Generalitat de Catalunya
Departament de Salut

PHEPA
Primary Health Care
European Project on Alcohol

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

Grant Agreement nº SPC.2002447 and Amendment

Final Report to the European Commission
DG SANCO
September 30th, 2005

Project Manager
Joan Colom, MD
Director of the Program on Substance Abuse

Project Leaders
Peter Anderson, PhD MD
Antoni Gual, PhD MD

Project Coordinator
Lidia Segura

Address for correspondence
Program on Substance Abuse
Health Department
Government of Catalonia
Travessera de les Corts 131-159
Ave Maria Pavilion
08028 Barcelona
Spain
Tel: + 34 93 556 64 01
Fax: + 34 93 227 29 74
E-mail: phepa@gencat.net

Index

Presentation of the final report

The current report is sent to the commission according to the conditions described in the article 5.2 of the amendment to grant agreement nº SPC.2002447 signed between the European Commission and the Directorate General of Substance Abuse and Aids[1] of the Health Department.

The report has been organized in three different parts.

The first part is the Executive Summary, in which the background and aims together with the organization, the final results and conclusions of the project are briefly presented.

The second part is the financial report.

The third part includes annexed documents with detailed information about the activities implemented in the framework of the Phepa Project, paying special attention to the meetings that have taken place and the products that have been developed.

[1] *Nowadays entitled Program on Substance Abuse and ascribed to the Directorate General of Public Health of the Government of Catalonia*

I. Executive Summary

1. Introduction

The European Union is the region of the world with the highest proportion of drinkers and with the highest levels of alcohol consumption per population. Alcohol is the third most important risk factor for ill-health and premature death after smoking and raised blood pressure, being more important than high cholesterol levels and overweight. Apart from being a drug of dependence and besides the 60 or so different types of disease and injury it causes, alcohol is responsible for widespread social, mental and emotional harms, including crime and family violence, leading to enormous costs to society. Alcohol not only harms the user, but those surrounding the user, including the unborn child, children, family members, and the sufferers of crime, violence and drink driving accidents.

Primary care health providers have been charged with the responsibility of identifying and intervening with patients whose drinking is hazardous or harmful to their health. Identification and brief intervention for alcohol consumption among patients in primary health care provides an opportunity to educate patients about the risks of hazardous and harmful alcohol use. Information about the amount and frequency of alcohol consumption may inform the diagnosis of the patient's presenting condition, and it may alert clinicians to the need to advise patients whose alcohol consumption might adversely affect their use of medications and other aspects of their treatment. Of utmost importance for screening and brief intervention programmes is the fact that people who are not dependent on alcohol find it easier to reduce or stop their alcohol consumption, with appropriate assistance and effort, than those who are dependent.

However, primary care health workers often find it difficult to identify and advise patients in relation to alcohol use. Among the reasons most often cited are lack of time, inadequate training, concern about antagonizing patients, the perceived incompatibility of alcohol brief intervention with primary health care, and the belief that those who are dependent on alcohol do not respond to interventions.

There is a strong evidence base for the efficacy, cost effectiveness and utility of health promotion interventions for hazardous and harmful alcohol consumption in primary health care settings. Much of this work has been undertaken through a series of international collaborative studies involving EU countries on the detection and

management of alcohol-related problems in primary health care coordinated by the World Health Organization. Screening instruments have been developed and tested, the efficacy of interventions demonstrated, the current practices and perceptions of primary health care physicians assessed, and the methods for encouraging the uptake and utilizations of interventions. The challenge is now to integrate health promotion interventions into daily clinical work.

The European Phepa Project (Integrating health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals' daily work) is a project first funded by the European Commission for the Health Promotion Program (HP2002) in December 2002.

The project was presented to the SANCO/G/3 under the field of Health education and/or promotion, information and training in the field of public health. The applicant organization and main beneficiary is the Directorate General of Substance Abuse and AIDS of the Department of Health and Social Security of the Government of Catalonia (Barcelona, Spain). The Grant Agreement nº SPC.2002447 between the EC and the main beneficiary was signed the 10th of December of 2002, 10 days after the official start of the project (1st December 2002). It was initially foreseen to last 24 months, with the project ending on 1st December 2004, but an extension of 6 months was requested of the EC, given the huge amount of work to be done. Amendment I to the Grant Agreement was signed 11th November 2004 and the project deadline was rescheduled to the 1st July of 2005 (final report to the Commission 1st October 2005).

The project supports the European Community's Public Health strategy and the European Charter on Alcohol and the European Alcohol Action Plan of the World Health Organisation.

2. Aims and Objectives

The project aimed to work towards the integration of health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals' daily clinical work. The main activities and tools developed were:

-European recommendations and clinical guidelines on best practice for health care purchasers and providers;

-a training programme for primary health care professionals;

-a comprehensive Internet site database on good practice, providing the evidence base in the domains of efficacy, economics, health outcomes and policy;

-and a series of country specific dissemination strategies.

3. Expected activities and results

The following activities were to be undertaken:

- Creation of an European expert group of public sector, health care Professional, non-governmental, scientific and private sector organisations that has been active throughout the project
- Creation of country based action groups of public sector, health care professional non-governmental, scientific and private sector organisations
- Collection of background data on countries
- Drafting recommendations and clinical guidelines and seeking endorsement at European and country level
- Creation and development of an Internet site database on good practice, providing the evidence base and maintained throughout project
- Documentation of exiting experiences of primary health care based interventions
- Developing and adapting existing training programme (skills for change of the WHO) for primary health care professionals
- Prepare strategy for implementing primary health care based interventions in pilot areas or country wide
- Document implementation strategies
- Case study evaluation and make recommendations for future actions

4. Organization, responsibilities and infrastructure

The project has been managed by The Directorate General of Substance Abuse and Aids with the contribution of institutions and experts of 18 European Member States, WHO and European Wonca. The whole list of Phepa Network Members is provided in *Annex 1*.

The following framework illustrates the PHEPA Network organization

The DG of Substance Abuse and Aids (Alcohol Unit) has been responsible for the 1) management and technical co-ordination of the project, 2) for leading the development of the products, 3) for organizing the meetings and 4) for writing the reports for the Commission. Within the DG a **project team** was constituted with technical and administrative personnel located (with the exception of Dr. Anderson) in Barcelona (Spain). The technical officers, the technical and administrative assistants of the Project Team are full-time and part-time posts funded by the project.

The 18 **national partners/observers**[2] were responsible for 1) creating the country based teams, 2) drawing the country profiles, 3) developing, together with the Country Based Team, the country strategy (only partners), 3) providing comments and feedback

[2] *Observers were considered those representatives coming from PECO countries. They were not able to be reimbursed for their work.*

on the project products, 4) participating in all the meetings and 5) preparing the country reports (only partners). The project funds covered up to 30 workdays of the partners.

Together with the Phepa members up to **9 experts** have participated guiding the execution of the project and its activities. They were responsible for 1) providing their expertise during the development of the products, 2) giving feedback to the Project Team and 3) attending the meetings.

All collaborators' (partners, observers and experts) subsistence and travel costs for attending project meetings were covered by the project.

The members of each **country based team (CBT)** were responsible for contributing to the development and dissemination of the country implementation strategy. Their participation (subsistence) in country meetings was covered by the project.

5. Results and products

Special attention is paid to the constitution of the Phepa Network and the development of the products.

5.1. Creation of the Phepa Network

During the 31 months, priority was given to the creation of the Phepa Network composed by the members of the project team and all the collaborators (partners, observers, experts and CBT members).

Some difficulties encountered throughout the project in relation with the Phepa Network have been:
-The replacement of two of the technical assistants that left during the project, which led to some readjustments of the activities and timetables.
-The impossibility to reimburse the work of the partners from accession and candidate countries (observers) after being previously budgeted as partners, causing some diminishment in their motivation to contribute to the project.
-The impossibility to substitute the Greek partner who left the project because of his difficulties in achieving the aims of the project in the short deadlines given.

-The difficulties in maintaining collaboration throughout the project as happened with the French partner who, even though he was extraordinary committed to the project at the beginning was unable to produce the final country report as requested.
-The Portuguese partner (Direcção Geral da Saúde) changed the representative and Dr. Ribeiro took over the responsibility of the project from Dr. Breda at the beginning of 2004.
-The Dutch partner (National Institute for Health Promotion and Disease Prevention) changed the representative and Dr. Huiberts took over the responsibility of the project from Dr. Boon by the end of 2003.

5.2. Meetings *(See Annex 2)*

Four meetings were organized and their agendas, list of participants and minutes are detailed in Annex 2.

The **first meeting** took place on 23rd and 24th February 2003 in Barcelona (Spain) with the following objectives*:*

- Introduce the project
- Present and discuss country profiles
- Present the evidence for screening and brief intervention programmes
- Present the evidence for engaging general practice in screening and brief intervention programmes
- Introduce the general principles for the development and Implementation of clinical guidelines
- Review the training programmes for managing hazardous and harmful alcohol consumption
- Discuss about the most suitable structure and contents for the web
- Discuss the management and implementation of the EU project:
    i. Roles and responsibilities of partners and experts
    ii. Management and administration

The **second meeting** was held on 9-10th October 2003 in Leiden (Netherlands) and focused on the*:*

- introduction and discussion on the products that had been drafted by the project team
- introduction and discussion on country profiles and country based teams
- preparation of country specific dissemination strategies

An **extraordinary meeting** aimed at achieving consensus in the content of the clinical guidelines was held in Barcelona, 15-16 March 2004 with the participation of 18 of the Phepa network members.
The contents of the clinical guidelines were discussed chapter by chapter giving the opportunity of the Phepa members to provide their opinion. All the comments received were taken into account in subsequent drafts.

The **last meeting** took place on the 20th and 21st October 2004 in Barcelona (Spain) and was aimed at:

- Discussing the products
  - Clinical Guidelines
  - Training Programme
  - Internet database and website
- Discussing project evaluation
- Discussing country reports
- Revision on the next steps and to consider an application for the 2005 call

Summary of the meetings and participants

	Partners and CBT members	Observers and CBT members	Experts
1st Meeting Barcelona	23	8	7
2nd Meeting Leiden	17	8	11
Clinical Guidelines Meeting	13	2	3
3rd Meeting Barcelona	27	3	3

In addition to these meetings, country based teams were committed to meet twice during the project period (see details below). The Danish CBT met only once but the Dutch met 4 times (see below). The number of participants in the meetings ranged from 4 to 23 showing the variability encountered of the country situation.

COUNTRY	NR	DATE	PARTICIPANTS
BELGIUM	1st	01/04/04	12
	2nd	27/05/04	23
	3rd	09/11/04	17
DENMARK	1st	16/11/04	4
ENGLAND	1st	24/03/04	7
	2nd	02/09/04	6
FINLAND	1st	01/12/04	6

GERMANY	1st	15/09/04	6
	2nd	15/12/04	6
IRELAND	1st	27/04/04	7
ITALY	1st	10/05/04	6
	2nd	11/05/04	6
NETHERLANDS	1st	14/05/04	8
	2nd	08/06/04	5
	3rd	28/09/04	4
	4th	16/11/04	10
SPAIN (Catalonia)	1st	17/11/04	23
	2nd	21/02/05	21
SWEDEN	1st	25/05/04	4
	2nd	25/10/04	7

5.3 Clinical Guidelines on Identification and Brief Intervention *(see Annex 3 (unchecked proofs for printing))*

The aim of the guidelines is to summarize the evidence of the harm done by alcohol and how to manage hazardous and harmful alcohol use in primary care. The guidelines also describe alcohol dependence and how it can be managed, so primary health care providers know what to expect when more difficult to manage patients are referred for specialist help.

The guidelines are based on a review of the evidence, and upon the experience of a task force created to draw up the guidelines. The guidelines rely, where possible, on evidence from well-designed research studies. Where this evidence was not available, recommendations are based upon appropriate clinical experience. The evidence is summarized in each chapter. The intention is to provide evidence that guides rather than dictates interventions, education and professional development. The guidelines are not intended to replace existing country based guidelines; rather, they aim to stimulate the development and implementation of guidelines in all countries.

Purpose of the guidelines The primary aim of the current guidelines is to provide up-to-date, evidence-based information for primary health care providers on the why and how of identifying and intervening for people with hazardous and harmful alcohol consumption. This information is required because of the size and importance of the health burden created by alcohol, and the variations in practice, and often lack of practice across Europe, for helping patients with hazardous and harmful alcohol consumption.

Audience for the guidelines The guidelines are intended for both primary health care providers (physicians and nurses) who help patients with hazardous and harmful alcohol consumption and for the managers, educators, financers and evaluators of primary health care services who wish to know the why and how of an effective intervention.

Development of the guidelines The guidelines are based on a review of the available evidence of harm and efficacy and the knowledge of a task force created by the PHEPA project to develop the guidelines. Identifying research involved searching relevant databases for published meta-analyses and reviews, hand searching relevant journals, searching website bibliographies, and contact with major research individuals and centres for other relevant information and guidelines. Databases searched included Medline, Psychinfo, and the Cochrane Database of Systematic Reviews. We relied heavily on publications and reviews of the European Commission, the World Health Organization, and the National Institute on Alcohol Abuse and Alcoholism of the United States (for references, see individual chapters.

Levels of evidence and strength of recommendations Organizations that prepare guidelines classify the quality of the evidence available and the strength of the ensuing recommendations. Each organization uses a slightly different system and there is currently no universally agreed system. Although the preferred level of evidence comes from systematic reviews and meta-analyses of epidemiological studies and randomized controlled trials, these are not available for all topics of interest. Where systematic reviews and meta-analyses are not available, authors of guidelines opt for randomized controlled trials as the next level of evidence. Controlled trials allow the researcher to conclude with a degree of certainty whether or not the treatment being tested is more effective than no treatment. Where randomized controlled trials are not available, authors opt for comparative studies, non-analytical studies and expert opinion in decreasing order. As the PHEPA project is not constituted as a formal guideline development group, we have decided not to grade the strength of our recommendations as other guideline authors have done, but rather to make recommendations that are consistent with other publications, based on the expert opinion of the members of the PHEPA project as a whole. The whole process was checked and found consistent with the AGREE (Appraisal of Guidelines for Research and Evaluation) instrument (AGREE Collaboration 2001)[3].

[3] *AGREE Collaboration (2001). Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument. Available from: http://www.agreecollaboration.org*

The Summary of the clinical guidelines has been translated to 8 languages (Flemish, Spanish, Finnish, German, Irish, Italian, Portuguese and Swedish).

5.4. Training Programme on Identification and Brief Intervention *(see Annex 4 (unchecked proofs for printing)).*

This training programme is the result of a joint effort made by the scientists and professionals who have participated in the European PHEPA project.

The aims of the Training Manual are:

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

The training programme is being developed under the following principles:

- Be clear, simple and flexible
- Help PHC professionals to solve already existing problems. Takes into account resistances against screening
- Be delivered in few hours and integrated in the regular continuing medical education
- Be adaptable to self-training formats
- Provide user friendly tools & materials that can be used in the daily practice

Alcohol is a main health determinant throughout the world, and Primary Health Care (PHC) is in a pivotal position to prevent and minimize most of the harm done by alcohol. This manual aims to enhance the skills, knowledge, attitudes and motivation of PHC professionals facing the challenges posed by their patients who drink in a hazardous or harmful manner.

Alcohol related problems are often under diagnosed in PHC settings, and hazardous drinking is usually forgotten. General Practitioners (GPs) tend to concentrate on the most severe and visible alcohol related problems, while most of the preventive activities that

should be routinely done with hazardous and harmful drinkers are often forgotten. Based on this assumption, the manual tries to present alcohol problems as a continuum ranging from hazardous drinking to severe dependence. Even though alcohol dependence is addressed in Session 5, the manual gives priority to the identification and brief intervention techniques that have proven cost-effective in PHC settings.

PHEPA contributes to the harmonization of responses to alcohol related problems, taking into account the differences that make country based customisation of the training package a necessity. Those differences relate not only to beverage type and drinking patterns, but also to the organization of PHC and specialized addiction units. Thus, we strongly recommend that every trainer adapts the core contents of this training package to individual training styles, the differing needs of course participants and to country specificities.

The WHO Collaborative Study on Alcohol and Primary Health Care (www.who-alcohol-phaseiv.net) has inspired relevant parts of this manual. In the frame of that study, the dissemination of identification and brief interventions is seen as a slow and sometimes difficult iterative process. Because of this, the philosophy behind the manual is that it is a better approach to target modest achievable goals than to aim at dramatic changes. If as a result of the training, PHC professionals start to revise their traditional misconceptions about alcohol, the trainer should be satisfied.

The organization of this training programme is inspired by the WHO's Skills for Change Package[4].
For each of the six training sessions, the manual offers five different sections that allow the trainer to prepare them with different levels of training:

- The **'Objectives and Aims'** summarizes the main goals to be reached during the session, and the materials (Overheads and Handouts) to be used.
- The **'Session Plan'** guides the trainer on the different topics to be covered during the session, and the recommended duration of each topic. In each of the topics the trainer will find detailed information on how to develop it, and the materials to be used. Even though the schedule provided is not strict, the trainer should be aware of the wide range of issues to be covered and the limited amount of time usually available for training.

[4] *Mason, P. & Hunt, P. (1997). Skills for Change. World Health Organisation; Copenhagen.*

- The **'Background notes'** offer detailed explanations and tips on how to conduct every one of the parts of each session.
- The **'Work Documents'** provide detailed information on the topics to be learned in each session.
- The **'Overheads'** offer visual aids for the explanations of each session.

A short form of the training programme has been translated to 10 languages (Dutch Spanish, Finnish, German, Irish, Italian, Portuguese and Swedish).

5.5. Internet Site and Alcohol Management Database (see www.phepa.net)

The website has been developed according to the needs of the project and it is available at: http://www.phepa.net and is continuously updated. It has been developed in the framework of the Autonomous Government Internet System and is subject to style, image and form restrictions.

Contents are organized in 6 main headings with the following subheadings:

Links	**Events**	**Resources and publications**	**Country Information**	**Evidence on Alcohol**	**About Phepa**
Links	**Activities**	**Resources and publications**	**Implementation in countries**	**Describing alcohol consumption and alcohol related harm**	**Introduction**
	News			**Alcohol and health**	**Who can use this site?**
				Identifying hazardous and harmful use	**What kind of information will I find?**
				Effectiveness of Brief Interventions	**Meetings**
				Cost and cost-effectiveness of BI	**Contributors**
				Implementing EIBI programmes	**Project evaluation**
				Assessing the harm done by alcohol and alcohol dependence	

The Alcohol Management Database is still in development but some evidence has already been included in the heading evidence on alcohol.

Up to now the information is not organized into levels depending of the type of visitor but it is planned to organize the information according to the following three subgroups.

-General Population

-Professionals and Policy Makers

-Phepa Members (A password for Phepa Members and a registration procedure (free) for people interested in the website will have to be created).

-Special attention has been placed on the provision and maintenance of information by project collaborators. The search of additional sources of funding, to be able to maintain the web once the project is ended, is also one of the main priorities. The further development of the internet site is one of the main priorities of the Phepa II project.

5.6. Country profiles and strategies

One of the activities of the project was to build up **country profiles** of the present situation of managing hazardous and harmful alcohol consumption in general practice.
Country partners were asked to answer a questionnaire developed by Dr. Anderson to assess the available services for the management of alcohol problems at the country or regional level. It was aimed at identifying currently what was going on, and at identifying deficiencies or areas in the country that need further work and strengthening.

The questionnaire was organized in three parts.
The **first part** was about **policies on the management of alcohol use disorders** and most of the questions were simple 'yes'/'no' answers. The **second part** is about **research and studies on the management of alcohol use disorders in general practice**. Again, most of the questions were simple 'yes'/'no' answers. The **third part** is mostly about **drinking behaviour**. The information gathered has helped to have a general overview of the country situation and to compare the countries according to the different variables. This questionnaire is being developed taking into account the feedback from the different countries and it will be useful to monitor the country situation.

Another of the project aims was to convene the **13 country based teams** to develop a **country based strategy** for the implementation of the programme to integrate interventions for hazardous and harmful alcohol consumption in primary health care settings.

The exact numbers and composition of the country based teams (see Annex 1) have varied from country to country, but the minimum proposed includes representation of:

- Governmental organizations

- Non-governmental organizations
- Health professional organizations and/or groups
- Scientific organizations and/or groups.

The country based strategy has been developed according to the following contents (See Annex 6; *not edited*):

1. Introduction
2. The use of alcohol
3. The harm done by alcohol
4. Measures to reduce the harm done by alcohol
5. Effectiveness and cost effectiveness of interventions in PHC
6. Current policies and activities
7. Integrating preventive interventions in PHC
8. Research needs
9. Bibliography

The strategy has been prepared by each country based team (see Annex 6) and has been endorsed by a number of key partners and stakeholders in each country. In some countries it has been presented to the country's Ministry of Health.

The contribution of all country based teams is detailed below.

Partners	Barriers and advances 2003 meeting	Preliminary questionnaire 2003	Country profile 2004-2005	Country strategy 2004-2005
Belgium				
Catalonia				
Denmark				
England				
Finland				
France				
Germany				
Greece				
Ireland				
Italy				
Netherlands				

Portugal				
Sweden				

Partner countries were requested to produce 4 main reports. Those coloured in green have been finally produced and those coloured in red have not. The Greek partner dropped out the project.

Observers	**Barriers and advances 2003 meeting**	**Preliminary questionnaire 2003**	**Country profile 2004-2005**	**Country strategy 2004-2005**
Bulgaria				**not requested**
Czech Republic				**not requested**
Hungary				**not requested**
Poland				**not requested**
Slovenia				**not requested**

Observer countries were requested to produce 3 main reports. The table shows which reports have been produced and which not. It is important to mention that the Slovene partner produced also the country strategy even though he was not requested to do so and he was not reimbursed for his work.

5.7. Project evaluation

A questionnaire was designed to sample quantitative and qualitative information *(see Annex 7)* on the following evaluation domains:

- The process of the project.
- Completion and delivery of the project's product.
- Assessment of the roles of the project's members
- Achievement of the aims of the project.

The responses to the questionnaire lead us to the following conclusions (a detailed report is available in Annex 7):

-Participants were mostly satisfied with having participated in the project and they mostly agreed in the idea of continuation with the project objectives.

-Not enough efforts were placed in explaining the project objectives, in discussing the role to be played by each participant and in involving members in the decision making process. Allocating more resources to the partners would have been of much importance.
-Lack of enough resources (financial and non-financial) was considered the main barrier confronted when carrying the activities.
-The Phepa Team was effective in creating a good atmosphere and in motivating people to participate.
-Being a member of the Phepa Network was more advantageous than disadvantageous. It was advantageous to participants especially because of the development of valuable relationships and the enhancement of the ability to affect the public policy. The main disadvantages are related with the conflict between the partners' current job and the partnership work.

Together with the responses to the questionnaire there are additional sources of information that led us to conclude that the partners' commitment was high:

- Documentation produced by the partners/observers

  Technical reports

	Expected	Produced
Country profiles	18	14 (78%)
Country strategies	12	11 (92%)
CG Summary translation	10 languages	8 (80%)
TM Summary translation	10 languages	8 (80%)

  Administrative documentation

	Expected	Produced
Invoices for Work (x 2)	26	23 (88%)
Time sheet	13	11 (85%)
Translation invoice	10	8 (80%)
Booking invoice	13	2 (15%)
CBT meeting signatures (x 2)	26	17 (65%)

- Archival records

  A total of 312 MB, 1482 files in 102 folders, of memory has been used to store the technical and administrative documents developed throughout the project.

- Direct observation /participation observation

-A total of 142 professionals have been involved (inputs in database) in the project at different levels and a total of 24 meetings related with the project have been carried out in all Europe.

-Around 2000 e-mails were sent or received in relation with the project (below only those related with the production of the country documentation.

-Partners and observers participation in meeting varied from those that were there but were not active (Greece) and those that were highly involved (Catalonia and England).

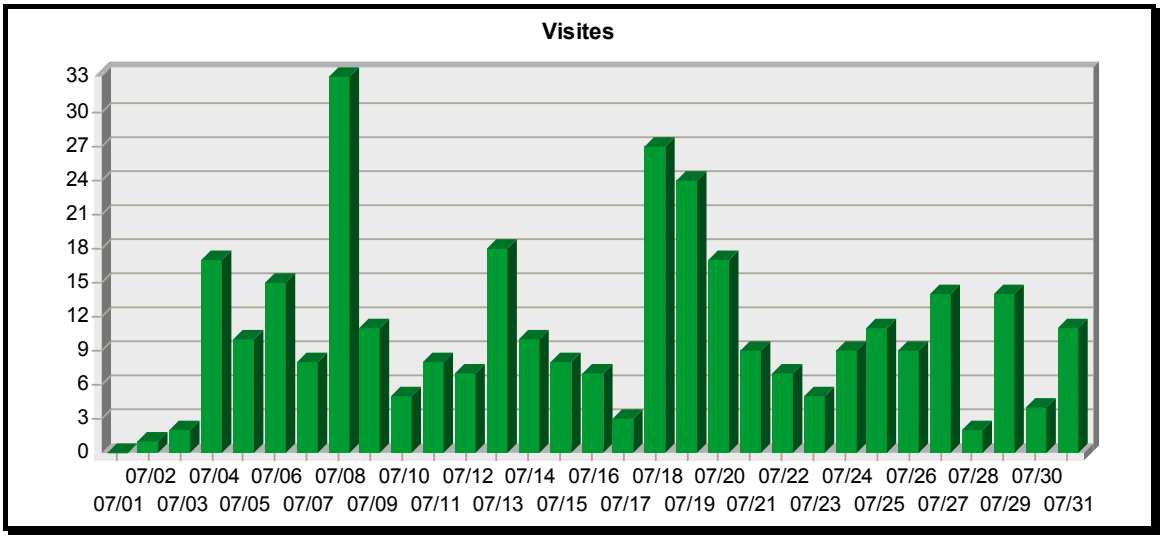
	Number of inputs of Partner/Observer name in minutes of the meetings	Electronic Communications Sent and received related with country documentation (technical or administrative)
Belgium	72	31
Catalonia	124	4 (more meetings)
Denmark	22	27
England	113	27
Finland	39	26
France	16	12
Germany	15	22
Greece	3	3
Ireland	44	32
Italy	17	36
Netherlands	9	26
Portugal	17	21
Sweden	46	29
Bulgaria	13	8
Czech Republic	13	5
Hungary	6	3
Poland	13	2
Slovenia	33	6

6. Visibility of the network and the project

It is quite early to measure the visibility of the network and the project and to measure its impact at a policy level but some progress has been done in the different countries in that direction and project findings support the EC in the development of its own strategy on alcohol.

Website visits is a way to evaluate the visibility of the network and the project. Below are detailed some figures of the visits we have had in July and in August of 2005 as an example of its impact. Of much interest is the origin of the visitors.

July 2005



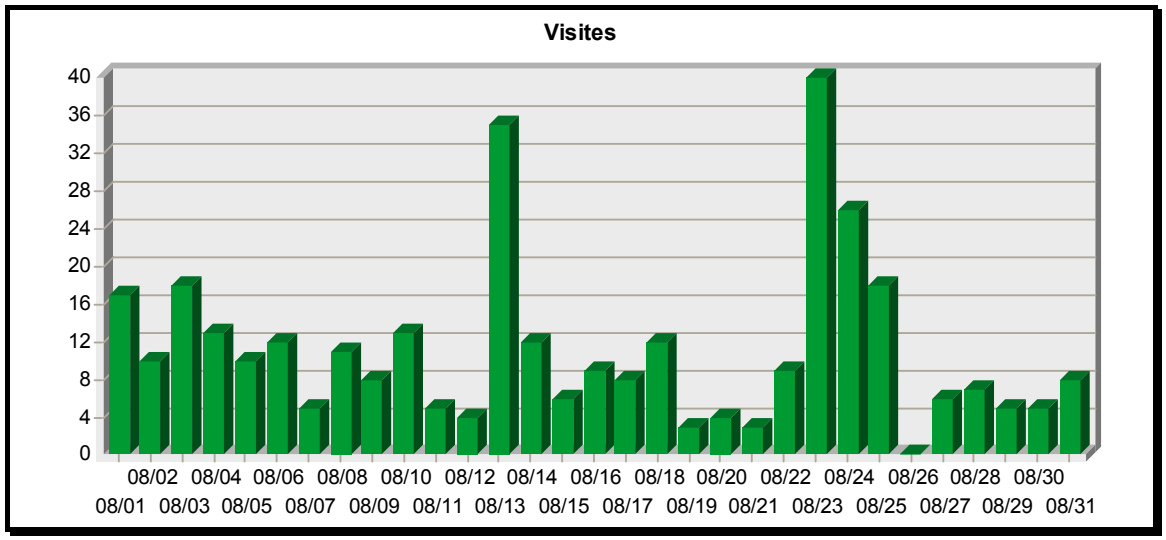
Summary	
Visits	326
Mean per day	10
International visits	84.66%
Unkown origin	0.31%
Visits from Spain (ES)	15.03%

Summary about visitor	
Number of visitors	157
Visitors only once	107
Visitors only once	50

	Countries	**Visits**	**%**
1.	Estats Units (US)	184	56.44%
2.	Spain (ES)	49	15.03%
3.	United Kingdom (UK)	27	8.28%
4.	Italy (IT)	14	4.29%
5.	France (FR)	9	2.76%
6.	Netherlands (NL)	6	1.84%
7.	Australia (AU)	4	1.23%
8.	Germany (DE)	4	1.23%
9.	Belgium (BE)	4	1.23%
10.	Denmark (DK)	3	0.92%

	Countries	Visits	%
11.	Western Europe – not identified (EU)	3	0.92%
12.	Suïsse (CH)	2	0.61%
13.	Poland (PL)	2	0.61%
14.	Hungary (HU)	2	0.61%
15.	Thailand (TH)	2	0.61%
16.	Singapur (SG)	1	0.31%
17.	Filipines (PH)	1	0.31%
18.	Canadàa (CA)	1	0.31%
19.	Finland (FI)	1	0.31%
20.	Unknown	1	0.31%
	Subtotal	320	98.16%
	Others	6	1.84%
	Total	326	100.00%

August 2005



Summary	
Visits	342
Mean per day	11
International visits	85.96%
Unkown origin	0.00%
Visits from Spain (ES)	14.04%

Summary about visitor	
Number of visitors	150
Visitors only once	97
Visitors more then once	53

	Countries	Visites	%
1.	United States (US)	213	62.28%
2.	Spain (ES)	48	14.04%
3.	Belgium (BE)	12	3.51%
4.	United Kingdom (UK)	12	3.51%
5.	Netherlands (NL)	8	2.34%
6.	Hungary (HU)	7	2.05%
7.	Italy (IT)	6	1.75%
8.	France (FR)	5	1.46%
9.	Sweden(SE)	4	1.17%
10.	Western Europe - unknown (EU)	4	1.17%

	Countries	Visites	%
11.	Irland (IE)	3	0.88%
12.	Thailand (TH)	3	0.88%
13.	Suïsse (CH)	3	0.88%
14.	Portugal (PT)	2	0.58%
15.	Austrailia (AU)	2	0.58%
16.	Poland (PL)	2	0.58%
17.	Tanzania (TZ)	1	0.29%
18.	Unió dels Emirats Àrabs (AE)	1	0.29%
19.	El Salvador (SV)	1	0.29%
20.	Denmark (DK)	1	0.29%
	Subtotal	338	98.83%
	Others	4	1.17%
	Total	342	100.00%

The Phepa project has participated presenting some communications or workshops in the following meetings:

-Comunicación "Phepa Project. Una web Europea para la diseminación de las intervenciones breves en Atención Primaria de Salud" presented in the XXXI jornadas Nacionales de Socidrogalcohol hola in Cordoba from 25 to 27 of March 2004.

-Primary Health Care European Project on Alcohol. Poster presented in the conference "Bridging the Gap. European Alcohol Policy Conference" organized by EUROCARE and hold in Warsaw (Poland) from 16 to 19 of June 2004.

-Workshop "Dealing with alcohol problems. What the Phepa Project has to say" presented at "Bridging the Gap. European Alcohol Policy Conference" organized by EUROCARE and hold in Warsaw (Poland) from 16 to 19 of June 2004.

-Communication in the Meeting of the Project Health Professionals and Smoking Cessation in a Larger Europe hold in Leiden 27-29 October 2004.

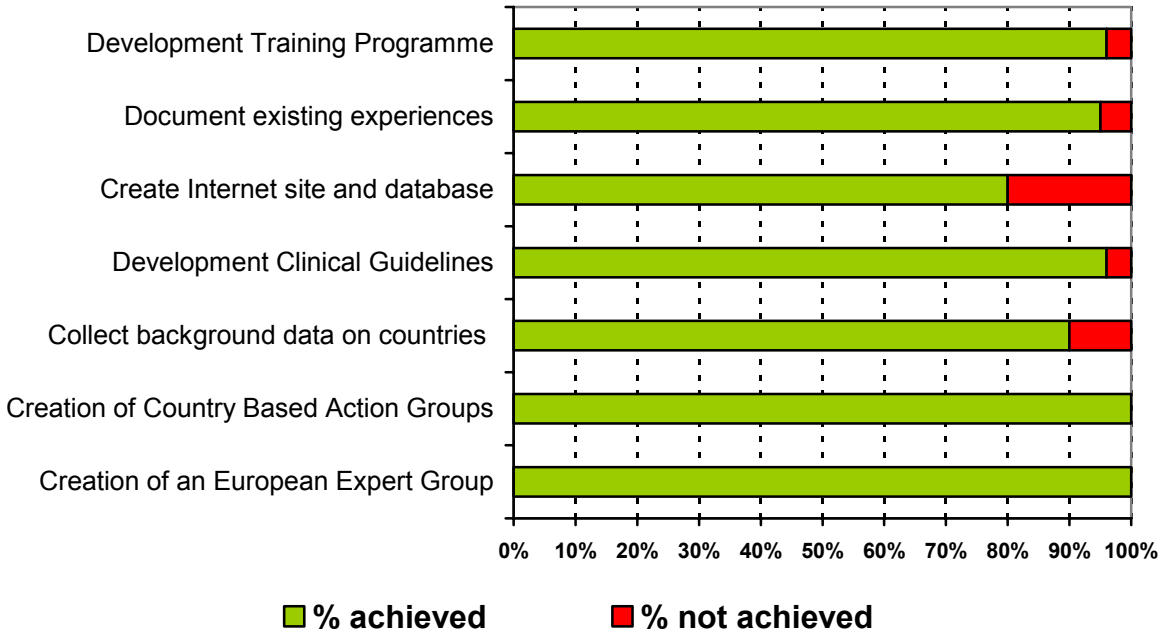
-Phepa Network members are also members of the International Network on Brief Interventions on Alcohol Problems (INEBRIA) aimed at promoting the wide implementation of brief interventions in a variety of settings for hazardous and harmful alcohol consumption at local, national and international levels.

-Phepa has participated giving a workshop in the 2nd Annual Conference of the International Network on Brief Interventions on Alcohol Problems that was held in Münster in September 2005.

It is expected the preparation of the following publishable papers:
- Short form of the clinical guidelines as a paper for publication
- Country profiles paper form about the current situation in the European Countries.
- Country strategies paper form.

7. Conclusions and next steps

1) Products have been developed and the level of achievement in all the activities that were planned it's shown in the following figure (%).



Of these activities, only the completion of the website with the alcohol database needs substantial work. The clinical guidelines and the training manual are currently in press.

2) The partners' commitment has been high from the beginning and in general they evaluated their participation in the project as more advantageous than disadvantageous.

3) The differences in the administration rules (economical, juridical, etc.) between the Catalan Government and the European Commission have been sometimes difficult to manage, forcing a change in the internal rules of the department to be able to adapt to the needs of the project.

What comes next?

We are now currently negotiating with the EC the contract of the PHEPA Project on disseminating brief interventions on alcohol problems Europe wide. The general objective of the new project is:

- to build on the experience and products of PHEPA I and
- to promote the dissemination of best practice on early identification and brief interventions on alcohol problems within the general population

The specific objectives are:

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

It is expected that a total of 24 associated partners (10 collaborating partners) will join the project and new partners will be from: **Estonia, Lithuania, Latvia, Romania, Slovak Republic and Turkey.**