ANNEX 6

PROJECT EVALUATION

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INTRODUCTION

A project entitled *Integrating Health Promotion Interventions for Hazardous and Harmful Alcohol Consumption into Primary Health Care Professionals' Daily Work* (or Primary Health European Project on Alcohol [PHEPA] for short) was funded by the European Union (EU) as part of the *Community Action Programme on Public Health* and was co-ordinated by the Programme on Substance Abuse, Health and Social Security Department, Government of Catalonia in Barcelona. This project (PHEPA1) commenced at the beginning of 2002 and was completed at the end of June 2005. Funding was then received from the EU for a continuation of the project in expanded form and this commenced in 2006 (PHEPA2) with the title *Project on Disseminating Brief Interventions on Alcohol Europe-wide.* A total of 24 countries in the EU, together with Eurocare and the WHO Regional Office for Europe, took part in PHEPA2. The author of this document was commissioned by the PHEPA2 Chief Investigators to carry out an evaluation of the project and this is his report.

As with PHEPA1, the general aim of the project followed on from Phase IV of the *WHO Collaborative Project on the Identification and Management of Alcohol-related Problem in Primary Health Care*, the aim of which was to develop and apply country-wide strategies for widespread, routine and enduring implementation of screening and brief intervention for hazardous and harmful drinkers throughout the primary health care (PHC) systems of participating countries. A report to WHO on the work of the Phase IV study was completed in 2005 and posted on the WHO website[1]. The specific aims of PHEPA1 entailed the development of four related products: (i) *Clinical Guidelines* for delivering SBI in PHC that could serve as a basis for guidelines to be used in participating countries; (ii) a *Training Manual* linked to the Clinical Guidelines that could also be adapted for use in participating countries; (iii) a website containing an *Alcohol Management Database* for use by PHC professionals and others interested in the promotion of brief interventions in primary care; and (iv) a *Country-based Strategy* aimed at integrating brief interventions for hazardous and harmful drinkers in the PHC systems of participating countries.

The aims of PHEPA2 follow on from the aims of PHEPA1, with the general objective of disseminating best practice on early identification and brief interventions on alcohol problems within the general population. More specifically, the aims of the project, as set out in the proposal that was accepted for funding, were as follows:

- to create a sustained European Platform of health professionals and brief interventions with representation in all partner countries, and with two meetings of the platform;
- to develop a model, an assessment tool and a registry to assess and document the current status of services for brief interventions in all partner countries from a health systems perspective;
- to build an Internet-based resource centre on brief interventions for health professionals, policy makers and providers;

- to roll out a training programme throughout Member States to upwardly harmonize the skills of European health professionals; and
- to roll out clinical guidelines throughout Member States to upwardly harmonize the quality of brief interventions.

The outputs of the project and the results to be achieved were as follows:

- a sustained European Platform of health professionals and brief interventions with representation in all partner countries, with two meetings of the platform, one in year 1 and one in year 2, to share and document experience and to identify strengths and weaknesses of the different country approaches to disseminating brief interventions;

- a model, an assessment tool and a registry to assess and document the current status of services for brief interventions in all partner countries from a health systems perspective. The model will describe all the elements that are required for effective dissemination of brief interventions. The tool will document the current status in each of the partner countries, identifying strengths and limitations. The registry will allow sharing of experience from country to country on guidelines, training programmes and the approaches adopted to ensure widespread uptake of brief interventions;

- an Internet-based resource centre for accessible to health professionals, policy makers and providers on brief interventions, providing information in the domains of effectiveness, cost-effectiveness, policy, epidemiology and evaluation;

- a training programme adapted and adopted in Member the States to upwardly harmonize the skills of European health professionals; and

- clinical guidelines adapted and adopted in the Member States to upwardly harmonize the quality of brief interventions.

The specific objectives of this evaluation, agreed with the Chief Investigators, were to answer the following questions:

1. Did PHEPA2 achieve what it set out to do (ie. achieve the outputs listed above)? If not, why not?
2. Was PHEPA2 successful in involving the PHEPA2 partners in the project and promoting productive collaborations and networking?
3. What impact did PHEPA2 have at country level?
4. To what extent has PHEPA2 supported the implementation of the European Commission's Communication on Alcohol[2]?

METHODS

Methods used in the evaluation were both quantitative and qualitative. Quantitative methods entailed the use of a questionnaire and qualitative methods consisted of the results of discussion groups specially convened at the final meeting of PHEPA2 partners in Prague on 4-5 December, 2008.

Questionnaire

This was adapted from a Partnership Self-assessment Tool developed by the *Center for the Advancement of Collaborative Strategies in Health* at the New York Academy of Medicine[3]. This tool was developed to help partnerships understand how collaboration works and what it means to create a successful collaborative process, to assess how well their collaborative process is working and to identify specific areas they can focus on to make their collaborative process work better. The tool measures a key indicator of a successful collaborative process – the partnership's level of *synergy*. It also provides information that helps partnerships take action to improve the collaborative process and identify strengths and weaknesses in areas that are known to be relative to synergy – leadership, efficiency, administration and management, and sufficiency of resources. It also measures partners' perspectives about the partnerships' decision-making process, the benefits and drawbacks they experience as a result of participating in the partnership and their overall satisfactions with the partnership. For best use of the tool, the partnership to which it is applied should have been in existence for at least six months, represent a group of people and an organisation that are working together to develop and modify strategies to achieve their goals, have begun to take action to implement its plans and have at least five active partners.

With these considerations in mind, the tool was seen as especially relevant to the requirements of evaluating the work of PHEPA. It had originally been modified and used for the evaluation of PHEPA1. The questionnaire is shown in Appendix 1 to this report.

An electronic version of the questionnaire was emailed to participants on 15 October 2008, in the run up to the meeting in Prague on 4-5 December. It was sent to 30 associated or co-associated partners from Belgium, Bulgaria, the Czech Republic, Denmark, England, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Ireland, the Netherlands, Latvia, Lithuania, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and Turkey. Owing to a disappointing response to the first emailing, questionnaires were sent out again on 11 November, stressing the need to return the questionnaire by the end of November. In cases where there was more than one associated or co-associated partner from a single country, it was permitted that more than one partner could complete the questionnaire. The questionnaire was also sent to a further 11 collaborators and two observers. The confidential nature of questionnaire responses was strongly stressed.

It should be pointed out that the author of this report was a partner in the PHEPA2 project and completed one of the questionnaires. Needless to say, however, every effort has been made to remain objective about the findings of this independent evaluation.

Following discussions and enquiries at the Prague meeting, continuing non-responders were followed up on 11 December and subsequently if necessary. The final sample consisted of 23 completed questionnaires from Belgium, Bulgaria, the Czech Republic, Denmark, England, Finland (2), Germany, Greece, Hungary, Ireland, Italy (3), Lithuania, the Netherlands, Poland (2), Portugal, Slovakia, Slovenia, Spain and EuroPrev. At the time of the Prague meeting, Romania, France and Turkey had dropped out of the project. No responses were received from partners in Estonia and Latvia.

Quantitative data from the questionnaire were entered into an Excel file and then imported into SPSS-15 for analysis. The questionnaire also included open-ended items and responses to these were treated as qualitative data.

Discussion groups

To supplement quantitative data from questionnaire with qualitative information, PHEPA partners attending the final meeting in Prague took part in small groups to discuss their experience of the project, followed by a plenary session at which the conclusions of each group were fed back and further discussed. Small groups were composed of six members who were asked to elect their own chairperson and rapporteur. No group included more than one participant from a single country and professional affiliations were also mixed as far as possible. Group discussion lasted for 75 minutes, followed by one hour in plenary session. The conclusions of each group were entered into PowerPoint presentations that were handed over to the author of this report. The plenary session was tape recorded and this too was taken away by the author.

In introducing the session at the Prague meeting, the author first reminded the PHEPA partners present of the aims of the project, as above. They were then asked to consider in their groups the following questions:

- What were the good things about PHEPA2? What was most helpful in your country?
- What were the not so good things? How could the project have been better from your country's viewpoint?
- Where should we go from here? How should the dissemination of brief interventions be taken forward in your country?

RESULTS

Questionnaire data

Responses to each item of the questionnaire will be summarised and commented on.

A. ROLE

What is your role in the project?

Eighteen respondents (78.3%) described themselves as a partner, with a further three describing themselves as an observer and two as an expert. One respondent stated that (s)he was both a partner and an expert but this person was treated for the purposes of this analysis as a partner.

What tasks are involved in your role?

Responses to this open-ended question were given by 19 of the 23 respondents. Responses varied but most comments from project partners focussed on disseminating PHEPA products, implementation and co-ordination of the project in their own countries. Translating PHEPA products into their languages was mentioned by several. Typical responses were as follows:

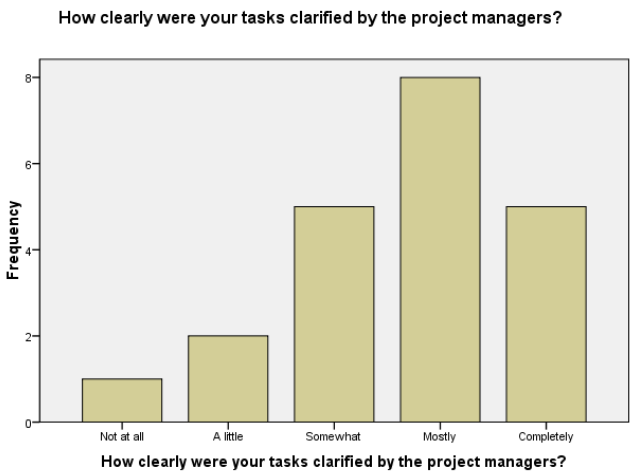
> "To implement brief alcohol intervention in my country by organizing training for professionals and meetings for experts based on tailored guidelines produced by the PHEPA project. To participate in the PHEPA meetings to share my expertise with other participants and to learn from their experiences."

> "To create conditions enabling (us) to carry out adaptation and translation of clinical guidelines and training manual into (language). To manage trainings, to evaluate results and effectiveness, to raise additional funds."

Understanding their role seemed to present difficulties for some experts and observers and they tended to leave this space blank. One expert wrote that their role had not been officially discussed with project managers.

How clearly were your tasks clarified by project managers?

The majority of respondents (60.9%) stated their tasks had been either mostly or completely clarified by the project managers. Again, the three respondents who stated that their tasks were only a little clarified or not at all were experts (2) or observers (1).



What are the main barriers you confront when carrying out these activities?

Eighteen of the 23 respondents entered a response to the question and these responses deserve careful consideration.

The majority of the barriers to progress listed by project partners referred to lack of interest and support on the part of professional colleagues and government authorities in the home country, including ministries of health in particular and frustrations over bureaucracy . Examples were:

> "Lack of manpower and interest in the alcohol field at the research institutes of general practice."

> "In my own country in relation to implementation: lack of professionals in primary health care; lack of motivation to do preventive work in this situation."

> "Bureaucratic problems regarding the establishment of the implementation of training in certain groups …. We contacted the Ministry of Health offering the know-how of the training but we didn't have a response yet."

> "The main barriers were: not having any money for the organisation work; having no help from the Government; having no help from the Ministry of Health; to persuade the GPs to identify their role in the brief intervention program."

> "Lack of leadership at local level, cutbacks in funding, bureaucratic administration."

> "Lack of influence on official decisions at national level (i.e. what to write in the official documents etc.)."

> "Red tape."

> "The lack of interested stakeholders (in the) home-country. Virtually no interest from the Government, professional associations, health care facility administrators, pharmaceutical industry, etc.".

> "Lack of time and lack of colleagues that would be really dedicated to the project."

Other respondents specifically mentioned problems in obtaining the necessary financial support in the home country:

> "Being involved in PHEPA gives impression to official authorities that we are heavily sponsored and can implement in our country without funds."

> "We joined the project during its second phase and we didn't receive any financial support for the translation of the products. We had to work pro bono all the time and it is still not clear if we will receive a reimbursement for the costs we have already made."

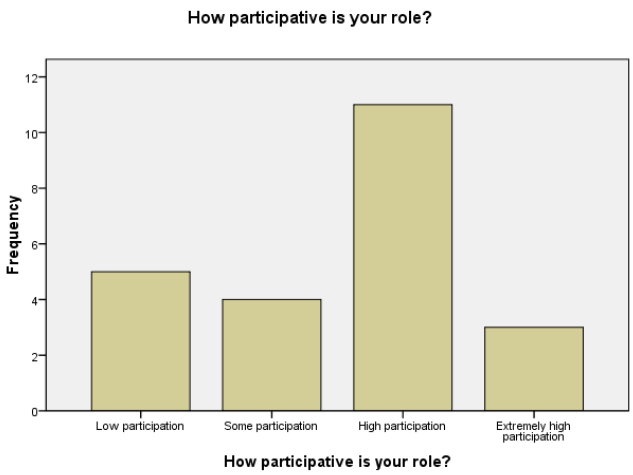
> "Lack of interest and financial support from the (country) Ministry of Health."

> "Changes in financing system and supporting institutions, e.g. due to cessation of anti-drug fund it was not possible to implement training on broader basis."

The lack of support from professional colleagues and authorities in respondents' home countries, together with lack of financial backing at home, is of course consistent with experience in other large projects aiming to implement brief interventions in the primary health care systems of participating countries, eg, the WHO Collaborative Project Phase IV Study.

A minority of the barriers identified by respondents referred to conduct of the project itself, viz, the lack of opportunities to share experiences at PHEPAS meetings and lack of information about the project between meetings. One of the observers again complained about a lack of clarity regarding their role in the project and an expert stated that lack of reimbursement for participation in PHEPA was a difficulty at their research institute.

<u>How participative is your role?</u>



A majority of respondents (60.8%) stated that their role involved either high or extremely high participation, with most opting for "high". Only two partners said they had only "some participation". Once more, however, all the respondents who scored low on this scale (< 4) and said they had either "some" or "low" participation were either observers (3) or experts (2).

How satisfied are you with your role in the project?

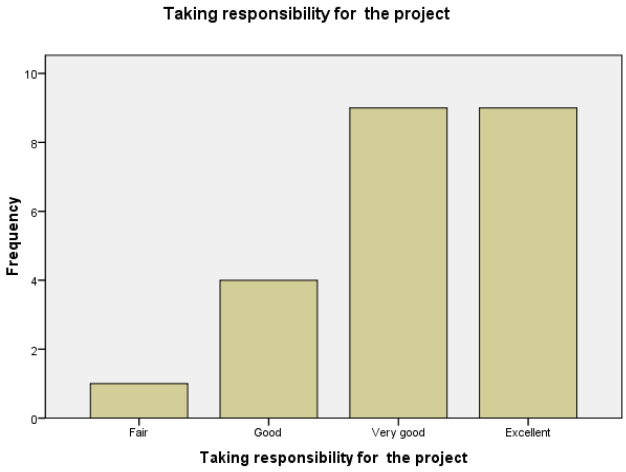
Most respondents (82.6%) were either somewhat or mostly satisfied with their role in the project. No respondent stated that (s)he was not at all satisfied. Both respondents who sated that they were only "a little" satisfied with their role in the project were partners.

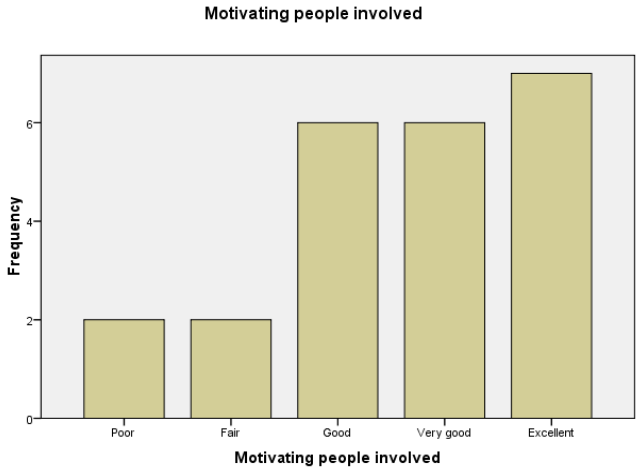
B. LEADERSHIP

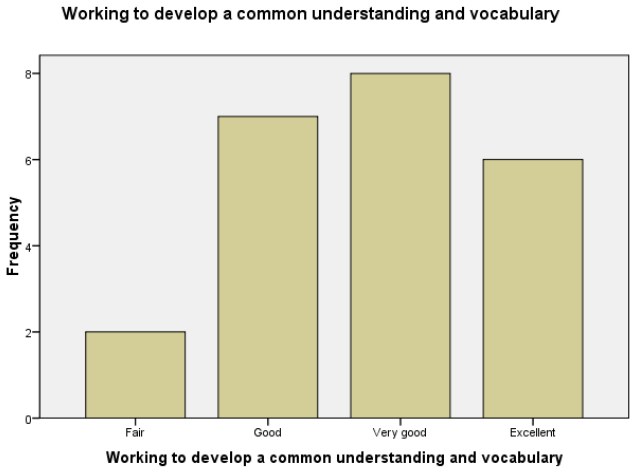
Ratings of the effectiveness of leadership in the following areas

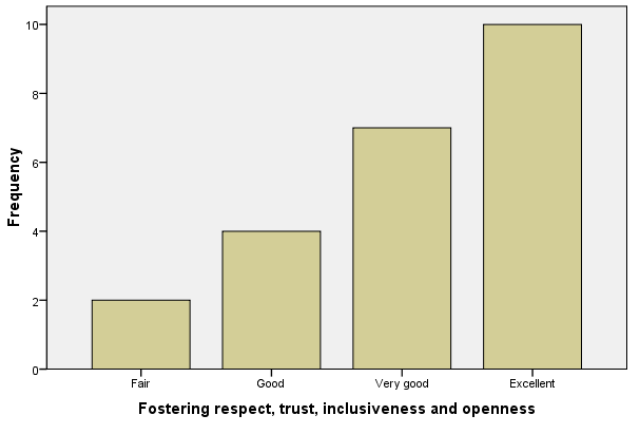
Generally speaking, project leadership was rated very highly by respondents over a range of aspects of leadership (see bar charts below). For "taking responsibility for the project", "motivating the people involved", and "working to develop a common understanding and vocabulary", a majority of respondents, ranging from 57.5% to 78.2%, gave ratings of either "very good" or "excellent". Particularly impressive

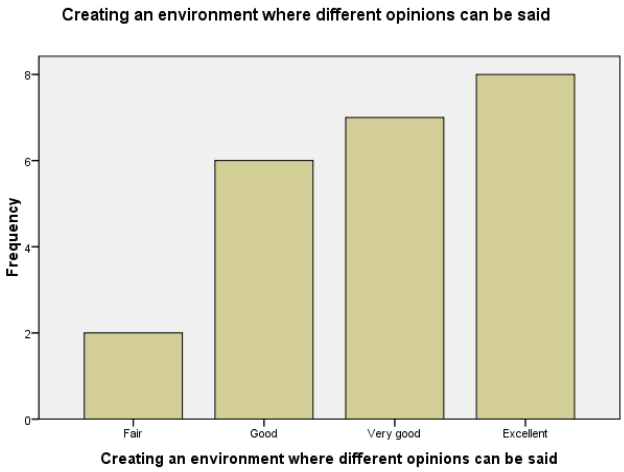
were ratings for "fostering respect, trust and inclusiveness" and "creating an environment where different opinions can be said" where the modal rating was for "excellent". Perhaps the only exceptions to these positive conclusions were for ratings on "combining the perspectives, resources and skills of the members", where the modal rating was for "fair". Even here, however, the majority of respondents (65.2%) rated leadership as "good" or better. "Resolving conflicts among partners was also rated somewhat less positively, with 43.4% of respondents rating leadership in this respect as "very good" or "excellent".

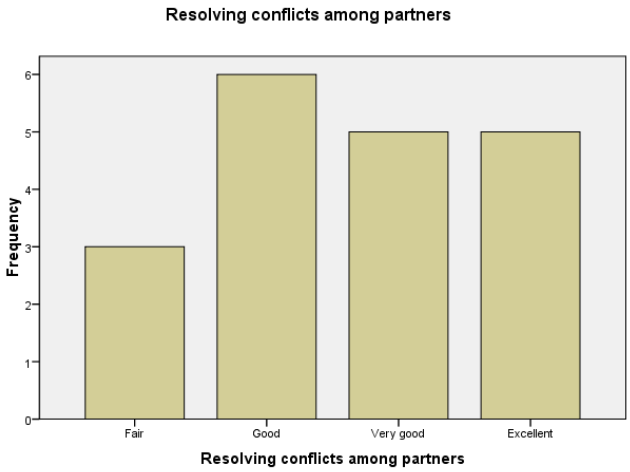












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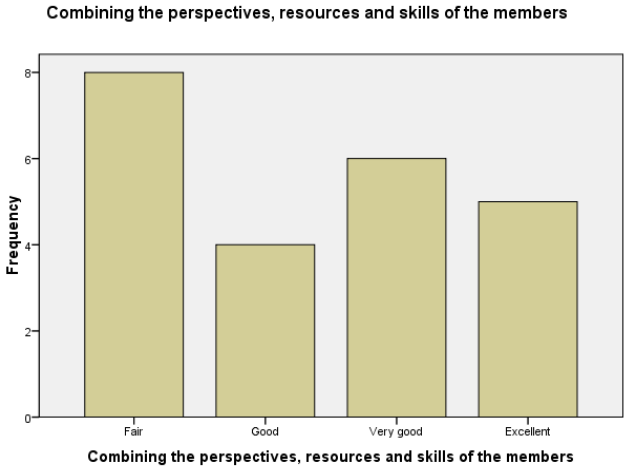
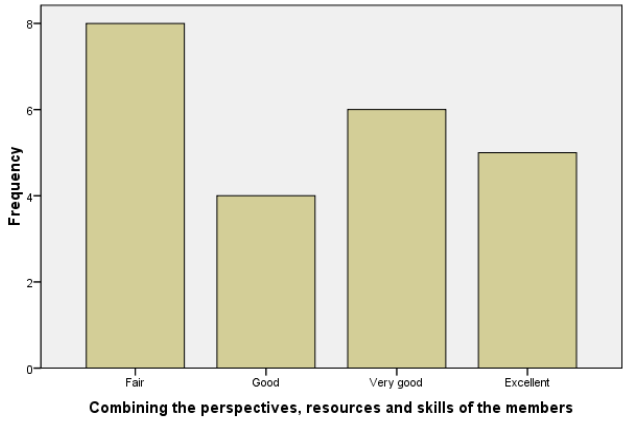


C. ADMINISTRATION AND MANAGEMENT

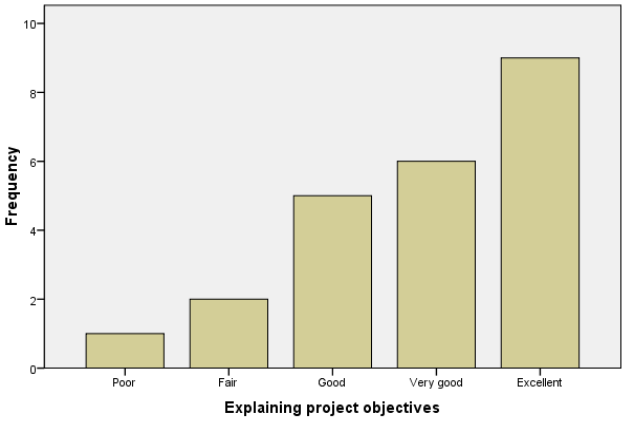
Ratings of the effectiveness of staff carrying out the following activities

Most aspects of administration and management of the project were rated highly by respondents. Especially positive were ratings for "explaining project objectives", "co-ordinating partnerships and activities", "preparing the material that informs partners etc." and "minimizing barriers to participate in meetings", for all of which "excellent was the modal rating. In other aspects of administration and leadership, a majority of respondents stated that the effectiveness of staff had been either "very good" or "excellent". Very few respondents to these items (< 3 in all cases) rated effectiveness as "poor" or "fair". The only exception to this was for rating to "combining the perspective skills of the members", where the modal rating was for "fair" (8 respondents, 34.8%), although the remainder (65.2%) did rate effectiveness on this dimension as "good" or better. Nevertheless, the relative lack of enthusiasm among respondents for this aspect of staff effectiveness is the only slight blemish on an otherwise very positive set of ratings.

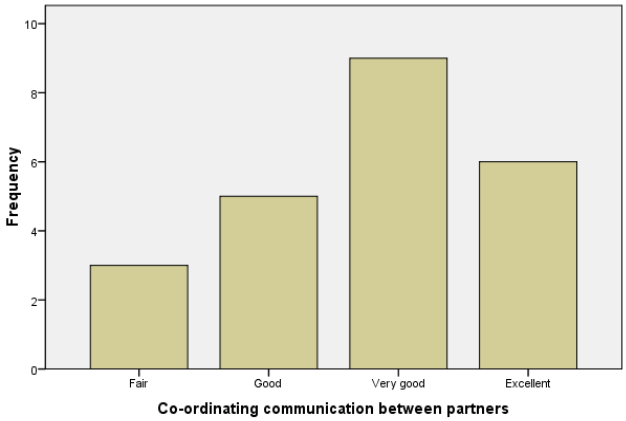
Combining the perspectives, resources and skills of the members



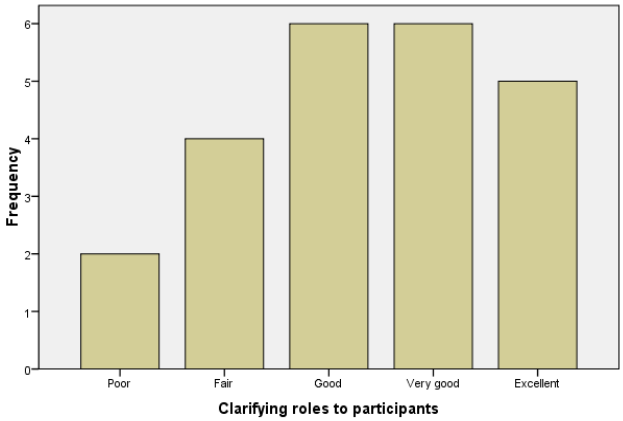
Explaining project objectives



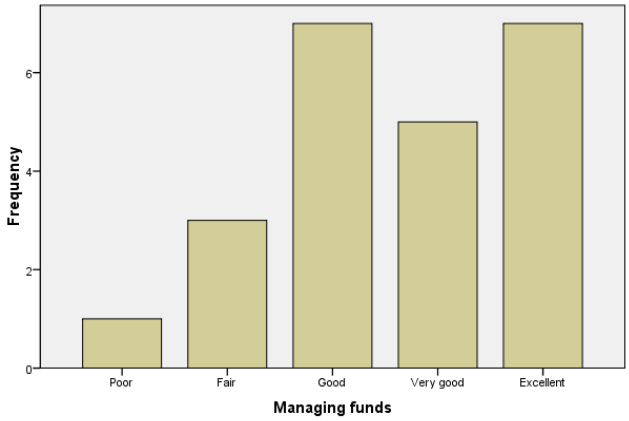
Co-ordinating communication between partners



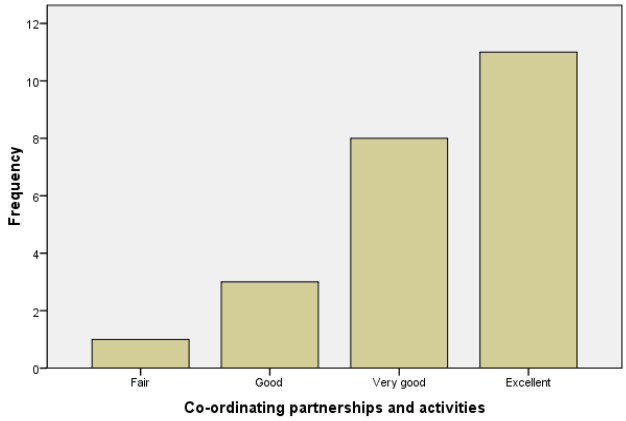
Clarifying roles to participants

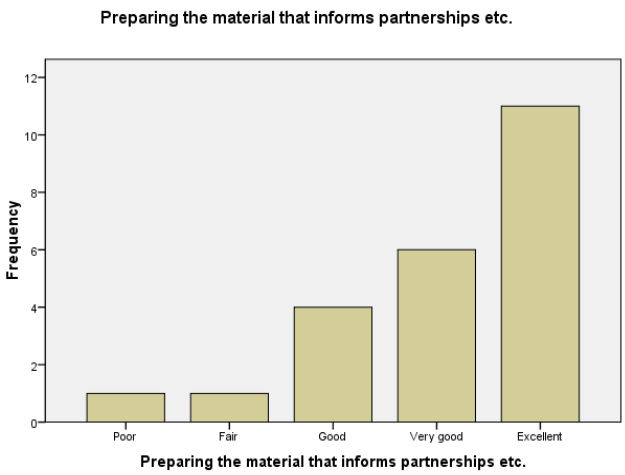


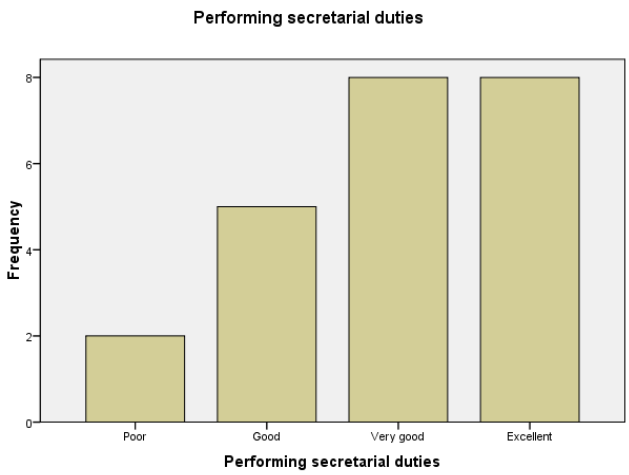
Managing funds

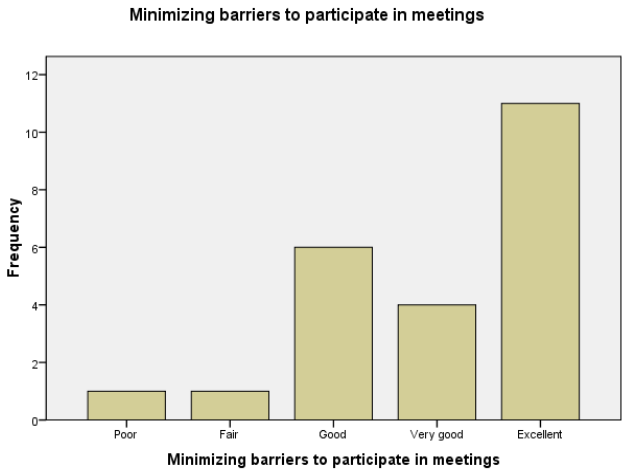


Co-ordinating partnerships and activities



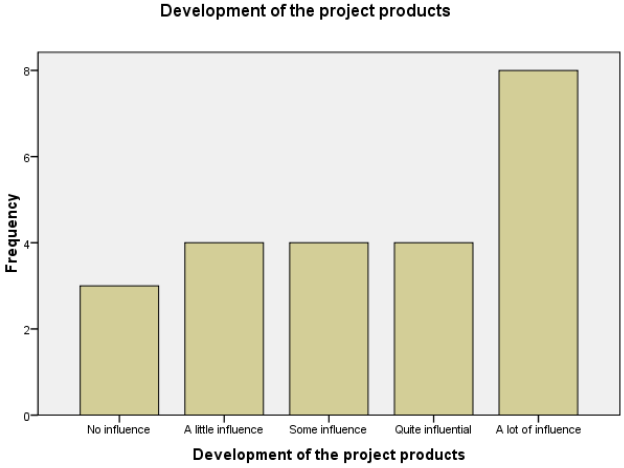


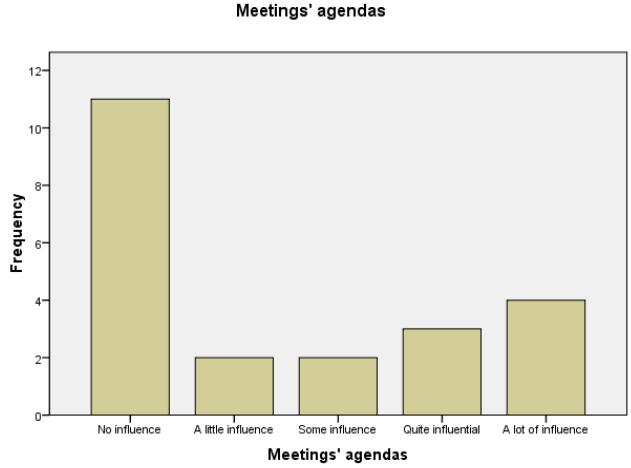




D. DECISION-MAKING

Ratings of the influence the respondent has had in the following areas:





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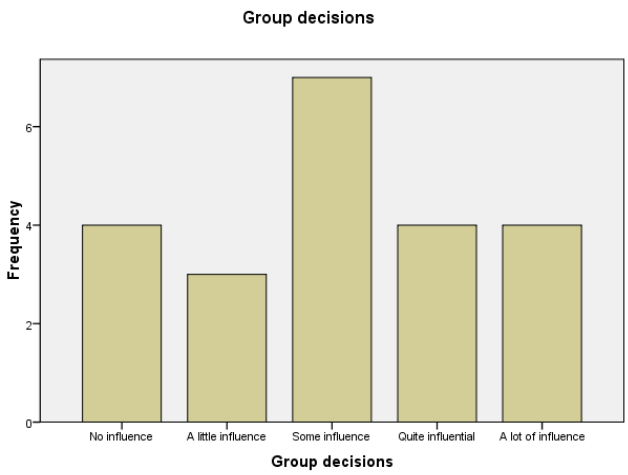

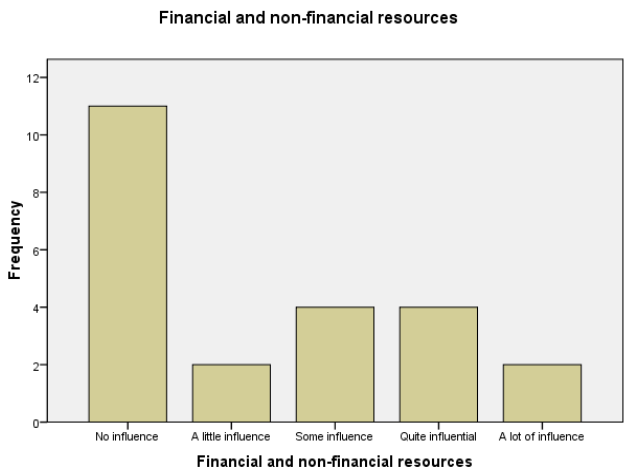

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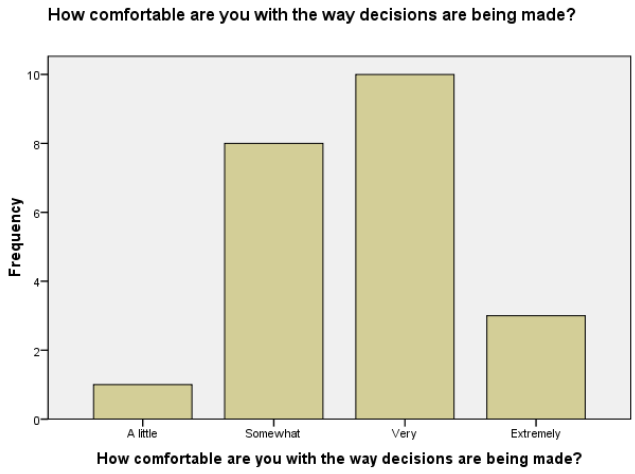
As will be seen above, respondents' ratings of the degree to which they were influential in decision-making in the project were mixed. The highest number of respondents stated that they had had a lot of influence on decisions regarding the development of products. There was a spread of responses to the question whether they had had an influence on group decisions, with the highest number stating that they had had "some influence" on these decisions. However, in regard to agendas for meeting and to financial and non-financial resources, the highest number of respondents stated that they had had no influence on these matters. Whether it would be practical or efficient to involve project partners in the setting of meeting agendas and the distribution of project resources, is, of course, debatable.



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In more general terms, the majority of respondents (79.3%) were either "somewhat" or "very" comfortable with the way in which decisions were made in the project, although only three were "extremely" comfortable.

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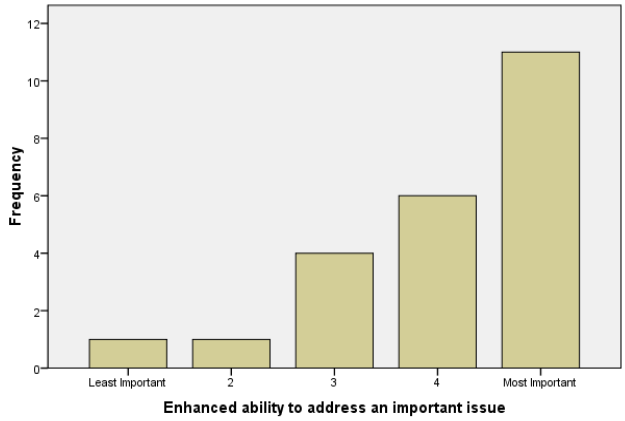
In the same way, 52.1% of respondents felt they had been left out of decision-making "never" or "almost never". It should be noted, however, that eight respondents stated they had been left out "sometimes" and two "most of the time".

E. BENEFITS AND COSTS

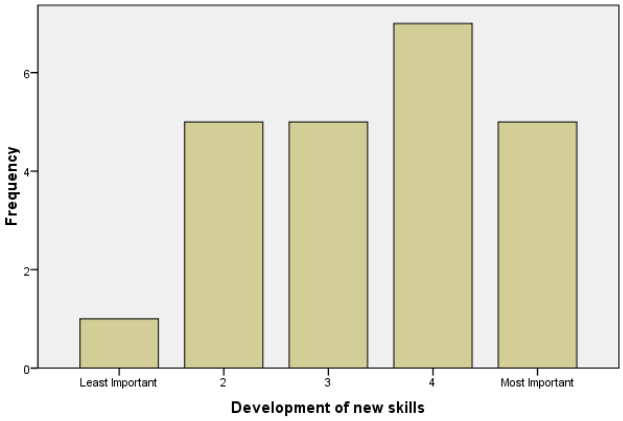
Ratings of the advantages of participating in the project.

When respondents were asked to rate the benefits of participating in PHEPA2, in terms of the advantages of so doing, a range of views were expressed (see bar charts below). Seen as most important in this regard were an "enhanced ability to address an important area" and the "development of valuable relationships". Somewhat less important, but still positively rated on the whole, were the "development of new skills", "increased utilization of my expertise and services", acquisition of new knowledge" and the "ability to have a greater impact than I could on my own". The only possible benefit that did not on the whole obtain positive ratings was the "acquisition of additional financial support"; some respondents gave this time high ratings of importance but the largest number (8) saw it as "least important". This is consistent with the identification of lack of financial support identified by some respondents as a barrier to progress in the project and commented on above.

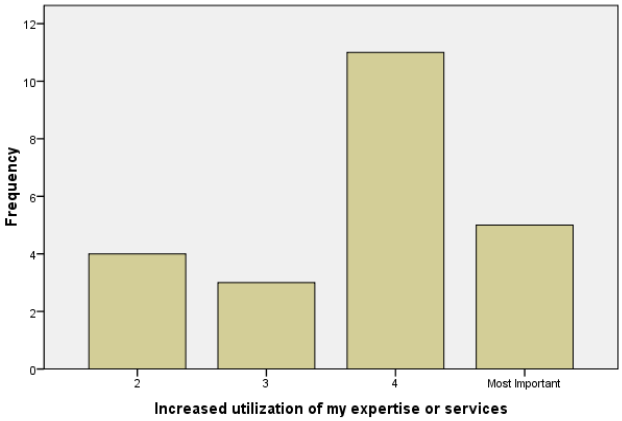
Enhanced ability to address an important issue



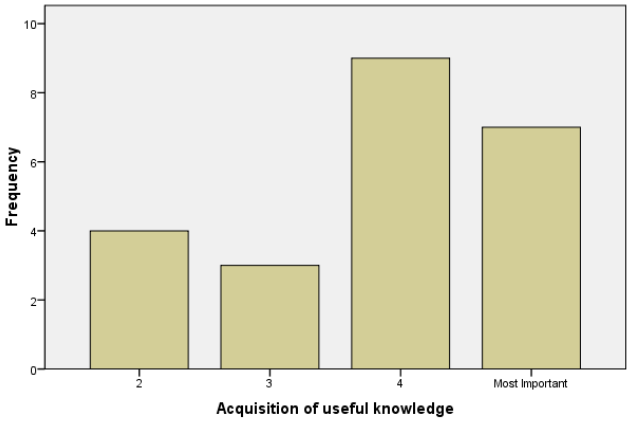
Development of new skills



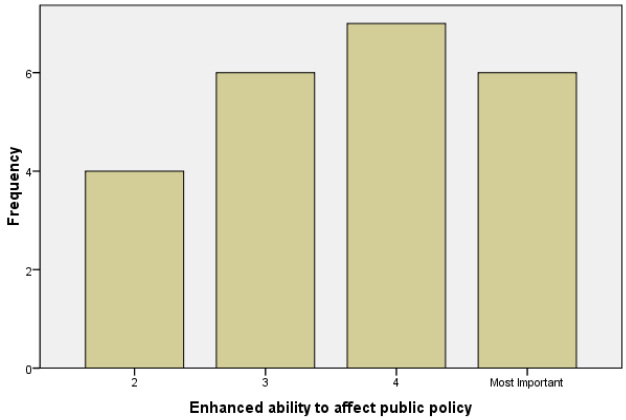
Increased utilization of my expertise or services



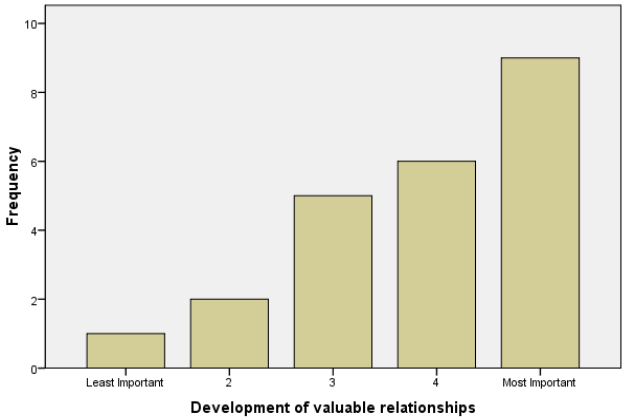
Acquisition of useful knowledge

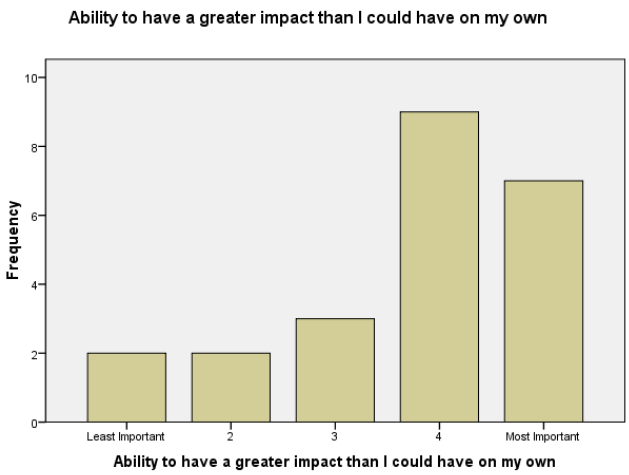


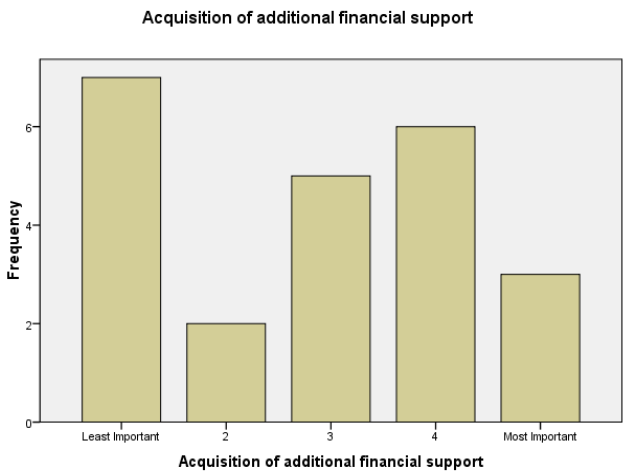
Enhanced ability to affect public policy



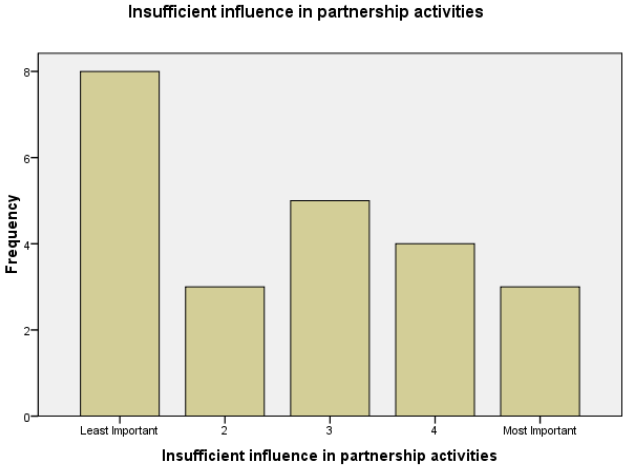
Development of valuable relationships

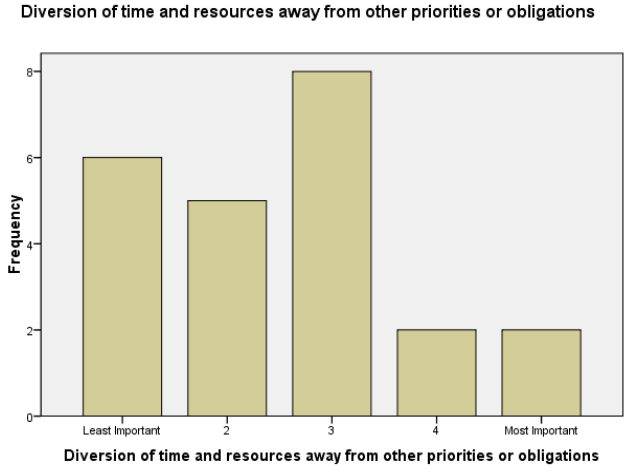






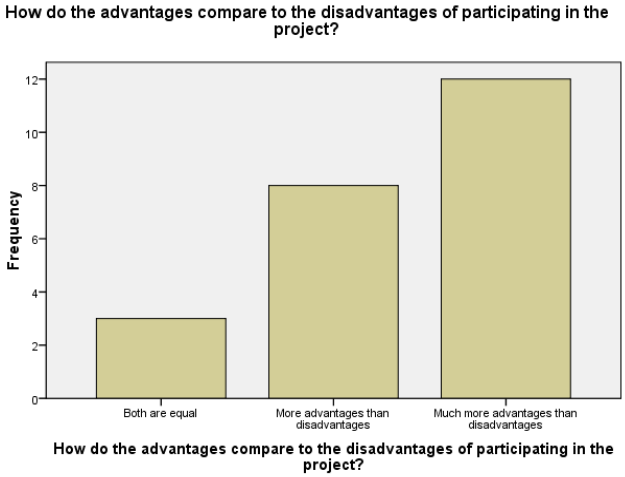
As for disadvantages of participating in PHEPA2, almost half (47.8%) of respondents thought that "insufficient influence in partnership activities" was not an important disadvantage, although another third (31.4%) believed that it was important. The largest number of respondents (8) was undecided whether a "diversion of time and resources away from other priorities of obligations" was or was not an important disadvantage, although the majority of the remainder thought that it was not important. Lastly, a majority (65.2%) thought that "conflict between my job and the partnership's work" was not an important disadvantage of participating in the project.





How do the advantages compare to the disadvantages of participating in this project?

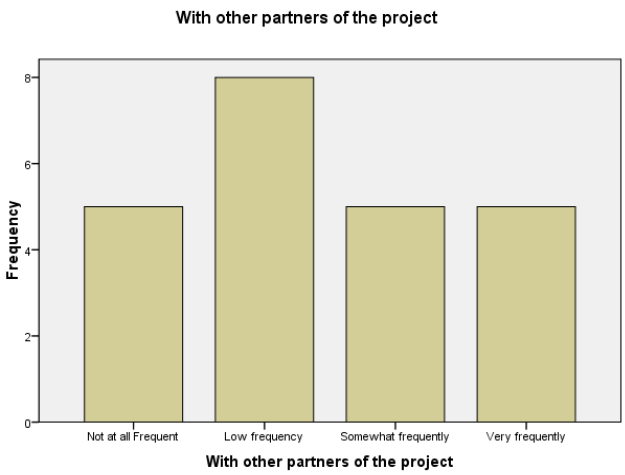
When asked for their overall rating of the advantages and disadvantages of participating in PEHPA2, the majority of respondents (52.2%) stated that the were many more advantages than disadvantages, while another 34.8% said simply that there were more advantages than disadvantages. No respondent thought that the disadvantages outweighed the advantages (see below).

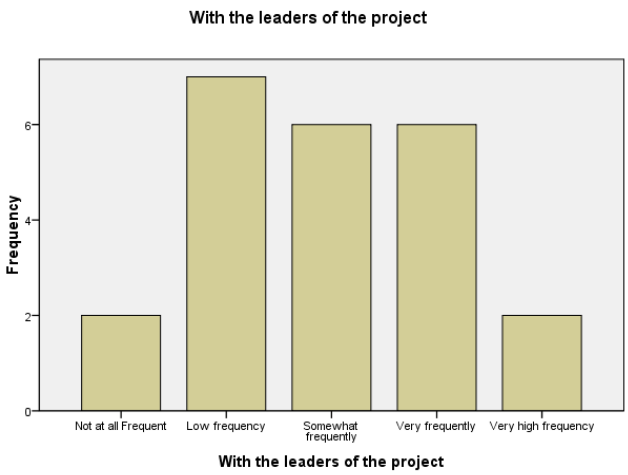


F. COMMUNICATION

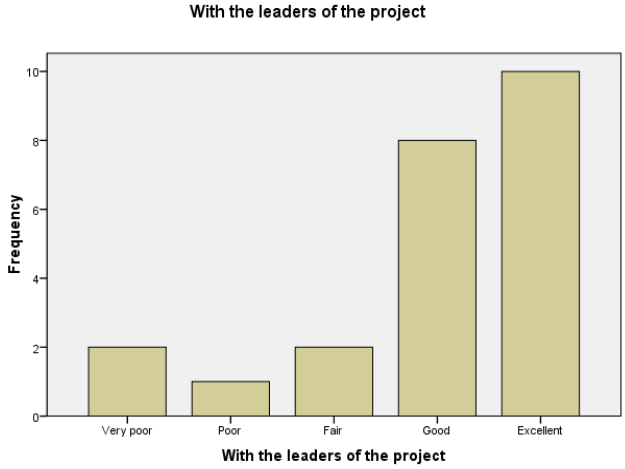
Ratings of the frequency of communication

When respondents were asked to rate the frequency of their communications (by telephone, email, etc.) with other partners in the project and with the leaders of the project, the modal value in each case was for "low frequency" but for rather more frequent communication with the leaders than the other partners.

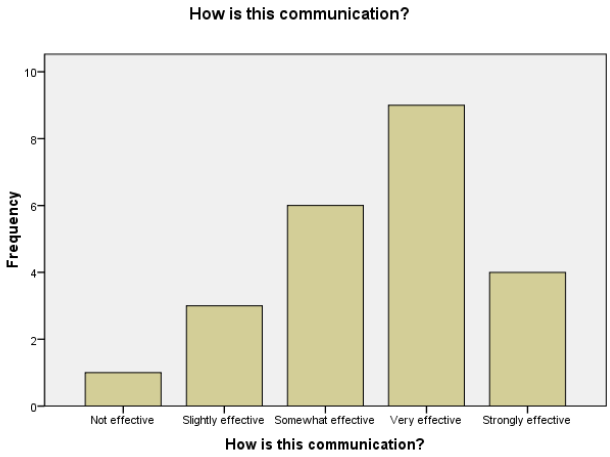




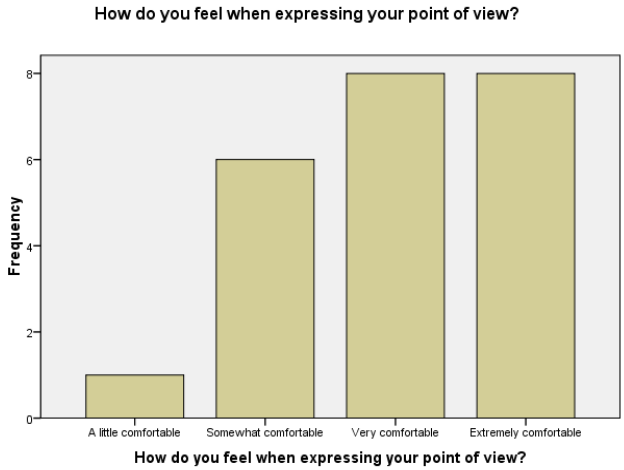
In regard to the quality of these communications, ratings were on the whole very positive. A small minority of respondents rated communications as "poor" or "very poor" (see below).



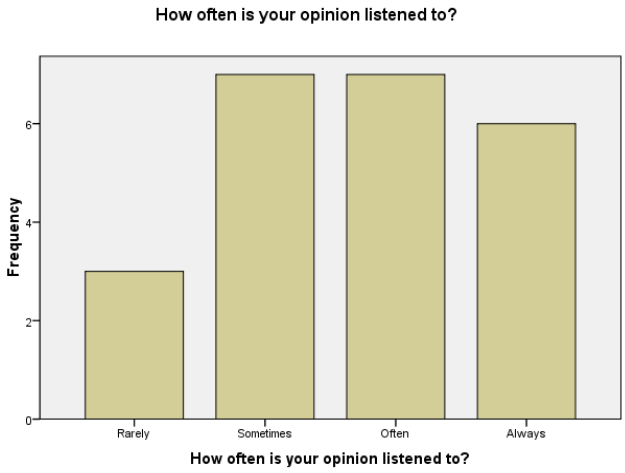
Regarding the effectiveness of the communication, a majority of respondents (56.5%) stated that it had been "very" or "strongly" effective, with again a minority who thought that it had been only a little or not effective (see below).



Respondents were also asked how they felt when expressing their point of view. A majority (69.6%) felt "very" or "extremely" comfortable ion this respect, with only one respondent feeling only "a little" comfortable.



Lastly regarding communications, respondents were asked how often their opinion had been listened to. Six respondents (26.1%) thought that they had "always" been listened to, seven "often" and seven "sometimes". Once more, a minority (3 respondents) thought that their opinion had been "rarely" listened to.



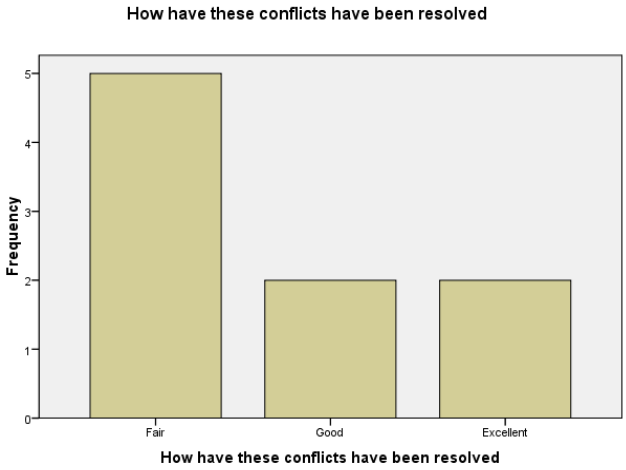
G. CONFLICTS

In an open-ended question, respondents were asked what (if any) had been the major points of conflict within the members of the group. Fourteen respondents wrote, in so many words, either that there had been no serious or major conflicts or no conflicts of any kind. A further six made no response to this question, suggesting that they too had not perceived any conflict in the group. One respondent said that there had been a conflict regarding the "understanding of the nature of SBI and its role in ameliorating alcohol-related harm." Minor sources of conflict that were noted related to "some people talking too much", "a lack of information about the specific role of the collaborating partners" and the fact that

"some partners simply disappeared and there was no chance to interact with them." One other respondent wrote:

> *"I don't think there were major conflicts. But I noticed that the project managers had the final decision. They did not always pick up the thoughts and ideas of other participants."*

Respondents were then asked to rate how these conflicts had been resolved. Only nine people responded to this item, presumably because the majority felt that there had been no conflicts to resolve. None of those who did respond thought that the way in which conflicts had been resolved was "bad" or "very bad" (see below).



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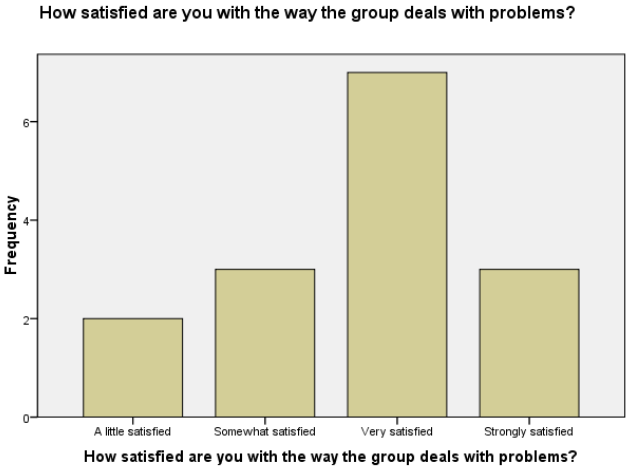
When asked how satisfied they were with the way that the group dealt with problems, a majority of those who responded (66.7%) were "very satisfied" or "strongly satisfied" with this aspect of the project.



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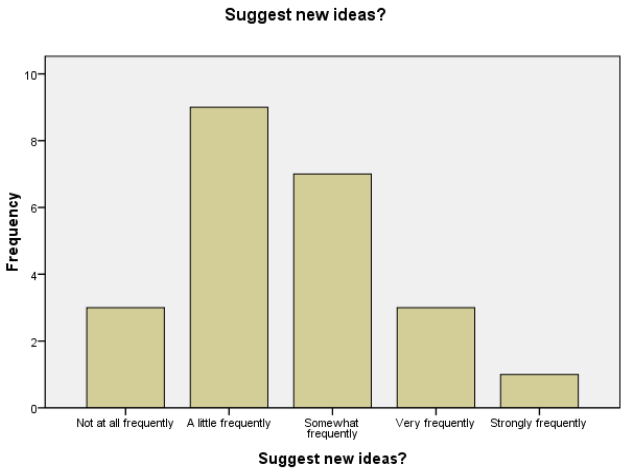
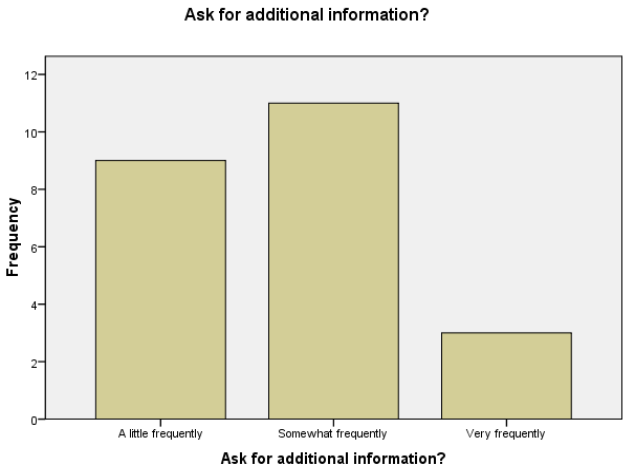
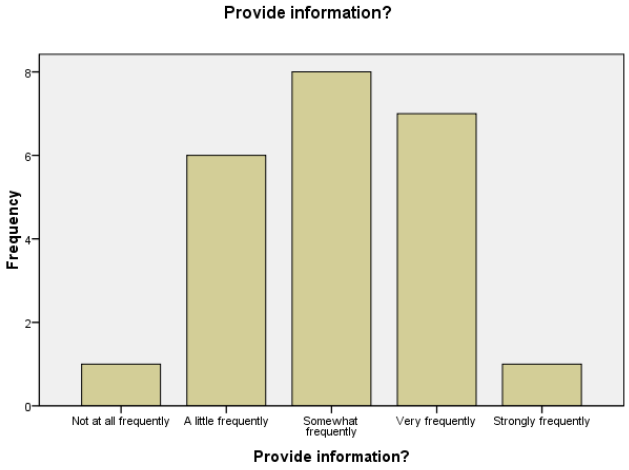
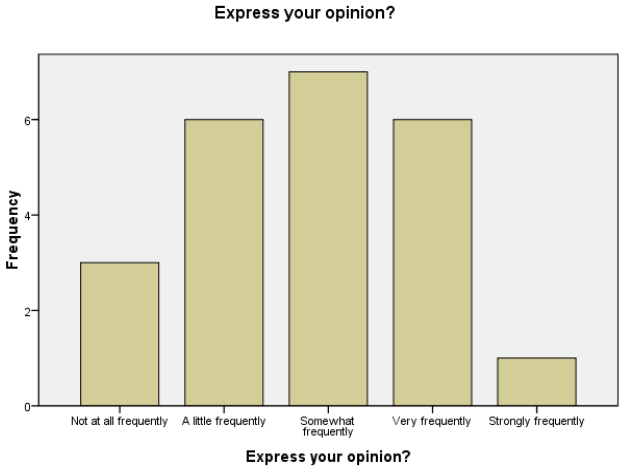
H. MEMBERS' PARTICIPATION

Respondents were asked how often they had made various kinds of contribution to the project (see bar charts below). In the main, "suggesting new ideas" and "asking for additional information" seemed to have occurred only a little or "somewhat" frequently. However, "providing information" and "expressing an opinion" occurred in the main "somewhat" or "very" frequently.

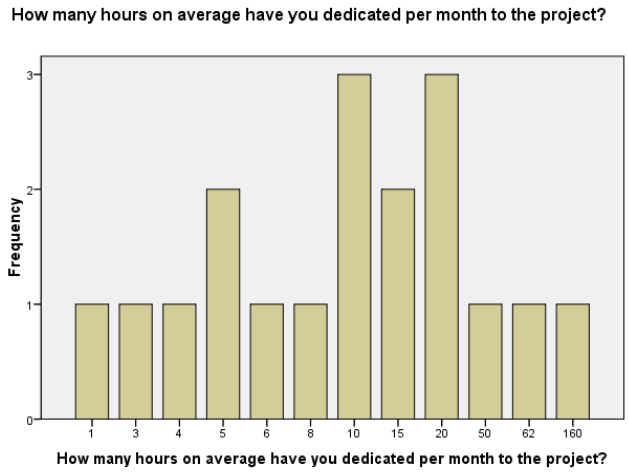








Respondents were asked how many hours on average they had dedicated to the project per month and the distribution of responses is shown below.



As will be seen, one respondent had entered a value of 160 hours, very probably due to a misunderstanding. (Another had entered separate values for each of three years of the PHEPA project and these were averaged for analysis.) The best indication of central tendency is therefore the median which was 10 hours per month.

I. MEMBERS' SATISFACTION

Respondents were asked to rate their satisfaction with different aspects of the project's work (see bar charts below). These ratings were on the whole very positive. A majority of respondents (72.8%) were either "mostly" or "completely" satisfied with "the way people in the group work together" and (63.6%) with "the general way the project is being developed". A smaller percentage (54.6%) was "mostly" or "completely" satisfied with "the rate of progress the project is making in achieving its objectives" and 40.9% were only "somewhat" satisfied with this. However, 68.2% were "mostly" or "completely" satisfied with "the progress of the groups since the beginning of the project". As will be seen, only a small minority were "a little satisfied" on these issues.

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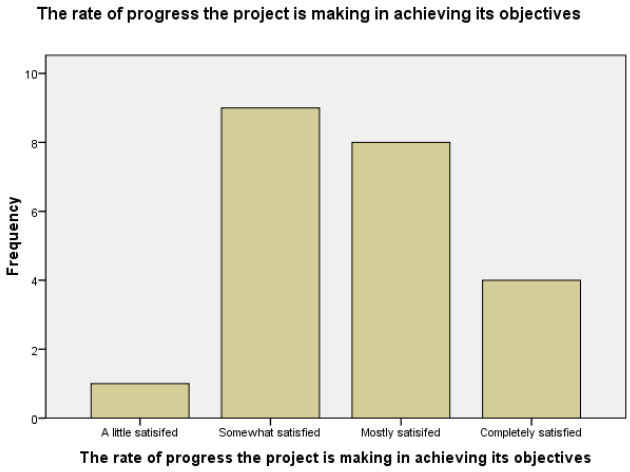

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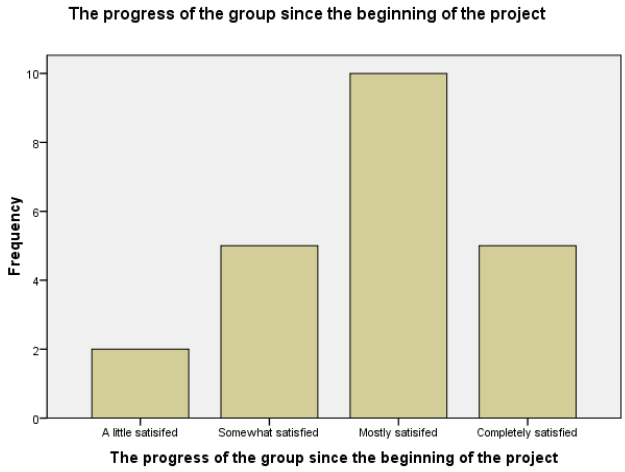

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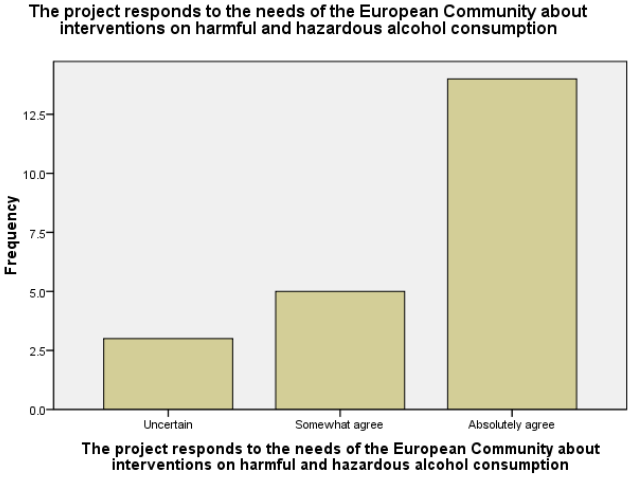
J. ACHIEVEMENT OF THE AIMS OF THE PROJECT

Respondents rated their level of agreement with various statements describing the achievement of three specific aims of the project had been achieved (see bar charts below). As will be seen, the modal response to all these statements was "absolutely agree" and the majority of respondents were confident that the project had responded to the needs of the European Community about interventions on harmful and hazardous alcohol consumption, that it had developed tools that are the most likely to work on this issue and that the tools are flexible enough to be adapted to the needs of different countries. Only a minority of respondents were uncertain or disagreed that these objectives had been met. This appears to be a strong endorsement on the part of the majority of PHEPA2 partners that specific key objectives had been met.



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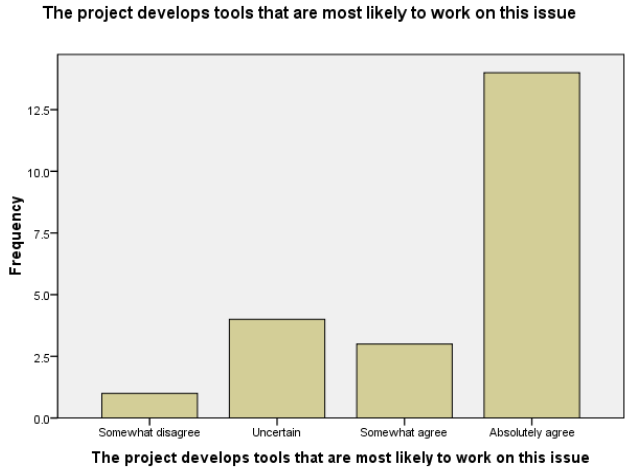

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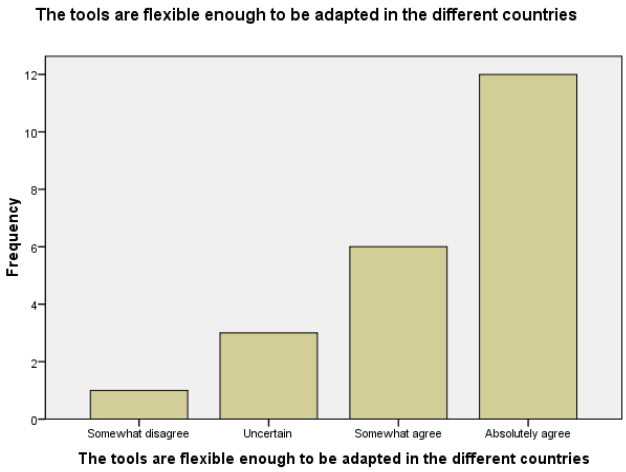

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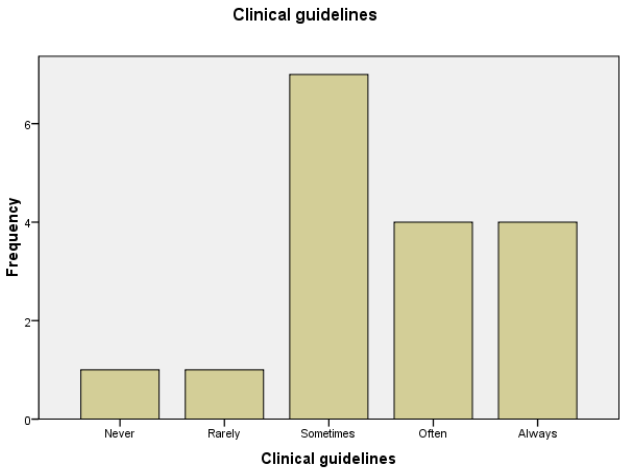
K. PRODUCTS OF THE PROJECT

In a final section of the questionnaire, respondents were asked to rate various aspects relating to the products of the PHEPA2 project.

Has your opinion been taken into account in the development of the products?



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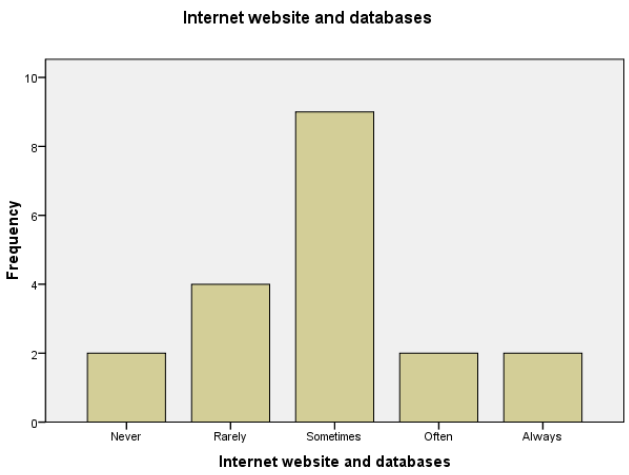

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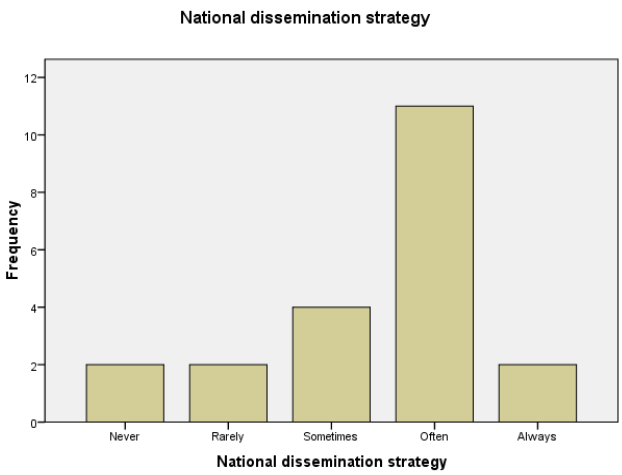

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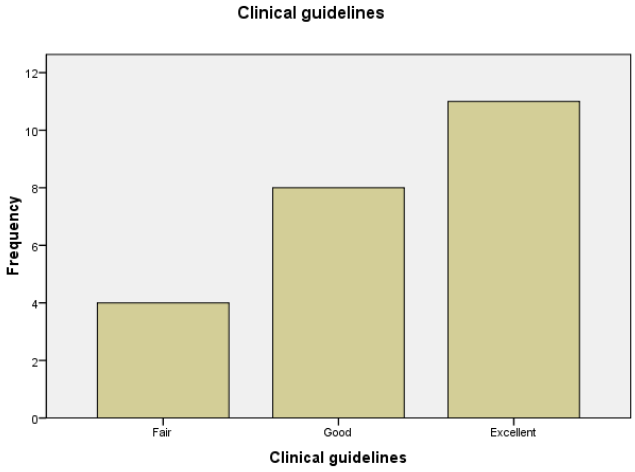
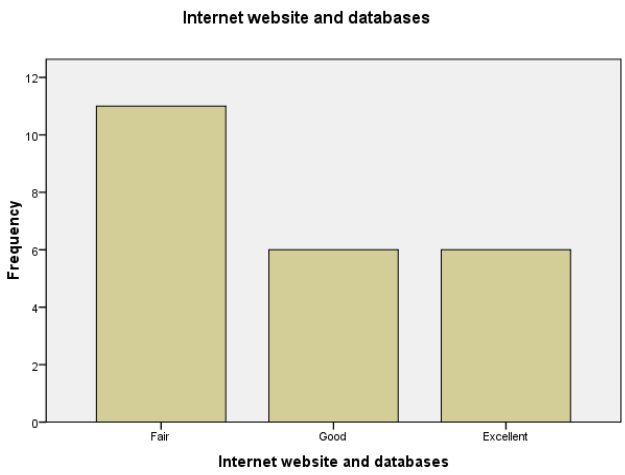
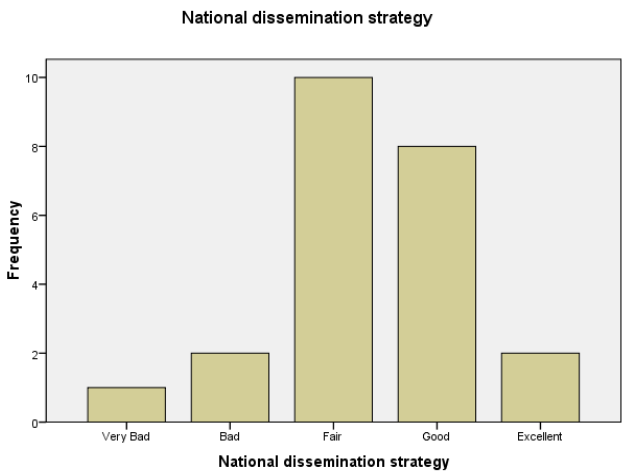
There were some missing data for these responses (see above). However, a majority of respondents thought that their opinion had been taken into account at least sometimes in the development of the clinical guidelines (65.2%) and the national dissemination strategy (73.9%) (ie, the strategy to be followed in each participating country). Rather less thought their opinion had been listened to in the development of the training manual (56.5%) and the website and databases (56.5%), with the remainder believing that they were listened only "rarely" or "never".

<u>What is your opinion on the achievement of the products?</u>







There were no missing data on these items and responses were, on the whole, very positive. No respondents thought that the clinical guidelines were bad or very bad and most (82.6%) thought that they were "good" or "excellent". A similar picture applied to the website and databases, although fewer respondents (52.2%) regarded these as good or excellent. For the training manual, one respondent rated this as "bad", while the majority (82.6%) though that it was good or excellent. Three respondents thought the national dissemination strategy was "bad" or "very bad", with the largest proportion 43.5%) stating that it was only "fair". Nevertheless, the group as a whole had very favourable opinions of the products of the project.

What would you change of the methodology used?

Ten respondents were prompted to make suggestions by this open-ended question. These were as follows:

> "Decentralised collection of advice how to run the planning and an intense exchange in between meetings how project members can individually contribute to a joint effort."

> "More flexibility of approach to take account of international differences in the organisation of primary health care and other, cultural factors."

> "Training manual is too rigid (too many sessions, too busy schedule) in relation to the needs of most general practitioners. There should be a more feasible (shorter) form of training which would allow more time for motivating discussions."

> "Sometimes it is better to make a risk factor screening with other somatic diseases, for example, hypertonia, sleeping disorders, headache, sugar level, obesity, nicotine abuse and so on. Most patients ….. complete the tests better if they can have answers for other health problems as well (next to the alcohol consumption disorders)."

"A much more 'condensed' training course, hopefully oriented to some specific areas such as workplaces and pediatric settings (also according to a possible pilot experience to be drafted) aimed at curbing alcohol-related problems among very young people. Gynaecologists would be also interested in focusing on a product coming from the PHEPA expertise. One more setting is the one related to road accidents (during the licence training, as well as in the mandatory programmes for people who are obliged to frequent a course after a positive BAC detected by the police)."

"As a new partner who joined in PHEPA2, we needed more exposure before the project started."

"It would have been nice if we could have carried out a pre-measurement to see whether or not primary care professionals are involved in each country and perform a post-measurement at the end of PHEPA2, including ideas about following up the dissemination and implementation of screening and brief interventions after the end of the project."

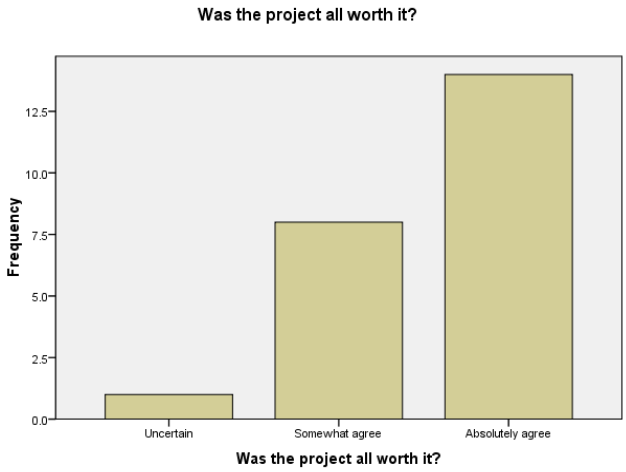
"It is important to put this subject on the agenda of the priorities of PHC, researchers and policy makers at national level and we think we are working on it."

"To enrich the cognitive-behavioural characteristics of the project by adding some more ideas and perhaps also techniques based on psycho-dynamic training (our participants have indicated that they received more from hands-on training, face-to-face communication and direct experiences than from presentations of facts and knowledge by lecturers and experts)."

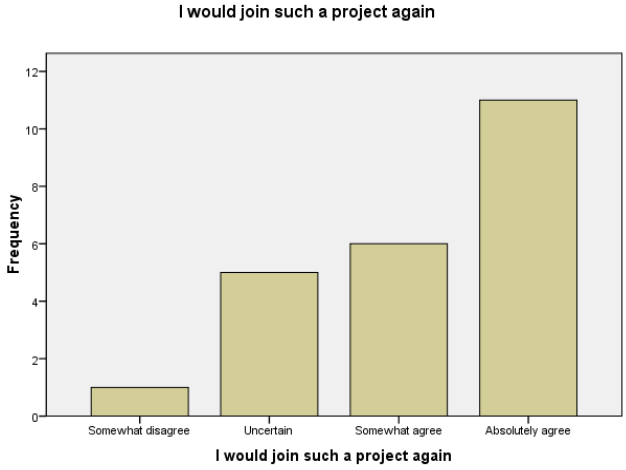
"The distribution of the budget and the payment methods. Phepa1 allowed much more flexibility, which was of benefit to the scientific work."

As will be seen, there were a variety of suggestions here and not much common material among them. Two respondents said that the training course should have been more flexible and shorter. Greater flexibility was also recommended for the method of payments to participants and for the general approach to implementing brief interventions across participating countries. Other suggestions may be consulted above.

As the last item on the questionnaire, respondents were asked f the project had been worth it and whether they would join such a project again.



It will be seen that 60.9% of respondents "absolutely agreed" that the project was all worth it, 34.8% "somewhat agreed" and only one was uncertain. None disagreed to any extent that it had been worth it.



Similarly, nearly half (47.8%) "absolutely agreed" that they would join such a project again, a quarter (26.1%) "somewhat agreed", a fifth of respondents (21.7%) were uncertain and only one "somewhat disagreed" with this statement.

Supplementary analysis

It will have been noted that, while the response of the project participants to almost every item on the questionnaire was positive and favourable to the project generally, many items showed a minority of participants who expressed various kinds of dissatisfaction. The question arises whether these were the same or different people. In other words, was there a "dissident minority" in the group who tended not to react favourably, or less favourably than others, to the project arrangements and were largely dissatisfied with their participation in it? To attempt to answer this question, a principal components analysis was carried out of all quantitative questionnaire items (except role in the project and time spent per month). If a large component were detected by this analysis reflecting high inter-correlations between items with significant loadings on the component in question, this would show that individuals

tended to respond in the same way, either positively or negatively, to those items. The meaning of the component could then be interpreted.

The results of this analysis were that six principal components were extracted accounting for, by definition, 100% of the variance between item responses (see below).

COMPONENT	INITIAL EIGENVALUES		
	TOTAL	% OF VARIANCE	CUMULATIVE %
1	30.011	45.471	45.471
2	11.745	17.795	63.266
3	7.984	12.097	75.363
4	6.312	9.563	84.926
5	5.734	8.689	93.615
6	4.214	6.385	100.000

Confining attention to the first component only, which accounted for 45.5% of the variance, and also to high loadings over 0.8, this component is described by the following loadings (see questionnaire, Appendix):

<u>Component 1</u>
(Influence in decisions on) meetings' agendas (.91)
(Effectiveness of staff in) minimizing barriers to participate in meetings (.90)
How satisfied are you with your role in the project? (.89)
(Effectiveness of staff in) performing secretarial duties (.89)
(Opinion taken into account in) clinical guidelines (.88)
(Quality of communication) with other partners of the project (.88)
(Effectiveness of leadership in) resolving conflicts among partners (.87)
(Effectiveness of leadership in) combining the perspectives, resources and skills of members (.86)
How comfortable are you with the way decisions are made? (.86)
(Influence in decisions on) financial and non-financial resources (.85)
(Opinion taken into account on) training manual (.85)
How effective is this communication (with other partners or leaders)? (.84)
Development of valuable relationships (benefit from participation) (.83)
(Influence on) group decisions (.82)
(How often do you) suggest new ideas (.82)
(Effectiveness of leadership in) creating an environment where different opinions can be said (.81)
(Effectiveness of staff in) clarifying roles to participants (.80)

It seems clear that this main component reflects the quality of the participant's experience of taking part in PHEPA2, particularly in terms of being able to contribute to decision-making and discussions, the quality of communications in the group and generally being satisfied with the experience of the project. It must be stressed again that the majority of participants reported a very favourable experience of the project and felt that they were able to contribute to and influence the group process. However, at the opposite pole of this dimension, there was a small minority who did not share this positive experience.

Conclusions from questionnaire data

On the basis of the questionnaire data reviewed here, the following seem the most salient conclusions:

1. Project partners had a clear understanding of their role in the project in terms of disseminating PHEPA2 products and promoting a national implementation strategy in their own countries, and contributing to the PHEPA2 group process.

2. In contrast, observers and experts did not have a clear understanding of their roles and more could have been done to clarify what was expected of them in the project.

3. The main barriers to fulfilling partners' roles in the project concerned lack of interest and support on the part of professional colleagues and government authorities in the home country, including ministries of health in particular, and frustrations over bureaucracy and financial backing at home. This is consistent with the experience of previous projects aiming to disseminate brief interventions in participating countries.

4. Most group members felt highly involved in the project and were satisfied with their role in it.

5. The project leadership was rated very highly by group members on the whole, particularly with regard to fostering respect, trust and inclusiveness, and creating an environment where different opinions could be expressed.

6. On the whole, the effectiveness of project staff in carrying out the administration and management of the project was highly rated by group members.

7. While comfortable in general with the way decisions had been made and with their influence on the development of products, most group members thought they had not been able to influence the setting of agendas for meetings and the distribution of financial and non-financial resources. A sizeable minority felt they had sometimes or often been left out of the decision-making process.

8. The main benefits identified by partners from taking part in PHEPA2 were an enhanced ability to address an important area and the development of valuable working relationships but not the acquisition of additional financial support. All believed that advantages of participating outweighed disadvantages.

9. Frequency of communications tended to be rated as low with other project partners but as higher with project leaders. The majority of group members rated the quality of communications positively but a minority rated them as poor.

10. A majority thought that communication in the project had been effective and felt comfortable in expressing their point of view which they believed had been listened to. A minority did not share these positive conclusions.

11. Participants perceived no major conflicts between members during the project. Most believed that any minor conflicts had been dealt with satisfactorily.

12. The most frequent kind of communication made by group members was thought to have been providing information and expressing an opinion. Suggesting new ideas and asking for additional information were thought to have occurred less frequently.

13. Participants reported spending an average of 10 hours per month on the project.

14. Most group members were very satisfied with the way the group worked together, how the project was developed and its rate of progress.

15. There was a strong endorsement by most participants of the project's achievements in respect of specific key objectives – responding to the needs of the European Community about interventions on harmful and hazardous alcohol consumption, developing tools that are the most likely to work on this issue and developing tools are flexible enough to be adapted to the needs of different countries.

16. Most felt that their opinion had been taken into account at least sometimes in the development of the clinical guidelines and the national dissemination strategy but less often in the development of the training manual and the website and databases.

17. The group as a whole regarded the project products – clinical guidelines, website and databases, training manual and the national dissemination strategy - very positively but this was not the universal opinion.

18. When participants were asked what aspects of the methodology they would change if the project were to be repeated, some diverse suggestions were made. Two partners thought that the training manual was too long and inflexible.

19. There was general agreement among the group, and no disagreement, that the project had been worth it. Most agreed that they would join such a project again.

20. Despite the fact that the majority of those taking part reported a very favourable experience of the project and felt that they had been able to contribute to and influence the group process, there was a small minority who did not share this positive experience. More could perhaps have been done to improve the experience of this minority.

Data from discussion groups

Feedback from each of the four discussion groups that were held at the Prague meeting will now be described under the heading of the three questions the groups were asked to consider (see Methods above). Some of the points listed below as conclusions from each of the groups were further clarified in rapporteurs' feedback to the plenary session and this has been incorporated in the summary of the groups' conclusions given below. It should also be noted that, while the questions the groups were asked to address referred specifically the PHEPA2, it was inevitable that many of the conclusions reached covered the achievements, or lack of them, of the whole PHEPA project, including PHEPA1 and PHEPA2.

What were the good things about PHEPA2? What was most helpful in your country?

Group 1:

- Gave co-ordination and support (knowledge, material, motivation), international networks (learning from others)
- PHEPA was a higher power, spiritual force, which helped
  - in getting funding, increasing visibility
  - in activating professionals

Group2:

- Cooperation between countries
- Standardised, common, minimal standards
- Motivating (not being alone, expert support, helps to go to politicians)
- Exchange process: problems and solutions of other countries; learn from others
- Practical materials: training manual example, guidelines
- Reframing public/professional understanding (public and professionals) about PHC role, about alcohol problems
- Dissemination of evidence-base in other settings
- Better collaboration between settings, professionals
- Create a European and even world network

Group 3:

- The professionalism and energy of the PHEPA team
- Incentive to collaborate
- Collaboration between various public stakeholders

- Inspiration and support for continuing personal engagement (when participants are few), ie, the success varies with the development of SBI/country
- Gives feedback with information.
- Strengthens organisation in contact with governmental authorities.
- Continues PHEPA1 and gives more time.
- Promotes prevention in competition with other demands.
- Promotes the work with alcohol
- Introduces new countries in SBI movement.
- To develop sustained platform.
- Internet-based resource

Group 4:

- Meeting colleagues – facilitate networking
- Help to get brief interventions started
- Good training methodology
  - Training Manual well accepted
  - Identification of key professionals
  - GPs training themselves
- Translation of Clinical Guidelines + Training Manual very useful

The conclusions summarised above regarding the good things about the PHEPA2 project reinforce some of the conclusions from the questionnaire data. Specific mention was made by three groups of the benefits of expert support for carrying out the required work and this support was thought to be especially valuable by Group 3 for participants from countries without much prior experience of brief interventions. All four groups mentioned in different words the benefits of international networks and cooperation, and the opportunity to learn from others. Through its prestige as a EU-funded study, membership of PHEPA2 also inreased participants' capacity to have an influence in their own countries on government authorities and professional colleagues. In the humorous words of Group 1, the project was a 'higher power' that helped to obtain funding, activate professional colleagues and increase the profile of brief interventions in the home country. It also help to promote preventive work in general and alcohol work in particular in the participant's home country. Continuation of the progress made by PHEPA1, thus allowing more time for the long process of implementation, was also mentioned.

In addition to these more general benefits, the project products were also endorsed by the groups. The translations of the training manual and the clinical guidelines, together with the Internet-based resource, were specifically identified as valuable practical outcomes of the project. In some countries, GPs had been encouraged by the project to develop their own training. The evidence base for the effectiveness of brief interventios in primary care had been usefully applied in other settings. The project had also contributed to the necessary reframing of alcohol issues among health professional in the home countries.

On a more expansive note, another benefit of the project was the start it had made towards the creation of a European network of scientists and professionals interested in brief interventions and even a worldwide network.

One group singled out 'the professionalism and energy of the PHEPA team' for praise.

What were the not so good things? How could the project have been better from your country's viewpoint?

Group 1:

- Too little time for interaction and networking (small group discussions needed)
- Too strict EU rules (money needed for salaries, organising training is difficult because money comes afterwards)
- Unclear what could be funded

Group 2:

- Support could have been diverted from PHC to other settings as this was so well prepared already
- Not directly adapted material and need to redo without support
- Different situations of different partners to be clarified from the beginning; different timing in different countries
- Adaptations made to material in country were criticized locally though the adaptations were justified
- Events (meetings) are not sufficient: what happens afterwards may need more attention.
- Integration in practice required without sufficient explanation/education of profession
- Reimbursement in the project itself might be given for practical work in the field for training, translation and adaptation, website making.
- More support from project leaders to endorse at public policy level
- (Note: some controversy here: official support and being present at meetings of official bodies does not guarantee support in reality)
- Clarify roles of partners from the beginning; to be defined in interaction with these partners

Group 3:

- Stronger coordination between technical focal point and national representative, i.e. asking if network was created and functional
- Not enough money to make a difference.
- Too rigid economic reimbursement.
- Insufficient recognition of country differences
- The assessment tool should have been changed into one qualitative question: "How and in what way has PHEPA2 improved SBI in your country"?

Group 4:

- Too short to reach enough GPs

- It doesn´t address structural problems: time, money, contracts, etc.
- Finances far too difficult
  - too complicated
  - book- keeping is time-consuming
  - coordinating EU + Catalan + local administration is an impossible mission

To turn now to the limitations of the project, the financial arrangements were one broad area of concern. Two groups thought that EU financial regulations regarding what funding could be used for, and when it was provided, were too strict or rigid to be useful. It was also unclear what could and could not be funded (eg, whether or not salaries could be supported), and it was thought that funding might have been more usefully applied to training, translation of materials and website development in the home countries. Similarly, another group viewed the financial arrangements as too difficult, complicated and time-consuming. It was also flatly stated by Group 3 that the funding provided by the project was not enough to make a difference, although this applied particularly to wealthier countries with a longer tradition of research and implementation of brief interventions.

Another area where some commonality appeared in the conclusions of these groups was in regard to insufficient flexibility to accommodate differences in the situations of participating countries, a point that was made in different ways by two of the groups. Such differences might have been clarified at the beginning of the project. Local adaptations to materials created difficulties and were not financially supported by the project. In some countries, integration of brief interventions in primary health care was already well advanced and attention could have been diverted to other setting for possible implementation.

In terms of how the project was run and led, it was thought by Group 1 that there had been too little time for interaction between members and networking in meetings, and that small group discussions should have been included. It was also suggested that the PHEPA meetings were not sufficient by themselves for optimal progress; more communication from leaders to project partners and between project partners would have been welcome after and between meetings. Despite the conclusion from the questionnaire data that the roles of project partners were well understood, Group 2 believed that partners' roles in the project should have been discussed and clarified better at the outset. This group also said that project leaders could have provided more support towards endorsement at the public policy level in participants' home countries, whereas Group 3 thought there should have been better coordination between the project leadership and the country representative, presumably regarding progress in creating a country network on brief interventions.

Group 4 made the general criticisms that, because the task of implementing brief interventions in practice took many years to reach its goal, the project was too short to reach sufficient numbers of GPs, particularly in countries where brief interventions were relatively new. Also, the project did not address

the key structural issues relating to time, reimbursement and GP contracts. One other specific point that was made was that the assessment tool used in the project could have been much simplified.

Where should we go from here? How should the dissemination of brief interventions be taken forward in your country?

Group 1:

- Topic should be kept on agenda
  - new project
  - contact with ongoing research and practical projects
  - INEBRIA, also group discussions of what is going on

Group 2:

- *Organisation:*
  - Decentralise implementation (usual local settings, with partner scientific associations)
  - Keep centralised monitoring
  - Exchange process between meetings
- *Training:*
  - Include training for students
  - Diversify training methodology
  - Develop e-learning tool facilities
- *Target groups:*
  - Role of nurses and their collaboration with physicians
  - EIBI in other settings to be studied and disseminated
  - Spread BI also to non-medical staff
- *PR:*
  - Integration EIBI into national programmes, public health
  - Promote application and control of alcohol-related rules better
  - Increase awareness of alcohol effects: reframe professional and public understanding
  - Web application for BI
- *Methods:*
  - Training implementation and quality assurance
  - Evaluation
  - Sharing the development of the programmes (changes, process, difficulties & solutions (good and bad stories)
  - Support (practical; financial) programmes in countries

Group 3:

- Telephone calls to drop out partners to find out what went wrong.
- Collaboration on implementation.
- Inspiring establishing INEBRIA in far continents (as in Latin America).

- PHEPA platform could continue as part of INEBRIA, eg, INEBRIA Europa.

Group 4:

- BI training should be placed in the curriculum and accredited in CME
- Need to influence political decisions to widespread BI
- BI in the workplace is a priority
- Tools to identify risky drinking in youth
- Continuously update the evidence on risky drinking
- To develop e-learning training programs at a EU level
- To develop e-BI at a EU level

When asked to say how the achievements of PHEPA2 should be carried forward in the future, groups made a range of suggestions. Group 1 felt that the topic of brief interventions should certainly be kept 'on the agenda' and welcomed the possibility of a new project, although of what form was not stated. Contacts with other, ongoing research and practical projects were suggested and the specific suggestion of linking with INEBRIA (International Network on Brief Interventions on Alcohol Problems) was made.

Group 3 suggested that those who had dropped out of the PHEPA2 project should be contacted and asked why they had done so. There should also be continuing collaboration on implementing brief interventions and the suggestion of links with INEBRIA was again made, with the idea of forming a branch called INEBRIA-Europa modelled on the development of INEBRIA-Latina.

Group 4 suggested that training in brief interventions should be placed on the curricula of health professionals and should be accredited in continuing medical education. There was a need to continuously update the evidence on risky drinking and to continue trying to influence political decision that might affect the widespread implementation of brief interventions, especially in countries newer to brief interventions. Particular priorities were screening tools to identify risky drinking among youth and for brief interventions in the workplace. It was also suggested that e-learning training programmes should be established at the EU level, together with an e-brief interventions. (This latter suggestion refers to a self-help Internet resource rather than the information website established in the PHEPA2 project.)

Finally, Group 2 made a number of suggestions collected under the headings of organisation, training, target groups, public relations and methods, and these may be inspected above. Some of these suggestions are similar to those made by other groups and some are novel.

The plenary discussion

In the plenary discussion that followed the feedback from group rapporteurs, the need for a new project was the first point made by one participant. However, any new project should schedule more interaction between its members at meetings and should continue activity between meetings. Another participant agreed and said that, so far in their country, only inputs had been made; if these were to have a more

permanent impact, it was essential to carry on the work started in PHEPA. It was pointed out that the implementation of alcohol brief interventions in routine practice was a long-term undertaking. The example of GPs' advice on smoking cessation was brought up; it had taken many years of effort before such advice became a routine part of practice and there was no reason to think that the same would not also be true of brief advice to heavy drinkers by GPs.

A concrete suggestion was made that the PHEPA2 group members should form a section of INEBRIA in order to continue meeting, report progress in their countries, exchange ideas and learn from each others' experience. This section of INEBRIA could have its first meeting at the next INEBRIA conference in Newcastle upon Tyne (UK) in October 2009. It was also suggested that the needs of different countries varied with respect to brief interventions; some countries where the implementation of brief interventions were well advanced had a need to collaborate with other countries in the same or similar situations; countries that were relatively new to brief interventions had different needs and would benefit more from contact with others in the same position. However, membership of INEBRIA could embrace both these needs, as well as provide a means whereby those with more experience of brief interventions could share their experience with those newer to it. Indeed, the transfer of knowledge in this was one of the reasons that INEBRIA had been set up.

Although this plan was generally approved, it was also pointed out that INEBRIA could not provide funding for continuing research and development projects and this was essential particularly in countries where fewer resources were allocated to brief interventions. It was also thought that the interval until October 2009 was too long to wait for contact between PHEPA members to continue and a gap in time might have damaging effects on the continuity of the group. Immediately establishing email contact by a mailing list was suggested as one way round this problem.

At this point, PHEPA2 members were reminded of the fact that "the next steps" was a topic for an hour-long discussion the following day. Although the present discussion was valuable, it could be continued on the following day when hopefully specific plans and decisions about future activity could be agreed.

By this time in the discussion, there was general agreement with the idea that two mechanisms for future progress were necessary: first, a continuing discussion and dialogue about brief interventions for which a scientific organisation like INEBRIA was appropriate; secondly, a mechanism to enable applications for funding collaborative work was necessary. Although INEBRIA could facilitate this process, it could not itself apply for funding.

The AMPHORA project, which was due to be described to the meeting the following day, was mentioned as a mechanism whereby collaborations to apply for funding could be developed. This would be of special benefit to those brief intervention 'start-up' countries where research funding internally was difficult to obtain.

The discussion moved to the question of how it could be ensured that the findings and the progress made by the PHEPA projects could have an impact within the EU. The writing of a report, while necessary and

useful, could not be relied on for this because such reports often gather dust and are ignored. It was necessary to draw the attention of National Counterparts for alcohol policy in the member states to the achievements of the project and there was a discussion of how best this could be done. The importance of bringing the project's achievements to the attention of DG SANCO, the EU public health programme, was also stressed. There was also some discussion of the need for different settings for the implementation of brief interventions in future collaborative work. Occupation health and midwifery services were mentioned here.

Towards the end of the meeting, the question was raised that, having established a European platform of health professionals interested in disseminating brief interventions in the PHEPA projects and having also agreed that a continuation of this platform was essential, how could that be achieved? Membership of INEBRIA, though useful, could not, it was suggested, provide sufficient impetus and support to the platform between INEBRIA meetings. At this point, the useful information was provided that one limitation of the EU public health programme was that its role was an enabling one only; it would not continue to support the platform. This European platform on brief interventions would need to self-sustaining.

At the conclusion of the discussion, there was universal agreement that the platform should be maintained in future, although the precise ways in which this could be done were still to be decided.

Conclusions from qualitative data

On the basis of the discussion groups and the plenary discussion summarised above, the following are the main conclusions that can be drawn.

1) Conclusions from small group discussions reinforced some of the conclusions from questionnaire data about the benefits to members of PHEPA2 participation, particularly with regard to support from experts in brief interventions and others project members, the formation of international networks and cooperation, and the prestige of the project which enabled participants to have an influence in their own countries on government authorities and professional colleagues.

2) The project also helped to promote preventive work in general and alcohol work in particular in the participant's home country and allowed a continuation of the progress made by PHEPA1 in the long process of implementation of brief interventions.

3) As in the questionnaire responses, the project products were positively endorsed by the discussion groups, together with the usefulness of the evidence base on brief interventions and the contribution to reframing of alcohol issues among health professionals.

4) The project was seen as an important contribution towards the creation of a European and, by extension, a woldwide network of scientists and professionals interested in brief interventions.

5) The financial arrangements of the project were thought to be too strict, rigid, difficult, complicated and time-consuming, as well as unclear about what funds could be used for. It was also thought that funding could have been more usefully applied to training, translation of materials and website development in the home countries.

6) The project was also thought by some to be insufficiently flexible to accommodate differences in the situations of participating countries with respect to the implementation of brief interventions.

7) In terms of how the project was run, it was thought that there had been too little time for interaction between members in meetings and that there should have been more communication between meetings.

8) It was thought that project leaders could have provided more support towards endorsements at the public policy level in participants' home countries and that there should have been better coordination between the project leadership and the country representatives.

9) In more general terms, it was believed that the project was too short to reach sufficient numbers of GPs, particularly in countries where brief interventions were relatively new, and that it did not address key structural issues relating to time, reimbursement and GP contracts.

10) There was support for the suggestions that: (i) training in brief interventions should be placed on health professionals' curricula; (ii) training should be accredited in continuing medical education; (iii) evidence on risky drinking needed to be continuously updated; (iv) there should be continued attempts to influence political decisions that might affect the widespread implementation of brief interventions, especially in countries newer to brief interventions; (v) screening tools to identify risky drinking among youth should be developed as a priority; (vi) attention should be paid to introducing brief interventions in the workplace; (viii) an e-learning training programme should be established at the EU level; (ix) an e-brief self-help intervention should be developed at the EU level.

11) A distinction was made between countries with a relatively long history of implementing brief interventions and greater resources to support this work and countries that lacked this prior experience and had fewer resources at their disposal. This distinction applied both to the kind and degree of benefits acquired from the PHEPA projects and to plans for future activity in the area.

12) With regard to how the progress made in the project should be carried forward and not lost, the specific suggestion was made of linking with INEBRIA, perhaps to form a branch of that network called INEBRIA-Europa modelled on the recent development of INEBRIA-Latina in Latin America.

13) There was also felt to be a need for a mechanism to allow bids for funding to support collaborative work on implementing brief interventions to be developed, particularly in countries with less experience in this field and fewer internal resources for this purpose.

14) It was felt essential to ensure that the findings and the progress made by the PHEPA projects should have an impact within the EU and suggestions were made as to how this could be achieved.

15) There was universal agreement that the European platform of health professionals and scientists interested in disseminating brief interventions widely in primary health care and other settings that had been established in the PHEPA projects should continue in some form.

SUMMARY OF FINDINGS

The substantive findings of this evaluation may be found in the sections above on "Conclusions from questionnaire data" and "Conclusions from qualitative data". Here an attempt will be made to summarise these findings in general terms.

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

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

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

Perhaps the main complaint about the project expressed by participants concerned the financial arrangements. These were seen as too strict, inflexible, overly complex and time-consuming. It was felt too that the funds provided could have been allowed to be spent in more useful ways. It is not clear

whether these arrangements could have been made more acceptable to participants within EU guidelines but they certainly seemed to be a barrier to efficient progress.

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

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

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

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

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

Did PHEPA2 achieve what it set out to do (ie. achieve the outputs listed above)?
Clearly yes. Clinical guidelines, a training programme and an Internet-based resource were produced and were regarded very positively by the majority of project partners.

Was PHEPA2 successful in involving partners in the project and promoting productive collaborations and networking?
Yes, on the whole – among the majority of participants.

What impact did PHEPA2 have at country level?

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

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

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

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

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APPENDIX

PHEPA2 Questionnaire

PRIMARY HEALTH CARE EUROPEAN PROJECT ON ALCOHOL

INSTRUCTIONS

This questionnaire has been designed to assess the PHEPA project •

The tool asks questions about different aspects of our Project and allows you to express your opinions and provide information about your experiences anonymously. There are no right or wrong answers to the questions. Thoughtful and honest responses will give us the most valuable information. Your answers will be used to generate a report for the EC. Please answer every question. Thank you for your collaboration.

A. ROLE

1. What is your role in the project?

- ☐ Partner
- ☐ Observer
- ☐ Expert
- ☐ Others (please specify:

2. What tasks are involved in your role?

3. How clearly were your tasks clarified by the project managers?

- ☐ Completely clarified
- ☐ Mostly clarified
- ☐ Somewhat clarified
- ☐ A little clarified
- ☐ Not at all clarified

4. What are the main barriers you confront when carrying out these activities?

5. How much participative is your role?

- ☐ Extremely high participation
- ☐ High participation
- ☐ Some participation
- ☐ Low participation
- ☐ No participation

• THE QUESTIONNAIRE IS PARTIALLY ADAPTED FROM THE PARTNERSHIP SELF-ASSESSMENT TOOL 2.0 DEVELOPED BY THE CENTER FOR THE ADVANCEMENT OF COLLABORATIVE STRATEGIES IN HEALTH AT THE NEW YORK ACADEMY OF MEDICINE. THE TOOL IS AVAILABLE ONLINE AT: HTTP://WWW.PARTNERSHIPTOOL.NET/.

6. How satisfied are you with your role in the project?

- ☐ Completely satisfied
- ☐ Mostly satisfied
- ☐ Somewhat satisfied
- ☐ A little satisfied
- ☐ Not at all satisfied

B. LEADERSHIP

7. Please rate the effectiveness of leadership in the following areas:

	Excellent	Very good	Good	Fair	Poor
a. Taking responsibility of the project					
b. Motivating people involved					
c. Working to develop a common understanding and vocabulary					
d. Fostering respect, trust, inclusiveness and openness					
e. Creating an environment where different opinions can be said					
f. Resolving conflicts among partners					
g. Combining the perspectives, resources and skills of the members.					

C. ADMINISTRATION AND MANAGEMENT

8. Please, rate the effectiveness of the staff carrying out the following activities:

	Excellent	Very good	Good	Fair	Poor
a. Explaining project objectives					
b. Coordinating communication between partners					
c. Clarifying roles to participants					
d. Managing funds					
e. Coordinating partnership activities and meetings					
f. Preparing the material that informs partners and helps them to take decisions on time.					
g. Performing secretarial duties					
h. Minimizing barriers to participate in meetings					

D. DECISION-MAKING

9. Please, rate the influence you have had in the following areas:

	A lot of influence	Quite influence	Somewhat influence	A little influence	No influence
a. Development of the project products					
b. Meeting's Agenda					
c. Group decisions					
d. Financial and non financial resources					

10. How comfortable are you with the way decisions are being made?

- ☐ Extremely comfortable
- ☐ Very comfortable
- ☐ Somewhat comfortable
- ☐ A little comfortable
- ☐ Not at all comfortable

11. How often do you feel that you have been left out of the decision making process?

- ☐ Always
- ☐ Most of the time
- ☐ Sometimes
- ☐ Almost never
- ☐ Never

E. BENEFITS AND COSTS

12. Please rate the advantages of participating in this project?

	Most important				Least important
Enhanced ability to address an important issue					
Development of new skills					
Increased utilization of my expertise or services					
Acquisition of useful knowledge					
Enhanced ability to affect public policy					
Development of valuable relationship					
Ability to have a greater impact than I could have on my own					
Acquisition of additional financial support					
Others (specify:)					

13. What are the disadvantages of participating in this project?

	Most important				Least important
Insufficient influence in partnership activities					
Diversion of time and resources away from other priorities or obligations					
Conflict between my job and the partnership's work					
Others (specify:)					

14. How do the advantages compare to the disadvantages of participating in this project?

- ☐ Much more advantages than disadvantages
- ☐ More advantages than disadvantages
- ☐ Both are equal
- ☐ More disadvantages than advantages
- ☐ Much more disadvantages than advantages

F. COMMUNICATION

15. Please rate your frequency of communication (by telephone, e-mail, etc) with the rest of members of the project?

	Very high frequency	Very frequently	Somewhat frequently	Low frequency	Not at all frequent
a. with other partners of the project					
b. with the leaders of the project					

16. Please rate the quality of your communication with other members of the project

	Excellent	Good	Fair	Poor	Very poor
a. with other partners of the project					
b. with the leaders of the project					

17. How is this communication?

- [ ] Strongly effective
- [ ] Very effective
- [ ] Somewhat effective
- [ ] A little effective
- [ ] No effective

18. How do you feel when expressing your point of view?

- [ ] Extremely comfortable
- [ ] Very comfortable
- [ ] Somewhat comfortable
- [ ] A little comfortable
- [ ] Not at all comfortable

19. How often is your opinion listened to?

- [ ] Always
- [ ] Often
- [ ] Sometimes
- [ ] Rarely
- [ ] Never

G. CONFLICTS

20. In your opinion, what (if any) have been the major points of conflict within the members of the group?

21. Please describe the way in which these conflicts have been resolved?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Bad
- [ ] Very bad

22. How satisfied are you with the way the group deals with problems?

- [ ] Strongly satisfied
- [ ] Very satisfied
- [ ] Somewhat satisfied
- [ ] A little satisfied
- [ ] Not at all satisfied

H. MEMBERS PARTICIPATION

23. How often do you:

	Strongly frequently	Very frequently	Somewhat frequently	A little frequently	Not at all frequently
a. Suggest new ideas					
b. Ask for additional information					
c. Provide information					
d. Express your opinion					

24. How many hours on average have you dedicated to the project per month: _____

I. MEMBERS SATISFACTION

25. Please, indicate your level of satisfaction in the following areas:

	Completely satisfied	Mostly satisfied	Somewhat satisfied	A little satisfied	Not at all satisfied
a. The way people in the group work together					
b. The general way in which the project is being developed					
c. The rate of progress the project is making in achieving its objectives					
d. The progress of the group since the beginning of the project					

J. ACHIEVEMENT OF THE AIMS OF THE PROJECT

26. Please, rate your level of agree with the followings areas:

	Absolutely agree	Somewhat agree	Uncertain	Somewhat disagree	Absolutely disagree
a. The project responds to the needs of the European Community about intervention on harmful and hazardous alcohol consumption.					
b. The project develops tools that are the most likely to work in this issue.					
c. The tools are enough flexible as to be adapted in the different countries					

K. PRODUCTS OF THE PROJECT

27. Please, rate if your opinion has been taken into account for the development of the products

	Always	Often	Sometimes	Rarely	Never
a. Clinical Guidelines					
b. Training Manual					
c. Internet website and database					
d. National dissemination strategy					

28. Please, rate your opinion on the achievement of the products?

	Excellent	Good	Fair	Bad	Very bad
a. Clinical Guidelines					
b. Training Manual					
c. Internet website and database					
d. National dissemination strategy					

29. What would you change of the methodology used?

30. Please, rate your level of agree with the followings areas:

	Absolutely agree	Somewhat agree	Uncertain	Somewhat disagree	Absolutely disagree
a. The project was all worth it?					
b. I would join such a project again					