insurance Fund (NHIF) according to the so-called National Frame Contract that defines and regulates the services, activities, obligations, financing, GP package of services and practically all aspects of GP work. GPs are overloaded, receive little additional payment for preventive medicine and are not motivated to become involved in preventive activities and practices[7].

4.2. Bulgarian Phase IV Project

Bulgaria is among the few countries to have participated in all four phases of the WHO Project. It joined Phase IV at its beginning. The activities carried out followed the study protocol and were planned, modified and developed taking into account the resources of the project team, the dynamics of health policy and the reform in the health care system, as well as other country-wide specifics related to and influencing the project implementation.

The developments and progress in implementation of the Phase IV Project were closely related to and strongly influenced by developments in the health care reform and the political situation in the country.

The central goal of Bulgarian Phase IV strategy was to influence decisions at the highest health care policy level and get Phase IV objectives and activities integrated in the policy of the Ministry of Health for PHC work and preventive medicine, as well as the policy of the National Health Insurance Fund (NHIF) and requirements of the National Frame Contract defining and regulating the package of GP work and services[2].

4.2.1. Customization

The main objectives in the customization component were to adjust the EIBI package to the country's particular needs and circumstances and to develop an appropriate EIBI dissemination strategy taking into account country-specific factors.

The brief intervention package that was selected was the Drink-less Programme. Validation of the AUDIT questionnaire, focus groups and a Delphi study were carried out under the auspices of the ECAToD Project.

Validation of the AUDIT questionnaire

Six GPs working in different practices participated in the validation of the questionnaire. The study included 600 patients who filled in the questionnaire. Patients seeking treatment or consultation for some health problem and over 18 years of age were chosen randomly from both sexes.

With regard to the needs of the study, one standard drink in Bulgarian conditions was defined as: 1 small bottle/box of light beer (330 ml) or 1 glass of wine (about 200 ml) or half a glass (25 ml) of liquor[5].

Focus groups

Six focus groups were carried out and the texts were processed and analysed:

- 2 with GPs - concerning alcohol and tobacco consumption;
- 2 with school doctors - concerning alcohol and tobacco consumption;
- 1 with Alcoholics Anonymous members - concerning alcohol consumption;
- 1 with specialized professionals - concerning alcohol consumption.

The main questions concerned which social institutions would have to participate in the development and realization of a community program for prevention of hazardous drinking, to whom such a community program would have to be addressed and what should be the possible elements of a community program for prevention of hazardous drinking.

Discussions within the six focus groups were very effective as a whole. Participants proved to be extremely active and they showed emotional involvement regarding both alcohol-related problems and their prevention.

A mini-report for each group and a Summary Report with analysis of the six focus groups was prepared. The focus groups suggested the following elements as advisable for a municipal program on prevention of hazardous alcohol consumption: health education, alternative activities, a media campaign, preventive messages, a change in public attitudes and understanding, amendments to legislation, and training for professionals. Such a program should address the general public, adults and adolescents, school curricula, journalists, specific risk groups, health care professionals (both PHC and specialists), and municipal administrations.

Institutions that should implement and realize municipal prevention programmes included local and central authorities, educational institutions, specialized health promotion centres, PHC and specialized services, religious institutions, volunteer organizations and funding bodies.

Delphi study
The aim of the Delphi study was to collect ideas for effective activities at the community level in order to assist the formulation of a strategy and a community action plan. The study was conducted in three successive rounds with separate questionnaires for each round. The institutional areas covered by the study included primary health care, specialized medical centres, public health institutions, state institutions and public organizations. A total of 63 specialists participated in the first round, 58 in the second and 60 in the third. All experts involved worked in areas concerned with alcohol-related problems – GPs, toxicologists, neurologists, cardiologists, psychiatrists, medical administrators, sanitation experts, psychologists, sociologists, educationists and juridical experts. The analysis and conclusions of the study showed the method to be a useful means for reaching consensus among GPs on important aspects of their work: health policy regarding alcohol-related issues, the preparation of new documents, decrees, regulations in the field and, especially, defining the PHC role in the process.

Field test of GP attitudes and recruitment procedure
A small field test with the objective of investigating GP attitudes and the procedure for recruiting GPs to work with EIBI for alcohol-related problems was carried out. The main objectives were to test the recruitment procedure and willingness of GPs to be involved, to present the Drink-less package, to discuss the Phase IV strategy and ideas, and to form a stable group of interested GPs that would support the project activities.

A total of 100 GPs from Sofia were randomly chosen and contacted by telephone. They were offered materials on alcohol- and drug-related problems and were invited to attend a presentation and 3-hour workshop. Of the 100 GPs, 22 refused immediately while the remainder showed some interest. These were offered materials and were invited to the presentation and workshop, 28 showing interest in coming to the workshop and 12 actually attending. This group was given a presentation and workshop on drug and alcohol dependence issues, alcohol-related problems, brief interventions, and the Phase IV Project and Drink-less package, followed by discussion.

As a result of this, conclusions were drawn and a group of interested GPs was formed. A focus group to discuss Phase IV objectives and strategy and current GP problems and practices was carried out. The topics of the focus group were understanding of alcohol issues, the GP role, common PHC practices, incentives for GPs to work with EIBI for alcohol- and drug-related problems and suggestions for the Phase IV strategy[5].

4.2.2. Strategic Alliance
The institutions identified for the Strategic Alliance at the highest political level were the Ministry of Health, the National Health Insurance Fund (NHIF) and the Bulgarian Physicians' Union. These are the key players for negotiating the PHC and GP model and hence the most important organizations for introducing, influencing and supporting the project activities and the creation and implementation of a country-wide strategy for implementation of early identification and brief intervention for harmful and hazardous alcohol consumption in PHC. The strategy was effected by presenting official proposals, statements, recommendations and reports, as well as contacting and meeting the Minister of Health, Deputy Ministers of Health and high Ministry of Health experts, the senior management of the National Health Insurance Fund and key figures in the Bulgarian Physicians' Union.

Special attention was also paid to involving middle-level managers and experts in the relevant institutions because they seemed to have relatively more consistent attitudes, were interested in practical activities and issues rather than politics, and were more stable in their positions and replaced less often.

In addition to working with these high-level institutions, efforts were made to broaden the alliance by involving NGOs working in the field of preventive activities, healthy lifestyle and drug use, such as the *Civil Alliance Against Drugs Foundation* and partners at the regional, local and municipal levels.

This was done in parallel with activities within the framework of the National Drugs Strategy for establishing multidisciplinary Municipal Drug Councils. These structures were involved in wider co-operation at local, municipal and regional levels in order to extend and combine their activities to work also with alcohol-related issues.

We also used opportunities to integrate Phase IV activities into existing prevention projects and campaigns, health promotion projects, healthy lifestyle activities, as well as in professional education and training for GPs, medical professionals, school health education and university curricula. This was carried out by the *National Centre for Addictions* and other educational, professional and non-governmental partner organizations.

An important achievement in the attempt to involve PHC professionals in working with alcohol problems was placing alcohol and drugs among the priorities of the NHIF. Another major step in this direction was developing Guidelines for dealing with alcohol problems at PHC level that were agreed and accepted by the NHIF[7].

4.2.3. Reframing

Reframing policy-makers', professionals' and public understanding of alcohol issues was one of the main components and a central activity in the project implementation. The focus here was on introducing the concepts of "safe limits" and "risky drinking", extending the view of alcohol-related problems beyond the notion of alcohol dependence, encouraging members of the general public to ask their GPs about drinking, as well as encouraging GPs to raise alcohol-related issues, and promoting the need for health care initiatives on a large scale. Some good results were achieved in this area.

In general, for the last 20 years alcohol-related issues have been largely neglected in the public, policy, professional and mass media spheres. This phenomenon was closely related to tradition, culture and the dominant public discourse on alcohol, and since 1989 to the emphasis on the epidemic spread of illicit drug use among young people.

In the area of reframing we targeted several levels. At the level of policy and decision-making we worked through personal contacts and meetings with key figures at the Ministry of Health - the Minister of Health, Deputy Ministers, NHIF senior management, Chiefs of Directories and Departments and the Parliamentary Health Commission, as well as other stake-holders and key persons, experts, policy-makers and decision-makers, regional and municipal administrators and Drug Councils.

The second target was at the level of health care professionals. The goal here was to reframe their understandings and attitudes through professional contacts and events, like participation and presentations at conferences of the Bulgarian Psychiatric Association, GP conferences, the conference of the NCA, and also through education and training events.

The third level actively and widely involved was the general public and mass media. Media advocacy was used to assist a Communications Strategy. A media lobby of journalists interested in the topic and willing to support our activities was established and sustained throughout the project. A mass-media strategy was developed with consultancy from media specialists. Two focused campaigns and three press conferences were organized on the topics of safe limits and risky drinking. Professionals from the Project Team participated in 8 specialized radio and 9 TV broadcasts, interviews and specialized programs. Popular journals and national newspapers printed 15 articles and published materials[7].

A whole specialized issue of the official monthly journal of the NHIF was devoted to the problems of alcohol and drugs. It reached all GPs, health care managers and officials.
The concept of risky drinking, safe limits, screening methods, the PHC role in early identification and brief intervention, and the rationale and need for a health policy concerning alcohol-related problems were the main themes.

The consultancy visit of Professor Heather (Phase IV Technical Focal Point) to Sofia in September 2001 was used to raise awareness and to achieve a focused influence on policy- makers, together with an impact on professionals and the general public. Practically it was influential at all levels, beginning with the senior management of the Ministry of Health and NHIF, experts at Ministry of Health and professional staff of the National Centre for Addictions. The main aspects of the concept of risky drinking and the policy towards alcohol-related problems were conveyed through the mass media with a large impact on the general public. The message reached an estimated number of 2.5 million of the population through two prime-time interviews on the leading TV channels and an article in a national newspaper that reached more than one million people. The impact was intensive and manifested in personal and professional contacts with intellectuals, health care professionals and even high officials. It resulted in increased media interest and openness to discussion of alcohol-related problems and issues[5].

4.2.4. Demonstration Project

Our plan was to carry out the demonstration project in a district in the country with a population of 50,000-100,000 and 30-50 actively working GPs. The design included the obtaining of administrative and political support at the regional level, training of GPs prior to starting the project and providing them with support throughout. This was intended to start with a press conference and a local media campaign, including TV news reports, live discussion and program participation, newspaper interviews and publications, with an intention to repeat the campaign at the finish of the demonstration project together with presenting the results and producing a publication for further dissemination of project results, conclusions and recommendations to the key institutions, key figures, policy- and decision- makers, experts and health care professionals. For a number of reasons, however, it was not possible to obtain the necessary funding to carry out the Demonstration Project.

4.2.5. Major problems

A number of major problems affected the Phase IV project in Bulgaria.

Instability of the political and economic situation

The political situation in the country for the period of the project remained unstable, together with a deep crisis at the economic and social levels. This resulted in limited financial resources and attention to social issues and preventive medicine, hence no possibility to obtain funds for the project.

Lack of funding

Despite sustained efforts to find funding for the project implementation, this was not obtained from any funding body. All the work for the project was fulfilled by the project team on a voluntary basis. Project activities were logistically supported by the *National Centre for Addictions*.

Constant changes in MH and NHIF management

Another negative impact was due to the frequent and radical changes in the senior management of the Ministry of Health (3 changes of Minister and the cabinet) and, especially, the National Health Insurance Fund (5 changes of director and senior management staff), i.e. the key figures that we activated to collaborate and support the Phase IV project were removed. Practically this wasted all our previous achievements and contacts, and we had to start negotiating from the very beginning again and again.

Strong alcohol industry lobby

Developments at an international level opened up new possibilities for wine exports and also increased alcohol production and the activity of alcohol industry. A tendency over the last two years was the widespread advertising of alcohol products in the mass media, TV and billboards in the streets. The alcohol lobby became very strong and influential in political circles.

PHC reform

The PHC reform was slow and generally unsatisfactory, both for patients and GPs. The NHIF was in a period of restructuring and the directors and senior management were often renewed. The National Frame Contract was the subject of sharp debates and the main priorities were scarcely defined as result of disagreement among the key partners at national policy level. This had a negative influence on the GP system and PHC work, bringing new tensions, dissatisfaction and uncertainty about the GP model, the role of GPs, their position and the package of their services, and destabilization and lowering of motivation among GPs to do preventive medicine and be involved in extra work and new activities[7].

4.2.6. Consequences for Phase IV

These changes in the MH and NHIF policy were the most important factor related to our Phase IV project development. The consequences were definitely unfavorable.

The debate on the main concepts of the PHC system was constantly renewed, resulting in the emergence of contexts and attitudes totally unfavorable to promoting and raising awareness, and understanding and acceptance of new preventive issues. This blocked our achievements and the possibility of negotiating Phase IV activities that we previously reached by contacting the key figures in the NHIF and MH.

4.3. Conclusions

The above analysis of the overall situation during the period of the project shows that effective changes in the alcohol policy in the country were unlikely to happen.

GPs were overloaded with documentation and had little time for the patient. They were not interested in working with preventive medicine in general. GPs felt they had a role in preventive medicine and preventing alcohol-related problems and diseases but were not willing to take on this role and not prepared for it.

In the current situation, the best and probably only way to include alcohol EIBI on a large scale in PHC work is to introduce this as obligation for the GPs imposed by the NHIF through the National Frame Contract. On the other hand, a significant proportion of GPs are willing to incorporate advanced methods and strategies in their professional practices. This would depend on taking the time and effort to practice preventive medicine for the benefit of their patients but these could potentially form the pioneer group that would introduce and sustain EIBI in PHC practice.

The main conclusion is that the Phase IV activities have established a solid ground for future efforts to introduce a PHC-based system for EIBI for harmful and hazardous alcohol
consumption in Bulgaria. Additional sensitization, energizing and support is needed for GPs in terms of education, training, diagnostic and intervention technology, and appropriate payment of PHC preventive work in order to enhance primary care-based EIBI and for GPs to accept their future role in preventive medicine and working with alcohol problems.
The future steps needed are to continue with strategic meetings with key figures at health policy level, to present new reports to the MH and NHIF, to sustain the debate on including EIBI in the National Frame Contract and to submit proposals to that end. Also we need to extend alliances and networking at regional, local and municipal and GP levels, keep good contacts with key administrators at these levels and with Drug Councils, join and integrate activities into a wide spectrum of existing projects, activities and campaigns.

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CHAPTER 5

CATALONIA

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5.1. Introduction

5.1.1. General information

Catalonia is one of 17 autonomous communities in Spain with an area of 32,000 km. It is located at the north-east coast of the country. At the end of 2001 the Catalan population was 6,506,000, of whom 3,318,000 (51 %) were female and 310,307 (4.8%) legal foreign residents. The age distribution of the population was: 13.8% under 15, 68.8% between 16-64 and 17.4% over 65 years old. The population density was 204 inhabitants/km^2. Unemployment rate was 9%. The proportion of the population with tertiary studies was 18%.

In 2001, Catalonia had 5 beds and 4.7 doctors per 1,000 inhabitants. GDP per inhabitant was €20,120[1]. Life expectancy at birth was 76.8 years for males and 83.4 for females. Life expectancy without disabilities was 66.8 for males and 69.0 for females. For men and women respectively, mortality rates related to neoplasia were 34% and 22%, related to the circulatory system 28% and 37% and related to the respiratory system 13% and 10%. Infant mortality rate (per 1,000 live births) was 3.2. Life expectancy in Catalan men is reduced by car accidents, cancer of the trachea, bronchi and lung and cardiovascular diseases. In women life expectancy is reduced by breast cancer, followed by car accidents and cardiovascular diseases[2].

5.1.2. Organization of health services

The *Generalitat* is the institution under which the self-government of Catalonia has been politically organised since democracy was restored in 1977. The Government of Catalonia is divided into departments and the Health and Social Security Department is responsible for health. The Catalan Parliament is authorized to legislate on all aspects of health. The Catalan health care model was established in 1990 under the LOSC (the Health Care Organisation of Catalonia Act). The LOSC created the Catalan Health Service (CatSalut), consolidated a mixed health system, organized all areas of health care services and integrated the public use of all health resources (hospitals, primary health care, mental health, etc.) into a single network. CatSalut is the cover provider of health services in Catalonia and guarantees their provision to the public. CatSalut plans, purchases and evaluates health services according to the population's needs. CatSalut purchases services from its various providers, of which the Catalan Health Institute (ISC) is the main example, through the use of contracts that state the health objectives and 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.

Primary Health Care (PHC) is the citizen's first level of access to the health care system and there are 345 PHC centres disseminated around the territory. 82% of PHC centres are managed by the ISC while the rest are managed by private organisations. PHC centres are composed of multidisciplinary teams and integrate health promotion strategies with preventive and curative interventions. There were 36 million PHC visits during 2002 and the mean number of consultations per inhabitant per year was 6[3]. In an evaluation study in PHC settings it was found that the total number of patients visited by professionals is about 2,000 (700-2,800) and he mean visits per week 126 ± 62[4].

Specialist health care is the citizen's 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 complementary networks. In 2001 Catalonia had 65 hospitals (17 with psychiatry units and 11 with hospital-based detoxification units), with 15,000 beds admitting 664,000 inpatients, 9 million outpatient visits and 3 million emergencies[3].

5.1.3. Alcohol consumption and alcohol-related problems

In 1989 the Program on Substance Abuse was created in the Health Department mainly to direct and manage services and propose or resolve governmental concerns within the area of substance abuse. A Catalan Drug Addiction Network (CDAN) with 60 centres was organized to offer different treatment modalities (methadone maintenance, etc.) to all dependent patients[5].

Catalonia has developed a particular model to deal with alcohol-related problems within the framework of a global strategy on drug dependencies. Excessive alcohol consumption has always been 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]. Alcohol consumption is rated third as a risk behaviour factor for health, causing 5.5% of total mortality[7]. Other studies indicate a total of 6.6% of annual mortality[8].

Annual per capita alcohol consumption has decreased in the last 10 years and has stabilized at around 10 litres pure alcohol per inhabitant per year[6]. As in other Mediterranean countries, wine consumption is culturally rooted in Catalan nutritional habits. In 2002 pure alcohol consumption in litres per capita was 10.49 litres (12.25 for age 15+); of this 2.4 l was spirits, 4.3 l wine and 3.8 l beer[9]. In the European league table (of 15 countries), Spain is 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[10]. According to the World Drink Trends, in 2002, Spain was located in 8th place in alcohol consumption [11].

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 younger people (15-29 years). The prevalence of risky drinkers was 9.5% (11.8% males and 7.8% females) of the Catalan population between 15-65 years. Among those between 15-29 years, 12.7% were risky drinkers (12.1% males and 13.3% females)[12]. 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 2002, 5,619 (44.2%) of patients treated in the Catalan Drug Addiction Network (CDAN) showed alcohol problems: 79% males, mean age 42.9 years, 56% with primary education and 47% employed[5]. In 2002, 85% of total emergencies caused by drugs were related to alcohol[13]. In 2000, 562 (41.2%) of the total of 1,363 alcohol tests carried out following fatal car accidents in Spain were positive for alcohol. In 2002, in 17.8% of the 11,135 alcohol tests carried out after a car accident, the driver had consumed alcohol[14]. In 1999 the figure for annual health and social costs of alcohol to Catalonia was €570 million[8].

5.1.4. Previous research on brief alcohol interventions

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[15-20]. The results of a recent meta-analysis support the efficacy of brief intervention for excessive drinkers in Spanish PHC settings[21]. 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 the meta-analysis by Ballesteros and colleagues[22], 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) [23]. A dose-response effect was not found.

5.2. Customisation

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 3 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 of Drink- less.

5.2.1. Early identification (screening) package

The AUDIT questionnaire has been validated in both the official languages of Catalonia (Catalan and Spanish)[24-25]. Additionally, a Systematic Interview on Alcohol Consumption (SIAC) was developed with 3 quantity-frequency questions and validated to detect risky drinking in PHC settings[26]. Later, the AUDIT-C[27] 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.

5.2.2. 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 package[28], 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 customised to the trainers' and trainees' needs.

5.2.3. Training the trainers

The choice of Addiction Specialists as trainers was made 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 3 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 customisation 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.

Training the trainers: first stage

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.

The two workshops were organized with identical aims and similar agendas but progress made in the first workshop was used to modify the starting-point for the second. Whereas the first was aimed mainly at addressing the usefulness of the Skills for Change package, the second was aimed at designing our customized training package.

The first workshop was held in December 1998 with 30 physicians, lasted one-and-a-half working days (14 working hours) and was sponsored by the pharmaceutical industry. The agenda included:

- Introduction and presentation by the General Director of Alcohol Policy in Catalonia, the scientific evidence for the efficacy of SBI in the alcohol field, the results of the previous WHO study (Phase III) and the future Phase IV strategy;
- Four parallel FGs organised during the one-and-a-half hours to shed light on the following issues: should CDAN physicians train GPs? how can CDAN co-ordinate with PHC Centres? is shared care a feasible option? what are the needs of the CDAN in training and supporting PHC centres?
- Presentation and revision of the Skills for Change package (relevant chapters and practical exercises) and the theoretical basis of the Stages of Change and of motivational interviewing strategies. Comments from participants were carefully recorded and suggestions taken into consideration in order to introduce changes to some of the exercises and to decide which would be suitable for the final version;
- Summary and discussion of the main findings of the 4 FGs;
- Proposal and discussion of the intervention model (training package) structured in 4 one-hour sessions to be delivered weekly over one month in PHC centres and with the following contents:
    - Introduction: project aims, impact of alcohol consumption on society, on the health system and in the PHC Centre, dinkers' classification (degrees of risk and levels of intervention)
    - Risky drinking: definition, screening tools and clinical approach (brief interventions)
    - Alcohol Dependence Syndrome (diagnostic criteria, treatment protocols in PHC, criteria for referral and shared care)
    - Co-ordination procedures between PHC and specialist teams
    - Agreement on level of implementation of SBI in this particular PHC Centre.

Conclusions reached from the workshop were, in summary:

1. More work was needed to fit the training package to PHC needs and facilities
2. Training should be directed to the PHC team as a whole
3. Every PHC centre should have someone responsible for co-ordinating training and follow-up
4. Training should be interactive and based on the Skills for Change package
5. Meetings to introduce the project should be arranged in every county
6. Pilot training interventions should be held before widespread training
7. Training materials need to be strongly adapted to our social context
8. Special attention should be paid to communication between PHC centres and the CDAN
9. Special emphasis must be placed on detecting and resolving resistance coming from both sides
10. All professionals in the CDAN (psychologists, social workers, nurses and doctors) should be able to participate in the training sessions
11. This program should be included in the contracts that the Catalan Health Services establishes with Health Regions and PHC Centres.

The structure of the second workshop was informed by the recommendations reached during the first. Main differences between workshops were:

A. Fewer GPs were invited to attend. Their opinions about the suitability of the program and the design and customization of the training package were important. The workshop was also attended by 4 psychologists and one policy-maker from the Catalan Health Service (CatSalut).

B. Focus groups were aimed at discussing different topics and practical issues. Five groups were run covering the following topics:

a. Advantages and disadvantages of working with PHC teams

- *Advantages*:

- better relations with PHC improve practice with risky drinkers and alcoholics
- less inappropriate referrals and better treatment options for patients
- the opportunity to integrate with the Drugs Network in the Health System
- improvement of shared care treatment.

- *Disadvantages:*

- excessive expectations that might lead to frustration
- possible overload by systematic referral
- co-ordination and ongoing support might be time-consuming
- the focus on alcohol might lead to reduced interest in other drug users.

b. What should Health Authorities do to facilitate dissemination of SBI in PHC settings? What can be done by addiction specialists? Health Authorities have a definite role at 3 levels: PHC, CDAN and mass media. At the PHC level alcohol should be part of contracts, CDAN facilities should be more publicized and the CDAN itself should be fully integrated with the Health System. At the CDAN level, special attention should be paid to facilitating communication between CDAN and PHC teams, and training work with PHC should be funded and fully acknowledged as part of routine activity. At the mass media level, campaigns to promote population changes in drinking habits should be promoted, with special emphasis on the risky drinking concept. On the other hand, addiction specialists should make an effort to improve their co-ordination with PHC teams, trying to acquire a better knowledge of PHC and demonstrating clearly the activities and characteristics of the CDAN.

c. Barriers and roadblocks in addiction specialists. How can they be removed?
Reluctance on the part of CDAN professionals could come about for several reasons: lack of confidence in training capacities, different 'languages' used, fear of receiving too many referrals, perception of lack of interest in primary prevention in PHC, fear of rejection, and fear of weak support from Health Authorities to implement the program. To overcome these barriers, several solutions were proposed: The program should be strongly supported by Health Authorities, including a public presentation; it should be included in contracts; training of CDAN professionals is essential; specific funding for these activities is required.

d. Barriers and roadblocks in PHC professionals. How can they be removed?
PHC professionals may be reluctant to accept the efficacy of SBI. They may fear the work overload the program could produce. Assessing risky drinkers might uncover alcoholics. There is some confusion between alcoholism and risky drinking. Treating alcohol problems generates defensiveness. Strong support from CDAN should be provided to PHC teams.

e. How to set clear criteria for treatment or referral in PHC?
Clear and consistent referral criteria should be defined. GPs should be able to refer any patient they think they should. No waiting lists should exist. Shared care would probably help to clarify referral guidelines.

C. The Skills for Change session was shortened and the contents of each training session and guidelines for the 'Session Plan' sheets were agreed. Agreement was also achieved on the duration of training sessions (one hour) and their delivery as regular Continuing Medical Education sessions in each PHC centre.

Evaluation
As part of the design, evaluation of the training procedures and of professionals' attitudes was completed at the end of every workshop and results from 57 participants were obtained. 70% of the trainers thought that training PHC teams in SBI was very important and they were willing to do it. 75% of professionals from the CDAN thought that being a trainer of PHC team was important work, and 88% had a very high degree of interest in becoming trainers. GPs and nurses were seen as the essential targets, although social workers were also to be taken into account. 93% of addiction specialists agreed that they were in good position to train PHC teams, and 79% also believed training should be conducted in group sessions. Consensus was not reached on which professionals from the CDAN should act as trainers but, in the focus groups conducted with GPs, it was stated that doctors working in a CDAN were seen as better trainers than other professionals in the CDAN. An ability to link training with support and referral appears to be the underlying reason for choosing doctors as the best trainers.

The number of hours that should be used to train and support PHC teams appeared as one of the possible barriers to overcome. Even though it was planned to dedicate 5 hours to training, most trainers thought this was not enough. In fact, 75% of trainers thought that 7 or more hours were needed for training, and 67% thought that providing support would also require more than 7 hours per year. Finally, the workshop was seen as a good way to train the trainers. 100% of the participants found the workshop very useful, rating the contents and the methodology as good or very good in more than 90% of cases. The Skills for Change Package was also accepted by 84% of the participants, although quite a few adaptations were suggested.

Training the trainers: second stage
Information collected in the previous meetings was used to design the definitive package and model of intervention and to allow personal customisation 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 training sessions finally agreed were 5: 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.

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.

In summary, data collected from workshops, together with evaluation results and the package design, showed that the methodology used was suitable to begin the dissemination process of SBI in PHC in Catalonia.

5.3. Reframing

In Catalonia the reframing of alcohol concepts is a huge task because consumption of alcohol, especially wine, is rooted in the culture and even seen as a healthy habit. There are still some social prejudices against those with alcohol problems that also influence the attitudes of health professionals. In recent years, the work of the CDAN in making treatment for alcohol dependence available to all citizens, the work on brief interventions conducted by some PHC organizations, and the targets for alcohol consumption set by the Catalan Health Plan have consistently contributed to a better understanding by health professional groups of the reframed alcohol concepts (risky drinkers, hazardous and harmful drinkers, excessive drinkers, etc.) and the rationale for SBI. There is still much to be done towards changing general public's perceptions and attitudes to alcohol.

The communications strategy in Catalonia was linked to the Demonstration Project and specially targeted at health professionals groups (specialists and PHC professionals) and the general public. Addiction specialists who acted as *Beveu Menys* trainers attended a workshop on *Bevue Menys* SBI concepts and techniques and were able to attend additional workshops to improve their communication skills aimed at changing behaviour and attitudes. As part of the communications strategy aimed at disseminating SBI to specialists, in May 2003 we launched a monthly Beveu Menys Bulletin targeted at professionals, containing relevant information on the project and contributing to reframing by including and updating relevant evidence-based studies of SBI methods.

User-friendly PHC professionals' packages were developed to include complete information aimed at reframing alcohol concepts and at convincing them of the widespread damage to public health and welfare from risky drinking and of their responsibility for detection and intervention.

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.

Media advocacy was also encouraged by inviting all journalists in the region to a press conference some days before the official launch of the project (November 2001). The conference was aimed at introducing the new project, increasing the media's interest in alcohol-related issues and encouraging them to promote the concept of risky drinking in their work. Over the last two years no additional media advocacy has been possible.

The communications strategy and the specific messages were evaluated as part of the evaluation of the Demonstration Project by pre- and post-strategy measures of the extent to which respondents understood and accepted the concept of risky drinking and other related matters. Among the general public, face-to-face interviews were conducted in a random sample obtained in PHC settings. Among health professionals, mailed questionnaires and personal interviews were used to record changes in attitudes to SBI and risky drinking. Data from the evaluation have not yet been analyzed but 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.

5.4. Building Strategic Alliances

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. The main alliances were 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)

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 received advice since the beginning by 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 lead 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).

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.

5.5. Demonstration Project

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 3 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).
A communication strategy was organized in order to start the dissemination process:

- 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).

5.5.1. Procedure

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 5 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.

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:
   1) To the trainer:
      - A list of participants and a registration sheet for signatures (attendance is proved by the signature)
      - A questionnaire evaluating the training course (quantitative and qualitative data)
   2) To the PHC coordinator:
      - BM packages for all participants
      - 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.

To encourage the scheduling of courses and the use of materials and to overcome roadblocks, new marketing and creative strategies were launched during 2003:

- A "Beveu Menys" Bulletin has been targeted at general practitioners and specialists and is published monthly by electronic mail. 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.

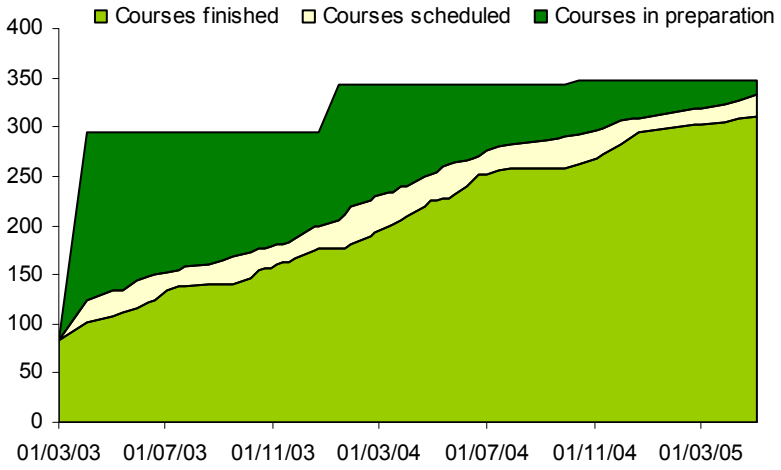
- Telemarketing targeted at PHC coordinators and BM trainers. This has contributed to the continuous updating of the database and to raising awareness.
- PHC proposals for Course Dates are proposed to trainers who can then fit them into their diaries.

5.5.2. Evaluation

Figure 5.1 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 is steadily increasing; courses are welcomed by PHC professionals, trainers' perceptions are positive and participants' attendance is maintained through all sessions. The course structure preferred on 44.6% of occasions is 5 sessions.

FIGURE 5.1.

Training Dissemination Status



A parallel, ongoing, pre-post evaluation procedure has been implemented in 10% (n=28) of randomly selected centres but at present only baseline results are available. Two researchers were trained to sample data before and 3 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 4 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 3 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 Risky Drinkers (RD) with Non-Risky Drinkers (NRD) (see Tables 5.1 and 5.2) we found significant differences in gender, work status, familiarity with the centre, being screened and receiving advice.

TABLE 5.1.
Sociodemographic characteristics of patients

		NRD	RD	Analysis	
		N (%)	N (%)	X^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
	Secundary	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 5.2.
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 3 months	242 (84)	46 (16)		
	Once every 6 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 (1)	<0,001
	Never	422 (86,1)	68 (13,9)		
Advice	Yes	40 (69)	18 (31)	4,52(1)	0,03
	No	256 (81,3)	59 (18,7)		

When comparing the 3 sources of information (see Table 5.3.) 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 5.3.
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

Up to date 17 BM bulletin has been produced. It is regularly received by 91.9% of the PHC centres and 84% of the trainers, and has resulted in increased requests for materials and an increase in the number of courses scheduled. The evaluation of the telemarketing strategy shows that at least 4 'phone calls are needed till PHC coordinator is contacted.

5.5.3. Economic Evaluation

Although no formal economic analysis has been yet carried out, some information on the demonstration project direct costs is available (Table 5.5).

5.6. Future Plans

During the current year we aim to achieve a widespread dissemination of the BM program to all PHC settings in Catalonia. That means that the remaining centres will have to be trained in this period. Substantial efforts will have to be made to promote an improved coordination between PHC professionals and specialists in order to overcome roadblocks for the effective implementation of the SBI methods.

Some of the initiatives planned for this year are the following:

- Getting together to form the PHC alcohol reference professionals network (XaROH).
- Organization in June of training workshop, 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.

TABLE 5.5
Direct costs from Demonstration Project

	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 sensitivation 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 sets of office furniture			550,00	
	1 sets 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**	

- Promotion of a yearly, 25-hour CME course entitled "BM training course in depth", aimed at training and updating as many PHC professionals 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.
- Dissemination of SBI techniques to other settings (hospitals, emergency rooms, etc.).

The Program on Substance Abuse of the Health Department remains strongly committed to this work, as can be seen from the fact that it is leading the Primary Health Care European Project on Alcohol (PHEPA), project co-funded by the European Commission, and has endorsed together with WHO, the development of the International Network on Brief Interventions for Alcohol Problems (INEBRIA).

5.7. Acknowledgements

Without the sustained help of Prof. Heather and the rest of participants of the Phase IV Study it would not have been possible to achieve the widespread dissemination of SBI in our country. Authors also want to acknowledge the support received by all the PHC and CDAN professionals involved in the dissemination of the program for their enthusiastic participation and for all the feedback provided during all the ongoing process. The members of the "Alcohol and Primary Health Care Group" have to be also acknowledged for being a permanent advisory group and helping the sustainability of the program. The authors also wish to recognize Montse Contel for her enormous contribution to the launch of the Program. Angela Bueno, Lourdes Serrano and Meritxell Torres are also thanked for their participation in the program evaluation. Finally, Claudia Fernandez, Encarna Moreno and Montserrat Rodriguez should also be acknowledged for taking care of the administrative site.

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CHAPTER 6

DENMARK

Sverre Barfod

6.1. Introduction

6.1.1. Brief country description

Denmark has a population of roughly 6 million. There are 3,600 general practitioners (GPs) and 12,000 physicians in total. Hospitals are almost all public and are managed by the Danish counties. Primary health care is almost completely public and based on agreement between the Organization of General Practitioners *(Praktiserende Lægers Organisation)* and the National Health Service (*Den offentlige Sygesikring*). The GP is paid partly per capita (25%) and partly by fee for service (75%). GPs work in their own clinics, mostly in groups. Around 25% work in single-handed clinics.

6.1.2 Brief history of responses to alcohol problems

Medical treatment is largely based in hospitals and is concerned with physical harm from heavy drinking. However, in the last few years an EU project on 'Healthy City Hospitals' has focused on prevention in hospitals and a guideline for hospital professionals is now available[1]. In Danish primary health care there has been no tradition of treating alcohol problems; for about a century, voluntary organizations have done this work. In the health services, treatment of alcohol abuse is provided mostly in outpatient clinics directed by the county authorities with a staff of social workers, psychiatrists and psychologists.

6.1.3. Available data on alcohol consumption and problems

According to data from the National Board of Health[2], Danes aged 14+ consumed 11.5 l of pure alcohol in 2001. This figure has been roughly unchanged since the mid 1970s. The peak was in 1983 with 12.8 litres. Since 1996 it has declined by 0.6 l. In comparison with 17 European countries, 6 consume more alcohol than the Danes: Luxemborug is at the top with more than 12 l, Iceland is bottom with less than 5 l. Alcohol-related deaths have more than doubled in the last 30 years, from 2% of all deaths in the early 1960s to 4.6% in 1998. The number of alcohol-related deaths per 100,000 inhabitants (aged 14+) in 1998 was 61 (liver cirrhosis 27, pancreatitis 27 and alcoholism/alcohol psychosis/alcohol poisoning 7 deaths).

6.1.4. Previous research on alcohol brief interventions

Alcohol research has been mainly in the field of sociology but in the last few years there have been some studies of treatment effectivenes. From 1994 the Danish National Board of Health *(Sundhedsstyrelsen)* has given funds specifially for research on alcohol problems. Unfortunately in the last few years priority has been given to non-medical projects but an essential study of matching was published in 2001 from the fields of psychiatry and behavioral science[3]. Early intervention has rarely been practiced and mainly only by specially interested GPs. Documentation of this is scanty.

6.2. Customisation

6.2.1. Findings from focus groups

In an interview survey in 1995[4], GPs explained their reluctance to talk about alcohol. They were not sure how to open the subject, had unfortunate experiences of trying to persuade patients to reduce consumption, and believed that patients did not listen or were lying. Also, GPs did not know what to do if patients really had serious alcohol problems.

These observations were confirmed in the Phase IV project. It emerged from two focus groups with 15 GPs in Frederiksborg County that GPs commonly felt it difficult to avoid moralising, or seeming to moralise, when asking patients about alcohol consumption and advising them to reduce. GPs found

it difficult to talk about alcohol if obvious symptoms were absent. And it was often frustrating when patients denied alcohol problems or hazardous comsumption. Many GPs felt a lack of ability in coping with these problems.

6.2.2. Specific aims of customisation

The materials used in the Phase IV project were customised during educational activity in continuous medical education (CME) groups. In Frederiksborg County, which was the local Phase IV intervention area, more than 90% of GPs are members of one or more groups. Participants in the GP focus groups suggested that these small CME groups could be used as arenas for disseminating knowledge and know-how and developing or training skills in handling risky drinking and alcohol abuse. This was one of the reasons the project leaders prepared and offered an educational package to these small CME groups.

The educational package consisted of two meetings, each lasting two hours, and was offered to 21 small CME groups in autumn 2001. The aim was to reframe understandingsof alcohol problems towards the concept of risky drinking and to teach when to talk about alcohol, how to raise the subject, the principles of brief intervention, handling barriers and difficulties, plus a demonstration of the principles of motivational interviewing[5].

The promotion of the CME project was done through an article in the local GP journal, through letters of invitation to each of the small groups and indirectly through a medical audit registration in November 2000.

6.3. Reframing

GPs accepted to some extent the idea of working with alcohol problems other than addiction ("alcoholism") but the experience of the CME courses was that we could not choose alcohol or hazardous and harmful drinking as the *only* topic for the project. GPs told us that if the project were aimed at tobacco, exercise and overweight *as well*, they would be more interested. We were thus convinced that alcohol problems do not “sell tickets”.

Hence we had to offer training of more generic skills, useable over a much broader range but including alcohol issues. In addition, many of the strategies we sought to teach were feasible to use in other areas too and relevant overall to the doctor-patient relationship. That is, difficulties in communication and frustrations can impede the doctor in talking about alcohol with the patient even when it is clinically relevant. For these reasons, in 2000 a project was designed to investigate whether education and training could enhance doctors' ability to communicate with patients in difficult matters such as reducing alcohol consumption and smoking cessation.

As promised during the meeting of Phase IV investigators in Bled, January 2000 we tried to develop a questionnaire on attitudes to reframing by testing the one presented in Bled. At the end of his visits to GPs, an academic detailer in one of the counties of Denmark asked each of them to fill in the questionnaire immediately. 30 questionnaires were sent to Newcastle for analysis but the data had a low internal consistency and no meaningful factor structure.

Reframing of the understanding of alcohol problems should take place in small-group based CME activities where the GPs’ understanding and attitudes should be highlighted and, if necessary – challenged and changed.

6.3.1. Communications strategy

The conception of early detection and brief intervention for hazardous and harmful drinking is now accepted in institutions responsible for educating medical professionals. But there is a large proportion of active professionals in both primary and secondary health care who lack knowledge in this area.

In some of the Danish counties, courses have been run on treating alcohol problems and members of the Danish Phase IV group were often invited to lead or contribute to these courses. As a part of the implementation activity in the intervention county of the project, recommendations for handling alcohol problems have been shown on the national health website from December 2003[6].

A proposal for a *national strategy* aimed at providing knowledge and training to medical professionals was sent to the Danish National Board of Health in 2003. Unfortunately the Board showed no interest. With support from the EU project (PHEPA), it could be possible to increase the interest of central authorities in this area in future.

6.3.2. Media contacts

Relevant articles published in professional journals are as follows:

i. Zachariassen A, Barfod S, Jørgensen AF, Sørensen E, Vendsborg P. Behandling af alkoholmisbrug efter kontrolprincippet i almen praksis. *Månedsskr Prakt Lægegern* 1991; 69: 629-632.
ii. Barfod S. Skal alkoholmisbrug overhovedet behandles i almen praksis. *Practicus* 1995; 96: 180-181.
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viii. Hansen LJ, Olivarius NdeF, Beich A, Barfod S. Encouraging GPs to undertake screening and a brief intervention in order to reduce problem drinking: A randomised controlled trial. *Family Practice* 1999; 16: 551-557.
ix. Thorsen T, Barfod S. Det er svært ikke at virke moraliserende. *Det Blå Blad* 2000; 22: 13-14.
x. Andreasen J. Lægen som motiverende sundhedskonsulent (Interview). *Ugeskr Læg* 2002; 164: 548-550.

In 2001 the project leader (SB) was a member of the *Hornum Committee* under the Ministry of Health with the task of describing the extent of alcohol abuse in Denmark and the target groups for treatment.

Examples of other media activities are:

- Articles in magazines:
  Barfod S. Så stil dog det spørgsmål! *Alkoholpolitisk Magasin* 1996; 4: 14-15.
  Barfod S. Praktiserende læger hjælper med ændring af drikkevaner. *Læge-Helse* 2002; 3: 15
- Interview on a regional radio programme
- Article in a county newspaper
- Lectures at conferences for social workers

6.4. Strategic alliance

6.4.1. Organisations signing up to the alliance

Intervention county: In the 3 years from 2000 to 2002 the Committee for Prevention (Forebyggelsesrådet) and the Board for Quality Development (Kvalitetsudviklingsudvalget) supported the activity of the project leader in facilitating co-operation between general practice, hospitals, private specialists, outpatient departments offering alcohol treatment, local authorities in the municipalities and NGOs.

National: Because of lack of interest from government authorities, this part of the work did not succeed.

6.4.2. What activities and how successful?

Intervention county: All partners in the alliance were invited to a meeting to discuss how co-operation could be described and improved. Very few attended and only two participatns had the professional or employer's authorisation to follow up on this task. A proposal for a guideline for GPs was mailed out to partners for comment and, after some valuable corrections, this became the recommendation mentioned under "Communications Strategy" (see 6.3.1. above). At the beginning of 2004 it was mailed to all GPs in the county.

National: Our suggestion for a national strategy included disseminating the effort to educate medical professionals, especially in general practice, in treating alcohol problems by:

a) establishing the education of trainers for advising on behavioural change, with the aim of assisting regional authorities of CME;
b) evaluating methods of training;
c) developing and distributing educational material (videos, information sheets, etc.);
d) sustaining international collaboration and the exchange of knowledge

As mentioned above, these plans found no support. However, because the demonstration project had funding for 3 years (2000-2002), this lack of interest from some of the alliance partners did not interfere with the completion of the project.

6.5. Demonstration Project

6.5.1. Background

From Phase III of the WHO Collaborative Project in Denmark, we had strong evidence to believe that Danish GPs regarded routine screening for risky drinking as inappropriate and maybe even counter-productive. This meant that screening could not be promoted as a routine procedure; it had to be presented as an *option*, e.g. as screening-like procedures in broad preventive consultations. Instead of routine screening, diagnostic indications of heavy, risky or harmful drinking had to be highlighted, as had methods for overcoming patients' denial of heavy drinking or alcohol problems, and methods for motivational interviewing, counselling and referrals to specialist treatment etc..

Thus, the contents of our intervention (i.e., the knowledge and skills we wanted to implement in general practice) were identification, counselling, treatment and appropriate referral of patients with heavy drinking or problem drinking – in short, *Alcohol Intervention* (AI). This adjustment of the original contents did not substantially change the implementation and research design.

6.5.2. Preparation and planning the intervention

Focus groups

During May and June 2000, we ran two focus groups (FGs) with a total of 15 GPs participating and lasting for two hours each. The purpose of the focus groups was to obtain information on GPs' preconceptions of alcohol problems and prevention, their attitudes to and experiences with alcohol intervention, counselling, treatment etc.. We also wanted to know what kind of barriers they perceived from patients taking part in counselling, referrals etc. and whether there any structural barriers that

make implementation of early identification and brief intervention (EIBI) or AI difficult. Moreover, we wanted to discover what knowledge and skills GPs needed to be able to deliver an optimal service to heavy drinkers and alcohol abusers. And how would they prefer to have CME-activities delivered/implemented?

As described in the section 6.2.1. above ("Findings from focus groups"), we then concentrated on factors that GPs perceived to be barriers to a smooth and efficient implementation of prevention and the handling of heavy and harmful drinking in general practice.

Patient attitudes
Because we had the impression – and this was confirmed by the FGs – that GPs were uneasy about patients' responses if they brought alcohol up as an issue during the consultation, we decided to investigate whether patients really dislike their doctors asking about their drinking habits and other life-style issues. First, we tried to construct a small questionnaire (22 items) as the data collection instrument. However, over two small pilots/validations, we realised that this method was not feasible. Instead, we set up a focus group with 8 patients from a general practice in Frederiksborg County addressing the same issues as the intended questionnaire.

From the focus group we received the impression that patients do accept their GP asking them questions about their alcohol consumption pattern when the problem presented might be alcohol-related. But screening-like procedures without relevance to the problem/disease would not be popular.

6.5.3. Intervention

In Denmark, there is a network of small CME groups. The members of these groups themselves decide which topics they want to deal with and how they will do that. The number of members is normally between 5 and 12. Some groups have a permanent character, while others are *ad hoc* - based on and devoted to a special problem - so that when the problem or issue has been exhausted the group is dissolved. In Frederiksborg County, over 90% of GPs are members of one or more groups.

Much implementation research in the medical field favours the use of local groups. New knowledge and skills can be discussed with colleagues in the context of the local medical culture and this is important because a consensus here is paramount for uptake in daily routine practice. Innovations, clinical guidelines etc. will acquire a more rapid footing in daily practice when the target group has a sense of ownership through discussing and accepting the innovation and through translating or transposing guidelines to local needs and sentiments.

The doctors were told that participation would enhance their skills and competence in handling alcohol issues and motivating patients etc.. Participation was free, i.e. the GPs did not have to draw on resources from their CME account.

Before launching the package in the first CME group we made an extension to the offer. Each participating GP could have a professional actor coming to the consultation room to simulate a patient with a problem or a disease that *might* be alcohol-related. The simulated patient in all cases had a somewhat high level of alcohol consumption (but this was not told to the GP unless s/he asked, or asked in a patient-centred way that persuaded the patient to drop resistance and be sincere). The simulated patient made an appointment for a consultation in the same way as ordinary patients. When entering the consultation room the actor revealed that s/he was an actor. The consultation lasted about 15 minutes (normal for a consultation) and was audio-taped. The tape was transcribed and used for feedback to the GP and for teaching and training at the second 2-hour meeting in the CME small group.

Both sessions in the group were focused on topics like:
- when should alcohol consumption be an issue?
- the transtheoretical model of change

- the spirit of motivational interviewing
- raising the issue of alcohol consumption
- avoiding resistance
- other MI techniques

The first meeting was focused on having GPs think about their practice and attitudes towards handling risky drinkers and alcohol problems, and to realising their problems and needs in relation to this category of patients and this task. Thus, the meeting was intended to function as an "eye-opener" (i.e., a starter that makes GPs consider their own practice regarding their handling of heavy drinkers) and to help participants define needs (knowledge, skills). Techniques of motivational interviewing and health behaviour change counselling were demonstrated and discussed.

During the second meeting GPs' experiences with the simulated patient were discussed and the transcriptions were used for this and for teaching, as mentioned above. Other specific issues and needs raised during the first meeting were also addressed.
However, in spite of what we regarded as a "special offer" and in spite of our marketing activities, the participation rate has been rather low. We will return to this below under the heading of "Problems and Miscellaneous" (section 6.5.6).

6.5.4. Monitoring

The year 2001 was scheduled as our year of intervention when all CME groups were supposed to have the 2x2-hour sessions. During that year we intended to monitor the project carefully, making it possible: 1) to know how the implementation actually ran; 2) to allow for adjustments and removal of unforeseen barriers and problems; 3) to know which parts of the intervention were the most appropriate and effective. (Unfortunately the participation of GPs transpired to be so scanty that changing project plans was necessary, see 6.6.)

We did not plan a full monitoring. Instead, we were less ambitious and had a panel of GPs and their partners (out-patient clinics, psychiatric wards, etc.) whom we visited regularly and asked relatively systematic questions about problems experienced, e.g., in asking patients about their alcohol consumption, in breaking the denials of problem drinkers, in the co-operation with referral institutions, and about information and written materials needed.

Supervisory meetings
Having participated in the small group-based CME and having tried out and practiced the new knowledge and methods in daily practice, GPs would have questions and problems they wished to discuss with each other and with those responsible for the intervention and the project. Therefore, we tried to set up meetings where such matters would be discussed and the GPs could be advised. We expected to have such meetings a couple of times during the year of intervention.

Internet
We are considering supplying the other elements of the intervention by an alcohol project-related homepage that is available only to the GPs in Frederiksborg County. (The restriction to GPs in this county is made to avoid contamination with the control areas). The homepage would be intended to bring new information about current interest and relevance for the handling of heavy drinking and alcohol problems; it should contain diagrams, forms and other tools for downloading and use during consultation. There should be a discussion database and a FAQ-site could be included.

6.5.5. Evaluation

Of course, one wants to know whether this approach to disseminating knowledge and know-how has any impact on the performance of the target group, the GPs. Therefore, we planned an outcome evaluation and a process evaluation.

Outcome evaluation
We used a quasi-experimental design with pre- and post-measurements, with Frederiksborg County as the intervention group and 5 other counties as the control group. In the intervention group, all GPs were asked to fill in a medical audit registration form for all their adult patient consultations during a 2-week period in November 2000 and this procedure was repeated after the intervention period (in the beginning of 2002). We expected that 50 of the 230 GPs in the county would be willing to fill in the registration form twice. To have a control group of the same size we approached 275 GPs selected randomly from 5 randomly selected counties. (The reason for not selecting only one county for the control group was to avoid the possibility that the chosen county would turn out to be very active in this particular field during the intervention year, thus reducing the ability to find a possible intervention effect.)

The categories in the medical audit registration form were built partly on the focus group discussions, partly on the goals of the intervention itself (more activity in the areas of identification, assessment, motivational interviewing, counselling, referrals etc.). Thus, outcome is here defined as the clinical performance of the GPs. Patient outcome measures such as morbidity, mortality, driving under intoxication, arrests for drunkenness, referrals to specialist treatment etc. were not considered appropriate because of small numbers as well as a certain time lag in such parameters, not to speak of possible confounders. Nevertheless, we were able to look into the available statistics at the end of the project to check whether our expectations were confirmed or not.

Process evaluation
In order to interpret and qualify any positive or negative evaluation effects, a process (or implementation) evaluation needed to be undertaken, the aim of which was to describe to what extent – or whether – the programme was implemented as planned, whether it ran smoothly, or whether there were any barriers that might explain suboptimal outcomes.

The above-mentioned monitoring of the implementation process (for adjusting the intervention) also worked as a data collection for the process evaluation. The data and experience from the monitoring was be supplemented by individual qualitative interviews with GPs and other key persons and by focus groups with GPs as participants.

6.5.6. Problems and miscellaneous

Low response rate at the pre-measurement
The medical-audit-like 2-week registration form was sent to all GPs in the County of Frederiksborg (N=246) and a random sample of GPs in five other counties (N=275). As an incentive the GPs were offered a gift if they filled in the forms.

However, the response rate was low. In Frederiksborg County we had a 34% response rate (84/246) and in the control group 22%. This problem was accentuated by the fact that only about half of those participating in the training sessions in the intervention group had made the medical audit registration beforehand.

GPs not interested
Another problem our project ran into was minimal interest from GPs to engage in the CME activities offered in this project. Five groups asked us to come and the attendance rate was not high. About half the members of these CME small groups participated in both meetings.

No quantitative evaluation
With the prospect of having very few participants in the intervention group (half of whom had not filled in the medical audit registration in November the year before) we faced a serious problem of statistical power. At best we had figured out at the beginning to have 25 GPs in the intervention group that participated in the intervention *and* registered patient contacts both before and after the

intervention year. Thus, remembering that this was a demonstration project that was to document the impact of a broad implementation of EIBI on the performance of GPs within a region (in this case, Frederiksborg County), we were in difficulties. Repeating the medical audit in the beginning of 2002 made no sense.

An alternative was a qualitative, in-depth interview study with those who had actually participated in the CME-activities.

6.6. Revised Demonstration Project

The problems described above led us to change the project plan in August 2001. The quantitative outcome evaluation was abandoned and the project was turned into a smaller method-development project where we tried to get GPs interested in participating in workshops in their own practices and let them define their own needs for training within the area of health behaviour change counselling and motivational interviewing.

We did not choose *alcohol* or *hazardous and harmful drinking* as the topic, as described in the beginning of this chapter. Instead, the project had the following outline.

6.6.1. Workshops

The teaching and training sessions were different from those already attempted and described above by being less top-down and less directive. While hitherto we had taught skills that we as teachers regarded important and useful for the particpating GPs, we now let them discover and decide what were the weaknesses that they wanted to improve/eradicate.

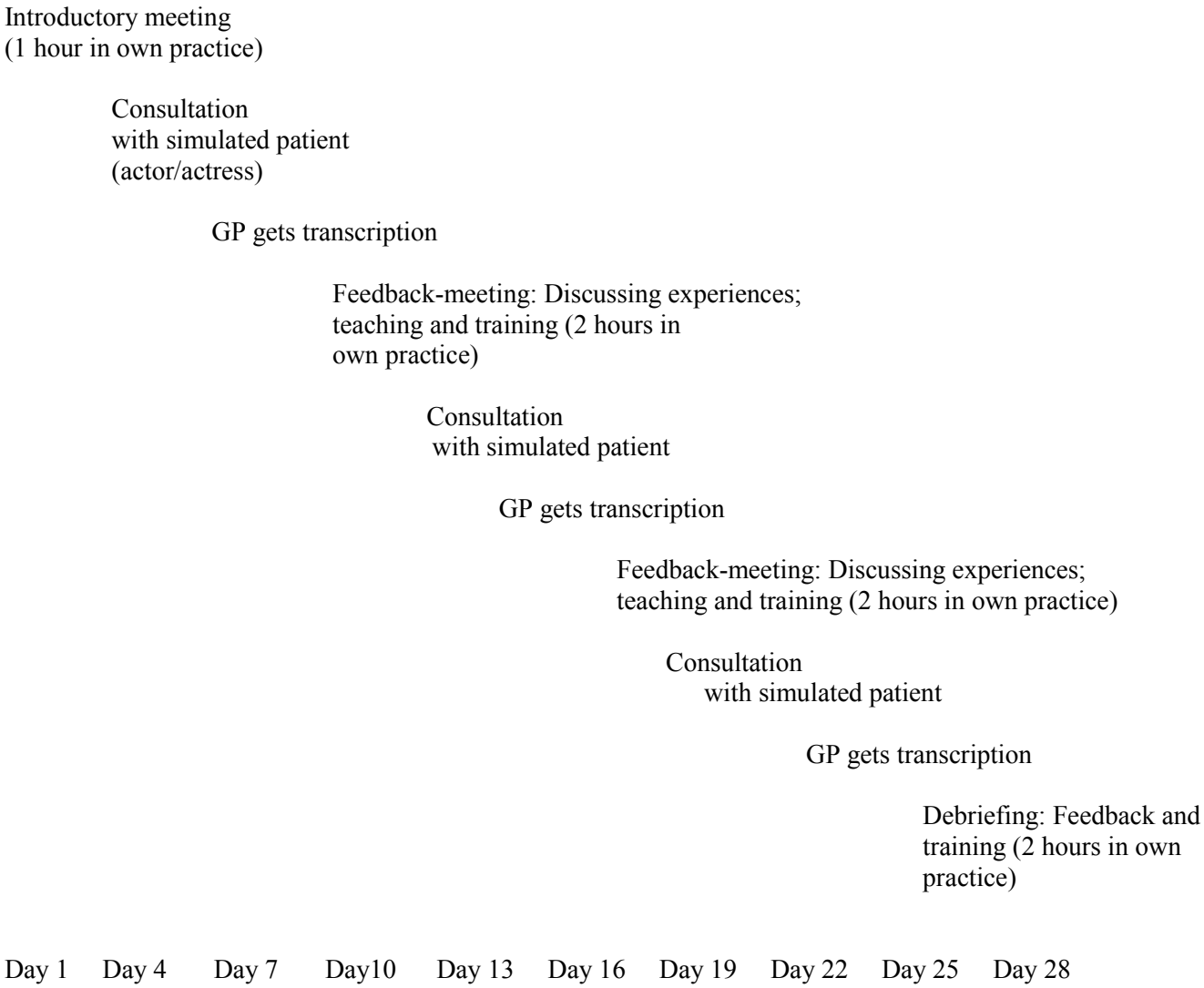
GPs were offered a multi-stepped workshop that allowed them to find out about their wants and wishes and to obtain training tailored to for this. Using catch-words, one could say that the clinician is the expert in what and how to learn, and the trainer's role is to facilitate and to provide useful ideas and skills. Training should start with what the GPs actually did in their everyday work setting. And if GPs were asked to decide what scenarios to focus on (i.e. clinical area – smoking, alcohol, nutrition, diabetes etc. – and communication skills), we believed that this approach would be far more interesting for them than the usual top-down model where experts arrived to tell them what they ought to learn.

6.6.2. Stages

The workshop started with an introductory meeting in the general practice clinic or health centre. Participating GPs agreed on a topic for the consultations with simulated patients that would come a few days later. These consultations were audio-taped and the transcriptions were sent to the doctors for them to consider own weaknesses and strengths and issues for the training session 3 days later. This procedure was repeated twice focusing on different scenarios. After the 3rd consultation and return of transcriptions, there was a debriefing seminar where experiences were summarised. In overview the steps were those shown in Figure 6.1.

FIGURE 6.1

Steps in the GP Workshop



A full stepped workshop had a 4-week course and included four meetings with trainers and GPs (a total of 7 hours), and three consultations (each lasting 15 minutes). GPs were paid for participating in meetings and received a standard fee for each simulated consultation.

When the first practice was completed, we started another course with different participants, since it was practically impossible to run parallel workshops with too many calendars to co-ordinate.

6.6.3. Evaluation

The introductory and debriefing meetings were audio-tape recorded for evaluation purposes, allowing comparison of GPs' self-reported communication problems and self-appraisal of skills etc. before and after. At the same time participants were asked to appraise the workshop and the didactic methods used so that the concept could be continuously improved.

The consultation transcripts were compared during the workshop period in order to reveal possible improvements in using motivational interviewing health behaviour change counselling. This evaluation was supplemented by yet another simulated consultation 4-6 months after the debriefing seminar. This consultation had a presented problem similar to that used at baseline. To reduce confounding of prior knowledge, a new simulated patient performed the acting.

The actors were instructed not to "deliver" certain replies or responses to the doctors handling the consultation but to study the case story and "to be" that patient and react as a person to the questions from the doctor. Three actors were hired (two female and one male), all graduates from the National Theatre School (Statens Teaterskole) and trained in performing patients with all kind of diseases and problems at the Laboratory of Clinical Skills (Laboratoriet for Kliniske Færdigheder) at the Rigshospitalet, Copenhagen.

At the beginning of the simulated consultation, the GP was handed a brief description of the patient in front of him/her. The actor him- or herself had supplementary information of the reason having an appointment that day and information on life-style according to the topic selected by the GP. The GP was aware it was a simulated consultation as the actor had an appointment. At the beginning of the consultation the actor placed the tape recorder on the desk and put it on.

The simulated consultation was intended to resemble a normal one as much as possible. The time used was normal for the actual clinic in question, for one 10 minutes and for the rest 15 minutes. The simulated patient was to have the same "treatment" as other patients, that is interruption in case of emergencies etc.. If the GP wanted to measure blood pressure etc., the simulated patient would hand over a note with the result.

Feedback
The audiotapes were typed out and sent to GPs as soon as possible, a few days before the lesson. The trainers at the 18 (6 clinics x 3 lessons) feedback meetings were the leaders of the project: Thorkil Thorsen, sociologist by training, senior researcher, and Sverre Barfod (SB), specialist in family medicine and GP.

At the meetings the transcriptions were made the starting point. Each GP had his/her own transcription but did not know the others. At the first meeting the necessity of openness and trust was underlined to promote the positive atmosphere necessary for benefits from the lesson. Attached to the transscripted consultation GPs received an invitation to find "difficult" passages or sentences where they wished they had done something else and so on.

At the feedback meetings we started with a common discussion of their experiences, our evaluation (brief) of the consultation, the strong and weak aspects of the GPs' performance as judged from the transcriptions. In addition, we included elements from the *motivational interviewing* techniques elicited from the discussion. This method made the lessons different between the participating clinics and the three feedback meetings at the same clinic were also different. Nevertheless, the ingredients were sufficiently common that it is correct to talk about a certain *education or intervention.*

Common elements were:
- stages of change
- what is motivational interviewing?
- raising the subject
- asking permission to do so
- linking the presenting problem to life-style
- no stigmatising, no frightening
- open, not closed, questions
- ambivalence

- exploring ambivalence and the motivational balance
- motivation
- readiness (importance/self-confidence)
- change talk
- preparing for self-motivating statements
- resistance and avoiding this
- handling resistance (reflection, rolling with resistance)
- relapse

The method of training included mini-lessons (3-5 minutes), role-plays, training techniques of asking, and discussing experience from former consultations.

Efficiency
Six clinics with 25 GPs attended the project and 23 GPs concluded the whole course. The efficiency of the course was evaluated be analyzing the behaviour of GPs at the beginning of the course and at the follow-up contultation 4-6 months after the last lesson.

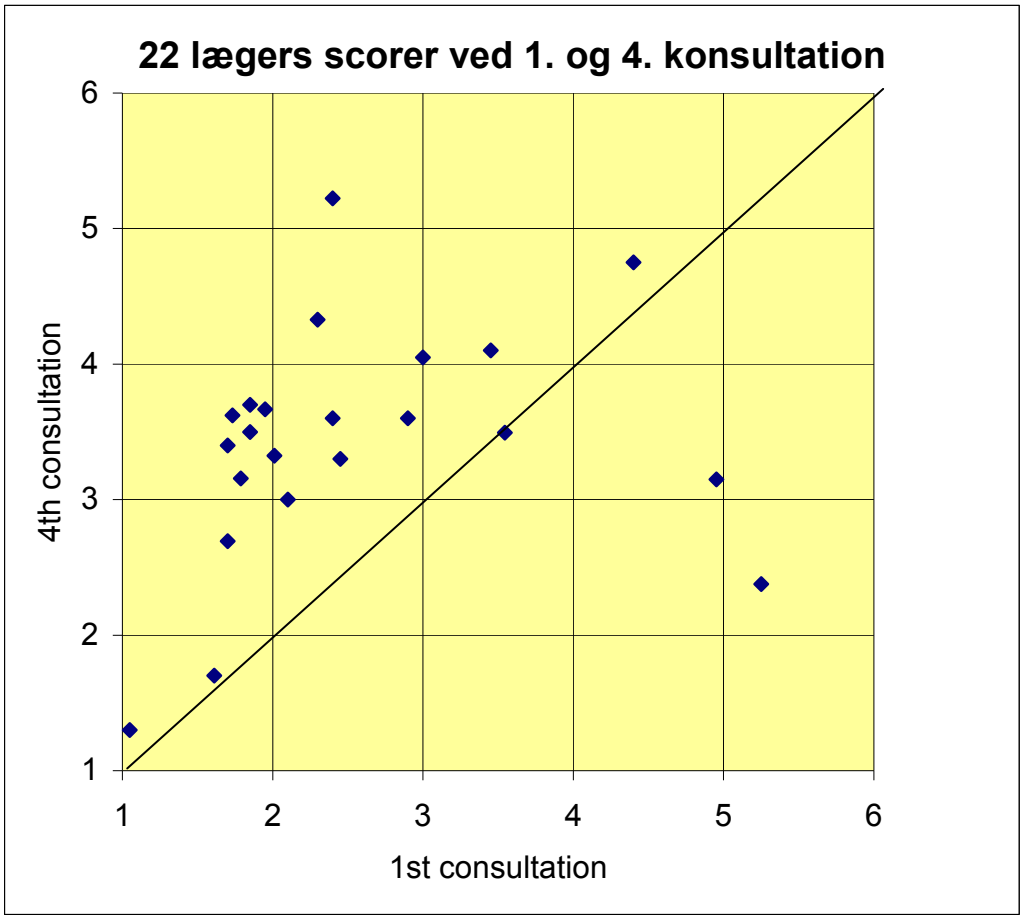
The analysis was based on the *One-Pass Coding System for Motivational Interviewing* developed by Resnicow and collegues at Rollins School of Public Health, Emory University, Atlanta, USA. The method was customised by Thorkil Thorsen. Transcriptions were rated according to the elements, techniques and strategies of motivational inteviewing, quantitatively and qualitatively. The rating concerns the GP behaviour only. As the recording from the first consultation was missing from one of the GPs, only 22 GPs could be evaluated: 11 females, 11 males.

Semi-structured group interviews were carried out during the last of the three feedback meetings. Items were the GPs' immediate thoughts on the design and conduct of the project. Supplementary to this, participating GPs were invited to one of two follow-up meetings 1½ years after the 3rd lesson. Nine of the GPs attended a follow-up meeting.

6.6.4. Results: did GPs change their behaviour?

Figure 6.2 shows the overall changes for each GP from the 1st to the 4th consultation about 6 months later.

FIGURE 6.2



The abscissa gives the score of the 1st consultation and the ordinate the score of the 4th consultation, with maximun of 7 points and minimum of 1 point. (Figure 6.1 is limited to the value of 6 because no GP obtained points above 6). Each co-ordinate represents a GP. GPs above the diagonal have improved their consultations (according to our scoring) . 19 of the 22 GPs scored higher after the intervention, 3 GPs scored lower. This result is statistically significant (*Wilcoxon signed rank test:* $p < 0,01$). It is important to note that, because of an ordinal scale, scoring can be used arithmetically only with great care. Thus, one cannot calculate a percentage improvement.

One of the four GPs who scored the highest at the 1st consultation improved only by one point while two others' scores fell markedly. The GP at the left lower edge of the figure scored low at both consultations but there is a little improvement all the same. The most marked improvement is shown among the GPs scoring between 1.5 and 2.5 before the intervention. While 16 of 22 GPs scored below 3 points at the 1st consultation, this was only the case with 4 GPs at the 4th consultation.

6.6.5. Costs

The implementation project had funding of 2.5 million DKK (c. 333,000 EUROS) from the National Board of Health. The Committee of Prevention and the Board of Quality Development in Frederiksborg County supported it with 400,000 DKK (c. 53,000 EUROS). The costs for the training of one GP amounted to about 8,000 DKK (excluding costs for the analysis). This is not unusual for similar CME-courses in Denmark.

6.6.6. Conclusion

The training project with three simulated consultations and three connected feedback meetings arranged in GPs' own clinics improved most GPs' skills concerning using *motivational interviewing* techniques and strategies.

6.7. Overall conclusion

Our overall conclusion from the Phase IV project in Denmark is that reframing understandings alcohol issues and implementing new skills for giving advice for changing behaviour demands intense planning in cooporation with local educational groups to succeed.

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CHAPTER 7

ENGLAND

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7.1. Introduction

7.1.1. Country description

England is the largest of the four countries making up the United Kingdom of Great Britain and Northern Ireland (UK). England covers an area of approximately 129,720 sq km.

In a 2001 census, the population of England was 49,138,831 (83.6% of the UK population). The UK population has grown by 17% overall since 1951 but, compared with many other developed countries over the same period, is growing more slowly. For the first time, people 60 and over form a larger part of the population than children under 16 (21% compared to 20%). There has also been a big increase in the number of people aged 85 and over- now more than 1.1 million or 1.9% of the population.

In 2002, life expectancy at birth for females born in the UK was 81 years, compared with 76 years for males. This contrasts with 49 and 45 years respectively at the turn of the last century in 1901. In recent years, the increase in life expectancy among older adults has been dramatic, particularly for men.

7.1.2. Health care services

The National Health Service (NHS) in the UK has recently undergone radical changes in the way health care services are organised and financed.

The NHS plan published in July 2000 set out proposals for modernising and reforming the NHS over 10 years. At the heart of the plan are patients and primary care, with Primary Care Trusts (PCTs} the organisations responsible for making it happen. PCTs presently have 3 core functions. First is a public health function - to improve the health of the local community and reduce inequalities in health. This involves health needs assessment and the active engagement of patients.

Secondly, PCTs help develop primary and community health services, including the independent practitioner services of general practice, dentistry, pharmacy and optometry, as well as directly providing some of these services themselves. From 2008 however the intention is that PCT's will cease providing any such direct primary and community services. This will help PCT's to focus on their main third role of commissioning secondary and tertiary care services, and supporting general practices in performing their own practice-based commissioning.

In tandem with the changes to PCT's, the independent practitioner services are all having new contracts to help them modernise. The first of these contracts to be finalised was with general practice, the new General Medical Services contract [nGMS] implemented from 1 April 2004. It is the greatest change to how GPs work within the NHS since the NHS was founded in 1948. Firstly, it gives GPs the ability to control and manage their workload through a more flexible provision of services, giving them the ability to choose the services they provide. This is achieved through a categorisation of services. All GMS practices provide *essential services* and a range of *additional services* which they can opt out of if experiencing difficulties, such as recruitment. They then have the opportunity to increase income further by providing a wider range of *enhanced services*. PCT's can commission these enhanced services from other providers, thereby introducing competition into primary care and helping to drive up quality. The nGMS contract also allows GPs to drop all their out-of-hours care to further help their work/life balance.

The nGMS contract also provides a major focus on quality and outcomes. The new quality framework rewards practices for delivering quality care with extra incentives to encourage even higher standards. The 4 components focus on clinical standards, organisational standards, experiences of patients and additional services. The framework is supported by new *Information Management and Technology* (IM&T) systems to collect national data and will create one of the best chronic disease data sets world-wide.

Finally the nGMS contract is associated with the largest sustained investment in primary care the NHS has ever made. Practice infrastructure is being modernised in premises and IM&T, and a new allocation formula provides equity and recognises practice circumstances
so that money flows according to patient need. the intended final outcomes are better services for patients. they will be empowered to use primary care more effectively and will have greater access to services which are shaped around their own needs.

7.1.3. Alcohol consumption and alcohol-related harm

Total alcohol consumption in the UK rose steadily during the last century; in 2001 per capita consumption calculated at 8.6 litres of ethanol represented a 121% increase since 1951. Compared with other countries in the European region, the UK has been classified as having a "middle level of consumption", defined as between 5 and 10 litres per person per year[1]. However, in contrast to other European countries, notably the wine-producing countries of southern Europe, consumption in the UK is still rising[2]. An *Interim Analytical Report*[3] prepared by the Prime Minister's Strategy Unit in 2003 stated that, "If present trends continue, the UK would rise to near the top of the consumption league within the next ten years" (p.13).

From the General Household Survey 20014, 12% of adults (16+ years) in England are abstainers (M=8.5%; F= 15.2%), 67.1% are moderate drinkers (M=64.4%; F=69.6%), 16.3% are 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 (21 units/week men, 14 units/week women). This represents an increase since 1988 when roughly 25% of men and 10% of women exceeded these weekly guidelines.

Within the general trend of increasing consumption, there has been a particularly marked increase among young people in the UK. Among school pupils who admit drinking during the previous week, consumption has nearly doubled from 5.3 units in 1990 to 10.5 in 20025. 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 countries6.

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 respectively3. 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 day3. Binge drinking is by no means confined to the younger age-group, however, since one-third of men and one-fifth of women between 45-64 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 equivalent3.

It is clear that England, in common with the other countries of the UK, 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.

Associated with this increase in consumption, there has, of course, been a significant increase in alcohol-related harm of all kinds. Adding together costs in the areas of health, crime/public disorder, workplace productivity and family/social networks, the *Interim Analytical Report*[3] estimated 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.

7.1.4. Responses to alcohol-related harm

The modern evolution of treatment services for problem drinking in the UK began with the establishment of specialised, self-contained inpatient units following the work of Glatt in the early 1950s[7]. These were controlled by psychiatrists, and had a strong emphasis on group therapy, close links with Alcoholics Anonymous and a commitment to total abstinence as a goal of treatment for all patients.

More recently, and following the publication of a report commissioned by the Department of Health and Social Security in 1978[8], there has been a move towards a community-based response to alcohol problems. This involves an attempt to integrate previously disparate services, such as psychiatric treatment, local non-statutory councils and hostel accommodation, to form a multi-disciplinary approach including psychiatrists, nurses, clinical psychologists and social workers, and the provision of training and support for professional groups in direct contact with problem drinkers, such as general medical practitioners and other primary health care staff.

The latest statement of Government policy in the field of alcohol problems is contained in the Alcohol Harm Reduction Strategy for England (AHRSE) published in 2004[9]. The measures discussed in the strategy framework fall into four categories: Education and Communication; Identification and Treatment; Alcohol-related Crime and Disorder; and Supply and Industry Responsibility. The AHRSE accepts that there is a clear association between price, availability and consumption but nevertheless rejects measures to control price and availability as policy levers, mainly because "the majority of those who drink do so sensibly the majority of the time" and "policies need to be publicly acceptable if they are to succeed" (p.23).

In the chapter on Identification and Treatment, the Government considers the best way of identifying and treating those who have established alcohol problems that may be affecting their health or their social functioning and 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. It states that: "Following screening, individuals may benefit from a brief intervention….. Brief interventions are usually 'opportunistic' – that is, they are administered to patients who have not attended a consultation to discuss their drinking" (p.37). Such brief intervention may be effective for patients whose problems are not yet too severe. A number of action points in the chapter are relevant to research and implementation of screening and brief intervention (SBI) and to the need to train health care staff to deliver it.

7.1.5. Research on alcohol brief interventions

Studies of the effects of brief interventions in medical settings were pioneered in the UK[10,11]. Randomised controlled trials by Wallace and colleagues[12] and by Anderson and Scott[13] provided the first scientific evidence that SBI delivered in general medical practice was effective in reducing alcohol consumption among hazardous and harmful drinkers who received it.

Subsequently, research on SBI in the UK has turned to studies of how it can be implemented in PHC and how GPs and other primary care staff can be persuaded to adopt it in routine practice. For example, as part of the WHO Phase III Strand 1 project, Kaner and colleagues[14] reported findings from a questionnaire survey of GPs in the English Midlands. Results showed that GPs did not to make routine enquiries about alcohol and may be missing as many as 98% of the excessive drinkers presenting to their practices. Kaner *et al.* also identified a range of obstacles and incentives to the routine implementation of SBI based on questionnaire responses.

Further research by this group in Newcastle, this time as part of the WHO Phase III Strand 3 study, showed that telemarketing is the most cost-effective means of disseminating brief intervention programmes in primary health care[15]. In a related study[16], it was shown that trained and supported GPs implemented a screening and brief intervention programme more extensively and systematically than those who received training alone or a control group and that this was a cost-effective strategy for encouraging GPs to use the programme on a longer-term basis. The Newcastle group has also conducted studies of the effectiveness of SBI delivered by nurses[17] and of methods for increasing implementation of nurse-led SBI in primary health care[18].

7.2. Customisation

The customisation strand of the Phase IV study in England was funded by the Alcohol Education and Research Council. The task of customising materials and services was approached using two methods - focus groups and a Delphi survey. Focus groups were carried out both with primary health care professionals and with patients or prospective patients of primary health care services to obtain their perspectives on the contents and delivery of an SBI programme. It was hoped that these perspectives could inform the adaptation of the programme so that it would be appropriate and acceptable for use in primary health care in England. Specific objectives were:

- To provide information about the appropriate customisation of materials for SBI in primary health care;
- To provide information about the most effective delivery of SBI in primary health care.

The aim of the Delphi survey was to obtain a consensus of expert views on how best to implement SBI in a routine and enduring fashion in primary health care throughout England.

7.2.1. Focus groups with primary health care professionals

The first round of the focus group study was conducted with a purposive sample of primary health care teams within Newcastle and North Tyneside Health Authority (n=75), stratified into two groups based on their previous experience of using the Drink-less package in Phase III of the WHO study in order to explore both user and non-user responses to the programme. Teams were also allocated to one of two focus group discussion topics:

- To explore responses to the Drink-less package
- To explore issues surrounding the achievement of widespread, routine and enduring implementation of SBI in primary health care, including training and support.

Four practice teams were recruited in this round. Groups were heterogeneous in nature in that they consisted of a number of different health care professionals (practice managers, GPs, practice nurses, receptionists etc) within existing teams. This was done to explore the team response to the screening and brief intervention programme and how it might be implemented within 'real' practice situations.

The findings of the first round were used to inform a further 4 professionally-homogeneous groups with GPs and practice nurses. The aim of these homogeneous groups was to explore professional differences in knowledge, attitudes to and experiences of discussing alcohol issues with patients and to derive different options for screening and brief alcohol intervention work. GPs were recruited from practices in the Gateshead area (n=30) and practice nurses from practices in the South Tyneside area (n=30).

Full details of sampling method, recruitment of practices, procedures and data analysis will be found in a report to the funding body[19].

Findings
Full details of the findings from these focus groups, including verbatim quotations from participants, will be found in the report to the funding body[19]. Some of the most important findings were as follows.

a) The majority of both nurses and GPs said that they had received little or no specific training on alcohol and what little information had been imparted had mostly come through more general training on health promotion and lifestyle issues.
b) This low level of training was presumably responsible for the considerable confusion regarding recommended levels for low-risk alcohol consumption[20].
c) A potentially useful grouping made by participants was the distinction between patients whom they felt they might be able to help and those they felt they could not. Much of what was said on this topic was consistent with the "stages of change" model developed by Prochaska and DiClemente[22-24].
d) Shorter and simplified versions of the AUDIT[25-29] might be used to save time in the busy general practice setting.
e) GPs were opposed to routine screening for excessive drinking unless it was part of a general health or blood pressure check.
f) New patient checks, diabetic or hypertension clinics, well man/woman clinics and general health screening were all mentioned as being appropriate circumstances in which to ask about drinking.
g) Most of the health professionals felt that patients would find it easier to discuss alcohol issues with a practice nurse, who was regarded more as a 'people's person', less formal than a GP and with more time to spend with patients.
h) There was a lack of support among participants for the idea of receptionists handing out screening questionnaires to all patients.
i) Participants emphasised the need for support to health professionals care if widespread implementation is to be achieved[30].

7.2.2. Focus groups with patients

These groups were conducted with a purposive sample of patients registered with practices within Newcastle and North Tyneside Health Authority. All practices within the study area (n=75) were invited to participate. Ten practices contacted the study centre regarding participation**.**

Participating practices were asked to select a random sample of 60 patients from their records, stratified by age (16-18, 19-25, 26-45 and 46+) and gender (male and female), to be invited to attend a focus group. A total of 43 patients (21 male and 22 female) returned their consent forms agreeing to take part in the study. Of these, 35 (81%) were over 40 years of age.

Due to the low response from patients aged under 40 years, a second recruitment strategy was developed. Market research methods were used to recruit participants aged between 18 and 30 years from the general public. Subjects were approached in Newcastle city centre, the research was explained to them and they were given an information sheet. To ensure that each focus group was as homogenous as possible and had a similar number of potential participants, patients who agreed to participate in the study were placed into groups determined by their age and gender. This gave a total of six groups with the following characteristics: female 18-30; male 18-30; female 40-55; male 40-55; female 56+ and male 56+. (No patients aged between 30 and 40 years agreed to participate).

Again, full details of methods and data analysis will be found in the report to the *Alcohol Education and Research Council*[19].

Findings

a) In general, participants did not resent being asked or advised about lifestyle issues, particularly if these issues were raised at certain clinics (e.g., patient registration, general check-ups, well man/woman clinics) where they expected them to be raised.
b) When asked what "excessive drinking" meant to them, participants gave a variety of replies but none appeared to use the concept of alcohol units to measure drinking level and define what was excessive.
c) Given the popularity of the AUDIT questionnaire, it is surprising that participants reported they would have difficulties in completing it. But most agreed that being asked to complete the AUDIT would be acceptable as part of general health screening, new patient registrations or while waiting to see a health professional, provided in the latter instance that privacy could be ensured.
d) The suggestion that screening alcohol consumption should be "layered" to avoid giving offence to patients could be met by the use of the FAST version of the AUDIT questions[29].
e) Apart from some small degree of confusion over the contents, the Drink-less intervention package was regarded positively be participants. It did emerge, however, that the materials should probably be specially adapted to suit the needs and concerns of younger drinkers.
f) When participants were asked to rank-order 5 types of health professional in terms of their preference for discussion of alcohol issues, the resulting order was: GP, practice nurse, counsellor, alcohol worker and lifestyle worker. However, a range of factors affected the interpretation of this order[19].
g) There was general agreement among participants about the need for more information to the general public on alcohol and its associated problems. A number of suggestions were made as to how this information could best be conveyed.

Combined findings from focus groups

When findings from both types of focus groups (i.e., with health professionals and with patients) were combined[31], the following were the main conclusions:

1. Discussions about alcohol are acceptable within specific contexts in primary care. A targeted rather than universal approach to alcohol screening and intervention would be more acceptable to patients and professionals and fits naturally with existing practice. However, there is still uncertainty among professionals as to the effectiveness of brief interventions and disagreement between professionals and patients as to who should carry them out.

2. Lack of resources and incentives remains a barrier to implementation. General practices that take on alcohol as an enhanced service through the nGMS contract will receive additional training and resources; however, the nGMS contract could become a disincentive if PCTs are financially unable to commission the work.

7.2.3. Delphi survey

The survey was conducted in 3 rounds. The first questionnaire consisted of 7 open-ended questions and was sent with an accompanying letter and guidelines for completing the study to all individuals (n=79) who had agreed to take part. Preparation of the second questionnaire began shortly after Round One questionnaires had been received. A total of 264 items were listed by respondents and a content analysis was conducted to establish the main themes and corresponding items. This number was culled to 157 after removing similar and redundant answers. The second questionnaire consisted of 8 sections:

- The best way to identify risky drinkers in primary health care without offending patients is by … (17 items)
- Patients can be encouraged to talk about their drinking by … (20 items).
- The most effective types of brief intervention for risky drinkers in primary health are … (18 items)
- Which PHC professionals should be involved in screening and brief interventions for excessive drinking and what should their respective roles be? (13 items)
- Primary health care professionals can be encouraged to routinely deliver screening and brief intervention by … (26 items)
- The concept of risky drinking can best be communicated to the general public via … (23 items)
- The concept of risky drinking can best be communicated to PHC professionals via … (13 items)
- The most important issues concerning screening and brief intervention in PHC are … (27 items)

Respondents were asked to agree or disagree with each item using a 5-point Likert scale The response categories ranged from '1' (Strongly Disagree) to '5' (Strongly Agree). After piloting, the second questionnaire was again sent to all individuals (n=79) who had initially agreed to participate.

Amendments were made to the third and final questionnaire which consisted of the same overall set of items as the second. This was sent to all individuals (n=68) who had completed the second round of the study. Using a mail merge facility, the median response and the individual's responses to each item were included on each questionnaire and the panel was asked to re-rate each item in light of the group's response. If new ratings differed by more than one point from the median, respondents were encouraged to comment on their reasons for this at the end of the questionnaire

The median and the inter-quartile range were calculated for the panel as a whole. The same statistics were also calculated separately for three sub-groups of the panel (see below). In analysing findings from Round 3, consensus was defined in terms of the inter-quartile range. Items with an inter-quartile range of =<1 were defined as having achieved group *consensus*; an inter-quartile range of 0 was taken to indicate *high consensus*.

The composition of the sample for each of the three rounds and for each category of experts is shown in Table 7.1. Fuller details of the method and analysis are given in the report to the funding body[19] and in a journal publication[32].

Findings

Details of findings and a discussion of their implications for practice will be found in the report to the funding body[19] and in Heather *et al.*[32]. Some of the main findings may be summarised as follows:

a) UK experts recommended a way of delivering SBI that is intermediate between universal screening for all patients attending a PHC facility and the abandonment of screening[33]. They were agreed that *routine* SBI should be carried out in special circumstances, i.e., new patient registrations, general health check-ups and special clinics where excessive drinkers were likely to be found.
b) There was strong support for the employment of a specialist alcohol worker to carry the main load of work created by the delivery of SBI. The specialist worker should be an integral member of the PHC team.
c) The findings suggested a model involving screening by other PHC staff, possibly in addition to screening by the specialist, followed by brief intervention, support and monitoring and onward referral to alcohol or addictions agencies where appropriate by the specialist worker.
d) In circumstances where the employment of a specialist alcohol worker is not feasible, the findings suggested a model of inter-professional co-operation in the delivery of SBI: (i) screening for excessive drinking is carried out in appropriate circumstances by the GP, practice nurse, district nurse and counsellor; (ii) referral of positive cases for brief intervention is made

to the practice nurse, the counsellor or the dietician, with additional involvement by the GP or the health visitor given time and interest; (iii) support and monitoring of the patient is carried out by the PHC staff member who gave the brief intervention; (iv) onward referral is made by the same staff member, perhaps in consultation with the GP.

TABLE 7.1

Composition of sample for Delphi survey

Subgroup	Recruitment	Round One	Round Two	Round Three
Academic	26	20	18	11
Researcher	28	21	24	12
G.P.	14	11	9	7
Nurse	15	7	7	6
Alcohol Service Worker	39	28	25	17
Director/Chief Exec. of Alcohol Service	5	5	5	5
Other	7	7	7	6

Numbers do not sum to totals in text as some individuals fall into more than one category.

e) The panel stressed the need for increased and improved training and education of health care professionals in skills related to SBI, particularly with regard to the recognition of risk and presentational factors, how to encourage patients to talk about their drinking and other brief intervention skills.

f) Experts showed broad agreement on the importance of principles bearing on the interaction between helper and patient derived from the motivational interviewing perspective[33] and the idea that behaviour change should be negotiated with the patient rather than prescribed or imposed.

The findings of the Delphi survey, together with those of the focus groups, were used to inform the development of the Demonstration Project (see below).

7.3. Reframing Understandings of Alcohol Issues

The aim of this component of the study was to develop a Communications Strategy to promote an understanding among the target audiences of the concept of "risky drinking", i.e., drinking above medically recommended levels with an increased risk of alcohol-related harm. The basic assumption of the strategy was that this should be seen as primarily a lifestyle issue and needs therefore to be distanced from concepts of “alcoholism” or severe dependence. Positive messages in relation to moderate drinking and healthy lifestyles were also to be communicated in the strategy. It was further assumed that, without such an improved understanding of the rationale behind SBI, no attempt at widespread dissemination could be expected to succeed in the long term. Three separate target groups were identified: health care professionals; the general public; stakeholders in SBI.

The development of the strategy was undertaken by a Communications Strategy Working Group, with the remit to advise and produce recommendations for a Communications Strategy on two levels:

a) on a national level for widespread dissemination throughout England;
b) on a local level for use in conjunction with the Demonstration Project component of this study.

As part of its output, the Working Group produced a document entitled, *Marketing Strategy for Screening and Brief Intervention in Primary Health Care*. This was intended to meet the objective of producing recommendations for promoting implementation of SBI throughout England. Included within this document was the Communications Strategy concerned specifically with the task of reframing understandings of alcohol-related issues among target groups. It was published by the charity, Alcohol Concern[34] and was widely distributed throughout England. It was also posted on the project web site **www.alcohol-phaseivproject.org.uk** and sent to the Cabinet Office Strategy Unit concerned with developing the Alcohol Harm Reduction Strategy for England.

As an illustration of the contents of the Communication Strategy, Table 7.2 summarises recommendations for communicating SBI among primary health care professionals.

7.4. Lead Organisation and Strategic Alliance

At the inception of the study, the lead organisation was the Centre for Alcohol and Drug Studies at Newcastle, North Tyneside and Northumberland Mental Health NHS Trust in collaboration with the Department of Primary Health Care at the University of Newcastle. Later and in the Demonstration Project, the lead was taken by the Division of Psychology at Northumbria University in collaboration with the Centre for Health Services Research, University of Newcastle upon Tyne and Gateshead Primary Care Trust. A Project Management Team was formed to run the Phase IV study and this met regularly on a monthly basis throughout the study.

7.4.1. Local alliance

A local Steering Group was formed to advise and co-ordinate research activities in the local area. This contained representatives of a range of local institutions and organisations, including universities, health care organisations, local government and public relations. The members of the Steering Group were influential in publicising and advancing the aims of the project on a local basis.

Another group of experts formed locally as part of the Phase IV study was a Policy Working Group. This had the remit of reviewing general policy on health in England and advising on what facets of health policy could be used to further the routine implementation of SBI. The group produced a document entitled, *Overview of Reforms and Developments in Health Policy: Implications for the Implementation of Brief Interventions in Primary Care* and this was included in the report to the funding body and posted on the project website.

7.4.2. National strategic alliance

To develop a Strategic Alliance on a nation-wide basis, a meeting was held at the Department of Health in London in May, 2000 which was attended by representatives of leading national organisations with a potential interest in promoting the implementation of SBI in England, including Alcohol Concern, the Royal College of General Practitioners, the Royal College of Nursing and the All-Party Parliamentary Group on Alcohol of the House of Commons.

Using contacts established at this meeting, publicity in various media and, following completion of the survey, the panel formed in the Delphi survey, a national Strategic Alliance was formed of organisations and individuals interested in promoting the widespread and routine implementation of SBI in PHC in England. Those joining the alliance were asked to sign a statement endorsing the aims of the Phase IV project. The membership of the Strategic Alliance contained 47 organisations and 92

individuals, including several Members of Parliament or Members of the European Parliament. The organisations in the Strategic Alliance are listed Appendix 7.1.

As part of the activities of the Strategic Alliance, a national one-day conference was held at the *International Centre for Life* in Newcastle upon Tune in June 2002. The conference was organised by a local public relations company, *Benchmark Communications Ltd* with the help of grant from *Pfizer Ltd*. The conference was titled, *Action on Alcohol: the Role of Primary Care* and was attended by over 300 delegates. Invited keynote addresses in the morning sessions were by Professor Sir Liam Donaldson, the Chief Medical Officer and Professors Griffith Edwards, Paul Wallace, Hazel Watson and Mike Kelly. In the afternoon there was a presentation of the latest findings from the Phase IV study by the project team, followed by another keynote address by Dr. Stephen Rollnick. The meeting concluded with a discussion among the members of the Phase IV Strategic Alliance of the best ways to take forward the alliance and the aims of the project.

7.5. Demonstration Project

Following completion of Strand 1 of the Phase IV study (customisation, reframing and strategic alliance), three attempts were made over a period of two years to obtain funding for a Demonstration Project but without success. Reasons for this failure to attract funding are unclear but it may be that funding bodies in the UK are not sufficiently familiar with the need for "translational research", i.e., research aimed at translating findings from efficacy and effectiveness research into routine practice.

Eventually, in 2004, the Tyne and Wear Health Action Zone (HAZ) invited tenders for a one-year project entitled, *Implementing Screening and Brief Alcohol Interventions into Pilot GP Practices* and our Phase IV team of investigators was successful in obtaining this grant. The application for funding specifically mentioned the opportunity to build on the research conducted in the WHO Phase III study, what had so far been accomplished in the Phase IV study and other research by our group. The project was described as an example of action research in which the participants in the project are invited to join researchers in meeting the project aims and an iterative process is used to make progress towards those aims. The project began in August 2004 and data collection has recently been completed.

The aims of the project were:

i) To pilot the routine implementation of alcohol SBI in at least one general medical practice in each of the five areas of the Tyne & Wear HAZ (Sunderland, Newcastle, South Tyneside, Gateshead, North Tyneside).
ii) On that basis, to develop Clinical Guidelines to assist primary health care professionals to deliver SBI in their everyday practices.
iii) At the same time, to develop a Training Programme for the routine delivery of SBI in primary health care.
iv) To roll out tried and tested Clinical Guidelines and a Training Programme to general practices across the HAZ and beyond.

TABLE 7.2
Summary of Communications Strategy for Primary Health Care Professionals

Objective	Channel	Content	Format
Raising awareness	▪ Professional (GP/Practice Nurse) education/training group meetings ▪ Individual practice team meetings	▪ Alcohol-related problems (health and social) ▪ Size of problems (nationally and locally) ▪ Public health/primary care issue ▪ Recommended levels ▪ 'Risky' drinking vs alcoholism ▪ What is SBI ▪ Evidence of effectiveness of SBI	▪ Presentation and discussion ▪ Overhead slides ▪ Handouts ▪ Printed SBI materials for demonstration ▪ Web site
Dissemination	▪ Telemarketing by GP or nurse ▪ Follow-up from awareness-raising meetings	▪ 'Risky' drinking and primary care ▪ SBI programme details ▪ Training programme details	▪ Telephone call and 'script'
Provision of SBI tools / materials	▪ Published screening tools ▪ Intervention materials ▪ Clinical guidelines	▪ Clinical guidelines for SBI and appropriate referrals ▪ Screening questions and scoring ▪ Information on units, sensible, hazardous and harmful levels, benefits of cutting down, strategies for cutting down etc for patients ▪ Available support services	▪ Written guidelines and decision making diagram/flow chart ▪ Screening tool and scoring template ▪ Unit calculator ▪ BI materials (advice card, handy card, booklet) ▪ CD ROM version ▪ Posters and leaflets for waiting room ▪ Directory of support services ▪ Web site
Training	▪ Practice team based training sessions (accredited)	▪ Recap of session for raising awareness (see above) ▪ Use of screening tools ▪ Stages of change (Helping people change) ▪ Brief interventions ▪ Motivational interviewing ▪ Diagnosis and treatment of dependence ▪ Available support services and referrals ▪ Audit and feedback mechanisms	▪ Overhead slides ▪ Handouts ▪ SBI Materials ▪ Interactive exercises ▪ Video ▪ Role play

7.5.1. Methods

The research protocol specified that at least one general practice from each of the 5 PCTs covered by the Tyne & Wear HAZ be included in the project. Selection of these practices began with a letter to each surgery within the HAZ with 3 or more partners introducing the research and asking for expressions of interest. A total of 118 letters were sent out. Sixteen (16) practices replied to this initial letter.

A second letter was sent to all 16 practices together with a "research contract", a brief description of the project and a questionnaire asking for a practice profile, previous experience of research and other relevant information. Practices were asked to review the information and, if they still wished to be considered, to complete and return the questionnaire. Twelve practices applied to undertake the research and 5 were chosen, one from each HAZ area, on the basis of achieving socio-demographic representativeness of practice populations and perceived ability to complete the project.

A payment of £1,000 was made to all participating practices in each of the 6 months of the active pilot phase of the project (i.e., £6,000 in total to each practice). This was done to compensate practices for the time and resources spent on the project and also to anticipate conditions under the nGMS contract in which practices would be paid to implement SBI.

The main method used to achieve the project aims was a series of meetings between practice staff and the research team. There were three *plenary* meetings attended by representatives from all participating practices at the beginning, middle and end of 6-month implementation phase. In addition to this, research staff attended monthly in-practice meetings to monitor progress and respond to queries. Continuous contact with practices was maintained via telephone, email and informal practice visits and this was regarded as key to sustaining involvement and ensuring that the project remained a priority in busy work schedules.
The agendas for the 3 plenary meetings were as follows:

1st meeting – 5/10/04

- Introduction to the project
- Previous research by the Newcastle group (including WHO Phases III and IV)
- Options for the SBI package, with emphasis on screening tools and delivery of screening
- Questions and general discussion

2nd meeting – 1/2/05

- Screening experiences – feedback from all practices and discussion
- Options for brief intervention
- General discussion and plans for intervention phase
- Plans for writing final report on research, including contributions of practice staff

3rd meeting – 26/5/05

- Experience of delivering brief interventions – feedback and discussion
- Project overview – screening conclusions, computer template, incentivising SBI
- Plans for final report and future work

Between plenary meetings practices used the PDSA cycle (Plan-Do-Study-Act) to adjust screening and brief intervention to their preferences and requirements. This method is popular in general practice research for testing and refining innovations in practice[35]. Practice staff were also asked to complete the shortened *Alcohol and Alcohol Problems Perception Questionnaire*[36] before and after the implementation phase of the project. As a way of monitoring changes in practice during the project, an audit of SBI activity was carried out from practice computer records before and after the implementation phase. Data collected were:

- Number of patients on the practice list
- Number of patients with recorded alcohol consumption levels, broken down by age and gender
- Number of patients with an updated consumption level within the last 6 months
- Number of patients with a read code for alcohol dependence syndrome

7.5.2. Findings

Although data collection has been completed, a report to the funding agency and articles for publication arising from this research have not yet been submitted, so the findings below should be regarded as preliminary.

Initial screening decisions

Screening tool(s). After trying various alternatives, practices opted for the following screening preferences: full AUDIT (1 practice); AUDIT PC (2 practices); AUDIT C (3 practices); FAST (2 practices). Three practices chose two different tools for use in different circumstances.

Screening delivery. All practices chose joint delivery by both practice GP's and nurses.

Consultations. Overall, the following types of consultation were chosen for the delivery of screening: New patient registrations; CHD clinics; Emergency contraception; Smear clinics; IHD clinics; almost universal screening (1 practice).

Levels of intervention and training

Two levels of brief intervention were eventually agreed by participants:

Level 1: simple structured advice. Based on research evidence for the effectiveness of brief intervention, this first level of intervention is aimed primarily at hazardous drinkers, although some practices opted to offer advice to all patients screening positive. The intervention was scheduled to last only 2-3 minutes.

Training for this level of intervention was agreed to comprise two 30 minute sessions and it was emphasised that training in screening and the intervention itself should be delivered together. Participants felt the need for specific "bridging techniques" to make the step from a positive screen to the offer of simple structured advice. A "training the trainers" approach, in which one member of a practice team would be trained to teach his or her colleagues in the practice setting, was thought to be suitable for this level of intervention.

In addition to development of the training programme in the form of PowerPoint slides anad accompanying notes, an existing version of the Drink-less pack, with the new titile of "How Much Is Too Much?", is being developed to assist the delivery of simple structured advice. This will be accompanied by clinical guidelines, both in a long form based on the guidelines produced by the PHEPA project and a short "how-to-do-it" form for use in routine practice.

Level 2: Behaviour Change Counselling: This 2nd level of intervention is aimed at harmful drinkers, those who have not benefited from brief advice and those patients who request a longer discussion of their drinking. It is scheduled to last for 10-15 minutes plus follow-up consultations when necessary. Counselling techniques are based on those described by Rollnick, Mason and Butler[36] for the negotiation of behaviour change in health care settings.

The development of the training programme for the Level 2 brief intervention was carried out by an independent company with considerable experience in training clinical communications skills (*Effective Professional Interactions*: Dr. Malcolm Thomas, Director; <www.effectivepi.co.uk>). Training takes place during a half-day session and includes an introduction to the stages of change model, motivational interviewing techniques and practical exercises in motivational techniques using

role-play. The training has been piloted with practice teams and is now being developed into a formal training programme.

IT issues
A data entry template was designed and created which could be installed on the clinical system of each of the 5 research practices. This template consisted of a list of on-screen prompts relating to alcohol which an individual clinician could access and run through within a consultation where alcohol appears to be an issue. The first problem encountered was that not all of the practices used the same clinical computer system interface. It was therefore necessary to create two systems, one for the EMIS computer system used by most practices and one for the slightly older EXETER system.

An initial task was to identify what information needed to be asked for and collected within the template. While we wanted to gather a maximum amount of data, if too many questions were included clinicians would be deterred from using it. Choosing which information to include involved selecting a number of read-codes from a predetermined national list which any EMIS-based practice in the country is able to access. In total there were 139 alcohol-related read codes from which to choose. The research team initially selected 15 read-codes from the total that it was felt would capture the main information required. This list was then presented to the 5 practices for their feedback and, after consultation, was reduced to a final list of 9:

Alcohol consumption screen **(68S)**
Alcohol consumption **(136)**
Alcohol use **(ZV4KC)**
Alcohol dependence syndrome NOS **(E23z)**
Nondependent alcohol abuse **(E250)**
Patient advised about alcohol **(8CAM)**
Contemplation stage **(67K1)**
Not Interested In Reducing Alcohol **(EMISQNO6)**
Alcohol leaflet given **(8CE1)**

Within this design stage, the main obstacle was the lack of suitable codes for 'hazardous', 'harmful' and 'dependence' - the terminology used by the WHO to define different types of consumption levels and drinkers; as such we were keen to promote the use of these definitions within this study. It was therefore unanimously decided by all practices that new read codes specifically for *Hazardous alcohol consumption* and *Harmful alcohol consumption* would be beneficial. Importantly, this would encourage consistency in the terminology health practitioners used. The *National Health Information Authority* agreed to the creation of the above codes (136S and 136T), both of which can now be accessed by any GP in the UK.

The majority of the practices successfully incorporated the new template into all other templates in which there is an existing read code for alcohol. It can now therefore be called up from within templates such as diabetes, epilepsy, and depression. If an entry is made to indicate a patient has been screened, the computer automatically takes the clinician into the full alcohol consumption template.
Implementation model
A best-practice implementation model derived from the findings of the Demonstration Project will be found in Figure 7.1.

Best practice SBI implementation model

Case identification routinely within GP and practice nurse consultations:

Opportunistic screening
Population led data exercise
Targeted screening
- AUDIT C
- FAST
- AUDIT PC

AUDIT

Negative screen:
- Positive reinforcement
- Unit awareness

Possible dependence:
- Referral for diagnostic evaluation

Positive screen
- Tier 1 simple structured advice following How Much is Too Much? materials
  - *'Your score indicates the possibility of future harm. What do you think... ?'*
- Assessment of motivation to change
- Offer of follow up appointment

Patient's consumption level decreases

Tier 2 Health Behaviour Change counselling
- 10-15 minutes of motivational enhancement

Referral to specialist agency

7.6 Conclusions: Obstacles and opportunities

In addition to the usual difficulties concerning lack of interest in alcohol SBI among health professionals and policy-makers, the main obstacle to progress in the Phase IV study in England was the failure to attract funding for the Demonstration Project and thus to ensure continuity in research activity. Staff who had been trained in SBI research and had become skilled and knowledgeable in this area were lost to other fields of study. Moreover, the impetus for widespread implementation of SBI that had been built up by the formation of the Strategic Alliance and strengthened by the national conference in Newcastle in 2002 was to a large extent dissipated and will have to be rebuilt.

Ironically, however, the hiatus caused by the delay in carrying out a Demonstration Project may have had unintended benefits for the effort to implement SBI in England. This is because the delay allowed time for several important developments to occur that have now provided a unique opportunity to make progress in the Phase IV study's central aim. These developments are:

- The Government's *Alcohol Harm Reduction Strategy for England* (AHRSE)[9], 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. While there are flaws in the discussion of SBI in the AHRSE, particular its neglect of the hazardous drinkers as opposed to patients with established alcohol problems, the prominence given to SBI in the document, especially in PHC, gives grounds for optimism that the Government now recognises its potential in the effort to reduce alcohol-related harm in England;

- The *New General Medical Services Contract* (nGMS) 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. It is clear that the nGMS needs reform if it is to assist the widespread implementation of SBI but the opportunity to effect such reforms does exist.

- A White Paper published by the Department of Health in November 2004 entitled *Choosing Health: Making Healthy Choices Easier*[37]. This includes alcohol consumption among the other health behaviours it addresses and proposed a new profession of "Health Trainers" to work in PHC to give advice to patients showing health-related risk behaviours.

In the light of these developments, the line of research initiated by the Phase IV study in England is clearly still of obvious relevance to implementing SBI routinely in PHC and is possibly more in line now with declared national priorities and government thinking than when the study began. More specifically, as promised in the AHRSE[9], in May 2005 the government invited tenders for research to carry out 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. The main questions that were to be addressed were:

a) Can it be demonstrated within the UK context and in a real-life environment that screening and brief intervention are clinically effective and cost effective in changing individual drinking behaviour?

b) What forms of screening and intervention for alcohol misuse are acceptable and reasonable to be implemented GPs, primary care staff, healthcare staff in other settings (A&E, outpatient clinics, inpatient wards) as well as staff in other settings such as criminal justice settings?

Our Newcastle team is part of a consortium that was successful in bidding for this research grant and will take particular responsibility for a cluster randomised trial in the PHC segment of the project.

While some answers to the questions above have been provided, at least in PHC, by the Tyne and Wear HAZ project (see above), the new project will investigate these questions on a much wider scale and in a more formal, quantitative fashion.

Acknowledgements
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APPENDIX 7.1.

Membership of the Strategic Alliance (Organisations)

- Addiction Prevention in Primary Health Care, London
- ADS (North West), Manchester
- Alcohol Concern
- Alcohol Counselling and Prevention Services, London
- Alcohol Education and Research Council
- Alcohol Problems Advisory Service, Nottingham
- Alcohol Recovery Project, London
- Alcohol Services for the Community
- Appleby Solutions Ltd
- C.A.I.S. Ltd
- City and Hackney Alcohol Service, London
- Clapham Family Practice, London
- Community Alcohol & Drugs Service, Kings Lynn
- Community Mentors Ltd
- Department of Nursing & Community Health, Glasgow
- Department of Pubic Health & Family Health APU, Chelmsford
- Drinksense
- Health Development Agency
- Heath Promotional Research Group University of Newcastle
- Hereford and Worcester Advisory Service on Alcohol
- Leeds Addiction Unit
- Manchester Community Alcohol Team
- Medical Council on Alcoholism
- National Association of Primary Care
- Newcastle & North Tyneside Drugs & Alcohol Service
- Newcastle & North Tyneside Health Promotions Department
- NORCAS
- North Lambeth Primary Care Group, London
- North Wales Drug & Alcohol Forum
- Northumberland CSMT
- Nursing Council on Alcohol
- Options
- Royal College of General Practitioners
- Royal College of Nursing Practice Nurses Association
- South Tyneside Drug & Alcohol Service, Tyne & Wear
- South Tyneside PCT
- Specialist Community Alcohol Team, Crewe
- Sunderland Community Health Council
- Swanswell Charitable Trust : Coventry Community Alcohol Service
  - Leamington Community Alcohol Service
  - Nuneaton Community Alcohol Service
  - Rugby Community Alcohol Service
- The Albert Centre
- The Department of Nursing & Community Health, Glasgow Caledonian University
- Trafford Alcohol Service, Manchester
- Trafford SMS, Manchester

CHAPTER 8

FINLAND

Kaija Seppä and Mauri Aalto

8.1. Introduction

8.1.1. Population

At the end of 2002 the Finnish population was 5,206,295 of whom 2,661,379 (51.1%) were female. The population density was 17 per square kilometre. Mean age of males was 38.2 years and of females 41.4 years. In the general population 16% were aged under 15 and 17% over 65. Life expectancy at birth was 74.6 years for males and 81.5 years for females. The life expectancy of Finnish men is reduced by cardiovascular disease, accidents and excessive alcohol consumption.

8.1.2. Provision of health care

Health services are available to all in Finland regardless of their financial situation. Public health services are financed mainly from tax revenues, either municipal or one-third from state tax. Central government's contribution to municipal health care is determined by population numbers, age distributions, morbidity statistics and a number of other factors. Gross domestic product (GDP) in Finland is €26,000 per head and the ratio of health care expenditure to GDP is 6.7%. This is one of the lowest percentages among EU member states. The public sector finances 76% of total health care expenditure, users of services 20% and others (employers, private insurance and benefit societies) 4%. The decline in public sector health care expenditure in recent years has led to increases in costs to households. Everyone in Finland is covered by obligatory sickness insurance, funded through taxes by the state, municipalities, employers and the insured population. The sickness insurance scheme reimburses fees paid by patients to private doctors, costs of medicines prescribed and transportation costs arising from treatment of illness. By far the greatest expenditure in relation to health insurance is compensation for sick leave and parental leave. All licensed Finnish doctors are covered by the reimbursement system, which is administered by the Social Insurance Institution.

At the beginning of 2003 Finland had 19,336 medical practitioners, equivalent to 269 inhabitants per doctor. Forty-nine percent of the Finnish medical profession is female. About 42% of Finnish doctors work in hospitals and about 20% in health centres.

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 4% of Finnish doctors work in occupational health care, offering both preventive services and primary 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. Many doctors, dentists and physiotherapists, particularly in cities, offer private care. There are also a few small, private hospitals. Only about 8 % of Finnish doctors earn their living solely as private practitioners.

However, about one third run a private practice in addition to working in a hospital or health centre. Most private practitioners now work in group practices.

8.1.3. Alcohol consumption and alcohol-related problems

Alcohol consumption increased by 28% in Finland from 1980 to 2001. A temporary decrease of 8% during 1990-1994 was interpreted as due to economic recession. The increase resumed after 1994 and in 2001 consumption reached the 1990 level. Current per capita consumption for those 15 years and older is 9.2 litres/year of absolute ethanol (2002 figures). Home-made and imported alcohol represents 20% of this. About half of all alcohol consumption is beer, with spirits making up a quarter. During recent years there has been a slight decrease in the share of spirits and beer and a slight increase in wines. Alcohol consumption in Finland is in the lowest third compared to other EU countries[1].

In 2001 there were 33,156 alcohol-related hospital treatment episodes; 10 645 were due to dependence, 2391 to pancreatitis and 2950 to alcoholic liver disease. Most of the pancreatitis patients had the acute form of the disease. Another peculiarity in Finland is the high number of deaths due to alcohol intoxication (n=401 in 2001). Altogether 2454 persons died of alcohol-related causes in 2001. Both alcohol-related mortality and morbidity are increasing in Finland[1].

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 lie in retail sales monopoly, age limitations and high taxation. The Finnish government has decided that, after February 2004, alcohol taxation will be 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 future EU member state Estonia. A disintegration of preventive measures is predicted to lead to an increase in consumption and in alcohol-related harm.

Traditionally, Finnish health care took care of alcohol-related health problems but alcohol abuse itself was not considered a task for health care. The situation changed in 1987 when a law for the treatment of substance abusers was introduced. The main provision of the law is that health care, in collaboration with social and specialised care of abusers, has to take responsibility for treatment and prevention of substance abuse. In spite of this, attitudes in primary health care towards preventive and therapeutic activities have remained quite negative, despite the fact that detoxification is undertaken and somatic complications are treated in primary care.

Even if the attitudes among primary health care workers have been somewhat negative, 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[2], one as part of health check-ups[3] and one in primary health care[4-6]. The last of these was part of a wider community action project[7]. Also, implementation of brief intervention has been promoted[8,9]. All this fits well with the focus on preventive cardiovascular activities in Finland.

8.2. Customization

A demonstration project was planned to take place in the city of Tampere and this is also where the customization was done. Tampere is a city in Southern Finland with about 200,000 inhabitants. Tampere Communal Health Centre serves all inhabitants of the city, with 77 general practitioners (GPs) and 177 nurses. The city is closely representative of the population of the whole country, including rural and urban areas. Alcohol consumption of the inhabitants is of a medium level for Finland. Of the GPs 52% specialize in general practice (national percentage 56%); 73% are women (nationally 60%); mean age is 43 years (nationally 40-45 years).

The customization aimed at discovering if and how primary health care personnel were willing to undertake early identification and brief alcohol intervention. This information was gathered via two structured questionnaires, six focus groups and contact by the project nurse with health professionals.

8.2.1. Questionnaire

A structured questionnaire was mailed to all GPs and nurses working at Tampere City Communal Health Centre to find out their attitudes, knowledge and beliefs regarding brief intervention for heavy drinkers[10]. Attitudes were mainly positive. However, only 18% of the respondents reported having enough knowledge to provide competent brief intervention; practical training was considered especially helpful for promoting it and more information on its evidence-base was thought desirable.

8.2.2. Focus groups

To acquire more information, not only on what but also how professionals thought brief interventions should be implemented, we ran six focus groups (out of the seven clinics in the health centre) including 18 GPs and 19 nurses[11]. Obstacles found were confusion regarding the content of brief-intervention, lack of self-efficacy in implementing them, difficulty in identifying heavy drinkers, uncertainty about the justification for initiating discussion on alcohol issues, lack of time and lack of simple guidelines. More experienced professionals considered that verbal questions rather than structured questionnaires was a better way to learn about patients' alcohol consumption; younger GPs in contrast preferred a questionnaire. A common opinion was that, instead of systematic screening, certain complaints of patients or certain situations (for example health check-ups) would justify asking and counseling.

8.2.3. Patient survey

Additionally, a patient survey was performed at two of the seven clinics right after consultation. In this survey 1000 patients were inquired if and when GPs or nurses had asked and/or advised them in relation to drinking, and 665 of them responded[12]. 6.3% of all participants and 11.9% of excessive drinkers reported that they had been asked about drinking at the consultation in question; 64.7% of all patients and 52.4% of excessive drinkers had never been asked about drinking. 6/0% of all patients 6.0% and 19.0% of excessive drinkers had been advised about drinking at the consultation. Only a small minority of the patients (<2%) reported a negative attitude towards talking about alcohol with a professional.

8.2.4. Guidelines

All the possible obstacles and facilitating factors to carrying out brief intervention found in the three surveys were separately analyzed by three members of the project team. The findings were categorized as follows: 1) tools found to be feasible in doing brief intervention; 2) ways of doing brief intervention; 3) themes for education on brief intervention; and 4) themes regarding implementation. The basic idea for guidelines came from focus groups; the opinion favouring having simple guidelines on when and how to do brief intervention was present in all groups.

The questionnaire completed by professionals[10] provided the justification for creating the guidelines; attitudes were positive and professionals considered brief intervention important. Focus groups helped to identify situations where GPs and nurses were willing to do brief intervention. They did not want to ask alcohol-related questions in all consultations but only in the following situations: health checks, accidents, high blood pressure, arrhytmia, sleep disorders, depression, anxiety, abdominal complaints, hang-over, and increased values in laboratory tests indicating heavy drinking (serum glutamyltransferase, serum desialotransferrin or mean erythrocyte corpuscular volume). Of the questionnaires available, AUDIT was preferred. Professionals were anxious about treating alcohol-dependent patients; thus referral to a specialist clinic was suggested if the AUDIT score was > 14. Also, how to do brief intervention was found intimidating and this is why it was suggested that a patient information leaflet designed for Lahti project should be given to patients. At least one follow-up consultation was suggested.

The guidelines thus created were called "minimum"; e.g., it was permitted to do more but all professionals should at least ask their patients to fill in the AUDIT. If the score was $\geq$ 8 but less 15, the patient information leaflet was to be given and one follow-up consultation arranged with the patient.

The guidelines (early identification and brief intervention package) were then tested in a meeting with the focus group participants to check that interpretations developed by the researchers were valid and accurately reflected the professionals' meanings and intentions. The finding from the patient survey[12] that patients are positive about being asked about their drinking did not change the professionals' opposition to screening every patient. It was thus agreed that the screening would be opportunistic and that only the selected situations would justify asking patients' about alcohol consumption. Finally, the guidelines on how to do brief intervention were revised and mailed with a covering letter to all the professionals in primary health care in Tampere. The different phases in creating the guidelines are presented in Figure 8.1 and the final guidelines in Table 8.1.

FIGURE 8.1
Sources of information for brief intervention quidelines.

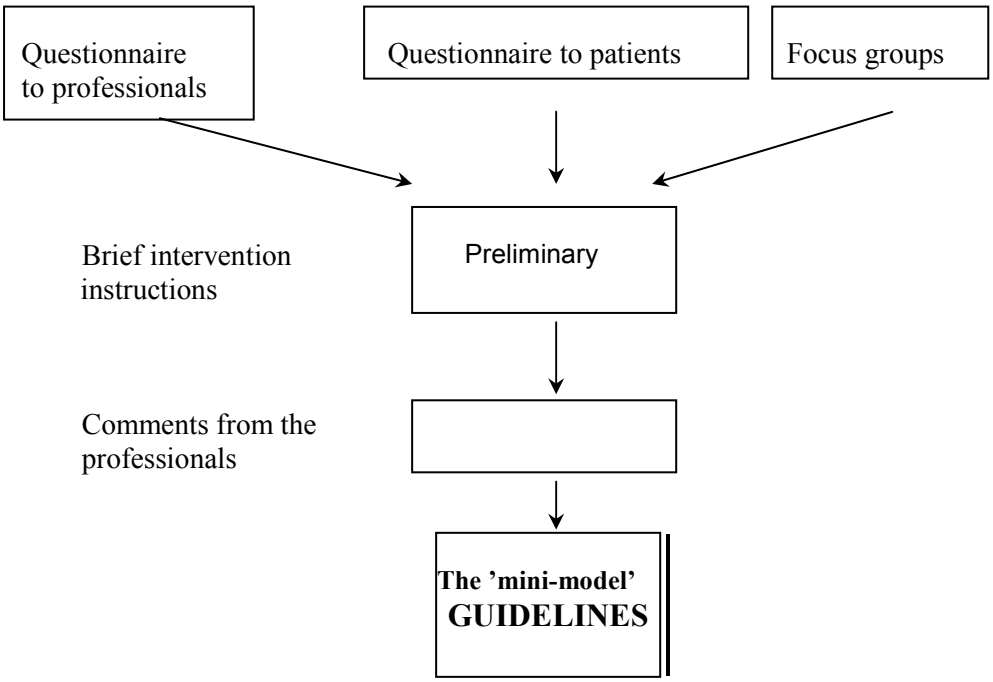

TABLE 8.1

Early Identification and Brief Intervention for Risky Drinking: guidelines developed in collaboration with health professionals.

ASK THE PATIENT TO FILL IN AUDIT (Alcohol Use Disorders Identification Test)
IN THE FOLLOWING SITUATIONS:

- health check-up
- accident or trauma
- high blood pressure
- arrhytmia
- sleep disorder
- depression
- anxiety
- abdominal complaints
- hang-over
- abnormal blood test value indicative of risky drinking (s-GT, S.CDT, MCV)

WRITE DOWN THE SCORE IN PATIENT DOCUMENTS

WHEN AUDIT SCORE IS 8-14
- inform the patient personally of the health risks of alcohol, mainly in relation to the patient's complaints; negotiate with the patient of how and how much to reduce drinking and give the written information (or give the written information at the very least)
- make a new appointment

WHEN AUDIT SCORE IS >!4
-you can refer the patient to a specialist clinic

(n.b. This is the minimum that should be done - more can be done if preferred.)

8.3. Reframing

Reframing the general public's understanding of alcohol issues was a central target and it was carried out through several media events. AUDIT was delivered to every household in the city of Tampere inside a local newspaper and a gallup poll was conducted by telephone to discover whether and how it had been noticed. Two posters were mounted in all health care waiting rooms, one informing about risky drinking limits and the other the AUDIT-questionnaire and its interpretation.

Simultaneously with the present project there was a large project in the same area aiming at the assessment and treatment of drink drivers. The AUDIT was also used in this project and was widely distributed to health professionals nationwide and also to health centres. Collaboration with the police included information about the brief intervention project and they planned to refer milder cases to health centres for brief intervention.

8.4. Strategic Alliance

An alliance of the following contributed in various ways to the project:

- The Ministry of Social Affairs and Health funded the project.
- The National Research and Development Centre for Welfare and Health (STAKES) administered the project, helped plan the focus group study, collaborated in producing material (posters/handouts) for general population, and collaborated in organising training sessions.

- The Finnish Society of Addiction Medicine helped and collaborated in the organization of training.
- The Finnish Society for Alcohol Researchers helped and collaborated in the organization of training.
- Tampere City Primary Health Centre afforded the opportunity to do the demonstration project in their centre.
- The Tampere City Temperance Movement collaborated in mass media events and communication with the public.

Collaboration has been fruitful but, for a project like this to prosper, the core workers have to be hard-working and highly active. But sometimes being too active is a disadvantage; efficient action includes putting an activity aside when that becomes necessary. Reminders are important; a project in hectic times like the present is otherwise easily forgotten.

8.5. Demonstration Project

The demonstration project took place in the city of Tampere and was preceded by customisation of material and reframing of understanding (see above)[13]. The reframing process took place during the entire period of implementation[14]. The guidelines on how to do early identification and deliver brief intervention (brief intervention package), developed together with local primary health care nurses and GPs, were mailed to all GPs in May 1999.

Based on experience in the Lahti project in which brief intervention had been given, but also based on the results of the focus group study described above, we decided to find a more motivational way of implementing brief interventions among health professionals. At first, we were in active contact with the centres but over time we adjusted this contact time to the extent to which responses had been received. Thus, we remained available for consultation in problematic situations and also willing to give education whenever needed but without being automatically present at all times. Occasionally, however, we contacted the Health Centre offering mainly practical education. In addition to these reminders, at one time we attempted telephone marketing. However, in our city GPs were too busy to take this kind of telephone call during working hours and too tired after work. Another way of dissemination was that we published several articles in local and national journals describing the project[15-23]. One year after the implementation we mailed a questionnaire to all GPs in the Tampere Health Centre. After four waves, 64/75 of them answered and 29 (44%) reported using the package[24].

The AUDIT and the written materials needed to apply the guidelines were provided for nurses and GPs. Later in autumn of the same year, a project nurse and physician held a workshop in each of seven health centres to promote the guidelines. Later, education based on needs was given and a project nurse and physician were available for consultation. As recorded in a project diary, requests for education and consultation were rare. However, reminders using local and professional publications were distributed frequently.

The main difficulty was that, even if the professionals who came to the training sessions and who were in contact with the project team were positive, a part of the professional group was never reached. There are probably many reasons for this, one of which may be the fact that primary health care professionals are very busy; in Tampere an average of 2700 patients are enrolled for every GP.

In order to discover whether widespread implementation had been successful, the possible change in activity related to brief intervention was measured by a questionnaire given to professionals and patients at the beginning and end of the project. In addition, professionals' skills, knowledge and attitudes in relation to early detection and brief intervention were measured using a questionnaire before and after the implementation. Analyses were carried out with the Statistical Package for Social Sciences 10.1. Comparisons of frequency measures for answers were made between baseline and follow-up. Nurse and GP data were analysed together and separately. In frequency comparisons the

chi-square test was used and in comparisons of means the T-test was used. Differences were considered statistically significant at $p < 0.05$.

Economic evaluation was based on interviews with GPs and the theoretical cost calculation was based on Finnish health care costs.

8.5.1. Questionnaire for professionals

Doctors and nurses were asked to record their knowledge, skills and attitudes to brief intervention using multiple-choice questions with six options[10]. Structured questions about gender, age, years of experience in practice and respondents' own alcohol consumption were also included in the questionnaire. In the questionnaire given after the implementation, respondents judged whether they had increased their brief intervention activity during the past year[25]. Because we focused on evaluating the success of implementation in a certain unit, not among individuals, about 20% of the respondents at baseline and follow-up were different individuals.

The response rate was 59.1% (150/254) before and 57.9% (147/254) after the implementation; for nurses 60.5% (107/177) and 59.9% (106/177) and for GPs 55.8% (43/77) and 53.2% (41/77) respectively. Nurses' mean length of experience was shorter (14.3 vs. 16.3 years, p=0.082) and weekly alcohol consumption was higher (3.8 vs. 2.4 drinks/week, p=0.026) after the implementation than before.

The proportion of respondents who estimated they had increased their activity in carrying out brief intervention during the past year was 26.0% (32/123) before and 26.9% (36/134) after the implementation. Those who had increased their activity during the implementation had generally more positive attitudes and reported having better skills and knowledge in relation to brief intervention than the rest of the sample.

Professionals' attitudes, skills, knowledge and training needs regarding brief intervention before and after implementation are presented in Table 8.2. Nurses, but not GPs had significantly more positive attitudes towards discussing alcohol with patients before than after the implementation. In other questions regarding attitudes, frequencies were stable over time. Motivational skills remained low even after the implementation. Several significant changes were seen in responses to questions regarding knowledge and training needs. Nurses reported that they knew the contents of brief intervention and some structured questionnaires better at follow-up than at baseline. Increased knowledge of some of the structured questionnaires was also found among GPs. Training needs decreased significantly among nurses but not among GPs during the study.

TABLE 8.2
Changes in attitudes, skills, knowledge and training needs regarding brief intervention during the three-year implementation

.

	Both GPs and nurses			
Percentage (n) of who…	Baseline (n)	Follow-up (n)	p-value	Change (%)
…have positive attitudes towards discussing alcohol with patients.	102/150	81/147	0.022	-12.9
…think patients take positive attitudes towards being asked about their alcohol consumption.	127/140	133/147	0.945	-0.2
…think detection and treatment of early phase alcohol abusers is appropriate for their work.	61/148	54/146	0.457	-4.2
…think that they know how to talk about alcohol drinking with patients.	96/148	97/147	0.840	+1.1
…think that they know how to motivate patients to participate intervention.	20/145	22/145	0.739	+1.4
…know the content of brief intervention well.	27/149	51/147	0.001	+16.6
…know some structured questionnaire.	34/144	86/143	0.000	+36.5
…know the definition of heavy drinking.	66/103	79/113	0.362	+5.8
…expressed need for training in detection of heavy drinkers.	70/150	41/146	0.001	-18.6
…expressed need for training in doing brief intervention.	84/147	59/146	0.004	-16.7

8.5.2. "Exit poll" among patients

A survey of patients directly after their GP consultation was carried out before and after the implementation period[12,26]. Subjects came from two independent samples of one thousand 16-65 year old consecutive patients consulting GPs at two primary health care centres at baseline and follow-up, of whom 655 and 768 respectively participated. No statistically significant differences were found regarding enquiries or advice about alcohol between baseline and three year follow-up. Of all patients, 19.1% (125/655) at baseline versus 19.7% (151/768) at follow-up were asked about alcohol during the consultation in question or during the past year (p=0.784). Likewise, of heavy drinkers, 30.9% (30/97) versus 33.9 (38/112) were asked (p=0.644). Of heavy drinkers, 13.4% (13/97) versus 14.9% (17/114) were advised about alcohol during the consultation in question (p=0.754). It can be concluded that brief intervention activity by health care professionals remained stable and did not increase from before to after the implementation period. This may have been due to the short follow-up, the way brief intervention was implemented in the present study or to a saturation in brief intervention activity that was reached before the present study began.

TABLE 8.3.

Patients' answers concerning the last time a doctor or nurse at the clinic had asked about their drinking and whether patients were advised about drinking.

	ASKED* Today/during past year %	ASKED* Over a year ago/never %	ADVISED* Today Yes (%)	ADVISED* Today No (%)
All				
Baseline (n=655)	19.1	80.9	6.0	94.0
Follow-up (n=768)	19.7	80.3	6.2	93.8
Heavy drinkers				
Baseline (n=97)	30.9	69.1	13.4	86.6
Follow-up (n=112)	33.9	66.1	14.9	85.1
Non-heavy drinkers				
Baseline (n=546)	17.2	82.8	4.6	95.4
Follow-up (n=564)	16.7	83.3	4.8	95.2
Men				
Baseline (n=244)	29.5	70.5	10.4	89.6
Follow-up (n=270)	30.7	69.3	11.2	88.8
Women				
Baseline (n=403)	12.7	87.3	3.2	96.8
Follow-up (n=489)	13.3	86.7	3.3	96.7
16-50 year olds				
Baseline (n=397)	19.1	80.9	4.6	95.4
Follow-up (n=438)	18.3	81.7	5.1	94.9
51-65 year olds				
Baseline (n=248)	19.0	81.0	8.1	91.9
Follow-up (n=315)	20.6	79.4	7.7	92.3

* No significant differences were found between baseline and follow-up

8.5.3. Economic evaluation

A questionnaire survey was e-mailed to six general GPs who specialized in brief alcohol intervention[26]. Cost calculations were based on Finnish health care prices[28] and adjusted by questionnaire results on the mean time used in screening and intervention and the extent of use of laboratory tests. A basic consultation (≤20 minutes, including salaries, administrative costs, cleaning, rents) amounted to €53.3 (2.665 €/min); an extended consultation (>20 min. or including laboratory tests or x-ray costs of equipment) = €94.8 (4.74 €/min). The mean time for screening was 5 minutes and for intervention 9 minutes. The cost of intervention (screening á €13.3 and intervention á €29.4€) for a GP with 1600 registered adult patients (50% male) was calculated under four different assumptions. (Table 8.4). 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). Early identification and brief intervention, especially when targeted opportunistically to the whole population, is cheap as compared to the treatment costs of alcohol-related complications (e.g. one acute pancreatitis = €30 000)[29].

TABLE 8.4
Costs of brief intervention (see text)

	Systematic screening (n=1600)		Opportunistic screening (n=640)	
	21 280 €		8 512€	
	↓		↓	
	Intervention to screen-positive		**Intervention to screen-positive**	
	All (n=309)	Motivated (n=155)	All (n=215)	Motivated (n=108)
	9 085€	4 557€	6 321€	3 175€
	↓	↓	↓	↓
Total cost	**30 365€**	**25 837€**	**14 833€**	**11 687 €**
Cost per one Intervention	**143€ (n=213)**	**241€ (n=107)**	**84€ (n=177)**	**131€ (n=89)**
Cost per one effective intervention	**706€**	**1230€**	**424€**	**649€**

8.6. Conclusions

The main finding of the present study is that early identification and brief intervention activity among GPs and nurses did not increase in the area of the demonstration project. The level of activity remained low and this conclusion is supported by the findings of a collaborative project in which GP consultations were videotaped[30]. However, several positive changes during the demonstration project indicated increased knowledge regarding brief intervention among professionals. This was especially true of nurses. The project's success in increasing knowledge is also reflected in a decrease in training needs. Instead, attitudes and skills among the professionals did not seem to develop positively. This may have been due to positive attitudes and that were already present at the beginning of the project. Increasing motivational skills seems to be a special challenge for the future. A national survey in occupational health care showed that brief intervention activity in the demonstration project area was higher than in other parts of Finland (unpublished).

At the present time, the Ministry of Social Affairs and Health is committed to promoting country-wide implementation of brief intervention in primary health care. This is partly a result of the present project, partly due to earlier work in the alcohol research field but also a consequence of a fear that reduction in alcohol taxation will lead to increase in alcohol consumption and thereby to an increase in alcohol-related morbidity and mortality. The costs of the implementation will be covered from the state budget and the work will be accomplished by project workers (six nurse-doctor pairs) in different parts of Finland. The money will be distributed based on project plans. This means that municipalities must take steps to apply the funding and identify suitable professionals to do the work. The Ministry of Social Affairs and Health will help to develop plans, co-ordinates projects (to commence at the beginning of 2004), organise training and produce the materials needed.

It is obvious that when money is provided nationally to brief intervention projects, it will be applied. Projects will last until 2006 which offers a sufficient perspective to make changes. There will be problems that will have to be faced. One is that Finnish primary health care is in crisis; lack of physicians generally and lack of interest in primary health care work means that the few who do work in primary care are very busy. The National Health Project, which provides money for the implementation of brief intervention, has also to confront these organizational problems. Overcoming them will hopefully lead to better future for early identification and brief intervention for hazardous and harmful drinking in Finland.

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CHAPTER 9

FLANDERS

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9.1. General Introduction

9.1.1. Country description

Belgium consists of two linguistic communities – Flemish and French. The Flemish linguistic community lives mainly in the region of Flanders (the western rather flat countryside of Belgium) and to a small extent also in the Brussels capital region (about 10-12% of the population). They form altogether 60% of the Belgian population (58.8% in 2002), amounting to about 6 million people in the Flanders region (5,940,251 in 2000, with a 1% increase in population every 4 years, amounting to 6,021,771 in 2004). The Flemish population is an increasingly elderly population with one quarter above 60 years, while half (56%) is between 20 and 60 years; in 5 years the ratio of 60+/20-59 years old increased from 40% to 50% in Flanders (against a smaller increase in mean age in the French-speaking part: 7% ratio increase from 40% to 47%).

9.1.2. Alcohol consumption

Alcohol consumption is highest in the middle-aged group, amounting to a mean of 10 glasses a week for men between 35 and 55 years[1]. The percentage of daily drinkers increases steadily from 8% among men 25 years of age to 20% between 65 and 70. According to health surveys in 1997[1] and 2001[2], women between 45 and 55 showed the highest percentages of daily drinkers (10%). Overconsumption (defined as more than 6 glasses per day at least once a month) is estimated by these surveys at 19.7% of the adult population. Hazardous use thus defined is present in one-quarter of the age-group 15 to 54 years of age[2].

Using the CAGE questionnaire as a basis, the health survey in 2001[2] identified 6.7% of men as 'problem drinkers' and 2% of women. These data are probably an underestimate by a factor of two or three when compared with calculations based on household budget analyses[3,4]. According to the latter studies, per capita consumption above 15 years of age is highest in the French-speaking part of Belgium (see Table 9.1). This difference is mainly related to higher wine and aperitif use by the French-speaking compared to the Flemish-speaking population.

However it should be noted that Flanders has twice as many cafés and restaurants serving alcohol as the French region[2]. Also, among Flemish boys 15-16 years of age, 8% have already been drunk more than 20 times compared to 6% in the Walloon region[5].

9.1.3. Burden of alcohol use

Based on data collected by the Comission of Distilled Spirits[6], there has been a slow but steady decrease in overall alcohol consumption from 9.1 litres of pure alcohol in 1995 to 7.9 litres in 2002. By contrast, there has been a significant increase in excessive alcohol use among youth (13-18 years) in Belgium and, more particularly so, in Flanders compared to the Walloon region[6,7]. The mean age for starting to drink alcohol is younger than for tobacco and other drugs[2] and the number of regular drinkers in all the younger age-groups is higher than for other drugs[8].

TABLE 9.1.

Alcohol consumption based on household budget analysis in different regions

	L/pure alc/p >15y/yr	% wine
Walloni	6.1	63
Brussels	5.8	70
Flanders	5.0	58
Belgium	5.5	62

The prevalence of hazardous alcohol use based on screening studies is estimated as 9% of the adult population[9].

More than 50% of mental health care for drugs relates to alcohol problems[10] and about 10% of avoidable death is estimated to be alcohol-related[11]. One in twelve accidents (8.5%) and 10% of all major accidents on the road are related to alcohol use[12]. Morevover, one-third of accidents at home among men and one in 8 among women are related to alcohol or drugs[13]. Depression and suicide have been demonstrated to relate to hazardous alcohol use in Belgian society[14], and intentional violence is related to alcohol equally among perpetrators and victims[15].

Recently a university-based study estimated that work-related problems due to alcohol were comparable with data from other countries (10% of the costs of criminality and exclusion and 5% of police costs)[13].

9.1.4. Health services dealing with alcohol problems

Belgian health organisation is characterised by a liberal system based on fee-for-service payments and free choice of physician. More than 80% of the population see their general practitioner yearly but direct access to specialist and hospital care is possible. GPs function mainly as sole physicians, although a slight increase in two-partner and group practices occurred recently. This is partly due to links between practitioners and their tutors after vocational training and partly to an increase in female physicians. No special fee exists for the provision of more lengthy mental health counselling. The mean time for consultation among GPs in Belgium (15 minutes) is estimated to be higher than in surrounding countries.

In mental health care different facilities co-exist financed by the linguistic communities and the federal health insurance system. On the one hand, ambulatory care provided by psychiatrists and private psychologists is regular practice. Psychiatrists generally function also as consultants to either regional mental health hospitals or psychiatric services linked to general hospitals; they are reimbursed, as are GPs, by health insurance which covers almost the entire Belgian population. On the other hand, centres for mental health deal with ambulatory mental health care, either autonomously or after referral by GPs. Such centres are financed on a salary basis by the linguistic communities and provide a variety of services, of which drug counselling and prevention is one.

GPs are organised in local circles that arrange after-hours services on a collaborative roster and sometimes co-ordinate home care and continuing medical education (CME) in addition. GPs are further organised in local quality circles, being groups of 8-24 GPs who meet 4 times a year. Historically these activities developed differently in the two main linguistic communities in Belgium but CME and quality assurance are endorsed by the scientific societies of both communities and the universities. Because of this different organisation and the responsibility for prevention assumed by the linguistic communities, the development of an implementation strategy for Belgium needed to include two customisation projects, one Flemish and the other French. The French-speaking customisation project is summarised in Appendix 9.1.

9.2. The Flemish Phase IV Project

The aim of the Flemish arm of the WHO project is to develop a cost-effective, GP-oriented quality assurance programme for early identification and brief intervention (EIBI) embedded in a health promotion policy initiated by the Flemish community through the creation of local health promotion groups (LOGOs) in 1998. Specific aims are:

- To develop a strategy promoting municipality and LOGO action to stimulate (i) safe alcohol use and (ii) enduring delivery in primary health care of EIBI for hazardous and harmful drinking;
- To evaluate the cost and outcomes of a primary care-oriented quality assurance project embedded in a regional (municipality and provincial levels) and nationwide (i.e. Flemish) implementation strategy.

9.2.1. Project development

At the start the project the coordinating team made requests at the federal state and Flemish community levels for specific funding for research and developmental costs of the programme but did not succeed due to competing priorities in the ministerial budgets at that time. Due to lack of specific funding, the project was embedded in the regular health promotion strategy of the *Scientific Society of Flemish General Practitioners* and into other Flemish initiatives for health promotion. The WHO Phase III and IV studies started as a research programme of the Flemish Institute of General Practitioners (VHI, grouping WVVH and 4 university centres in general practice) which during the time of the study became the Research Department of the *Wetenschappelijke Vereniging voor Vlaamse Huisartsen* (WVVH).)

In the Flemish community health promotion is co-ordinated by voluntary groupings of municipality representatives, health care institutions, preventive care organisations and associations of health professionals in areas of about 300,000 people (i.e., LOGOs). The aim is the accomplishment of health targets defined by the Flemish Parliament; a LOGO can however add its own local targets. Alcohol is not a formal health target but actions against drug and alcohol problems are supported the Flemish Ministry department responsible for health by a convention with an NGO association (VAD) combining specialised services and a large number of Centres of Mental Health. This association prepares the policy and training of prevention and municipality workers and this is coordinated at a provincial level in preventive drug platforms.

Through "reflective participation"[16] the project coordinator and municipality prevention workers were able to put the target of 'safe alcohol use among adults' on the agenda of a number of municipalities and proposed it as provincial policy in Flemish Brabant through the provincial prevention platform for drugs. This policy was endorsed for 2003 to 2006 by the provincial deputation (i.e. the elected district board).

9.3. Customisation

9.3.1. Defining targets for QA and CME (Strand 1)

Focus group research among GPs

This began by adding to the WHO Phase III focus group research on habitual care by GPs the adaptations needed by those who used the Drink-less package and the early detection and brief intervention strategy that was being followed. Focus groups on strategies for collaboration with mental health care were added[17].

Focus groups taught us that the hidden character of alcohol and the social and economic background of alcohol misuse and dependence strongly influence the views of practitioners. This gives GPs a major emotional burden in dealing with alcohol problems, expressed as "workload" or "lack of time". (The same phenomena was found in other countries taking part in the ECATOD training project). In the focus groups feelings were expressed of ineffectiveness, powerlessness and deception after major efforts to help people. Generally GPs are neither trained nor feel they have the time to deal with

ongoing counselling of patients with alcohol misuse. On the other hand, a tension exists between the perceived responsibility on the part of the GP to remain available and supportive to alcohol patients and specific lack of public support for such this continuing work. In Flanders the relationship with specialists is coloured by the GP's fear of "loosing" patients. GPs also complained of inadequate training and insufficient facilities.

GP who were provided with the Drink-less package in Flanders expressed similar views and feelings of deception in the focus groups but these were mixed with new ideas on the possibilities of the tools provided, although questionnaires for detection and counselling are not regularly used.

The actual clinical approach to alcohol problems consists mainly of blood testing and repeatedly confronting patients with the negative consequences of alcohol use. This is complicated by a lack of clear distinction between hazardous alcohol use and harmful use or dependency. Flemish practitioners believe that dealing with dependent alcohol users is a task for specialised services. Hazardous alcohol use does not constitute an easily demonstrable "disease entity" and GPs have some difficulty dealing with deviant behaviour when disease is still absent.

On the one hand, the suggested early identification is welcomed as a strategy to deal with alcohol before major problems occur. The family support role of general practitioners is seen as an advantage of GPs over specialists in dealing with alcohol counseling. On the other hand, use of secreening questionnaires differs fundamentally from the curative approach GPs are trained for. GPs who took part in the WHO Phase III study recommended initial training in local QA groups followed by ongoing support for implementation.

It was concluded that any promotional strategy towards Flemish GPs should stress:
- the clear distinction between hazardous drinking, harmful alcohol use and dependency;
- allowing cumulative positive experiences with new tools to promote an approach linked to the medical model highlighting the negative effects of alcohol misuse as a cause of disease;
- acknowledging the time and psychological burdens facing GPs involved in dealing with patients and families with alcohol problems and providing peer group support for this;
- providing an official support strategy at national and local levels for reducing advertising and decreasing the accessibility of alcohol.

Delphi study
Based on the problems identified in focus groups, a Delphi study was carried out from April to June 1999 to develop a consensus on collaboration between primary care and mental health care[17].

The consensus statement considers the role of the GP in Flanders to:
- act as a central key person due to easy accessibility
- provide motivating and supporting interpersonal counseling
- refer complicated patients (defined in terms of comorbididty) and dependent patients
- assess the fullfilment of an agreed and developed therapeutic plan
- arrange hospitalisation when required and check for compliance after release
- provide biomedical aftercare
- monitor relapse

To take the role as coordinator of care for alcohol problems, GPs need to develop a better knowlegde of social services.
Pretesting quality assurance in local QA groups
These findings were integrated into an experimental package of 3 sessions for local quality assurance groups and CME. The sessions provide an introduction to forms of alcohol use and EIBI (Session 1), discussion of experiences with EIBI and a more comprehensive motivational exercise related to

different stages for change (Session 2) and a follow-up and discussion about collaboration with mental health care (Session 3). This approach was tested in 13 local groups of GPs (supported by an unconditional grant by Merck, formerly LIPHA) and some undergraduate and vocational training sessions[17]. This appeared to be too lengthy and we have decided to reduce the sessions to two at the most. Materials for AUDIT and short advice cards were adapted form the original Drink-less package to include new ideas about GP involvement with dependent drinkers and reduced, more sophisticated strategies. A similar programme was developed for tobacco.

Additionally training of local prevention delegates and QA-group facilitators was tested in a joint effort between WVVH and the health district prevention authority, called 'Centrumlogo', responsible for a population of 320.000 people living north-east of the Brussels capital region. Although this was embedded in an international conference with Phase IV collaborators (October 2001), it did not provide the expected stimulus for interest among LOGO workers nor QA groups in training for health behaviour change (tobacco and alcohol). This may be partly explained by the English language training sessions, partly because only tobacco has been officially retained as a health target for health promotion teams.

9.3.2. Embedding EIBI within the strategy of the Scientific Society of Flemish GPs

A problem occurring as a result of the origin of our project outside the Scientific Society was the testing of a quality assurance package and materials before the development of an officially authorised recommendation. Development of a Flemish recommendation was started according to the usual policy of the Scientific Society of Flemish GPs (Task Group Prevention of WVVH). A recent study[9] indicated the usefulness of reduced questionnaires for screening. However, the evidence-base for counselling after such a questionnaire is not well-established. Discussion of the state of the art within the Task Group led to the decision to develop this simplified screening and advice strategy integrated in a more comprehensive view of behavioural change. A simplified screening procedure is now proposed for evaluation and a new working group has been was created within the Scientific Society to support GP promotion of behavioural change (Working Group on Behavioural Change, WVVH). This EIBI approach will be embedded into a 4-year strategy developed by this working group based on an "ABC" philosophy[18]. The three main clinical approaches proposed for health behaviour change are:

A: Anamnesis - 'ask' and 'assess alcohol use'
B: Begeleiding (guidance) - 'advice','agree' about targets and 'assist' according to stage of change
C. Continuity of care – record-keeping or 'annotate' and 'assure follow-up'

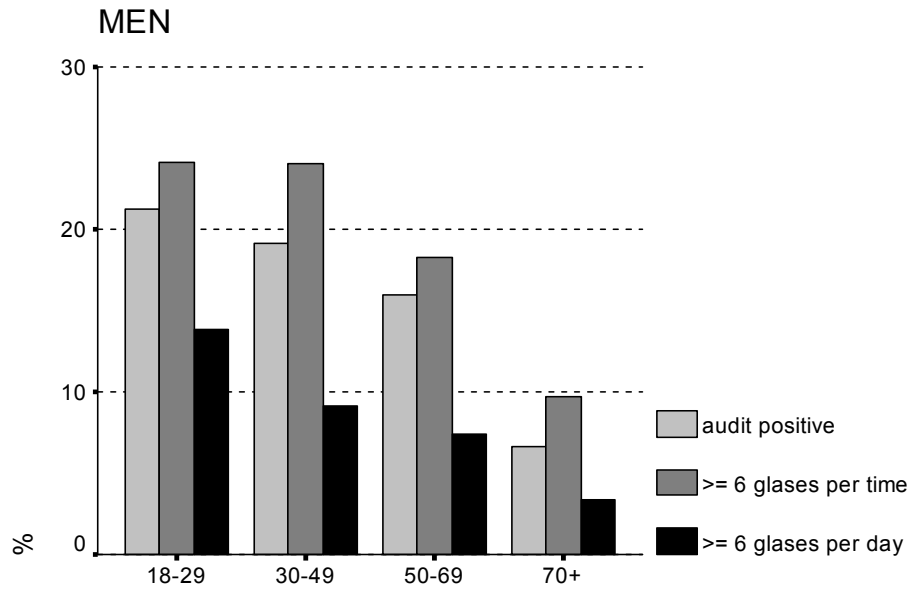
9.3.3. Embedding the primary care-oriented action into community health promotion

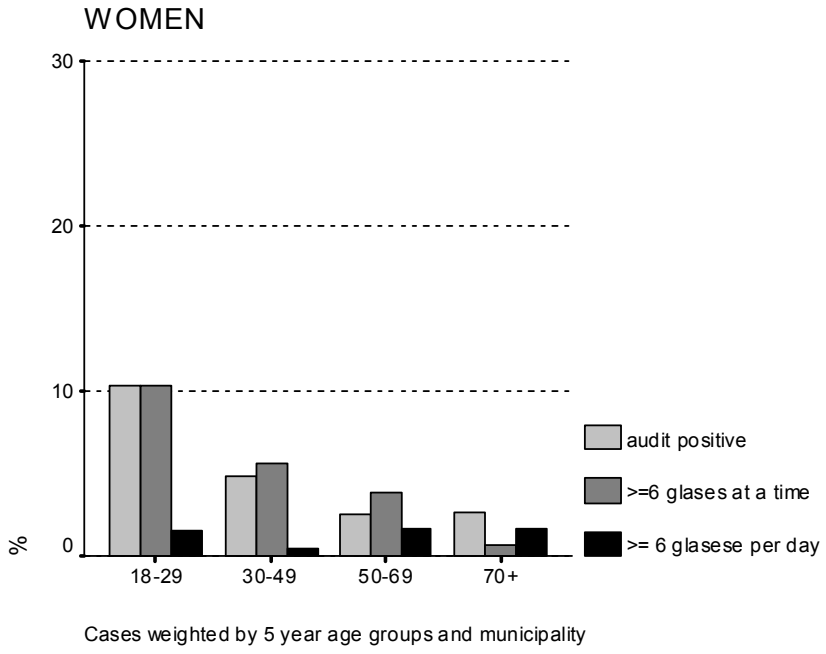
Community survey

To promote discussion with local municipalities on health promotion policy, a population survey was developed in Centrumlogo (Flemish Brabant), one of the LOGOs mentioned above.

This survey was designed to test the feasibility of including AUDIT questions in a general population survey. Figure 9.1 compares the results of regular health survey measures in Belgium for problematic alcohol use with measures based on the AUDIT questions.

FIGURE 9.1
Comparison of audit results for men to regularly used measures according to health survey in Centrumlogo (May 2000)





Questions from a reduced psychosocial well-being scale[19] were added to the health survey. Results allowed us to exclude this questionnaire as a pre-screening test for detection of mental health problems, including alcohol as illustrated in Table 9.2.

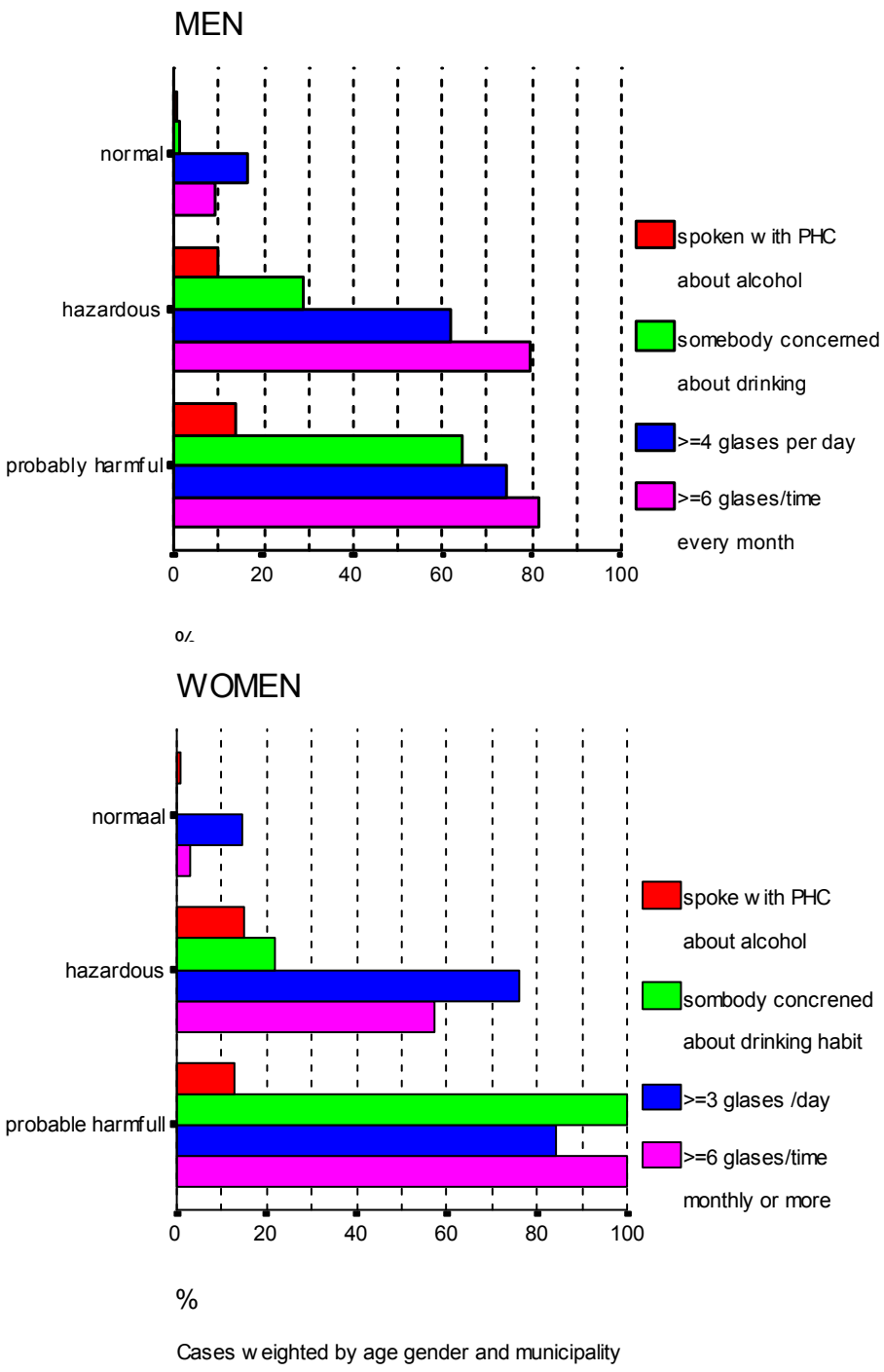
TABLE 9.2
Comparison of AUDIT results and Depcare Well-being scores

		Depcare Wellbeing score		
Audit results		**bad**	**good**	
normal alcohol use	**n=**	52	806	858
	%	**81,3**	**87,1**	
hazardous use	**n=**	7	85	92
	%	**10,9**	**9,2**	
harmfull use	**n=**	5	34	39
	%	**7,8**	**3,7**	
Total	**n=**	64	925	989

PPV= 18,6 NPV= 12,9 sens=9,2 spec=6,1

Differences between municipalities in alcohol use were discussed with interested local boards. The attention of regional GP representatives was directed to the low involvement of practitioners and other primary health care workers in preventive advice for alcohol (Figure 9.2).

FIGURE 9.2
Percentage of drinkers counseled in primary health care in Centrumlogo about alcohol according to results on AUDIT questionaire (Y-axis) included in health survey.



These results were submitted to local GP representatives, municipality discussion groups and the so-called 'Provincial Prevention Platform on Drugs' (co-ordination the work of local prevention workers on alcohol and drug issues). A number of municipalities decided to run specific actions on alcohol and tobacco in 2003. Furthermore, data from the survey contributed to the establishment of an official provincial strategy towards alcohol misuse in the adult population.

9.4. Communications Strategy

At the end of 2002 a working group was created to develop a population communications strategy directed towards the adult population, in collaboration with municipality workers in the province of Flemish Brabant. Four key messages were retained:

- Safe use for whole population (folder, poster, gadget for measurement of own consumption);
- Referring and discussing problems related to alcohol in primary and mental care. The same folder and poster will be used and training is provided to a wide range of primary care workers. Trainees include general practitioner co-ordinators of local QA groups, health care and social welfare workers integrated into collaborative groups for home care, the so-called "SITS" (collaborative groups for home care: nurses and social workers, pharmacists, physiotherapists, policemen). Training was provided by mental health care prevention workers to such groups in 2004-2005 in a number of pilot training groups for motivational approaches;
- The promotion of the role model or exemplary role of specific groups such as parents, teachers, GPs, police etc.;
- Countering social pressure to drink.

The province of Flemish Brabant will produce all needed materials and the communication is scheduled to start at the end of 2005 with new promotion of training in QA groups of GPs and home-care staff. Additionally, materials will be distributed to all participants and all municipalities in the province will be approached and invited to join. A number of municipalities have agreed to pilot the strategy (Tienen, Dilbeek, Vilvoorde, Kraainem and Wezembeek). Several of these municipalities usually run an information campaign about safe use linked to the so-called 'BOB campaign', a successful annual campaign around Christmas with road controls for the prevention of drink driving.

The messages now initiated will indicate that safe use is always necessary. Other messages will be used to sustain public attention and activate the campaign.

Finally, the Flemish Association against Alcohol and Drug Problems (VAD) will run a new nationwide (Flemish) communications policy aimed at adult safe use which will start at the end 2005 and will be launched together with the provincial communication strategy described above. This information policy was prepared during an action year 2004 dealing mainly with the relationships between sport and alcohol, and pregnancy and alcohol. It is the last step in a 4-year plan to run a public alcohol campaign which first targets youth and then adds adult alcohol use to the messages at the end.

9.5. Alliance Building

9.5.1. Integration of primary care actions for hazardous alcohol use into drug policy

A report on the WHO Phase III project together with a new proposal was sent in 1999 to the Minister of Health for the Flemish Community, with a request for support for a demonstration project. This was not accepted. It was hoped that tobacco as a health target would be replaced by health behaviour change in 2003 for the new 5-year programme but this was not the case.
A proposal was submitted in 2000 jointly with VAD to the Secretariat for Scientific Research (Department of the Prime Minister) for a cost-benefit analysis of reimbursement to GPs. This was not successful due to competing priorities, although it was well scored.

We tried to establish a joint policy document with VAD for the federal state during elections in April 2003, in collaboration with French-speaking Belgian colleagues. In the end the document was not signed and was withdrawn by VAD due to their aim of obtaining support for a comprehensive drug and alcohol policy and not a specific alcohol plan.

We conclude that a further major effort is needed to set alcohol as a specific target for health promotion on the polictical agenda. As part of the PHEPA project we succeeded in two succsessful large-scale national meetings in reaching agreement on a consensus statement on the priority of an alcohol policy with a large number of French and Flemish speaking bodies (NGOs, public officers of regional governments, provincial delegates, scientific institute delegates). Screening and brief intervention in primary care was defined as one of the major cornerstones for such a policy in conjunction with local community networking and actions embedded in a large scale public information policy.

One consequence of this country team work was the alliance bulding with the sister organisation SSMG, extending customisation efforts for training to the French-speaking GP community in Belgium (see Appendix 1).

9.5.2. Guideline development and integration into the policy of WVVH Taskforce Prevention

The collaborative WHO project, including the development of practice tools and the package for quality assurance, preceded the development of a formal guidelines authorised by the official Belgian committee set up for this purpose. The Taskforce Prevention of WVVH required the development of a formal guideline before further implementation in the field. A first version was developed in 1999-2000 by the research team.

In a thesis at one of our major universities[9], the AUDIT was validated as the best screening instrument for the Flemish-speaking population, using lower cut-off points than normal. However, the study also pointed to the advantages of using simpler screening tests (5-shot, AUDIT-C) as very good alternatives.

Our analysis of Phase III Strand 3 results and focus groups showed that Flemish GPs did indeed request a choice of screening strategies adapted to their own motivations and practice feasibility.
The development of a formal guideline was therefore postponed to allow for adaptation of an early identification strategy and to coincide with a review of Dutch Recommendations on Alcohol[20] planned at the beginning of 2004. As a result, development of the new Flemish guideline will run in parallel with the guideline development in the PHEPA project which the WVVH joined in 2003. A new version of the Flemish draft guidelines was submitted to the Task Force on Guideline Development of the Flemish Scientific Society in April 2005 and has now been adapted according to their comments. Pre-testing in local quality groups of GPs is planned for the beginning 2006.

It has been agreed with WVVH to enter the recommendation for alcohol to the formal authorisation committee (CEBAM) in March 2006 at the latest. This committee, situated at the Catholic University of Leuven, verifies the quality and evidence-base of all recommendations for good practice in primary care. This allows us to run the planned demonstration project in a local area in 2006-2007 using quality assurance to test the draft of the recommendations and before widespread use in Flanders.

9.5.3. Introducing adult alcohol use as a topic for local health promotion activities

Presentation of the strategy to selected Health Promotion Boards, called LOGO teams and created recently in Flanders (Autumn 1999), did not lead to a formal collaboration. Joint training involving foreign experts was set up between WVVH and Centrumlogo and open to other LOGO teams in October 2000.

Results of the health survey carried out by Centrumlogo were published in a widely distributed newsletter to all possible workers in health promotion, including municipality representatives in this LOGO. Data were presented to a number of these municipalities in detail and some chose alcohol policy as their priority for 2003.

Alcohol was also proposed as a local target to be added to the five Flemish targets for health promotion in 2003 for the whole Centrumlogo. However, the Health Promotion Board changed and expanded this choice in a submission for financial support to the Province of Flemish Brabant to drug addiction policy (including tobacco, alcohol and drugs). We disagreed with this procedure and withdrew from the LOGO team. A limited number of the 17 communities still planned a specific alcohol policy. Their efforts will be reiterated through the launch of the provincial policy on alcohol at the end of 2005. Indeed, a number of specifically interested prevention workers continued to develop an alcohol communications strategy, co-ordinated by the Provincial Platform on Drug Use for the whole province and some municipalities, and now plan a community information strategy which addresses municipalities as a specific target for action.

9.6. Further Planning

9.6.1. Development of national and regional alcohol policies

Primary care-oriented actions embedded in a formal policy

As part of the PHEPHA project, the research group of WVVH held 3 major meetings to sensitise local authorities and scientific bodies for jointly designing a specific Alcohol Action Plan. This should enhance the involvement of the different levels of responsibility in Flanders and Belgium more generally.

i. A meeting was organised by the country-based PHEPHA team (VAD, Province Flemish Brabant, WVVH, VVGG, SSMG) at the start of 2004 to provide the scientific evidence on safe use, the effectiveness of EIBI and task definitions in primary and mental health care. The debate defined better the complementarity of an alcohol policy at provincial, linguistic and federal levels and tried to put alcohol higher on the political agenda for the Flemish Elections in June 2004.

ii. A further meeting was proposed to the Working Party for Alcohol of the provincial drug platform of Flemish Brabant in 2004 to involve local municipalities and LOGOs in launching the key messages defined for the provincial communications strategy on alcohol. In this approach mental health care will be specifically involved in sensitisation of intermediate health workers (pharmacists, nurses, home care, physiotherapists, school medicine, child medicine, social services etc.). This will allow us to define the subsidiarity of involvement of local prevention and community workers in Flanders. The launch of this plan is scheduled for November 2005.

iii. Finally, a second PHEPHA meeting took place in November 2004, paying particular attention to the possibilities for an enhanced federal policy on EIBI in primary care.

The main effort of the WVVH research team from 2000 to 2005 was to try to orient different actors towards a common goal of developing a local alcohol action. The procedure followed was “reflective participation” in health promotion planning at provincial, LOGO and municipality levels.

In the meantime, active participation in local mental health projects and dialogue with prevention teams made the team known in the province of Flemish Brabant and more recently at federal level. (We worked successively on: detecting alcohol misuse in primary care; dealing with dependence through GPs in collaboration with mental health care; developing a consensus on dealing with violence and showing its relationship to alcohol abuse). The core of the original project team for WHO Phases III and IV is now working on a project on depression and suicide and was involved in a

working group of a Flemish health conference on the relationship between alcohol and drug abuse with depression and suicide). Alcohol has been integrated as one of the 5 topics in a comprehensive pilot programme which is aiming at continuing professional development in mental health (i.e. training coupled with quality assurance). As a result, local quality assurance groups of GPs are already being trained in EIBI on a regular basis at their own request.

The workplace as a complementary target
An active policy towards companies and factories has been piloted mainly through mental health centre collaborators and prevention workers and coordinated at VAD which published a guidebook for such a strategy at the end of 2002. In this philosophy, the municipality itself is seen as an important company. It would be possible to include this in the local strategy if specific financial support can be obtained.

We also considered the development of a parallel policy for EIBI at the workplace level. This has not been realised owing to an ongoing debate on reorientation of the formal policy of the Ministry of the Flemish Community towards prevention in the workplace. However, a recent study on the impact of alcohol on work may reactivate this debate in Flanders[21].

It should be noted that this workplace approach is part of a more comprehensive community action policy called *Schakel Jezelf In* launched in 1998 by VAD for both alcohol and drug problems. Until recently this policy has given priority to strategies for youth (school-based evaluations and school and youth organisation-based actions) together with the workplace policy. It is well supported by the networks of provincially coordinated municipality workers for prevention on alcohol and drugs use, partly working from Centres of Mental Health and partly from a variety of municipality departments or social services.

Provincial action plan for drugs as a basis for further strategies
In 2003 the Province of Flemish Brabant made safe alcohol use among adults one of its priorities for prevention policy. In this province a number of municipalities are considering development of alcohol action plans, or more comprehensive drug strategies with special attention to alcohol, in municipalities with special prevention workers coordinated by the Provincial Platform on Drugs or as a result of coordination efforts in Centrumlogo. In these municipalities WVVH has suggested supporting quality assurance for GPs according to the model developed and customised by the Research Group of WVVH in collaboration with WHO Phase IV. The promotion of this could be left to LOGOs and municipality working groups supported by WVVH and Centres of Mental Health care. Municipality actions are also supported by regional coordinators of prevention workers based in the Mental Health Care Centres.

Such efforts towards an adult alcohol policy should be co-ordinated in a stepwise planned and complementary programme. This can be pursued at provincial level. A remaining difficulty is the diverse aims of all actors in this process. The provincial initiative in Flemish Brabant was planned as a pilot phase upon which the later VAD action can build nationally. Delay in development of the population communication strategy postponed the provincial programme however to coincide with the Flemish VAD information action towards adult alcohol use. It has the additional advantage of directly addressing local communities.

9.6.2. Proposal for a demonstration project

As no specific funds were available for a formal demonstration project in 2004, the project will be embedded into the actual planning of the different groups involved. It will thus consist of:

- Guideline submission and associated quality assurance for GPs in Flemish Brabant by the Task Group Prevention WVVH in collaboration with the Province of Flemish Brabant;
- Reframing understandings of other health care and social welfare workers regionally through Centres of Mental Health in the Province of Flemish Brabant;

- Results measured for costs and effects using existing data sources (sentinel network of GP, police data, national health survey) by comparing dissemination of EIBI in the strategy followed in Flemish Brabant with the national strategy of guideline dissemination and the VAD communication policy in Flanders as a whole.

The development of indicators for good GP preventive performance has been recently undertaken by the WVVH Task Group Prevention and should allow us to collect baseline and follow-up data on adequate GP preventive care in the future, including EIBI.

Other issues, in particular cost-utility evaluation, will depend on further financial resources.

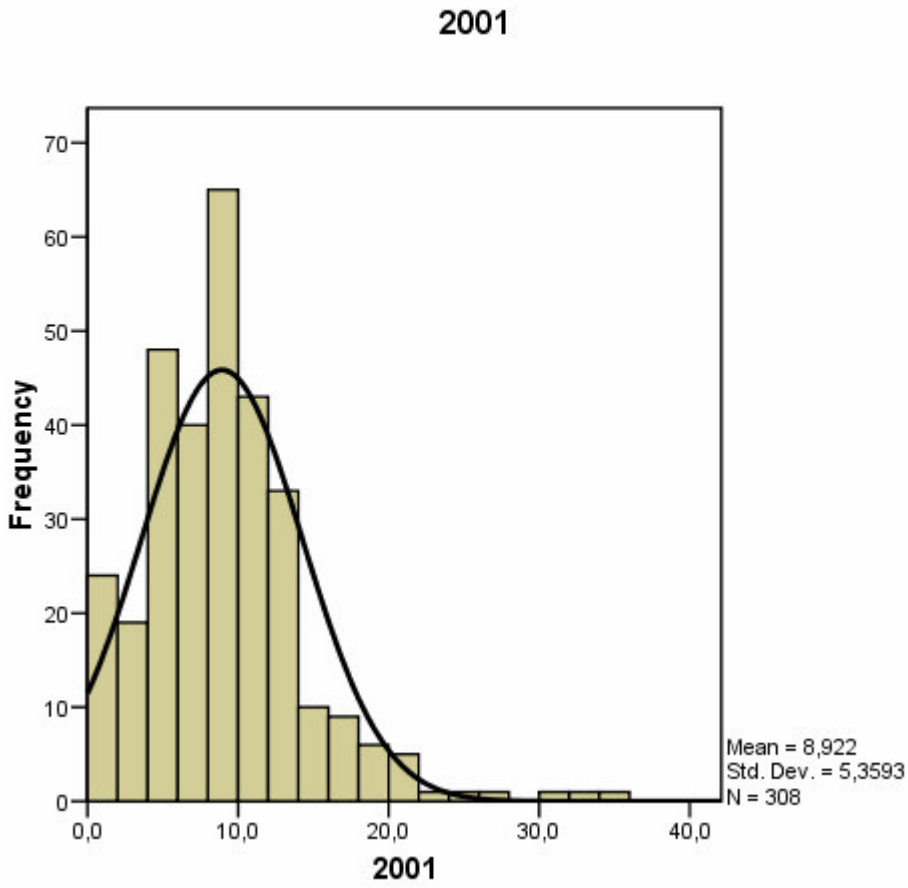
9.6.3. Customising alcohol measures for evaluation purposes

Data collection on alcohol-related problems was proposed to the sentinel GP network in 2003. Instead, however, a register of intentional violence was started in collaboration with the Research Group of WVVH. This includes particular attention to the relationship between violence and alcohol abuse. The pilot register was completed in 2001 and the formal register which started in 2002 ran till 2004. During the program 2004-2005 no data on alcohol will be collected in this registry but from 2007 onwards crisis interventions by GPs, including alcohol intoxications and social problems related to alcohol, will be prepared by our Institute in collaboration with the Institute of Public Health. In the meanwhile a web-based case management tool will be lanched in 2006 and will be linked to problem identification when dealing with psychosocial problems in primary care.

Road accidents are regularly registered at police and federal level and followed up annually. Data were analysed by Centrumlogo and sent to 17 municipalities in Flemish Brabant, linked to survey results, to draw their attention to alcohol as a major health topic. These data are readily available at national level and can be further followed up without problems.

FIGURE 9.3

Distribution among local municipalities of the percentage (X-axis) of road accidents under influence of alcohol in Belgium.



(Data kindly provided by National Institute for Road Safety, 2004)

Health promotion surveys were carried out in 1997 and 2001 and were repeated in 2004. Questions measure problematic alcohol use in the Belgian population, such as drinking above 6 glasses a day. We have proposed a slightly modified approach based on the results of the Centrumlogo survey.

A procedure has now been initiated by the Task Force Prevention of WVVH to develop a consensus on Flemish indicators for primary preventive care. We favoured the inclusion of alcohol-related process measures. Alcohol-related measures were not retained by the expert review committee for large scale use. The proposed parameters will be used, however, in the demonstration project.

9.7. Funding

The WVVH/VAD project proposal could not be developed as a project in its own right, although several attempts were made to raise funds for a cost utility analysis and the demonstration project. (The last proposal made to the National Knowledge Centre in May 2005 was refused in October 2005 because of 'too many competing other offers'.) Most work was therefore carried out on a voluntary basis by the research team of WVVH involved in other projects, as highlighted above.

Specific project money was linked to the WHO Phase III study in 1998 (e.g., testing the Drink-less programme) and is available for guideline development (Flemish Community sponsorship by Task Force Prevention WVVH). The philosophy followed by the research group aims to integrate EIBI into regular local and regional prevention plans for which budgets are readily available in Flanders. Supportive scientific activities were financed by the WVVH Research Department or sponsored through participation in international projects (first ECATOD, than PHEPHA).

Acknowledgements
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- Testing of the QA package by local GP groups was unconditionally supported by industrial sponsorship from 1998-2000 Merck (formerly LIPHA).
- Focus groups: Drink Bewust Programme Flemish Community (1998) and ECATOD Project (1999-2000)
- Regional heath survey in 2000 (Centrumlogo)
- Community action support: municipalities and Province of Flemish Brabant
- Guideline and indicator development: WVVH Taskforce Prevention in a regular contract with the Ministry of the Flemish Community (Department for Health and Welfare)
- Sentinel network registration: Monitoring network coordinated by the Public Health Institute WIV Louis Pasteur, supported by the two linguistic communities and the federal Ministry of Health.

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APPENDIX 9.1
French-speaking Customisation Programme

Lead organisation:
Société Scientifique de Médecine Générale (SSMG)

Coordinator:
Bernard Dor, MD for the "SSMG Commission Alcoology".

Start date: 1999

Introduction:
To study the feasibility of extending experiences of the Flemish Phase III and IV into the French-speaking community, the SSMG (Scientific Society of French-speaking General Practitioners) started a project in 1998.

The overall aim of the French-speaking working group on alcohol of the SSMG is to promote integration of screening and brief interventions for hazardous and harmful alcohol use into primary health care in the French-speaking community. A customisation and feasibility study of training and screening was performed among 40 GPs and 500 addditionally trained physicians.

Customisation of training strategy in the French region:
Customisation was performed by organising and evaluating results of the training of GPs for screening for hazardous and harmful drinkers and in the brief interventions techniques (EIBI).

This training took part in SSMG's regular meetings on continuing medical education, with no initial intention in 1998 to extend this into a broader policy of continuing education to all primary care workers, nor by including a "community enhancement" dimension.

This project in 1998 was the first attempt to integrate dealing with hazardous and harmful drinking in the French-speaking community. Earlier initiatives were related only to dealing with alcohol addiction, and mainly based on hospital or the specialised sector.

Feasibility of screening by French speaking GP - the PROBEX Study:
In 1998 an enquiry was carried out among 300 GPs to study their view on dealing with alcohol problems.

In 1999 the SSMG joined an action research project (PROBEX) in partnership with the School for Public Health of the University of Liège (Prof. Gosset) and with financial support from the Belgian French Community Government and the regional governement of the Walloon Region. This action research project was carried out with nearly 40 general practitioners with following aims:

- to study and evaluate the relevance and acceptability of a number of intervention tools put at the disposal of the participating doctors in order
- to disseminate the tools as well as
- to evaluate the impact of the training of GPs in the effective management of this category of drinkers.

No such study existed in French-speaking Belgium at that time.

The training module was adapted to the needs of the participating doctors. The tools developed by the French Phase IV team were used and adapted to the needs of Belgian French-speaking GPs after evaluation of relevance and acceptability by a small experimental group of GPs.

The above-mentioned political authorities gave their financial support to the PROBEX project which was planned over a period of 39 months, with an end initially projected for the Autumn of 2003 but eventually deferred to the Spring of 2004.

Training of the PROBEX practitioners was performed in November 2001 (two days).

Evaluation: Data were collected on the tools, doctors and patients included from November 2001 to September 2003.

One focus group with 10 PROBEX fellow-practitioners was organised in the Spring of 2002. It showed that there was little perceived need, motivation and preparation among GPs in the practice for networking around alcohol; in particular, the main obstacle was lack of financial valorisation of preventive care in Belgium.

Probex results:
After 18+ months (September 2003) 2096 patients had been recorded by trained GP and had completed the AUDIT. Of these 421 (20.1%) proved positive. At 18 months a follow-up of 268 was available. Of these, 32 % had reduced their consumption; the doctor-patient relationship was improved in 16% of cases; global health, as estimated by the GP, was improved in 22% of cases, stable in 25% of cases and deteriorated in only 10%.

Customisation of materials:
PROBEX's results allowed the improvement of the quality of continuing training aimed at disseminating EIBI. For instance, among the documents (booklets and support sheets) offered to pilot practitioners, some are far more utilised than others; diagnostic categories will be more clearly defined and promoted. In the course of the research many practitioners persisted in considering hazardous drinkers as the main problem compared to dependent drinkers.

Extension of training through SSMG's continuing training groups (dodecagroups and workshops). In 2003 more than 500 Belgian French-speaking GPs (members of the SSMG), meeting in small groups of 15 to 20 general practitioners each, were trained using the developed educational module ("quality assurance package") (CD-ROM; paper documents; down-loadable on SSMG's website : www.ssmg.be).

Further planning:
At the beginning of 2004 SSMG continued the distribution programme started in 2003 to adapt it according to experience in the PROBEX-study and to integrate those efforts into a broader concept with community implications. Collaboration between WVVH and SSMG work is now activated through joint participation in the PHEPA network supported by the European Union.

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CHAPTER 10

FRANCE

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10.1. Introduction

10.1.1. Country description

France has 62 million inhabitants, including two million people living in the overseas regions (the French Caribbean islands Guadeloupe and Martinique, French Guyana and the island of La Réunion in the Indian Ocean). One in six people lives in the Paris region, Île-de-France. The GNP per inhabitant was estimated at 25,700 Euros in 2002. Population density is 107 inhabitants per km². Some regions are mainly devoted to agriculture and wine and spirits production is of major economic and cultural importance. The 'alcohol lobby' and the 'peasants' lobby' both have a real influence on political decisions.

A first rapid social evolution changed the face of French society after WWII, with the transformation of the peasantry into an industrial working class. (The proportion of the population working in or for agriculture has fallen from 50% to 3%). A second change occurred after the mid-1970s crisis, with the rise of a service economy (now 71% of GNP) and the decline of industry.

10.1.2. Alcohol consumption and alcohol-related harm

These social and economic changes influenced drinking patterns in the second part of the 20th Century. Although France has remained near the top of international statistics for average alcohol consumption for more than half a century, there has been a constant decrease first in consumption and then in alcohol-related morbidity (e.g., liver cirrhosis) and mortality. Drinking every day during meals, generally wine (or beer in the East and North, cider in Normandy and Brittany), which was the norm until the 1960s, has become the behaviour of a minority, mainly the elderly, the industrial workers and the peasants; the so-called 'Anglo-Saxon model' of drinking was adopted first by the elites, then by youth, then by the majority of the population. It is the main reason for the rise in spirits and beer consumption, the decline of wine, and the rapid decrease in overall average consumption which is now at the 4th rank in official European figures, with 10.3 litres per year per adult. In spite of this decrease, 45,000 deaths are still attributed to alcohol every year and it is the second cause of avoidable death after tobacco.

10.1.3. Health services

Prevention programmes and the medical treatment system may have contributed to this phenomenon. Public health and prevention are poorly developed in France and, for alcohol-related problems, prevention has been mainly entrusted to an NGO, now called *Association nationale de prevention en alcoologie et addictologie* (ANPAA: National Association for Prevention of Alcohol and Drug Addiction). The treatment of alcohol-dependent patients was left to psychiatric hospitals up to the 1960s and then to specialised in-patient clinics, but since the mid-1970s a rather dense network of out-patient clinics has been developed with the initial intention of offering excessive drinkers a place to assess the risk related to their drinking and receive advice. However, these centres rapidly became devoted to 'alcoholics'. Two hundred and fifty (250) of these centres now exist in France and about 100,000 people receive care in them each year.

Availability of health services is ensured by 'social security', an obligatory insurance funded by both workers and employers which makes up 35% to 100% of health expenses (75% on average). Life

expectancy is high: 75.6 years for men and 83.1 years for women. Primary health care is provided only by general practitioners (GPs). Most of the 60,000 GPs are independent professionals directly paid by their patients on centrally fixed tariffs; the social security funds reimburse the patient's expenses after the event. Few GPs have a receptionist in the surgery. Most work alone but a quarter share an office with fellow GPs or other health professionals. Continuous medical education is poorly organised, though there is a high density of CME associations (13,000).

10.1.4. Research on alcohol brief interventions

Little research was carried out in France on the GP's role in alcohol-related problems before the WHO Phase III study. French teams were included in Phase III, in particular during its Strands 1 and 2[1]. One clinical trial was conducted in 1995[2]. Half of GPs were trained for screening only, the other half for screening and brief intervention (5-10 minutes advice). Patients included in this study were males reporting drinking more than 280g per week. An important effect was seen in patients in both conditions (half had reduced consumption to under 280g per week) but no differences were found between groups. This study was considered by its authors as disappointing. The only effective intervention ever published in the field by a French team concerns smoking cessation[3].

At the beginning of WHO Phase IV study in 1999, ANPAA decided to develop a programme called *Boire moins c'est mieux* (BMCM: "Less is better") in collaboration with the WHO study group. This programme had nationwide objectives and implications but the research aspects were mainly situated in the *Île-de-France* region (11 million inhabitants). The four general goals of Phase IV have been developed during the last four years[4].

10.2. Customisation

BMCM worked on this objective by adapting:

- intervention tools;
- screening strategies;
- training methods;
- GP mobilization strategies.

10.2.1. Adapting intervention tools

With a commission from the Social Security Public Health Department, in 1998 the *Comité Français d'éducation pour la santé (CFES)* developed a screening and intervention instrument *Alcool, ouvrons le dialogue,* based upon Prochaska and DiClemente's[5] approach – a 10-page tear-off pad and a waiting-room poster containing an invitation to 'open a dialogue' about alcohol consumption. In the contents, the AUDIT questionnaire was not used as a systematic screening tool but as a self-administered evaluation of the patient's initiative following an interview.

In 1998-99 BMCM carried out a series of focus groups (with two medical 'peer groups', 10 doctors in each) to determine needs for screening and intervention materials in general medical practice. The French GP's situation has 3 main characteristics: (1) they are paid on a fee basis and receive the same amount whatever they do during the consultation, which is partially reimbursed to the patient by the social insurance fund after the event; (2) they work alone in their offices (group practices do exist but usually doctors share the business premises); and (3) they usually have no assistant present in the practice, only a 'telephone secretary' to deal with appointments. The results of the focus groups were clear: doctors considered they could participate in such a public health strategy but they wanted something easy, simple and short, and would appreciate an extra fee for this extra work. The Drink-less booklet, translated into French, and CFES' 'O*uvrons le dialogue'* were examined during these focus groups and useful recommendations were provided to our team[6].

In 1999, Social Security, which had become the common funding institution of both CFES and BMCM, demanded the development of a common instrument. On the basis of the focus group results, BMCM had chosen the 'very short, one-shot counseling session' strategy and CFES wanted to keep its own more motivational and opportunistic approach. The compromise solution consisted of two different booklets that have been available since the beginning of 2002. The first is designed for patient's information, i.e., it gives the meaning of alcohol-related risk, explains the 'standard drink' concept (in France a standard drink contains 10 grams of pure ethanol), and the 'safe limits' (now 21 drinks/week for males and 14 drinks/week for females). The AUDIT and the CAGE questionnaires are given, together with a diary for self-recording a week's consumption. The cover displays a very neutral dialogue situation.

The second booklet is called 'How to Reduce Alcohol Consumption'. It has the same cover but its contents are aimed at a change in drinking habits, rehearsing the qualitative and quantitative goals, highlighting the role of motivation and giving advice for reduction of consumption. The two booklets can be ordered separately or can be included in a kit containing 30 copies of each, a poster (with the same picture as on the booklet cover) and an 'instruction manual' for the doctor, as a reminder of the CFES approach. The kits are delivered free of charge at doctors' request. In addition to this kit, BMCM developed a simpler instruction for use published in an article in 2003 in the *Revue du praticien-médecine générale*, the main French journal for GPs[7].

The contents of an 'ideal' brief intervention, as promoted by BMCM, are summarized by a 'check-list' as follows: feed-back of screening test results; information on alcohol-related effects on health; explanation of the standard drink; discussion of personal motivation for change; fixing clear objectives; methods for reducing consumption; verification of the patient's consent; delivering the booklet and offering a second consultation if the patient wishes.

The FRAMES acronym[8] serves as a general framework for advice. Role-play in training sessions and the experience related by doctors show that this kind of brief intervention lasts between 5 and 10 minutes.

In January 2002 we trained 10 GPs in a 2-hour session on screening methods and brief intervention. The focus group held two weeks after this showed that most doctors experienced difficulties when delivering a brief intervention. The main reason was the low level of screening activity, mainly done when symptoms were present; these GPs still thought of alcohol mainly when there was possible alcohol abuse or dependence present and guilt feelings attached to loss of control could explain screened patients' reluctance to enter a discussion about their drinking habits. In subsequent training sessions, we insisted on role-playing screening situations so that the screening would be seen in a more natural way. Following this, more or less systematic screening seemed to be better accepted by the doctors.

10.2.2. Adapting screening strategies

In collaboration with Dr. Pascal Gache in Geneva (co-ordinator of the Phase IV study in Switzerland) and Dr. Jean-Bernard Daeppen in Lausanne, Switzerland, we carried out an evaluation of the French translation of AUDIT. The results show that, in French as in the other languages, AUDIT is an efficient screening test, with high sensitivity and specificity and two cut-offs in each gender: ≥6 and 12 for females, and ≥7 and 12 for males (first figure for a hazardous drinking diagnoses, second for abuse or dependence)[9].

Following recommendations from the focus groups at the beginning of the programme, BMCM wished to offer French GPs a screening questionnaire more adapted to their professional situation than AUDIT. According to the participants' view, AUDIT had two major defects: (1) it is a self-administered waiting-room questionnaire, and when there is no secretary present it is difficult to persuade waiting-room patients to complete it; (2) it seemed too long for use as an interview questionnaire.

On inspecting the similarities between most screening instruments used more or less for the same purpose, we hypothesized that we could develop a sufficiently short interview questionnaire by identifying the most discriminating questions among 9 taken from different sources: AUDIT[10], CAGE[11], TWEAK[12] and the Five-shot questionnaire[13]. We wanted to obtain an 'AUDIT-like' questionnaire, that is: (1) having two cut-offs, so as to separate patients in an intermediate situation capable of benefiting from a brief intervention; and (2) with at least the same informative values. The study described below was performed in the first six months of 2001. The result is a questionnaire, called FACE (for Fast Alcohol Consumption Evaluation or *Formule pour approcher la consommation par entretien*) made up as follows (Table 10.1)[14].

TABLE 10.1
The FACE questionnaire

Questions	In French	In English	Source	Scoring
1	A quelle fréquence vous arrive-t-il de consommer des boissons contenant de l'alcool ?	How often do you have drinks containing alcohol ?	AUDIT 1 Five-Shot	0 to 4 (like in AUDIT)
2	Combien de verres standard buvez-vous lors d'une journée ordinaire où vous buvez de l'alcool ?	How many drinks do you have when you drink alcohol ?	AUDIT 2 Five-Shot	0 to 4 (like in AUDIT)
3	Votre entourage vous a-t-il déjà fait des remarques au sujet de votre consommation d'alcool ?	Have you ever been annoyed about your drinking ?	CAGE TWEAK Five-Shot	No = 0 Yes = 4
4	Avez-vous déjà eu besoin d'alcool le matin pour vous sentir en forme ?	Have you ever drunk first thing in the morning to get rid of a hangover ?	CAGE TWEAK Five-Shot	No = 0 Yes = 4
5	Vous arrive-t-il de boire et de ne plus vous souvenir le matin de ce que vous avez pu dire ou faire?	Have you ever drunk and forgotten the next day what you could have said or done ?	TWEAK AUDIT 8	No = 0 Yes = 4
Total				**0 to 20**

The interpretation of the score is comparable to that of AUDIT: for women, hazardous drinking from 4 to 8, dependence above 8; for men, hazardous drinking from 5 to 8, dependence above 8. In our study the informative values of AUDIT and FACE are sufficiently similar: for hazardous drinking males, FACE cut-off > 4, sensitivity 87.8%, specificity 74%; for hazardous drinking females, FACE cut-off > 3, sensitivity 84.4%, specificity 84%; for abuse or dependence, both genders, FACE cut-off > 7, sensitivity 75%, specificity 95.8% .

On the basis of these results we constructed an 'easy, simple, short' and efficient enough screening questionnaire but we needed to clarify whether it was more acceptable than AUDIT or than the AUDIT embedded in a health questionnaire validated by Daeppen and colleagues[15]. For this purpose we prepared a second study comparing screening activity between the three methods used successively (in randomly assigned order) among 76 doctors. This study was carried out in France and French-speaking regions of Belgium and Switzerland with, respectively, Dr Bernard Dor and Dr Pascal Gache.

We began the French part of the study in 2002 and in Belgium and Switzerland in 2003. The results seemed to confirm our opinion of the better acceptability of FACE than AUDIT and AUDIT embedded in a health questionnaire. Details of the results are given below in Section 10.5 and Table 10.2. We now assume that FACE is equivalent to AUDIT in terms of screening properties but seems a better tool in French, Belgian and Swiss situations because of a much better acceptability to both doctors and patients[16].

10.2.3. Adapting training methods

The first experimental training sessions were completed in January and March 2002. They were based upon the conclusions of our qualitative approach, i.e. the focus groups. Having concluded that GPs do not need so much information on the consequences of alcohol consumption, we mainly used the concept of hazardous drinking, using a figure of the 'risk pyramid' adapted from Skinner[17]. The usual content of a training session is:

(1) how to carry out a brief intervention (check list);
(2) role-play, with some examples of professional situations where a brief intervention is to be given;
(3) situations in which excessive drinking, according to participants, could be suspected, so that they can realize how frequently they should think of asking questions about alcohol consumption;
(4) the advantages of a more systematic approach to detection, either psychologically-speaking or for public health;
(5) the public's confidence concerning the GP's role in alcohol-related problems.

Up to the end of 2004, we had trained nearly 400 GPs and 140 occupational doctors. All the members of our team have been trainers. The duration of sessions varied from two hours to two days (for occupational doctors); in this case the second session occurred a week after the first. A two-day session seemed optimal because doctors could test the screening and brief intervention in the interval and react on the second day; but we feel that the shorter sessions also gave 'good enough' results, as shown in a demonstration study.

10.2.4. Adapting medical mobilization strategies

In France, telephone marketing to disseminate new medical practices had not been used before our programme. BMCM developed a randomised controlled study in which mail was compared with mail plus telephone marketing. The content of the marketing followed the advice of a communications specialist and was tested before widespread use among a panel of GPs.

The effects of an economic incentive were also evaluated in the French medical context. For this purpose we compared two 3-month phases, the first without payment and the second with an additional fee paid by BMCM in proportion to detection and brief intervention activity. The level of this incentive (the amount given for each action) was determined by reference to the present consultation fee: 1/10 for a screening questionnaire (2€) and 1/2 for a brief intervention (10€). We hypothesized that this economic stimulation would produce, not only an increased subscription to training sessions, but also enduring activity in detection and brief intervention.

BMCM tested the effects of a community action in one of the 4 sites where the research project was carried out, Saint-Quentin en Yvelines. With the financial help of the *Syndicat d'agglomération nouvelle* (Community Council) and the operational support of the *Institut de promotion de la santé* (Health Promotion Institute), BMCM developed a programme combining meetings with opinion leaders, letters to associations, debates based on a movie, an information letter to every household inserted in the Community Council monthly magazine, and a poster on every bus stop shelter.

The results of various combinations of these incentives are presented below in the section on demonstration studies (10.5).

10.3. Reframing Understandings of Alcohol Problems

The main objective here was to shift the social (and, therefore, medical) representations of alcohol-related problems from 'alcoholism' to 'hazardous drinking'. A previous attempt to do this occurred in France in the 1970s. The creation of the *Centres d'hygiène alimentaire* (Centres for Healthy Nutrition) was a response to the need for counselling heavy drinkers to reduce their consumption. But, as mentioned above, these centres have rapidly been transformed into outpatient clinics for treatment of alcohol dependence. The concern about risky drinking was re-introduced through the WHO Phase III study, with the works of Rueff and his collaborators Huas and Bouix (Paris)[18-19], Gache

(Besançon)[20], and Chambonnet (Nantes)[21]. Nevertheless, secondary prevention had almost disappeared from the French medical scene after the early 1980s. At the instigation of the Social Security Prevention Department, the former *Comité Français d'éducation pour la santé* (now *Institut national de prévention et d'éducation pour la santé*: INPES), began in the late 1990s to design a new strategy that included leaflets for screening and intervention aimed at general practitioners and media campaigns (radio, TV and magazines). The transformation of the MILDT (Inter-departmental Mission against Drug Use and Dependence), through the inclusion of alcohol and tobacco into its competences, was also a trigger for a new way of considering the link between alcohol use and alcohol-related harm.

BMCM's first attempt to capture the public's attention was an article in *Le Monde*, the leading national newspaper, by Pascal Gache and Philippe Michaud in 1999[22].

ANPA's decision to carry out the BMCM programme is, of itself, an important development. Until the official beginning of the programme in 2000, ANPA was mainly dealing with primary prevention and treatment of alcohol dependence, with little involvement in secondary prevention.

In association with governmental and social security authorities and with ANPA, in its annual media campaign INPES has decided to insist on the fact that regular alcohol consumption above the threshold of 3 10g-drinks a day may affect the individual's health, even in absence of dependence or drunkenness. Three campaigns have been launched with this theme (2001, 2002 & 2003) and BMCM played a role on the steering committee.

Five articles in the GP press have already been published by our team and the GPs working with us in *Le généraliste* and *La revue du praticien médecine générale.* The chief of these are:

- "Brief interventions in GP practice" (March 2003)[7]
- "The general public trusts the GP on alcohol, tobacco and drugs" (June 2003)[23]
- "Detection of hazardous drinking in general practice and in occupational health: let's FACE it" (January 2004)[14]

The *Revue du praticien* also published papers in relation to Phase III study by Chambonnet[21] (Nantes, 1998), Bouix[19] (Paris, 2002) and Huas[2] (Paris, 2002).

In 2001, the *Institut national de la santé et de la recherche médicale* (INSERM: National Institute for Health and Medical Research) completed a review of the medical consequences of chronic excessive alcohol consumption in which strong evidence was collected for each disorder, apart from dependence[24].

In 2001 the highest administrative authority in Ministry of Health (*Direction générale de la santé*) prepared a public plan to reduce the alcohol-related burden and this was presented in September 2001 by the Minister himself, Dr Bernard Kouchner. Dissemination of early intervention was considered to be one of the 3 major priorities. This aspect was highlighted by the Minister during the press conference and reported by press agencies and several daily newspapers.

In March 2003 the *Société Française d'alcoologie* (SFA: French Scientific Society of Alcohology) organised a 2-day meeting on 'Alcohol-related Harm Beyond Dependence', where Phase IV and the BMCM programme were presented. Proceedings and recommendations were published in SFA's journal at end 2004[25].

This activity is not sufficient to change GPs' opinions about their ability and legitimacy for implementing early detection and brief intervention but it is noticeable that the results of a poll conducted on behalf of BMCM among a sample of 1600 persons showed that general public is ready to consider that the danger of excessive drinking does not consist only in dependence and traffic accidents. The same sample showed a very high level of confidence about doctors' ability to respond to alcohol-related problems.

The major action of BMCM regarding the reframing concern was carried out in March 2003. We arranged a conjunction between: (1) the meeting of the SFA on March 13-14; (2) the WHO Phase IV investigators meeting in Paris on March 14-17; (3) a press conference involving most partners, the Ministry of Health and Social Security national board and Prof. Nick Heather on March 17; (4) a new mass-media campaign directed at the general public; and (5) publication of our main results in the GP press. These initiatives were successfully realised and two national newspapers, including *Le Monde*, and two GP journals (*Le Quotidien du médecin* and *La Revue du praticien*) published articles or editorials on the need to reduction of alcohol-related harm and the programme *Boire moins c'est mieux*.

In conclusion, the project began the task of reframing but placed it on a long-term footing in which governmental agencies and professional associations continue to play a key role.

10.4. Choosing a Lead Organisation and Building a Strategic Alliance

The BMCM programme aims at the nationwide dissemination of early detection and brief intervention but the research has been mainly carried out in the Parisian administrative region. The strategic alliances have been mainly built at these two levels, national and regional, and they are justified in political, financial and operational terms.

10.4.1. Lead organisation

ANPA (since 2003 ANPAA) is a non-profit NGO founded in 1872 as the 'National League Against Alcoholism' and then renamed the 'National Committee for Defence Against Alcoholism'. It has two main activities: primary prevention and the management of outpatient alcohol-care units (*Centres de cure ambulatoire en alcoologie*) disseminated throughout the nation - in total 120 out of the 250 units, which supply about 40% of consultations for alcohol dependent patients at a national level.

ANPAA counts about 2500 members and 800 employees. Its board of administrators decided in 1999 to integrate the BMCM programme into ANPA as a new department devoted to secondary prevention. The programme has two steering groups: (a) within ANPA, for management purposes, meeting as often as necessary; (b) with funding institutions, twice a year. Administratively, BMCM is placed under the direct responsibility of ANPAA's director. The scientific responsibility is held by Dr Philippe Michaud.

10.4.2. Main strategic alliances

Funding institutions and authorities contributing to BMCM's budget until 2003 were:

- **National level** : *Direction générale de la santé* (Ministry of Health, Public Health General Direction); *Mission interministérielle de lutte contre la drogue et la toxicomanie* (Interdepartmental Mission against Drug Use and Dependence - this 'mission' belongs to the Prime Minister services); *Caisse nationale d'assurance maladie* (National Social Insurance Fund) and its prevention fund; *Ligue nationale contre le cancer* (National League against Cancer); *Institut national de prévention et d'éducation pour la santé* (National Institute for Prevention and Health Education); *Laboratoires Merck Lipha-santé* (Pharmaceuticals).

- **Regional level :** *Conseil régional d'Île-de-France* (Parisian Regional Council); *Caisse régionale d'Assurance maladie* (Social Insurance Regional Fund); *Direction régionale des affaires sanitaires et sociales* (Regional Directorate of Social and Health Affairs); *Mutualité sociale agricole* (National Farmers' Social Insurance Fund); *Conseil général du Val-d'Oise* (Community Council, Département du Val-d'Oise).

- **Local level :** *Syndicat d'agglomération nouvelle de Saint-Quentin en Yvelines* (Greater City Council, Saint-Quentin en Yvelines).

Operational alliances were :

- **International level:** *Société scientifique de médecine générale* (Scientific Society of General Practitioners), Brussels, Belgium; *Département de santé communautaire, Hôpital universitaire de Genève (*Geneva Hospital Community Health Department*)*, Switzerland.

- **National level**: *Institut national de prévention et d'éducation pour la santé* (National Institute for Prevention and Health Education); *Société Française d'alcoologie* (Scientific Society of Alcohology); *Union nationale des associations de formation médicale continue* (National Association for Continuous Medical Education); *Sylia-Stat Corporation*, medical data statistical processing; *Unité de santé publique, Hôtel-Dieu de Paris* (Public Health Department of a Parisian public hospital).

- **Regional level:** *Observatoire régional de santé d'Île-de-France* (Regional Health Watchdog); *Formations et développements* (Association for Training and Development Strategies); *Société de médecine du travail de l'Ouest de l'Île-de-France* (Union of Occupational Doctors - western Parisian region); *Union régionale des médecins libéraux* (Regional Representative Council of Practitioners).

- **Local level:** *Institut de promotion de la santé* de Saint-Quentin en Yvelines (Institute for Health Promotion); *Comités départementaux de prévention de l'alcoolisme du Val-d'Oise,* Pontoise, *du Val-de-Marne,* Créteil, *des Hauts-de-Seine,* Nanterre (local committees for prevention of alcoholism); *Directions des affaires sanitaires et sociales des départements du Val-d'Oise,* Pontoise*, de Seine-et-Marne,* Melun*, des Yvelines,* Versailles*, de l'Essonne,* Evry.

Other alliances:

- **Operational alliances in other regions inside ANPAA:** *Comités régionaux de prévention de l'alcoolisme* (Regional Committees for Prevention of Alcoholism) in the following regions: Aquitaine (Bordeaux), Burgundy (Dijon), Franche-Comté (Besançon)**;** Brittany (Rennes), Rhône-Alpes (Lyon).

Although there has been no formal alliance, all these bodies have been involved in different ways. The first group of funding institutions are mainly public health authorities that have strongly supported the programme, both in the objectives and in the operational aspects, by facilitating the reframing, by publishing recommendations, especially the Public Health Directorate of the Ministry of Health. This political support could determine a major decision still in the balance - the creation of a 'prevention consultation' with an extra fee. On the operational side, the alliance with the National Institute for Prevention and Health Education has been especially useful for the intervention booklets, and with the Institute for Health Promotion of Saint-Quentin en Yvelines, for the community action at that site.

10.5. Demonstration Studies

Two demonstration studies were initially planned, the main being TMP - Three Methods for Promotion (of early identification and brief intervention) and the other, REPEX - REPérage des buveurs EXcessifs (identification of heavy drinkers) intended as a preliminary study. But a third soon seemed to be necessary, prior to REPEX, to develop the 'easy, simple, short' screening interview questionnaire that French GPs seemed to want (DAME – *Dépistage au moyen d'un entretien*, interview screening). Thus three quantitative studies were decided on: DAME was successfully concluded in 2001; REPEX was completed in France in July 2002 and in Belgium and Switzerland in November 2003; TMP began in September 2002 and ended in August 2003.

10.5.1. DAME

DAME is a validation study with an original design. Given the objective, i.e., to create a questionnaire as discriminating as AUDIT for two diagnoses (hazardous drinking and alcohol dependence), we used 9 questions in total taken from existing questionnaires to select items giving the highest discrimination between the groups studied (heavy drinkers/not heavy drinkers or dependent/not dependent).

The AUDIT questionnaire was completed by patients in the waiting room before consultation at the researcher's invitation. The 9 questions under test were asked, after consent, by the GP during the consultation. 'Gold standard' diagnoses were performed by the researcher, an experienced addiction specialist, by means of an interview carried out after the medical consultation.

We conducted the study with 41 GPs working in Paris or on the outskirts of Paris. Seven hundred and seven (707) files were collected (40% men), but 120 were excluded, including 48 refusals and 19 non-French speaking patients. Because of the geographic characteristics of the medical population, many patients were originally from Northern Africa and culturally Muslim, which explains the high level of abstainers (39.9%) in the patient sample. Seventy-three patients (41 men, 32 women) reported they drank more than the safe limits (210g or 140g per week); among these 11 presented three or more of the DSM-IV diagnostic criteria for substance abuse (9 men, 2 women) and 25 for the alcohol dependence diagnosis (19 men, 6 women). Average consumption among drinkers was 181g per week (men) and 84g per week (women). The low number of dependent patients, especially in women, obliged us to recruit men and women for the analysis.

A logistic regression analysis selected a cluster of questions with the required property and without any correlation (or with only a weak correlation) with each other. This logistic regression was successively run on with the two diagnoses in each gender. The questionnaire built up with this selection procedure finally gave an assessment tool, FACE (see above), as efficient as AUDIT.

10.5.2. REPEX

REPEX was a quantitative and qualitative study aiming to evaluate doctors' and patients' acceptance of 3 screening methods: AUDIT, AUDIT embedded in a health questionnaire, and FACE. The design sought comparisons between 'real' and 'optimal' levels of screening, given the definition of "patients eligible for screening": aged 18 or more; not having had a consultation in the last 7 weeks. The GPs participating in the study had to screen in a naturalistic way, i.e., for the AUDIT, with questionnaires at patients' disposal in the waiting room and a poster inviting them to fill it in; for the FACE, with an interview about alcohol during the consultation. If they worked with an assistant, he or she could encourage patients to answer the waiting-room questionnaires, but not actively help to complete them. During one week for each method, doctors had to note in a diary the age and gender of every patient seen, the reason for exclusion if any, the results of the screening test if the patient was eligible and had answered the questionnaire, and the reason for not answering in the opposite case. Every participating doctor had to test the 3 methods in an order assigned at random and had two weeks rest between two test weeks.

This study was conducted in France, in French-speaking parts of Belgium and in Geneva, Switzerland. Twenty-three (23) GPs participated in France, 23 in Belgium and 31 in Geneva. The results are summarised in Tables 10.2 and 10.3.

It is noticeable that the presence of a full-time assistant raises the levels of screening in the 3 countries - for instance, in France where this assistance is statistically linked with a much higher rate of screening with AUDIT (50.6% of usable questionnaires if there is a full-time assistant, versus 40.2 % if not, $p<0.0001$) and with AUDIT-HQ (36.6 % of usable questionnaires if there is a full-time assistant versus 27.8% if not, $p<0.01$).

In Geneva, questionnaires were also given to the assistants. Twenty-one (21) answered a final questionnaire and most preferred self-administered questionnaires with which their role was more active. Ten preferred AUDIT, 7 AUDIT-HQ and 6 FACE.

Our overall conclusion is that it may be necessary to offer a menu to the doctors, so that all can choose and be at ease with the screening tool. But FACE seems to be the most acceptable after the research experience, for doctors as well as for clients, even when there is a well-motivated assistant at the doctor's practice.

TABLE 10.2
REPEX: main results in the 3 samples : (a) patients

Patients samples			
	France	**Belgium**	**Geneva**
AUDIT	N= 1617 eligible 52.1 %	N= 768 eligible 60.9 %	N= 1593 eligible 41.7 %
HQ*	N= 1677 eligible 51.6 %	N= 679 eligible 54.3 %	N= 1595 eligible 45.6 %
FACE	N= 1779 eligible 48.8 %	N= 689 eligible 60.1 %	N= 1610 eligible 42.8 %

	France	**Belgium**	**Geneva**
AUDIT	31.1 % + help** 10.7 %	61.3 % + help** 13.0 %	71.4 % +help** 2.6 %
HQ*	22.7 % + help** 7.7 %	61.5 % + help** 7.9 %	64.6 % +help** 3.0 %
FACE	87.1 %	95.0 %	88.8 %

** + help : questionnaire completed with doctor's help

% of eligible patients for whom usable questionnaires are available (errors in scoring)

	France	**Belgium**	**Geneva**
AUDIT	41.8 % (1.2 %)	74.3 % (3.4 %)	74.0 % (2.0 %)
HQ*	30.4 % (5.6 %)	69.4 % (11.4%)	67.6 % (4.5 %)
FACE	87.1 % (21.6 %)	95.0 % (12.0 %)	88.8 % (8.5 %)
	$p< 10^{-8}$ ($p<10^{-8}$)	$p< 10^{-8}$ ($p<10^{-4}$)	$p< 10^{-8}$ ($p<10^{-5}$)

Patients' opinions about the screening methods : % of patients agreeing with the opinion

	France	**Belgium**	**Geneva**
Number of responders	AUDIT 102 HQ* 78 FACE 162	AUDIT 70 HQ* 55 FACE 82	AUDIT 227 HQ* 151 FACE 253
I was not disturbed by the questioning	AUDIT 87.2 HQ* 95.7 p=0.038 FACE 95.1	AUDIT 97.1 HQ* 94.9 NS FACE 91.5	AUDIT 95.6 HQ* 96.6 NS FACE 98.0
It invaded my privacy	AUDIT 49.0 HQ* 46.3 p<0.001 FACE 28.5	AUDIT 26.6 HQ* 28.1 NS FACE 25.9	AUDIT 37.6 HQ* 34.7 NS FACE 31.6
It made me speak of alcohol with my doctor	AUDIT 68.4 HQ* 64.4 p<0.007 FACE 49.7	AUDIT 56.5 HQ* 51.9 NS FACE 40.2	AUDIT 49.0 HQ* 37.8 p=0.10 FACE 45.2
The doctor gave me advice about my drinking	AUDIT 32.6 HQ* 33.8 NS FACE 43.4	AUDIT 38.1 HQ* 34.0 NS FACE 26.3	AUDIT 32.1 HQ* 23.3 p=0.07 FACE 35.5
I would accept to answer once a year	AUDIT 90.0 HQ* 92.2 p=0.003 FACE 77.6	AUDIT 98.4 HQ* 96.5 NS FACE 94.9	AUDIT 87.0 HQ* 89.7 p=0.085 FACE 92.8

**HQ = AUDIT embedded in a Health Questionnaire NS = not significant*

TABLE 10.3
REPEX: main results in the 3 samples : (b) general practitioners

Doctors' opinions about the screening methods (# of doctors agreeing with the opinion).			
	France (N=23)	**Belgium (N=23)**	**Geneva (N=31)**
Questionnaire was intrusive	AUDIT 2 HQ* 3 NS FACE 5	AUDIT 4 HQ* 4 NS FACE 6	AUDIT 6 HQ* 0 NS FACE 9
Questionnaire scoring can't be made in routine	AUDIT 8 HQ* 9 p=0.014 FACE 1	AUDIT 2 HQ* 6 NS FACE 3	AUDIT 3 HQ* 6 NS FACE 1
My screening was as complete as possible	AUDIT 6 HQ* 5 p<0.001 FACE 17	AUDIT 16 HQ* 13 NS FACE 15	AUDIT 23 HQ* 16 p=0.68 FACE 22
Patients found questionnaire too long	AUDIT 1 HQ* 14 $p<10^{-6}$ FACE 0	AUDIT 2 HQ* 12 $p<10^{-4}$ FACE 1	AUDIT 11 HQ* 18 $p<10^{-4}$ FACE 1
Doctors' global impressions (# of doctors agreeing with the opinion)			
	France (N=23)	**Belgium (N=23)**	**Geneva (N=31)**
Preferred method	AUDIT 4 HQ* 1 FACE 17	AUDIT 4 HQ* 4 FACE 13	AUDIT 8 HQ* 4 FACE 18
Method possibly in line with medical routine	AUDIT 1 HQ* 0 FACE 13 More than one method 5	AUDIT 2 HQ* 3 FACE 10 More than one method 7	AUDIT 3 HQ* 3 FACE 12 More than one method 13"
A systematic screening could be achieved in routine	Yes 14 Yes with restrictions 7	Yes 14 Yes with restrictions 7	Yes 23 Yes with restrictions 7

**HQ = AUDIT embedded in a Health Questionnaire NS = not significant*

10.5.3. TMP Study

TMP is a complex study designed to answer the question,'Of the following elements, which are useful for an efficient approach to EIBI dissemination among GPs: telephone marketing, community action, economic incentives?' The research was carried out in four cities: Evry, Cergy-Pontoise, Marne-la-Vallée, Saint-Quentin en Yvelines (Table 10.4).

The study had two phases. In the second an economic incentive was added, being the extra fee proposed for each screening (2€) and each BI (10€). Every trained GP was paid monthly on the base of his or her activity, recorded by sending a copy of the questionnaires used for screening. At the end of the first phase, we also paid all doctors for the work already done but they were not aware that this would happen before the end of the term. The community action is described above (Section 10.2.4) and was conducted in a single site during both phases (Saint-Quentin). The telephone marketing, unusual in the French medical context, was tested through a randomised controlled trial. The telephone marketing grid and presentation were adapted from the work of Lock and colleagues[26], with the help of a French professional. The results are described in Table 10.5.

TABLE 10.4
Description of geographic sites in TMP study

	Evry	Cergy-Pontoise	Marne-la-Vallée	Saint-Quentin en Yvelines	TOTAL
Population (census, 1999)	79 726	178 656	246 607	142 737	647 726
Distance from Paris	28km (S)	30km (NW)	13km (E)	25km (SW)	
Number of GPs	60	138	203	115	516
Specificity of dissemination strategy	None	None	One phase only (2^{nd})	Community action	

TABLE 10.5
TMP main results

	Criteria		Number of GPs trained / number of contacts		Screening activity (mean / trained GP)		BI activity (mean / trained GP)	
	Tests		X^2	P	F (or H)	P	F (or H)	P
Effect of telephone marketing (TM)	RCT (all sites, 2 phases)	Mail+TM	60/373	10^{-7}	107,0	0,49	20,1	0,31
		mail	9/382		146,6		31,6	
Effect of economic incentive	Phase comparison (three sites)	phase 1	24/292	0,49	28,9	$<10^{-4}$ (H)	6,3	$<10^{-4}$ (H)
		phase 2	45/463		157,3		29,8	
Effect of community action	Site comparison (two phases)	SQEY	18/199	0,57	111,1	0,31 (H)	17,0	0,69 (H)
		CP+ Evry	26/359		59,6		11,9	

F : Snedecor's test for comparison of means (ANOVA, variances equal)
H : Kruskal-Wallis' test for comparison of means (variances different)

There is strong evidence for the efficiency of telephone marketing (on participating in training sessions) and economic stimulation (on activity of trained doctors); although a better result was found in Saint-Quentin where we achieved the community action, the difference was not significant for the same criteria cited in Table 10.5. However the proportion of inhabitants of Saint-Quentin screened during the action (1999 persons, 1.4 % of total population) is much higher than that measured in the comparison sites Cergy-Pontoise and Evry (1620 persons, 0.6 %, $p<10$), and this difference could be attributed to the influence of the community action.

Two post-intervention studies were conducted: the first was a postal survey about changes in doctors' perceptions and practice on alcohol-related risk, which showed no statistically significant differences between before and after (but the low rate of respondents resulted in a lack of statistical power); and the second, a qualitative study which indicated that integration of EIBI activity in medical practice is realistic for trained GPs and also changes their overall relationships with patients[27].

10.6. Conclusion

At the end of 2003, *Boire moins c'est mieux* had largely fulfilled some of the objectives of the Phase IV study in France. The first apparent success is the mobilization of a wide strategic alliance, both for funding and for action. The second is the study's contribution to reframing understandings of alcohol issues and the movement towards a policy that gives GPs (and, in the second place, occupational doctors) a major role in secondary prevention. The third is the creation and continuity of a team that has adopted the objectives and methods of the Phase IV study. This team has created and validated the instruments essential for EIBI for French practitioners and is now able to continue towards the target of nation-wide dissemination, notably by its capacity to train the trainers.

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CHAPTER 11

ITALY

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11.1. General Introduction

11.1.1. Country description

Italy has been a Democratic Republic since 1948. In 2002 the residential population was nearly 57 million, slightly more than 190 people per square kilometre. Life expectancies for men and women were approximately 76 and 82 years respectively. In 2000 Italy was the "oldest" country in Europe, having an elderly index (116.54) among the highest in the world. The north and the south of the country represent different social, cultural and economic realities, with the northern region being much richer and more industrialized than the southern region which is predominantly agrarian.

11.1.2. Health services

The National Health Service (*Servizio Sanitario Nazionale*: SSN) was introduced in 1980 under legislation enacted in 1978. A series of reforms took place in 1992 and are still in progress. The SSN offers universal coverage financed by social insurance contributions and taxation, and the majority of hospitals and primary health care centres currently remain in public ownership. However, public health services are undergoing a basic reorganization according to the principle of devolution of health issues and related matters to the 20 Italian Regions. Due to this change, the role of the Minister of Health, who oversaw regional health activities until a few years ago, has been limited to the formulation of broad guidelines and regulations, with a minor influence on the budget allocations of health care services provision of the regional authorities. The State allocates financial resources to each region for the health care needs of the population on the basis of *per capita* criteria (using as the main variables the proportions of young, adult and elderly and the prevalence rates of the main diseases). The regional health authorities (*Assessorati alla Salute*) provide the framework for the provision of local health services (*Aziende Sanitarie Locali*: AUSL).

Hospital care and curative treatment are provided free of charge in hospitals, clinics and other bodies falling under the SSN. Almost 7% of GDP is currently spent on health, equivalent to approximately US$1500 (parity purchasing power) per inhabitant. Total expenditure on health services is determined yearly at the central government level through the national budget. These funds are regularly allocated to the regions and are obtained from contributions from all workers, both employed and self-employed, additional levies on employers for each of their employees, health taxes paid by self-employed workers and national government funding to cover the remaining costs.

11.1.3. Alcohol policy

Over the last few years the majority of National Health Plans (NHPs) produced by the EU Member States, including Italy[1,] have followed a general population approach, based on epidemiological findings in their different contexts and social realities, and setting "evidence-based" targets, objectives or goals. Starting from 2000, this kind of approach received renewed impetus from the suggestions of WHO *Health 21*, as well as from the documents, recommendations and programmes of the European Commission, Council and Parliament[2-11].

* The full composition of the Working Group is given in Appendix 11.1.

The promotion of primary and secondary prevention, as well as programmes linked to alcohol abuse and related problems, found a formal implementation in Italy for the first time in the 1998-2000 NHP by means of two main targets to be reached within the year 2000:

- *To reduce by 20% the prevalence of male and female drinkers consuming respectively more than 40 gr. and 20 gr. alcohol a day;*
- *To reduce by 30% the prevalence of drinkers consuming alcohol between meals.*

As a consequence of the reduction in prevalence of people drinking alcohol at levels associated with an increased risk to health, a consistent decrease in the level of alcohol-related problems and diseases at the population level was expected. In order to reach these targets by the year 2000, a number of strategies and actions were identified in several areas (Information, Drink Driving, Legislation, Advertising, etc.). The most recent NHP in 2000-2003, while not setting new targets for alcohol, confirmed the previous approach by leaving it to regional autonomy to implement alternative strategies and programs, explicitly including early detection and brief intervention in the primary health care services of the SSN.

With different degrees of regional magnitude, alcohol represents, together with tobacco, one of the most important risk factors for the Italian population. In line with the *European Charter on Alcohol* (December 1995), the Ministry of Health set up a national committee to promote and develop an action programme based on the WHO European Alcohol Action Plan (EAAP). This committee includes representatives of several ministries, i.e., Social Affairs, Foreign Affairs, Agriculture, Justice, Labour, Finance, Industry, Education, and Transport, as well as experts and officers from the Ministry of Health[12].

The promotion of primary and secondary prevention, as well as of programmes linked to alcohol abuse and related problems, has found full implementation in the 1998-2000 NHP and its two main targets mentioned above. In order to reach these targets, a number of strategies and measures have been identified, including:

- regulating the advertising of alcoholic products and disseminating explicit warnings as to their alcohol contents and potential harm to health;
- initiatives to reduce the alcoholic contents of drinks and to increase quality control;
- preventive information and education campaigns (at national and regional levels) aimed at reducing alcohol consumption among specific population groups, such as pregnant women and young people, and/or in specific social contexts, such as schools and barracks;
- initiatives to promote alcohol rehabilitation with the participation of general practitioners and to help heavy drinkers withdraw from drinking;
- measures to monitor and regulate the distribution and sale of alcoholic beverages in community settings, particularly at sporting and cultural events and in motorways rest areas;
- tax incentives to reduce alcohol consumption;
- more effective enforcement of regulations on limits to blood alcohol concentrations when driving;
- initiatives to promote a ban on the sale of alcoholic beverages to minors;
- reorganization of health services devoted to diagnosis, care and rehabilitation of alcohol problems;
- setting up of an epidemiological network for monitoring alcohol consumption and alcohol-related diseases (development of adequate indicators);
- reduction of the limits of blood alcohol concentration for safe driving;
- recognition and support for the work carried out by NGOs and self-help groups;
- possible introduction of alcohology in the teaching curricula of several faculties (medical, social).

Measures and regulations are being discussed in Italy to promote the prevention of alcohol misuse for under-age drinkers, and to delay the age of onset of use as well as preventing alcohol abuse[13-23]. A debate is also in progress concerning issues like the need for a code of practice on labelling, packaging and merchandising of alcoholic beverages. Moreover, a number of key barriers to progress in the specific implementation of evidence-based management of alcohol use disorders in general practice in Italy have to be taken into account[24]. The most important are:

- lack of financial incentives for GPs
- lack of a specific National/Regional programme for general practice and PHC
- co-operation among addiction services and formal links with GPs are still to be promoted
- lack of "evaluated" results to prove the efficacy of the chosen pilot strategy
- the idea of submitting to evaluation the effectiveness of HP strategies by health authorities and administrators is still missing

Italy is the first country in the European Region to achieve the target set by the *WHO Health for All* strategy of a 25% reduction in per capita alcohol consumption during the period 1980-2000[13]. Italy reduced per capita consumption by 36% during this period (see Table 11.1). The decrease in average alcohol consumption was due mainly to wine, as well as to a decrease in spirits consumption. Beer consumption increased steadily throughout the period.

TABLE 11.1

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	1981-2000 Changes (%)
Wine	86.2	62.1	51	- 40.8
Beer	17.9	24.9	28.1	+ 57
Spirits	3.5	2.5	1.2	- 65.7
Pure alcohol	11.7	9.1	7.5	- 35.9

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

Some useful indicators available from ISTAT (National Institute of Statistics), which carries out annually a nationwide health survey of 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 a 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 *per capita* consumption, there were increases in the above-mentioned ISTAT indicators:

a) an increase in the prevalence of drinkers, indicating that the number of people exposed to alcohol-related harm and risk has widened, particularly among adolescents and females. (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 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;

b) a constant and progressive increase in beer drinkers (particularly among teenagers);

c) an increase in the number of women drinking more than ½ litre of wine daily (and beer for young people)

d) 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 11.2 and 11.3). 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 well-established modality of binge-drinking observed in northern European countries.

This last trend sheds a new light on the dynamic of alcohol consumption within the Italian population, calling for a major effort to respond to an emerging culture, apparently widespread among the younger population, linked to new modes of consumption that appear much more unhealthy than before[25-32]. Furthermore, an in-depth analysis of the prevalence of drinkers according to the different variables investigated in 1998 in the ISTAT survey confirms a worrying change in youth's attitudes towards alcohol consumption, resulting in a better understanding and the need for a renewed effort to set and monitor targets specifically aimed at reducing risk among the younger generation.

The number of alcohol abusers in Italy is estimated at 3½ million, with one million alcoholics; only a small proportion of them (less than 30,000) is currently under treatment in the public health services. A consistent proportion of alcoholics is currently under treatment within private health or self-help organizations.

TABLE 11.2
Consumers of alcoholic beverages between meals among males
Prevalence (%) in years 1993-2000 and changes (%) during the period 1995-2000

Age group	1993	1994	1995	1996	1997	1998	1999	2000	Var.% 95-00
14-17	9,8	13,4	12,9		18,4	15,2	18,0	16,8	30,7
18-24	30,9	36,5	35,2		40,6	39,9	39,3	42,5	20,6
25-44	37,6	39,5	39,8		42,1	46,2	40,3	39,4	-1,0
45-64	36,8	39,2	39,5		38,7	42,3	36,7	37,3	-5,5
65-74	27,0	29,3	28,5		29,8	30,0	26,9	28,2	-1,0
75+	22,0	18,8	21,6		20,0	21,2	19,1	16,4	-24,4

TABLE 11.3
Consumers of alcoholic beverages between meals among females
Prevalence(%) in years 1993-2000 and changes (%) during the period 1995-2000

Age group	1993	1994	1995	1996	1997	1998	1999	2000	Var.% 95-00
14-17	7,1	8,0	6,0		10,8	9,7	12,8	12,2	103,7
18-24	13,2	15,0	16,5		22,4	20,8	25,2	24,8	50,2
25-44	12,3	13,2	12,8		15,1	15,4	15,4	15,4	20,7
45-64	9,1	9,9	9,5		11,6	12,4	11,4	10,9	15,1
65-74	5,8	5,7	5,1		6,4	6,4	6,2	5,6	9,9
75+	4,6	3,6	3,9		4,0	3,7	4,0	4,1	3,7

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 on the occasion of the Alcohol Prevention Day in year 2004 (http://www.governo.it/GovernoInforma/Dossier/alcol_prevenzione/index.html) and 2004.

The emerging trends and the epidemiological findings[33-38] strongly contributed to a demand for the National Health Plan 2003-2005 to renew the effort to implement actions and strategies that can help in the following areas:

- promoting healthier lifestyles and habits (life skills);
- tackling misleading risk-taking cultures;
- improving settings (family, schools, communities);
- strengthening health protection of vulnerable groups;
- decreasing "gradients" within and between groups (inequalities in health) and reducing harm;
- ensuring a wider range of initiatives devoted to the early detection of alcohol abuse.

This last policy has been the common ground of specific activities[39-48] carried out at the local level and of four different projects carried out in Italy in four different areas over the last few years and these have produced findings that are being evaluated in drafting a forthcoming National Strategy aimed at including early detection and brief intervention activities in the daily work of the Italian NHS General Practitioner. (Two of these projects subsequently combined to share methods and collect data – see Section 11.4. below.) All these projects were carried out in the framework of the WHO Phase IV Project under the national coordination of the *Istituto Superiore di Sanità* and represent a valuable scientific programme to produce the evidence-base for shared utilisation at the international level of common instruments and methodologies to contribute to the reduction of alcohol-related risk and harm in individuals and society.

The following sections of this chapter will examine the results of these projects. Full membership of the Italian Phase IV working group may be found in Appendix 11.1.

11.2. Florence 1 Unit: Northern Chianti & Scandicci Project

11.2.1. Introduction

In the city of Florence (about 400,000 inhabitants) and its metropolitan area (about 900,000 inhabitants in all), there has been a focus on alcohol consumption and related problems by both researchers and clinicians since the second half of the 1970s. At that time, one of the first Italian surveys was carried out[49], followed by another four-part survey on the topic of alcohol and the

workplace[50,51], and the creation of both in- and out-patient programs and school educational programs, as well as the planning and implementation of a community alcohol action project in the district of Rifredi within the city itself (1992-1997)[52,53]. Health professionals from the Careggi Hospital in Florence also took part in the WHO Phase III study.

With regard to the WHO Phase IV Project, the contiguous areas of Scandicci and Northern Chianti, situated along the belt surrounding Florence southwards and westwards, were identified following an interest in prevention of alcohol problems shown at the same time (1998) by both Scandicci Municipality and Leonardo, an association of local general practitioners. Therefore the *Scandicci* and *Northern Chianti* Project (Florence 1 Project) is made up of two components:

(A) the first component is the WHO Early Identification and Brief Intervention (EIBI) program implemented in the five Chianti municipalities of Impruneta, Tavarnelle, Barberino, Greve, and Bagno a Ripoli through a number of GPs applying the WHO study among their clients; minimal communication strategies with the Municipality authorities were added;

(B) the second component consists of both an EIBI program engaging other GPs in the same association and a full Community Alcohol Action Project (CAAP) in the town of Scandicci. The latter was been implemented between 2000 and 2004, while the EIBI part, that had begun in 2002 with alcohol training for all health professionals involved in the study, started in 2004 and will end by 2006.

Implementation of EIBI in (A) and (B) is contemporary.

This project has contacts with the other Italian projects that are part of WHO Phase IV. It is co-ordinated with the EIBI project in Friuli Venezia Giulia (see Section 11.3. below) and also with the other project in the north-west surroundings of Florence (Florence 2, see Section 11.4. below).

11.2.2. Customisation

In Italy it is unusual for primary health care professionals to ask their patients straightforward questions about their drinking habits, since the context would be interpreted by both parties as investigating the issue of alcoholism. In practice, the doctor might become judgemental and the patient might feel offended.

Therefore the chief investigators, including the GP representative involved in the project planning, decided that proposing to use all direct questions from AUDIT would risk making the project unsuccessful. Instead, a simplified *Alcohol Card* drawn from AUDIT, that had already been tested in general population surveys in Tuscany, was agreed on; it asks how many glasses of each type of alcoholic beverage and how frequently were drunk per day, whether the patient drinks outside meals (indicating a drinking behaviour which tends to deviate from cultural norms in Italy), how frequently he or she had six or more drinks per occasion, and if somebody had ever suggested to him/her cutting down or stopping. Also blood tests of high-risk drinkers (SGPT, gamma-GT, MCV, triglicerides) are recorded .

A 4-page leaflet, *Check Your Alcohol Intake*, developed from educational material used in the Rifredi alcohol community project, was also prepared by the investigators and accepted with minor changes by GPs during the training day. It is to be handed out to risky drinkers. It reminds one of the alcohol content of the different types of beverages and the high-risk levels, and suggests recording alcohol intake daily.

A *Communications Skills Training Program* for the helping professions, developed in Florence during the 1980s by a team appointed by Regione Toscana Health Authority[54] and succesfully used among a range of health professions, was simplified for incorporation in the Brief Intervention guidelines.

The aim of a focus group with GPs attending one-day training was how the *Alcohol Card,* the *Check Your Alcohol Intake* leaflet and the *Communication Skills Brief Intervention* pack could work in the GP's office during the WHO study period. On a whole, GPs accepted the Brief Intervention pack and recommended minor changes both to the card and the leaflet.

11.2.3. Reframing

Among Italian GPs both knowledge and practice in the alcohol field are lower than in other medical disciplines and may be lower than among other PHC professionals[52]. Therefore, any alcohol program whose aim is to involve physicians must focus primarily on education. Also, drawing on the observation of the failure of expert-lead educational programs addressed to doctors when the subject is not spefically biological, the investigators assumed that the best way of motivating GPs to participate in alcohol training would be if they were actively part of the training organisation and perhaps of the teaching team, rather than just the target of an educational program. Luckily enough, at the end of the 1990s, there occurred the birth of *Leonardo*, one of the few GP co-operatives or associations of family doctors in Italy; this has gathered together dozens of physicians in the greater Florence area and sets both practical and educational goals for its members. An innovative project such as this one, promoted by WHO, was sufficiently attractive *per se* to the *Leonardo* whose president was invited to join the team of investigators and who accepted.

In 2001 the *Leonardo* GPs in the project areas who were part of the co-operative numbered 32 and their clients amounted to 41,600 in total, as shown in Table 11.4 below:

TABLE 11.4

***Leonardo* GPs and their clients**

Municipality	*Number of GPs (2001)*	*Number of Clients (2001*
Scandicci	15	19,500
North Chianti:		
Impruneta	7	9,100
Tavarnelle	3	3,900
Barberino	2	2,600
Greve	2	2,600
B.a Ripoli	3	3,900
Total	*32*	*41,600*

11.2.4. Strategic Alliance

Building alliances has been a long process, due both to the bureaucracy of the local alcohol institutions and to the relatively low concern among health administrators regarding the issue of alcohol problems.

Initiated by the Florence Health Agency Alcohol Centre in 1998-1999 with the agreement of *Leonardo* GPs co-operative, the process involved the Florence Health Agency Education Unit, both the Addiction Department and the Florence Health Agency Management, and the Scandicci Municipality. WHO Europe contributed to moving the process forward by making the project official via the Italian Ministry of Health in 2001.

Community action in Scandicci started in 2000, while the EIBI program began in June 2002 with alcohol training for GPs. After the project began in 2000, the following agencies entered the alliance:

- the Municipality Police
- the community network of pharmacies
- the local branches of nation- or region-wide associations: a) *COOP* Consumers; b) *Slow Food*, gourmets aiming to educate people how to eat and drink; c) *Humanitas*, a volunteer association
- the town shopkeepers' association, two associations for youngsters, one catholic parish
- the Florence College of Physicians (*Ordine dei Medici*) and the Family Medicine Scientific College (SIMG)
- the local Health Care Addiction Unit. (Due to overlapping of alcohol prevention activities between the unit and the Alcohol Center, this alliance transpired to be ambiguous on some occasions.)

11.2.5. Demonstration Project

The two components of the Project, that is (A) only EIBI in the 5 northern Chianti towns, and (B) EIBI plus the Community Action Alcohol Project in Scandicci, provided the context to evaluate whether the EIBI program needs to be supported by other community actions to make its impact on the population successful.

11.2.5.1. Early identification and brief intervention (EIBI) in Northern Chianti and Scandicci

Training for GPs

A 2-session alcohol training program for GPs was planned in 2000 by the Florence Health Agency Alcohol Centre and the *Leonardo* GPs co-operative. It was agreed that, even though a greater number of sessions could be more profitable, the very busy doctors would not be able to attend more than 8 hours of education on this topic. The aim was to inform doctors about the extent of risky drinking so that they could take action for their patients' health, and to involve them in the WHO Phase IV project. A few subsequent meetings with two local Addiction Units, the Florence Health Education Unit and the leader of WHO Phase IV Florence 2 project resulted in a common document endorsed by the Florence Agency Health Manager in 2001.

Training for GPs in the Scandicci and Northern Chianti municipalities was organised by the Florence Family Medicine Scientific College (SIMG) and took place on Saturday, 29 June 2002 in the premises of the Florence College of Physicians. Attending physicians obtained credits from the Italian Health Ministry. Teachers came from the Alcohol Centre and the tutor was from SIMG. The methods included lectures, role-plays, group and plenary discussions, and focus groups. The following were the aims, objectives and contents of the two sessions:

<u>Session one</u>	
Aim:	to inform GPs about alcohol-related problems among their patients
Objectives:	identify risky drinkers and alcohol-related problems use communication skills to educate patients how to reduce or stop drinking if necessary
Contents:	early identification of hazardous alcohol drinkers vs alcoholics biological markers Communication Skills & Brief Intervention
<u>Session two</u>	
Aim:	to inform GPs about Phase IV and consequently take action
Objectives:	understand the meaning of a local alcohol prevention approach adapt and share the EIBI principle

Contents: the WHO Phase IV Project
the local prevention project and its planning
focus groups: tailoring diagnostic and educational tools.

Forty-three GPs, including a few from districts other than the study areas who had not taken part in earlier phases of the WHO Collaborative Project, attended, demonstrating a high level of interest. The conventional daily limit of 40g alcohol for men and 20g for women to divide moderate from high-risk drinking caused some surprise among the participants. The comparison between pre-test and post-test showed that participants improved their knowledge about alcohol, the average score per person increasing from 64% at the beginning to 76% at the end of the day (maximum score=100%). According to the results of a questionnaire completed by participants, 49% considered the training as relevant or very relevant, while 30% said it was rather relevant; 59% rated it as good or excellent; and 57% as effective or very effective. Depending on the particular question, between 4 and 9 physicians (11-21% of respondents) were critical of the training. Participants were also invited to take part in one of three parallel one-hour focus groups led by three experts and aimed at customising the EIBI package (see above). At the end of the day trainees agreed to incorporate a customized version of the WHO Phase IV package into their practice at the start of the Project. A further meeting focused on implementing the package was planned just before the EIBI program was scheduled to start in 2004.

GP intervention

A protocol on how to implement EIBI was agreed among the project chief investigators, including the chief of the *Leonardo* co-operative:

a) All GPs involved in the EIBI must have been trained in the Alcohol Training for General Practitioners;
b) A short seminar with GPs should take place just before the start of the EIBI programme. On that occasion GPs would fill in a questionnaire to express their views on alcohol-related problems among their patients;
c) A random sample of clients (18-75 years) at GPs' offices would be enrolled in the study; they shall be given the *alcohol card*. After a patient has turned out to be a risky drinker, he/she should enter a 12-month EIBI *brief intervention*, i.e. receiving:
    - a baseline and 6- and 12-month educational intervention by the GP aimed at modifying the client's drinking behaviour
    - baseline and 6- and 12-month blood test and a 4-page leaflet informing about the risk of alcohol
    - a 3-month clinical follow up.
d) The interaction between physicians and their patients should be randomly evaluated by means of both a self-report questionnaire and a videotape focusing on communication;
e) The quantitative evaluation should rely on intervention rates and community diagnoses of alcohol-related disease. The qualitative evaluation should rely on interviews with key people in the community.

Training for PHC professionals other than GPs

A 6-day alcohol training program on prevention for PHC health professionals and employees was successfully implemented in Scandicci during one semester between 2002 and 2003. It was a component of a longer program started at the beginning of 2002 as part of the Scandicci Alcohol Community Project that also included training on the topic of treatment of alcohol dependence. Its methods included lectures, role-play and group discussion. Aims, objectives and contents were the following:

Aim: to increase concern among PHC professionals about alcohol-related problems among their clients and get them involved in early identification of risky drinkers and related brief intervention.
Objectives: improve communication skills with clients
identify risky drinkers and alcohol-related problems and motivate them to change

their drinking habits
co-operate with GPs and existing alcohol services

Contents: communicational skills
risky alcohol drinkers and alcoholics local prevention projects
customising diagnostic and educational tools

About 20 professionals (midwives, nurses, community nurses, employees) attended, showing high interest. A noteworthy change observed was a shift from the attitude of identifying drinking alcohol with alcoholism to the idea of risky drinking. Some participants decided to add a few simple Q/F questions to their routine health records and agreed to co-operate with GPs.

11.2.5.2. Community Action Alcohol Project in Scandicci

In 1997 the Alcohol Centre and the Education Unit of the Florence Health Agency developed and proposed to the municipality of Scandicci an intersectoral, multi-component community alcohol prevention project. The project was endorsed in 1998 and fully formalised in 1999. Since the town was too large for the project, only 3 out of 6 districts were chosen by the town council, totalling 21,851 residents (June 1999).

A *Project Promotion Group*, intended to support the development of the project, was appointed in 1999 and included representatives of the three local Municipality Districts, the Municipality of Scandicci and the Greater Florence School System. In this context, the task of the Alcohol Centre professionals was to: (a) facilitate community interactions; (b) evaluate the baseline, process and outcome phases; (c) be available as experts on issues of alcohol and food.

The aim was to promote "responsible drinking" and prevent alcohol-related problems in the sectors of health, education and road traffic. The objectives were: (a) people in the community to acknowledge both the benefits and the risks of alcohol; (b) school teachers to produce educational tools together with their students; (c) PHC professionals to be able to reduce or stop their patients' risky drinking; (d) community personnel to be mobilised. The method was the following: (a) facilitating interactions in the community and activating local resources to carry out preventive initiatives; (b) planning local training courses; (c) spreading messages produced within the community itself; (d) ensuring that all messages from each sector of the project were circulated in appropriate ways and informing the local media about all phases of the project.

A needs analysis on 154 community key persons from 33 institutions or groups interviewed through 19 focus groups and 13 individual interviews indicated that there was concern about alcohol abuse, especially regarding young people, alcohol-related violence within the family, drinking and driving, and problems of public order. The traditional drinking pattern (i.e., having wine at meal-times) was sometimes seen to be changing. The results were fed back to the community together with an information booklet.

A 19-member Co-ordinating Committee was established to support initiatives, including local institutional and volunteer organisations and groups. Among the initiatives successfully completed during the years 2000-2003 were:

i) three school projects (2001-2002) carried out by 18 elementary and middle school teachers who had attended a 2-year communication skills training programme: (a) watercolor community workshop; (b) collection of local stories about eating and drinking ; (c) drawings on food and drinking. A limited number of the drawings by 320 pupils were displayed in 2001-3 in Scandicci at a Spring exhibition and at the Scandicci October fair;

ii) six thousand Alcohol Carousels, card disks giving information about the limits and risks of alcohol, were distributed in shops, markets, schools, chemist shops and GP offices during Spring 2002. People who used them showed great interest in the issue;
iii) a one-day alcohol training for policemen in 2000;.
iv) two movies on alcoholism, risky drinking and eating, shown in one parish theatre at the end of 2002;
v) newspaper or TV coverage of the local events in the project on a few occasions.

Epidemiological baseline evaluation
In February 2001 a convenience sample of 299 persons in the community area of Scandicci as well as in the Northern Chianti area were interviewed by telephone in a collaboration with the Tuscany Regional Health Agency. The average alcohol consumption *per capita* per day in Scandicci was 13.4g and in Northern Chianti 12.5; this is somewhat less than indicated by national statistics (15.8g in 2000 according to World Drink Trends). As expected, wine was the most popular beverage, being about 82% of all the alcohol consumed. In Scandicci 11.7% of people and in Northern Chianti 9.7% were to be considered *at risk* since they drank more than 40g per day if men or 20g if women. These percentages parallel those in other contemporary Tuscan surveys. Abstainers in Scandicci were 13.6% (men) and 25.7% (women); and in Northern Chianti, 18% and 30% respectively.

11.3. Martignacco Unit: Municipality of Martignacco Project (Region Friuli Venezia Giulia)

11.3.1. Introduction

This section of the chapter will mainly underline the importance of the role that municipalities can play, not only in promoting healthy lifestyles but also in proposing innovative projects leading to useful changes in primary health care services.

After the newly elected administration of the Municipality of Udine resigned from the WHO Collaborative Study in 1999, the smaller Municipality of Martignacco decided to continue this work in PHC and to propose the integration of risky alcohol consumption activities with smoking cessation strategies. This political decision was taken because of previous experience in preventive community projects and the conviction that mayors have a leading role in public health. General practice can be the ideal setting to make connections between the scientific and policy-making worlds.

As will be more clearly explained below, the study area is still represented by the primary care work located in the city of Udine but enlarged by the surrounding small municipalities to form a total of about 120,000 inhabitants. The control group is the city of Gorizia and its surrounding towns. This section summarizes the work carried out by both administrations.

11.3.2. Customisation

In 1998 the Municipality of Udine, in partnership with the *Vlaams Instituut* in Brussels, successfully applied for EU funding to enable six other participating countries (Belgium, Slovenia, Bulgaria, Hungary, Russia and Latvia) to create a common method for carrying out qualitative research - the ECAToD Project (an exchange of methodology between EU countries, newly-independent states and CCE to define essentials of **E**uropean **C**ommunity **A**ctions supporting primary health care action against **To**bacco consumption and hazardous **D**rinking). This project created the basis for a common approach to Delphi and Focus Group methodologies and stimulated links between the PHC setting and the local community in its wider meaning (see also Chapter 1).

The specific aims of the customization phase were set by a group of experts, mainly taking into consideration the public administration's point of view (see Table 11.5). The following activities were carried out:

i) Focus groups
ii) Delphi study
iii) A survey to validate the AUDIT questionnaire

11.3.2.1. Focus groups

Guidance Notes on Focus Group Methodology were prepared by Dr. Leo Pas, Dr. Pierluigi Struzzo and Professor Nick Heather and were adapted for use by investigators in the WHO Phase IV study. (See Phase IV Study Protocol, especially sub-section 4.1.1 of the Protocol on "Focus Groups", [pp.6-7] for a full understanding of the context of these notes. Focus groups are also mentioned in sub-section 4.4 of the protocol on "Customization of EIBI Training" [p.20] and in Section 5 on "Reframing Understanding of Alcohol Issues" [p.23].) A total of 8 focus groups were carried out (GPs, young people, smokers and ex-smokers).

TABLE 11.5
Aims of customisation according to the ECAToD objectives

To analyze and compare each participant's primary health care service situation/projects in respect to the prevention and early diagnosis of alcohol health-related problems
To assess availability of epidemiological data of participants' health services
To define adequate measures for evaluating future community action programmes
To define the essentials of community action and support for primary health care as a tool to create more efficient health care systems in the proposed field
To define the essential elements of success for such community action programmes
To develop proposals for implementation programmes in all participating countries

GPs: The recruitment phase was difficult; out of 20 invitations only 8 participated. There was general agreement on the difficulty in dealing with alcohol-related problems within the office. Risky or hazardous drinking is neither completely understood nor correctly addressed. Patients are referred to the Alcoholics Centres and no specific procedure is previewed for risky drinkers. The GP's role is mainly focused on medical actions such as blood testing, assessment of liver function, improving drugs and/or time limitation of driving permissions. Brief intervention (not really clearly understood) is considered as a further intrusion into the patient's life. Packages to help GPs and their patients should not be used because of the increase in workload. Barriers to implementation were identified (lack of a sense of role, lack of time, not their problem) and possible incentives were suggested (training, communication skills, counselling techniques, positive approach, etc.).

Young people: Teenagers participated actively and the recruitment was easy. Sixteen youngsters agreed on the fact that any authoritarian approach has a contradictory effect. They do not think risky drinking among young people is a real problem in their area; it could possibly refer to the adult population. The distinction between alcohol use and abuse is more difficult to explain. There was agreement with the definition that loss of control is the result of alcohol abuse. The activity suggested that, to increase awareness of drinking problems, a campaign of information is needed targeted towards young people. Alcohol should not be sold to drivers, public places should have special devices to check blood alcohol level, and special promotions of alcohol should be abolished. Risks involved in alcohol consumption should be written on the product and the price should be increased. For young people, direct experience is important. Therefore it is useful to involve other young people in talking about the damage caused by alcohol.

Delphi study
Aim: To identify ingredients of a community action plan on alcohol from the views of specific groups of experts.

Method: in an area of about 2-300,000 inhabitants, at least 10 respondents in each group were identified to answer a set of questions in 3 rounds over a period of 3-4 months.
Specific groups of respondents were selected:

- NHS or other experts from official organizations
- people working in socio-cultural or non-profit associations
- at least 20 GPs
- nurses working in health services and occupational or school settings.

Recruitment: an invitation letter was sent followed by a 'phone call after 5 days
Questions in Round 1:

1. In your opinion, what are the strategic issues in reducing alcohol consumption?
2. How could you contribute to this initiative?
3. List what actions you would expect from the following experts (list of experts follows).

Delphi results

- It is necessary to train the trainers and to increase awareness of these problems in the population. Activities proposed up to now are not enough to awaken the community or, at least, it seems necessary to consider a new strategic approach for the general population. The demand for collaboration between corporate bodies indicates limited co-operation at present between existing structures and the relevant professionals and experts. Counselling from general physicians was another priority expressed by the group interviewed.
- Performing EIBI is not characteristic of our health-care culture but it seems to be a useful tool for primary health care.

Survey
In addition to the identification of alcoholics, there is a need to find an instrument to measure risky alcohol consumption. The aim of the questionnaire was to validate items about alcohol use so that each participating country could identify alcoholics and risky drinkers in the same way and with the same measures of alcohol consumption.

Nearly 300 individuals, recruited in different primary care centres in each participant's area, were given the AUDIT questionnaire. Those with high scores were double-checked with CIDI (Composite International Diagnostic Interview) which is a diagnostic tool for alcohol dependence. At the end of the survey, investigators had identified and double-checked a group people with a score of 8 or above (equivalent to risky drinker or more).

Inclusion criteria : Each 3rd female patient attending GP office
Each 3rd male patient attending GP office
Exclusion criteria : Those unable to read or understand the AUDIT
< 16 years of age,
> 70 years of age.
Interviewers : Psychologists or GPs involved in the project interviewed the same patient according to standard CIDI WHO protocol.

Survey results: The CIDI is not applicable in practice. AUDIT questionnaire should be limited to the first 3 questions. 54 subjects were identified as risky drinkers (9.4% of the total) and, of these, 13 (2.2% of the total) showed signs of dependence. The prevalence of risky drinkers was low because the entire region is already sensitized to alcohol issues and there is much denial of the problem.

For more detail on these issues the reader is referred to the specific reports[55-57]. One important general finding that emerged was that is not realistic to use long questionnaires in PHC and general practice in particular. Even a 10-question instrument may be too long for routine, everyday work.

11.3.3. Reframing

Friuli Venezia Giulia is a wine-producing region and alcohol continues to place a heavy burden on the general population's health. No data on moderate or risky drinking exist. Since 1980, when the first "training the trainers" meeting on the Hudolin methodology (a psychosocial treatment method for alcohol dependent people based on group therapy and family/community involvement) was held, the only known "safe" drinking pattern was abstinence; no risky or moderate drinking was accepted and no official drinking limits were set by the Alcohol Units, formally part of the National Health Service. Any level of drinking was considered dangerous and possibly leading to alcoholism. A couple of hundred Clubs in the region are now dealing with thousands of alcohol dependent people and their families. Information and preventive work with GPs, primary care workers and the general public were, and still are, carried out by experts and other trained people who disseminate ideas strictly linked to the concept of "alcoholism". GPs and primary care workers were involved in the work of the Alcohol Units only as part of wider projects and did not initiate "unorthodox" activities. In this setting, the proposal for an innovative project, like Phase IV, was cautiously accepted only because it was supported by the prestige of WHO.

The first step was to ask the main representatives of the alcohol services and GPs to discuss the project at a two-day meeting. An expert from the Phase IV Coordinating Centre in Newcastle (Dr. Eileen Kaner) was invited to present the rationale for the study in June 1998. A *consensus document* was produced from the input of 20 alcohol experts (8 general practitioners, 2 directors, 2 sociologists and 8 community workers of the Alcohol Services of the Local Health Units of the two cities, Udine and Pordenone). (Even if not directly participating, the NHS experts in Pordenone have followed the project with close attention and are now, in fact, implementing what we were trying to demonstrate.) The consensus reached was as follows:

Alcohol: 1 standard drink = 10 grams of alcohol = 1 glass of wine. GPs should be able to estimate their patients' consumption levels. The safe drinking threshold is 3 standard drinks for men and 2 for women, preferably with 1-2 days/per week of abstinence. A list of specific situations was composed in which any drinking is allowed.
In the identification process, GPs should allocate their clients to the following groups: Abstainers, Moderate drinkers, Risky drinkers, Alcohol dependents.
GPs and other PHC workers are encouraged to adopt a 5-minute brief intervention to counsel risky drinkers. Alcohol dependents should be referred to specialist alcohol services and smokers should be invited to join cessation clinics.

11.3.4. Strategic Alliance

A major strength of working with politicians is the credibility it brings and the possibility of creating partnerships. Formal agreements were made between the Municipality of Martignacco and the following organizations:

- University of Udine, Faculty of Economics, Faculty of Languages, course in Public Relations (Prof. L Brusati, Prof. R. Kodilija)
- University of Siena, Faculty of Medicine, Public Hygiene (Prof. M. Giacchi)
- Florence Health Unit, Alcohol Centre (Dr A. Allamani)
- Regional School for the Continuing Training of General Practitioners (Dr. R. Paduano)
- Local Health Unit of Udine, District of Udine City (Dr. M. Casini)
- Local Health Unit of Pordenone (Dr. G. Di Gregorio, Dr. A. Beacco)
- The Provincial Association of Industries
- The Provincial Association of Medium and Small Industries
- The Association of Commerce and Public Places
- Another 32 small municipalities in the Region

The Local Health Unit of Pordenone is presently following up a group of more than 100 GPs working on EIBI. Discussions are active and the entire Local Unit is highly motivated to follow this

methodology. The results achieved by the city of Pordenone will be included in the final national report on the project.
The municipalities will support the project by involving the local community, their GPs, bars and restaurants, and by supporting the proposed surveys among the general population. The strength of this project results from the partnerships that have been created.

11.3.5. Demonstration Project

At the end of the demonstration project it should be clear whether the knowledge and behavior of GPs in the control area (Gorizia) (no specific training nor a specific communication strategy for the GPs) will be the same as GPs in the intervention area (Udine) where specific training, support and a communication strategy will be provided.

In more general terms, the expectation is that a well-implemented community action in both areas (with the involvement of mayors, bars, restaurants, industries and the general population) will persuade GPs in Gorizia (without any other support) to obtain more information about EIBI and carry it out in their own offices.

The city of Gorizia was chosen as the control group because the University of Udine (Public Relations) is located there. A sub-sample of this control group of GPs recently received vocational training on EIBI by a local association. From one point of view this is causing confusion, since the sample is no longer strictly a control group. From another point of view, however, it demonstrates that the Local Health Units are attempting to update their knowledge and practices according to what is promoted internationally.

In the Udine intervention group GPs will receive training and a specific communication strategy according to the WHO Phase IV Study Protocol and to what will be jointly agreed in Rome. Community actions will be carried out in both areas in order to obtain maximum diffusion in Udine and to persuade the Gorizia community to ensure that GPs utilize EIBI without specific support.
In order to take baseline measures from the 76 GPs in Udine and a comparable sample in Gorizia, a survey was run in 2002. Topics such as the attitude towards alcohol issues, self-efficacy, knowledge of prevention tools and the need for training were explored.

No significant differences were observed between the two areas in sample characteristics such as gender, age, experience and reasons for non-response. Even if deriving from two distinct cities, with the same background but with different involvement, they showed the same attitudes towards BI. The vast majority had a positive or very positive attitude (97%) to asking their patients about alcohol and tobacco. 94% of GPs think it is useful to enquire about alcohol; 98% consider it relevant to their practice. No difference between the two groups was observed when addressing self-efficacy (success at motivating patients to modify their lifestyle or influencing patients' drinking patterns). As regards their opinion of possible drinking limits, they gave (62% -71%) the first choices either to one occasion and for weekly doses (for men and women), demonstrating a preference for the lowest possibility. The results of this study also show that the implementation of a short period of early identification and brief intervention in general practice has no significant negative effect on the attitudes, self-efficacy and commitment of GPs in Italy.

The results have been published in *General Practice On-Line*[57] and can be found there http://www.priory.com/fam/italgp.htm

A questionnaire to evaluate the baseline knowledge of EIBI in the general population is now ready to be administered to a significant sample of the general public. This will be carried out by the end of 2004. At the moment the dissemination of the project to the local community (bar, industries) is ongoing. Mayors are actively involved in this work.

11.3.5.1. Training

In accordance with the Faculty of Medicine of the University of Udine, a postgraduate course on early identification and brief intervention was launched on September 2004. The aim of the course (88 hours) is to provide knowledge and expertise in the early identification of risky situations mainly linked to lifestyles and will include medicine and social science issues such as Counselling, Laboratory techniques, Nutrition, Pediatrics, Psychology, Respiratory diseases, Occupational medicine, Sexual behaviors. Elements of demography, epidemiology, statistics, community medicine, health policies, economics etc. will also be provided.

The University of Udine is currently providing trainees to run the Martignacco Office and to administer the questionnaires reviewed above. Their role is mainly to maintain contacts with the other municipalities included in the project. (The 22 small municipalities are now involving their local communities in disseminating activities to reduce smoking and drinking in bars, restaurants, and occupational settings). Trainees are also preparing a website (in both Italian and English) and trialling a Press Centre for the investigators and all regional participants in the project. Their input will be very useful when the communication strategy is implemented and an economic evaluation will also be carried out with their assistance.

The Regional School for the Continuing Training of GPs will conduct GP training, first within Udine city. Then, after the Demonstration Project has been completed, the training methodology will be disseminated to the entire Friuli Venezia Giulia region. The School has also decided to offer occasional sessions when more interested GPs can be trained in depth in motivational interviewing.
Through the Alcohol Unit, the local Health Unit organized a 6-day training session on motivational interviewing (Prof G. Guelfi) for a limited number of GPs (30), but only 13 individuals attended (including only 6 GPs). Incentives were promised for the participating GPs but, until now, no contacts have been made and relationships remain only formal.

11.3.6. Future plans

Thanks to the partnership between the University of Udine and the University Bocconi of Milano, the specific expertise of an economist has been requested to perform the economic evaluation of the local project.

More focus groups need to be done, with GPs and hopefully other PHC workers, to customise materials. An agreement with the Regional School of GPs on a training module will need to be reached. The baseline general population survey will be carried out in the near future. All aspects of the demonstration project, the communication strategy and the data collected will need to be planned, performed and analysed. Indicators for the reduction of the burden of alcohol within the general population will have to be defined and investigated. All the local community actions will have to be completed and the results analysed.

All results of the project will eventually have to be disseminated to the general population and to official organizations. No major objections to this from GPs are expected. An additional objective is to obtain financial support for this work from the regional government.

11.4. Padua and Florence 2 Units: Padua and North-West area of Florence projects

11.4.1. Introduction

Since the development of Phase III of the WHO Collaborative Study, both *Centro di Alcologia* in Florence and *Associazione Eurocare Italia* in Padua have contributed to the evaluation of the results of questionnaires targeting GPs. In regard to Phase IV, partners in the Florence 2 and Padua areas have worked together to share the results of the project as far as customisation and reframing are concerned.

11.4.2. General description

In recent years health policies have moved towards a population approach for the prevention of health-related problems, including alcohol use. In particular, WHO guidelines and European health plans have been translated at the national level to focus on health determinants rather than risk factors. This means a different perspective to coping with behaviours related to general population health and life-styles.

Regarding alcohol use, the approach adopted by the Florence 2 and Padua areas focuses on awareness of the risk related to alcohol consumption as an incentive to the reducing alcohol use and identifying life-styles that can counterbalance the rewards produced by alcohol, thus promoting community health. In these respects, the community alcohol programmes of the *Clubs of Alcoholics in Treatment* promote sobriety which includes both abstinence and risk awareness related to alcohol consumption, together with the management of relapse and the search for lifestyles which are positive and rewarding at the emotional, spiritual and cultural level. In these geographical areas the concepts of primary prevention, screening, care and rehabilitation are superseded as separate categories by including them in a global approach to health promotion.

11.4.3. Customisation

A Steering Committee was established to implement the research project. Members of this steering committee included researchers, medical doctors, GPs and experts in the alcohol field. A qualitative study was carried out to better understand GPs' experiences and needs. Focus groups and training were used in this study. The aim was to build an EIBI package that could be effective and meet the GPs' needs.

Objectives of the focus groups were:

- To analyze GPs' perceptions and understand their experiences in the field of alcohol-related problems;
- To assess the GP's role in primary health care related to alcohol problems;
- To self-evaluate GPs' knowledge and competencies on alcohol-related problems
- To discuss among participants the most feasible way to involve GPs in interventions on alcohol.

In 2000, 3 focus groups were organized with the participation of about 5-7 GPs each. GPs involved in the focus groups belonged to MEDICOOP, an organization of GPs working in the North-west area of Florence. The main results concerned the following 3 topics:

i) Problems and difficulties in working on alcohol:
- Lack of sufficient knowledge;
- Need to be supported by the local community and local policy-makers in their work;
- Need to have available instruments and tools.

ii) GPs' involvement
- Provision of an adapted EIBI package;
- Recognition of GPs' role in prevention work related to alcohol
- Provision of economic support.

iii) Training for GPs:
- Receiving more training on alcohol in general and on EIBI instruments;
- Feeling more competent in preventive work in the alcohol field.

These results were discussed in the training sessions included in the customisation process. The following conclusions on the GPs' role have been drawn by the Steering Committee:

A. *Information – education* for the general population;
B. *Diagnosis and brief intervention* for risky drinkers;
C. *Motivation and referral* for people with alcohol dependence.

Some problems linked to their work setting were underlined by GPs:
a) they work primarily with adults/elderly people, who have strong cultural beliefs on alcohol;
b) young people rarely go to see their GPs
c) women tend to hide problems related to their alcohol consumption
d) a tendency to minimize alcohol consumption by patients
e) GPs themselves have difficulties asking their patients questions on alcohol consumption

A specific request from GPs was to be supported by the local community in their work for alcohol-related problems, in terms of implementation programmes aiming at reframing the understanding of alcohol issues.

As far as customised training is concerned, the Steering Committee designed a two half-days course or a one day intensive course in agreement with SIMG, a national organization for GPs. The first part of the course is focused on information and training on alcohol problems; the second part on the use of the EIBI package. The provisional training programme was designed to devote 20% to information, 20% to early identification, 40% to brief intervention and 20% to alcohol dependence.
The training course was based on the results of GP focus groups and responses to their needs in relation to alcohol interventions.

11.4.4. Reframing

A Working Group dealing with the identification of an effective communication strategy was established. The members of this group are representatives of the local partners in the project. They have collected and analyzed the existing information/educational materials on alcohol, dividing them by target groups (young people, women) and by subject (mainly driving and work). Starting from these materials, some have been reprinted and new tools have been produced:

- European Charter on Alcohol;
- *Alcol Informa*: complete directory of national public services, non-governmental organisations and groups dealing with alcohol-related problems;
- Women and Alcohol;
- GUIDA: Guidelines on EIBI and diagnosis of alcohol-related problems for health professionals;
- *Alcol: sai cosa bevi? Più sai, meno rischi!*: an information leaflet on alcohol to be used for brief intervention by GPs.

These materials and tools were used both for GP training and for actions targeting the general population in the Demonstration Project.

11.4.5. Strategic Alliance

At the national level, partners participating in the WHO Collaborative study are co-ordinated by Dr Emanuele Scafato, *Istituto Superiore di Sanità*, Rome as National Supervisor, Chief Investigator and Country Co-ordinator. Strategic alliances with national partners have been built:

- *Istituto Superiore di Sanità* (ISS), Rome;
- EUROCARE Italia, Padua;
- *Società Italiana di Medicina Generale* (SIMG);
- *Azienda Sanitaria di Padua*
- *Società Italiana di Alcologia*
- *Centro di Alcologia dell'Università degli Studi di Firenze, Azienda Ospedaliera di Careggi;*
- *Società Italiana di Alcologia*

The lead organizations (i.e., *Centro di Alcologia* in Florence and *Associazione Eurocare Italia* in Padua) activated existing community programmes and networks in order to implement the project.

At the local level in Florence, strategic alliances have been built with the following partners:

- *Università di Firenze, Centro di Alcologia*,
- Municipalities of the North-west area of Florence,
- *Associazione dei Club degli Alcolisti in Trattamento (*ACAT) *di Scandicci, Sesto Fiorentino e Campi Bisenzio*;
- *Azienda Ospedaliera Careggi*, Florence;
- *Istituto Fondazione Andrea Devoto*, Florence;
- *Dipartimento delle Dipendenze, Azienda Sanitaria 10*, Florence;
- *Servizio Tossicodipendenze, zona Nord Ovest*, Florence;
- *Osservatorio Socio-Epidemiologico, Dipartimento delle Dipendenze, Azienda Sanitaria 10,* Firenze;
- MEDICOOP, *Cooperativa di MMG operante nell'Area Nord Ovest di Firenze.*

At the local level in Padua, strategic alliances have been built with the following partners:

- Local Municipalities
- Municipal Healthy City Office Padua
- Drugs and Alcohol Addiction Service
- GPs' associations and networks
- Volunteer associations (particularly with the Association of the Club of Alcoholics in Treatment (ACAT) in Padua
- Regional Association of City Government (ANCI - Veneto)

11.4.6. Demonstration Project

The Demonstration Project will include the implementation of EIBI by GPs supported at the same time by community action. GPs' activity is shown in Figure 11.1 below.

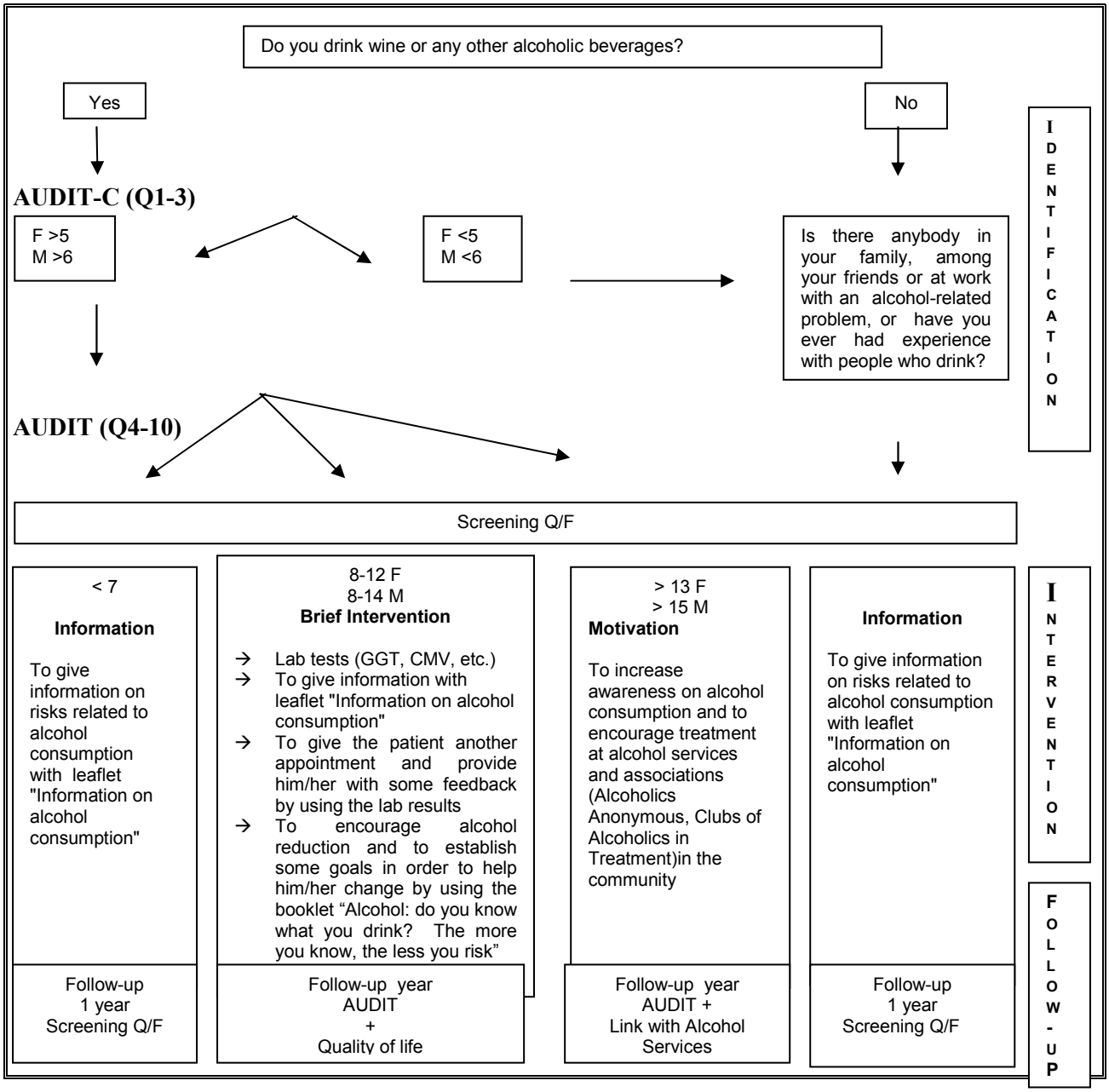
1. Identification: assessment of alcohol use of their patients by GPs using AUDIT and other questions on quantity-frequency. This assessment consists of two phases: (i) information on alcohol consumption (yes/no), quantity/frequency and binge drinking, based on the first three AUDIT items (AUDIT-C); (ii) information on alcohol consumption patterns, based on the remaining AUDIT items. Subsequently the choice of one of 3 different kind of intervention is made according to the total AUDIT score.

2. Intervention*:* three different interventions according to the AUDIT score:
   - *Information* on alcohol consumption and related risks (cut-off point <7);
   - *Brief Intervention* to encourage a reduction in alcohol consumption (cut-off points 8-12 female, 8-14 male);
   - *Motivation* to enter an alcohol program in public services or alcohol community programmes (cut-off point >13 female, > 15 male);

3. Follow-up after one year based on the different AUDIT scores in order to evaluate changes in alcohol consumption and quality of life.

In general terms, GPs carry out some kind of minimal intervention with everybody, including those patients with no reported alcohol consumption. This minimal intervention consists of one question on alcohol problems in the family, relatives or friends (see Figure 11.1) and in informative intervention.

FIGURE 11.1
GP screening and brief intervention package



The effectiveness of GP interventions will be closely related to reaching the following objectives:

- GP training on alcohol-related problems in order to carry out an effective prevention strategy
- Education and information activity, both on the available local resources and on alcohol-related issues in general terms. These community actions should be performed on the one hand by involving community key-figures working in hospitals, addiction services and self-help groups, and, on the other hand, by targeting the general population with specific information and communication strategies.

11.4.7. Future Plans

The next step in the project is a Demonstration Project in two different areas, one in the north-west area of Florence and another one in the Padua area. The evaluation will be designed and an economic evaluation is needed.

11.5. Conclusions

The possibility of improving the capacity to deal with alcohol problems seems to have received new strength from the experiences reported above. This Italian experience was extremely important for focusing 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 should be limited to the primary health care settings.

The need for a much more formalised approach to alcohol-related problems and diseases and the possibility of implementing early detection of alcohol abuse into the daily work of general practitioners by mean validated instruments has started to become a priority of public health strategy, even if many obstacles and prejudices have to be overcome and much effort made to convince that the common practice will not be affected by difficult screening procedures and that the cost-benefit ratio will be higher than today. The currently reported feelings and perceptions of GPs in considering early detection and brief intervention for alcohol abuse, clearly influenced by the burden of the pilot testing procedures, should not be underestimated but taken into account and accurately evaluated together with the other countries' experiences to try to find a common (and easier) way to tailor a 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 subsequent evaluation.

The country adaptation of EIBI and the creation of a specific country strategy will be a challenge for the forthcoming years, together with the need to implement methodologies and specific approaches to early detection and interventions aimed at preventing people becoming alcohol dependent. A general point should be made on the opportunity for developing and implementing at the general population level, and for all individuals negative on the AUDIT questionnaire, a preventive communication strategy oriented not only to reducing alcohol-related harm but at increasing awareness of the risks (particularly among youngsters) of an unhealthy lifestyle where alcohol, combined with smoking, inappropriate dietary habits and low levels of physical activity, are becoming common throughout the population.

In terms of implementing the EIBI strategy, the *Istituto Superiore di Sanità,* the *Osservatorio Nazionale Alcol, OssFAD, Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute Osservatorio* , the *WHO Collaborating Centre for Research and Health Promotion on Alcohol and Alcohol-related Health Problems* are now collaborating with the SIMG (Italian Society of General Practitioners) in a national project funded by the *Fondo Nazionale Droga* (Dependences National Funding) of the *Ministero del Lavoro e delle Politiche Sociali – Welfare*, *Presidenza del Consiglio,* to verify the feasibility of the early detection (AUDIT) and brief intervention in primary health care settings. Furthermore, the implementation of Phase IV of the WHO Project is linked to the activities of the national PRISMA project (Italian Project on Prevention, Identification and Strategies Management for Alcohol-related Problems), already acknowledged on the international Phase IV website (http://www.gencat.net/salut/phaseiv/) and currently funded for 3 years by the *Presidenza del Consiglio*. The demonstration projects will be realised in the 4 local areas where the EIBI project was carried out over the last few years involving all the partners that contributed to this report. Original documentation and methodologies have been printed and distributed in 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 institutions together with the strong commitment of the Italian Society of General Practitioners (SIMG) which is fully involved in the ongoing funded projects.

Far from being completed, the WHO Phase IV Project will proceed through the implementation of national as well as European ongoing research and activity, particularly by means of the creation of a national strategy in the EU PHEPA project (http://www.phepa.net/) . This will help to achieve both health and social outcomes giving people more opportunity to play an active role in the individual as well as the collective process of establishing healthier contexts and a much safer environment.

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APPENDIX 11.1

Composition of Italian WHO Phase IV EIBI Working Group

Coordinating body: Istituto Superiore di Sanità, Rome

Project supervisor and national coordinator (appointed by WHO in agreement with the Italian Ministry of Health):
ISS: Emanuele SCAFATO*, Istituto Superiore di Sanità (ISS), WHO CC for Research and Health Promotion on Alcohol and Alcohol-related Health Problems, Osservatorio Nazionale Alcol dell'Osservatorio Fumo Alcol e Droga – OssFAD, Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute, Rome, Italy*

Principal Investigators:
Florence 1: Allaman Allamani *Centro Alcologico, Florence Health Agency, NHS.*
Martignacco: Pierluigi Struzzo, N.H.S., *Regional Network of the Healthy Cities, Udine*
Padua:Franco Marcomini, Addiction Department, Alcohol Unit, Padua and Tiziana Codenotti, EUROCARE Italia Association, Padua
Florence 2: Valentino Patussi, Research Centre for Alcohol Studies, Florence

Units composition

Istituto Superiore di Sanità Unit
Chief investigators: E. Scafato *(ISS)*, R. Russo *(ISS)*, G. Farchi *(ISS)*, C. Gandin *(ISS)*, , P.G. Zuccaro *(ISS)*, F. Cicogna *(Ministry of Health),* Alessandro Rossi *(SIMG)*
Collaborative Investigators L. Di Pasquale *(ISS)*, L. Galluzzo *(ISS)*, R. Scipione *(ISS)*, E. Chessa *(ISS)*, S. Mariotti *(ISS)*, S. Ghirini *(ISS),* N. Parisi *(ISS)*

Florence 1 Unit
Chief investigators: A. Allamani, *Centro Alcologico, Florence Health Agency, NHS, with the co-operation of* E. Scafato, *National Coordinator, National Institute of Health, Rome.*
Collaborative Investigators: V. Boscherini, *Cooperativa Medica "Leonardo",* Florence;I. Basetti Sani, G. Bardazzi A. Centurioni, *Centro Alcologico,FHA;* P. Ammannati, *Dietetic Unit, Florence Health Agency;* F. Voller, F. Cipriani, *Epidemiology Unit, Regione Toscana Health Agency*; R. Brunetti*, Health Education Unit, Florence Health Agency;* A. Orsetti, G. Guidoni, P. Trotta, *Addiction Department, FHA;* L. Seriacopi, *School Educational System, Florence*; E. Forni, *Polytechnic Institute, Turin;* E. R. Martini, *ASSCOM, Milan;* P. Struzzo N.H.S., *Regional Network of the Healthy Cities, Udine;* V. Patussi C*entro di Alcologia e Nutrizione, University of Florence.,*

Martignacco Unit
Chief investigators: P.Struzzo *N.H.S., Regional Network of the Healthy Cities, Udine*
E. Scafato, *National Coordinator, National Institute of Health, Rome.*

Padua and Florence 2 Units
Chief investigators: F. Marcomini, *Addiction Department, Alcohol Unit, Padua,* T. Codenotti*, EUROCARE Italia Association, Padua,* V. Patussi, *Research Centre for Alcohol Studies, Florence,* G. Bartoli, *Research Centre for Alcohol Studies, Florence,* E. Scafato, *National Coordinator, National Institute of Health, Rome.*

Collaborative Investigators:
O. Bazzani, *Research Centre for Alcohol Studies, Florence,* M. Cecchi, *Addiction Department, Florence Health Agency,* G. Guidoni, *Addiction Department, Florence Health Agency,* S. Polvani,

Epidemiological Office, Addiction Department, Florence Health Agency, F. Muscas, *Cooperativa Medica MEDICOOP Sesto Fiorentino, Florence,* V. Cerrato, *Ass. EUROCARE Italia, Padua*, L. Nadir*, Ass. EUROCARE Italia, Padua,* E. Pattarino, *Italian Society of GPs (SIMG),* A. Rossi*, Italian Society of GPs, SIMG*

CHAPTER 12

RUSSIAN FEDERATION

Vladislav Medvedev, Tatiana Kryshtal & Nick Heather

12.1. Introduction

12.1.1. Description of local area

St. Petersburg is one of the largest metropolitan areas in Europe, being the 4th largest city (after London, Paris and Moscow). It is situated at latitude 59° 57' North and longitude 30°19' East. St. Petersburg was created in 1703 by Tsar Peter the Great (1672–1725). The city is situated at the east coast of Finnish gulf on 42 islands of the river Neva delta. St. Petersburg was a capital of Russia in 1712–1728 and 1732–1918.

The total area of the city is 1400 sq. km. The population on 1 January 2001 was 4.5 million. Density of population is 3479 per 1 km^2. St-Petersburg is situated at the crossing of naval, river, railway and auto ways and is a European gate to Russia. It is connected with direct international flights to 27 cities of Europe, Asia and America. The seaport of St-Petersburg is the largest port in north-west Russia.

Kalininsky district, in which the project was mainly located, is situated in 39.7 km^2 of territory and includes 7 municipalities.

12.1.2. Medical care

Medical care in the district is provided in the following departments of primary health care:

- 2 centres of family medicine: the Family Medicine Centre with 5 GPs and 6 family nurses, and the Family Medicine Office with 3 GPs and 5 nurses
- Out-patient clinics (for adults): №s 10, 16, 76, 86, 90, 96,
- Out-patient clinics (for children): №s 9, 41, 42, 54, 55, 57, 59, 61,
- Maternity welfare centres: №s 10, 29, 32, 39,

The total number of doctors is approximately 1500 and nurses nearly 2000. The population of the Kalininsky disrict of St-Petersburg on 1 January 2000 was 462,389 (men 207,937, women 254,452).

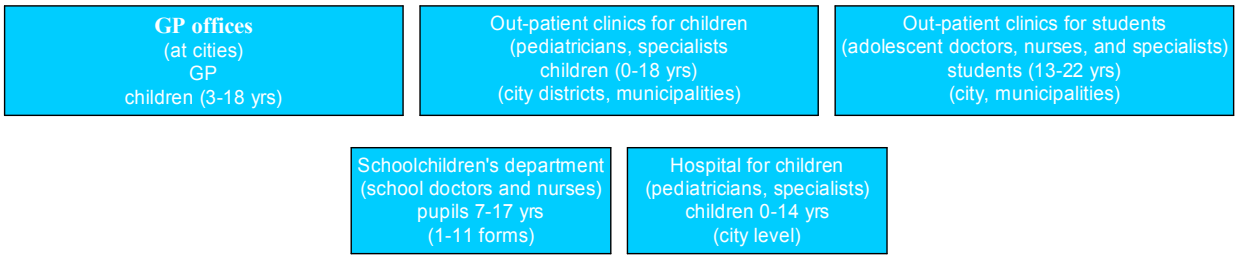
Medical care for adolescents and young people in the district follows the structure applying to the Russian Federation as a whole and is displayed in Figure 12.1.

12.1.3. Alcohol consumption and alcohol-related problems

To place the project in context, this section will summarise, as far as possible, the level of alcohol consumption and the extent of alcohol-related problems in the Russian Federation.

Over two million people (2.4 million) were registered as alcoholics in 1999 in Russia (15% female). This official figure is almost certainly an under-estimate and the true number is probably much more than this. In 1998, 24,000 people died in Russia as a result of poisoning by low-grade alcohol.

FIGURE 12.1:
Medical Care For Adolescents In the Russian Federation



Per capita sales of alcohol in litres in Russia from 1992 to 1999 were as follows:

1992 - 5.0	1996 - 7.2
1993 - 5.0	1997 - 7.5
1994 - 6.8	1998 - 7.3
1995 - 9.3	1999 - 7.6

If home-produced alcohol is included, the figure for 1999 increases to 14.3 litres per capita. This is significantly more than other European countries and is exceeded only in Latvia, Slovenia and Estonia[1].

Liver cirrhosis mortality (per 100,000 inhabitants) was recorded as follows:

1984 – 0.70	1994 – 1.52
1986 – 0.20	1995 – 1.80
1992 – 0.33	1998 – 1.23

The decrease in liver cirrhosis mortality from 1985 to 1993 was a consequence of a rigorous anti-alcohol policy by the state. The sharp rise in 1994 was a result of the abolition of the state monopoly and the introduction of market reforms, together with the importation of a large amount of low-grade spirits from abroad[2]. Reasons for the decrease from 1995 to 1998 are unclear but, even taking this decrease into account, the 1998 level of cirrhosis mortality was well above that recorded before the anti-alcohol measures were introduced in the mid-1980s.

Alcoholic psychoses per 100,000 inhabitants (an index of severe alcohol dependence) were recorded as:

1984 – 20.4	1992 – 13.3
1986 – 6.9	1995 – 49.0
1988 – 5.1	1998 – 28.6

Nemtsov[2] has documented a new growth in alcohol-related mortality, fatal alcohol poisonings and incidence of alcoholic psychoses beginning in 1999-2000. Excessive consumption of alcohol is a significant factor, or possibly the leading factor, in the low life expectancy in Russia compared with other European populations.

As part of this project, a survey was carried out in 2000 among patients of three PHC centres, two in the Kalininsky district and one in the Petrogradsky district of St. Petersburg. All patients who agreed to take part were included. The survey used the AUDIT screening questionnaire[3] to establish levels of hazardous and harmful drinking and the CIDI[4] to establish diagnosis according to ICD-10. The AUDIT questionnaire and scoring template were translated into Russian, together with an

information sheet for patients, for the purposes of this survey. Breakdown of categories of alcohol consumption and alcohol-related harm in this sample is shown in Table 12.1.

It will be seen that there is a very small proportion of total abstainers in this sample (2.4%). There is also a very high proportion of patients drinking at dependent or harmful levels or at increased risk of alcohol-related harm (31.5% in total). This is mainly attributable to the drinking of male patients, among whom more than one quarter are either "harmful drinkers" or "alcohol dependent".

With specific regard to adolescent drinking and illicit drug-taking, registered alcoholism and "narcomania" (i.e. dependence on illicit drugs) morbidity among adolescents (per 100,000 adolescents 15–18) from 1991-98 is shown in Table 12.2. This shows an enormous increase in the incidence of illicit drug problems during the 1990s but there is also a substantial increase in alcohol-related problems among adolescents. The mean age of first using alcohol is 12.7 years.

TABLE 12.1

Breakdown of categories of alcohol consumption and alcohol-related harm among patients in three PHC centres in St. Petersburg

Category	Total (%)	Males (%)	Females (%)
Abstainers	11 (2.4)	5 (2.4)	6 (2.4)
Low risk drinkers (equal or less than 4 U/day/M and 2 U/day/F; less than 5U×1 occasion/M and less than 3U×1 occasion/F)	304 (66.1)	98 (46.2)	206 (83.1)
Hazardous drinkers (more than the above without any detectable drinking problem)	75 (16.3)	52 (24.5)	23 (9.3)
Harmful drinkers (showing physical, emotional, social etc. signs of alcohol-related harm)	42 (9.1)	34 (16.0)	8 (3.2)
Alcohol dependent (according to ICD-10)	28 (6.1)	23 (10.8)	5 (2.0)
Total	460 (100.0)	212 (100.0)	248 (100.0)

TABLE 12.2

Registered alcoholism and narcomania in adolescents in Russian Federation, 1991-1998

	1991	1992	1993	1994	1995	1996	1997	1998
Alcoholism	7.6	9.2	7.6	11.3	12.2	11.7	10.8	11.5
Narcomania	4.6	4.5	9.5	19.5	40.8	59.8	67.5	71.4

12.2. The Phase IV Study in St. Petersburg

Owing to the location of the Chief Investigators (VM, TK) in a Department of Adolescent Medicine at the Medical Academy of Postgraduate Studies (MAPS) in St. Petersburg and to the particular problem of excessive alcohol consumption by young people in St. Petersburg, it was decided to focus the Russian arm of the Phase IV study on adolescents and young people. However, the structure of Phase IV components described in Chapter 1 was applied to this target population. While the eventual aim was to disseminate early identification and alcohol brief intervention (EIBI) throughout the Russian

Federation, the Phase IV Project was confined to the St. Petersburg and the North-west region of Russia.

The Phase IV project in Russia was supported by two grants from the Know-How Fund (Health Sector Small Partnership Scheme) in London. The first, awarded in February 1998, enabled the Phase IV Technical Focal Point, Professor Nick Heather, to visit St. Petersburg to discuss with Russian partners at MAPS the feasibility of carrying out a collaborative study and to develop an application for full funding. This was submitted in September 1998 and awarded in November of that year. A request for an extension, required mainly because of changes to personnel at MAPS, was agreed in January 2001, with a revised completion date of June 2002. A further extension was allowed in May 2002, with a final completion date of 31/12/2002. This funding enabled Professor Heather to make three further visits to St. Petersburg and contributed to various expenses of the project (printing costs, translation of materials, local travel).

A list of personnel and collaborating organisations will be found in Appendix 12.1.

12.3. Customisation of EIBI materials and services

This part of the project was assisted by a grant from the European Union (the ECATOD project), administered by Dr. Pierluigi Struzzo in Udine, Italy and Dr. Leo Pas in Brussels, Belgium. The ECATOD funding was intended to help investigators from eastern European counties to carry out the customisation component of the WHO Phase IV study by providing training in focus group and Delphi study methodology.

12.3.1. Focus groups with health professionals

To investigate the attitudes of health professionals to implementing EIBI in PHC, 4 focus groups (FGs) were run, composed of 6–9 participants each. All participants were women under 50 years of age. There were no problems with recruitment because all participants were teachers at MAPS. Venues for the groups were the Department of Adolescent Medicine and the Department of Nurse Training at MAPS. Moderators and observers were:
T. Krishtal CM, Assistant, Department of Adolescent Medicine and Valeology.

M. Oganova CM, Assistant, Department of Adolescent Medicine and Valeology.
L. Yaremenko, Assistant, Department of Family Medicine
V. Medvedev MD, Professor, Department of Adolescent Medicine and Valeology

In summary, the group discussions indicated that very few general practitioners or nurses in Russia pay attention to the drinking habits of their patients. Most believe that screening and diagnosis of alcohol problems are not their responsibility and that, in any case, excessive alcohol consumption is a widespread national characteristic.

Thus responding to drinking problems is not an area in which GPs and nurses normally work. The findings suggest that to change doctors' passive attitudes to the identification of drinking problems will be very difficult. This may be easier in nurses, but nurses in Russia are closely dependent on doctors and have no autonomous decision-making capacity. Effective incentives for changing doctors' attitudes and encouraging active intervention are not yet known.

Most group participants did believe they could modify the patient's drinking habits by simple advice. They were shown the "Helping People Change"[5] or "Skills for Change"[6] packages during the groups but stated they had never used them or heard about them and only a minority thought they would be prepared to use them. Nevertheless, discussion of how to change the attitudes of GPs and nurses had some effect. The expectation that discussions would facilitate and motivate doctors and nurses to use methods to identify and classify alcohol problems in general practice was party confirmed. The actual knowledge of health professionals about the harms of drinking was shown to be very low.

Many of the nurses appeared to have difficulty in discussing the topic of the focus group and were not prepared to interact or discuss the relevant issues. GPs, however, interacted well but there was little flexibility in their attitudes. Participants seemed to have a rigid orientation towards teaching programs. In general terms, participants were simply not ready for the identification and classification of alcohol problems among their patients. They were not familiar with the stages of change model[7]. There were very few written materials available in this area for doctors and nurses in Russia at the beginning the project.

The main conclusions of this investigation were that, in order to change attitudes, it would be necessary to create legislation, organize intersectoral cooperation and begin adequate education of health professionals and young people themselves. These possibilities will be returned to below.

12.3.2. Focus groups with young people

Two FGs were run to investigate the attitudes and beliefs of young people to alcohol consumption. Participants were university students. Groups were held at MAPS on 23-24 July 2002. The moderator for both groups was T. Krishtal and the observer was V. Medvedev. Both groups consisted of 10 young people. In the first group (3 men, 7 women), the mean age was 18.1 (range 17-20); in the second group (8 men, 2 women), the mean age was 18.1 (range 17-19).

Most participants said that they mostly used alcohol to relax at the end of a working week or a busy day, especially beer and gin-tonic. On holidays, it was traditional and expected to drink champagne. They also sometimes used alcohol, usually gin or some other form of spirits, if they were in a bad mood.

For the majority of participants, the age of first drinking was between 12 and 14 years but was usually later in girls. If a friend began drinking heavily, most participants said they would have a "hear-to-heart" talk with them and try to help make decisions about solving the problem. There was no suggestion that the friend should seek help from a doctor.

Most of the students defined heavy drinking in terms of negative effects on studying or on health. No consensus about a "normal" amount of alcohol emerged; this was considered to be a matter of individual choice. Some participants had heard of the concept of a "standard unit" of alcohol but were not sure how much alcohol this represented.

All participants said they would reduce their intake of alcohol in the event of illness and if advised to do so by a doctor. They would consider abstaining only in the event of serious illness. This topic caused intense discussion but most students were not convinced that their own drinking could cause or aggravate serious illness. However, they all agreed that alcohol should not be used during pregnancy.

Participants believed it was necessary to educate schoolchildren about alcohol, beginning at age 11-12, and to educate students during their first semester. This should be aimed especially at those who had left home and were living in hostels. It was thought that such education would help to avoid alcohol problems in the conditions of independent living outside the control of parents.

The advertising of beer on TV was thought to influence only those who had not yet acquired a taste for beer. Advertising produced a desire to drink beer as "something tasty" or thirst-quenching. However, all agreed that beer advertising should be banned from TV.

All participants had visited a beer festival. On these occasions, a mood of celebration was caused by the feeling of being on holiday and by music but the high price of beer during festivals and the presence of many drunk young people were unpleasant. Festivals also produced large amounts of

litter and this detracted from the holiday mood.

Participants thought it was essential to strictly supervise the sale of spirits and ensure that only those over 18 years could buy it. For beer and wine, however, those over 14 who had obtained a passport should be allowed to purchase. It would be ineffective to forbid the use of alcohol among schoolchildren and to promote the idea that they should not drink but it was essential that training in a culturally acceptable way of drinking should be provided. The recommended amount should be between 1 and 6 units, with larger amounts being reserved for holidays, birthdays and other special occasions.

12.3.3. Delphi survey

Because of the unreliability of mail in Russia, it was not possible to use the postal system. We therefore had to modify our work with the Delphi. It was carried out at meetings during sessions of Baltic Summer School of Health Care in 2001. At the beginning, participants were given a 1st round questionnaire and responded to items on 5-point scales. The 2nd round was completed orally. After one month participants were interviewed again in a 3rd round. GPs and general nurses (GNs) were interviewed at meeting of the Association of Family Medicine at 2-monthly intervals. Social workers were interviewed at monthly intervals while completing postgraduate studies.

The composition of the expert group was: Health service managers = 6; Social workers = 14; GPs = 20; Pediatricians = 11; School psychologists =13; Nurses = 10. All these experts had considerable experience in working with young people but not necessarily with alcohol problems.

The results were not encouraging for the implementation of EIBI. Managers and nurses believed that the most effective policy against alcohol-related harm would be the introduction of prohibition measures at the state level, despite the fact that such measures had been rescinded in Russia in the early 1990s.

Neither intervention methods nor community action were included as proposals in responses to Delphi items. At the same time, respondents agreed that, in view of present living and cultural standards, preventive programmes would be ineffective. In answer to the question, “Are your doctors ready for prevention work and do they need special training?”, they replied: “They never will work in this field.”

Nurses’ responses revealed a lack of motivation for independent work with patients. The reason for this situation is no doubt the specific role of the nurse in Russia, where nurses work only as the doctor’s assistant. This may be the reason they feel powerless in regard to alcohol-related problems and believe in prohibition measures at the state level.

GPs appeared much better motivated for preventive work with their patients and attached great importance to healthy life-style promotion. They understood their role in the mass media in influencing priorities for children, adolescents and youth. The more positive attitudes of GPs’ may be accounted for by the fact that they had been trained in healthy life-style promotion. In addition, GPs are more active and skilful in their relationships with patients than outpatient clinic doctors. In the latter case, we found misunderstanding, lack of knowledge and unwillingness to discuss health promotion and disease prevention.

12.3.4. Conclusions regarding customisation and implications for future work

The overall conclusion of this investigation is that the implementation of EIBI in PHC in Russia is a great challenge. The findings of both focus groups and the Delphi survey reflected the fact that drinking problems are not an area in which doctors and nurses of ordinary outpatient clinics normally work or are expected, at least by young people, to work. The extent of outpatient clinics doctors’ (therapists) knowledge about alcohol-related harm was found to be low in St. Petersburg.

It is clearly better among social workers and, especially, among GPs. The ascending order of knowledge was: nurses, therapists, social workers and GPs. Effective incentives for changing doctors' and other health professionals' attitudes are unknown but a strategy with this aim would need to involve the following:

(i) Legislation. Important here is the introduction of controls on alcohol advertising in Russia, especially advertising on TV, and we note that this would have the support of young people. We hope for a definite improvement in this connection from the fact that the State Duma of the Russian Federation is currently considering new legislation regarding limitations on alcohol and tobacco advertising. Another essential improvement would be stricter enforcement of existing legislation regarding the sales of alcohol to minors. It is essential that State Laws regarding alcohol advertising and sales are duplicated at the local level. These measures would encourage health professionals to believe that their efforts to reduce alcohol-related harm among their patients are being supported by government action.

(ii) Clinical guidelines on EIBI for doctors and nurses separately will be developed at MAPS. We note that an EU-funded project in Barcelona, under the control of Dr. Peter Anderson, Dr. Antoni Gual and Dr. Joan Colom, includes plans to develop clinical guidelines for EIBI for use in the European region (PHEPA). We hope that these guidelines can be adapted for use in Russia.

(iii) Education of health professionals. Better education of health professionals concerning the harmful effects of alcohol is urgently needed. As a result of work on the customisation component of the project, we have organized at MAPS a range of new training courses on alcohol intervention. These will be described in the section on Reframing (12.4.) below.

(iv) Intersectoral co-operation and coalition building. Of particular importance for the secondary prevention of alcohol-related harm among young people is co-operation between the health and education sectors which is at present poor. The formation of a Strategic Alliance in St. Petersburg as part of the project was an attempt to make progress in this direction (see section 12.5.).

(v) Mass media involvement. Probably the most important development in support of reducing alcohol-related harm in Russia is a change in the currently favourable public attitudes to drinking and drunkenness, attitudes that are deeply embedded in the culture. This would obviously require government commitment and expensive mass media campaigns that are well beyond the scope of the present project.

(vi) Early, active and adequate education of children and adolescents. This will be ineffective if it only involves the input of PHC professionals. Intersectoral co-operation will be essential for the following reasons:

a) Alcohol education should begin as early as possible as part of comprehensive health promotion programmes;
b) Schools and colleges have a suitable infrastructure to allow a comprehensive intervention;
c) A new methodology is needed that can help to move from knowledge to attitude and behaviour change;
d) The proportion of health professionals with good or acceptable levels of knowledge, attitudes, skills and behaviour regarding alcohol must be raised. It will be necessary to train intervention teams of doctors, nurses, teachers, social workers, psychologists and volunteers (students of senior schools or institutions);
e) The proportion of schoolchildren, parents, teachers, physicians, nurses with good or acceptable level of knowledge, attitudes and skills regarding alcohol must be increased;
f) Experience in other countries should be adapted for use in Russia.

12.4. Reframing Understandings of Alcohol Issues

The aim of this component of the project is to bring about a better understanding of the concept of "risky drinking" and of the practice of EIBI among relevant professional groups and among young people.

12.4.1. Training health professionals

As a result of work in this project and following requests from health professionals during the focus groups described above, we organized new training courses or modified existing courses on health promotion in St. Petersburg MAPS:

Family doctors: Education on Preventive Medicine is a part of the post-graduate course for family doctors at MAPS and since 1999 has included all family doctors in St. Petersburg and the North-west region of Russia. The course is situated in the Department of Family Medicine at MAPS. The Helping People Change package[5] is now an obligatory part of this course and we have increased the emphasis on training doctors to enquire about alcohol consumption and intervene when necessary. These additions include statistical data and other information on young people's alcohol consumption and improvements in skills related to increasing young people's motivation to discuss alcohol problems.

We have also introduced regular focus group discussions to monitor changes in doctors' attitudes to the difficulties and resources needed to work in this area. The time devoted to the study of adolescent and young people's drinking has been increased and now takes 4 hours in total. In the current year, trainees include 8 GPs working in two centres of family medicine in the Kalininsky district.

Family nurses: Family nurses are also included in the course on Preventive Medicine just described. Trainees currently include 11 nurses working in the Kalininsky district.

School doctors, Pediatricians, Doctors for adolescents: These doctors are trained in the Department of Adolescent Medicine of MAPS. A workshop on "Principles of Preventive Medicine for Young people" includes the theme "Teenagers and Alcohol" and alcohol training passages from *Helping People Change*. This part of the syllabus is also obligatory. Trainees include 28 doctors working with teenagers in the Kalininsky district in 2000-02.

Also, training of doctors at 10 Youth Consulting Centres and the City Diagnostic Centres for Children and Adolescents is being undertaken on the themes of preventive medicine, including "Alcohol, Drugs and Smoking". The first of these courses was completed in March 2002 and 32 doctors were included. In future, all doctors in these centres will receive training on alcohol issues on a yearly basis at the Department of Adolescent Medicine.

School nurses: All school nurses (46 persons) were trained in the Kalininsky district. Fifty-two percent (52%) of the nurses responded that they were ready to carry out preventive work on alcohol.

Social workers: A new training course for social workers began in March 2003. This course was dedicated to medical-social care for teenagers and focussed on aspects of preventive medicine, including "Alcohol, Drugs and Smoking". Material on alcohol was emphasised and included EIBI training.

12.4.2. Training volunteers

In addition to the above changes in the syllabus at MAPS, we have recruited students to work as volunteers in visiting schools to educate adolescents about excessive drinking and other high-risk behaviours. There is a public organization called "Looking to the Future" which has developed the organization, training and implementation of volunteer activity in schools. This programme touches on all risk factors of teenage life, including alcohol, and attempts to train skills for non-risky behaviour. The work of the volunteers is coordinated by adults – teachers, psychologists, heads of

teenage clubs. In the last two years, youth organizations working in different preventive programs have been united in an umbrella organization called "ECHO" and this will carry out community action, meetings, conferences and training. This project is supported by UNISEF.

The Department of Adolescent Medicine works together with volunteers and acts as the centre for training team-leaders and developing tutorials. At an ECHO conference, T. Krishtal and V. Medvedev led a Round Table for team-leaders on the prevention of excessive alcohol consumption and the training of volunteers using the *Helping People Change* model. The Department of Adolescent Medicine is currently producing a printed tutorial for volunteers, and will design and develop a poster and a booklet for young people called “Drink Less but Better”.

There now exists one team of volunteers organised by the Department of Adolescent Medicine to carry out training with teenagers in city schools and at the Technical University. The leader of the team of volunteers is T. Krishtal. This group of volunteers consists of 4 young women and 3 young men who are all university students and have been working on the prevention of high-risk behaviour for two years. The program delivered consists of 10 2-hour lessons on the problems of teenagers, including one lesson on alcohol. The contents of this lesson are as follows:

- to show how alcohol can affect the life of a teenager and how alcohol and tobacco can go together in teenage behaviour;
- to explain pros and cons of drinking;
- to define the difference between normal consumption and abuse;
- to impart skills in how to refuse drinks;
- to learn first-aid treatment for acute alcohol intoxication

The techniques used include brain-storming, small group work, role-play, didactic instruction and plenary discussions. So far a total of 9 sessions have been completed in the Kalininsky district, including 158 students. Plans for the future include the creation of a team of volunteers at the University outpatients department № 76. The setting up of the team and the initial training is planned for February 2003. Volunteers are considered to be an important resource for the dissemination of knowledge on risk factors of teenage life. Training by the peer-led method is acknowledged to be effective and to produce positive results in the primary and secondary prevention of excessive drinking.

12.4.3. Introduction of alcohol information in medical records

From January 2003, information on alcohol consumption and risky drinking was inserted into medical documents (patients’ registration cards) in two Youth Clinics in Kalininsky. These measures were discussed and accepted at the meeting of Health Care managers in the Kalininsky district in March 2002. There are plans to extend this initiative to other clinics in the district and elsewhere. This will help to disseminate information about recommended consumption levels and the concept of risky drinking among health professionals and adolescent patients.

12.5. Strategic Alliance

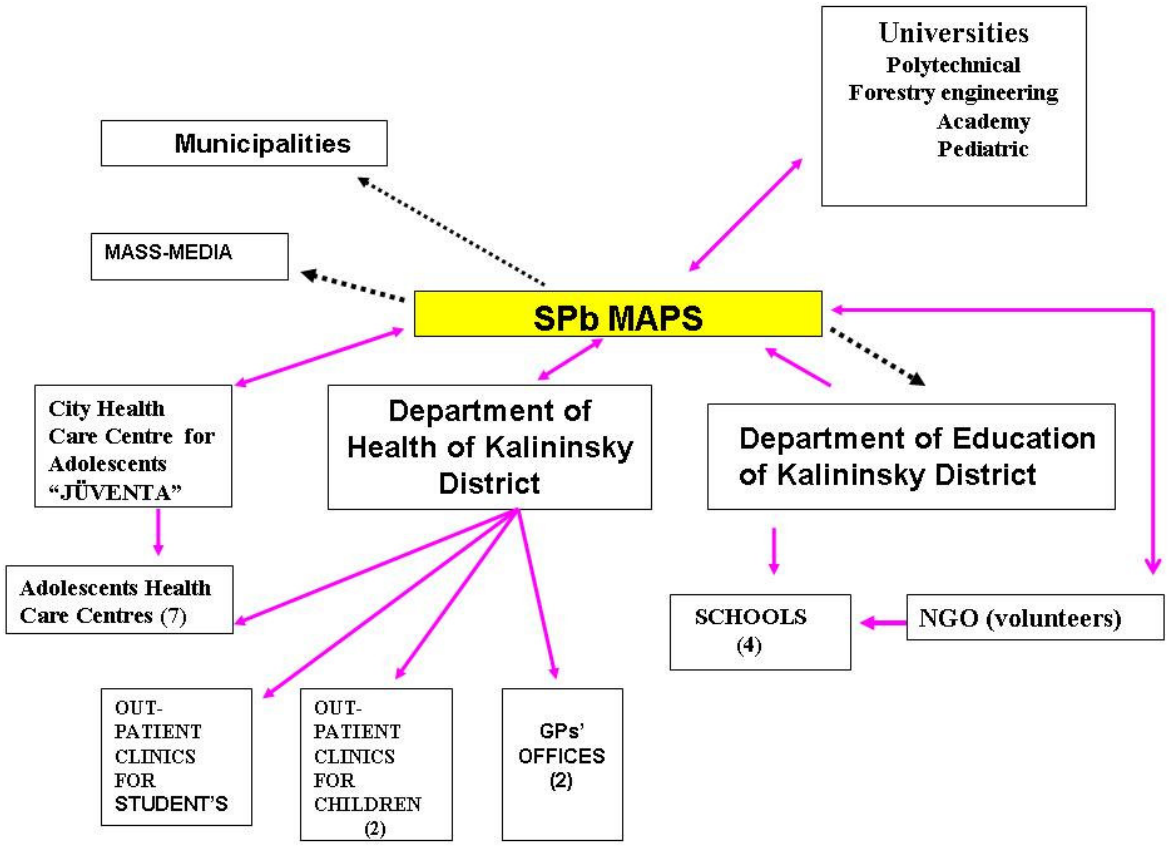
Figure 12.2 displays the strategic alliance that has been established in the Kalininsky District of St. Petersburg to further the aims of the project. In the figure, solid lines represent links to organisations that have agreed to contribute to the project and lines with arrows at each end represent instances where mutual co-operative work has been undertaken. Dotted lines represent instances in which it has not been possible to develop co-operation or to elicit a commitment to the aims of the project.

It will be seen from the figure that it has been possible, via the Department of Health in the Kalininsky District, to influence the work of a range of health care facilities, i.e., Adolescent Health Care Centres, Outpatient Clinics for Children and for Students, and GP offices. In addition, there has been direct contact with the City Health Care Centre for Adolescents (Juventa). However, it has not proved possible to develop similar links via the Education Department and contacts with

schools, universities and with an NGO organisation for volunteers (see above) have been direct. In addition to the failure to achieve co-operation from the Department of Education, it has also been impossible to establish collaborative links with the municipalities and mass media organisations. The formation of such links represents a challenge for the future.

FIGURE 12.2

THE STRATEGIC ALLIANCE



12.6. Demonstration Project

The demonstration project is intended to show that dissemination of screening and brief alcohol intervention in primary health care in a local area is possible, and will hopefully serve as a model for similar applications throughout Russia. The aim is to provide a practical demonstration of how implementation can be achieved, with some evidence of the impact on alcohol-related harm and its cost to the community.

The specific objectives are:

i) To measure adolescents' and young people's alcohol consumption and knowledge of acceptable levels of consumption;
ii) To assess motivational changes in doctors (GPs and outpatient doctors) in a local district;
iii) To assess the implementation of EIBI among young people and professional skills in carrying out brief alcohol intervention.

12.6.1. Surveys of young people's alcohol consumption and knowledge of acceptable levels

Schoolchildren: Eighty-five (85) pupils from 8th–10th forms (14–15 years old) were interviewed by means of a special questionnaire in two schools. The area covered by the questionnaire was smoking, illicit drug-taking and alcohol consumption. With regard to alcohol, the main questions concerned: age of first drinking alcohol; alcoholic beverage preferences; experience of intoxication; interest in information on alcohol effects; preferences for discussion of alcohol problems (parents, teacher, friend, psychologist, specialist).
Results can be found in a report to the Know-How Fund[8]. The data gathered in this survey can serve as a baseline from which to measure any changes alcohol consumption and attitudes to alcohol among schoolchildren that may occur in future.

Students of Universities and Academies: A questionnaire on the same topics as given to schoolchildren (see above) was given to 666 university undergraduates (age 16-18). Once more, the data collected in this survey of students can serve as a baseline with which similar data collected in future surveys may be compared to determine whether changes in alcohol-related behaviour or attitudes have taken place. Detailed findings are available in the report to the Know-How Fund[8].

12.6.2. Assessment of motivational changes in doctors

Interviews to assess motivational changes with regard to preventive work in general and brief alcohol interventions in particular are currently in progress at MAPS. Doctors attending courses at MAPS will be interviewed before the commencement of their studies and two months after the course has been completed.

12.6.3 Assessing the implementation of EIBI among young people and professional skills in carrying out brief alcohol intervention

A questionnaire developed by the Finnish investigators in the WHO Phase IV project[9] was translated into Russian for this purpose. This instrument, known as the "exit poll", measures the extent to which patients leaving a health care centre were asked about their alcohol consumption, whether they received any advice about their drinking and the nature and quality of this advice.

The exit poll survey in St. Petersburg was carried out in an outpatient clinic for students (No. 76) and involved 489 students. These were all first-year students of the Technical University and two technical secondary schools. Students were questioned after receiving a medical examination prior to the commencement of their studies. The survey involved the work of 3 nurse researchers and was carried out over a 3-day period.

Results were analysed by age and gender and are presented in Appendix 12.2. It will be seen that, among male students, very few had been asked about their alcohol consumption. In anything, younger students were more likely to have been asked. Fully three-quarters of the sample had never been asked about their alcohol consumption at any time. Rather more of the younger students were counselled about their drinking, presumably in the form of general warning about the dangers of excess without specific enquiry about their drinking habits. Nevertheless, over 90% of the total sample received no counselling about alcohol and this must have included a substantial number of heavy drinkers. Disappointingly perhaps, three-quarters of the sample said they would not be interested in receiving further information on alcohol. This indicates the need for education among the patients themselves, as well as among health professionals.

Much the same patterns were evident in the data for female students. Somewhat more of the younger girls than boys were asked about their drinking and received counselling about it, although again the great majority of the sample as a whole had never been asked about drinking or received any counselling. Roughly the same proportion as among the young men (one-quarter) were interested in receiving further information.

These useful data represent a baseline for assessing the effects of attempts to encourage health professionals to deliver EIBI to young people and the success of efforts to formally implement EIBI.

12.7. General Conclusions

As with the experience in other countries involved in the WHO Phase IV project, the findings of the Russian arm indicate that the attempt to implement EIBI among young people attending health care facilities presents a formidable challenge. It took over 20 years from the first widespread knowledge of the harmful effects of cigarette smoking to the time when smoking was routinely enquired about in primary health care and intervention given when necessary, and even this is still imperfectly delivered in many countries. It follows that the effort to implement EIBI regarding excessive drinking will be an ongoing task with many drawbacks and little evidence of obvious progress. Yet this task must be undertaken if the harmful effects of excessive alcohol consumption are to be reduced, especially in a country like Russia where the extent of this harm is enormous.

A beginning to this task has been made in the current project. In particular: a) a screening instrument has been developed and intervention materials with accompanying guidelines are being developed; b) attitudes of health professionals to this work have been investigated and the main obstacles to progress identified, with some suggestions for how these obstacles might be overcome; c) behaviour and attitudes of young people themselves have been investigated using both qualitative and quantitative methods; d) a database has been established by means of which changes in implementation practice and the alcohol-related behaviour and consumption of young people can be assessed; e) a beginning has been made in the attempt to educate both health professionals and young people about the concept of risky drinking; f) lastly, a strategic alliance of individuals and organisations sharing the aim of widespread implementation of EIBI among young people in the St. Petersburg area has been established and will be carried forward.

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APPENDIX 12.1

PERSONNEL AND COLLABORATING ORGANISATIONS

Russian partners:

Vladislav Medvedev MD, Professor, Department of Adolescent Medicine, MAPS - Principal Investigator from July 2000

Tatiana Krishtal CM, Assistant Professor, Department of Adolescent Medicine, MAPS - Program Coordinator from July 2000
Alexander Koulikov MD, Head of Department of Adolescent Medicine, MAPS
Karina Pokhis MD, Head of Department of Nurse Training, MAPS - Principal Investigator 1998–1999

UK partner:

Nick Heather PhD, Professor of Alcohol & Other Drug Studies, Newcastle, North Tyneside & Northumberland Mental Health NHS Trust & University of Northumbria - Technical Focal Point for Phase IV Project from 1998

Collaborating organisations:

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APPENDIX 12.2

RESULTS OF "EXIT POLL" SURVEY

SURVEY – men

Questions	15 years	16 years	17 years	18 years	More than 18	Total	TOTAL %
1. NUMBER OF STUDENTS	**32**	**51**	**82**	**69**	**75**	**309**	
2. WHEN have you been asked about alcohol consumption by a doctor or a nurse in this clinic recently?							
Today	6,3%	7,8%	8,5%	4,3%	4,0%	19	6,1%
During last year last year	9,4%	17,6%	10,9%	4,3%	14,6%	35	11,3%
More than year back	3,1%	11,8%	7,3%	1,4%	9,3	21	6,8%
Never	**81,3%**	**62,7%**	**72%**	**91,3%**	**72%**	234	**75,7%**
3. Have you been counselled on a question of alcohol consumption by a doctor or a nurse **IN THIS VISIT?**							
YES	12,5%	15,7%	6,1%	4,3%	5,3%	24	7,7%
NO	**84,4%**	**86,3%**	**90,2%**	**95,6%**	**94,7%**	282	**91,3%**
4. How often do you use alcoholic drinks?							
- Never	**18,7%**	**7,8%**	**14,6%**	**10,1%**	**5,3%**	33	10,6%
- Less than once a month	**28,1%**	21,6%	22%	14,4%	6,7%	53	17,1%
- Once a month	9,4%	9,8%	17,1%	**30,4%**	21,3%	59	**19,1%**
- Once a week	6,3%	**25,5%**	**24,4%**	18,8%	**29,3%**	70	**22,6%**
2-4 times a week	15,6%	**21,6%**	9,7%	15,9%	**22,6%**	52	16,8%
5 or more times a week	**21,8%**	**13,7%**	**9,7%**	**7,2%**	**10,6%**	35	11,3%
5. What do you usually prefer drinking?							
Beer	**71,8%**	**72,5%**	**50%**	**71%**	**78,7%**	209	**67,6%**
Wine	25,6%	25,5%	**35,4%**	21,7%	14,6%	76	24,6%
Spirits	15,6%	15,7%	12,2%	**31,9%**	6,6%	50	16,2%
6. What is your usual dose? Vodka (in gram); a wine glass Ml Beer a bottle ml M – mean grams	M=250,0 M=1,2 (180 ml) M=3.8 (1.9 l)	M=256,7gr M=3,25 (406ml) M=2.9 (1460ml)	M=285,7gr M=3,8 (480ml) M=3.3 (1165ml)	M=261,6 M=4,2 (522,4ml) M=3,6 (1800ml)	M=268,2 M=4,3 (537,5ML) M=4.3 (2150 ml)		
7. Would you like to more information on alcohol consumption? YES	77,0%	31,4%	29,3%	18,8%	14,6%	82	26,5%
NO	**23,0%**	**70,6%**	**68,3%**	**81,1%**	**85,3%**	235	**76,1%**

SURVEY– women

Questions	15 years	16 years	17 years	18 years	More than 18	Total	Total %
1. NUMBER OF STUDENTS	**14**	**35**	**69**	**53**	**9**	**180**	100%
2. **WHEN** have you been asked about alcohol consumption by a doctor or a nurse in this clinic recently?							
Today	7,1	14,3	2,9	1.9	-	**9**	5
During this year	**14,3**	5,7	8,6	7.5	**11,0**	**15**	8,3
More than year back	-	**11,4**	5,8	3.8	-	**10**	5,5
Never	**78,6**	**68,6**	**82,6**	**86.8**	**88,0**	**146**	**81,1**
3. Have you been counselled on alcohol consumption by a doctor or a nurse **IN THIS VISIT?**							
YES	7,1	**17,1**	4,3	9,4	11	**16**	8,8
NO	**92,8**	**82,8**	**94,2**	**90,5**	**88**	**163**	**90,5**
4. How often do you use alcoholic drinks?							
Never	**7,1**	**5,7**	**11,6**	**9,4**	22,0	**78**	**43,3**
Less than once a month	7,1	14,3	11,6	**30,2**	22,0	**32**	17,7
Once a month	**50**	**28,6**	**42**	**43,4**	-	**69**	**38,3**
Once a week	**21,4**	**31,4**	**23,2**	11,3	**33**	**39**	21,6
2-4 times a week	7,1	11,4	7,2	5,7	-	**13**	7,2
5 or more times a week	**7,1**	**8,6**	**4,3**	**0**	-	**7**	3,8
5. What do you usually prefer drinking?							
Beer	64,3	54,3	31,8	66,1	22,0	**87**	48,3
Wine	50,0	48,6	62,3	49,1	44,0	**97**	53,9
Spirits	7,1	17,1	8,7	3,8	11,0	**16**	8,9
6. What is your usual dose? Vodka (in gram); a wine glass Ml Beer a bottle ml M – mean grams	M =108.3 M=3.0 (375 ml) M=2.4 (1.2 l)	M=137.5г **M=7.9 (992 ml)** M=1.95 (978.3ml)	M=206g M=2.0 (250ml) M=2.8 (1400ml)	M=128.7 M=2.4 (302ml) M=2.6 (1300ML)	M=133.3 M=2.4 (303.5 ml) M=3.2 (1611ml)		
7. You would like to receive more information on alcohol consumption? YES	21.4	31.4	26.1	9.4	44,4	**41**	22,8
NO	**71.4**	**68.6**	**72.5**	**90.6**	**44,4**	**136**	**75,6**

CHAPTER 13

SLOVENIA

Marko Kolšek

13.1. Introduction

13.1.1. Country description

Slovenia is a wine-producing country on the sunny side of the Alps between Italy, Austria, Hungary, Croatia and the Adriatic Sea. It is approximately 20.000 km^2 with two million inhabitants. Of these, 15.6% are children under 15 years of age and 14.3% above 65 years. Average life expectancy is 71.3 years for men and 78.8 years for women. GDP in 2003 was 13.900 U$D. Total expenditure on health is estimated at 8.2% of GDP.

13.1.2. Health services

There is a compulsory health insurance. The National Health Insurance Institute of Slovenia (NHIIS) usually covers 85% of the costs of primary health care (PHC) and 95% of the costs of secondary/tertiary care for all adults, but in addition the majority of the population is voluntarily insured (at a fee of approximately 20 Euros per month) in order to obtain all medical services free. In any case, all services for children, pregnancy, emergencies, some chronic diseases (e.g. malignant diseases, diabetes mellitus, etc.) and preventive care are free.

There are approximately 4,200 practicing physicians in Slovenia, equivalent to 476 inhabitants per doctor (i.e., much lower than most EU and central European countries). There are 860 general practitioners/family physicians (GP/FP), but pediatricians (167) and school medicine specialists (73) are also seen as »first contact« doctors. They work in health centres in public health services (approximately 75%) or as individual contractors with the NHIIS in practices that may be located in health centres or in their own premises. Nurses and other health care professionals work alongside these doctors.

Everyone is supposed to be registered with a doctor in a health centre or in a private practice, with no financial difference between patients. To see a doctor, one can make an appointment. GP/FPs diagnose conditions, provide health care advice and prescribe medication; they also do preventive care. Doctors in PHC also serve as gatekeepers for the secondary health care services but, if necessary, they can refer patients to a specialist clinician, therapist or other health care professional based in an out-patient clinic or hospital.

13.1.3. Alcohol consumption, problems and treatment

High alcohol consumption has been a problem for many years, while drinking alcohol is a part of the Slovenian culture. In the late 19th and early 20th Centuries, there were some abstainer organisations. After the 2nd World War there were political initiatives to decrease consumption but with no significant success. In the late 1970s, modern group therapy for alcoholics was introduced by Dr. Janez Rugelj (based on the work of the Croatian psychiatrist, Dr. Vladimir Hudolin), together with the introduction of more than 100 “Clubs of Treated Alcoholics” that are still run by social workers, nurses or GP/FPs[1]. These clubs are the same as the “Clubs” in northern Italy that were introduced there a little later by Hudolin[2]. During last 30 years there have also been some media campaigns to inform the population about the risks of heavy drinking.

Alcohol consumption in Slovenia is one of the highest in Europe – 12.3 litres of pure alcohol per year per person over 15 years[3]. Also, the exact amount of unregistered alcohol production is unknown but it is estimated to be 5–7 litres of pure alcohol per year per person over 15. While in some European wine-producing countries (e.g. France, Spain), alcohol consumption has significantly decreased in the last 10–15 years, there has been no such trend in Slovenia. Among adolescents, consumption is

increasing, according to data from the international ESPAD study[4]. Even school-children of 10 are already drinking alcohol; only 40% are teetotallers and 14% have already been drunk[5]. More than one third of adult men and approximately 10% of adult women are risky drinkers and approximately 10%-15% of adults are alcoholics[6]. The result is a very high standardised death rate/100,000 inhabitants over 15 years for liver cirrhosis (52.3 males; 18.9 females; 38.9 both sexes) and for suicides over 15 years (52.1 males; 14.5 women; 33.0 both sexes)[7].

There has been no previous research on brief alcohol interventions in Slovenia and brief interventions (as they are currently defined) have not been used or taught in Slovenia until now.

13.2. Customisation

The main aims of the customisation part of the project were to develop a screening instrument that would be valid and accepted by the PHC team and patients, and to find an acceptable way to use such an instrument and carry out brief intervention. Partly for these purposes, we used the results of another project in which we have participated.

In 1998 Slovenia became one of the participating countries (with Belgium, Bulgaria, Hungary, Italy, Latvia, Russia and Slovenia) in a 2-year project funded by the EU to develop a common method to carry out qualitative research: the ECAToD Project (European Community Actions supporting primary health care action against Tobacco consumption and hazardous Drinking) (see Chapter 1). This project created the basis for a common approach to Delphi and focus group methodologies and stimulated links between the PHC setting and the local community.

One of the specific aims of the ECAToD project was to prepare for the customisation of different materials for early identification and brief intervention (EIBI) against drinking problems. The following were carried out: 1) Focus groups; 2) Delphi survey; 3) survey to validate the AUDIT questionnaire.

Some aims of customisation according to the ECAToD specific objectives on alcohol were:

- to analyse and compare each participating country's PHC service situation/projects in respect of the prevention and early recognition of alcohol health-related problems;
- to define the essentials of community action and support for PHC as a way of creating more efficient health care systems in the proposed field;
- to define the essential elements of success for such community action programmes;
- to develop proposals for implementation programmes in all participating countries.

13.2.1. Focus groups

Focus groups were run according to guidance document prepared by Pas, Struzzo and Heather[8] for use by investigators in the WHO Phase IV study. We ran 4 focus groups on alcohol issues (GP/FPs and low-risk drinkers). The overall results demonstrated some barriers for the implementation of EIBI and some suggestions for how they might be overcome:

- neither doctors nor patients were familiar with low-risk alcohol drinking limits and the terms »hazardous« and »harmful« drinking;
- the GP/FP's role should be redefined and clear goals should be set so that the topic of alcohol becomes a normal and routine part of their everyday work. (At present, it seems that EIBI is nobody's role, so it is not the GP/FP's problem and there is a lack of awareness that only the PHC team can implement EIBI widely);
- there is a lack of guidelines for GP/FPs' everyday work on EIBI;
- there is a lack of customized materials for EIBI;
- there is a lack of knowledge about EIBI among GP/FPs and nurses;
- GP/FPs do not have »extra« time available to do EIBI;

- broader social action should be taken to change the majority beliefs that encourage heavy drinking;
- changes in alcohol policy and in society as a whole should be introduced to make the PHC team's efforts on alcohol issues more successful.

13.2.2. Delphi survey

In a Delphi survey of possible community action on the reduction of alcohol problems, 51 experts from 4 groups were recruited from: a) primary health care services; b) paramedical services for primary health care; c) polititians and governmental services; d) nongovermental and voluntary organisations, trades unions, etc..

A final sample of 45 of experts participated. Three rounds of a set of questions were prepared over a 4-month period. First round questions were as follows:

i) Which actions or measures could reduce alcohol drinking in your community ?
ii) In what way could you participate in these actions?
iii) What kind of approach could be used for certain population groups (children and adolescents, employees, marginal groups, lonely or widowed people, others)?
iv) Describe what actions or measures you would expect from individuals, groups or organisations: general practitioners/ family physicians, pediatricians, occupational medicine specialists, other physicians, nurses, somatologists, other medical professionals, polititians, the National Health Insurance company, other insurance companies, students' organisations, primary schools, secondary and middle schools, mass media, church, others?
v) Do you have any other suggestions?

An analysis of answers resulted in 4 groups of measures that should be implemented:
A. measures on the state level (legislation, price and tax policy, public policy);
B. health promotion and health education;
C. measures for specific groups (children and young people, widowed, etc.);
D. measures by specific groups (physicians, politicians, mass media, etc.).

It was also agreed that there should be a comprehensive national program to reduce heavy drinking. One important aim of such a program should be the promotion of healthy life-styles and of drinking under the low-risk drinking limits.

To assist more effective local action, some countrywide measures should be implemented:

- stricter legislation on alcohol production, sale and availability (especially to children and youth);
- more severe penalties for the violation of laws related to alcohol;
- promotion of non-alcoholic drinks by subsidising the costs of production and sale.

The program should be directed at the population as a whole and to specific groups of the population. Special attention should be given to children and their education in the family and in school. Other groups in the population should also be considered. All these groups should be involved in the planning and conduct of different programmes. Many different organizations and professions in society (teachers, mass media, church, employers, etc.) have an important and specific role in actions to reduce alcohol-related problems. Health professionals' education should be revised to make them aware of their role, to inform them widely about alcohol problems and to teach them how to manage different aspects of the same problem at different stages.

13.2.3. Survey to validate the AUDIT questionnaire

In the lat 1990s the original AUDIT questionnaire[9] was introduced in Slovenia but was not well accepted either by doctors or patients, mainly because it seemed too long. We therefore decided to validate the original AUDIT-10 questionnaire (10 questions with cut-points 8 for men and 7 for women) and the shorter AUDIT–C[10] (the first 3 questions with cut-points 5 for men and 4 for women). We disguised the 3 AUDIT-C items in a questionnaire about eating, physical activity, smoking and coffee drinking in order to reduce the emotional significance of alcohol.

Patients were randomly selected in GP practices. For patients reaching the cut-points of the AUDIT–10 or AUDIT–C, a CIDI questionnaire[11] was given to those patients who did not refuse to complete it. Responses are given in Tables 13.1 and 13.2.

TABLE 13.1:
Responses to the original AUDIT-10 and CIDI questionnaire

	Female	Male	Total
No. of patients	169 (53.0%)	150 (47.0%)	319 (100.0%)
AUDIT-10 positive	26 (15.4%)	31 (20.7%)	57 (17.9%)
CIDI positive	14 (8.3%)	16 (10.7%)	30 (9.4%)
CIDI negative	7 (4.1%)	5 (3.3%)	12 (3.8%)
CIDI not completed	5 (3.0%)	10 (6.7%)	15 (4.7%)

TABLE 13.2:
Responses to the AUDIT–C and CIDI questionnaire

	Female	Male	Total
No. of patients	158 (52.8%)	141 (47.2%)	299 (100.0%)
3 Q AUDIT positive	26 (16.5%)	74 (52.5%)	100 (33.5%)
CIDI positive	2 (1.3%)	19 (13.5%)	21 (7.0%)
CIDI negative	12 (7.6%)	25 (17.7%)	37 (12.4%)
CIDI not completed	12 (7.6%)	30 (21.3%)	42 (14.0%)

A total of 20.7% of men and 15.4% of women had positive screening results for at least hazardous drinking on AUDIT-10. The figure for men seems too low according to available data on drinking levels in the Slovenian population. The GP/FPs commented that they thought many patients' responses were invalid because they knew they were problem drinkers. Only a half of those who screened positive on the AUDIT also had positive scores on the CIDI questionnaire. This is not unexpected because the CIDI is intended more to detect harmful drinking and dependence while the AUDIT is concered more with hazardous and harmful drinking.

A total of 52.5% of men and 16.5% of women had positive screening result for at least hazardous drinking on the AUDIT–C which is closer to indications from available national data. One quarter of men and less than one tenth of women had a positive score also on the CIDI questionnaire.

We found some problems during the validation process:

- the original AUDIT–10 and the CIDI are too long for use in everyday GP/FPs' practice;
- cut-points on the AUDIT–C may be too sensitive;

- the time period asked about is not defined in the AUDIT;
- there is a similar problem with all questionnaires and also in interviewing patients: *valid responses*. It seems as though all risky drinkers or patients who believe their doctor may assess their drinking as immoderate respond by underestimating consumption.

For everyday work with patients in primary care we found AUDIT–C usable in our country. It is convenient for incorporation in a life-style questionnaire, together with questions about eating habits, smoking and physical activity.

During the Phase IV study, we made some small changes to the items in AUDIT-C as a result of focus groups analysis, the experiences of some GP/FPs who used it in their practices and the comments of patients who completed it:

- the period of time asked about was defined for all three questions (i.e., the previous 12 months);
- response items for the second question were slightly changed and "half of a drink" was added as an option because some patients had difficulty in responding if they did not drink a whole glass.

The Slovenian version of AUDIT-C is shown in Appendix 13.1.

We subsequently carried out an analysis of a sample of 303 life-style questionnaires that were filled in by patients during preventive check-ups at their GP/FPs' practices. As a consequence of this analysis, we redefined cut-points for a positive score on the adapted screening test for Slovenia: for men = 6 points, for women = 5 points. Using these cut-points reduces the number of false positive and false negative results obtained considering the low risk limits for drinking that are set in Slovenia.

We are considering the development of "screening" questions that can be used in an interview with patients. This is because some patients, and some physicians too, dislike questionnaires. When suitable verbal questions have been prepared, we will conduct a study to compare this method with written questionnaires and validate it. We are also considering using actual amounts of wine, beer or spirits instead of units in the adapted AUDIT–C because some patients had difficulties translating drinks to units of alcohol.

13.3. Reframing

Slovenia is a well-known wine-producing country but spirits and beer are traditionally produced too. Nevertheless, a half of Slovenian families now produce some of their alcoholic beverages (wine and spirits) and this production is not under control[5]. There is a belief that drinking alcohol is normal behaviour and being drunk is not at all unusual, but it is unusual to be a teetotaller. Most people still think in terms of the "alcoholism" concept. On the other hand, a more rigorous law on alcohol availability was recently introduced. However, just before this, alcohol advertising was made possible again after many years of full restriction when any kind of alcohol advertising was forbidden. For example, it is now possible to advertise beer on TV or wine in newspapers or posters if a specific warning is added: "The Minister of Health warns that immoderate alcohol consumption can harm your health."

In order to try to modify the "alcoholism" concept, a reframing process was started by:

- articles in several public and medical journals and publications[12-20]
- alcohol issues included in the 6th year medical faculty curriculum
- alcohol issues included in vocational training of GP/FPs
- training of EIBI included in vocational training of GP/FPs
- EIBI information introduced in several CME courses
- a handbook on EIBI for GP/FPs published
- training of more trainers for EIBI begun

In addition, a one-and-a-half year widespread population-based information campaign called *Message in the Bottle* was started in October 2003 with collaboration between the Department of Family Medicine at the Medical Faculty, the Academy of Art, the Faculty of Social Work (all 3 at the University of Ljubljana) and a marketing professional. The campaign was supported by the Ministry of Health, the NHIIS, several communities, newspapers, TV and many different companies and organisations throughout the country. The campaign included press conferences, articles in the mass media, art exhibitions on issues of alcohol-related harm, posters and an information leaflet for the general public.

At the beginning of the campaign a national press conference was organised, followed by reports in all the leading national mass media (journals, radio, TV), several journalists' articles on reframing understandings of alcohol issues and several interviews with different experts in alcohol field. The Art Academy students prepared several innovative designs on alcohol-related issues that were presented as posters, brochures, leaflets, TV and movie spots. Leaflets with important information on alcohol issues were sent to the readers of the most popular national daily newspapers. Exhibitions of posters were organised at the most frequented streets and squares in bigger towns and in some large companies where leaflets were distributed to passers-by. Posters and leaflets were sent to all GP/FPs in Slovenia, all centres of social work, pharmacies, universities, colleges, high schools and railway stations.

13.4. Strategic Alliance

Many different organisations participated in various ways in this project:

Department of Family Medicine at the Medical Faculty:
reframing understandings of alcohol issues was included in the 6th year curriculum;

Society of Family Physicians:
EIBI training was included in the vocational training curriculum for family medicine;

Ministry of Health
financial support was provided for a wide population-based information campaign called *Message in the Bottle* that began in October 2003 and will last till spring 2005; the adapted AUDIT–C questionnaire was included in a life-style questionnaire given to adults (between age 40-70) for preventive check-up every 5 years; training of GP/FPs in EIBI was supported;

Art Academy, Department of Design
several designs were prepared during a course for students on the concept of low-risk, hazardous and harmful drinking, and the harmful effects of alcohol;

Faculty of Social Work
students conducted a survey on drinking habits, knowledge of alcohol issues and attitudes to drinking among visitors to health centres and social work centres; also a terrain survey (interviews of passers-by at exhibitions) on the public's experience of the *Message in the Bottle* campaign was conducted;

GP/FPs and school medicine specialists, health centres
patients informed by posters and brochures about the concept of low-risk, hazardous and harmful drinking, the risks of heavy drinking, and the benefits of reduced drinking;

Centres of Social Work
clients informed by posters and brochures;

Colleges, high schools and universities
students informed by posters and brochures;

National railway company
passengers informed by posters and brochures;

Two big national journals
brochures distributed at reduced fees;

CINDI programme leaders
publication and distribution of handbook on EIBI for GP/FPs supported;
training of more trainers of EIBI for GP/FPS and nurses organized.

13.5. Demonstration Project

A Demonstration Project has not been carried out in Slovenia because we were unable to obtain the necessary funding. It had been planned to take place in a wine-producing region and a control region was selected too. A preliminary survey of drinking habits, knowledge of alcohol issues and attitudes to drinking among GP/FPs and their patients in both regions was carried out.

However, it seems that not having run a demonstration project is not such a big loss because we have succeeded in influencing some very important changes in the country as a whole. It would surely be a pity not to begin the nationwide reframing process or to omit the AUDIT–C questionnaire in the national, compulsory preventive check-up programme for adults, when these developments were possible and supported in the country as a whole, merely because the demonstration project had not been carried out. It would also be unhelpful to carry out a demonstration project in a small region, possibly followed some years later by a nationwide project, when the situation was already suitable for implementing some Phase IV objectives throughout the country.

13.6. Conclusions

The main products of the Phase IV study in Slovenia are:

- customisation of a screening instrument (adapted AUDIT-C);
- a widespread population-based information campaign called *Message in the Bottle* aimed at reframing understandings of alcohol issues;
- education on alcohol issues included in the Medical Faculty curriculum;
- education on EIBI included in vocational training of family physicians;
- many GP/FPs are now sensitised to their important role in EIBI;
- early identification is included in regular preventive check-ups among the adult population.

In the future we intend to:

- continue the project on reframing understandings of alcohol issues among the general population;
- continue to educate more trainers for EIBI;
- start step-by-step to educate all practising GP/FPs and nurses in EIBI;
- develop and validate some verbal questionnaires for the early identification of hazardous or harmful drinking;
- advocate to the Ministry of Health to institute National Health Insurance reimbursement for GP/FPs to deliver EIBI;
- prepare and publish a self-help leaflet for risky drinkers;
- encourage all clinicians to include early identification of risky drinking in their everyday work with patients in hospitals and out-patient clinics;
- encourage nursing schools and colleges to include information on EIBI in their curricula.

If all these planned activities are successful we expect that in a few years the widespread, routine and enduring implementation of EIBI in PHC will be reality in Slovenia. If we continue to educate and

encourage PHC teams, we believe they will slowly accept EIBI, in the same way that they have accepted the measurement of blood pressure in their routine everyday work over last two decades.

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APPENDIX 13.1

Slovenian version of AUDIT–C (adapted by Marko Kolšek)

1. How often did you drink alcohol during the last 12 months (beer, wine, spirits, alcoholic cider) ?
   a) never (0 points)
   b) once a month or less (1 point)
   c) 2 - 4 times a month (2 points)
   d) 2 - 3 times a week (3 points)
   e) 4 times a week or more (4 points)

2. How many drinks containing alcohol did you have on a typical day when you were drinking during the last 12 months? (One drink – unit is: 1 dcl of wine **or** 2,5 dcl of beer or cider **or** 0,3 dcl of spirit.)
   a) 1/2 or 1 drink (0 points)
   b) 2 drinks (1 point)
   c) 3 - 4 drinks (2 points)
   d) 5 - 6 drinks (3 points)
   e) 7 drinks or more (4 points)

3. How often during the last 12 months did you drink
   - **men**: 6 drinks or more per occasion?
   - **women**: 4 drinks or more per occassion?
   a) never (0 points)
   b) less than once a month (1 point)
   c) monthly (2 points)
   d) weekly (3 points)
   e) daily or almost every day (4 points)

Slovenian national recommendations for low-risk drinking are:
MEN: 14 units or less per week (2 units or less per day) and 5 units or less per occasion

WOMEN: 7 units or less per week (1 unit or less per day) and 3 units or less per occasion

(1 unit of alcohol = approx. 10 g pure alcohol)

CHAPTER 14

SWITZERLAND

Pascal Gache, Arabelle Rieder-Nakhle, Karine Micalizzi & the Phase IV Geneva Steering Committee*

14.1. Introduction

14.1.1. Country description

Switzerland has 6.5 million inhabitants, including 1.6 million people living in the French-speaking part, "la Romandie". The GNP per inhabitant was estimated at 30,500 Euros in 2002. Population density is 174 inhabitants per km². Some regions are mainly devoted to agriculture (central Switzerland) and wine (Valais, Geneva, Neuchâtel, Tessin). Switzerland is a confederation with 26 cantons. The political power is divided into three levels: federal, cantonal and municipal. Most important political decisions are made on the cantonal level. People are often called on to vote according to the direct democracy system. Four languages are regularly spoken in Switzerland (Swiss-German, French, Italian and Romanche). The three first are national languages.

14.1.2. Alcohol consumption and alcohol-related harm

Although Switzerland has remained near the top of international statistics for average alcohol consumption for more than half a century, there has been a constant decrease first in consumption and then in alcohol-related morbidity (e.g., liver cirrhosis) and mortality. All but elderly Swiss have adopted the so-called 'Anglo-Saxon model' of drinking (week-end drinking). Switzerland is now at the 11th rank in official European figures, with 9.0 litres per year per adult in 2004. In spite of this decrease, 3 000 deaths are still attributed to alcohol every year and it is the second cause of avoidable death after tobacco[1].

14.1.3. Health services

There is no state insurance health system in Switzerland. A compulsory private insurance system is the basis of health care access. Availability of health services is ensured by a federal law. GPs are well disseminated over the country. Practitioners are well trained and Swiss medicine has a good reputation.

14.1.4. Research on alcohol brief interventions

Hardly any research was carried out in Switzerland on the GP's role in alcohol-related problems before the WHO Phase III study. A Swiss team was included in Phase III in 1998. In 2000, the team conducted a survey among primary care physicians from Geneva to document and compare GP' beliefs, attitudes, and practices regarding early intervention, preventive medicine and treatment of established alcohol dependence. 384 GP's' received a questionnaire, 195 responded and 185 questionnaires were analysed. The Swiss GPs' believe they are not really effective in helping patients to reduce drinking despite having been trained to do it. Paradoxically they all think they have a central role to play in the field of early detection of hazardous drinkers. Swiss GPs believe they would feel more confident in managing problem drinkers if they were better trained, if they had a lighter workload and if there were supportive government health policies. In summary, GPs wish to be involved in the detection and management of problem drinkers but incentives such as training and health policies have to be developed[2].

* Members of the Phase IV Geneva Steering Committee will be found in Appendix 14.1.

14.1.5. Swiss national campaign on risky drinking

In 1998, the federal government undertook a national campaign, "Ca débouche sur quoi ? (Where does it lead?)" focused on risky drinking. Three kinds of action were implemented. First, TV spots, advertising and radio messages were addressed to the public at a national level. This part of the program represented 70% of the budget invested in the national campaign. Second, municipalities were invited to promote safe drinking at the workplace, sports events, schools, colleges and universities. This program, called "les communes bougent", was not implemented in the city of Geneva but in a few small towns around it. Third, doctors and especially GPs were invited to participate in training sessions on early detection and brief intervention. About 1000 GPs were trained and customized materials were distributed[3].

14.2. Customisation

The Swiss Geneva team involved in the WHO Phase IV study worked on this objective by adapting:

- intervention tools;
- screening strategies;
- training methods;

14.2.1. Adapting intervention tools

We adapted intervention tools from the national campaign and from material developed by a team of investigators in Lausanne (Dr J.B. Daeppen) as we participated in a randomised control trial on alcohol brief intervention implemented in our walk-in clinic. Interns were randomly assigned to two groups: specifically trained in brief intervention (BI) and a control group trained in cholesterol management. Results are still in process.

14.2.2. Adapting screening strategies: Alcohol Use Disorders Identification Test (AUDIT) in French

In collaboration with Dr. Philippe Michaud (co-ordinator of the Phase IV study in France) and Dr. Jean-Bernard Daeppen in Lausanne, Switzerland, we carried out an evaluation of the French translation of AUDIT. The aim of the study was to validate a French version of the AUDIT. We conducted a diagnostic cross-sectional study in three French-speaking areas (Paris, Geneva and Lausanne) [4].

We examined psychometric properties of AUDIT as to its internal consistency, and its capacity to correctly diagnose alcohol abuse or dependence as defined by DSM-IV and to detect hazardous drinking (defined as alcohol intake >30 g pure ethanol per day for men and >20 g of pure ethanol per day for women). We calculated sensitivity, specificity, positive and negative predictive values and Receiver Operator Characteristic curves. Finally, we compared the ability of AUDIT to accurately detect "alcohol abuse/dependence" with that of CAGE and MAST.

1207 patients presenting to outpatient clinics (Switzerland, N=580) or general practitioners (France, N=627) successively completed CAGE, MAST and AUDIT self-administered questionnaires and were independently interviewed by a trained addiction specialist. AUDIT showed a good capacity to discriminate dependent patients (with AUDIT≥13 for males, sensitivity 70.1%, specificity 95.2%, PPV 85.7%, NPV 94.7% and for females sensitivity 94.7%, specificity 98.2%, PPV 100%, NPV 99.8%) and hazardous drinkers (with AUDIT ≥7, for males sensitivity 83.5%, specificity 79.9%, PPV 55.0%, NPV 82.7% and with AUDIT ≥6 for females, sensitivity 81.2%, specificity 93.7%, PPV 64.0%, NPV 72.0%). AUDIT gave better results than MAST and CAGE for detecting "Alcohol abuse/dependence" as showed on the comparative ROC curves. The results show that, in French as in the other languages, AUDIT is an efficient screening test, with high sensitivity and specificity and two cut-offs in each gender: ≥6 and 12 for females, and ≥7 and 12 for males (first figure for hazardous drinking diagnoses, second for abuse or dependence).

In France, Dr Michaud developed the FACE questionnaire (for Fast Alcohol Consumption Evaluation or *Formule pour approcher la consommation par entretien*). This instrument, built upon AUDIT, CAGE and TWEAK, is a five-item questionnaire administered by the GP him/herself. The interpretation of the score is comparable to that of AUDIT: for women, hazardous drinking from 4 to 8, dependence above 8; for men, hazardous drinking from 5 to 8, dependence above 8. In our study the informative values of AUDIT and FACE are sufficiently similar: for hazardous drinking males, FACE cut-off > 4, sensitivity 87.8%, and specificity 74%; for hazardous drinking females, FACE cut-off > 3, sensitivity 84.4%, specificity 84%; for abuse or dependence, both genders, FACE cut-off > 7, sensitivity 75%, specificity 95.8%. [5]

On the basis of these results Dr Michaud constructed an 'easy, simple, short' and efficient screening questionnaire but we needed to clarify whether it was more acceptable than AUDIT or than the AUDIT embedded in a health questionnaire validated by Daeppen and colleagues[6] For this purpose he proposed a study comparing screening activity between three methods used successively (in randomly assigned order) among 77 doctors. This study was carried out in France and French-speaking regions of Belgium (Dr Bernard Dor) and Switzerland (in Geneva).

The French part of the study began in 2002 and in Belgium and Switzerland in 2003. The results seemed to confirm our view of the better acceptability of FACE than AUDIT and AUDIT embedded in a health questionnaire. Details of the results are given below in Section 14.5 and Tables 1 and 2. We now assume that FACE is equivalent to AUDIT in terms of screening properties but seems a preferable tool in French, Belgian and Swiss situations because of a much better acceptability to both doctors and patients[7].

14.2.3. Adapting training methods

The first experimental training sessions took place in June 2000. 120 GPs' from the Geneva canton participated in a half-day training on early detection and brief intervention (EDBI). The training was divided into four parts.

(1) Explanations of the results of the survey (see above) and the importance of ED and BI
(2) How to screen with AUDIT
(3) How to deliver a BI and when
(4) How to manage alcohol dependence after a positive screening result

We distributed materials to each participant. We did not undertake an evaluation of this training.

14.2.4. Adapting medical mobilization strategies

GPs from the Geneva canton are very often asked to participate in continuing medical education (as everywhere in Switzerland) and refuse to participate most of the time. To involve GPs, we contacted them through a health insurance network (REMED) which includes three quarters of the GPs who work in the canton.

In the recruitment phase of the study on the acceptability of the screening methods, we used telephone marketing with good results. Half the doctors approached agreed to participate. In some cases, we carried out personal marketing to recruit participants in this study.

14.3. Reframing Understandings of Alcohol Problems

The main objective here was to shift the social (and, therefore, medical) representations of alcohol-related problems from 'alcoholism' to 'hazardous drinking'. A previous attempt to do this occurred during the first years of the Swiss national campaign. During the first training session with GPs, the Swiss Geneva team faced a lot of resistance to the concept of risky drinking because doctors mainly focused alcohol-related problems and alcohol dependence.

We (Geneva team) also published an article in the Swiss French-speaking medical journal for GPs, "Médecine et Hygiène". In this article we developed the concept of excessive drinking and the community approach, including GPs, to alcohol problems.[8]

We contributed to two other articles published in a French GP journal (Revue du Praticien)

- Intervention brève en médecine générale ("Brief interventions in general practice") (2003)[9]
- Parler d'alcool reste un sujet tabou ("Talking about alcohol is still taboo") (2002)[10]

In conclusion, the Geneva team always kept in mind the necessity of reframing understandings of alcohol-related issues. In this regard, we should consider that the national campaign did much for this purpose. Unfortunately, no valid and reliable assessment has been carried out.

14.4. Choosing a Lead Organisation and Building a Strategic Alliance

Because we started our work after the beginning of the national campaign, we tried to utilise materials and ideas from it. *L'office fédéral de la santé publique* (OFSP) encouraged us to pursue our specific actions among GPs' in the canton of Geneva.

14.4.1. Main strategic alliances.

Funding institutions and authorities contributing to our project were:

- **National level** : *Office fédéral de la santé publique*
- **Cantonal level :** *Direction Générale de la Santé, Unité d'alcoologie des hôpitaux Universitaires de Genève*
- **Local level :** *Fondation Armand Slavic pour le développement de la recherche en alcoologie clinique*

Operational alliances were:

- **European level:** *Boire moins, c'est mieux,* Paris, France. *Société scientifique de médecine générale* (Scientific Society of General Practitioners), Brussels, Belgium;
- **National level**: *Swiss Society of General Practice, Swiss Society of Internal Medicine*
- **Regional level:** *Association des Médecins Genevois, Fédération Genevoise de prévention de l'alcoolisme, Unité d'alcoologie des hôpitaux Universitaires de Genève, Groupe des Enseignants en Médecine Générale de la Faculté de Médecine de Genève, Institut de Médecine Sociale et Préventive de la Faculté de Médecine de Genève.*

14.5. Demonstration Study (REPEX): collaboration with the French and Belgian teams

REPEX was a quantitative and qualitative study aiming to evaluate doctors' and patients' acceptance of three screening methods: AUDIT, AUDIT embedded in a health questionnaire (AUDIT-HQ), and FACE. The design allowed comparisons between 'real' and 'optimal' levels of screening, given the definition of "patients eligible for screening": aged 18 or more; not having had a consultation in the last 7 weeks. GPs participating in the study were asked to screen in a naturalistic way, i.e., for the AUDIT, with questionnaires at patients' disposal in the waiting room and a poster inviting them to fill it in; for the FACE, with an interview about alcohol during the consultation. If they worked with an assistant, the GP could encourage patients to answer the waiting room questionnaires but not actively help to complete them. During one week for each method, doctors had to note in a diary the age and gender of every patient seen, the reason for exclusion if any, the results of the screening test if the patient was eligible and had answered the questionnaire, the reason for not answering in the opposite case. Every participating doctor had to test the three methods in an order assigned at random and had two weeks rest between two test weeks.

This study was conducted also in France and in the French-speaking part of Belgium. Twenty-three (23) GPs participated in France, 23 in Belgium and 31 in Geneva. The results are summarised in Tables 10.2 and 10.3.

It is noticeable that the presence of a full-time assistant raises the levels of screening in the three countries - for instance, in Switzerland where this assistance is statistically linked with a much higher rate of screening with AUDIT (50.6% of usable questionnaires if there is a full-time assistant, versus 40.2 % if not, $p<0.0001$) and with AUDIT-HQ (36.6 % of usable questionnaires if there is a full-time assistant, versus 27.8% if not, $p<0.01$).

In Geneva, questionnaires were also given to the assistants. Twenty-one (21) answered a final questionnaire and most preferred self-administered questionnaires, for which their role was more active. Ten preferred AUDIT, 7 AUDIT-HQ and 6 FACE

FACE was the best screening mode in the three French-speaking countries. However, in the Geneva context it may be necessary to offer a choice of two screening instruments to the doctors (AUDIT, FACE).

14.6. Conclusions

Interesting findings emerged from the Phase IV WHO collaborative study in Switzerland. First, we trained about 150 GPs' to carry out EDBI. We also participated in an international study focused on the acceptability of screening instruments in routine conditions of general practice. Swiss GPs are not so different from Belgian or French colleagues even if practice conditions are different.

For the future, GPs have told us that prevention is now an important aspect of their work. and they asked us to globalise the preventive approach to major health risk factors such as alcohol, tobacco, overeating and lack of physical exercise. We are considering this request.

TABLE 14.1
REPEX: main results in the 3 samples : (a) patients

Patients samples			
	France	**Belgium**	***Geneva***
AUDIT	N= 1617 eligible 52.1 %	N= 768 eligible 60.9 %	N= 1593 eligible 41.7 %
HQ*	N= 1677 eligible 51.6 %	N= 679 eligible 54.3 %	N= 1595 eligible 45.6 %
FACE	N= 1779 eligible 48.8 %	N= 689 eligible 60.1 %	N= 1610 eligible 42.8 %
	France	**Belgium**	***Geneva***
AUDIT	31.1 % + help** 10.7 %	61.3 % + help** 13.0 %	71.4 % +help** 2.6 %
HQ*	22.7 % + help** 7.7 %	61.5 % + help** 7.9 %	64.6 % +help** 3.0 %
FACE	87.1 %	95.0 %	88.8 %
** + help : questionnaire completed with doctor's help			
% of eligible patients for whom usable questionnaires are available (errors in scoring)			
	France	**Belgium**	***Geneva***
AUDIT	41.8 % (1.2 %)	74.3 % (3.4 %)	74.0 % (2.0 %)
HQ*	30.4 % (5.6 %)	69.4 % (11.4%)	67.6 % (4.5 %)
FACE	87.1 % (21.6 %)	95.0 % (12.0 %)	88.8 % (8.5 %)
	$p< 10^{-8}$ ($p<10^{-8}$)	$p\ 10^{-8}$ ($p<10^{-4}$)	$p< 10^{-8}$ ($p<10^{-5}$)
Patients' opinions about the screening methods : % of patients agreeing with the opinion			
	France	**Belgium**	***Geneva***
Number of responders	AUDIT 102 HQ* 78 FACE 162	AUDIT 70 HQ* 55 FACE 82	AUDIT 227 HQ* 151 FACE 253
I was not disturbed by the questioning	AUDIT 87.2 HQ* 95.7 p=0.038 FACE 95.1	AUDIT 97.1 HQ* 94.9 NS FACE 91.5	AUDIT 95.6 HQ* 96.6 NS FACE 98.0
It invaded my privacy	AUDIT 49.0 HQ* 46.3 p<0.001 FACE 28.5	AUDIT 26.6 HQ* 28.1 NS FACE 25.9	AUDIT 37.6 HQ* 34.7 NS FACE 31.6
It made me speak of alcohol with my doctor	AUDIT 68.4 HQ* 64.4 p<0.007 FACE 49.7	AUDIT 56.5 HQ* 51.9 NS FACE 40.2	AUDIT 49.0 HQ* 37.8 p=0.10 FACE 45.2
The doctor gave me advice about my drinking	AUDIT 32.6 HQ* 33.8 NS FACE 43.4	AUDIT 38.1 HQ* 34.0 NS FACE 26.3	AUDIT 32.1 HQ* 23.3 p=0.07 FACE 35.5
I would accept to answer once a year	AUDIT 90.0 HQ* 92.2 p=0.003 FACE 77.6	AUDIT 98.4 HQ* 96.5 NS FACE 94.9	AUDIT 87.0 HQ* 89.7 p=0.085 FACE 92.8

*HQ = AUDIT embedded in a Health Questionnaire NS = not significant

TABLE 14.2
REPEX: main results in the 3 samples : (b) general practitioners

Doctors' opinions about the screening methods (# of doctors agreeing with the opinion).			
Questionnaire was intrusive	AUDIT 2 HQ* 3 NS FACE 5	AUDIT 4 HQ* 4 NS FACE 6	AUDIT 6 HQ* 0 NS FACE 9
Questionnaire scoring can't be made in routine	AUDIT 8 HQ* 9 p=0.014 FACE 1	AUDIT 2 HQ* 6 NS FACE 3	AUDIT 3 HQ* 6 NS FACE 1
My screening was as complete as possible	AUDIT 6 HQ* 5 p<0.001 FACE 17	AUDIT 16 HQ* 13 NS FACE 15	AUDIT 23 HQ* 16 p=0.68 FACE 22
Patients found questionnaire too long	AUDIT 1 HQ* 14 $p<10^{-6}$ FACE 0	AUDIT 2 HQ* 12 $p<10^{-4}$ FACE 1	AUDIT 11 HQ* 18 $p<10^{-4}$ FACE 1
Doctors' global impressions (# of doctors agreeing with the opinion)			
	France (N=23)	**Belgium (N=23)**	***Geneva (N=31)***
Preferred method	AUDIT 4 HQ* 1 FACE 17	AUDIT 4 HQ* 4 FACE 13	AUDIT 8 HQ* 4 FACE 18
Method possibly in line with medical routine	AUDIT 1 HQ* 0 FACE 13 More than one method 5	AUDIT 2 HQ* 3 FACE 10 More than one method 7	AUDIT 3 HQ* 3 FACE 12 More than one method 13"
A systematic screening could be achieved in routine	Yes 14 Yes with restrictions 7	Yes 14 Yes with restrictions 7	Yes 23 Yes with restrictions 7

*HQ = AUDIT embedded in a Health Questionnaire NS = not significant

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APPENDIX 14.1

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CHAPTER 15

CONCLUSIONS

Nick Heather

15.1. Scope of these Conclusions

It was made clear in Chapter 1 that the Phase IV research collaboration should be seen as a collection of similar studies, albeit sharing a common focus on a number of specified components, rather than as a single research design applied in different places. Unlike in previous phases of the *WHO Collaborative Project on Detection and Management of Alcohol-related Problems in Primary Health Care,* it is not possible here to pool data from different centres and form a composite data base for statistical analysis. Neither is it possible directly to compare or contrast findings from different participating countries to reach firm conclusions about the nature of the implementation process at a cross-cultural level, since these findings are only fully meaningful within the specific contexts of each country's health system, political organisation and socio-cultural background. For these reasons, this concluding section of the Report will be relatively short and readers looking for tangible conclusions with clear implications for practice should refer to individual country chapters.

Nevertheless, it is possible to advance a few broad generalisations regarding the collective experience of the Phase IV study and this will be attempted in this chapter. The main problems encountered in conducting the research and its limitations will first be considered before moving to its main achievements and issues requiring further research.

15.2. Problems and limitations

Roughly 20 years ago, Thom and Tellez[1] described the attempt to involve GPs in detecting and managing alcohol problems as "a difficult business" and the Phase IV study showed that this characterisation still applies today. Serious difficulties were encountered in several aspects of the research.

15.2.1. Attitudes of primary health care professionals

One of the central problems was in persuading PHC professionals to become engaged in the research. In all countries taking part, some GPs, practice nurses and members of other professional groups joined the research effort with commitment and enthusiasm and, indeed, made essential contributions to it; many others, however, did not. In several countries, difficulties were encountered in arranging the attendance of health professionals, especially GPs, at focus groups and other types of meeting and in obtaining their co-operation with completing questionnaires and other aspects of the research process. This occurred despite the fact that in many of the studies the principal investigators were themselves GPs. This undoubtedly increased the credibility and practical relevance of the study but was clearly insufficient to engender the full co-operation of those it sought to enlist in action research.

It is often pointed out that GPs and nurses are extremely busy people who have little spare time to devote to research and the Phase IV study was not, of course, the first to come across this problem[2]. It is also obvious that PHC professionals face demands on their time from many competing branches of health care and alcohol work may not be high in practitioners' priorities regarding this competition, as shown by the Phase III, Strand 1 study[3]. A third possible reason for lack of enthusiasm – that working with alcohol problems is not regarded as a legitimate part of medical practice – seems no longer to be generally the case[3], although it may have been partly true in some countries taking part in Phase IV.

This effort to engage PHC professionals was not helped by the publication during the Phase IV study of two articles by Beich and colleagues in a prominent medical journal[4,5]. These articles claimed to show that screening for excessive alcohol use in general medical practice "created more problems than it solved"[4] and "does not seem to be an effective precursor to brief interventions"[5]. The

methodology and conclusions of these articles have been severely criticised[6,7], the criticisms stemming mainly from the fact that the difficulties in screening reported applied only to the artificial situation of conducting an RCT of SBI and would not apply in routine practice. Whatever the validity of these criticisms and the replies to them by the authors of the studies, there is little doubt that these publications had some detrimental effect on efforts to promote screening for hazardous and harmful alcohol consumption in general medical practice and on the progress of the Phase IV study. It seems unlikely, however, that this damaging effect will be permanent, simply because of the overwhelming strength of the evidence supporting SBI and the necessity for screening if those patients at risk for alcohol-related harm but without obvious signs of such harm are to be identified.

If GPs are too busy to become involved in alcohol SBI or face too many competing priorities in their work, one solution is to turn to nurses for the delivery of SBI in routine practice, since nurses are by far the largest workforce in health services, are a relatively unexplored resource in the attempt to reduce alcohol-related harm[8] and are keen to expand their work to take on new challenges[9]. Nurses work in the front-line of PHC delivery in many countries and are in an excellent position to identify, advise and monitor hazardous or harmful drinkers[10]. Unfortunately, it seems that in some countries taking part in Phase IV the nursing profession has insufficient status *vis-à-vis* the medical profession to take up this role and it is to be hoped that this relationship will change in future in line with international changes in the role of nursing in delivering health services. More generally, it is possible that the Phase IV study tended to pay insufficient attention to involving a range of professionals groups other than GPs in the routine delivery of SBI – not only practice nurses but health visitors, dieticians, medical social workers, etc.. The precise nature of these other groups depends on the particular arrangements for health care in different countries but this may well be an area for development in future.

With regard to participation of PHC professionals in SBI research, the difficulties experienced in the Phase IV study clearly reflect a wider problem – attitudes to the inclusion of alcohol SBI in routine practice – that is precisely the topic of the study itself. Depending on the longer-term success of efforts to reframe understandings of alcohol problems and to enlist health professionals in strategic alliances to implement alcohol SBI on a widespread and enduring basis, future research in this area may face fewer difficulties than found in Phase IV.

15.2.2. Funding

Another serious problem in many participating countries was an inability to obtain necessary funding from national bodies for aspects of the Phase IV research. Thanks partly to the valuable support provided by the ECATOD project, this was less of a problem for the customisation component of the study but applied particularly to the demonstration project. In several countries well-constructed applications for funding were rejected, sometimes after several attempts with either the same or different institutions. While the effort was made to get round this problem in various ways, it severely restricted progress on this essential part of the study protocol.

Reasons for this failure to attract funding are unclear. It may be that funding organisations still favour conventional forms of research, like RCTs and randomised surveys, at the expense of action research and qualitative methods, which may be seen as "unscientific". At the same time, funders may not sufficiently appreciate the need for "translational research"[11], i.e., research aimed at translating research evidence into routine practice. Again, if true, it is to be hoped that these attitudes among funding bodies will change in future.

15.2.3. Lack of government support

A related problem was lack of support from governmental authorities for Phase IV research. Over the whole study, this was found to apply in some instances at all levels of government – local, regional and national. A specific facet of this lack of support was the difficulty found in persuading authorities to include alcohol SBI in health promotion campaigns and strategies and in plans for the regulation and reimbursement of PHC activity. This presumably reflects the long-standing failure by

governments to recognise the full extent of alcohol-related harm in comparison with that caused by illicit drug-taking and other health-damaging behaviours.

There are encouraging signs, however, that governments around the world are beginning to realise the potential benefits of widespread SBI in PHC as one effective means of responding to a rising tide of alcohol problems in their societies. This was partly seen in the Phase IV study in which, towards the end of the research, some governments of participating countries began to include alcohol SBI in national strategies to combat alcohol-related problems.

15.2.4. Economic evaluation

An important argument in attempting to persuade governments to support SBI is that it leads to tangible economic benefits for society – in other words, SBI produces cost-offsets in which the costs of delivering SBI in PHC are more than offset by reductions in costs of the future use of health services. While there is evidence that such cost-offsets do occur, this evidence comes mostly from the USA[12-15]. (There is also evidence that SBI is extremely cost-effective as a way of reducing morbidity and mortality in comparison with interventions in other areas of health care[16-18].) It was therefore thought important in Phase IV to examine the possibility of cost-offsets of SBI within the health system of each participating country, so that a convincing argument could be made to governments that SBI in PHC was deserving of national expenditure. It was recognised that a full and rigorous economic evaluation would be beyond the resources of most participating countries but it was hoped that a start could be made by at least calculating the costs of delivering SBI. To this end, the advice of an internationally recognised expert on health economics in the alcohol field was sought (Professor Christine Godfrey) and a guidance document was prepared by the Phase IV Co-ordinating Centre (see Chapter 2).

It is obvious that these intentions were not on the whole fulfilled and that the economic evaluation aspect of the research must be regarded as a limitation of the findings. With a few honourable exceptions, participating countries were not able to mount an economic study of the kind envisaged. The reasons for this were probably connected with the difficulty in enlisting the services of a local health economist in this highly specialised area of research and, once more, a failure to attract the required funding. Nevertheless, this topic is one that should be included in countries' further plans to gather government support for SBI in PHC after the end of the Phase IV study.

15.3. Achievements and implications for future research

The achievements of the Phase IV study are best considered under the headings of each of the 4 study components.

15.3.1. Customisation

It was in this component of the study that most progress was made. All participating countries succeeded in making adaptations to materials or procedures involved in SBI implementation – screening instruments and methods of delivery, the intervention package and its delivery, the SBI training programme – to suit the requirements of the local health system and socio-cultural setting. The use of focus groups, and to a lesser extent Delphi surveys, proved ideal for this purpose and, once again, the resources and training provided by the ECATOD project were invaluable in those countries that might not otherwise have been able to carry out a full customisation.

The success of the customisation component bore out the validity of the underlying rationale for the Phase IV study that widespread and routine implementation of SBI in each country represented a set of different challenges requiring unique solutions. In the preceding chapters examples abound where some particular characteristic of PHC or some other differential feature of the country called for the development of some special type of screening instrument, screening procedure, intervention materials or training module.

This is not, of course, to claim that SBI implementation in different countries has nothing in common. Indeed, building on the achievements of the Phase IV study, PHEPA plans to distribute a standardised SBI training module, using a "train the trainers" approach, that can be applied internationally. However, it is likely that this module will require further adaptations in varying degrees in each country that makes use of it. So too, Clinical Guidelines provided by PHEPA can be used as a summary of the evidence-base relevant to SBI and for guidance on general principles related to SBI methods but those interested in country-wide implementation will still have to choose among a range of options applying to the practical delivery of SBI on a day-to-day basis. The customisation component of the Phase IV study has provided local platforms on which these future developments can be soundly based.

15.3.2. Reframing

The reframing component can be included as an achievement of the study but must be judged as only a partial success. The notion of hazardous or "risky" drinking and it relevance to public health was introduced, typically without much difficulty, to a range of PHC professionals and other stakeholders in formal training programmes and in other ways. Probably the most immediate appeal of SBI for most professionals was the implications it had for early intervention and secondary prevention. However, it did not prove possible to devise a valid and reliable measuring instrument to record the cognitive and attitudinal changes that the reframing process aimed for, so there was little hard evidence that such changes had taken place. This again is something for future research to consider.

While some success was evident in the attempt to reframe understandings of alcohol issues among health professionals, this did not apply to similar aims among the general public. As originally envisaged at the beginning of the study, reframing among the general public requires sophisticated mass media campaigns, preferably targeted at specific population groups. Although progress was made in some countries in describing what such a campaign might eventually look like, a mass media campaign was simply outside the resources available to the investigators in nearly all participating countries. To shift the general public towards a broadened understanding of alcohol problems, and away from an exclusive focus on "alcoholism", would clearly require the support and financial backing of central government and would be a large undertaking. Nevertheless, if the benefits of widespread SBI implementation are to be fully realised, such campaigns would seem essential.

15.3.3. Lead organisation and strategic alliance

One palpable achievement of the Phase IV study was the establishment in each participating country of a lead organisation for the country-wide implementation of SBI that can serve as a base for future developments in this field of work. At the same time, all these lead organisations succeeded in gathering endorsements from a range of organisations and individuals that are highly relevant to the aims of the study in each country. Thus, at the very least, the foundations of a broad movement of support for the widespread, routine and enduring implementation of SBI in PHC have been laid down, as was the original intention of the study protocol.

15.3.4. Demonstration project

Although, as noted above, several countries were unable to obtain the necessary funding to mount a demonstration project or were late in doing so, some achievements in this component of the study were realised. In early discussions among Phase III investigators of the form Phase IV should take, the idea was mooted for a quasi-experimental study in each country in which an organised programme of SBI implementation in one or more areas would be compared with a matched control area(s) in which no formal implementation programme took place. After due consideration, this idea was rightly rejected as too complex and ambitious for a collaborative enterprise of the kind represented by Phase IV and the alternative idea of including a "demonstration project" as merely one component of the study, following the lead given by the proposal from the USA[19], was adopted. As it transpired, these demonstration projects came in various shapes and sizes, some controlled in various ways and some simply before-after designs, but all made some contribution to demonstrating how widespread implementation can be achieved in the circumstances of the country in question.

There probably is, however, a need for examples of the kind of quasi-experimental study originally envisaged. This is for at least two reasons. First, we need firm evidence that any particular method of achieving routine implementation is effective since this cannot be taken for granted. For instance, there is good evidence that clinical guidelines alone are insufficient for this purpose[20,21]. Although they are complex in design and expensive to run, the firm evidence required can only come from adequately controlled quasi-experimental or cluster RCT studies. Secondly, we do not have evidence yet that the beneficial public health effects of routine and widespread implementation of SBI in PHC can be detected at a community level in reduced levels of hazardous alcohol consumption and indices of alcohol-related harm in the population at large (e.g., morbidity and mortality statistics, drunkenness arrests, drink-driving offences, etc.). Again, such evidence could only be obtained from adequately controlled community-based studies.

15.4. End of the WHO Collaborative Project

The conclusion of Phase IV marks the end, after 25 years, of the 4 phases of research making up the *WHO Collaborative Project on Detection and Management of Alcohol-related Problems in Primary Health Care.* The overall aim of this programme of research was to reduce alcohol-related harm around the world by increasing the ability of PHC to detect and intervene against harmful and hazardous alcohol consumption. Phase IV took this line of research to its logical conclusion by acting directly to aim for a widespread, routine and enduring implementation of SBI in the PHC systems of a range of European countries together with Australia (a country that has always played a prominent part in the WHO Collaborative Project). So what remains to be done at the end of Phase IV?

First, while it was necessary to call a halt at some point to the Phase IV study and write-up the work of the study in this Report, the nature of Phase IV research means that it is, by definition, incomplete. As has been made clear several times in the Report, the iterative nature of action research implies a continuous and incremental process in which no definite end-point can yet be discerned. It is often pointed out that large-scale changes to routine practice, even those that are well-supported by basic research evidence, takes a very long time. A much-quoted historical example is that it took nearly 50 years and many deaths at sea from the discovery in 1747 that scurvy could be treated and prevented by supplementing diets with citrus fruits to the provision of a daily ration of lime or lemon juice to all men in the British Royal Navy in 1795[22]. More recently, and more relevantly to present concerns, in developed industrial countries it has taken 40 years for advice against cigarette smoking to be widely available in PHC and some would argue that even this accepted practice is not routinely found[23,24]. All the investigators involved in the Phase IV study are therefore continuing their efforts to achieve the study's primary goal in the full recognition that this will be a protracted and arduous task.

Secondly, the aims of Phase IV have been taken up on a wider international stage. As well as the majority of countries taking part in Phase IV, the EU-funded PHEPA includes a range of additional European countries (Czech Republic, Estonia, Germany, Greece, Ireland, Latvia, Lithuania, Netherlands, Poland, Romania, Slovakia, Sweden and Turkey)[25]. In addition, another WHO Collaborative Project is seeking to disseminate brief interventions in the PHC systems of developing countries and a start has been made in South Africa and Brazil[26]. Finally, as noted in Chapter 1, following on from Phase IV an international network was formed (INEBRIA) to share ideas and increase communication among researchers and practitioners interested in alcohol SBI[27]. Thus, in addition to its achievements in the participating countries, Phase IV has contributed to an international movement dedicated to reducing alcohol-related harm by achieving the widespread, routine and enduring implementation of screening and brief interventions for hazardous and harmful alcohol consumption, a movement that is steadily gathering momentum.

15.5 References

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