

PHEPA II

“Disseminating brief interventions on alcohol problems Europe wide”

**Grant Agreement n°2005309
and Amendment n°1, 2 and 3**

**Final Report
to the European Commission**

April 28th, 2009

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Presentation of the final implementation report

The current final technical implementation report is sent to the commission according to the conditions described in the Article I.5.1 of the amendment nº 3 to grant agreement nº **nº2005309** signed between the European Commission and the Department of Health of the Government of Catalonia as main partner and the associated partners.

The report has been organized in two parts:

- Part one, the final report itself, which describes the background and aims of the project, the organization and project work packages, the project outcomes and the conclusions.
- Part two includes annexed documents that present detailed information about the work that has been developed in the framework of the Phepa Project and each specific work package. These are further detailed in the table of contents. Generally the annexes include: list of project partners; meetings that have taken place over the project's period; products developed during the project (assessment tool and registry, internet resource centre) and dissemination activities.

1. Introduction and Background

Alcohol is the third greatest contributor to ill health after smoking and raised blood pressure.

The European Union is the region of the world with the highest proportion of drinkers and with the highest levels of alcohol consumption per population. 55 million European adults drink to dangerous levels

Hazardous and harmful alcohol consumption is a leading cause of disability and premature death in Europe, leading to considerable costs to the health care sector and harm to both adults and children.

BI in PHC are highly cost effective interventions to reduce hazardous and harmful alcohol consumption. At a cost of €1900 per year of ill-health and premature death prevented, primary health care brief interventions for hazardous and harmful alcohol consumption are amongst the cheapest of all medical interventions that lead to health gain.

More than 60% of adults visit their GP at least once a year and these visits represent an opportunity to identify individuals who may be using alcohol at hazardous and harmful levels and offer brief advice.

However, BI are rarely embedded in routine clinical practice by health care providers. Only a small proportion (1 in 80) of hazardous and harmful drinkers and (1 in 20) dependent drinkers are being identified in primary care. In addition few patient records (8%) contain any indication that alcohol use was recorded.

Primary care health workers often find it difficult to identify and advise patients in relation to alcohol use but those *General Practitioners who work in a supportive work environment* -one in which identification and counselling materials, training and support with difficult cases were all available -*feel more positive- secure and committed- about working with alcohol problems; advise an managed a greater number of patients* (Anderson et al 2004).

In view of the effectiveness and cost effectiveness in leading to health gain, financers of health services should provide funding for primary health care based identification and brief intervention programmes to reduce hazardous and harmful alcohol consumption.

The Project on Disseminating brief interventions on alcohol problems Europe wide (PHEPA II) has run for 35 months from 01/04/2006 to 28/02/2009. The current final technical implementation report covers the whole period.

The PHEPA II project has built on the scientific evidence for the effectiveness of different strategies in disseminating brief interventions and on the experience of PHEPA I, co-financed by the European Commission, which developed European recommendations, a European training programme and country wide dissemination strategies in 16 European countries.

Objectives



Phase I (2002-2005)

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

Phase II (2006-2009)

- To create a sustained European Platform of health professionals and brief interventions with representation in all partner countries,
- To develop an assessment tool and a registry to assess and document the current status of services for brief interventions in all partner countries
- To build an Internet based resource centre for health professionals, policy makers and providers, on brief interventions;
- To roll out a training programme throughout Member States to harmonize the skills of European health professionals
- To roll out clinical guidelines throughout Member States to harmonize the quality of brief interventions.

The project has also built on the experience of Phases III and IV of the World Health Organization's project on early identification and brief interventions in primary care, which included participants from 12 European countries.

The project has supported the [Council Conclusions of 5 June 2001](#) on a Community strategy to reduce alcohol-related harm, reiterated by the Council Conclusions on alcohol and young people of 2 June 2004 and the 2005 work plan for Community Action in the field of public health that includes the following topic area:

[The dissemination of best practice on early identification and brief interventions on alcohol problems within the general population.](#)

The project supported Member States in the implementation of advice by doctors or nurses in primary health care, an action area described as good practice and effective in the Communication from the EC: [EU strategy to support MS in reducing alcohol related harm](#)¹.

[Experience gained in Member States tends to show that improved enforcement of current regulations, codes and standards is essential to reduce the negative impact of harmful and hazardous alcohol consumption. Licence enforcement, server training, community- and workplace-based interventions, pricing policy \(e.g. reducing "two-drinks-for-one" offers\), coordination of public transport and closing times, advice by doctors or nurses in primary health care to people at risk, and treatment, are interventions that appear effective to prevent alcohol-related harm among adults and reduce the negative impact on the workplace. Education, information activities and campaigns promoting moderate consumption, or addressing drink-driving, alcohol during pregnancy and under-age drinking, can be used to mobilise public support for interventions.](#)

¹ COM(2006) 625 final

The action has been consistent with the recommendations of the:

- [WHO resolution WHA58.26](#) on Public-health problems caused by harmful use of alcohol, 2005²,
- The [Framework for alcohol policy in the WHO European Region, 2006](#)³:

Health professions need to play an active role and be supported by health authorities to implement screening and brief intervention for hazardous drinking.

- and the [resolution WHA61.4 on Strategies to reduce the harmful use of alcohol, 2008](#)⁴.

Early identification and effective treatment in health-care settings of alcohol-use disorders, including in patients with co-morbid conditions, is proposed as a target area within the health sector response to reduce associated morbidity and mortality and improve the well-being of affected individuals and their families.

The action included in this project is recommended in the Alcohol in Europe Report⁵.

X. Advice for hazardous and harmful alcohol consumption and alcohol dependence

Recommendations for advice

Relevant actor

| | |
|---|-----------------------------------|
| X.1. Integrated evidence-based guidelines for brief advice on hazardous and harmful alcohol consumption should be developed and implemented in different settings upwardly to harmonize the quality and accessibility of care. | (II) MS/region (III) Municipal |
| X.2. Training and support programmes to deliver brief advice on hazardous and harmful alcohol consumption should be developed and implemented in different settings upwardly to harmonize the skills of primary care providers. | (II) MS/region (III) Municipal |
| X.3. Resources should be made available to ensure the widespread availability and accessibility of identification and advice programmes for hazardous and harmful alcohol consumption and alcohol dependence. | (II) MS/region (III) Municipal |

² WHA58.26. Geneva, WHO, 2005. Available online URL: http://www.who.int/qb/ebwha/pdf_files/WHA58-REC1/A58_2005_REC1-sp.pdf

³ Framework for alcohol policy in the WHO European Region. Copenhagen, WHO, 2006. Available online URL: <http://www.euro.who.int/document/e88335.pdf>

⁴ WHA61.4. Geneva, WHO, 2008. Available online URL: http://www.who.int/qb/ebwha/pdf_files/A61/A61_R4-en.pdf

⁵ Anderson P and Baumberg B (2006). Alcohol in Europe. London: Institute of Alcohol Studies Available online URL: http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm

2. Aims and Objectives

The general aim of the Phepa II project was to build on the experience and products of PHEPA I and promote the dissemination of best practice on early identification and brief interventions on alcohol problems within the general population.

The project had five general objectives:

- The first general objective was to create a sustained European Platform of health professionals and brief interventions with representation in all partner countries, and with two meetings of the platform;
- The second general objective was to develop a model, an assessment tool and a registry to assess and document the current status of services for brief interventions in all partner countries from a health systems perspective;
- The third general objective was to build an Internet based resource centre for health professionals, policy makers and providers, on brief interventions;
- The fourth general objective was to roll out a training programme throughout Member States to upwardly harmonize the skills of European health professionals; and
- The fifth general objective was to roll out clinical guidelines throughout Member States to upwardly harmonize the quality of brief interventions.

In order to meet these objectives, seven work-packages were proposed as outlined below:

Work package n° 1: Coordination of the project

This work package has been led by the Department of Health of the Government of Catalonia and has involved all other partners. The main objective has been to ensure the timely delivery of all the project objectives outlined and the main tasks carried out have been: coordination with the all the associated partners of the project, to ensure timely delivery of all the project deliverables, to convene and host three meetings of the Platform, preparation of interim and final reports and management of all financial aspects of project.

Work package n° 2: Dissemination of the results

This work package has been led by the Department of Health of the Government of Catalonia and has involved all other partners. The main objective has been to ensure the adequate dissemination of all the project objectives outlined . The main tasks carried out have been the publication of model and (D2) and assessment tool (D3) and dissemination to the target audience, launch of registry of assessment tool in project website (D4) and alert the target, launch of Internet site Resource Centre in project website (D5) and alert the target audience, printing and sets of country based guidelines (D6), and dissemination to the target audience and printing and sets of country based training programmes (D7), and dissemination to the target audience.

Work package n° 3: Evaluation of the project

This work package has been led by the University of Northumbria and has involved all other partners. The main objective has been to report on the timely delivery of all the project objectives outlined and their deliverables indicating lessons learnt from the implementation of the project. Notes of successes and failures and any difficulties encountered with the implementation of the project, including experiences and difficulties in completion of the assessment tool and in

preparing and implementing the country based recommendations, guidelines and training programme, have been made during all project process.

Work package n° 4: European Platform

This work package has been led by the Department of Health of the Government of Catalonia and has involved all other partners. The main objective has been to create a sustained European Platform of health professionals and brief interventions with representation in all partner countries to promote the dissemination of best practice on early identification and brief interventions on alcohol problems within the general population. The meetings of the Platform have been used to inform the members of the objectives, work programme and deliverables of the project; to help manage the timely delivery of the project deliverables; to share experiences and the achievements in the different countries; and to identify problems of implementation and dissemination in the countries and, through the experience of other countries, to try to solve these problems. Agendas and background papers have been prepared for each of the meetings, and notes of the meetings disseminated to the partners within one month of the meeting. The meeting papers have been posted on the project website. The meetings have taken the form of plenary discussion and small group work.

Work package n° 5: Assessment tool and registry

This work package has been led by the Department of Health of the Government of Catalonia and has involved all other partners. The main objective has been to develop a model, an assessment tool and a registry to assess and document the current status of services for brief interventions in all partner countries from a health systems perspective. Based on a systematic review of the existing literature, a comprehensive model has been developed to describe the elements and conditions contributing to the implementation of effective brief intervention programmes. The domains identified in the model, have been adopted as the framework for the assessment instrument. The assessment tool has been tested for face and content validity.

Work package n° 6: Internet Resource centre

This work package has been led by the Department of Health of the Government of Catalonia and Institut d'Investigacions Biomèdiques August Pi I Sunyer (IDIBAPS) and has involved all other partners. The main objective has been to build an Internet based resource centre for health professionals, policy makers and providers, on brief interventions for hazardous and harmful alcohol consumption. The structure of the Resource Centre and its content has been based on the headings and content of the European recommendations and guidelines developed during PHEPA1: Describing alcohol consumption and alcohol related harm; Alcohol and health; Identifying hazardous and harmful alcohol use; Biochemical tests; Effectiveness of brief interventions; Costs and cost effectiveness of brief interventions; Assessing the harm done by alcohol and alcohol dependence; Managing alcohol dependence; and Implementing screening and brief intervention programmes. The Resource Centre will have three levels or tiers of information: level one, headline statements summarizing the current scientific evidence as key points and recommendations; level two, the key scientific findings that support the headline statements; and level three, more descriptive and detailed text to back up the key scientific findings. The Resource centre has been modelled on the highly successful existing Resource Centre for smoking cessation (www.treatobacco.net) developed by the Society for Research on Nicotine and Tobacco and the World Health Organization.

Work package n° 7: Country roll out

This work package has been led by the Department of Health of the Government of Catalonia and Institut d'Investigacions Biomèdiques August Pi I Sunyer (IDIBAPS) and has involved all other partners. The main objective has been to roll out a country based adapted and adopted version of

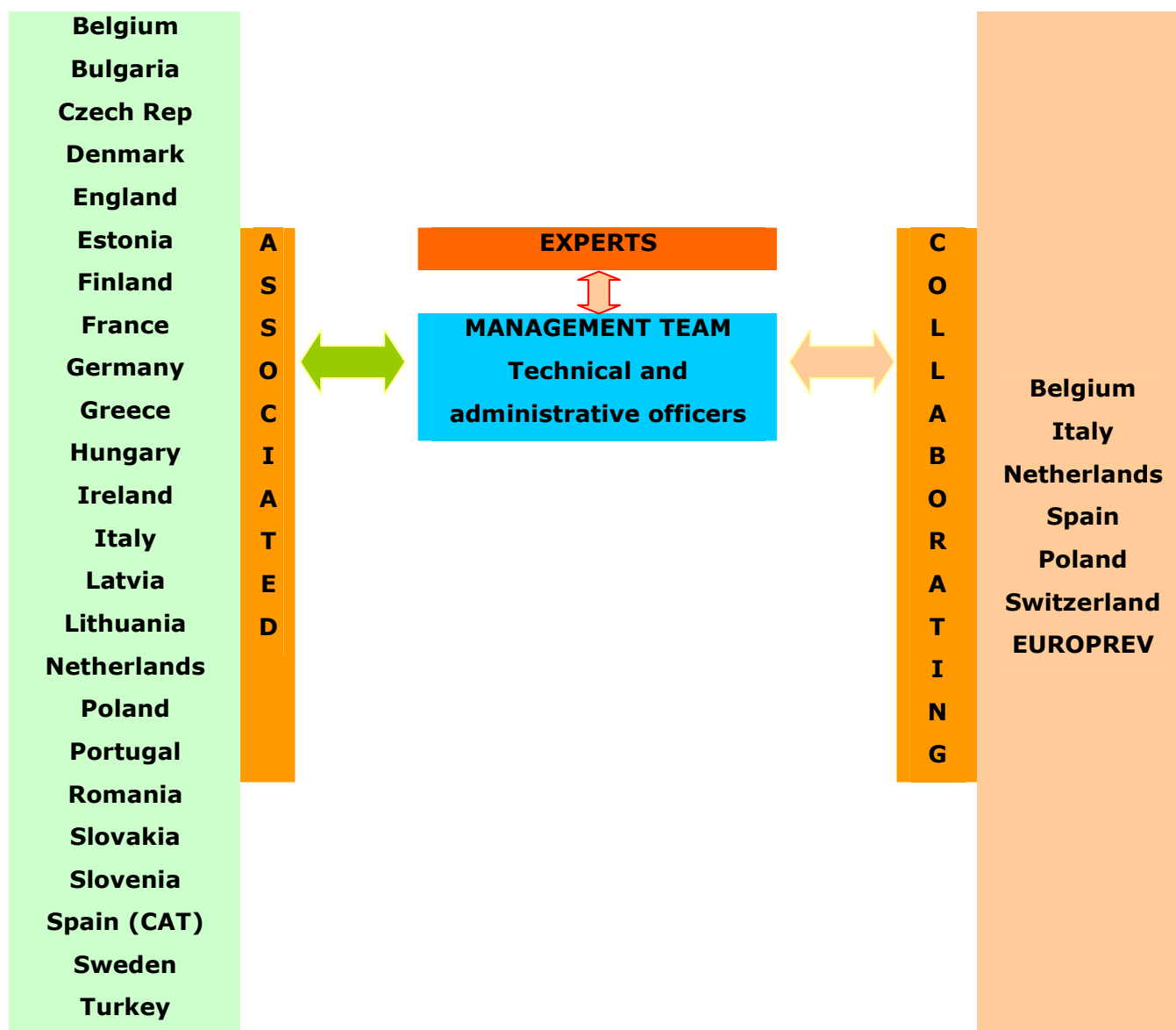
the European recommendations and guidelines developed in PHEPA1 throughout Member States to upwardly harmonize the quality of brief interventions; and to roll out a country based adapted and adopted version of the European training programme developed in PHEPA1 throughout Member States to upwardly harmonize the skills of European health professionals.

3. The Phepa Platform – Composition and roles

The PHEPA project has been managed by the Program on Substance Abuse of the Department of Health of the Government of Catalonia and has involved 25 associated partners and 10 collaborating partners. In addition, 9 experts acted as consultant partners to the network.

Many of the partners were involved in both the PHEPA I project and the Phases III and IV projects of the World Health Organization

See below the Phepa Platform framework



The platform comprised representatives of 25 (23 MS, 1 candidate and Switzerland) European countries, from governmental and non-governmental bodies, Public Health institutes, professional and scientific organizations representing primary care providers and academic Institutes of general and family practice.



The project management team, associated and collaborating partners and experts had different roles, tasks and responsibilities to carry out.

3.1. The main partner or the management team has been based at the Alcohol Unit of the Program on Substance abuse of the Directorate General of Public Health of the Department of Health of the Government of Catalonia and is responsible for: 1) the technical and financial management and co-ordination of the project; 2) for leading the development of the products; 3) for organizing the meetings and 4) for writing the reports for the Commission. Within the Unit a **project team** (4 people) was constituted and located in Barcelona (Spain). The technical officers, the technical and administrative assistants of the Project Team are part-time posts funded by the project.

| Name | Responsibilities | E-mail |
|-------------------|------------------------|--|
| Joan Colom | Project Manager | joan.colom@gencat.net |
| Lidia Segura | Project Coordinator | lidia.segura@gencat.net |
| Claudia Fernández | Administrative officer | claudia.fernandez@gencat.net |
| Encarna Moreno | Administrative officer | encarna.moreno@gencat.net |

3.2. The **25 associated partners** were responsible for: 1) creating the country based teams; 2) developing, together with the Country Based Team, the country strategy; 3) contributing to the roll out within their country of the products; 3) providing comments and feedback on the project products; 4) participating in all the meetings; and 5) preparing the country reports.

| Country | Organization | Contact Person |
|-------------|--|---|
| Belgium | Domus Medica | Pas, Leo |
| Bulgaria | Horizonti 21 Foundation | Alexieva, Daniela |
| Czech Rep | National Institute of Public Health | Sovinova, Hana |
| Denmark | The Research Unit of General Practice | Barfod, Sverre |
| Denmark | Danish Alcohol Policy Network- Alkoholpolitisk Landsrad | Damgaard Jensen, Johan |
| England | Northumbria University | Heather, Nick |
| Estonia | Estonian Temperance Union | Lauri, Beekmann |
| Finland | University of Tampere, Medical School | Seppä, Kaija |
| France | Institute for Secondary Prevention Promotion in Addictology | Michaud, Philippe |
| Germany | Zentralinstitut für seelische Gesundheit | Mann, Karl and Christoph von der Goltz |
| Greece | Hellenic Society for the Study of Addictive Substances | Diakogiannis, Ioannis |
| Hungary | Lokarmill Mentalhygienic Health Support Foundation | Sineger, Eleonora |
| Ireland | The Irish College of General Practitioners | Anderson, Rolande J |
| Italy | Istituto Superiore di Sanità | Scafato, Emanuele |
| Latvia | State Addiction Agency | Sarmite, Skaida |
| Lithuania | Vilnius Centre for Addictive Disorders | Subata, Emilis |
| Netherlands | The Netherlands Institute of Mental Health and Addiction | Lemmers, Lex |
| Poland | College of Family Physicians in Poland | Mierzecki, Artur |
| Portugal | Instituto da Droga e da Toxicodependência | Ribeiro, Cristina |
| Romania | Ministry of European Integration | Petcu, Cristian Adrian |
| Slovakia | Research Institute of Child Psychology and Pathopsychology | Nociar, Alojz |
| Slovenia | University of Ljubljana, Medical Faculty | Kolsek, Marko |
| Spain | Institut D'Investigacions Biomèdiques August Pi i Sunyer | Gual, Antoni |
| Sweden | Linköping Universitet | Bendtsen, Preben and Fredrik Spak |
| Turkey | Tobacco Free Life Association | Soydal, Tahir |

The members of each **country based team (CBT)** contributed to the development and dissemination of the country implementation strategy and to the roll out of the project products. All the members of the platform, including the CBT members, are listed in Annex I.

3.3. There were 10 **Collaborating Partners** , who also participated in guiding the execution of the project and its activities. They have been responsible for: 1) providing their expertise during the development of the products; 2) contributing to the country based team work; and 3) attending the platform meetings.

| Country | Organisation | Contact Person |
|-------------|--|--------------------|
| Belgium | General Medicine Scientific Society ASBL | Dor, Bernard |
| | EUROPREV | Godycki, Maciek |
| Italy | Società Italiana di Medicina Generale | Rossi, Alessandro |
| Italy | Community Research Centre Martignacco | Struzzo, Pierluigi |
| Italy | Azienda Sanitaria di Firenze | Allamani, Allaman |
| Italy | Alcohol Centre, University of Florence | Patussi, Valentino |
| Netherlands | Radboud University Nijmegen | Laurant, Miranda |
| Poland | PARPA | Brzozka, Krzysztof |
| Spain | Ministry of Health and Consumer Affairs | Lizarbe, Vicenta |

3.4. In addition, the project had 9 **European experts** who acted as consultants, providing input to decision making with regards to the project and content of products developed. Expert partners were expected to attend and contribute their personal knowledge and expertise to all general partner meetings. There was also active e-mail communication between the experts and the project management team on many Phepa products.

| Last name | Name | Institution |
|-----------|---------|--|
| Anderson | Peter | Public Health Consultant |
| Berner | Michael | Universitaetsklinikum Freiburg |
| Carral | Vanessa | IDIBAPS |
| Drenthen | Ton | Dutch College of GPs (NHG) |
| Drummond | Colin | Kings College London |
| Ergüder | Toker | Tobacco Free Life Association |
| Garmyn | Bart | Centrum Informatie en Documentatie |
| Jalocha | Dariusz | College of Family Physicians in Poland |
| Kuokkanen | Martti | Finnish Institute of Occupational Health |

4. Work process, timetable and meetings

4.1. Timetable

The timetable initially planned for the project was 24 months and it ended up, following the acceptance of 3 different amendments, as a 35-month project.

The reasons for this extension and for the discontinuity of some actions, can be attributed to a number of factors:

EC site:

- the changes occurring in the EC with the creation of EAHC
- the delay in the signature of the contract
- the changes in technical and financial officers responsible for the project
- the changes in monitoring tools (financial) and guidelines in the final balance payment
- the lengthy bureaucracy of the amendment acceptance process (including loss of documentation)

Main partner site:

- maternity leave of the administrative assistant
- study leave of supporting staff
- miscalculation of the tasks that could be covered by the human resources available

Associated partner site:

- changes in institution names and
- discontinuation of some communication

See in the tables below an overview of the rescheduled timetable due to the 2 extensions accepted:

| | 2006 | | | |
|-------------------|---------------------|--------------------------------------|------------------------|-------------------------|
| Initial timetable | April Starting date | June 1 st meeting Tallinn | Oct Contract signature | Nov 1 st pay |

| | 2007 | | | | 2008 | |
|-------------------|--|-------------------------------------|------------------------------------|--------------------------------------|--------------------|------------------|
| Initial timetable | March 1 st amend 1 st ext:9-month 31/12/08 | June 1 st amend approved | July 2 nd amend request | Oct 2 nd meeting Istanbul | Nov Interim Report | March Final Date |

| | 2008 extension | | | |
|---------------------------------------|-------------------------------------|--|--|--|
| 1 st extension on 9 months | June 2 nd amend approved | | | 31 st Dec Final Date Dec 3 rd meeting Prague Amend |

| | 2009 extension | |
|---------------------------|---------------------------------------|-----------------------|
| 2nd extension on 2 months | 28 th Februar y Final date | 30 April Final report |

Authorization to start the action in April 2006 was requested to be able to organize the 1st International Meeting of PHEPA II in Estonia (Tallinn) on 19th - 20th June 2006 in order to avoid as much as possible discontinuity of action between PHEPA I and PHEPA II which was applied for on 15th April 2005 but the contract not signed until 11th Oct 06.

The time between authorization to start the action in April 2006 and the contract signature (11th Oct 06) and first payment (Nov 06), meant that at the end of the first year of the project progress made was not as expected according to the global time plan and forced us to request in March 2007 a first amendment to the EC Commission for the 9-month extension without extra-funding and to prolong our PHEPA Project until the 31st of December 2008. The terms of the amendment also included requesting permission to postpone the preparation of the interim report until the 31st September of 2007 and to organize a 3rd Meeting Platform. All terms were agreed by the EC Commission on 12th July 2007.

Later on it took almost one year, until June 2008, for the EC to approve a 2nd amendment requested on 17th July 2007. Again, this 1-year delay caused an enormous discontinuity in the development of the main work packages since it included permission to move budget from one associated beneficiary to another to facilitate the development of WP 6 ("internet resource centre") and to transfer budget from staff to subcontracting category to achieve better quality in the final results of the WP 5 ("assessment tool and registry") and WP 3 ("evaluation").

Following the delivery and acceptance of the interim report on the 30th November 2007, in the subsequent year and a half the work produced by PHEPA finally moved ahead smoothly according to the initial plans.

Some final very last moment 3rd amendment on 3rd Dec 2008 including a 2 month extension until 28th of February and to move specific amounts from one heading to another according to partners' needs.

The general final development of the project and its time schedule over the course of 35 months can be seen at a glance in the following table:

4.2. Project meetings

Throughout the duration of the project, work package planning and product development was supported by collaborative effort of the entire project partners. This was achieved through a series of meetings, where overviews of progress were presented and larger scale decisions were discussed and made.

4.2.1. General Platform meetings

Three Platform meeting have been organized. The agendas, minutes and list of participants are detailed in Annex 2 and also in the project website.

The **1st meeting took place on 19th and 20th June 2006 in Tallinn (Estonia)** and was organized in collaboration with the Estonian partners, Tamara Janson and Lauri Beekmann of the Estonian Temperance Union with the following objectives:

- Get to know each other (especially new partners)
- Introducing the project and its objectives
- Summing up the achievements of PHEPA I, and building on its experience and products
- Discussing the elements of the project
- Sharing experiences
- Achieving a strong involvement of all the partners

Brief summary of participants:

| Total participants | Associated Partners | Collaborating Partners | Experts | Management Team |
|--------------------|---------------------|------------------------|---------|-----------------|
| 30 | 23 (92%) | 3 (30%) | 1 | 3 |

The **2nd meeting took place on 9th-10 October 2007 in Istanbul (Turkey)** and was organized in collaboration with the Turkish partners, Tahir Soydal and Toker Erguder of the Tobacco Free Life Association with the following objectives:

- Introduce country experiences and achievements
- Debate and partner inputs on implementing the training programme at the country level
- Debate and partner inputs on implementing the guidelines at the country level
- Discussion on background papers.
- Updating on administrative and financial issues for the interim report
- Introducing the European Alcohol Policy conference plans and the phepa input
- Updating and discussing of deliverables

Brief summary of participants:

| Total participants | Associated Partners | Collaborating Partners | Experts | Management Team |
|--------------------|---------------------|------------------------|---------|-----------------|
| 36 | 20 (80%) | 5 (50%) | 7 | 4 |

The **3rd meeting took place on 4-5th December 2008 in Prague (Czech Republic)** and was organized in collaboration with the Czech partner Hana Sovinova of the National Institute of Public Health with the welcome words of Dr. Milan Bořek, the director.

The meeting objectives were:

- Updating on country experiences and achievements
- Wrap up on the deliverables of the project and the things to be done until the end of the project
- Evaluating the project
- Clarifying the final financial aspects to be done until the end of the project
- Debate on next steps

Brief summary of participants:

| Total participants | Associated Partners | Collaborating Partners | Experts | Management Team |
|--------------------|---------------------|------------------------|---------|-----------------|
| 24 | 13 (52%) | 4 (40%) | 4 | 3 |

4.2.2. Country based team meetings

Country based teams were committed to meet twice in order to plan, implement and monitor the country roll out of training manual and clinical guidelines. In the country reports more details can be found but see below for a general overview of some the meetings supported by the project.

| Country | Date | Objectives | Participants |
|----------------|--------------------------------|-------------------------|--------------|
| Bulgaria | 11-12 th April 2007 | Constitution of the CBT | 8 |
| | Dec 2008 | Coordination | 3 |
| Czech Republic | 16 Dec 2007 | Constitution of the CBT | 7 |
| | 19 Sept 2009 | Coordination | 11 |
| England | 10 Dec 2008 | Coordination meeting | 3 |
| Estonia | Jan 2008 | Constitution of the CBT | 3 |
| Germany | 20 Sept 2007 | Constitution of the CBT | 6 |
| Ireland | 23 Nov 2007 | Constitution of the CBT | 7 |
| | 20 August 2008 | Coordination | 7 |
| Lithuania | 10 October 2008 | Coordination of the CBT | 7 |
| Poland | 25 Sept 2007 | Constitution of the CBT | 9 |
| | 18–19 Oct 2008 | Coordination | 6 |
| Slovakia | 24-27 Oct 2008 | Constitution of the CBT | 8 |
| | 21-24 Nov 2008 | Coordination | 8 |
| | 12-15 Dec 2008 | | 15 |
| Spain | 11 July 2008 | Constitution of the CBT | 7 |
| | 20 Jan 2009 | Implementation | 7 |

5. Project development and deliverables

Over the 35 months, the Phepa platform and management team have been working actively on the work packages and deliverables planned, resulting in the series of products described below. Phepa coordination has been facilitated by using a single e-mail address phepa@gencat.cat that allowed multiple users and accesses.

5.1. WORKPACKAGE 4: European Platform (See Annex 1)

The Platform representatives in all partner countries have met twice throughout the duration of the project, once in year one, and once in year two. The purpose of the Platform will be to share and document experience, and to identify strengths and weaknesses of the different country approaches to disseminating brief interventions and to promote the dissemination of best practice on early identification and brief interventions on alcohol problems within the general population.

The platform has been composed of a total of 88 professionals and the exact numbers and composition of the country varies from country to country from one member to a maximum of 9 members. The recommended representation comprised members of 4 different types of organizations: Governmental, Non-governmental, health professional organizations and/or groups and scientific organizations and/or groups. See below the members of the platform by country and by type of organization.

| Country | Platform Members | Gov | Non-Gov | Health Prof Org | Scientific Org |
|----------------|------------------|----------|---------|-----------------|----------------|
| Belgium | 6 | 2 | | 2 | 2 |
| Bulgaria | 3 | 1 | 2 | | |
| Czech Republic | 2 | 1 | | 1 | |
| Denmark | 4 | 2 | | | 2 |
| England | 3 | | | 1 | 2 |
| Estonia | 3 | | 3 | | |
| Finland | 4 | 2 | | | 2 |
| France | 1 | | | | 1 |
| Germany | 9 | | | | 9 |
| Greece | 2 | | | 2 | |
| Hungary | 1 | | | 1 | |
| Ireland | 7 | 1 | 1 | 5 | |
| Italy | 8 | 3 | | | 5 |
| Latvia | 1 | 1 | | | |
| Lithuania | 2 | | | | 2 |
| Netherlands | 8 | 5 | | 2 | 1 |
| Poland | 3 | 1 | | 2 | |
| Portugal | 3 | 3 | | | |
| Romania | 1 | 1 | | | |
| Slovakia | 1 | | | | 1 |
| Slovenia | 2 | | | | 2 |
| Spain | 6 | 5 | | | 1 |
| Sweden | 6 | 1 | | | 5 |
| Turkey | 2 | | | 2 | |
| | 88 | 29 (33%) | 6 (7%) | 18 (20%) | 35 (40%) |

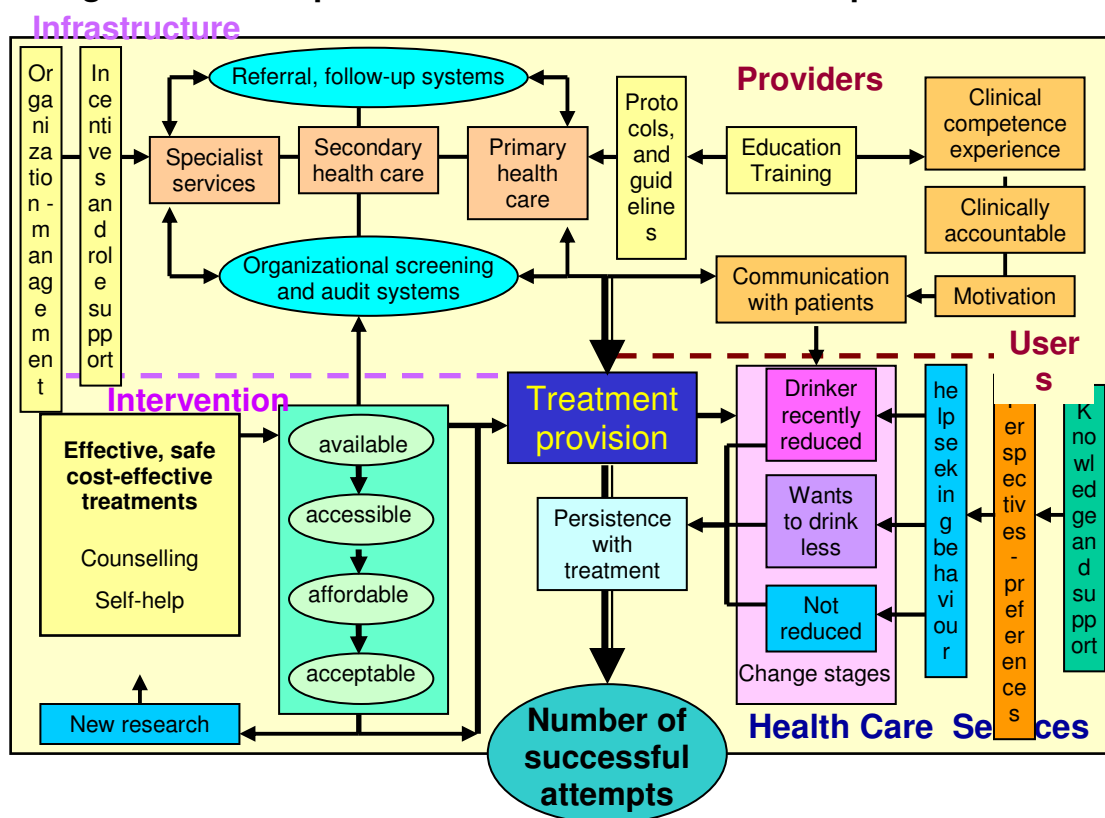
5.2. WORKPACKAGE 5: Assessment tool and registry

A model, an assessment tool and a registry to assess and document the current status of services for brief interventions in all partner countries from a health systems perspective has been developed.

5.2.1. The **model** (see the figure below) is based on systematic reviews of the literature and describes all the elements that are required for effective dissemination of brief interventions within a health care systems perspective including the domains of

- organization of health care,
- support for providing brief interventions,
- availability of brief interventions,
- provision of effective brief interventions by health care providers and
- uptake of effective brief interventions by the general population.

Integration of components in the health service and practice domains



5.2.2. The **tool** was developed based on the final model aimed at documenting the current status of brief interventions in each of the partner countries, identifying strengths and limitations in the five health care system domains.

It is a management tool, not a scientific tool, and has taken into account the feedback from the different countries and it will be useful to monitor the country development.

It is designed to:

- Provide a baseline description of services for managing hazardous and harmful alcohol consumption, identifying areas where services may require development or strengthening;
- Provide a mechanism for monitoring service provision over time;
- Allow sharing of information and examples of practice; and
- Provide a mechanism for coalitions or partnerships to discuss and have a shared view on services for managing hazardous and harmful alcohol consumption.
- It is primarily intended to help service development within countries; it is not to compare one country with the other

The tool consists of a questionnaire and some template documents that need to be completed for certain questions.

- **Development of the tool**

The questionnaire is an adaptation of a tool to assess the available services for smoking cessation at the country or regional level first developed in 2003. The start point of this tool was based on the available World Health Organization questionnaires and enhanced in three phases by seeking specific input from a relevant and wide set of experts. The development included a focus group methodology and an examination by a European expert panel. The feasibility of implementing the tool was assessed in two phases by 14 individuals, and piloted in 18 countries. The main sections were reduced to its current form, and ambiguous questions were removed or clarified (for a detailed explanation on the developmental process see: Anderson, 2006). The assessment tool on smoking cessation was adapted for the services for the management of hazardous and harmful alcohol consumption on the primary health sector by Peter Anderson in 2004 with the assistance from the partners of the Phepa project⁶.

- **Description of the tool**

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

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

⁶ The assessment tool questionnaire can be found on:
<http://www.gencat.cat/salut/phepa/units/phepa/html/en/dir360/index.html>

- **Data collection**

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

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

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

The information gathered has helped to have a general overview of the country situation and to compare the countries according to the different variables. The final questionnaire can be seen in Annex 3.

5.2.3. The general results and the results in each country, once re-scaled and analyzed, have been placed in the report on the **registry of Europe wide practice** (see Annex 3) to allow a general overview and sharing of experience from country to country in the different topics covered by the tool. The registry allows us, for example, to compare the previous and current situation in the different topics.

The main conclusions of the report on "what need to be done" are:

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

SUMMARY

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

5.3. WORKPACKAGE 6: Internet resource centre

During the project it has been created and promoted the **use of an Internet based resource** centre for health professionals, policy makers and providers, on brief interventions providing information in the domains of effectiveness, cost effectiveness, policy, epidemiology and evaluation.

Within the PHEPA website, a database has been developed covering the evidence for brief interventions, modelled on the treatobacco.net database:

<http://www.treatobacco.net/home/home.cfm>

The database includes six main headings and several subheadings. It is structured as follows:

1. Health effects
 - a. Social well being
 - b. Reduced work performance
 - c. Intentional and unintentional injuries
 - i. Violence
 - ii. Drinking and driving
 - iii. Injuries
 - iv. Suicide
 - d. Neuropsychiatric conditions
 - i. Alcohol dependence
 - ii. Anxiety and sleep disorders
 - iii. Depression
 - iv. Nerve damage
 - v. Brain damage
 - vi. Cognitive impairment and dementia
 - e. Gastrointestinal, metabolic and endocrine conditions
 - i. Liver cirrhosis
 - ii. Pancreatitis
 - iii. Type II diabetes
 - iv. Overweight
 - v. Gout
 - f. Cancers
 - i. Gastrointestinal tract
 - ii. Liver
 - iii. Breast
 - iv. Other cancers
 - g. Cardiovascular diseases
 - i. Hypertension
 - ii. Stroke
 - iii. Arrhythmias
 - iv. Coronary heart disease (CHD)
 - h. Cardiomyopathy
 - i. Immune system
 - j. Lung diseases
 - k. Post-operative complications
 - l. Skeletal conditions

- m. Pregnancy
- n. Reproductive conditions
- o. Total mortality

2. Identifying hazardous and harmful alcohol consumption

- a. AUDIT
- b. SHORT AUDIT
- c. CAGE
- d. ASSIST
- e. FAST
- f. AUDIT AND ALCOHOL DEPENDENCE
- g. TWEAK AND T-ACE
- h. LABORATORY MARKERS

3. Efficacy of interventions

- a. OVERALL EFFECTIVENESS
- b. EFFECTIVENESS IN MEN AND WOMEN
- c. DOSE OF BRIEF INTERVENTIONS
- d. BRIEF INTERVENTIONS IN YOUNG PEOPLE

4. Cost effectiveness

5. Implementing brief interventions

- a. SUPPORT AND RESOURCES
- b. PROFESSIONAL'S WORKLOAD
- c. ENVIRONMENTS
- d. RELEVANT PROFESSIONALS
- e. SERVICE USERS
- f. PROVIDERS
- g. SERVICE USER POPULATION
- h. ATTITUDES TOWARDS SCREENING AND INTERVENTION

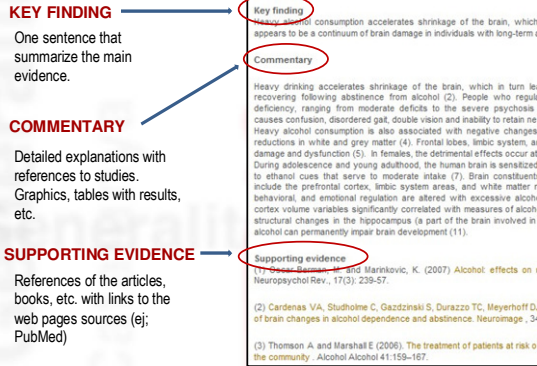
6. Supportive alcohol policy measures

- a. Information and education
- b. Health sector response
- c. Community programmes
- d. Drink-driving policies
- e. Addressing the availability of alcohol
- f. Addressing the marketing of alcohol beverages
- g. Pricing policies
- h. Drinking environments
- i. Reducing the public health impact of illegally and informally produced alcohol

The complete database is included under the heading “**evidence on alcohol**” of the Phepa website available at: <http://www.phepa.net>. Under each heading, there is a list of key findings. For each key finding, there is a brief commentary and links to supporting evidence.

Online database

THE INFORMATION IS ORGANIZED AS FOLLOWS:

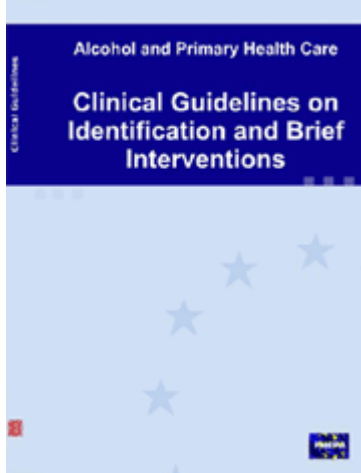


5.4. WORKPACKAGE 7. Country roll out





5.4.1. Country roll out of country based recommendations and guidelines

European Recommendations were developed in the PHEPA I project and can be downloaded from the project website.

Clinical Guidelines_ (3.5 Mb)



Summary

| | |
|-------------|---|
| Netherlands |  |
| Finland |  |
| Germany |  |
| Italy |  |
| Portugal |  |
| Spain |  |
| Sweden |  |

The CG Chapter by Chapter

- [Describing alcohol consumption and alcohol related](#)
- [Alcohol and health](#)
- [Identifying hazardous and harmful alcohol use](#)
- [Effectiveness of brief interventiions](#)
- [Costs effectiveness of brief interventions](#)
- [Implementing identification and brief programmes](#)
- [Assessing the harm done by alcohol and dependence](#)

2000 copies of the Clinical guidelines were printed and over 1200 have been distributed around Europe during the Phepa II period to all partners and also through all conferences were Phepa has participated.

The CG is also the most downloaded document from the website:

-2006: 12,229

-2007: 668

-2008: 379

In Phepa II, in order to upwardly harmonize the quality of Brief Interventions, associated partners have been working in adapting and adopting the development and implementation of Clinical guidelines in their country.

The main actions carried out by each country partner for the integration of interventions for hazardous and harmful alcohol consumption in primary health care settings are explained in the country report available in Annex 4.

The recommendations have been already translated to [Catalan](#) , [Czech](#) , [Greek](#) , [Polish](#) , [Slovak](#) , [Slovene](#) and [Spanish](#). All of them have been posted on the website.



The roll out activities vary from country to country and are described in detail in the country reports (See Annex 4). Only 4 countries (France, Turkey, Latvia and Romania) have not done any roll out activities. The table below provides a brief summary of what has been done in the countries:

| Country | Translation/ Adaptation of the CG | Country roll out |
|----------------|--|--|
| Belgium | Partially adopted together with other National Guidelines. | Guidelines are utilized as training adjunct in a programme for health behaviour change and dealing with psycho social problems. Meetings at regional and national level PHEPA. |
| Bulgaria | Not foreseen | Some preparation meetings have taken place but no major progress |
| Czech Republic | Adopted and adapted In the Czech Republic the | Clinical guidelines have been submitted to the professional societies of psychiatrists, GPs’ and Public Health |

| | | |
|---------|---|---|
| | existing Law states in article § 19 that health care professionals are within the framework of their profession obliged to provide patients who consume alcohol with EIBI. CD-Rom and website . | workers to be recommended as evidence based instruments for EIBI. |
| Denmark | PHEPA has influenced the publication of a guideline for handling alcohol problems in general practice. Planned to be published by the end of March 2010. | Necessary to build up an organisation which can educate MI and SBI trainers on a larger scale. The contribution from municipalities and training and motivating 300 "new" GP will be essential. |
| England | The National Institute for Health and Clinical Excellence (NICE) was asked by the Department of Health to develop public health guidance aimed at the prevention and early identification of alcohol-use disorders in adults and adolescents. | A Programme Development Group (PDG) has been established to review the evidence and issue guidance and it is chaired and composed of two members of Phepa Team. |
| Estonia | Not foreseen | Some preparation meetings have taken place but no major progress |
| Finland | Partially adopted together with other National Guidelines. | Successful wide regional implementation project funded by the Ministry of Social Affairs and Health have been carried out. |
| Germany | Partially adopted and adapted in other existing National Guidelines and guides. | In collaboration with actions of the <i>Bundeszentrale für gesundheitliche Aufklärung</i> , the <i>Deutsche Gesellschaft für Suchtmedizin</i> und Suchttherapie, the <i>Deutsche Gesellschaft für Psychiatrie, Psychotherapie</i> und Nervenheilkunde and the <i>Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin</i> . 5th June 2007 PHEPA was presented at the Conference of the German Centre for Addiction Issues by Dr.Thomas Hintz |
| Greece | Adopted and adapted The clinical guidelines produced by PHEPA are the only ones existing in the country. Website | Planned for 2008 but in specific settings: psychiatry residents, military medical settings, etc. |
| Hungary | Partially adopted by the National Institute of Alcoholology and Addictology | Plans for implementation were stopped in the spring of 2008, when the National Institute of Addictology and similar |

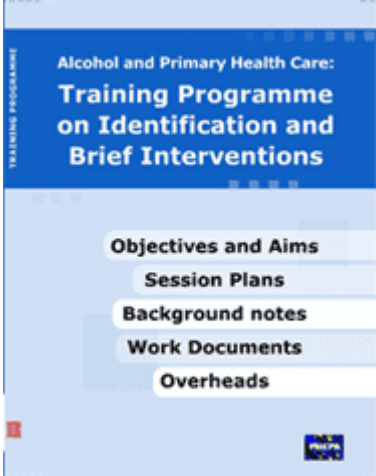
| | | |
|-------------|--|---|
| | | centres were closed down by the Government. Since 31 st May, 2008, the Phepa team activities in Hungary have been done from a the Budakeszi TÁMASZ mainly in collaboration with GP. |
| Ireland | Partially adopted by ICGP guidelines as part of the overall alcohol project. The Phepa Guidelines and training documents are available in Ireland on the ICGP website. | It is estimated that over 75% of Irish GPs are members of the ICGP. The guidelines have been used in all ICGP training events on alcohol and will be updated in the next two years. |
| Italy | Partially adopted together with other National Guidelines | Inclusion in the National Strategy |
| Lithuania | Not foreseen | Some preparation meetings have taken place but no major progress |
| Netherlands | The Dutch Ministry of Health and the PHEPA country team have taken the initiative to form the Partnership (started in 2005) Early Identification Alcohol Problems between the Trimbos Institute, the NIGZ, the Dutch College of General Practitioners, IQ Healthcare (Radboud University Nijmegen) and the Dutch Institute for Healthcare Improvement. | The partnership has developed a number of different products based on the PHEPA-guidelines and training programme. Priorities are implementation of screening and brief interventions in primary health care and implementation of screening and brief interventions in hospital settings. For both priorities task groups are formed. Below we will give a short description of the objectives, activities and expected results of the two task groups. |
| Poland | Adopted and adapted Website | Included in the procedures of the College of Family Physicians and in the contract with National Health Fund in primary health care. It is financed by National Health Fund. The way of financing - as a service due under the contract for primary health care (similar to the smoking prevention program). |
| Portugal | Adopted and adapted by the National Program of Alcohol Related Problems in his project on "Early Identification and Brief alcohol Intervention in Primary Health Care" | Structural changes in Primary Health Care Services and in the institutional and governmental responsibilities on alcohol have slowed down the process but it will continue in the coming years. |
| Slovakia | Adopted and adapted for | Has been partially funded by the Anti |















| | | |
|----------|--|--|
| | <p>practical use</p> <p>Website</p> | <p>Drug Fund. Already adopted by psychologists but others have yet to be involved.</p> |
| Slovenia | <p>Adopted and adapted as Clinical guidelines for the management of alcohol-related problems for Slovenian PHC teams</p> <p>Paper and website</p> | <p>The management of implementation of EIBI falls to the Department of Family Medicine at the Medical faculty, University of Ljubljana in collaboration with the Ministry of Health Slovene Family Medicine Society and CINDI Slovenia.</p> |
| Spain | <p>Adapted in Catalunya</p> <p>Available at website in Catalan</p> <p>Also adopted and adapted by PAHO Available at Spanish</p> <p>Partially adopted by the Ministry of Health</p> | <p>Included in the Governmental Plan, in the health plan and in other relevant strategies.</p> <p>the “prevention of problems derived from alcohol” was included in the 1st Conference on Prevention and Promotion of Health in Clinical Practice was held in Madrid, June 2007. A group of experts formed by professionals working in the National Health System and who were proposed by the Scientific Societies, the 17 Autonomous Communities and the Ministry of Health and Consumer Affairs drew up a report in which are compiled a series of key points and recommendations which may serve as a base for the development of preventive actions in clinical practice, especially in primary healthcare and other ambits of action. They could also be of benefit to people who are responsible for designing policies, administrators.</p> |
| Sweden | <p>Short version of the clinical guidelines in Swedish has been offered to governmental organisations for further distribution and has helped incitement to further discussion in Sweden about the importance of alcohol preventive measures in PHC.</p> | <p>Formal workshops and meetings with Governmental institutions were held in 2006 and with all important stakeholders in 2007. A similar meeting will be held in 2009.</p> |

5.4.2. Country roll out of country based training programmes

A training programme was developed in the PHEPA I project and can be downloaded from the project website.

Training Programme_(0.8 Mb)



| | Summary | Slides |
|--------------------|---|---|
| Netherlands |  |  |
| Finland |  |  |
| Germany |  |  |
| Italy |  |  |
| Portugal |  |  |
| Spain |  |  |
| Sweden |  |  |

In order to upwardly harmonize the skills of European health professionals, associated partners have been working towards adapting and adopting the uptake of training in their country, based on the Training Program developed in the PHEPA I project.

In the PHEPA I project, 2000 copies of the Training Manual were printed and over 1000 have been distributed around Europe.

The Training Manual downloads from internet:

-2006: 1,365

-2007: 89

-2008: 178

The main actions carried out by each country partner for the integration of interventions for hazardous and harmful alcohol consumption in primary health care settings are explained in the country report available in Annex 4.

The training programme has been already translated to [Czech](#), [Italian](#), [Polish](#), [Slovak](#), [Slovene](#). All of them have been posted on the website.



Again, the roll out activities vary from country to country and are described in detail in the country reports (See Annex 4). Only 4 countries (France, Turkey, Latvia and Romania) have not started any action toward the country roll out. In the table below there is a brief summary of what has been going on in the countries:

| Country | Translation/ Adaptation of the TM | Country roll out |
|----------|-----------------------------------|--|
| Belgium | Partially adapted and adopted | Phepa training materials are used as background for trained teachers who meet twice a year in the college to discuss application in training in their region. Adapted power point presentations have been developed for this use. Training materials are updated and will be displayed on the website (current website is being reworked for beginning 2009). There are plans to include EIBI training on alcohol in the undergraduate medical curriculum. |
| Bulgaria | Partially adapted | Trainings took place 19-21 Jan 07 with 16 participants and June |

| | | |
|----------------|--|--|
| | | 2008 |
| Czech Republic | CD-Rom and website | Several trainings have been done during the Phepa project. 29 Nov 2006 -17 part 19 Sept 2007 -10 part 23/30 Sept 2008 – 15 part 6/27 Nov 2008 – 15 part |
| Denmark | Partially adapted | The Zealand Region, one of five regions in Denmark, has trained GPs and their staff, primarily nurses, in brief intervention and motivational interviewing in the regular CME courses. |
| England | Partially adopted | Training program nationwide The Department of Health is promoting a training programme developed in earlier work by the PHEPA2 team for England. This provides training in the use of the How Much Is Too Much? pack. |
| Estonia | Partially adopted | Some trainings have taken place |
| Finland | Partially adopted in existing training programmes. | Training program nationwide The VAMP-project had a national coordinator (Phepa coordinator) and 14 regional coordinators working in all the five Finnish provinces. At the end of the project there were 46 municipalities with about 1000 general practitioners and 5000 nurses working in these municipal health centres. The population in the municipalities involved was about 25% of the total Finnish population. The target groups included both primary and occupational care as well as hospital settings. The project used modern and multi-faceted implementation tools, e.g. only short lectures, but group-works and role-plays. Additionally, it built local strategic alliances and also used population approach. |

| | | |
|---------|--|---|
| | | 6-7 March 2008 – 38 part |
| Germany | Adopted and adapted to German needs. | Two trainings are planned. To ensure their dissemination, important institutions will be involved – the German Association for General Practitioners, the Institute for continued medical education for GP's (IHF), Departments for General Medicine at Universities or professional Chambers of Physicians. To date no widely-accepted training programme for PHC professionals wishing to deliver alcohol SBI exists in Germany but a training programme has already been developed and is being tested (Demmel 2003) and some pilots have been done. |
| Greece | Partially adopted Phepa materials have partially influenced the development of the programme on education for primary and secondary healthcare professionals that is being prepared by the National Centre of Confrontation of Dependences in collaboration with the sanitary regions and the National Faculty of Public Health | Ministry of Health and Social Solidarity, National Centre of Confrontation of Dependences, Ministry of the Interior, Public Administration and Decentralization are managing the program. The plans are to include a certificate of specialization which will be a basic criterion and condition of employment of workers in prevention centers, detoxification clinics and rehabilitation centers. |
| Hungary | Partially adopted | Training has been done by the National Institute of Alcoholology and Addictology also in collaboration with the National Family Doctors' Institute and has been incorporated to the own educational program. 22-24 November 2007 24-25 April 2008 |
| Ireland | Partially adapted in regular training courses | Over 180 GPs and Practice Nurses have participated and |

| | | |
|-------------|---|---|
| | <p>on clinical skills for alcohol problems run by the ICGP over the past three years for GPs and Practice Nurses.</p> | <p>Phepa funded two training courses.</p> <p>Modules have also been delivered at CME level and within the training schemes for GPs. The main problem in this area is the shortage of trainers with both experience in alcohol skills training and knowledge of General Practice. The ICGP is considering introducing a 'train the trainers programme' to help build capacity. This will require extra funding but the current climate is not conducive. In fact, the Health Service Executive's funding support for the ICGP project on alcohol is expected to be cut by one fifth next year.</p> <p>23 November 2007 – 21 part 07 March 2008 – 12 part</p> |
| Italy | Paper and website | Recommended by the National Committee on Alcohol |
| Lithuania | Partially adapted | 1 training took place the 16 Dec 2008 with 30 participants |
| Netherlands | <p>PHEPA training program has been adapted with more emphasis on motivational interviewing techniques. The new training is divided in two parts: (1) a basic training in motivational interviewing techniques and (2) training in working with the protocols for brief advice and brief intervention.</p> | This training will be available to health care professionals by mid 2009. |
| Poland | Adopted and adapted by the College of Family Physicians in Poland in cooperation with the Sate Agency for Prevention of Alcohol Related | Two pilot courses entitled "The program of hazardous and harmful drinking prevention" took place on 30 th of September 2008 in Szczecin and on 30 th October 2008 in Lodz with the participation of 50 doctors. In 2009 every family physician in |

| | | |
|----------|--|--|
| | Problems. Website | Poland will attend this course. Starting the country-wide education will be preceded by training the team of lecturers (family physicians and specialists of dependence treatment). |
| Portugal | Adopted and adapted by the National Program of Alcohol Related Problems in his project on "Early Identification and Brief alcohol Intervention in Primary Health Care" | Continuing the training program of professional in Primary Health Care and planned follow-up sessions. More local and regional support for the trainings is needed. |
| Slovakia | Adopted and adapted Website | Started in Autumn 2008 and was carried out in the network of selected centres of educational and psychological prevention as part of its educational and psychological counselling centres. 24/27 October 2008 21/25 November 2008 12/15 December 2008 |
| Slovenia | Adopted and adapted as TM for Slovenian Trainers for EIBI in PHC settings Paper and website | Training the trainers strategy in CME courses and in collaboration with CINDI project team, Slovene family medicine society and Department of family medicine at Medical faculty of University of Ljubljana. In use. Till now approximately one third of practising family physicians and one tenth of nurses in PHC have finished the course on EIBI. |
| Spain | Catalan Training Module inspired the Phepa training one. | Region-wide training-the trainers strategy aimed at creating a network of reference professionals on alcohol working in all PHC of Catalonia. Funded by the Health Department with the Support of the Spanish Society of Family Physicians and also the Society of Family nurses. |
| Sweden | Partially adopted together with other already existing | Since first FAMMI, and then FHI, have organised and stimulated training to health care workers in motivational interviewing and |

| | | |
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| | trainings. | BI there have been no PHEPA trainings. PHEPA has instead been engaged in monitoring the need for additional training at the local level and supported such initiatives through various governmental and non governmental organisations. |
|--|------------|---|

5.4.3. Country Reports (See Annex 4)

Following the experience of PHEPA I, the project convened 24 country based teams to develop and, if possible implement, a **country based strategy** for the integration of interventions for hazardous and harmful alcohol consumption in primary health care settings.

With the exception of Turkey, Romania, France and Latvia from which countries we do not have any report, it can be said that great progress has been made in the majority of the participating countries towards integrating screening and brief interventions in primary health care.

This process has been carried out under the following principles:

Population has the right to be advised and receive treatment

- All persons have the right, from a very early age, to valid and unbiased information and education regarding the consequences of alcohol consumption for health, the family and society.
- All persons that have a dangerous level of consumption, as well as the members of their families, have a right to accessible treatment and proportional care.

Advocate on EIBI effectiveness

- there is abundant evidence that SBI delivered in PHC settings is effective in reducing alcohol consumption among hazardous and harmful drinkers and hence in reducing alcohol-related harm in the PHC population;
- there is also good evidence, that SBI in PHC is highly cost-effective and, if routinely implemented, would result in considerable financial savings for the health care system;
- the widespread and routine implementation of EIBI in PHC would have large benefits for individual patients and for public health

The need to overcome barriers:

- there is further substantial evidence that general medical practitioners, practice nurses and other PHC staff very rarely implement alcohol SBI in their routine work and that, as a consequence, the majority of hazardous and harmful drinkers presenting to PHC are overlooked and not advised to reduce consumption;
- there is a need to provide effective incentives and acceptable conditions of work for PHC staff to deliver SBI, paying attention to the obstacles to implementation that have been identified in research;
- there is also a need to tailor the contents and procedures of SBI to the practical context of PHC.
- there is still some misunderstanding of basic facts on drinking alcohol (low risk – hazardous – harmful – moderate – risky – “healthy” – “cultural” – binge – drunkenness – addiction)
- there is a need to be focused on the range of problems rather than just on the narrower focus on dependence.

Building alliances

- Patients approve of being asked and advised about alcohol drinking
- It is important to support already existing governmental initiatives in the country and when applicable assisting the revision of the national strategy.

The complete reports covering the activities carried out in the framework of the Phepa II are detailed in Annex 4.

5.5. Additional deliverables (See Annex 5)

In addition to the deliverables planned in the project and in order to facilitate the implementation of the training and the guidelines at country level a set of additional deliverables are being developed within the project.

Guide to managing risky drinkers in primary health care

This guide has been written in accordance with the criteria of the PHEPA Training Programme on identification and brief interventions and the PHEPA Clinical Guidelines on identification and brief interventions. The guide briefly describes how to screen and how to intervene in risky drinking and it is developed as a complementary and summary tool based on the Guidelines and Training Manual. The Guide is aimed to help GPs in integrating early identification and brief intervention in their daily work.

It includes an introduction with the main facts on the impact of alcohol on health, a glossary of key concepts, key questions and recommendations. It describes how to do it in 3 steps: screening, brief advice for at-risk drinking and assessment, treatment and referral for alcohol dependence. It finishes with some appendices on the management of alcohol dependence.

Minimum skills for providers

This document summarizes the skills needed by a PHC professional in order to manage appropriately and effectively patients presenting with hazardous or harmful alcohol use or alcohol dependence. Those skills are divided into 7 different areas which cover the whole spectrum of activities related to the topic: general abilities, screening, assessment, treatment planning, counseling, referral and documentation skills. Based on this document, a **Minimum Skills List** will be agreed.

- general skills
- screening skills
- assessment skills
- treatment planning skills
- counselling skills
- referral skills
- documentation skills

Quality assessment criteria

A set of criteria (quality and quantity indicators) to measure at an individual level the quality of interventions concerning alcohol use of patients is being developed.

Quality assessment protocol

Set of criteria or indicators to measure the quality of the implementation of the topics included in the protocol on EIBI.

- Quality assessment training
- Practice based protocols
- Use of an identification instrument
- Fuller assessment
- Identification of hazardous and harmful alcohol consumption
- Brief advice
- Brief counselling

-Assessing and managing alcohol dependence

Curricula for PHC professionals

These education guidelines are intended to assist in establishing educational programmes that will produce general practitioners with clinical competence in the treatment of alcohol use disorders.

The knowledge, skills and attitudes concerning alcohol use disorders should be taught in both experiential and didactic format. With their own panel of continuity patients, general practitioners should be able to demonstrate competence in screening, assessment, intervention with families and individuals, and referral. Family Physicians should also demonstrate competence in the primary prevention of alcohol use disorders, particularly for children, adolescents, and pregnant women.

Fact sheets on EIBI aimed at policy makers.

The factsheet summarizes the state of the art and is aimed at providing policy makers and programme implementers the main ideas and evidence on early identification and brief intervention, though promoting its prioritization by Member States and facilitating its inclusion in the national strategies on alcohol.

A factsheet covering the following areas have been prepared:

- The why of brief interventions
- Cost effectiveness of brief interventions
- How to implement brief interventions

A Guidance for GPs has also been produced.

6. Evaluation of the project (See Annex 6)

It was agreed by the management team to request that Professor Heather, retired Emeritus Professor, take the lead in the evaluation of the Phepa project. Dr. Heather was the leader of the Phase IV WHO on SBI and is one of the leading experts in the UK in the field. Since his retirement he has continued to work as consultant and expert.

The specific objectives of the evaluation were to answer the following questions:

- Did Phepa II achieve what it set out to do (i.e. achieve the outputs listed above)? If not, why not?
- Was Phepa II successful in involving the Phepa II partners in the project and promoting productive collaborations and networking?
- What impact did Phepa II have at country level?
- To what extent has Phepa II supported the implementation of the European commission's communication on alcohol?

The methods used in the evaluation were both quantitative and qualitative. Quantitative methods entailed the use of a questionnaire and qualitative methods consisted of the results of discussion groups specially convened at the final meeting of Phepa II partners in Prague on 4-5th December, 2008. Group discussion lasted for 75 minutes, followed by one hour in plenary session. In the discussion groups the main questions covered were:

- What were the good things of Phepa II? What was most helpful in your country?
- What were the not so good things? How could the project have been better from your country's viewpoint?
- Where should we go from here? How should the dissemination on BI be taken forward in your country?

The conclusions of each group were entered in power point presentations and the plenary session was tape recorded.

The complete evaluation report including the results and the main conclusions by the author can be find in annex 6 which include the following attempt to summarise the findings.

Final conclusions

It is clear from the evaluation that PHEPA2 was a successful project – successfully run, successful in terms of its benefits for project members and successful in producing tools that will be valuable in the effort to implement brief interventions in routine practice in EU member states. Most project partners had a clear understanding of their role in the project and were satisfied with their level of involvement in it. Its main benefits were seen as valuable support in the task of implementing brief interventions in their home countries, the chance to form international networks and collaborations with colleagues in the same area of work and an enhanced ability to be influential at home due to the prestige of an EU-funded project. The perceived advantages of participation in the project clearly outweighed the disadvantages and most would be happy to join such a project again. It is likely that the project was especially useful to those countries that were relatively new to brief interventions and that possessed fewer financial and other resources to assist the implementation of brief interventions.

The main obstacles to fulfilling partners' roles in the project were related to the indifference and lack of support, financial and otherwise, for the project objectives among professional and government authorities in the home country. However, this is a common experience in projects over the years that have aimed to introduce or increase the delivery of alcohol brief interventions in primary health care and other settings and cannot be described as a failing of this particular project. It was also said that the project was too short and that it failed to affect structural issues

like time and reimbursement for brief interventions. Again, however, these could be seen as unavoidable limitations of this kind of project.

The way the project was run also received general approbation. The project leadership was highly rated by participants along several dimensions and they were credited in particular with creating an environment that fostered respect, trust and inclusiveness and in which different opinions could be freely expressed. Very few conflicts within the group were noticed and those that were noticed were only minor. Project staff were also commended for their efficiency. The administration of the project did not, however, go without criticism. It was felt by some that there was too little opportunity for personal interaction between group members during meetings and too little communication on the project between meetings.

Perhaps the main complaint about the project expressed by participants concerned the financial arrangements. These were seen as too strict, inflexible, overly complex and time-consuming. It was felt too that the funds provided could have been allowed to be spent in more useful ways. It is not clear whether these arrangements could have been made more acceptable to participants within EU guidelines but they certainly seemed to be a barrier to efficient progress.

It should also be recognised that, while the majority of participants expressed very positive views about the project and the way it was run, there was a minority who did not on the whole share this positive experience. These few individuals felt somewhat left out of the decision-making process and wished to have made more of a contribution to the progress of the project than they felt they were able to. It is not clear what could have been done about this but perhaps the project leaders could have been more vigilant to the existence of this relatively discontented minority and could have sought to address their concerns.

Another slight blemish on the project was that the observers and experts attached to the project, as opposed to the partners themselves, were unclear about their roles and more could have been done to remedy this.

When considering the extent to which the specific aims of the project (see Introduction) were met, it is important to note that this evaluation can only rely on the views of participants as to the usefulness of the project products. It was not possible to acquire more objective data on, for example, the extent to which the clinical guidelines and the training manual were used in each country or the extent to which they were effective in upwardly harmonising the quality of brief interventions or, indeed, the increase, if any, in the delivery of brief interventions in the primary health care systems of those countries. The effectiveness of the assessment tool was not addressed at all by this evaluation.

That having been said, it is clear that the group of PHEPA2 participants as a whole regarded the project products – clinical guidelines, training programme, Internet-based resource – as valuable tools in the task of implementing brief interventions in their home countries. This enthusiasm was not universal in the group but was the view of the clear majority of participants.

In terms of the objectives of the project set out in the Introduction, the following verdicts can be arrived at:

Did PHEPA2 achieve what it set out to do (ie. achieve the outputs listed above)?

Clearly yes. Clinical guidelines, a training programme and an Internet-based resource were produced and were regarded very positively by the majority of project partners.

Was PHEPA2 successful in involving partners in the project and promoting productive collaborations and networking?

Yes, on the whole – among the majority of participants.

What impact did PHEPA2 have at country level?

Although objective evidence of this impact is lacking, the implementation strategy developed in the project was favourably viewed by the majority of participants and examples of the benefits to progress in implementing brief interventions made in most countries were provided.

To what extent has PHEPA2 supported the implementation of the European Commission's Communication on Alcohol?

The project has clearly supported the communication by contributing an important element to a comprehensive strategy to reduce alcohol-related harm in Europe.

Another marker of the success of a project is whether or not those who took part in it wish to remain connected in order to continue the work they had engaged in during the project. At the final meeting of PHEPA2 in Prague in December 2008, there was unanimous agreement among those present that the European platform of health professionals and scientists established in the project should continue to meet and collaborate and suggestions as to how this could be accomplished are now under active consideration.

7. Dissemination of the project

Measuring the visibility of the platform and project and its impact at a policy level is a rather difficult task but some of the indicators available demonstrate that Phepa products are considered a gold standard and Phepa partners the experts in the field.

7.1. Website impact

If one googles "alcohol problems in primary health care", PHEPA project appears in the first position followed by the WHO SBI international project.

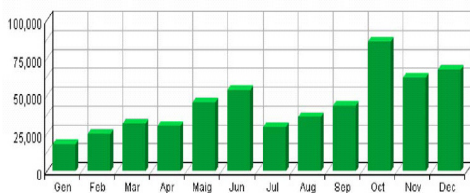
Due to the changes in the institution websites monitoring system, data from 2008 is not comparable to the previous information reported in the previous interim report.

In the graphics below the PHEPA website access, downloaded documents and visits are detailed during the reporting period as example of its impact.

| | 2006 | 2007 | 2008 |
|-------------------------|------------|------------|------------|
| Visits | 22.658 | 6.295 | 6.262 |
| Mean per day | 62 | 17 | 17 |
| Mean duration per visit | 46 minutes | 18 minutes | 20 minutes |
| International visits | 88.18% | 88,59% | 93,88% |
| National visits (Spain) | 8,38% | 11,37% | 6,12% |
| Individual visitors | 8284 | 3670 | 4.115 |
| Visitors only once | 6199 | 3114 | 3584 |
| Visitors twice | 2085 | 556 | 531 |

Web accesses

2006



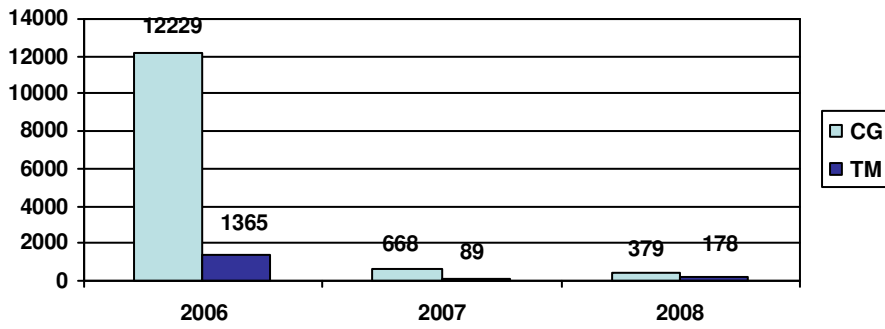
2007



2008



The most downloaded document is the Clinical guidelines and the Training Manual is the second one.




In summary, the website has had an excellent utilization rate in number of visits, mean visits per day, etc. The utilization rate was high during 2006, decreased in 2007 and has stabilized in 2008 with an steady increase by the end of the year, when the health part of the database was completely uploaded. It has had more than 35,000 visits during the whole period and around 90% have been international.

7.2. Participation in Workshops

The Phepa project has run some workshops, with different levels of participation, at 6 different events: 2 European alcohol policies, 2 Inebria Conferences, 1 WONCA conference and 1 Italian meeting.


-Conference “**Bridging the Gap. European Alcohol Policy Conference**” organized by EUROCARE and held in Helsinki (Finland) from 20-22 November 2006 - <http://btg.health.fi/?dmy=1&i=701&v=>



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-The **3rd Annual Conference of the International Network on Brief Interventions on Alcohol Problems** (INEBRIA <http://www.inebria.net>) that was held in Lisbon the 26th and 27th of October 2006. Phepa Platform members are also members of INEBRIA, aimed at promoting the wide implementation of brief interventions in a variety of settings for hazardous and harmful alcohol consumption at local, national and international levels.



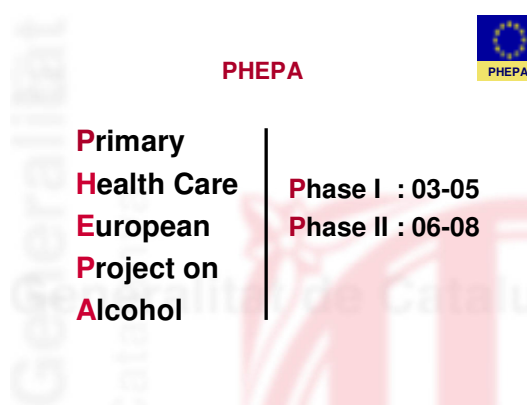
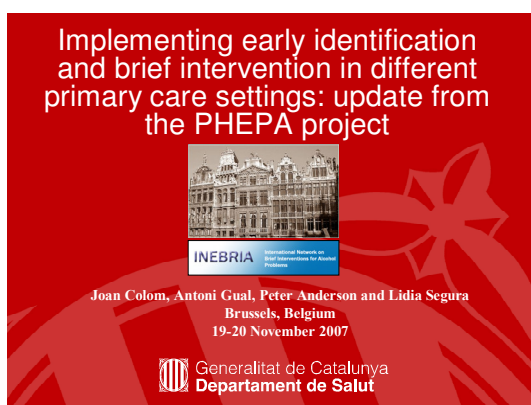
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Phepa ran a **workshop “Implementing early identification and brief intervention in Primary Care in Europe”** in collaboration with **EUROPREV** at the **13th Wonca Europe Conference**, that was held in Paris, the 17th to 20th of October 2007. Presenters were 4 associated partners of the project.

Wonca is an acronym for the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians, or World Organization of Family Doctors for short. Wonca Europe is the European regional branch of Wonca. It has more than 40 member organisations and represents more than 45.000 family physicians in Europe. Wonca Europe has about 400 direct members. The society is the academic and scientific society for general practitioners in Europe.



The **4th Annual Conference of the International Network on Brief Interventions on Alcohol Problems** (INEBRIA [Http://www.inebria.net](http://www.inebria.net)) that was held in Brussels on 19-20th November 2007.



Phepa run a workshop with the participation 4 associated partners at the **3rd European Conference on Alcohol Policy. Building Capacity for Action** (<http://www.ias.org.uk/buildingcapacity/conference/index.html>) that was held in Barcelona on 3rd – 5th April 2008. That conference gathered together more than 300 participants from 34 European Countries.

STRAND 8: BUILDING CAPACITY FOR ALCOHOL POLICY Alcohol in Primary care. Implementing brief interventions

Chair: Antoni Gual (ES)

Rapporteur: Rolande Anderson (IE)

[- The implementation of early detection and brief intervention in Italy,](#) Emanuele Scafato (IT)  **Abstract**

- Are GPs´ ready to deliver brief intervention in a "wet" country? The Czech experience, Hana Sovinova (CZ) and Ladislav Csemy (CZ)  **Abstract**

- Alcohol related problems in Portugal. New strategies to implement brief interventions, Cristina Ribeiro (PT)  **Abstract**

- Applying the international evidence on brief interventions within a national health system, Crispin Acton (UK)  **Abstract**

More recently Phepa participated in the meeting **“Il bere a Rischio nella comunità: identificare, intervenire, valutare. Un’esperienza con i Medici di Medicina Generale”**, which took place in Firenze on January 2009.



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- Conclusions and final remarks

8. Final comments and next steps

The delays in the contract preparation, caused some discontinuity between PHEPA I and PHEPA II and in addition further difficulties in the preparation and acceptance of the amendments caused some delays in the development of the products and deliverables but all difficulties encountered were finally solved.

All deliverables agreed in the contract have been developed to a high standard and publicly posted in the website (assessment tool and registry, database, etc). In addition, some other complementary deliverables have been developed but only for internal use and there are no plans to be published in the website unless finished.

20 out of 24 (83%) associated partners have been highly committed during the current period. Latvia and Turkey have been less committed and France and Romania not been committed at all. From the new Member States, Czech Republic, Slovenia, Slovakia and Poland have been highly involved.

A total of 88 professionals have been involved in the platform and the country based teams or coalitions have made great progress towards integrating

The future plans for the Phepa network include:

- Preparing several scientific papers on the results of the assessment tool and the report on country strategies.
- Maintaining the platform through the creation of the European branch of Inebria (<http://www.inebria.net>) following the example of Inebria Latina. First meeting is planned to take place in Newcastle in October this year.
- Inputting to the WP6 of the AMPHORA project, co-financed by the **7th framework programme of research of the European Commission**, that will address the gaps in considering the contribution of early identification, brief advice and management of alcohol use disorders as public health measures in reducing the harm done by alcohol.
- Updating the database through the collaboration of the platform with the Amphora project.

Acknowledgements

The Phepa management team wants to acknowledge the work done by all associated partners, collaborating partners and experts that have been contributing to Phepa I and Phepa II project and also to all the colleagues outside Europe that have been always supporting our work and initiatives.

It has been a pleasure for us to collaborate with all of you and we look forward to finding ways to collaborate in the very near future.