Annex 2

Project meetings

PHEPA II
Agenda
Tallinn, Estonia, 19-20 June 2006

Co-financed by the European Commission and the Health Department of the Government of Catalonia

Monday 19th June

Chair: Rolande Anderson

09.00 Welcome and introductions – Joan Colom

09.15 Introduction and objectives of the meeting – Joan Colom

- Summary of the final products of PHEPA I
- Products of PHEPA II

09.30 Introduction to PHEPA II project

- Deliverables – Peter Anderson
  - European Platform of health professionals and brief interventions
  - Assessment tool and registry
  - Web and Internet site database
  - Roll out training programme
  - Roll out clinical guidelines
  - Development of toolkit and policy summary
  - Support to municipal alcohol policy development
  - Support to regional alcohol policy development
  - Links with other projects
  - Plans for Helsinki European alcohol Policy conference
- Administrative matters – Lidia Segura

10.00 Brief presentations on the final products of PHEPA I

- Guidelines and recommendations – Peter Anderson
- Training manual – Antoni Gual
- Web and Internet site database – Lidia Segura
- Country reports – Peter Anderson
- Evaluation of the project – Lidia Segura

10.30 Coffee break

11.00 Experiences and lessons in implementing brief interventions

- Three case studies
  - Catalonia – Antoni Gual
  - England – Nick Heather
  - Finland – Kaija Seppä

12.30 Lunch

Chair: Marko Kolsek

14.00 Group work to discuss elements of project

Three groups to discuss partners' needs and input to project

15.30 Coffee break

16.00 Report of group work and discussion

17.00 Close of day

18.00 Social programme and dinner

Tuesday 20th June

Chair: Kaija Seppä

09.00 Results of the assessment tool

09.30 Group work on updating the assessment tool

Three groups to discuss assessment tool

10.30 Coffee break

11.00 Report back from groups and general discussion

11.30 Presentation of report, Alcohol in Europe

12.00 Discussion of input to Helsinki conference

12.30 Lunch

Chair: Leo Pas

14.00 Presentation on plans for database

General discussion

15.00 Next steps

15.30 Close of meeting

PHEPA II
Minutes
Tallinn, Estonia, 19-20 June 2006

Co-financed by the European Commission and the Health Department of the Government of Catalonia

Monday 19th June

Chair: Rolande Anderson

Welcomes all participants, old and new partners, and gives the floor to Dr. Colom.

Welcome and introductions by Joan Colom (*see file attached: Estonia Meeting Main presentation)*

Dr Colom welcomes the participants and thanks them for being here despite the short notice. He explains that this meeting is the first of the Phepa II project and that it has been arranged together with the Estonian Partner (Tamara Janson and Lauri Beekmann from Estonian Temperance Union).

He asks all participants to introduce themselves.

He explains that the project contract has not been signed yet but that the Phepa Management Team decided to start to avoid interruption of the work we all are doing. The official starting date is the 1st of April 2006 and the project will last until the 1st of April 2008. He also adds that the meeting is financially covered by the Government of Catalonia.

Introduction and objectives of the meeting – Joan Colom (*see file attached: Estonia Meeting Main presentation)*

Dr. Colom emphasizes the importance of getting to know each other, especially because new partners have joined the project. He adds that the reason for the meeting is to introduce the new project and its objectives, to sum up what we did during the previous phase and to build on that experience and products. He explains that the meeting has been arranged to discuss the elements of the new project, to share experiences and to achieve a strong involvement of all the partners.

Summary of the final products of PHEPA I

Products of PHEPA II

Dr. Colom summarizes what was done during the Phepa I project and introduces the aims, objectives, packages, products and deliverables of the Phepa II. He also acknowledges the work done by some partners in translating the final products of the Phepa I and shows the audience the copies of the Slovenian translation of the Clinical Guidelines and Training Programme, acknowledging the work done by Dr. Marko Kolsek.

Discussion:

Dr. Pas mentions the importance of rolling out the products in every country and the need to involve other associations and institutions. He also raises the question of the amount of budget available. He also asks if the project is expecting the Belgian group to roll out the products in both Belgian Regions.

Dr. Gual replies that there is no commitment with the EC on that, this is a decision to be taken in each country.

Dr. Spak asks about the use of rolling out the products in other settings.

Dr. Gual answers that the products are focused 100% on PHC but Phepa II is open to start working in other settings. However there is no obligation to do it since there is still much to be done in PHC. He adds that in each country there is a different situation and that Phepa II offers the opportunity to learn of each other by sharing experiences.

Administrative matters – Lidia Segura (*see file attached: Estonia Meeting Main presentation*)

Lidia explains that she and Claudia are in charge of the administrative matters. She explains that the EC has not transferred yet the last payment of the Phepa I (30% of the final costs incurred) despite the fact that the Final report was sent in October 2005. She mentions then there is a negative economical balance for the Catalan Government.

She thanks all partners for their help during the sampling of the administrative documents of PHEPA II (Statutes, Attestation, VAT Nbr, Declaration of honour, Mandate letter, Legal Entity Form, etc.) and that all information was provided to the EC.

She mentions that a contract draft from the EC was received in December but that it has not been signed yet and explains that the budget figures have been calculated according to EC rules for each country and only associated partners will be reimbursed for their work.

The project has two types of partners: 24 associated partners and 9 collaborating partners (6 countries and PREV-NET). Associated partners are subject to contract and are requested to work towards the project aims whereas collaborating partners are only requested to collaborate and participate as observers and all their contribution is voluntary.

Both types of partners will be reimbursed for the travel and subsistence costs of their participation in meetings and the reimbursement will always be done after the meeting.

Brief presentations on the final products of PHEPA I (*see file attached: Estonia Meeting Main presentation)*

Guidelines and recommendations – Antoni Gual

Training manual – Antoni Gual

Web and Internet site database – Lidia Segura

Country reports – Lidia Segura

Evaluation of the project – Lidia Segura

All the products are introduced and when introducing the website www.Phepa.net

Lidia requests partners to send the Phepa Management Team information about their activities and initiatives and that PMT will include it in the country pages. Lidia also announces that all the word files of the products and the cover layouts will be included in the website in a restricted area (under a password).

Experiences and lessons in implementing brief interventions

Three case studies

Catalonia – Antoni Gual (see file attached: Antoni Gual – Catalonia)

England – Nick Heather (see file attached: Nick Healther – England)

Finland – Kaija Seppä (see file attached: Kaija Seppä – Finland)

Chair: Marko Kolsek

Dr. Kolsek explains the afternoon agenda and that Dr. Anderson will go through the deliverables of PHEPA II and how they link with other activities.

Introduction to PHEPA II Deliverables – Peter Anderson (see file attached: Peter Anderson - deliverables, link with other projects and feedback)

European Platform of health professionals and brief interventions

Assessment tool and registry

Web and Internet site database

Roll out training programme

Roll out clinical guidelines

Development of toolkit and policy summary

Support to municipal alcohol policy development

Support to regional alcohol policy development

Links with other projects

Plans for Helsinki European alcohol Policy conference

Dr. Anderson lists the deliverables of the Phepa II project and links them with the objectives of the proposed Building Capacity Project, a proposal put in strategically by the Slovenian

Government, the first government of the new EU countries that will also have the European Presidency (2008).

Group work to discuss elements of project

Four groups to discuss partners' needs and input to project

Participants are divided in 4 groups:

Group 1: Toni Gual, Daniela Alexieva, **Rolande Anderson**, Claudia Gandin, Sverre Barfod, Maciek Godycki-Cwirko, Joan Colom

Group 2: **Nick Heather**, Lex Lemmers, Marko Kolsek, Thomas Hintz, Stefan Matula, Tamara Janson, Philippe Michaud

Group 3: Panagiotis Panagiotidis, **Leo Pas**, Cristina Ribeiro, Krysztof Pacholik, Egle Pinceviciute, Artur Mierzecki, Olga Montserrat

Group 4: Pierluigi Struzzo, Lidia Segura, Sarmite Skaida, Frederik Spak, Kaija Seppä, Eleonora Sineger.

Reflecting on the deliverables and links with other projects:

1. **What do you want from the project?**
2. **What can you give to the project?**
3. **What results should we expect at the country level**

Report of group work and discussion

	What do you want from the project?	**What can you give to the project?**	**What results should we expect at the country level**
Group 4: Rapporteur: Kaija Seppä	-Involve other professionals and contact politicians. -To share with other Phepa members the knowledge about implementation, barriers, how they have solved the barriers. -Networking and contacts are very important. More collaboration inside Phepa Network, possibility to travel to other participant countries as experts -Interactive courses through websites and credits granted to those participants. -Country information on the website on how to approach patients, how to arrange the trainings. Interactive teaching courses, possibility of circulating country info before the meetings (like in the KBS). -More time for open conversations on important topics … we could have a mailing list or forum in the website Involve Phepa more in the community (not only GPS and alcohol specialists)	- Focus on the issues - Work on National level as far as possible - Willing to be available for collaboration as experts - Willing to give expertise to GPs - Translate the whole products as adapted versions (not all members) - Link to national pages in native language	-Direct Phepa to national guidelines -Expect more results than only the number of professionals being trained -Link Phepa to community interventions -We have to have the political agreement -Get the consensus with the PHC professionals …

Group 3 Rapporteur:	-Policy on alcohol directed to PHC professionals not only to specialists and	- Serve as an expert group to assess countries that have	- Collaboration between Mental Health and PHC

Cristina Ribeiro	more than education -How to motivate the GP -Networking on coordinating and who will be the task force in each country -exchange experiences, public communication and meetings for specific groups -Know how to train the trainers and who must be the trainer … -We need to know more about evaluation … qualitative, quantitative … comparative measure between the countries … -Networking …linking societies … -Training the training development … medical education … e-learning … -Overcome the barriers … internet database will be a support … -Identify the most important targets … -Collaboration among the mental health professionals and PHC -Specific expertise - clearly identify and use it to exchange experiences … risky behaviours … if they have more chances they will buy our offer … for instance more communication … -Some of the suggestions can be handled by INEBRIA too: research collaboration	younger history in SBI (through an internet database?) - Importance of detecting specific expertise	- Not only risky drinking but also risky behaviours (may be first, to focus later on alcohol and tobacco) - INEBRIA as expertise network

Group 2 Rapporteur: Nick Heather	- New countries & older countries to share expectations (Knowledge, enforce, make simpler the information) - Brand new teams. Acquire the basic knowledge and disseminating strategies	-Share knowledge and practical know how -Web site for GPs and nurses -How to use the experience in non medical settings (Dr. Matula,	-To reinforce the strategy by many ways (updated guidelines) -Continue collaboration to reinforce the network

	- Continue the process of implementation	Education Ministry, Pedagogues, Psychologists, Social Workers)	-Solidarity -To gain better knowledge of marketing strategies
Group 1: Rapporteur: Rolande Anderson	-Curriculum … what GP think about the idea -Ways to motivate policy makers and what motivates GP … -Publication of experiences --Phepa II have to focus on what we can do to help the implementation, focus on health services, model of services and service level instead of the clinical level (European communication on alcohol)	-Disseminate evaluation also outside PHC setting	-Consolidation -Giving back the responsibility to PHC networks -Inviting parents groups and representatives from schools.

Nick Heather says that the service model existing in each country is almost unique. Phepa I was a move to standardization and if at the end of the Phepa II, new countries have produced their own strategy that will be a considerable achievement. Phepa II will have to work also towards customization following the recommendations of the WHO collaborative project.

Dr. Ribeiro talks about the common needs, barriers etc and the importance of country-based case presentations, not only evidence based presentations.

Dr. Maciek Godicky-Cwirko also emphasizes that standardization is only possible in the hard concepts and that we learn form other's experiences and mistakes.

Dr. Gual adds that PHEPA II has to clarify which essential elements have to be taken into account for EIBI dissemination. We should find the frame that optimizes dissemination.

Dr. Spark suggests that dissemination experiences in the tobacco field can be also illustrative.

Prof. Nick Healther suggests that PHEPA II provide a brief intervention pack "Oven ready BI pack" piloted and customized in different countries as an additional element to complete the pack already produced.

Dr. Maciek Godicky-Cwirko adds that we should work towards the inclusion of this trainings in the curriculum for health professionals (standardized professionals training program and vocational trainings) and to document how to do it.

Dr. Cristina Ribeiro adds the importance of linking with other European Projects.

Dr. Leo Pas proposes that the Phepa Management Team synthesize all the comments by the groups as a matter of reflection. Peter Anderson will provide the feedback on that.

Tuesday 20th June

Chair: Leo Pas

Results of the assessment tool by Peter Anderson (*see file attached: Assessment tool*)

Dr. Anderson presents the results and emphasizes that surprisingly in another project on tobacco the figure was different and he explains that the model was developed based on a review of the literature. He mentions that the results depend on the interpretation of the questions and on who responds to the questions (government's vs NGO).

It should be worth while trying to pursue an assessment or measure of what is available at country level and it would be helpful at country level to make a change rather then doing a cross comparison.

Group work on updating the assessment tool

Four groups to discuss assessment tool

Reflecting on the assessment tool:

1. What do we need the tool for?

2. How should we update or complete the tool…

3. How should we report on it?

4. How should we document or store the tool (format/database, etc) …

Report back from groups and general discussion

Group 1 *Rapporteur: Toni Gual*

- Need for baseline measurements, especially in new Phepa members
- Need to compare (concerns on the political implications)
- If we need to compare, then we need:
  - Objective measurements
  - Detailed information. Specificity.
  - Who fills it
  - Accreditation procedure
  - Geographical differences taken into account
- Peer review strategy needed
- We should agree on the methodology (define standards):
  - Health authorities fill the Q
  - Peer review (Country based teams?)
  - Phepa experts
- We should take responsibility for the results as Auditors or Accreditors

Group 2 *Rapporteur: Nick Heather*

- Useful for country level; have 2 or more people independently filling it in; then bring together and discuss differences
- Very dubious and negative about international comparisons
- Maps at best misleading, and potentially very dangerous
- Core of problem is notion of scientism; not objective; Enormous work to go into objective measures

- Could develop some scientific questions, which are also fraught with methodological problems
- For internal audit, the instrument too long and too quantitative; now think about how to develop the instrument
- Reporting within countries; could be held centrally
- Can make some generalizations on country progress based on tool
- Could be on Phepa website, but, in initial stages only to Phepa partners

Group 3. *Rapporteur: Leo Pas*

Aim

To provide a valid baseline measure of the situation in the specific country and to provide description to indicate direction to develop facilities

Target group

Will be all instances who are involved in intersectorial policy development (on implementation of EIBI)

Health minister,

Focal point for drug, Social care Municipalities, PHC association

Academic and scientific associations

Methodology	Define facilities	& needs of facilities in the countries	Collecting reflection questionnaire	Distinguish qualitative/ Quantitative Objective collection ?
Who	Coordinator Phepa	Intersectorial team (Include PHC)		
Time table	Phase I. October 06 Working document, clarifications, changes, additions	Phase II. December 06 Adapted by Phepa	Phase III. April-June 07 Value issue (promote EIBI in PHC) & define prioirities	Phase IV Dec 2007 Country overviews Discuss relevance in teams

Group 4. *Rapporteur: Pierluggi Struzzo*

- Differences in how questionnaire was filled in
- Took formal paper that exists at national level to compare the results

- Sometimes there is a conflict between objective questions and comments added in the last questions
- Tools are available for comments to compare between countries
- Specify a minimum requirement to answer the questions
- Could send comments to modify questions
- Could use it to monitor, to push for resources
- Have a common publication on how things are done.
- Include in the database for internal reasons

Discussion

Dr. Gual points out that it seems that there is no agreement on the use of the tool. Some see the tool as useful for cross comparisons and others see it really negatively but taking into account that this is an European Project, we need maximum objectivity of the measurement but European differences in the EIBI topic can be used at national level to help those countries that are behind to force their Governments to give them more support.

Dr. Heather suggests that using the tool for political purposes is fine but not for scientific purposes. The validity of the results is questionable and they won't be accepted in any international journal.

Dr. Pas suggests working together on the tool for internal use and debating on it until later decisions can be taken.

Dr. Maciek Godicky-Cwirko also comments that it would be difficult to set standards to assess each topic. Protocols and standards have to be set to assess each area. The tool has not to look for standards in a general way but it can help to know if protocols are fulfilled at national levels.

Dr. Ribeiro says that both are possible, the tool can be used to describe the situation and to help countries know the way to develop each area.

It is agreed that the document will be used only internally until next meeting and that partners will be asked for additional suggestions on contents and process.

Phepa team will send back the revised form (improved) with time enough before the meeting that country teams can fill in the tool again. It is clear that the debate is on the use for country comparisons but not at national level, so we continue with the idea of going forward and a decision will have to be taken later.

Presentation of report, Alcohol in Europe (see file attached: Alcohol in Europe)

The 10th recommendation talks about Advice for hazardous and harmful alcohol consumption and alcohol dependence, and recommendations for advice:

10th.1. Development of guidelines, brief advice and implementation in different settings

10th.2. Training and support programmes to deliver brief advice

10th.3. Resources to ensure the widespread of identification and advice programmes.

- Available in web site: www.ias.org.uk

Dr. Heather says that it is a magnificent piece of work and that the report is going to be really useful for the group.

Dr. Anderson says that the French translation will be available by the end of July at the EC website and that the summary is already translated by all BTG partners in to the different languages. He adds that the report was peer-reviewed by the Industry but received good comments.

Dr. Pas discusses the use of the data included for the Phepa project. It is said that 25% is a realistic target with tangible benefits. This is a useful single piece of information.

Dr. Peter Anderson mentions the launch of the Communication from the Commission to the Member States with recommendations in what have to be done from all parts.

The insufficient evidence on education is also discussed. It does not mean that we do not have to educate but it is not an alternative to other policies. Education sensitizes population for policy measures (taxation has to be used but education helps to clarify to the population the reason why).

Discussion of input to Helsinki conference – Peter Anderson (see file attached: Helsinki Conference**)**

More information available at www.health.fi on registration fees and submission deadlines.

Phepa project will look for additional budget to support the attendance of some partners. Decision has to be taken.

Partners are invited to participate and especially proposing sessions on BI. Dr. Seppä would like to organize a session but says that more proposals are welcomed. Opportunity to promote BI may be in parallel sessions (working groups, training sessions…). Phepa project is going to propose a workshop following the experience in Warsaw, and Dr. Gual ask for partners interested in collaborate.

Phase IV project will try to propose another one especially if the report is already published by WHO. Nick will coordinate a session.

Dr. Pas could present data on cost effectiveness.

Inebria – Cristina Ribeiro (see file attached: inebria poster)

Cristina Ribeiro invites partners to participate in the 3rd Annual Conference of Inebria. More information available at: www.inebria.net

Presentation on plans for database – Peter Anderson (see file attached: Database)

General discussion

Following the example of the www.treatobacco.net website that includes evidence on BI (implementation, cost-effectiveness, etc.) following the guidelines. We have the opportunity to complete it during Phepa II modelling it according to this model.

The need to work together and develop it collectively is mentioned.

Phepa members will invite people to start working in groups. Phepa will organize the information and will offer block areas available for volunteers.

Dr. Ribeiro would like to help in developing one topic and Dr. Sparks says that he will share it with their group and respond on that in September.

Dr. Michaud asks if the industry will be welcomed to support the translation of some of the information in French.

Dr. Gual replies that for the products, like in the Slovenian Translation, a solution has been found but the EC will be consulted for conditions.

Next steps

1. Maintain European Platform of health professionals and brief interventions to encourage networking and sharing of experience, finding ways to do more of this (country audit visits, more time during meetings etc)
2. Standardize, update and roll out training programme, perhaps developing minimum skills for providers, quality assessment criteria, and curricula for PHC teams, with tools for education; and Develop an intervention pack for PHC professionals (like Drink less, NIAAA, WHO packs etc)
3. Standardize, update and roll out clinical guidelines, perhaps developing minimum standards and quality assessment criteria
4. Develop, provide and update the evidence base, making it available and accessible, perhaps through the Internet site database
5. Continue to document examples of good practice, describing how it was done, providing case studies, perhaps through updated, revised and completed county reports – developing country stories

6. Perhaps based on the assessment tool, describe the minimum requirements of a 'model service'.
7. Through the assessment tool, document and monitor service provision
8. Prepare a series of fact sheets aimed at policy makers: short 2-3 page state of the art summaries on:

    -The why of brief interventions

    -Cost effectiveness of brief interventions

    -How to implement brief interventions

9. Embed and link brief interventions into other relevant alcohol and primary care projects:

    -Other EC funded projects (Pathways for Health, Building Capacity, if co-financed)

    -WHO initiatives

    -Primary care initiatives (Europrev, WONCA etc)

    -Conferences, e.g. Helsinki etc

10. Embed brief interventions into alcohol policies and programmes at European, country, regional and municipal levels, also through social marketing, supported by advocacy training
11. Support coalition building at country level, and consider extending BI in other settings (work place, A&E, and general hospitals.
12. Build capacity of health care users, and assess hazardous drinking and changes through surveys etc.

The estimated money available (final figures only when the EC provides the final contract) has to be dedicated to implement at least 2 meetings and 2 trainings in each country.

Country roll out – own contribution

- Country based team meeting for 8 people
    - Travel: 1.200-1600 €
    - Per diem: 1.300 - 2.800 €
    - Room booking: 300-600 €
- 2 trainings:
    - Trainer: 600 -1000 €

Partners are requested to also provide an estimation of the costs they will incur during the roll out.

The Phepa Management Team will ask to Torker Ergüder, the Turkish partner from the Ministry of Health to consider hosting the next meeting of the Phepa Project. The date has to be decided but most probably will be in the autumn.

It is also planned to have Small Phepa Meetings:

-The 3rd Inebria Conference to be held in Lisbon (26th-27th October)

-The Helsinki Conference

-The 4th Inebria Conference in Brussels.

Phepa team will welcome ideas to prepare adequately the Phepa Workshop in Helsinki.

Phepa team will send several e-mails:

- explaining the plan for the development of the assessment tool and the idea is to have a better form by the end of the year.

- proposing a new structure for the database and inviting partners to volunteer to work with it.

- explaining what is feasible to be done at country level according to budget and partners will have to reply on their estimated costs.

- asking for volunteers to develop the fact-sheets

Dr. Seppä will coordinate the proposals on EIBI sessions in Helsinki.

PHEPA II
Participants List
Tallinn, Estonia, 19-20 June 2006

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PHEPA II

Istanbul, Turkey, 8-9 October 2007

Grand Cevahir Hotel

Safir Hall

Monday 8th October

Chair: Joan Colom

09.00 Welcome and introductions

Dr Tahir Soydal - Tobacco Free Life Association

Dr. Joan Colom -Department of Health, Government of Catalonia

09.15 Introduction and objectives of the meeting

Dr. Joan Colom

09.30 Some country experiences

Ireland – Dr. Roland Anderson

Italy – Dr. Emanuelle Scafato

Turkey - Prof. Dr. Oğuz Karamustafalıoğlu

10.30 Coffee break

11.00 Some country experiences (continued)

Czech Republic – Dr. Hana Sovinova

Portugal – Dr. Cristina Ribeiro

Slovenia – Dr. Marko Kolsek

Germany – Dr. Michael Berner

12.30 Lunch

Chair: Marko Kolsek

14.00 Implementing the training programme at the country level

Antoni Gual

Discussion of background papers:

How to manage risky drinkers in primary health care

Minimum skills for providers (Part I of paper)

Curricula for PHC professionals (Part III of paper, minimum skills for providers)

Partner input of implementation of training programme at country level

15.30 Coffee break

16.00 Implementing the guidelines at the country level

Peter Anderson

Discussion of background papers:

Quality assessment criteria (Part II of paper, minimum skills for providers)

Quality assessment paper

Fact sheets re EIBI

Partner input of implementation of guidelines at country level

17.30 Close of day

18.00 Social programme

Tuesday 9th October

Chair: Lex Lemmers

09.00 Administrative and financial issues

Lidia Segura

09.30 European Alcohol Policy conference, Barcelona, 2-5 April 2008

Discussion of PHEPA input

Joan Colom

10.00 Updates and discussion of deliverables

Database

Peter Anderson

10.30 Coffee break

Chair: Emmanuele Scafato

11.00 Updates and discussion of deliverables

Assessment tool

Fact sheets

Country reports

Peter Anderson

12.30 Next steps

13.00 Close of meeting

13.00 Lunch

PHEPA II
Istanbul, Turkey, 8-9 October 2007

Meeting Minutes

Monday 8th October

The morning session is chaired by Joan Colom

Dr. Colom (Department of Health, Government of Catalonia) welcomes all participants and thanks everyone for attending the second meeting of the Phepa II project that has been organized in collaboration with Dr. Soydal and Dr. Ergüder from Tobacco Free Life Association, the Turkish partner of the project.

Dr. Soydal welcomes everyone to Istanbul and explains the current situation of alcohol policies in Turkey.

Joan Colom opens a round of participants' introductions.

Joan Colom explains that the project duration has been extended until December 2008 and introduces the meeting aims and objectives *(See the presentation "Phepa at the Istanbul Meeting Final")*

- Summing up what we did during the previous year and building on that experience
- Discussing the deliverables of the project and the things to be done
- Sharing experiences
- Achieving a strong involvement of all the partners
- Clarifying the financial aspects
- Debate on next steps
- Deciding input of Phepa Project to the European Alcohol Policy Conference

After the introduction some participants talk about the experience in their countries:

Ireland – Dr. Rolande Anderson – (*See the presentation "Country Report_Ireland_Rolande Anderson")*

-The cutbacks in the Irish Health System and the impact on continuity of projects and the overload to primary health workers (approximately 2,000 GPs per 5 million inhabitants).

-Impact of the smoking ban and random breath testing on drinking patterns (more drinking at home, big increase in purchase, etc.) in Ireland.

-The prominence of the alcohol industry (public persuasion) at country level (Ireland and England) and at European Level (stakeholder in the Alcohol Health Forum launched in the framework of the EC Communication on Alcohol) and the need to find ways to resist and counteract. Traditionally the treatment has been a threat to them but now they are threatened by BI strategies.

-The high prevalence of harmful drinking and the significant positive results found in a small study carried out in Ireland on the impact of BI in drinking patterns (different targeted groups: help seeking, etc)

Italy – Dr. Emanuelle Scafato – (*See the presentation "Country Report_Italy_Emmanuele Scafato")*

-Great achievements in Italy. EIBI and PHEPA have been introduced in all relevant documents (national strategy on alcohol, etc.)

-Alliances with all relevant professional and scientific societies (physicians, addiction, paediatrician, alcohology, etc.).

-Organization of the first Phepa training on the 17th and 18th of October, 2007 targeted at all Professionals working in the Italian Health System, not only GPs.

-Phepa materials, as the European Standard, will not be customized or adapted at national level until feedback from the first course is received

-Importance of training accreditation to motivate participants but applications received before the number of credits was decided showing the interest of participants.

-From all the 150 applications only 24 participants were selected by the Committee to take part in the training.

-The recent developments in Italy on alcohol policy due to the commitment by the minister (law on advertising).

-The need to harmonize and change cut-offs of tests according to the samples and to clarify that screening is not diagnosis and that professionals have to use their skills to identify the problem. It is Important to calculate positive predictive value when validating tests.

Turkey - Prof. Dr. Oğuz Karamustafalıoğlu – *(See the presentation "Country Report_Turkey_Oğuz Karamustafalıoğlu")*

-The high percentage of abstainers due to religious and social restrictions and the high percentage of problems among the non abstainers.

-The impact of immigration on the abstainers' rate.

-The lack of trained physicians and health professionals to screen, intervene and treat alcohol problems.

Czech Republic – Dr. Hana Sovinova – *(See the presentation "Country Report_Czech Republic_Hana Sovinova)*

-The Phepa course was welcomed by participants.

-Importance of introducing hazardous drinking in legislation and alcohol plans and not only harmful or problematic drinking (equally to smoking).

-The importance of adapting phepa materials to country needs (different translation and cut-offs of the validated instruments and shorten courses)

-The need for substantial funding to carry on with the trainings (health system, participants and phepa).

Portugal – Dr. Cristina Ribeiro – *(See the presentation "Country Report_Portugal_Cristina Ribeiro)*

-The importance of determining the quality of Clinical Guidelines and assuring that PHC professionals use CG to guide their consultation on alcohol problems.

Slovenia – Dr. Marko Kolsek - *(See the presentation "Country Report_Slvoenia_Marko Kolsek)*

-The possibility of using the EC presidency of Slovenia to promote the EIBI (also Portugal with the Health Impact Assessment meeting) in Slovenia. Special focus on the reduction of injuries related with alcohol during the alcohol policy conference in Barcelona.

Germany – Dr. Michael Berner - *(See the presentation "Research Project_Germany_Michael Berner)*

-Visit: www.alkohol-leitlinie.de

The afternoon session was chaired by Marko Kolsek.

Implementing the training programme at country level

Discussion of background papers lead by Dr. Antoni Gual

Curricula for PHC professionals (Part III of paper, minimum skills for providers) – *(See the document minimum skills for providers.doc)*

Minimum skills for providers (Part I of paper) – *(See the document minimum skills for providers.doc)*

How to manage risky drinkers in primary health care – (*See the document How to manage risky drinkers in primary health care)*

Peter Anderson comments that the proposal from Dr. Gual is for the maximum level of skills, and minimum curricula also have to be considered. It is open to leave it to 2 approaches: all patients or target special populations. to the curricula should not go beyond what is written in the training manual and clinical guidelines.

Leo Pas suggests developing three levels of recommendations:

1. Recommendation of choice strategies for identification, document process they are following and refer to specialized treatment. The 5 A's described in the training manual.
2. Knowledge and skills –formulate to what PHC professionals should do – performance – CG
3. Mental Health Physicians - how to understand the need for interaction with the PHC professionals.

Cristina Ribeiro explains about the existence of the European Academic Educational Agenda and she proposes that that language used in the curricula has to be similar to the documents used with the documents linked.

It is also mentioned that the curricula are not only specific to alcohol problems, they are also useful for other health behaviours.

It is agreed to write a menu list and relate each item to the time to be consumed to put it into practice.

Maciek Godycki-Cwirko states that there are 20% of patients that are susceptible to receive BI and that GPs complain about the lack of time and being busy. He says that it can be helpful, to avoid resistances, to adapt the time to the status of alcohol problems of the patients.

Frederik Spak mentions that the list also relates to other lifestyle behaviour and that can be related with national guidelines at country level.

Michael Berger emphasizes the importance to focus on a core or mandatory list, a real core and minimum skills.

There is agreement on the idea of building a list of core elements after the meeting (core versus desirable) and asking phepa partners for opinions (consultation). The main 3 areas have to be discussed.

Emmanuele Scafato does not agree with the minimum and maximum. He considers the list as qualifying skills to increase capacities (phepa qualifying skills).

Standards, we choose the criteria to qualify professionals – How to measure? According to what? What happens at country level? How to transfer them?

Miranda Laurant emphasizes the importance of taking into account the organization of the health system. List of skills depends on the HS organization.

Peter Anderson says that it is a global idea and it has to be adapted at country and regional level. They are reframed at European Level and the core essential chosen at European Level

Maciek Godycki-Cwirko suggests using the results and experience gathered by the German group. He adds that it is important to assess how much time is needed to do EIBI to be able to negotiate with professionals.

Ioanis Diakogiannis says that the list has to have in mind to which targeted group of professionals the information is going to be given. He says that in Greece for example there are no family physicians and suggest targeting the information to military doctors. He also says that it can be helpful also to educate medical students and residents. Also rural area doctors can be a target group.

Antoni Gual agrees on the idea of entitling them "Phepa qualifying standards" and the idea of mentioning and including the time needed for each point.

Bart Garmyn says that the guidelines cannot be published if evidence tables are not included. He has the view that unless they are official guidelines they will not receive attention.

It is decided to provide some summary at European Level, not to be rigid and make them adaptable to countries.

Cristina Ribeiro says that the point of assessment of dependence is really important but during training there is not time enough to do it. She adds the importance of telling PHC professionals to liaise with secondary centres to help patients to cut down and achieve abstinence. It is important to explain to GPs how to help patients to cut down and the consequences of doing so.

Michael Berner stresses that evidence has to be linked with it.

Peter Anderson suggests that the work has to be guided by Phepa Clinical Guidelines and training Manual. He says that the products will have to be generic enough to be adaptable at country needs.

16.00 Implementing the guidelines at the country level

Peter Anderson

Discussion of background papers:

Quality assessment criteria (Part II of paper, minimum skills for providers)

Quality assessment paper

Fact sheets re EIBI

Quality assessment protocol

Quality assessment training

Criteria to measure the knowledge, skills and attitudes of PHC professionals concerning alcohol:

- Measurement of knowledge: PHC professionals should answer correctly at least 70% of the questions of a multiple choice questionnaire. The questionnaire will contain 20 questions on SDU contents, validated screening tools, components of brief interventions, basic motivational principles, assessment of alcohol dependence and referral criteria.
- Measurement of attitudes: Attitudes of PHC professionals will be measured through an adapted version of the SAAPPQ. A score above ?? for role security and a score above ?? for therapeutic commitment should be obtained.
- Measurement of skills: Skills of PHC professionals will be evaluated using audiotaped or videotaped interventions, or through direct observation, using the MITI (Motivational Interviewing Treatment Integrity Code). A score above 4 in the empathy scale should be obtained.

Quality assessment protocols

Based on Clinical Guidelines on Identification and Brief Interventions

Practice based protocols

The clinical guidelines recommend the introduction of practice based systems, including identification tools, protocols and aids and computerized support.

Quality assessment criteria

- The presence of a practice based protocol that includes:
- Who to screen for hazardous and harmful alcohol consumption
- What identification instrument to use
- Cut off criteria for assessment
- Cut off criteria for brief advice
- Main elements of brief advice

- Cut off criteria for brief counselling
- Main elements of brief counselling
- Cut off criteria for referral for specialist help

Use of an identification instrument

The clinical guidelines recommend the use of the first three questions of the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT-C).

Quality assessment criteria

Documentation of which validated identification instrument is used

Fuller assessment

The clinical guidelines recommend that male patients who score 5 or more with the AUDIT-C, or whose alcohol consumption is 210g of alcohol or more per week and female patients who score 4 or more with the AUDIT-C, or whose alcohol consumption is 140g of alcohol or more per week should be invited to complete the full ten item AUDIT for a fuller assessment.

Quality assessment criteria

- Documentation of which assessment instrument is used
- A review or audit of patient records (paper or electronic) of proportion of identification instrument positives that have documentary evidence of fuller assessment, and numerical recording of result of assessment, if relevant.

Brief advice

Quality assessment criteria

- A review or audit of patient records (paper or electronic) of proportion of identification/assessment instrument positives that have documentary evidence of brief advice having been given, related to numerical result of assessment, if relevant.
- If resources permit, video-recording of consultation, with objective assessment of clinical skills, including Giving Feedback, Providing Information, Enabling a goal to be established, Giving Advice on Limits, and Providing Encouragement

Brief counselling

Quality assessment criteria

- A review or audit of patient records (paper or electronic) of proportion of identification/assessment instrument positives that have documentary evidence of brief counselling having been given, related to numerical result of assessment, if relevant.
- If resources permit, video-recording of consultation, with objective assessment of clinical skills, including Giving Brief Advice, Assessing and Tailoring Advice to Stage of Change and providing Follow-up.

Assessing and managing alcohol dependence

Quality assessment criteria

- A review or audit of patient records (paper or electronic) of proportion of patients positive for alcohol dependence based on the results of an identification/assessment instrument or clinical assessment that have documentary evidence of management of alcohol dependence or referral related to numerical result of assessment, if relevant.

The proposal on the quality assessment protocol is introduced by Antoni Gual.

It is mentioned that attitudes and skills are never assessed because it is difficult and due to a bad inter-rate liability.

Michael Berger says that in Germany they have used MITI, but not very successfully. He suggests not using MITI for the quality assessment.

Frederik Spak thinks that it has to be discussed with GP what it will be feasible to do as a quality assessment.

Leo Pas says a decision has to be made as to what attitudes to measure and he adds that in Europrev studies, attitudes and performance of GPs are studied by interviewing patients.

It is also said that methodology has to be adapted to the audience of the program and the less sophisticated measure will be more applicable

Cristina Ribeiro mentions the importance of having an instrument to measure the difficulties at consultation.

Bart Garmyn recalls WHO Phase III in which commitment and motivation by professionals was measured and mentions that motivation is different from one country to another.

Nick Heather recalls also the WHO project in which the knowledge or reframing the knowledge on alcohol was considered very important.

Maciek Godwirko says that it has to be a before and after instrument. He also says that it is important to bear in mind the need of other tools, for real life, for measuring performance in daily practice – like the rate of screening in PHC.

Michael Berner emphasizes the need for checking the objectivity of the instruments to be used.

Frederik Spak talks about the experience in Sweden. He says that there is a national examination for professionals in Sweden before and after (1 year) but effectiveness is not measured in all courses

Nick Heather says that achieving the accreditation for that course can help in attracting participants.

Leo Pas says that the course must be formative and it has to be measured to what extent their needs are covered by the course. He stressed the need to define what the target of the assessment is. He adds that trainings have to be done at national and regional level.

Svere Barfod says that there is no accreditation rule for GPs in Denmark and none will accept it

Cristina Ribeiro adds that it is important not to fragment the contents and assess knowledge, attitudes and skills by confronting professionals to a practical case, asking them to solve real situations.

Leo Pas says that usually simulated patients are used to assess everything.

Tuesday 9th October

First morning session chaired by Lex Lemmers

Inebria input to the Phepa Meeting *(See the presentation "Inebria_Leo Pas")*

Leo presents the main aspects and program of the Inebria conference

Promotes the registration

Administrative and financial issues *(See the presentation "Financial and Administrative Matters")*

Lidia Segura

-Originals can be kept in their institutions but at least copies have to be provided.

-Decisions on money have to be discussed at individual level, country by country.

European Alcohol Policy conference, Barcelona, 2-5 April 2008 *(See the presentation "Introduction Barcelona Conference_Joan Colom")*

Discussion of PHEPA input

Joan Colom

Several proposals are raised:

-Description on the implementation of EIBI in countries

-Practical workshop – skills, attitudes, knowledge – building capacity for training

-Discussing where EIBI policies stand in relation for example with taxes and other more effective policies.

-Collecting all the possible references in EIBI in legislation and policy documents

-Discussing on the Phepa materials and resources being PHEPA the reference center for BI

Updates and discussion of deliverables lead by Peter Anderson

Database

Within the PHEPA website, it is planned to have a database covering the evidence for brief interventions, modelled on the treatobacco.net database:
http://www.treatobacco.net/home/home.cfm

Breast

Example of commentary and supporting evidence:

Key finding

Alcohol increases the risk of female breast cancer in a dose dependent manner.

Commentary

The Collaborative Group on Hormonal Factors in Breast Cancer pooled data from 58 515 women with invasive breast cancer and 95 067 controls from 53 studies, and found strong evidence that alcohol increases the risk of female breast cancer (one of the most frequent cause of death among younger women) in a dose dependent manner at all ages. The cumulative risk by age 80 years increased from 88 per 1000 non-drinking women to 133 per 1000 women who, at baseline, drank 6 drinks (60g) a day. It is possible that alcohol increases the risk of breast cancer by increasing sex hormone levels that are known to be a risk factor for breast cancer.

Example of commentary and supporting evidence:

Collaborative group on hormonal factors in breast cancer. (2002) Alcohol, tobacco and breast cancer - collaborative reanalysis of individual data from 53 epidemiological studies, including 58,515 women with breast cancer and 95,067 women without the disease. *British Journal of Cancer*, 87, 1234 – 1245.

Questions:

1. Health effects
2. Identifying hazardous and harmful alcohol consumption
3. Efficacy of interventions
4. Cost effectiveness
5. Implementing brief interventions
6. Supportive alcohol policy measures

Questions

Under each heading, there will be a list of key findings.

For each key finding, there will be a brief commentary and links to supporting evidence

Svere Barfod says that the database is useful, informative and very much needed.

It is agreed that it is important to include data not only health but social effects

It is agreed to include also a chapter on how to implement BI.

It is agreed to link the database to national links.

The database if finished could be marketed during the Barcelona conference but it needs to be decided who is taking over the responsibility to update and maintain the information.

Leo Pas suggests expanding the database not only to primary health but to hospitals and occupational health

Nick Heather suggests checking the BMJ public health website to avoid overlapping in the information contained.

Frederik Spak and Lex Lemmers volunteer for the Implementing Chapter.

Bart Garmyn and Michael Berner volunteer for Identifying hazardous and harmful alcohol consumption.

Second morning session chaired by Emmanuele Scafato

Updates and discussion of deliverables lead by Peter Anderson

Assessment tool

A tool to describe the available services for the management of hazardous and harmful alcohol consumption at the country or regional level

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

The tool was completed in PHEPA I, by Belgium, Bulgaria, Czech Republic, Denmark, England, Germany, Ireland, Catalonia, Italy, Netherlands, Portugal, Slovenia, Finland, Sweden

In PHEPA II, the plan is to revise and update the tool for those countries which have already completed it and to complete it for those countries who have not completed it.

A revised version of the tool was sent last week, together with the template documents that need to be completed for certain questions. The tool is similar to the previous version, with some questions dropped, others shortened, and a few questions modified.

In this meeting, discuss the revised version of the tool, and agree the timetable for completion (provisionally June 2008).

Peter Anderson opens the following question: Do we have to continue with the exercise of responding to the assessment tool or do we have to drop it?

It is proposed that the assessment tool will have to be reviewed and updated by June 2008

It is mentioned that there are two options when responding to it: by achieving consensus or individually.

Leo Pas comments that there is no place for comments in the majority of the items and that it is difficult to choose or tick a specific response in some cases.

Frederik Spak suggests that some parts need quantification and if they are not enough clarified they have to be dropped.

Svere Barfod says that in page 4 where the legislation on health care infrastructure is asked about, there is some information missing on the left side.

Leo Pas says that there are some difficulties in clarifying the score of the scales. Sometimes there are inconclusive or contradictory responses. He says that those items where is no consensus from the coalition have to be dropped.

Ioannis Diakogianis agrees on updating the tool. He reflects that there are a lot of question marks in many items. Reality is different on what it is stated in the papers.

Frederik Spak suggests adding a scale from 1 to 10 in item number 5.

Peter Anderson reframes the question as follows: in your opinion in which stand is that carried out in your country?

Miranda Laurant suggests adding in number 5 the categories: social workers and psychologists to allow them to fill it in.

Nick Heather says that the assessment tool is meaningless and useless and has to be dropped but he also adds that he knows that he represents the minority view. He has a lot of ifs, buts and reservations. The instrument's validity is in doubt and not reliable at all.

Svere Barfod states that some institutions other than the one he represents will have a better perspective than him when responding to some items.

Frederik Spak says that he can use the instrument for policy arguments. Politicians need to be persuaded and the tool can be helpful for that use.

Georgy Vasilev agrees that the tool can be useful as a political tool but not for scientific purposes.

Peter Anderson also wants to know if there is any modification that has to be done to facilitate the work of responding to it.

Emmanuelle Scafato adds that modifications have to be mild in order to be able to compare the measurements done before and to be able to measure the impact of the PHEPA project. He thinks that the only modification that has to be done is the internal standardization of the responses.

It is agreed then that besides the difficulties, the exercise will be carried out. It is agreed to check the questions, to introduce only mild modifications and to circulate it again for comments, bearing in mind the need to be able to compare the next results with the previous ones. E-mail will be circulated next week reminding what to do and asking for comments.

Fact sheets

In the Commission's communication on alcohol:

Good practice:

Advice by doctors or nurses in primary health care to people at risk, and treatment, are interventions to prevent alcohol-related harm amongst adults

Actions to be undertaken by Member States:

Allocation of the necessary resources in primary health care, to advice and treatment regarding hazardous and harmful alcohol consumption, to provide training for health care professionals and to prioritise alcohol prevention at workplaces, counselling for children in families with alcohol problems and education and awareness-raising actions to protect the unborn child.

Prepare a series of fact sheets aimed at policy makers: short 2-3 page state of the art summaries on:

- The why of brief interventions
- Cost effectiveness of brief interventions
- How to implement brief interventions
- Guidance for GPs

Peter Anderson explains that there is a plan to develop 4 separate fact sheets and that only one has already been drafted by Rolande Anderson.

Leo Pas suggests that when developing the fact sheets it could be interesting to review the work done at Flemish level.

Nick Heather says that the fact sheets are a good idea and have to be carried out.

It is agreed that they have to be ready for the Barcelona Conference and that they will be developed in English and then maybe translated into other languages.

Lex Lemmers also mentions that in the Netherlands they have developed some fact sheets that can be helpful for the work that has to be done.

Toni Gual says that the fact sheets will have to be useful standing alone but also have sense together.

It is agreed to change the title of the one called "Guidance for GP" to something related to be aimed at policy makers.

Rolande Anderson explains that he drafted the fact sheet for the Helsinki conference but he mentions that it needs to be looked at carefully and adjusted and changed to make it thematically in keeping with the others.

It is agreed that each fact sheet needs to refer to the others. Need to relate with the clinical guidelines and the training manual

It is clarified that the document presented by Antoni Gual "How to manage…." is not a fact sheet but an addendum to the training manual. A document to be produced as a pocket guide to be given to participants when training is carried out

Emmanuelle Scafato adds that the fact sheets will later need harmonization at local level according to national strategies.

Examples coming from different countries are welcomed but especially if translated.

Volunteers to draft fact sheets and volunteers to review them are requested:

Nick Heather offers to review the work done himself and mentions that Christine Godfrey might be asked to review the one on cost-effectiveness.

Miranda Laurant volunteers to draft the "how to implement" according to their Dutch document by January and Leo Pas to check it.

It is agreed that the one on cost-effectiveness will be drafted by the Catalan team by the middle of November, that Roland Anderson will also redraft the one he developed.

After all the fact sheets have been drafted, the Catalan team will be responsible to check their internal consistency.

Country reports

One of the strengths of the PHEPA website and PHEPA I was the development of the country reports:

http://www.gencat.net/salut/phepa/units/phepa/html/en/dir360/index.html.

The website contains completed country reports for Belgium, Catalonia, Denmark, England, Finland, Germany, Ireland, Italy, Netherlands, Portugal, Slovenia and Sweden.

In PHEPA II, we would like to invite the partners to revise the existing reports, or to complete reports for countries where these have not been completed, following the same table of contents of the existing reports. All of the country reports can be used as models for revision or new reports, and the example for England was sent last week as an illustration.

The Cochrane review by Eileen Kaner and colleagues provides additional information on effectiveness, and the Alcohol in Europe report can be used as source material: http://ec.europa.eu/health-eu/news_alcoholineurope_en.htm

The plan is to have the revised and/or newly completed country reports ready by the end of March 2008. During the Istanbul meeting, we will invite each country partner to report back on their plans for either revising the existing report or preparing one, when a report does not currently exist.

It is stated by Peter Anderson that the country reports were one of the strengths of the PHEPA I project but the group needs to discuss if it is worth updating them during the PHEPA II.

It is agreed to have more time to produce the country report until end of September 2008 (1st of October). It is also important to have in mind that during 2008 there will be an updated WHO alcohol survey which data will be helpful to complete the country report.

Poland agrees to produce the document for 1st of October 2008 but for the moment they can translate the report to the parliament that they produce yearly and include in the website.

Participants are encouraged to send all details and documents produced at a country level to Lidia to be able to update the country webpages.

Next steps

Training - curricula and skills - levels of required criteria:

Methodology to determine list of attitudes, knowledge and skills for providers, with a proposed methodology for choosing the criteria, with the criteria, perhaps in 2 or 3 levels:

1. Essential criteria for all phc or equivalent providers
2. Criteria for those with a special interest in providing identification and brief intervention programmes
3. Criteria for those who regard themselves as "specialist providers"

Deadline: to have the criteria ready as a background PHEPA paper for the Barcelona conference

Quality assessment of training and guidelines:

Finalize (small modifications) and circulate

Deadline: to have the quality assessment criteria ready as a background PHEPA paper for the Barcelona conference

Administrative issues:

Send e-mail with presentation, accompanying documentation and clear guidance again

Please ensure all needed documentation is completed NOW

Need country interim report for period 1/4/06 to 30/9/07 NOW

Interim report being prepared to be submitted before 1/12/07

Final report to be submitted before 01/03/09

Barcelona conference:

Register!!!

Five examples:

1. Show products developed and how they are used in the countries
2. Implement BI programme within comprehensive policy
3. Country examples and how to implement
4. Practical workshop on BI training
5. Legislation and policy for BI
6. Documentation

Database:

Check BMJ webiste

Rephrase headings into questions

Add key terms with different language versions

Complete key statements, with commentaries and supporting evidence

Provide country links

Lex: Efficacy

Michael and Bart: Identifying

Leo, Frederick and Lex: Implementing brief interventions

Circulate for comment

Have working version ready for Barcelona conference

Assessment tool:

Reservations and difficult, but carry on
Some modification to questions and re-circulate
E-mail circulation with responses within 2 weeks
Revised version after another 2 weeks
Completion by end of June 2008

Fact sheets:

Examples form Leo and Paul
Stand alone fact sheets that make sense altogether
Drafted by secretariat by end of November
Miranda be end of January for how to implement
Reviewers for each fact sheet
Final versions ready for Barcelona conference

Country report:

To be revised and completed beginning of October 2008

Leo Pas suggest avoiding the Delphi methodology when producing the minimum skills. It is agreed to be flexible and pragmatic.

It is clarified that "equivalent" refers to other health professionals that have similar responsibilities to GP (for example military doctors) and that "specialists" refer to GP that are specialist on alcohol.

Rolande Anderson proposes to use the acronym ASK (Attitudes, Skills and Knowledge) and it is agreed to have it ready for April for the Barcelona Conference.

It is encouraged to use the phepa e-mail address when writing to Lidia instead of the personal one to facilitate the classification of the communication.

It is agreed that an e-mail with all the details on the administrative aspects will be sent to participants including the slides presented.

It is agreed that all presentations and minutes will be included in the website.

It is suggested that "recommended" be added to the quality assessment tool

Registration is encouraged for the Inebria meeting and the Barcelona Conference. B. Garmyn recommends registering or making the reservation for the Inebria Meeting before October 19th.

There is agreement on the importance of having a third meeting but it is clarified that due to the high amount of work to be done, it won't take place before or after the Barcelona Conference. The place and dates are still not fixed but it might be in Prague (still to be confirmed by Hana Sovinova) between May and September 2008.

Finally, in order to be able to fix the date, participants are requested to circulate the important dates in 2008 to avoid any overlapping with important meetings (for example WONCA meeting will take place from the 2 to the 5th of September 2008).

"PHEPA Project on disseminating brief interventions on alcohol problems Europe wide" (PHEPA II)

Istanbul, Turkey, 8-9 October 2007

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Third PHEPA Meeting

Prague, Czech Republic, 4th – 5th December 2008

Agenda

Wednesday, 3rd December

20:00 Welcome dinner

Thursday, 4th December

Chair: Hana Sovinova

09.00 Welcome

Milan Bořek, MD - Director National Institute of Public Health

Joan Colom – Director Program on Substance Abuse, Department of Health, Government of Catalonia

09.15 Introduction and objectives of the meeting

Joan Colom

09.30 Wrap up on the PHEPA objectives and deliverables

-Roll out of the training and clinical guidelines

-Assessment tool

-Database

-Country strategies

-Additional documents

10.30 Coffee break

11.00 Wrap up continued

12.30 Lunch

Chair: Nick Heather

13.30 Administrative and financial issues

Georgios Margetidis, Lidia Segura and Claudia Fernández

14.00 Small group discussion

The good, the bad and the what next of PHEPA

Nick Heather

15.30 Coffee break

16.00 Feedback from groups and discussion

17.31 Close of day

18.30 Social programme

Friday 5th December

Chair: Joan Colom

09.00 PHEPA in a broader context.

Contribution of PHEPA to the changing science and policy fields.

Science: Antoni Gual

Inebria

AMPHORA project

-WP 6 – Colin Drummond

Policy: Peter Anderson

EC – Communication

WHO – Global strategy

10.30 Coffee break

11.00 Discussion of next steps

12.00 From Pizzas to Prague – the story of PHEPA

The PHEPA team.

12.30 Close of meeting

Third PHEPA Meeting

Prague, Czech Republic, 4th – 5th December 2008

Minutes

Thursday, 4th December

Chair: Hana Sovinova

Welcome

Milan Bořek, MD - Director National Institute of Public Health

Joan Colom – Director Program on Substance Abuse, Department of Health, Government of Catalonia

Hana Sovinova welcomes all participants to Prague. She acknowledges all work done in the framework of the Phepa Project. She introduces her Director Dr. Milan Borek.

Dr Milan Borek, Director of the National Institute of Public Health, welcomes all participants to the National Institute of Public Health and expresses thanks for the opportunity and the important occasion to organize the final Phepa meeting. He reviews the importance of alcohol among the State duties, and also the importance of the project for focusing on the prevention of alcohol problems. He says that the conception of the project is very useful because it focuses on the role of GPs on the prevention activities. He thinks that GPs have a prominent role in society and are in a pivotal position to approach the whole population. He finishes by saying that his institute supports this kind of activities and he hopes that the project will continue in the coming years. He wishes participants a pleasant stay in Prague. He thanks those present for their attention and wishes participants a pleasant and fruitful meeting.

Dr. Joan Colom thanks the Director of the NIPH for his words of welcome and for having hosted and helped to organize this meeting. He also announces that Mr. Georgios Margetidis from (EAHC) will be attending the meeting in the afternoon session. He goes on to welcome new participants (Vanesa Carral, Christoph von der Goltz and Colin Drummond). He also informs that Peter Anderson will be joining the meeting on Friday. He finishes by also welcoming Phepa members to the last meeting of the project and asks participants to introduce themselves.

Introduction and objectives of the meeting

Dr. Joan Colom introduces the objectives and the meeting agenda (See at website: Introduction Joan Colom.ppt)

Wrap up on the PHEPA objectives and deliverables

Lidia Segura starts by introducing some of the financial aspects (time constraints, signature forms) related with the reimbursement of the participants for their attendance to the meeting and also the meeting logistics. Lidia requests participants to contact with Claudia during the breaks to

sort out the reimbursements documents needed and the shuttles to the airport. She also explains the last communications with the EAHC in order to request for a third amendment and its contents: two month extension and also movements in the budget in order to fit partner's needs better (See at website: financial and administrative matters.ppt). Lidia appreciates the partners' collaboration in producing the needed documents and feedbacks to the European Commission.

Leo Pas express his worry about the documents to prove the activities done in the framework of the Project. **Lidia Segura** responds that the amendment will provide some extra time but not much and that any question on documentation will be formulated to the EAHC. Joan Colom stresses that the extension should not be considered as extra time otherwise the project won't be finished. **Lidia Segura** suggests sorting cases out individually during coffee and lunch breaks.

Lidia Segura goes on to introduce the things done in the roll out of the training and clinical guidelines, the plans for the country stories and the finalization of the additional documents. Lidia stresses the importance of providing all country reports in order to produce the final report following the Imhpa example and also the importance of partners to update the contents in the website specially to include the most involved partners in the country team and the most relevant information of what is going on in their country (See at website: Wrap up Lidia Segura.ppt).

Joan Colom asks participants to talk briefly about things that have been done in the framework of the project to roll out the clinical guidelines and the training manual.

Dr. Panagiotis Panagiotidis (associated partner Greece)

He says that Greece have trained around 30 trainers to start working. They have been collaborating with Universtities of Thesaloniki, Prata and Crete. They have also approached the Athens University but not succeeded. They have also tried to involve the Health Ministry because they are now planning on health issues on alcohol for 2009-2012 and they hope they can put the training into the official health training. He says that they are trying to involve the Ministry of Defence but the bureaucracy is even worse there.

Christoph von Golz (associated partner Germany)

He apologizes for not being able to reply to all since he joined the project only 4 weeks ago. Translation of the manual is in preparation, they are in contact with the German Association of GPs, they have been working on building the platform with 9 scientific members and they are preparing an article on dissemination for a German research journal on addiction.

Pierluigi Struzo (Collaborating partner from Italy)

In the Region of Friuli, he says that they have 3 pre-graduated training for medical students and 24 hours of training in the postgraduate school for GP in the region. They trained 800 working GP in CME activities on health styles including alcohol. The training manual has been translated into

Italian at National level. They are now exploring how to collaborate at National and Regional level in the training activities and they are working on how to involve the Italian Association on General Practitioners on the training activities. The training work done in Friuli has been recognized by other regions.

Marko Kolsek (associated partner Slovenia)

EIBI Training included in CME courses of specialization of GPs to guarantee that all GP and nurses receive the training. They have trained 6 trainers. They are collaborating with CINDI projects in order to organize trainings for working professionals together. They are in discussions with the faculty of nursing to introduce training on EIBI for nursing students.

Leo Pas (associated partner Belgium)

We have been working on adapting the training to Belgian needs and context, shortening the length of the training and adapting it to different settings (quality circles and CME circles). We have realized that we need specialized trainers in the different provinces and they have trained GPs to do it in conjunction with professionals of mental health. For the guidelines in Belgium they have an authorization committee for guidelines that were created an independent committee to look at the European Guideline. Unfortunately they have decided that they want to redo the work, Leo is acting as expert providing evidence, they have added a new criterion and that is adding patients' views on what is the role of primary care. This will be difficult and will postpone the roll out of guidelines.

Nick Heather (associated partner England)

He says that England is a special case because it's been working on EIBI for a long time. In fact Phepa products have not been influential in England. This is because things were already underway to develop, for example, CG and training program. As far as CG is concern the Department of Health has asked the National Institute of Clinical Excellence (NICE), a prestigious lobby, to produce CG in 2010 (Eileen Kaner is chairing the group and Nick Heather and other experts are contributing). The experience with the Training program is that it was too long for their purpose and Eileen and Nick developed a shorter one in conjunction with the package "how much is too much" and that is being taken up by the government mainly as a research project called "SIPS" and lead by Colin Drummond and secondly in terms of a national roll out of SBI that the Department of Health is planning specially using e-learning. In the future the SBI training will be provided online. It's been very useful to participate in Phepa but the products have not been influential.

Krzysztof Brzózka *(associated partner Poland)*

In Poland in 2007 we had a meeting where all Polish partners took part. In that meeting they discussed the national strategy to implement SBI in PHC. The Phepa books have been translated

and both documents were the basis for the following steps. The Association of National Physicians organized pilot, preliminary trainings for family physicians following the Phepa programme in two districts of the north and central part of Poland. In each training 27 participants took part and the trainers group consisted in 4 physicians and 1 psychologist (team of 5 people). The trainings were evaluated and well valued by participants. They considered that the trainings met their expectations. The plan for next year is to carry on the trainings in the rest of the provinces of the country and the association of family physicians, together with Parpa, would like to come to an agreement with the National Health Fund for funding the practice of brief interventions, meaning that we are looking for ways to pay GP for their work. It is still not decided on what basis.

Svere Barfod (associated partner Denmark)

Concerning the guidelines, some time ago he tried to get the involvement of the scientific society to fund and to promote the roll out of the CG but the response at that point was that it was essential but there were no funds for doing it. One year ago, he contacted the special consultant on alcohol problems in the National Board of health in Denmark; even though he had no funds he agreed to begin with working on the guidelines. They have now got funds for writing the guidelines and the first draft is now being finished. This is a great step. The Danish medical association has had a committee on alcohol abuse but now with the changes in the structure the committees are on stand by. We have been working on a questionnaire for GPs and municipalities and now we are analyzing the results.

On educating the GPs there are some regions running courses, and phepa has contributed to them, and the Danish Medical Association has general courses of 1-week in duration on preventive issues which include alcohol problems combined with motivational aspects.

Danish association of municipalities has had an annual meeting on alcohol abuse and for the first time a GP has been invited to hold the lecture.

Fredrik Spak (associated partner Sweden)

For Sweden it is running very well, the annual budget for rolling out on GPs and nurses is 6 million Euros, and that means at European level 3000 million Euros. That means that everybody will be trained. So far 10% have been trained and it is extended to nurses and occupational health and we are now starting training with the social services that is also working very well. Phepa project has a marginal role in the influence on Sweden because there were already many issues going on an also the proposed phepa training course was very long. In Sweden we are now trying to train physicians in conjunction with other lifestyles.

Cristina Ribeiro (associated partner Portugal)

In Portugal there are 3 phases of the program on alcohol related problems in PHC. The first phase had been to prepare 2 national inquiries, one to the health institutions that work on addiction and

the another to PHC professionals on what are their needs on this matter. We have the results and more of 75% of professionals want to have some kind of training program. The Second phase we are now doing is the dissemination of training programmes in regional centres in the north of Portugal. The main problem we have had is that in 2006 an organic law was launched that restructured the alcohol institute and has been moved from the Directorate of Public Health to the Institute on alcohol and drug Addictions, after that we had to review all our project and have adapted it to the new context. What we have done is to translate the Training Program and the Clinical Guidelines and we would like to publish them. The Portuguese Association of General Practitioners are now very interested and have done 2 Summer schools on primary health care and we had a national conference last September that included alcohol in conjunction with our colleagues in Brazil.

Eleanora Sineger (associated partner of Hungary)

The government has stopped the functioning and also has taken away the money from the National institute of psychiatry, alcohology and addictology. They also stopped the treatment centres and put the money to other programs. We tried to continue the program through NGO and we have translated short forms of the TM and CG to use for GPs because no additional funds or sponsors were found to editing the whole materials. We have 27 trainers in Budapest and in the central part of the country and some other university cities. There are 800 GPs and only 1/3 uses the program in their daily work. We are working on the Hungarian part of the website and the health ministry has put the report on the website of the health ministry.

We work together with the National Institute of GPs.

Antoni Gual (associated partner of Spain)

In Catalonia our focus is continuity and updating the system in EIBI. We have developed new materials to give continuity; the second important thing is that the National Society on GP has taking co-responsibility in implementing the program with our supervision. We have two more activities that we think will be powerful. A distance learning EIBI training package has been developed and has started working with the support of tutors. One course has been done and well received. The last thing is the internet based intervention tool for general population and we hope to have it ready at the beginning of 2009.

Kaija Seppä (associated partner Finland)

We have had two large BI implementation projects in Finland, one lead by Martin in occupational health and one lead by Kaija Seppä in Primary health care.

We are now worried, when the projects are over, about how to continue, how to keep BI going. We have trained thousands of professionals around Finland. We are very positive about what is happening and hope to have a snowball effect. I have now the feeling, after years of working

together, that something has happened, I just have preliminary results. We have translated the summary of Phepa CG and have been delivered to all trained professionals (medical and nurses) as complementary material to give an extended overview. The National Finnish Guidelines was launched in 2005 and now they are being updated.

The Phepa training manual was far too broad for Finnish purposes. We have tailored our own training material following.

We are also now implementing education on alcohol to medical schools.

Hana Sovinova (associated partner Czech Republic)

In the Czech Republic last week we finished the third round of the training, we have organized it as a training of trainers and we invited people from the different regions working on PH and prevention and health promotion to attend this 4-module training, all together 20 hours, and they will serve as training in their regions to organize trainings to colleagues in the regions. We trained 14 new trainers in EIBI. We also prepared the Czech versions of the TM and CG in CD and these were distributed to our trainers and other interested people. They were not printed due to lack of money. We are now working on the website. We are now also doing a population cross-sectional survey using AUDIT to establish and describe the risky and harmful drinking in our society.

Emanuele Scafato (associated partner Italy)

We have been working a lot according to the Phepa standards. We organized 3 courses in the national institute during this year. The participants were 24 for each one and each training course lasted 2 days (residential course) and accredited by the state government for general practitioners and all PHC professionals (wide definition: including prevention professionals and doctors for occupational health and psychologists). We think it is important to include all professionals in the training standards on alcohol. We succeeded also in introducing it as a reference in the governmental program as well as in the national plan on alcohol that was the first one that was delivered in agreement between the state and the regions. Based also in the phepa standards, we distributed 1000 copies of the TM around Italy; the National Centre of Control of Diseases (CCM) has founded a project with 100.000 Euros to the region in Tuscany to train all the regions. Each month a course has been planned in each region. More or less 4 courses have been done and 16 regions in the next year. Also 3 more courses have been also planned by the national institute. We are now working a lot on evaluation of the courses because we want to customize much more the courses to the needs of the professionals. We are now, in this phase, asking them in a so call of voluntary bases, not really formalized as we would like to, to train colleagues in their centres to multiply the effect. We will have an in depth analysis on the 100 participants replies and we would like to customize it to the real needs and to the feedback on impact at local level.

Vanesa Carral gives an overview on the current developments on **the assessment tool** (See at website: Wrap up Assessment Tool.ppt). She lists the countries that have completed the updated tool , the results obtained and also the comparison with the 2006 results.

Pierluigi Struzzo makes a remark because in the presentation the input provided by the region of Friulia was missing.

Leo Pas insists on the poor reliability of the documents, the questionnaire and the variables not only for describing the situation but also to monitor the progress within a country and to compare countries.

Eleanora Sineger mentions that she provided the response but her country was not listed. She will send it again.

Fredrik Spak mentions that the purpose of the instrument is not clear for him and his reluctance to respond to the questionnaire.

Nick Heather adds that feelings on the instrument have been expressed repeatedly and emphasizes the importance of adding space to include comments on all questions in order to clarify the underlying aspects of the response given.

Antoni Gual says that inputs to the questionnaire have to be as objective as possible but the results can not be used as objective information but as qualitative.

Leo Pas would like to comment on the final report resulting from the assessment tool, he thinks that it is not good to give a too positive picture of the situation but using it as a supporting information for the things that still have to be done at European level.

Vanesa Carral gives an overview on the current developments on the **database** (See at website: Wrap up Database.ppt). The evidence on health is completed and she explains the website structure and also the plans for uploading the remaining parts (planned for the end of February).

Leo Pas requests some feedback or guidelines to be able to produce his part according to the standards.

Fredrik Spak also mentions that he is working on the Implementation but he doesn't know about the structure.

Administrative and financial issues

Georgios Margetidis from Executive Agency on Public Health (EAPH) starts explaining that PHEPA II was funded and final grant agreement negotiated before EAHC was created so this introduces some difficulties in the follow up of the project. He explains that in the technical and financial

Annex everything is described including the budgetary issues that rule in the implementation of the project.

He says that EAPH has put in place different guidelines on how to produce the final reporting to the EC, the documents needed to show the expenses incurred and to monitor if the money has been used to do what was stated in the project that we will do. It is also stated how to calculate the balance and to submit the costs incurred by the project in the final report.

He adds that EAHC process is quite rigid because is tied up to the same financial regulations of the EC.

He explains the rules to move money from one heading to another and he mentions that the needs have to be well defined in the very beginning and changes later are restricted to a 10% in the 2005 projects.

Any change in the initial plans have to be reported to EAHC and before using the money, so in the current situation of the project, they understand that some of the expenses have been incurred and that we are now informing them of the changes needed. He says that he understands the situation but also that this is procedure is not the usual one.

He also mentions that submitting a request for an amendment is not a guarantee of having it approved.

The current amendment requests a derogation of the project and some financial changes. He sees no problem for the extension but he can not confirm that the other part will be acceptable. He says that making an exception now will open the door for future problems and claims for equity from other groups. He understands that the changes have been made to facilitate the roll out in the different countries according to specificities and different needs in each one.

He reminds those present of the importance of being sure that the expenses incurred are eligible and providing the needed documentation and insists on using the tools provided because the calculations are done automatically, facilitating the control of the inputs.

Small group discussion.

The good and the not so good and what next of Phepa.

Nick Heather lists which partners have replied to the Evaluation questionnaire circulated in advance. He introduces the work in groups and the questions that the groups have to reply to. This part will be completed in the report of Nick Heather on evaluation.

Friday 5th December

Chair: Joan Colom

PHEPA in a broader context.

Contribution of PHEPA to the changing science and policy fields.

Science: Antoni Gual

Inebria

AMPHORA project

-WP 6 – Colin Drummond

Antoni Gual reviews the contribution of Phepa to Inebria and also introduces the AMPHORA project aims and workpackages (See at website: Broader context Amphora Antoni Gual.ppt). **Colin Drummond**, workpackage leader, of the one on EIBI and assessment on alcohol problems explains his plans (See at website: Broader context Amphora Colin Drummond.ppt).

Nick Heather starts by valuing the Amphora project and the activities proposed but says that he is disappointed due to the use of the early diagnosis concept, he says that using it is like going back to the discussions carried out in the 70s and reminds those present that hazardous and harmful alcohol consumptions are not included as diseases in the ICD. He also adds that BI is important not only for early identification but also for the BI impact on Public Health, the impact on reducing future risks. He emphasizes the importance of reflecting properly the terminology agreed in recent years. He adds that there is no reference in the project to natural recovery and mutual aids. He mentions that there is a big group of people that recovers without needing specialized help.

Colin Drummond says that he was not happy with the title of the workpackage either. He says that the content will reflect the different understandings. Regarding natural recovery, he says that the project focuses on what governments and clinicians can do to improve the treatment. The ideas is what can be added from scientific and specialist treatment to the process of natural recovery.

Nick Heather adds that it is important not to reinforce the old fashioned medical model and its prejudices and preconceptions on the treatment of alcohol related problems.

Peter Anderson says that the workpackage is going to be renamed to ensure that the understandings, concepts and contents are clear and emphasizes that the workpackage will build up on previous experiences from WHO collaborative project and Phepa. He says that treatment will be approached from a PH perspective and the project will be a mapping exercise to show EC policy makers what we know we need and what is already available. Peter also emphasizes that this process and previous ones have to be mutually helpful and that this workpackage protocol will benefit from being reviewed and exposed to Phepa and Inebria networks. The more exposure we give to the goals and work to be done the better.

Colin Drummond explains that the EC have commissioned the work and that there is some hope that the finding and recommendations will be supported by them.

Peter Anderson says that he is less optimistic on the impact of EC in the countries. He says that Amphora will focus on dissemination of the activities and translating documents into practice for policy makers and that Amphora will try to convene meetings of experts embedded with the presidency activities.

Leo Pas suggests coming back to the ideas placed in the who-phase IV projects that were not achieved. For him key issues are linked with the work experts are doing in different countries not only with GP but also with emergency departments and GPs and to the identification of new targets. He thinks that interviewing 100 GPs in 6 different countries does not bring anything unless you bear in mind the differences in the countries and the differences in similarities in the Health Care System . He adds that the work has to be complemented and embedded in current activities like the study from EUROPREV on auditing practice by patients interviewing.

Colin Drummond that the project will use already existing standardize instruments to evaluate GP work, instruments that need no special understanding. He says that the protocol and methodology is not completed decided but he adds that the project will provide definitions of what we understand by hazardous and harmful alcohol consumption. He adds that only countries with official information are going to be used in order to make comparisons possible. Amphora will not be able to focus on specificities in each country.

Policy: Peter Anderson

EC – Communication

WHO – Global strategy

Peter Anderson introduces the way that PHEPA has been embedded in the EC communication and also the development plans for the WHO global strategy. Peter Anderson says that Inebria participated, thanks to Nick Heather, in the last WHO public hearing that took place in Geneva and that Inebria is committed to contribute to the WHO global strategy by producing different documents (see at website: Broader context Phepa Peter Anderson.ppt).

Leo Pas thanks Peter for helping to put the work done by the network in a broader context. He says that the network needs to continue working towards the implementation of training, needs support to work at national level, and needs shared expertise. He says that there is a lot to be done towards broadening the training to medical and nursing students and also to develop e-learning tools. He also asks for de-centralized interaction between partners and members and not only at meetings. He says that Inebria is a forum in which to meet but maybe not a place to produce documents or projects. He says that there is a lot of work to be done and asks if there is

any plan to get money for PHEPA III. He does not see the options in Amphora for the Phepa network and he thinks that we have to look for options to maintain it.

Peter Anderson says that we look forward to another call from DG Sanco but such a Phepa network will not be funded again, and that we will have to wrap it up in a different way.

Discussion of next steps

Nick Heather suggests convening an Inebria-EUROPA platform following the example of Inebria Latina. This platform will provide not only the opportunity to share but also research together. He adds that decisions will have to be made on how to participate and he likes the idea proposed by Fred Spak to convene the first meeting of the platform in Newcastle to discuss.

Piero Struzzo suggest not arriving empty-handed in Newcastle and start working right now, creating a mailing list on what is the main aspects were to work together, on identifying the areas and gaps and also on options to apply for projects or submitting proposals. He says that the mailing list will help learning and working together from the very beginning and creating a top-down think tank to arrive to Newcastle with specific ideas. He adds that there are still many open areas and that he is very interested in expanding the BI to other lifestyle areas.

Fredrik Spak suggests that they could take the responsibility to send the message requesting the interest of each one and to prepare a proposition together to be circulated in February. He says that his interest is the implementation and maintenance phase as well as the research in all theses areas.

Cristina Ribeiro says that implementation is also very important for Portugal and not only under a research perspective (extra payment of professionals for example).

Leo Pas says that he is willing to contribute to the proposal and that his areas of interest are to move from the training manual to a quality program and extending the BI issue to other professionals.

Kaija Seppa says that she agrees with Fredrik's proposal. She says that it is really important to hear other's needs. She adds that the network has to do more on collaborative research, that there are several practical needs on how to implement the EIBI and there is need to discuss around specific topics in small groups.

Leo Pas says that there are still many answers not responded and he says that creating a forum like this one will be helpful not only for applying for a new project but specially for sharing experiences.

Fredrik Spak mentions that in Sweden there some discussion on defining what EIBI and SBI mean and what we are asking professionals to do. He suggests meeting in the Hotel Lobby after lunch to discuss this a little. In his opinion doing EIBI is maybe intervening too late.

Leo Pas says that in Belgium they work under the "case finding" paradigm. Looking at the patient as a whole and taking into account that alcohol problems also happen together with other psychosocial problems.

Allaman Allamani adds that Phepa, as international network, has contributed as an umbrella to motivate and involve professionals. He asks what will happen now with that.

Pierluigi Struzzo comments on proposing BI not as another task to do but as good tool to intervene. If we propose it as a part of the whole intervention and also useful for intervening with other lifestyles problems it will be very helpful and GP will work better. If they understand that BI saves time they are not going to ask for reimbursement of the BI activities.

Svere Barfod comments that in offering BI to GP they talk about the advantages they give to them.

Cristina Riveiro comments that the reform in Portugal is also contributing to prioritize PHC professionals' activities. It is important because there are many tasks they have to do. In Portugal we are trying to integrate alcohol in the other lifestyles interventions.

Lidia Segura suggests involving EUROPREV, as partner of Phepa, in the discussion on how to continue with Phepa network. She also adds that joining Inebria will help as Inebria is recognized legally as an association and can help when setting agreements.

Nick Heather comments that there has never been any book (commercial purposes) written on the EIBI (following other examples). He raises this as a possibility that Inebria could do and not only at policy level. This is one way in moving things forward.

Peter Anderson says that is a good idea. The bible book (scientific one) and with some policy documents arising from it.

Leo Pas also says that the edition of a book could be good idea. In addition he mentions that there is a point in continuing sharing on the adaptation of the guidelines. Europrev is collecting guidelines and maybe we can contact them. In addition WONCA also endorses some meetings if there is a network to do it. We can explore these different possibilities. He finishes by saying that Phepa has to continue maintaining and updating the website.

Fredrik Spak asks about the continuity of the database.

Peter Anderson responds that it will depend on what happens with Phepa. Inebria is the logical way to try to kept it going. There is a cost on that and there is a limit on what you can ask people to do on a volunteer basis. We can also look on a long term on a some kind of funding.

Kaija Seppä agrees on the idea of writing a book. She adds that she will be willing to participate in a research project comparing the lifestyles approach or the "sole" approach. He also adds that in

Nordic countries GP did not want to do systematic screening at the very beginning. They started by selling the idea of opportunistic screening (screening trauma patients) and now GP are ready to do it systematically. We have to implement it step by step and it takes it a long time.

Antoni Gual tries to summarize what has been said until now.

-We do not want to lose the things that have been done.

-Proposals on how to meet and to be in contact (mailing lists).

-Prepare new research projects together.

-Sharing experiences and discussing "hot topics" in the area

-Produce knowledge (writing a book).

He raises the question "How do we move on"?

Pierluigi Struzzo suggests creating a group (mailing list) to start talking about it.

Antoni Gual suggests taking into consideration the options that Google groups offer.

Peter Anderson suggests the idea of going ahead with the Inebria Europe and maybe launching it in the Newcastle meeting and planning to produce the book. He also agrees on finding ways to go forward and finding mechanisms to keep networking and meet. There are many informal ways to go ahead but there are also ways to find some base money to keep going.

Nick Heather, talking as chair of the Inebria Conference, proposes that Phepa submits a Symposium on "Results of Phepa". Regarding the pre-meeting in the Conference, he agrees to support it (venue, coffee and timing) but reminds those present that someone else will have to organize it (take that on) since he is too committed with the main conference organisation.

Peter Anderson agrees on having a symposium in Newcastle and also suggests having another one in the next European conference in Slovenia (May 2010) and can allow to continue communication.

Nick Heather says that there are plans to publish selected proceedings of Inebria as well in the Drug and Alcohol Review.

Fredrik Spak says that the 2010 Inebria Conference will be in Sept 8-10 in Goteborg (Sweden).

Peter Anderson says that 2009 call for DG SANCO won't include any possibility for a Phepa III but there are other opportunities in other DG for funding.

Fredrik Says adds that in Sweden guidelines are going to be produced on lifestyles behaviours (physical activities and nutrition) and he wonders if it will be contra productive for Phepa to contribute and collaborate with EIBI developments in a broaden perspective.

Peter Anderson says that we have to gather evidence on that proposal before going ahead with integrating it.

Joan Colom finishes by adding that Catalonia would like to continue supporting the network and agrees to look for different ways to continue working together (workplace activities, etc.)

It is agreed to start a mailing list and sharing information on fundings and possibilities on how to move on.

The conference finishes with a final presentation (See at website: Pizza to Prague.ppt).

"PHEPA Project on disseminating brief interventions on alcohol problems Europe wide"

(PHEPA II)

Prague, 4th-5th December 2009

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