"PHEPA II"
"Disseminating brief interventions on alcohol problems Europe wide"

Grant Agreement nº2005309
and Amendment nº 1

Interim Report to the European Commission
DG SANCO

Annexes

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

Project Coordinator
Lidia Segura

Address for correspondence
Program on Substance Abuse
Health Department
Government of Catalonia
Roc Boronat 81-95
Tel: + 34 93 551 36 10
Fax: + 34 93 551 75 14
E-mail: Phepa@gencat.net

Index

Annex 1. European Platform Members

Belgium

Partner:
Pas, Leo
Domus Medica
leo@pas.telenet.be
Team Members:
Garmyn, Bart
Domus Medica
fa632823@skynet.be
Dor, Bernard
SSMG, French Community Project of WHO Phase IV
Geirnaert, M.
VAD (Director)
Ansoms, S.
VAD (Chairman)
Caubergs, Chris
Provincial Coordinator of Drugs, Province Flemish Brabant
chris.cauberg@vl-brabant.be

Bulgaria

Partner:
Alexieva, Daniela
Horizonti 21 Foundation
daniela_alexieva@yahoo.com
tel. +359 888 311 872
Team Members:
Dr. Georgy Vassilev
National Centre for Addictions
ncn@mbox.infotel.bg
tel. +359 2 8326 136
Momtchil Vassilev
National Centre for Addictions
ncn@mbox.infotel.bg
tel. +359 2 8326 136

Czech Republic

Partner:
Dr Hana Sovinova
National Institute of Public Health, Prague
sovinova@szu.cz
Team Members:
Dr Ladislav Csémy
Prague Psychiatric Centre
csemy@pcp.lf3.cuni.cz

Denmark

Partner:
Barfod, Sverre
The Alcohol Group, Central Research Unit of General Practice
s.barfod@dadlent.dk
Team Members:
Lundh, Jesper
Central Commitee of Quality and Information for General Practice
lundh@dadlnet.dk
Groenbaek, Morten
National Institute of Public Health
mg@niph.dk
Broholm, Kit
National Board of Health

England

Partner:
Heather, Nick
School of Psychology & Sport Sciences, Northumbria University,
Newcastle Upon Tyne
nick.heather@unn.ac.uk
Team Members:
Longley, Mary
Alcohol Concern, Waterbridge House, London
Phillips, Richard
Alcohol Concern, Waterbridge House, London
Foster, John
Dept. Of Health, Mental and Biological Sciences, Middlesex University,
Queensway, Enfield, Middlesex
Harris, Linda
Wakefield Integrated Substance Misuse Service, Grosvenor House, Wakefield
Waller, Seta
Health Development Agency, Holborn Gate, London

Estonia

Partner:
Janson, Tamara
Estonian Temparance Union
Tamara.Janson@ut.ee
Team Members:
Beekman, Lauri
Estonian Temperance Union
Lauri@ave.ee ; lauri@pereraadio.ee
Veskimägi, Madis
Estonian Temperance Union
madis@tostamaa.ee

Finland

Partner:
Seppä, Kaija
University of Tampere, Medical School
Kaija-Liisa.Seppa@uta.fi
Team Members:
Aalto, Mauri
National Public Health Institute
mauri.aalto@ktl.fi
Kuokkanen, Martti
Helsinki City Health Department
mkuokkanen@kolumbus.fi
Heljälä, Leena
Finnish Institute of Occupational Health
leena.heljala@ttl.fi

France

Partner:
Michaud, Philippe
Institute for Secondary Prevention Promotion in Addictology
contact@ippsa.asso.fr

Germany

Partner:
Mann, Karl
Central Institute of Mental Health
karl.mann@zi-mannheim.de
Group Members:
Berner, Michael
University Medical Center Freiburg
michael.berner@uniklinik-freiburg.de
Bischof, Gallus
University of Lübeck
gallus.bischof@ukl.uni-luebeck.de
Demmel, Ralf
University of Münster
demmel@psy.uni-muenster.de
Härter, Martin
University Medical Center Freiburg
martin.haerter@uniklinik-freiburg.de
Herrmann, Markus
Universities of Halle and Magdeburg
Markus.Herrmann@med.ovgu.de
Hintz, Thomas
Central Institute of Mental Health
thomas.hintz@zi-mannheim.de
Kremer, Georg
Evangelic Hospital Bielefeld
Georg.Kremer@evkb.de
Leménager, Tagrid
Central Institute of Mental Health
tagrid.lemenager@zi-mannheim.de

Greece

Partner:
Diakogiannis, Ioannis
Hellenic Society for the Study of Addictive Substances
diakoi@med.auth.gr
Team Members:
Panagiotidis, Panagiotis
Hellenic Society for the Study of Addictive Substances
psypanpan@yahoo.gr

Hungary

Partner:
Dr Eleonóra Sineger
Hungarian Association of Addictologists, Budapest
sineger@chello.hu

Ireland

Partner:
Anderson, Rolande James
The Irish College of General Practitioners
rolande.anderson@icgp.ie
Team Members:
Bedford, Declan
Specialist in Public Health Medicine
Breen, Robbie
Department of Health and Children, Health Promotion Unit
Clerkin, Cait
GP at Baltinglass, Co. Wicklow
drpcarolan@eircom.net
Jordan, Tony
Irish National Alcohol Alliance
francisajordan@eircom.net
Ò Cuinneagáin, Anne
Eastern Regional General Practice Training Programme
ergpts@eircom.net
Ward, Aidan
GP at Castleknock, Dublin
ckclinik@indigo.ie

Italy

Partner:
Scafato, Emanuele
Instituto Superiore Di Sanita, Scientific Governmental Research Organization
scafato@iss.it
Team Members:
Allamani, Allaman
Azienda Sanitaria Firenze, Centro Alcologico, Dipartimento Dipendenze
all.alcologico@asf.toscana.it
Patussi, Valentino
Centro di Alcologia e della Nutrizione; University of Florence
v.patussi@dfc.unifi.it
Struzzo, Pierluigi
Comunity Research Centre "G.A.Feruglio"

pierluigi.struzzo@uniud.it
Ermanno Moscatelli
Community Research Center of the Municipality of Martignaco
moscatelli@adriacom.it
Marcomini, Franco
Associazione Eurocare Italia
eurocare@dada.it
Codenotti, Tiziana
Associazione Eurocare Italia
eurocare@dada.it
Gandin, Claudia
Instituto Superiore Di Sanita
claudia.gandin@iss.it

Latvia

Partner:
Dr. Skaida, Sarmite
State Addiction Agency
sarmite@dr.lv

Lithuania

Partner:
Subata, Emilis
Vilnius Centre for Addictive Disorders,
emilis.subata@vplc.lt
Pinceviciute, Egle
Vilnius Centre for Addictive Disorders
Egle.pinc@delfi.lt

Netherlands

Partner:
Lemmers, Lex
The Netherlands Institute of Mental Health and Addiction, Netherlands Institute of Mental Health and Addiction
llemmers@trimbos.nl
Team Members:
Bovens, Rob
Netherlands Institute for Health Promotion and Disease Prevention, Alcohol Education and Prevention Program
Jansen, Jan
Netherlands Institute for Health Promotion and Disease Prevention, Youth Department
Drenthen, Ton
Dutch College of GPS (NHG)
t.drenthen@nhg-nl.org
Boomsma, Louwrens
Dutch College of GP
l.boomsma@nhg-nl.org
Henkelman, Laurens
Netherlands Institute of Mental Health and Addiction
van Barneveld, Teus
The Dutch Institute for Healthcare Imporvement (CBO)
Laurant, Miranda

Centre for Quality of Care Research (WOK)
m.laurant@wok.umcn.nl

Poland

Partner:
Dr. Artur Mierzecki
College of Family Physicians in Poland
roklr@sci.pam.szczecin.pl
Team Members:
Godycki-Cwirko, Maciek
EUROPREV
maciekgc@uni.lodz.pl
Brzozka, Krysztof
PARPA
krzysztof.brzozka@parpa.pl

Portugal

Partner:
Ribeiro Gomes, Cristina
Direcção Geral da Saúde
cribeiro@dgsaude.min-saude.pt
Team Members:
Heitor, Maria Joao
Direcção Geral da Saúde
Pires Preto, António
Direcção Geral da Saúde

Romania

Partner:
Petcu, Cristian Adrian
Ministry of European Integration, Ministry of Health, General Directorate of the Contractions Regulation, the Relation with Provisioneres and Marketing (CNAS-DGNCRFM)
andrenut2004@yahoo.com

Slovakia

Partner:
Nociar, Alojz
Research Institute of Child Psychology and Pathopsychology
lanociar@r3.roburnet.sk

Slovenia

Partners:
Dr Marko Kolsek
University of Ljubljana, Department of Family Medicine
marko.kolsek@mf.uni-lj.si
Team Members:
MD Tonka Poplas-Susic
University of Ljubljana, Department of Family Medicine
Tonka.Poplas-Susic@MF.UNI-LJ.SI

Spain

Partner:

Gual i Solé, Antoni
Institut D'Investigacions Biomèdiques August Pi i Sunyer
tgual@clinic.ub.es

Team Members:

Colom i Farran, Joan
Program on Substance Abuse, Health Department, Government of Catalonia
joan.colom@gencat.net
Segura García, Lidia
Program on Substance Abuse, Health Department, Government of Catalonia
lidia.segura@gencat.net
Miriam Torres
Program on Substance Abuse, Health Department, Government of Catalonia
miriam.torres@gencat.net
Lizarbe, Vicenta
Ministerio de Sanidad y Consumo
vlizarbe@msc.es

Sweden

Partner:

Bendtsen, Preben
Department of Health and Society, Social Medicine and Public Health Science, Linköping University, Linköping
prebe@ihs.liu.se

Team Members:

Romelsjö, Anders
Stockholm University, Stockholm
anders.romelsjo@sorad.su.se
Spak, Fredrik
Göteborgs University, Göteborgs
fredrik.spak@socmed.gu.se
Brandell, Astri
National Institute of Family Medicine (FAMMI)
astri.brandell@telia.com
Damström Thakker, Kerstin
PHC Researcher
Johansson, Kjell
PHD Student

Turkey

Partner:

Soydal, Tahir
Tobacco Free Life Association
tahir.soydal@saglik.gov.tr ; tsoysal@mynet.com

Team Members

Ergüder, Toker
National Tobacco Control Programme Officer
ergudert@euro.who.int

Annex 2. Meetings

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

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

Monday 19th June

Chair: Rolande Anderson

09.00 Welcome and introductions – Joan Colom

09.15 Introduction and objectives of the meeting – Joan Colom
- Summary of the final products of PHEPA I
- Products of PHEPA II

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

10.00 Brief presentations on the final products of PHEPA I
- Guidelines and recommendations – Peter Anderson
- Training manual – Antoni Gual
- Web and Internet site database – Lidia Segura
- Country reports – Peter Anderson
- Evaluation of the project – Lidia Segura

10.30 Coffee break

11.00 Experiences and lessons in implementing brief interventions
- Three case studies
  - Catalonia – Antoni Gual
  - England – Nick Heather
  - Finland – Kaija Seppä

12.30 Lunch

Chair: Marko Kolsek

14.00 Group work to discuss elements of project
Three groups to discuss partners' needs and input to project

15.30 Coffee break

16.00 Report of group work and discussion

17.00 Close of day

18.00 Social programme and dinner

Tuesday 20th June

Chair: Kaija Seppä

09.00 Results of the assessment tool

09.30 Group work on updating the assessment tool
Three groups to discuss assessment tool

10.30 Coffee break

11.00 Report back from groups and general discussion

11.30 Presentation of report, Alcohol in Europe

12.00 Discussion of input to Helsinki conference

12.30 Lunch

Chair: Leo Pas

14.00 Presentation on plans for database
General discussion

15.00 Next steps

15.30 Close of meeting

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

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

Monday 19th June

Chair: Rolande Anderson

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

Welcome and introductions by Joan Colom (*see file attached: Estonia Meeting Main presentation)*
Dr Colom welcomes the participants and thanks them for being here despite the short notice. He explains that this meeting is the first of the Phepa II project and that it has been arranged together with the Estonian Partner (Tamara Janson and Lauri Beekmann from Estonian Temperance Union).

He asks all participants to introduce themselves.

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

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

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

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

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

Discussion:
Dr. Pas mentions the importance of rolling out the products in every country and the need to involve other associations and institutions. He also raises the question of the amount of budget available. He also asks if the project is expecting the Belgian group to roll out the products in both Belgian Regions.
Dr. Gual replies that there is no commitment with the EC on that, this is a decision to be taken in each country.
Dr. Spak asks about the use of rolling out the products in other settings.
Dr. Gual answers that the products are focused 100% on PHC but Phepa II is open to start working in other settings. However there is no obligation to do it since there is still much to be done in PHC. He adds that in each country there is a different situation and that Phepa II offers the opportunity to learn of each other by sharing experiences.

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

Lidia explains that she and Claudia are in charge of the administrative matters. She explains that the EC has not transferred yet the last payment of the Phepa I (30% of the final costs incurred) despite the fact that the Final report was sent in October 2005. She mentions then there is a negative economical balance for the Catalan Government.
She thanks all partners for their help during the sampling of the administrative documents of PHEPA II (Statutes, Attestation, VAT Nbr, Declaration of honour, Mandate letter, Legal Entity Form, etc.) and that all information was provided to the EC.
She mentions that a contract draft from the EC was received in December but that it has not been signed yet and explains that the budget figures have been calculated according to EC rules for each country and only associated partners will be reimbursed for their work.
The project has two types of partners: 24 associated partners and 9 collaborating partners (6 countries and PREV-NET). Associated partners are subject to contract and are requested to work towards the project aims whereas collaborating partners are only requested to collaborate and participate as observers and all their contribution is voluntary.

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

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

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

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

Experiences and lessons in implementing brief interventions

Three case studies

Catalonia – Antoni Gual (see file attached: Antoni Gual – Catalonia)
England – Nick Heather (see file attached: Nick Healther – England)
Finland – Kaija Seppä (see file attached: Kaija Seppä – Finland)

Chair: Marko Kolsek

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

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

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

Dr. Anderson lists the deliverables of the Phepa II project and links them with the objectives of the proposed Building Capacity Project, a proposal put in strategically by the Slovenian Government, the first government of the new EU countries that will also have the European Presidency (2008).

Group work to discuss elements of project

Four groups to discuss partners' needs and input to project

Participants are divided in 4 groups:

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

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

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

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

Reflecting on the deliverables and links with other projects:

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

Report of group work and discussion

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

Group 3 Rapporteur: Cristina Ribeiro	-Policy on alcohol directed to PHC professionals not only to specialists and more than education -How to motivate the GP -Networking on coordinating and who will be the task force in each country -exchange experiences, public communication and meetings for specific groups -Know how to train the trainers and who must be the trainer … -We need to know more about evaluation … qualitative, quantitative … comparative measure between the countries … -Networking …linking societies … -Training the training development … medical education … e-learning … -Overcome the barriers … internet database will be a support … -Identify the most important targets … -Collaboration among the mental health professionals and PHC -Specific expertise - clearly identify and use it to exchange experiences … risky behaviours … if they have more chances they will buy our offer … for instance more communication … -Some of the suggestions can be handled by INEBRIA too: research collaboration	- Serve as an expert group to assess countries that have younger history in SBI (through an internet database?) - Importance of detecting specific expertise	- Collaboration between Mental Health and PHC - Not only risky drinking but also risky behaviours (may be first, to focus later on alcohol and tobacco) - INEBRIA as expertise network

Group 2 Rapporteur: Nick Heather	- New countries & older countries to share expectations (Knowledge, enforce, make simpler the information) - Brand new teams. Acquire the basic knowledge and disseminating strategies - Continue the process of implementation	-Share knowledge and practical know how -Web site for GPs and nurses -How to use the experience in non medical settings (Dr. Matula, Education Ministry, Pedagogues, Psychologists, Social Workers)	-To reinforce the strategy by many ways (updated guidelines) -Continue collaboration to reinforce the network -Solidarity -To gain better knowledge of marketing strategies
Group 1: Rapporteur: Rolande Anderson	-Curriculum … what GP think about the idea -Ways to motivate policy makers and what motivates GP … -Publication of experiences --Phepa II have to focus on what we can do to help the implementation, focus on health services, model of services and service level instead of the clinical level (European communication on alcohol)	-Disseminate evaluation also outside PHC setting	-Consolidation -Giving back the responsibility to PHC networks -Inviting parents groups and representatives from schools.

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

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

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

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

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

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

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

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

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

Tuesday 20th June

Chair: Leo Pas

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

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

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

Group work on updating the assessment tool
Four groups to discuss assessment tool

Reflecting on the assessment tool:

1. What do we need the tool for?

2. How should we update or complete the tool…

3. How should we report on it?

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

Report back from groups and general discussion

Group 1 *Rapporteur: Toni Gual*

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

Group 2 *Rapporteur: Nick Heather*

- Useful for country level; have 2 or more people independently filling it in; then bring together and discuss differences
- Very dubious and negative about international comparisons
- Maps at best misleading, and potentially very dangerous
- Core of problem is notion of scientism; not objective; Enormous work to go into objective measures
- Could develop some scientific questions, which are also fraught with methodological problems
- For internal audit, the instrument too long and too quantitative; now think about how to develop the instrument
- Reporting within countries; could be held centrally
- Can make some generalizations on country progress based on tool
- Could be on Phepa website, but, in initial stages only to Phepa partners

Group 3. *Rapporteur: Leo Pas*
Aim
To provide a valid baseline measure of the situation in the specific country and to provide description to indicate direction to develop facilities

Target group
Will be all instances who are involved in intersectorial policy development (on implementation of EIBI)
Health minister,

Focal point for drug, Social care Municipalities, PHC association
Academic and scientific associations

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

Group 4. *Rapporteur: Pierluggi Struzzo*

- Differences in how questionnaire was filled in
- Took formal paper that exists at national level to compare the results
- Sometimes there is a conflict between objective questions and comments added in the last questions
- Tools are available for comments to compare between countries
- Specify a minimum requirement to answer the questions
- Could send comments to modify questions
- Could use it to monitor, to push for resources
- Have a common publication on how things are done.
- Include in the database for internal reasons

Discussion

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

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

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

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

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

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

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

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

The 10th recommendation talks about Advice for hazardous and harmful alcohol consumption and alcohol dependence, and recommendations for advice:
10th.1. Development of guidelines, brief advice and implementation in different settings
10th.2. Training and support programmes to deliver brief advice
10th.3. Resources to ensure the widespread of identification and advice programmes.

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

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

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

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

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

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

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

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

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

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

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

Dr. Pas could present data on cost effectiveness.

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

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

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

General discussion

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

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

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

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

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

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

Next steps

1. Maintain European Platform of health professionals and brief interventions to encourage networking and sharing of experience, finding ways to do more of this (country audit visits, more time during meetings etc)
2. Standardize, update and roll out training programme, perhaps developing minimum skills for providers, quality assessment criteria, and curricula for PHC teams, with tools for education; and Develop an intervention pack for PHC professionals (like Drink less, NIAAA, WHO packs etc)
3. Standardize, update and roll out clinical guidelines, perhaps developing minimum standards and quality assessment criteria

4. Develop, provide and update the evidence base, making it available and accessible, perhaps through the Internet site database
5. Continue to document examples of good practice, describing how it was done, providing case studies, perhaps through updated, revised and completed county reports – developing country stories
6. Perhaps based on the assessment tool, describe the minimum requirements of a 'model service'.
7. Through the assessment tool, document and monitor service provision
8. Prepare a series of fact sheets aimed at policy makers: short 2-3 page state of the art summaries on:
   -The why of brief interventions
   -Cost effectiveness of brief interventions
   -How to implement brief interventions
9. Embed and link brief interventions into other relevant alcohol and primary care projects:
   -Other EC funded projects (Pathways for Health, Building Capacity, if co-financed)
   -WHO initiatives
   -Primary care initiatives (Europrev, WONCA etc)
   -Conferences, e.g. Helsinki etc
10. Embed brief interventions into alcohol policies and programmes at European, country, regional and municipal levels, also through social marketing, supported by advocacy training
11. Support coalition building at country level, and consider extending BI in other settings (work place, A&E, and general hospitals.
12. Build capacity of health care users, and assess hazardous drinking and changes through surveys etc.

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

Country roll out – own contribution

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

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

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

It is also planned to have Small Phepa Meetings:
-The 3rd Inebria Conference to be held in Lisbon (26th-27th October)
-The Helsinki Conference
-The 4th Inebria Conference in Brussels.

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

Phepa team will send several e-mails:
- explaining the plan for the development of the assessment tool and the idea is to have a better form by the end of the year.
- proposing a new structure for the database and inviting partners to volunteer to work with it.
- explaining what is feasible to be done at country level according to budget and partners will have to reply on their estimated costs.
- asking for volunteers to develop the fact-sheets

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

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

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

Dr. Daniela Alexieva
Horizonti 21 Foundation
Tel: +359 8877 82777
Bulgaria
Email address: daniela_alexieva@yahoo.com

Dr. Rolande James Anderson
The Irish College of General Practitioners
Tel: +35 31 (01) 676 3706
Ireland
Email address: rolande.anderson@icgp.ie

Dr. Peter Anderson
Public Health Consultant
Tel: +45 39 29 41 11
Denmark
Email address: PDAnderson@compuserve.com

Dr. Sverre Barfod
The Research Unit of General Practice
Tel: +45 4772 0325
Denmark
Email address: s.barfod@dadlnet.dk

Dr. Lauri Beekmann
Estonian Temparance Union
Tel: +37 252 61884
Estonia
Email address: Lauri@ave.ee

Dr. Joan Colom
Department of Health of the Government of Catalonia, Program on Substance Abuse
Tel: +34 93 556 6166
Spain
Email address: joan.colom@gencat.net

Ms. Claudia Fernández
Department of Health of the Government of Catalonia, Program on Substance Abuse
Tel: +34 93 556 6378
Spain
Email address: claudia.fernandez@gencat.net

Dr. Claudia Gandin
Instituto Superiore di Sanita
Tel: +39 06 49904192
Italy
Email address: gandin@iss.it

Dr. Maciek Godycki-Cwirko
EUROPREV
Tel: +48 42 678 1695
Poland
Email address: maciekgc@uni.lodz.pl

Dr. Antoni Gual
Institut D'Investigacions Biomèdiques August Pi i Sunyer
Tel: +34 93 227 9923
Spain
Email address: tgual@clinic.ub.es

Prof. Nick Heather
Northumbria University
Tel: +44 191 227 4521
England
Email address: nick.heather@unn.ac.uk

Dipl.-Psych. Thomas Hintz
Central Institute of Mental Health
Tel: +49 621 17033904
Germany
Email address: Thomas.Hintz@zi-mannheim.de

Dr. Tamara Janson
Estonian Temperance Union, Universtity of Tartu
Tel: +37 252 61884
Estonia
Email address: Tamara.Janson@ut.ee

Dr. Marko Kolsek
University of Ljubljana, Medical Faculty
Tel: +386 1 438 69 15
Slovenia
Email address: marko.kolsek@mf.uni-lj.si

Dr. Lex Lemmers
The Netherlands Institute of Mental Health and Addiction
Tel: +31 30 2971100
Netherlands
Email address:
llemmers@trimbos.nl/hriper@trimbos.nl

Ph D. Stefan Matula
Research Institute of Child Psychology and Pathopsychology
Tel: +4212 4341 4054
Slovakia
Email address: xvudpapb@stonline.sk

Dr. Philippe Michaud
Institute for Secondary Prevention Promotion in Addictology
Tel: +33 607 91 4494/3
France
Email address: bmcm@anpa.asso.fr

Dr. Artur Mierzecki
College of Family Physicians in Poland
Tel: +48 91 48 00 871
Poland
Email address: roklr@sci.pam.szczecin.pl

Ms. Olga Montserrat
Department of Health of the Government of Catalonia, Program on Substance Abuse
Tel: +34 93 556 6352
Spain
Email address: olga.montserrat@gencat.net

Dr. Krzysztof Pacholik
PARPA
Tel: +48 22 532 0304
Poland
Email address: krzysztof.pacholik@parpa.pl

Dr. Panagiotis Panagiotidis
Hellenic Society for the Study of Addictive Substances
Tel: +30 231 0629425
Greece
Email address: psypanpan@yahoo.gr

Dr. Leo Pas
Scientific Society of Flemish GP
Tel: +32 475 266470
Belgium
Email address: leo@pas.telenet.be

Dr. Egle Pinceviciute
Vilnius Centre for Addictive Disorders
Tel: +370 5 213 9123
Lithuania
Email address: egle.pinc@delfi.lt

Dr. Cristina Ribeiro
Directorate General of Health
Tel: +35 1966095450
Portugal
Email address: cribeiro@dgsaude.min-saude.pt

Ms. Lidia Segura
Department of Health of the Government of Catalonia, Program on Substance Abuse
Tel: +34 93 556 6401
Spain
Email address: lidia.segura@gencat.net

Prof. Kaija Seppä
University of Tampere, Medical School
Tel: +358 3 2157101
Finland
Email address: Kaija-liisa.seppa@uta.fi

Dr. Eleonora Sineger
Hungarian Association of Addictologists (HAA)
Tel: +36 128 88526
Hungary
Email address: angyal.zsuzsanna@freemail.hu

Dr. Sarmite Skaida
State Addiction Agency
Tel: +371 7388012
Latvia
Email address: sarmite@dr.lv

Dr. Frederik Spak
Dept of Social Medicine, Sahlgren Academy, Goteborg University
Tel: +46 317 736869
Sweden
Email address: Fredrik.Spak@socmed.gu.se

Dr. Pierluigi Struzzo
Community Research Centre Martignacco
Tel: +39 432 299136
Italy
Email address: pierluigi.struzzo952@virgilio.it

Annex 3. The assessment tool

A tool to describe the available services for the management of hazardous and harmful alcohol consumption[1] at the country or regional level

The aim of this instrument is to develop a comprehensive tool that can be used to describe the available services for the management of hazardous and harmful alcohol consumption at the country or regional level. It is not a tool that will be completed in one day or at one time; rather it is a tool that will be gradually completed over time, building up a detailed and sophisticated profile of the management of hazardous and harmful alcohol consumption. The aim of the tool is to identify currently what is going on, and to identify deficiencies or areas in the country that need further work and strengthening.

Within each country or region, it is suggested that one person is nominated for ensuring that the tool is completed and returned.

It is suggested that the tool is completed by country or regional coalitions or partnerships that are set up to support the development of services for managing hazardous and harmful alcohol consumption. If no such coalition or partnership exists, it is suggested that a coalition is formed, with its first task to complete the tool. The tool can also be completed through meetings with individual experts. The tool can be divided into separate sections for different experts to complete. Certain questions require opinion or expert judgement; in this case, consensus can be achieved at meetings of coalitions or partnerships.

The tool:

- Provides a baseline description of services for managing hazardous and harmful alcohol consumption, identifying areas where services may require development or strengthening;
- Provides a mechanism for monitoring service provision over time;
- Allows sharing of information and examples of practice; and
- Provides a mechanism for coalitions or partnerships to discuss and have a shared view on services for managing hazardous and harmful alcohol consumption.

Certain questions of the tool ask respondents to provide document and organizational references. When asked to do so please complete the attached document and organization reference templates, a separate template for each document and organization.

[1] Hazardous alcohol consumption is a level of consumption or pattern of drinking that is likely to result in harm should present drinking habits persist. Harmful drinking is defined as 'a pattern of drinking that causes damage to health, either physical or mental'.

Completion of the tool[2]

It is preferable that you complete the tool electronically as a word document.

Within the tool there are text boxes. Just place the cursor in the text box and type. (Pressing the tab key moves you from box to box). You can also cut text from other documents and paste them into the text boxes. There are no limits to the size of the text boxes.

Within the tool, there are check boxes. Just place the cursor in the check box that you want to mark and left click the mouse. If you want to correct the check box, just left click the mouse again.

Where data is not available, please do not collect or estimate it, but mark that it is not available. Where the answer is not known, please indicate this in the extra comments box that is placed after each question.

The timetable is that the tool should be completed and returned to Peter Anderson by e-mail by 30th June 2008: peteranderson.mail@gmail.com. It is preferable to return the tool if it is 75% to 80% completed, rather than waiting for it to be 100% completed.

If you have any queries, please contact Peter Anderson by e-mail.

[2] The tool was first developed in 2004 by Peter Anderson. It has been revised for the European Commission funded PHEPA Project, with assistance from the partners of the Project.

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

Please cross the box, place a cross in the table or type your answer where indicated.

PART I

Personal details of contact person for completion of tool

Name:

Organization and position:

Address (name and number of street, postal code, town):

Telephone:

Fax:

Email:

Website:

Country:

If you are answering for a jurisdictional[3] region rather than a country as a whole, which jurisdictional region is it?

Please note**: unless you state otherwise in the tool, it will be assumed, if you are completing the questionnaire for a jurisdictional region other than a country, that all your answers are for this jurisdictional region.**

Population size of the country/region:

Date of completing the tool (dd-mm-yy):

[3] Such a jurisdictional region could be a region within a country or a municipality

Is there a country-wide or region-wide formal or informal coalition or partnership that deals with the management of hazardous and harmful alcohol consumption?

☐ **Yes**

☐ **No**

If yes:

What is the name of the coalition?

When was it established?

Please describe the aim of the coalition in one sentence:

PART II

A. COMMUNITY ACTION AND MEDIA EDUCATION

1. Have there been public education campaigns implemented in your country or region in the past 24 months in the listed media that provide information about <u>why</u> heavy drinkers should reduce their alcohol consumption (e.g., the harm done by alcohol) and that provide information on <u>how</u> to reduce their alcohol consumption (e.g., you don't need do it alone, effective help is available, etc.) If so, were they publicly funded?

	Provide information about **<u>why</u>** heavy drinkers should reduce their alcohol consumption	Provide information on **<u>how</u>** to reduce their alcohol consumption	Were the campaigns publicly funded		
	If yes, please tick box	If yes, please tick box	Fully	Partial	No
Television	☐	☐	☐	☐	☐
Radio	☐	☐	☐	☐	☐
Newspapers and magazines	☐	☐	☐	☐	☐
Billboards	☐	☐	☐	☐	☐
Other (please state)	☐	☐	☐	☐	☐

Please add any extra comments here

C. HEALTH CARE INFRASTRUCTURE

Integrated health care system

2. To what extent on a scale from 0 to 10, would you say that the management of hazardous and harmful alcohol consumption is integrated in the health care system, including co-operation or relationships between primary health care and secondary health care, similar to that for other chronic diseases such as hypertension or diabetes?

Not at all Fully
0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Please add any extra comments here

Structures for quality of care

3. For each topic in the table, is there a formal governmental organization, or organization appointed or contracted by the government that:

	Yes	No	If yes, please provide filename for organizational reference (and complete organization reference template)
3.1. Has the responsibility of preparing clinical guidelines for managing hazardous and harmful alcohol consumption?	☐	☐	
3.2. Monitors health outcomes at the population level from managing hazardous and harmful alcohol consumption?	☐	☐	
3.3. Monitors the quality of care provided for managing hazardous and harmful alcohol consumption?	☐	☐	
3.4. Reviews the cost effectiveness of interventions for managing hazardous and harmful alcohol consumption?	☐	☐	
3.5. Reviews the safety of pharmacological treatments for managing alcohol dependence?	☐	☐	
3.6. Provides information on managing hazardous and harmful alcohol consumption to health care providers?	☐	☐	

Please add any extra comments here

Research and knowledge for health

4. Is there a formal research programme for managing hazardous and harmful alcohol consumption with specifically allocated funding from governmental, government appointed or non-governmental organizations (excluding the pharmaceutical companies and the alcohol industry)?

- ☐ **Yes, from governmental organizations**
- ☐ **Yes, from government appointed organizations**
- ☐ **Yes, from non-governmental organizations**
- ☐ **No**

Please add any extra comments here

5. Is education on managing hazardous and harmful alcohol consumption formally part of the curriculum of undergraduate/basic professional training of the following health care providers?

	Undergraduate/ basic professional training		**Postgraduate professional training**		**Continuing medical education**	
	Yes	No	Yes	No	Yes	No
Medical students	☐	☐	☐	☐	☐	☐
Nursing students	☐	☐	☐	☐	☐	☐
Pharmacy students	☐	☐	☐	☐	☐	☐

Please add any extra comments here

Health care policies and strategies for managing hazardous and harmful alcohol consumption

6. Are there official written policies on managing hazardous and harmful alcohol consumption from the Government or Ministry of Health? Please mark all that apply:

- ☐ **Yes, a governmental written stand alone policy on managing hazardous and harmful alcohol consumption**
- ☐ **Yes, a governmental written policy on managing hazardous and harmful alcohol consumption which is part of an overall alcohol policy or strategy**
- ☐ **No, but there is a governmental policy on managing hazardous and harmful alcohol consumption in preparation**
- ☐ **No, there are no governmental policies on managing hazardous and harmful alcohol consumption**

If yes,

Please give filename for document reference:

(and complete document reference template)

Please add any extra comments here

7. If available, the governmental policy on managing hazardous and harmful alcohol consumption includes:

	Yes	No
A strategy on training for health professionals	☐	☐
A national funded research strategy for managing hazardous and harmful alcohol consumption	☐	☐
A strategy to support interventions by primary care professionals	☐	☐
Intensive support for managing alcohol dependence in specialised treatment facilities	☐	☐

Please add any extra comments here

Structures to manage implementation within health services

8. Is there an identified person within the Department of Health or Government, or who is contracted by the Department of Health or Government, who oversees or manages services for hazardous and harmful alcohol consumption?

☐ Yes
☐ No

Please provide his/her contact details:

Name:

Organization and position:

Address:

Telephone:

Email:

Website:

Please add any extra comments here

Funding health services and allocating resources

9. Is there government funding for services for the management of hazardous and harmful alcohol consumption?

☐ Yes
☐ No

If no,

☐ Funding is being prepared

10. Is the amount of funding reviewed from time to time?

☐ Yes
☐ No

If yes,

- ☐ Annually reviewed
- ☐ Reviewed every 2 to 5 years
- ☐ Reviewed every 5 years or longer
- ☐ Other (please specify):

Please add any extra comments here

11. Is a proportion of alcohol taxes specifically earmarked or allocated (this means hypothecated) to fund the costs of services for managing hazardous and harmful alcohol consumption?

- ☐ Yes
- ☐ No

12. If yes, please state the proportion:

13. Is yes, is the money raised from the tax actually spent on the costs of services for managing hazardous and harmful alcohol consumption?

- ☐ Yes
- ☐ No

14. Is the proportion of tax allocated for services for managing hazardous and harmful alcohol consumption reviewed from time to time?

- ☐ Yes
- ☐ No

If yes,

- ☐ Annually reviewed
- ☐ Reviewed every 2 to 5 years
- ☐ Reviewed every 5 years or longer
- ☐ Other (please specify):

Please add any extra comments here

D. SUPPORT FOR TREATMENT PROVISION

Screening, quality assessment, referral and follow-up systems

15. To what extent on a scale from 0 to 10, do you consider that the following screening and support systems are available for primary health care providers **in managing hazardous and harmful alcohol consumption?**

Availability of:	Not at all Fully
Screening instruments to identify at risk drinkers	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Case notes or computer records to record alcohol risk status	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Protocol charts or diagrams as an aid for managing hazardous and harmful alcohol consumption	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Support by facilitators or advisors for managing hazardous and harmful alcohol consumption	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Systems to follow-up patients for monitoring and advice	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Please add any extra comments here

Protocols and guidelines

16. Are there multidisciplinary clinical guidelines for managing hazardous and harmful alcohol consumption in your country/region that have been approved or endorsed by at least one health care professional body?

☐ **Yes**

☐ **No**

If yes:

☐ Stand alone guidelines for managing hazardous and harmful alcohol consumption

☐ Part of other clinical care guidelines (e.g. mental health guidelines)

If yes, please provide filename for document reference(s):

(and complete document reference template(s))

If no:

☐ **Guidelines are being prepared**

Please add any extra comments here

17. If there are endorsed clinical guidelines for managing hazardous and harmful alcohol consumption, have there been any studies in your country on their implementation or adherence?

☐ Yes
☐ No

If yes, please provide filename for document reference(s):

(and complete document reference template(s))

If no:

☐ Studies are being prepared

Please add any extra comments here

18. Are the following health care providers reimbursed for managing hazardous and harmful alcohol consumption, or is the management of hazardous and harmful alcohol consumption within their terms of service (contract) and part of their normal salary?

	Reimbursed for managing hazardous and harmful alcohol consumption		Managing hazardous and harmful alcohol consumption within terms of service and part of normal salary	
	Yes	No	Yes	No
General practitioners	☐	☐	☐	☐
Nurses working in general practice	☐	☐	☐	☐
Doctors in hospital	☐	☐	☐	☐
Nurses in hospitals	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐
Dentists	☐	☐	☐	☐
Addiction specialists	☐	☐	☐	☐

Please add any extra comments here

19. For the following professional groups, are there specialized guidelines or protocols, a written policy on managing hazardous and harmful alcohol consumption by the professional association, training for managing hazardous and harmful alcohol consumption within professional vocational education and training for managing hazardous and harmful alcohol consumption within accredited continuing medical education?

For the following professional groups, are there the following for managing hazardous and harmful alcohol consumption:								
	Specialized guidelines or protocols		Written policy on managing hazardous and harmful alcohol consumption by professional association		Training for managing hazardous and harmful alcohol consumption within professional vocational training		Training for managing hazardous and harmful alcohol consumption within accredited continuing medical education	
	Yes	No	Yes	No	Yes	No	Yes	No
General practitioners	☐	☐	☐	☐	☐	☐	☐	☐
Nurses in general practice	☐	☐	☐	☐	☐	☐	☐	☐
Nurses in general hospitals	☐	☐	☐	☐	☐	☐	☐	☐
Specialist nurses	☐	☐	☐	☐	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐	☐	☐	☐	☐
Midwives	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatrists	☐	☐	☐	☐	☐	☐	☐	☐
Obstetricians	☐	☐	☐	☐	☐	☐	☐	☐
Addiction specialists	☐	☐	☐	☐	☐	☐	☐	☐

Please add any extra comments here

E. INTERVENTION AND TREATMENT

Availability and accessibility

20. On a scale from 0 to 10, to what extent do you think that patient help for hazardous and harmful alcohol consumption is obtainable (obtainable means that patients can get the help) in the following settings?

Help is obtainable from:	Not at all 0 1 2 3 4 5 6 7 8 9 10 Fully
General/family practice	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Hospital clinics	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Pharmacists	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Specialist clinics	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Addiction services	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Please add any extra comments here

F. HEALTH CARE PROVIDERS

Clinical accountability

21. To what extent do you estimate on a ten-point scale that the following health care professionals consider advice for hazardous and harmful alcohol consumption as part of their routine clinical practice?

Advice is routine in clinical practice:	Not at all 0 1 2 3 4 5 6 7 8 9 10 Fully
General practitioners/ Family doctors	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Nurses working in general practice	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Pharmacists	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Midwives	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Dentists	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

If there are any publications on this topic, please provide the filenames for the document reference(s) and complete the document reference template(s):

Please add any extra comments here

Treatment provision

22. Have there been any studies, surveys or publications on the following or similar outcomes in primary health care (general practice/family practice) in your country or region, and if so, what are the main findings of the most recent results?

	Date of information **Please write NO, if information not available**	Main findings	Please provide filename for document reference (and complete document reference template, one for each document)
Patients are asked or screened about their alcohol consumption			
Patients with hazardous or harmful alcohol consumption are given advice			
Advice meets quality criteria			
Practice protocols and guidelines are followed			
The effectiveness of interventions for hazardous and harmful alcohol consumption			
The cost effectiveness of interventions for hazardous and harmful alcohol consumption			
The use of the AUDIT questionnaire			
The attitudes of health care providers to managing hazardous and harmful alcohol consumption			
Increasing the involvement of health care providers in managing hazardous and harmful alcohol consumption			

Please add any extra comments here

G. HEALTH CARE USERS

Knowledge

23. Have there been any studies, surveys or publications that provide answers for the following or similar information concerning hazardous and harmful alcohol consumption and if so, what are the main findings of the most recent results?

	Date of information **Please write NO, if information not available**	Main findings	Please provide filename for document reference (and complete document reference template, one for each document)
People know that hazardous and harmful alcohol consumption can be dangerous to their health			
People know about effective methods to reduce hazardous and harmful alcohol consumption			

Please add any extra comments here

Help seeking behaviour

24. Have there been any surveys, studies, or publications which provide information on the proportion of hazardous and harmful alcohol users who have ever used one of the following methods to reduce their alcohol consumption and if so, what are the main findings of the most recent results?

	Date of information **Please write NO, if information not available**	Main findings	Please provide filename for document reference (and complete document reference template, one for each document)
Help from a doctor			
Help from a nurse			
Help from a pharmacist			
Help from a dentist			
Help from friends or family			
Advice from the Internet			
Specialist clinic			
Self-help group			
Help line telephone service			
Willpower alone			

Please add any extra comments here

Annex 4. Internet Resource Structure

This will be a database that is built over time. To begin with, it will include six main headings:

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

Under each heading, there will be a list of key findings. For each key finding, there will be a brief commentary and links to supporting evidence

HEALTH EFFECTS

NOTE: These are the examples of the main headings, and sub-headings, and key findings for each condition. Under breast cancer, is an example of the commentary and supportive evidence.

REGULAR HEAVY DRINKING

NEUROPSYCHIATRIC CONDITIONS

Anxiety and sleep disorders

Over one in eight of individuals with an anxiety disorder also suffer from an alcohol use disorder. Alcohol aggravates sleep disorders.

Commentary and supporting evidence

Depression

Alcohol use disorders are a risk factor for depressive disorders in a dose dependent manner, often preceding the depressive disorder, and with improvement of the depressive disorder following abstinence from alcohol.

Commentary and supporting evidence

Alcohol dependence

The risk of alcohol dependence begins at low levels of drinking and increases directly with both the volume of alcohol consumed and a pattern of drinking larger amounts on an occasion. Young adults are particularly at risk.

Commentary and supporting evidence

Nerve damage

Clinical studies find that between one quarter and one third of alcohol dependent patients have damage to the peripheral nerves of the body, with the risk and severity of damage increasing with lifetime use of alcohol.

Commentary and supporting evidence

Brain damage

Heavy alcohol consumption accelerates shrinkage of the brain, which in turn leads to cognitive decline. There appears to be a continuum of brain damage in individuals with long-term alcohol dependence.

Commentary and supporting evidence

Cognitive impairment and dementia

Heavy alcohol consumption increases the risk of cognitive impairment in a dose dependent manner.

Commentary and supporting evidence

GASTROINTESTINAL, METABOLIC AND ENDOCRINE CONDITIONS

Liver cirrhosis

Alcohol increases the risk of liver cirrhosis in a dose dependent manner. At any given level of alcohol consumption, women have a higher likelihood of developing liver cirrhosis than men.

Commentary and supporting evidence

Pancreatitis

Alcohol increases the risk of acute and chronic pancreatitis in a dose dependent manner.

Commentary and supporting evidence

Type II diabetes

Although low doses decrease the risk compared with abstainers, higher doses increase the risk.

Commentary and supporting evidence

Overweight

Alcohol contains 7.1 kcal/g and is a risk factor for weight gain. In very heavy drinkers alcohol can replace calories due to meal skipping and lead to malnutrition.

Gout

Alcohol increases the risk of high blood levels of uric acid and gout in a dose dependent manner.

Commentary and supporting evidence

CANCERS

Gastrointestinal tract

Alcohol increases the risk of cancers of the mouth, oesophagus (gullet) and larynx (upper airway), and to a lesser extent, cancers of the stomach, colon and rectum in a linear relationship.

Commentary and supporting evidence

Liver

Alcohol increases the risk of cancer of the liver in an exponential relationship.

Commentary and supporting evidence

Breast

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

Commentary and supporting evidence

<u>Example of commentary and supporting evidence:</u>

Key finding

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

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

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

CARDIOVASCULAR DISEASES

Hypertension

Alcohol raises blood pressure and increases the risk of hypertension, in a dose dependent manner.

Commentary and supporting evidence

Stroke

Alcohol increases the risk of haemorrhagic stroke with a dose-response relationship. The relationship with ischaemic stoke is J-shaped, with low doses reducing the risk and higher doses increasing the risk. Episodic heavy drinking is an important risk factor for both ischaemic and haemorrhagic stroke, and is particularly important as a cause of stroke in adolescents and young people.

Commentary and supporting evidence

Irregularities in heart rhythms

Episodic heavy drinking increases the risk of heart arrthymias and sudden coronary death, even in people without any evidence of pre-existing heart disease

Commentary and supporting evidence

Coronary heart disease (CHD)

Although light drinking reduces the risk of CHD, beyond 20g a day (the level of alcohol consumption with the lowest risk), the risk of heart disease increases, being more than the risk of an abstainer after 80g a day. The reduced risk is much less in very old age, where over-reporting of CHD on death certificates also occurs.

Commentary and supporting evidence

Cardiomyopathy

Over a sustained period of time, a high level of alcohol consumption, in a dose dependent manner, increases the risk of damage to the heart muscles (cardiomyopathy).

Commentary and supporting evidence

IMMUNE SYSTEM

Alcohol can interfere with the normal functions of the immune system, causing increased susceptibility to certain infectious diseases, including pneumonia, tuberculosis and possibly HIV.

Commentary and supporting evidence

LUNG DISEASES

People with alcohol dependence have a two- to four- fold increased risk of acute respiratory distress syndrome (ARDS) in the presence of sepsis or trauma.

Commentary and supporting evidence

POST-OPERATIVE COMPLICATIONS

Alcohol increases the risk of post-operative complications and risk of admittance to intensive care in a dose dependent manner.

Commentary and supporting evidence

SKELETAL CONDITIONS

There appears to be a dose-dependent relationship between alcohol consumption and risk of fracture in both men and women that is stronger for men than for women. In high doses, although in a dose dependent manner, alcohol is a cause of muscle disease.

Commentary and supporting evidence

REPRODUCTIVE CONDITIONS

Alcohol can impair fertility in both men and women.

Commentary and supporting evidence

TOTAL MORTALITY

It has been estimated, at least in the UK, that in younger people (women under the age of 45 years and men under the age of 35 years), any level of alcohol consumption increases the overall risk of death in a dose dependent manner.

EPISODIC HEAVY DRINKING

SOCIAL WELL BEING

Negative social consequences

For getting into a fight, harming home life, marriage, work, studies, friendships or social life, the risk of harm increases proportional to the amount of alcohol consumed.

Commentary and supporting evidence

Reduced work performance

Higher alcohol use results in reduced employment and increased unemployment and reduced productivity.

Commentary and supporting evidence

INTENTIONAL AND UNINTENTIONAL INJURIES

Violence

There is a relationship between alcohol consumption and the risk of involvement in violence, which is stronger for episodic heavy drinking than for overall consumption. The higher the alcohol consumption, the more severe the violence.

Commentary and supporting evidence

Drinking and driving

The risk of drinking and driving increases with both the amount of alcohol consumed and the frequency of high volume drinking occasions. There is a 38% increased risk of accidents at a blood alcohol concentration level of 0.5g/L.

Commentary and supporting evidence

Injuries

There is a relationship between the use of alcohol and the risk of fatal and non-fatal accidents and injuries. People who usually drink alcohol at lower levels, but who engage periodically in drinking large quantities of alcohol, are at particular risk. Alcohol increases the risk of attendance at hospital emergency rooms in a dose dependent manner.

Commentary and supporting evidence

Suicide

There is a direct relationship between alcohol consumption and the risk of suicide and attempted suicide, which is stronger for episodic heavy drinking than for overall consumption.

Commentary and supporting evidence

ALCOHOL DEPENDENCE

BENEFITS OF REDUCING DRINKING

IDENTIFYING HAZARDOUS AND HARMFUL ALCOHOL CONSUMPTION

NOTE: these are the examples of the main headings

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

AUDIT-C

FAST ALCOHOL SCREENING TEST

CAGE

BIOCHEMICAL TESTS

EFFICACY

NOTE: these are the examples of the main headings

QUANTITY OF ALCOHOL CONSUMED IN A SPECIFIED TIME PERIOD

FREQUENCY OF DRINKING (NUMBER OF DRINKING SESSIONS IN A SPECIFIED TIME PERIOD)

INTENSITY OF DRINKING (AMOUNT OF ALCOHOL CONSUMED IN A DRINKING SESSION)

LABORATORY MARKERS

HEAVY DRINKERS AND BINGE DRINKERS

GENDER

AGE

SEVERITY OF PROBLEMS

LENGTH OF SESSIONS

NUMBER OF SESSIONS

COST EFFECTIVENESS

NOTE: these are the examples of the main headings

COSTS OF IDENTIFICATION AND BRIEF INTERVENTION PROGRAMMES

BENEFITS OF IDENTIFICATION AND BRIEF INTERVENTION PROGRAMMES

COST EFFECTIVENESS OF IDENTIFICATION AND BRIEF INTERVENTION PROGRAMMES

IMPLEMENTING BRIEF INTERVENTION PROGRAMMES

NOTE: these are the examples of the main headings

CONDITIONS FOR EFFECTIVE IMPLEMENTATION

STRATEGIES FOR EFFECTIVE IMPLEMENTATION

TARGETED APPROACHES

FUNDING

MONITORING

SUPPORTIVE ALCOHOL POLICY MEASURES

NOTE: these are the examples of the main headings

ECONOMIC AVAILABILITY OF ALCOHOL

PHYSICAL AVAILABILITY OF ALCOHOL

MARKETING OF ALCOHOL

EDUCATIONAL PROGRAMMES

DRINKING ENVIRONMENTS

COMMUNITY PROGRAMMES

Annex 5. Additional deliverables

5.1. GUIDE: HOW TO MANAGE RISKY DRINKERS IN PRIMARY HEALTH CARE

This guide has been written in accordance with the criteria of the PHEPA Training Programme on identification and brief interventions and the PHEPA Clinical Guidelines on identification and brief interventions. It is also inspired in 'Helping patients who drink too much. A clinician's guide. 2005 Edition' from the NIAAA.

Introduction

Alcohol increases the risk of a wide range of medical and social problems in a dose dependent manner, with no evidence for a threshold effect. Generally the more serious the crime or injury, the more likely alcohol is to be involved. Harm to others is a powerful to reason to intervene for hazardous and harmful alcohol consumption.

Apart from being a drug of dependence, alcohol is a cause of 60 or so different types of disease, including injuries, mental and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, skeletal diseases, reproductive disorders and pre-natal harm. For the individual drinker, alcohol increases the risk of these diseases and injuries in a dose dependent manner, with no evidence for a threshold effect. The higher the alcohol consumption, the greater is the risk.

The risk of death from alcohol is a balance between the risk of diseases and injuries that alcohol increases and the risk of heart disease that in small amounts alcohol decreases. This balance shows that, except for older people, the consumption of alcohol is not risk free. The level of alcohol consumption with the lowest risk of death is zero or near zero for women under the age of 65, and less than 5g of alcohol a day for women aged 65 years or older. For men, the level of alcohol consumption with the lowest risk of death is zero under 35 years of age, about 5g a day in middle age, and less than 10g a day when aged 65 years or older.

Throughout the European Union as a whole, alcohol is one of the most important causes of ill-health and premature death. It is less important than smoking and raised blood pressure, but more important than high cholesterol levels and overweight.

There are health benefits from reducing or stopping alcohol consumption. All acute risks can be completely reversed if alcohol is removed. Even amongst chronic diseases, such as liver cirrhosis and depression, reducing or stopping alcohol consumption are associated with rapid improvements in health. Primary Health Care (PHC) providers play a crucial role in this field since they are in a pivotal position inside Health Systems.

Key questions and recommendations

KEY QUESTIONS	RECOMMENDATIONS
Should hazardous and harmful alcohol use be identified? Since alcohol is implicated in a wide variety of physical and mental health problems in a dose dependent manner, there is an opportunity for PHC providers to identify adult patients with hazardous and harmful alcohol consumption. Numerous studies have shown that most patients with hazardous and harmful alcohol consumption are not known to their health care provider.	The identification of hazardous and harmful alcohol consumption and episodic heavy drinking should be offered to all adult patients of PHC facilities.
In which groups of patients should hazardous and harmful alcohol use be identified? A truly preventive approach can only be reached if all adult patients are screened for hazardous and harmful alcohol consumption, including patterns of episodic heavy drinking. If such an approach is not feasible, limiting screening to high risk groups or to some specific situations may be a feasible option. Such groups could include young to middle aged males and special health clinics (e.g. for hypertension).	All adult patients should be routinely screened for hazardous and harmful alcohol consumption at least every 2 years
What are the best questions or screening instruments to identify hazardous and harmful alcohol use? The simplest questions to use are those that ask about alcohol consumption. The first three questions of the World Health Organization's Alcohol Use Disorders Identification Test, which was designed to identify hazardous and harmful alcohol consumption in primary care settings, have been well tested and validated. The first question asks about frequency of drinking; the second the amount of alcohol consumed on an average drinking day; and the third the frequency of episodic heavy drinking.	The use of the first three alcohol consumption questions of the AUDIT is one preferred method to identify hazardous and harmful alcohol consumption.
How should questions or screening instruments be administered? The identification of hazardous and harmful alcohol consumption works best when it is incorporated into routine clinical practices and systems, such as systematically asking all new patients when they register; all patients when they attend for a health check; or all men aged 18-44 years, when they attend for a consultation. There is no evidence available to suggest that systematic identification of hazardous and harmful alcohol consumption lead to adverse effects, such as discomfort or dissatisfaction amongst patients.	The identification of hazardous and harmful alcohol consumption works best when it is incorporated into routine clinical practices and systems
Are biochemical tests useful for screening? Biochemical tests for alcohol use disorders such as liver enzymes (e.g. serum γ-glutamyl transferase (GGT) and the aminotransferases), carbohydrate deficient transferrin (CDT) and mean corpuscular volume (MCV) are not useful for screening because elevated results have poor	Biochemical tests should not be relied on for routine screening for hazardous or harmful

sensitivity, identifying only a small proportion of patients with hazardous or harmful alcohol consumption.	alcohol consumption or alcohol dependence in PHC.
Are brief interventions effective in reducing hazardous and harmful alcohol consumption and alcohol related problems? Brief interventions are effective in PHC settings in reducing hazardous and harmful alcohol consumption and alcohol related problems in patients without alcohol dependence. Eight patients need to be advised for one patient to benefit. There is little evidence for a dose response effect and it does not seem that extended interventions are any more effective than brief interventions. The effectiveness is certainly maintained for up to one year. Brief interventions are also effective in reducing mortality. 282 patients need to receive advice to prevent one death within one year.	PHC physicians and other PHC professionals should offer at least a very brief (5 minute) intervention to all patients identified with hazardous or harmful alcohol consumption.
What are the components of effectiveness? Based on the contents of evaluated interventions, three essential elements of advice have been proposed, including feedback, the giving of advice and goal setting. There is mixed evidence to suggest interventions with more than one session are any more effective than one session alone. Motivational interviewing appears to be an effective intervention technique.	Interventions can be described with reference to the 5-As counselling framework: **assess** alcohol consumption; **advise** patients to reduce alcohol consumption; **agree** on individual goals; **assist** patients for behaviour change; and **arrange** follow-up.
What is the cost effectiveness of brief interventions? At a cost of €1960 per year of ill-health and premature death prevented, PHC brief interventions for hazardous and harmful alcohol consumption are amongst the cheapest of all medical interventions that lead to health gain. In other words, if a primary health care provider is going to undertake a new activity, giving brief advice to patients with hazardous and harmful alcohol consumption will give one of the best health benefits for the practice population than spending ten minutes doing anything else.	Within PHC activity and within the alcohol treatment field, there should be an urgent reorientation of resources to deliver identification and brief intervention programmes for hazardous and harmful alcohol consumption.

KEY CONCEPTS

Hazardous Alcohol Consumption. Hazardous drinking is a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others. Hazardous drinking patterns are of public health significance despite the absence of any current disorder in the individual user.

Harmful Alcohol Consumption. Harmful use refers to alcohol consumption that results in consequences to physical and mental health. Some would also consider social consequences among the harms caused by alcohol.

Risky drinking. This term is used as a synonimous of Hazardous Alcohol Consumption and is gaining increasing popularity even though it is not an accepted term by the WHO.

Alcohol Dependence. Alcohol dependence is a cluster of behavioural, cognitive, and physiological phenomena that may develop after repeated alcohol use4. Typically, these phenomena include a strong desire to consume alcohol, impaired control over its use, persistent drinking despite harmful consequences, a higher priority given to drinking than to other activities and obligations, increased alcohol tolerance, and a physical withdrawal reaction when alcohol use is discontinued.

Standard Drink Unit. A volume of beverage alcohol (e.g. a glass of wine, a can of beer, or a mixed drink containing distilled spirits) that contains approximately the same amounts (in grams) of ethanol regardless of the type of beverage. The term is often used to educate alcohol users about the similar effects associated with consuming different alcoholic beverages served in standard-sized glasses or containers (e.g. the effects of one glass of beer are equal to those of one glass of wine). In Europe, the term ''unit" is employed, where one unit of an alcoholic beverage contains approximately 10 grams of ethanol; in North American literature, ''a drink" contains about 12 grams of ethanol.

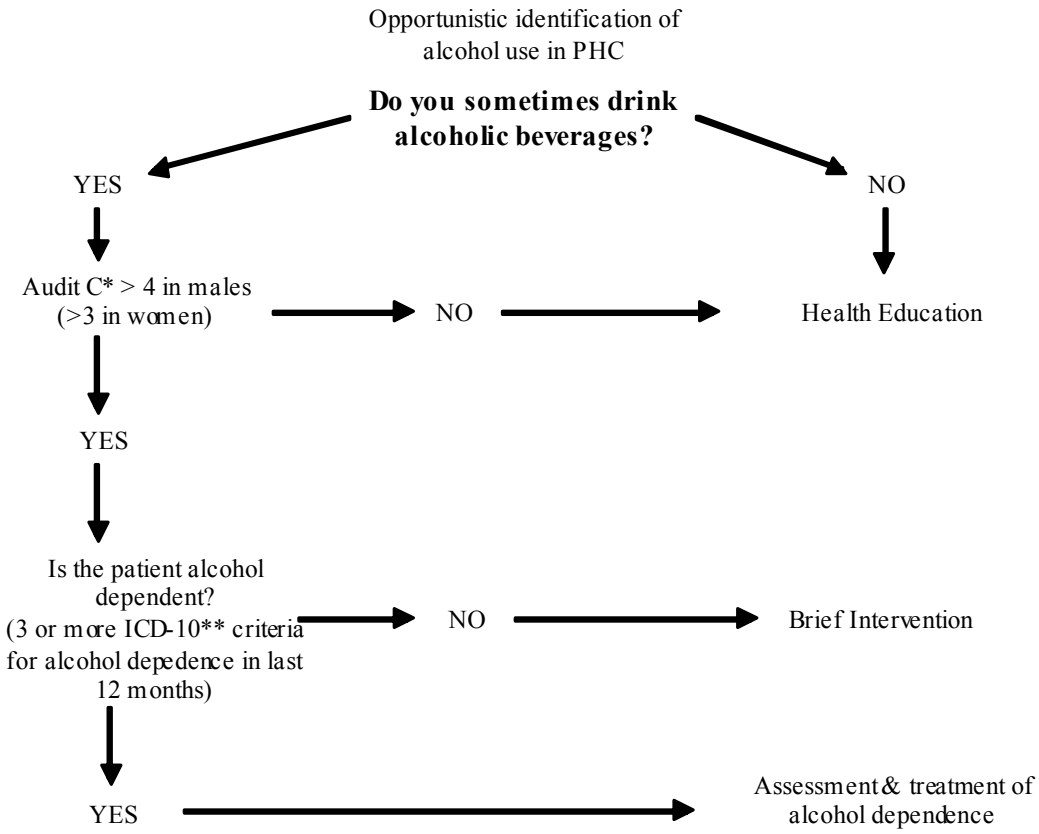
AUDIT. The Alcohol Use Disorders Identification Test is a questionnaire which consists of 10 questions about recent alcohol use, alcohol dependence symptoms, and alcohol-related problems. As the first screening test designed specifically for use in primary care it was developed and evaluated over a period of two decades, and it has been found to provide an accurate measure of risk across gender, age, and cultures settings.

AUDIT-C. It contains the first 3 questions of the Audit. Reliable to screen hazardous drinking in primary health care settings.

Brief Intervention. A treatment strategy in which structured therapy of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of alcohol. It is designed in particular for general practitioners and other PHC workers. Also known as minimal intervention. Brief intervention is often linked to systematic screening testing for hazardous and harmful alcohol use.

HOW TO DO IT

Step 1. SCREENING



*** AUDIT-C**

1: How often did you have a drink containing alcohol in the past year?
(0) Never; (1) Monthly or less; (2) 2-4 times a month; (3) 2-3 times per week; (4) 4 or more times a week.

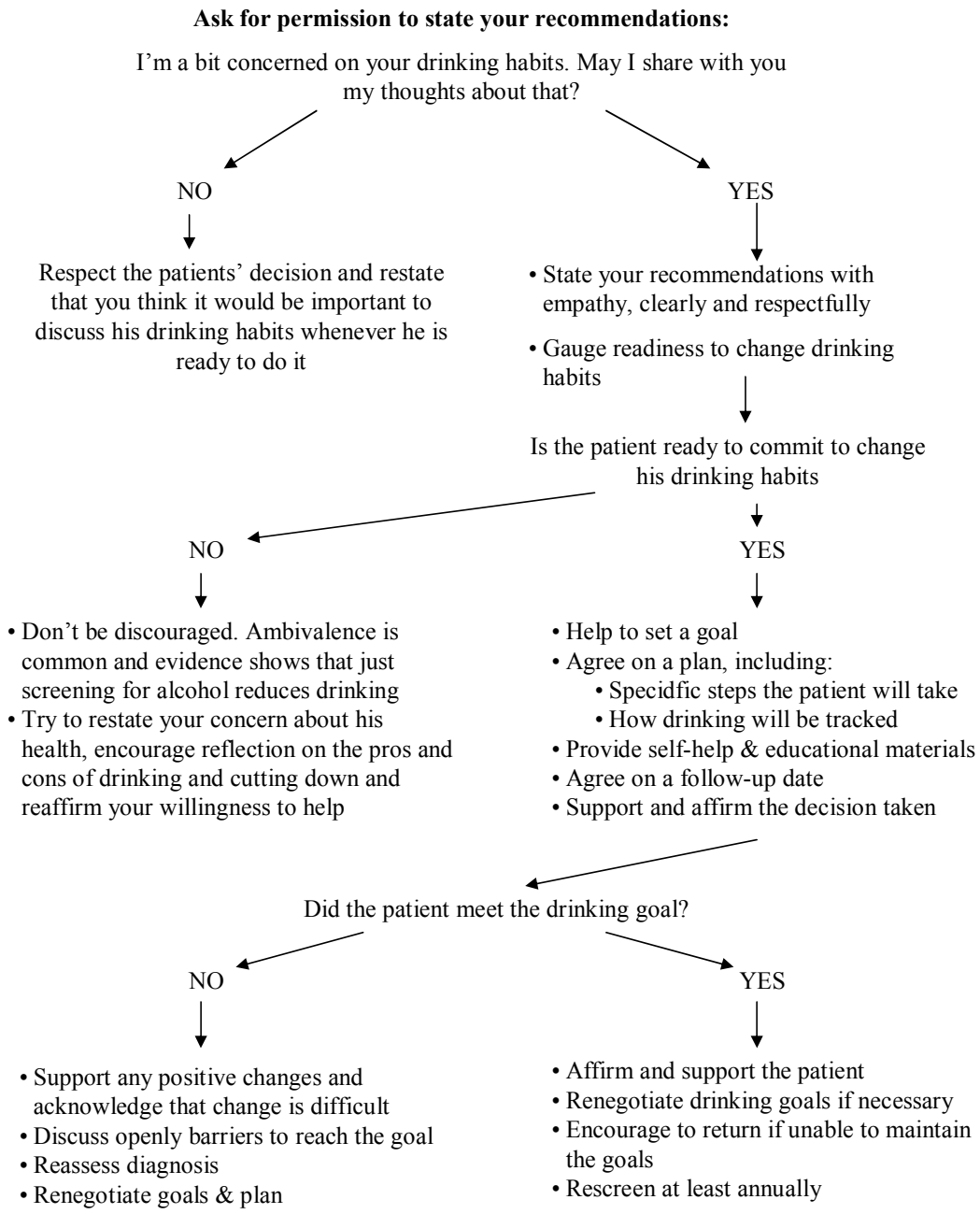
2: How many drinks did you have on a typical day when you were drinking in the past year?
(0) 1 or 2; (1) 3 or 4; (2) 5 or 6 ; (3) 7 to 9; (4) 10 or more.

3: How often did you have six or more drinks on one occasion in the past year?
(0) Never; (1) Less than monthly; (2) Monthly; (3) Weekly; (4) Daily or almost daily.

**** ICD-10 DEPENDENCE CRITERIA**
A definite diagnosis should be made only if 3 or more of the following have been present together at some time in the last 12 months:

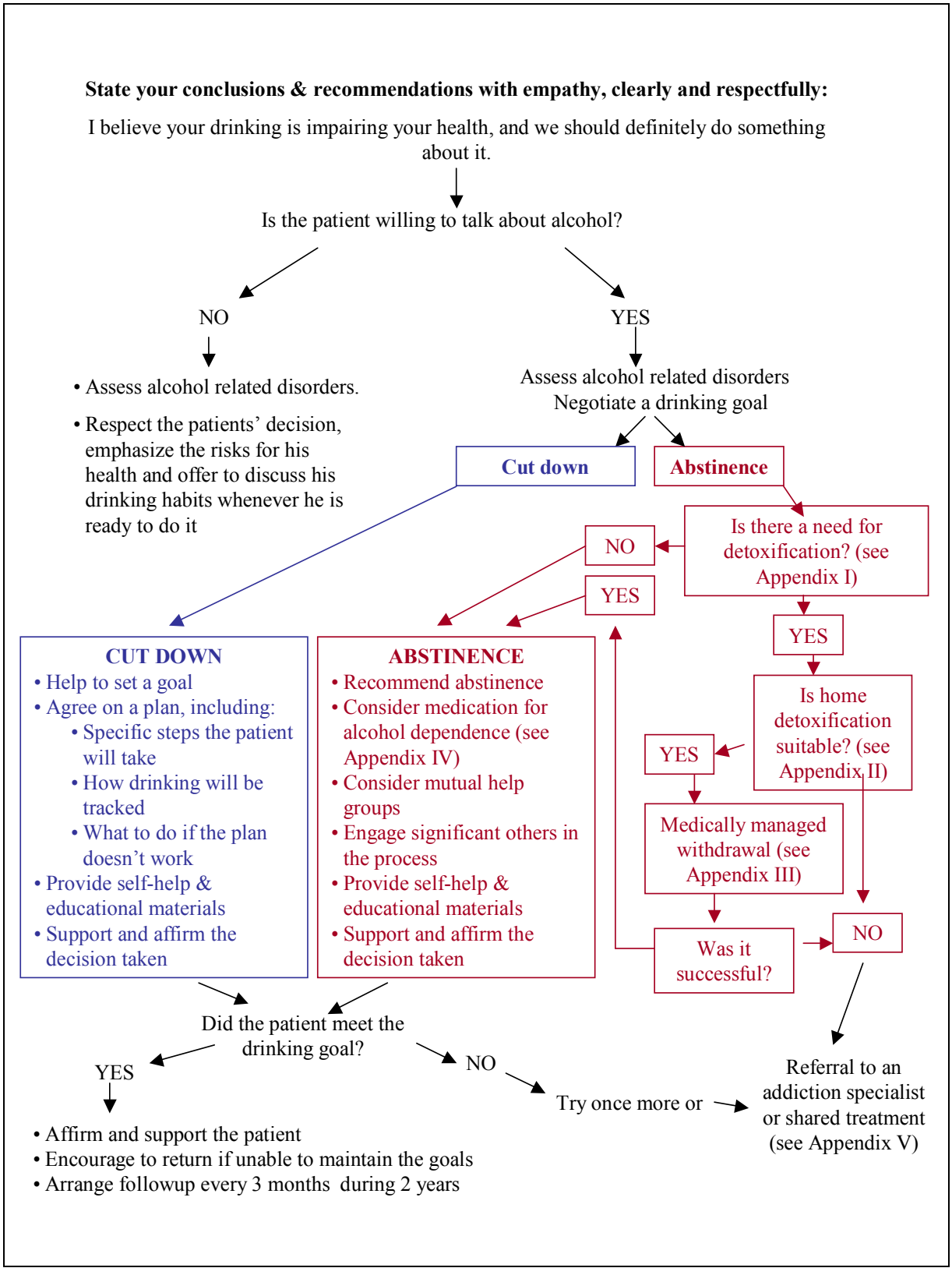
A strong desire or sense of compulsion to drink.
Difficulty in controlling drinking in terms of its onset, termination or level of use.
A physiological withdrawal state or drinking to relieve or avoid withdrawal symptoms.
Evidence of tolerance.
Progressive neglect of alternative pleasures or interests because of drinking.
Persisting with alcohol use despite awareness of overtly harmful consequences.

Step 2-A. BRIEF ADVICE FOR AT-RISK DRINKING



COUNSELING STYLE: Brief interventions are most likely to be succesful if delivered with empathy, showing the patient that we care, and that we respect that he holds the final responsibility for trying to change his drinking habits

Step 2-B. ASSESSMENT, TREATMENT AND REFERRAL FOR ALCOHOL DEPENDENCE



Appendix I. Is there a need for detoxification?

Detoxification Criteria

- Previous DT or seizures
- Morning withdrawal signs
- Drinking first thing in the morning
- Patient willing to take medication
- Actual withdrawal signs
- Severe physical condition

Appendix II. Is home detoxification suitable?

Conditions needed for outpatient detoxification

- Daily alcohol consumption below 25 standard drinks/day.
- No severe medical or psychiatric complications
- Patients commitment to:
- Alcohol abstinence during the detoxification.
- Staying at home
- Avoidance of risky activities.
- One relative without addictive problems must be responsible to control the medication and supervise the treatment.
- No availability of alcoholic beverages at home during the detoxification.
- Daily contact with GP or nurse (in person or by phone)

Contraindications for outpatient detoxification

- Confusion or hallucinations.
- History of previously complicated withdrawal.
- Epilepsy or history of fits.
- Poor nutritional state.
- Severe vomiting or diarrhoea.
- Risk of suicide.
- Severe dependence coupled with unwillingness to be seen daily.
- Failure of home-assisted withdrawal.
- Uncontrollable withdrawal symptoms.
- Acute physical or psychiatric illness.
- Polysubstance use.
- Home environment unsupportive of abstinence

Source: Scottish Intercollegiate Guidelines Network. The management of harmful drinking and alcohol dependence in primary care. A national clinical guideline. Draft 2.11, 2003.

Appendix III. Outpatient Detoxification tapering doses

	Diazepam, 5 mg cps.	
Dosage	Low	High
1	1-1-1	4-4-4
2	1-0-1	4-3-4
3	0-0-1	3-3-4
4	STOP	3-3-3
5		3-2-3
6		2-2-3
7		2-1-3
8		1-1-3
9		1-1-2
10		1-1-1
11		1-0-1
12		0-0-1
13		STOP

Appendix IV. Medication for alcohol dependence[4]

Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider's judgment in an individual circumstance.

	Disulfiram	Naltrexone	Acamprosate
Action	Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking	Affects glutamate and GABA neurotransmitter systems, but its alcoholrelated action is unclear
Contraindi-cations	Concomitant use of alcohol or alcoholcontaining preparations or metronidazole; coronary artery disease; severe myocardial disease	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure	Severe renal impairment (CrCl ≤30 mL/min)
Common side effects	Metallic aftertaste; dermatitis	Nausea; abdominal pain; constipation; dizziness; headache; anxiety; fatigue	Diarrhea; flatulence; nausea; abdominal pain; headache; back pain; infection; flu syndrome; chills; somnolence; decreased libido; amnesia; confusion
Usual adult dosage	250 mg daily	50 mg daily	666 mg / 8 hours
Before prescribing	At least 12 hours after drinking. A disulfiram alcohol reaction can occur up to 2 weeks after the last dose. Warn about alcohol in the diet, medications and toiletries. Increased efficacy when supervised	Evaluate for possible current opioid use; consider a urine toxicology screen for opioids, including synthetic opioids. Obtain liver function tests.	Establish abstinence
Followup	Monitor liver function tests periodically	Monitor liver function tests periodically	
Length of treatment	At least 3 months	At least 3 months	At least 6 months

[4] Modified from Helping patients who drink too much. A clinician's guide. 2005 Edition.National Institute on Alcohol abuse and alcoholism. US.

Appendix V. Referral to an addiction specialist

When to refer to specialized treatment

- Previous unsuccessful treatment attempts
- Severe complications:
    - Risk of withdrawal symptoms from moderate to severe.
    - Serious medical illness.
    - Family unable to provide support.
    - Psychiatric co morbidity.
    - Regular use of other addictive substances.
- Treatment cannot be managed by the PHC team.

5.2. MINIMUM SKILLS FOR PROVIDERS[5]

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

GENERAL SKILLS:

1. Recognize the social, political, economic, and cultural context within which alcohol use exists, including risk and resiliency factors that characterize individuals and groups and their living environments.
2. Describe the behavioral, psychological, physical health, and social effects of alcohol on the person using and significant others.
3. Recognize the potential for alcohol use disorders to mimic a variety of medical and mental health conditions and the potential for medical and mental health conditions to coexist with alcohol use.
4. Understand the established diagnostic criteria for alcohol use disorders, and describe treatment modalities and placement criteria within the continuum of care.
5. Describe a variety of helping strategies for reducing the negative effects of alcohol.
6. Be familiar with medical, psychological and pharmacological resources in the treatment of alcohol use disorders.
7. Recognize that crisis may indicate an underlying alcohol use disorder and may be a window of opportunity for change.
8. Understand the need for and use of methods for measuring treatment outcome.
9. Understand the importance of self-awareness in one's personal, professional, and cultural life.
10. Understand the obligation of the addiction professional to participate in prevention and treatment activities.

SCREENING SKILLS

1. Gather data systematically from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender.
2. Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and co-occurring mental disorders.
3. Assist the client in identifying the effect of alcohol on his or her current life problems and the effects of continued harmful use.
4. Determine the client's readiness for treatment and change as well as the needs of others involved in the current situation.

ASSESSMENT SKILLS

1. Select and use a comprehensive assessment process that includes but is not limited to:
   - History of alcohol and drug use

[5] This Criteria have been designed as a summarized adaptation of: Center for Substance Abuse Treatment. Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice. Technical Assistance Publication (TAP) Series 21. DHHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

- Past and current status of physical health, mental health, and substance use
- Education and basic life skills
- Socioeconomic characteristics, lifestyle, and current legal status
- Use of community resources
- Treatment readiness
- Level of cognitive and behavioral functioning.

2. Analyze and interpret the data to determine treatment recommendations.
3. Seek appropriate supervision and consultation.
4. Document assessment findings and treatment recommendations.

TREATMENT PLANNING SKILLS

1. Establish rapport, including management of a crisis situation and determination of need for additional professional assistance.
2. Review the treatment options that are appropriate for the client's needs, characteristics, goals, and financial resources.
3. Apply accepted criteria for diagnosis of alcohol use disorders in making treatment recommendations.
4. Construct with the client and appropriate others an initial action plan based on client needs, client preferences, and resources available.
5. Use relevant assessment information to guide the treatment planning process.
6. Explain assessment findings to the client and significant others.
7. Examine treatment options in collaboration with the client and significant others.
8. Consider the readiness of the client and significant others to participate in treatment.
9. Prioritize the client's needs in the order they will be addressed in treatment.
10. Formulate mutually agreed-on and measurable treatment goals and objectives.
11. Identify appropriate strategies for each treatment goal.
12. Develop with the client a mutually acceptable treatment plan and method for monitoring and evaluating progress.
13. Reassess the treatment plan at regular intervals or when indicated by changing circumstances.

COUNSELING SKILLS

1. Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy.
2. Facilitate the client's engagement in the treatment and recovery process.
3. Work with the client to establish realistic, consistent, achievable goals.
4. Promote client knowledge, skills, and attitudes that contribute to a positive change in alcohol use behaviors.
5. Encourage and reinforce client actions determined to be beneficial in progressing toward treatment goals.
6. Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress toward treatment goals.
7. Recognize how, when, and why to involve the client's significant others in enhancing or supporting the treatment plan.
8. Facilitate the development of basic and life skills associated with recovery.
9. Adapt counseling strategies to the individual characteristics of the client, including but not limited to disability, gender, sexual orientation, developmental level, culture, ethnicity, age, and health status.
10. Make constructive therapeutic responses when the client's behavior is inconsistent with stated goals.
11. Facilitate the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress and preventing relapse.

REFERRAL SKILLS

1. Continuously assess and evaluate referral resources to determine their appropriateness
2. Arrange referrals to other professionals, agencies, community programs, or appropriate resources to meet the client's needs.
3. Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through.
4. Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality rules and regulations and generally accepted professional standards of care.
5. Evaluate the outcome of the referral.

DOCUMENTATION SKILLS

1. Demonstrate knowledge of accepted principles of client record management.
2. Protect client rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of client information with third parties.
3. Prepare accurate and concise screening, intake, and assessment reports.
4. Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules.
5. Document treatment outcome, using accepted methods and instruments.

5.3. QUALITY ASSESSMENT CRITERIA

At an individual level the quality of interventions concerning alcohol use of patients should be measured both through quality and quantity indicators.

1 Qualitative measures

Those criteria try to measure the knowledge, skills and attitudes of PHC professionals concerning alcohol.

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

2 Quantitative measures

- Rate of general screening, defined as the percentage of patients attending the consultation who are asked about their alcohol use through a validated instrument (ie, Audit, Audit-C, etc).
- Rate of high risk group screening, defined as the percentage of patients attending the consultation and included in a defined high risk group (adolescents, pregnant women, etc) who are asked about their alcohol use through a validated instrument (ie, Audit, Audit-C, etc).
- Rate of screening of new patients, defined as the percentage of new patients attending the consultation who are asked about their alcohol use through a validated instrument (ie, Audit, Audit-C, etc).
- Rate of interventions, defined as the percentage of identified patients (hazardous, harmful and dependent drinkers) who receive counseling, treatment or appropriate referral.
- Rate of documentation, defined as the percentage of medical records that contain clear information on the drinking habits of the patient

At a multidisciplinary team level, the assessment of quality should be done taking into account the percentage of professionals who accomplish the criteria stated above. There is a need to agree on what are the desirable levels, the acceptable levels, and the expected increase in SBI activity per year of implementation.

5.4. QUALITY ASSESSMENT PROTOCOL

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

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

Based on Clinical Guidelines on Identification and Brief Interventions

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

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

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

Quality assessment criteria
Documentation of which validated identification instrument is used

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

Quality assessment criteria
- Documentation of which assessment instrument is used

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

Identification of hazardous and harmful alcohol consumption

The clinical guidelines suggest a range of options for identifying hazardous and harmful alcohol consumption:
All patients by receptionist, nurse or physician;
All patients during certain time periods, for example, one month every 6 months;
All new patient registrations;
For certain age groups, for example middle aged men;
For patients with specified symptoms, diagnoses, signs and laboratory test results, or those who attend special clinics (e.g. for cardiovascular diseases or depression).

Quality assessment criteria

- According to option adopted for identifying hazardous and harmful alcohol consumption, a review or audit of patient records (paper or electronic) of proportion of denominator with numerical recording of alcohol consumption or of result of screening test.

Brief advice

Quality assessment criteria

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

Brief counselling

Quality assessment criteria

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

Assessing and managing alcohol dependence

Quality assessment criteria

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

5.5. CURRICULA FOR PHC PROFESSIONALS[6]

These education guidelines are intended to assist in establishing educational programs that will produce family physicians with clinical competence in the treatment of alcohol use disorders.

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

Attitudes

A. Family Physicians shall understand that:
    1. Alcohol problems are preventable, diagnosable and treatable. These problems are chronic, commonly relapse and remit, and are both individual and family diseases.
    2. Like people with other medical problems, individuals and families with alcohol use disorders are to be respected, supported and treated by their family physicians.
    3. It is important to work with family members as a unit of care in the management of alcohol use disorders.
    4. Expressions of denial, dishonesty, anger, irrationality and other potentially offensive behaviors are often inherent symptoms of alcohol use disorders, to be expected, understood, accepted and managed by family physicians.
    5. Family physicians, working in concert with other medical and mental health professionals and lay self-help groups, can maximize the effectiveness of treatment for alcohol use disorders.
B. Family Physicians shall be aware of their own attitudes, their personal and family experiences, and the potential implications of these on the therapeutic relationship.

Knowledge

Family Physicians shall recognize:

A. The epidemiology of alcohol use disorders and its impact on society, including:
    1. Overall prevalence
    2. Risk factors for hazardous, harmful alcohol use and dependence
    3. Contribution to major causes of morbidity and hepatitis mortality by age groups, including cardiovascular disease, cancer, hepatitis, cirrhosis, homicide, suicide, motor vehicle accidents, trauma and acquired immune deficiency syndrome (AIDS).

[6] This document is based on the Recommended Curriculum guidelines of the American Academy of Family Physicians (http://www.aafp.org/online/en/home/aboutus/specialty/rpsolutions/eduguide/substanceuse.html)

4. Association with family dysfunction, child and spousal abuse, violence and crime
5. Risks to children and adolescents with parents who abuse alcohol

B. A practical definition of alcohol use disorders with reference to:
   1. Cultural and subcultural norms
   2. Tolerance and withdrawal
C. The disease concept of substance use disorders, including information on:
   1. Criteria for distinguishing hazardous, harmful use, and dependence
   2. The similarity of substance abuse to other chronic medical diseases
   3. Application of the disease concept in facilitating patient acceptance of a diagnosis and appropriate treatment
D. Familiarity with effective prevention strategies and an understanding that strategies may be primary (trying to dissuade starting), secondary (trying to curb early use before organic disease begins) and tertiary (trying to minimize the consequences of existing organic disease)
E. The natural history of alcohol use disorders
F. Relevant pharmacology, including:
   1. Concepts of tolerance, cross-tolerance, physical dependence, psychologic dependence, addiction and withdrawal
   2. Pharmacologic equivalents of various alcoholic beverages and the dose-response effect of alcohol on psychomotor skills including driving
   3. Presence of alcohol in commonly used medications
   4. Appropriate prescribing of potentially addictive medications, include opioid analgesics, sedative-hypnotics, and stimulants, with methods of monitoring for and preventing diversion, abuse, and addiction
G. Signs and symptoms of early and later alcohol use disorders, including:
   1. Psychosocial and behavioral changes in the individual and the family
   2. Symptoms, physical signs and laboratory evidence (e.g., chronic liver disease, track marks)
   3. Co-morbid biomedical and psychiatric diagnoses: Anxiety disorders, depression, hypertension, diabetes, hepatitis C, pancreatitis
H. Information on treatment and its effectiveness, including:
   1. Different stages of alcohol use disorders and the relevant goals of treatment at each stage
   2. The potential advantage and disadvantages of various treatment modalities including:
      a. Brief office interventions with patients and families
      b. Lay, self-help groups for persons affected with a substance use disorder and their families (e.g., 12-step programs)
      c. Professionally administered psychotherapies for individuals, families and groups
      d. Inpatient treatment programs
      e. Pharmacologic treatment, including management of withdrawal, pharmacotherapy of addiction and treatment for coexisting biomedical and psychiatric disorders
   3. Outcomes of different treatment modalities - e.g., harm reduction, abstinence based programs, family systems
I. Special considerations in prevention, diagnosis, and treatment for:
   1. Pregnant women
   2. Children and adolescents
   3. Elderly
   4. Homeless
   5. Cultural groups represented in the residency's patient population

6. Children in families with a history of alcohol and/or substance abuse disorders

J. Legal and ethical issues concerning:
   1. Confidentiality of medical records
   2. Laws regarding driving and alcohol use disorders

Skills

Family Physicians will demonstrate skills in the following areas:

A. Prevention
   1. Providing primary prevention as appropriate, especially for children and adolescents with a substance abusing parent, women contemplating pregnancy and persons at particular risk for, alcohol problems
B. Screening with appropriate instruments:
   1. All patients for alcohol use
C. Assessment
   1. Social, psychologic and physical problems in patients who screen positive for hazardous drinking or for alcohol abuse or dependence
   2. Readiness to change in all patients with hazardous or harmful, alcohol use
D. Treatment, office-based:
   1. Brief intervention
      a. With a goal of secondary prevention in persons with hazardous drinking but without symptoms and signs of alcohol dependence
      b. With a goal of abstinence, harm reduction or referral for further treatment in patients with alcohol dependence
   2. Motivational interviewing to facilitate behavior changes
   3. Inclusion of family in assessment and initial treatment
E. Pharmacotherapy and medical management
   1. The management of alcohol intoxication, and withdrawal
   2. The management of biomedical complications of alcohol use
F. Referral to specialized treatment programs and other community resources
G. Care of affected family members.

5.6 FACT SHEETS ON EIBI AIMED AT POLICY MAKERS.

5.6.1. GUIDANCE FOR GPS

Author; Rolande Anderson (ICGP, Ireland)

Context - What is EIBI? Why EIBI? (efficacy of EIBI and the extent of the problem)

EIBI = Early Identification and Brief Intervention

Alcohol is a drug of dependence. The European Union is the region within the World with the highest proportion of drinkers and with the highest levels of alcohol consumption per population. It has been estimated that at least fifteen percent of the adult population drink at hazardous levels and approx six per cent drink at harmful levels. It may be considerably higher. Alcohol is the cause of at least 60 different types of diseases and conditions including accidents and injuries, psychiatric (especially depression) and behavioural disorders, gastrointestinal conditions, cancers, cardiovascular diseases, immunological disorders, lung diseases, muscular and skeletal disorders, reproductive disorders and pre-natal harm (especially fetal alcohol syndrome disorders). Alcohol is also a principal cause of social type harm including absenteeism, street and domestic violence and other crime and road traffic accidents. Alcohol can devastate families and cause family members to have a wide variety of alcohol related physical, emotional and psychiatric symptoms and conditions. General Practice professionals encounter all of these issues on a daily basis and often only treat the presenting complaint without knowing how to intervene effectively. The Doctor/Practice Nurse/Dietician/Counsellor within General Practice all have the potential to make a huge difference to help patients and their families who struggle in life as a result of alcohol problems. There is considerable ignorance amongst the general population about health risks associated with alcohol as well as about guidelines for risky drinking and gender differences. The Primary Care health professionals could reduce this ignorance very significantly by becoming actively involved in early identification and brief interventions.

What is EIBI? Early Identification and Brief Interventions for alcohol problems

Early Identification;

Early Identification of alcohol problems is an essential precursor to Brief Interventions. The attempt is to help patients who are having alcohol related health problems as early as possible. There are a range of alcohol problems that present in primary care.

Brief intervention;

A treatment strategy in which structured therapy of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of alcohol or (less commonly) to deal with other life issues. It was designed in particular for general practitioners and other primary health care workers.

Brief Interventions are of proven efficacy in terms of cost and outcome. The skills involved in Brief Interventions for alcohol problems are readily transferable to other areas, for examples, smoking cessation, drug problems and other lifestyle issues. Brief Interventions for alcohol are at the top of the league of evidence-based treatment methods. There exists now a large body of evidence from over 50 controlled trials for their effectiveness. They are most effective for hazardous and harmful drinking. The number needed to treat (NNT) is about 8 for both hazardous and harmful alcohol consumption and for alcohol related harm. This means that eight patients at risk need to

be offered advice for one to benefit. This compares very favourably to other conditions that present in primary care. For example, the NNT for smoking is between 10 and 20 depending on whether nicotine replacement therapy is used. Furthermore there is some evidence to suggest that brief interventions can reduce alcohol related mortality.

Instructions for primary care staff

Alcohol problems in Primary Care;

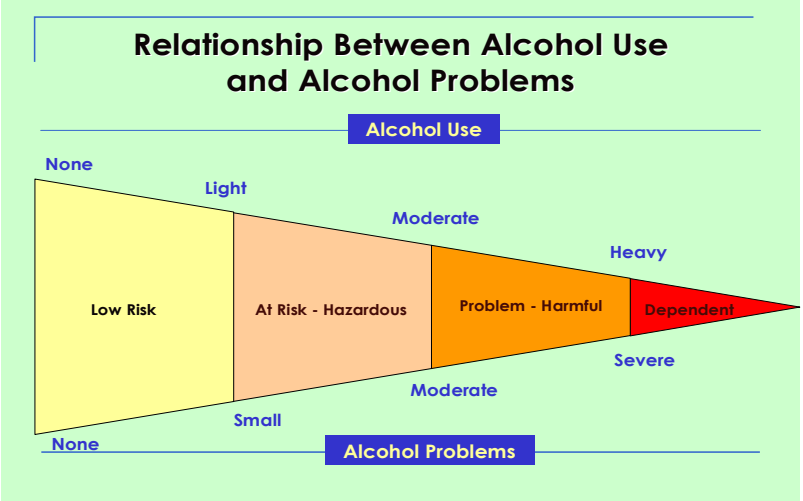
Hazardous Drinking; Is a level of consumption or pattern of drinking that is likely to result in harm should present drinking habits persist. It also constitutes any drinking by pregnant women, children under 16 years of age and patients who are very ill or receiving various treatments or those patients who perform activities that are not advised when drinking.

Harmful Drinking; A pattern of drinking that causes damage to health, either physical or mental.

Dependence on alcohol; Is a cluster of psychological, behavioural, and cognitive phenomenon in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value.

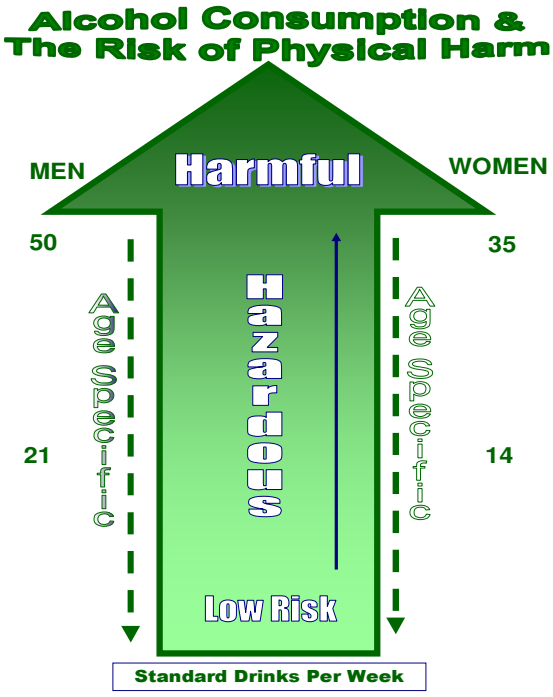
Heavy Episodic Drinking; Sometimes called binge drinking which can be particularly damaging to health. Regular consumption of at least six standard drinks. In most countries the biggest concern is the tendency to regularly 'drink to get drunk'.

Traditionally alcohol problems were equated with alcohol dependence. The range of problems is in fact on a continuum and can be depicted as follows;



Individuals can move from low risk to hazardous and harmful drinking or vice versa at any stage of their lives.

Hazardous and harmful drinking to physical health can also be estimated by primary care staff using a weekly consumption chart involving standard drinks. While this is a crude estimate it does provide a useful talking point and a good introduction to this topic;



Definition of Standard drink; What constitutes a standard drink differs from country to country but is roughly equivalent to one standard measure of wine, spirits or a glass (250 ml) of beer.

The diagram indicates that the more an individual drinks the more he or she is at risk of health problems. ***There is no level of alcohol consumption that is risk free.*** Obviously considerably younger and older individuals should drink even less to avoid hazardous and harmful consumption. The limits for hazardous drinking per week are set at a low level and may need adjustment in some countries.

Armed with all of the above knowledge the following style of Brief intervention (Ask, Assess, Assist and Arrange) is recommended (with practice the initial session should take between 5 and 15 minutes, if someone is screened as dependent it will take a little longer);

Ask

Just Ask! – but show concern, interest and empathy

- The approach and manner of the primary care professional is essential. In general terms the practitioner should be genuinely interested and seek permission to ask about alcohol.
- Training will enhance the skills that are required. The principal should be to use a motivational style of interviewing. Guidelines and training documents are available from Phepa "Primary Health Care European Project on Alcohol" (www.Phepa.net)

- Patients expect to be asked about their alcohol consumption and patterns by primary care staff. Patients generally trust their family doctors and practice nurses. Very few patients will object to being asked

  You can make a big difference! - - - - to the future health and well-being of patients and their family by asking and intervening.

- There is a great deal of ignorance and some confusion about basic information regarding alcohol amongst the general population. Primary care staff have an important role in informing patients about issues such as risky consumption limits, gender differences, age specific issues, links between depression and alcohol, sources of further information, sources of help and much more besides
- Remember 'patients' are often family members who are presenting with symptoms that are caused directly or indirectly by alcohol problems at home

Assess

- Patients can be relatively easily identified and informed of their risk category (low risk, hazardous, harmful, dependent) by asking about frequency of consumption and amounts consumed. Questionnaires are very helpful. The score is important but so too is the discussion and it is a useful way to engage the patient in a discussion about their drinking.

  AUDIT 'C' is a good initial starting point and the full AUDIT questionnaire can be used if the patient scores above the cut-off point.

  AUDIT 'C' Questionnaire

1. How often do you have a drink containing alcohol?	
(0) Never (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	☐
2. How may drinks containing alcohol do you have on a typical day when you are drinking?	
(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more	☐
3. How often do you have six or more drinks on one occasion?	
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	☐
Scores in brackets on the left hand side, put in box on right and add up **TOTAL**	☐

Recommendation:	*Ask these questions from memory and do a mental "tot".* *Use full A.U.D.I.T. if score in AUDIT 'C' is::* *> or = 5 for adult men* *>or = 4 for adult women*

and/or Use consumption 'Arrow' Chart; and if concerned (i.e. above hazardous, harmful limit) do full A.U.D.I.T.

A.U.D.I.T. Scores:

> or = 7 for adult women, 8 for adult men	- 14 = likely to be hazardous
Both sexes	15 – 19 = harmful
Both sexes	20 + = likely dependence

Use clinical judgement in all cases but especially with borderline scores

NB. there is no stereotype of a person with a drinking problem

Patients in the low risk category should be encouraged to continue at low risk consumption. With simple advice and perhaps some literature and follow-up, patients mostly in the hazardous and some in the harmful range are likely to reduce their drinking and change their risk status. Brief Interventions can also be helpful to identify and treat patients in the dependent category. Primary care staff should also refer patients for more detailed help if they are in the harmful/dependent categories, though some patients will spontaneously recover in these categories too.

Who should be screened and how often should patients be screened?

This is a matter for each practice to decide. All new patients as a minimum should be screened. Random screening and targeted screening (related to symptoms, patterns of attendance and/or family information) is the ideal. Again ideally all patients within a practice should be screened at some stage and then re-screened within 2-3 years. Due to practical obstacles, like time and resources, a more limited approach to screening may have to be adopted.

Assist

- with presenting complaint. Patients are more likely to change if there is a link between the presenting complaint and alcohol. For example if it can be established that headaches are due to alcohol consumption, change is more likely
- encourage patients to change, by using brief intervention, motivational techniques, gentle persuasion, mutual respect, sincere concern and patience
- explain screening results sensitively and inform patients of the advantages of cutting down or stopping, such as improved health, relationships and financial status
- don't jump to conclusions - there could be other explanations than alcohol for the presenting symptoms
- provide practical assistance;

  – ***if in hazardous category patients might be advised to;***

    - set a date to cut down and look for support
    - keep a weekly diary of consumption
    - water down alcohol and drink slowly
    - drink water and/or soft drinks between alcoholic drinks
    - put alcohol on their least favoured hand at meals and have a glass of water on the favoured hand so that they drink less
    - avoid solitary or secretive drinking
    - never drink and drive
    - keep active and develop interests

- continue to ask for help from family, friends, self-help groups and professionals

- ***if in harmful/dependent category patients might be advised to;***

  - discuss methods of stopping and how to stay stopped
  - set a date to stop drinking and look for support
  - drink water and/or soft drinks
  - keep active and develop interests
  - consider taking specific medication that reduces craving or is a deterrent, if appropriate
  - attend specialist Counsellors and/or Psychiatrists as appropriate.
  - attend support groups such as (e.g.) Alcoholics Anonymous, if appropriate
  - undergo specialist detoxification, or arrange same, as appropriate.
  - take vitamins as necessary
  - read recommended literature including leaflets
  - continue to ask for help from family, friends, self-help groups and professional

Arrange

- arrange a follow up appointment and continue to be actively involved
- relapse should be addressed as a learning opportunity and the approach should be based on patience and long term goals
- arrange appropriate continuing prescriptions, tests and appointments if necessary
- consider arranging a consultation with family members to support
- suitable reading
- arrange for someone in recovery, that you know and trust, to talk to the patient in confidence

International research shows that 30% of patients make significant changes to their alcohol consumption following brief interventions by primary care staff. A significant percentage also change their risk category. Follow-up is an essential component. Patients may change even if they do not follow up and their may be a time lag between the intervention and a positive change. ***Do not be discouraged if there is no immediate improvement.***

Further Reading;

- Phepa Guidelines and Training Documents (www.Phepa.net)
- Sign (Scottish Intercollegiate Guidelines Network) (www.sign.ac.co.uk)
- Alcohol in Europe (A Public Health Perspective), Anderson, P. and Baumberg, B.

Annex 6. Country reports

Belgium

After the Phepa I country meetings the proposal and texts of the meetings were forwarded to the ministries of the Flemish Community and to the drugcel coordinating the inter-ministerial drug and alcohol policy at federal level.

Among other factors the Phepa project influenced the creation of working committees to review the old health target on tobacco to develop a more comprehensive strategy for a Flemish Tobacco , alcohol and drugs policy . The alcohol working group sessions were coordinated by the administration delegate to our first Phepa country meetings.
Finally a strategy was publicly defended on 23rd and 30th November 2006 and submitted to the Flemish Parliament for approval (see: http://www.gezondheidsconferentie.be/).

Also, several members of the drugscel of the federal government supported the idea forward by the Phepa I country report to develop a specific Alcohol policy. This happily coincided with publication of other reports and activities for development of a European and WHO strategy.

Flanders: Contribution to the development of a Flemish Stategy for tobacco, alcohol and drugs.

Domus Medica contributed to the steering group preparing the selection of strategies (Dr G Thijs) and to the working groups on alcohol strategies (Dr L Pas and Dr B Garmyn).

The strategy for early detection and brief interventions was retained as one of he best documented on effectiveness. The retained strategy highlights not only the well documented possibilities primarily in general practice, but also calls for application of EIBI in a number of primary care settings including nurse care, emergencies and pharmacies.

For the Working group on epidemiology for the health targets on alcohol a text was developed about the social costs of alcohol. It was retained in the official publication of a manual with epidemiological data on tobacco, alcohol and drugs documenting the background of the implementation strategies proposed for the New health targets (see : http://www.zorg-en-gezondheid.be/uploadedFiles/subsite02/cijfers/Middelengebruik%20in%20Vlaanderen,%20een%20stand%20van%20zaken_def.pdf)

As a consequence the agreement by the Ministry of the Flemish Community with the new health targets for call for projects to implement these strategies was launched by the Ministry of the Flemish Community in August 2007 and DOMUS MEDICA (L Pas) introduced a proposal for the rolling out of EIBI in the province of Flemish Brabant in multidisciplinary coordination including pharmacies (Flemish Association of Pharmacies) and local multidisciplinary groups. At the meeting of the provincial Drug coordination group it was decided to support in particular GP and multidisciplinary initiatives for alcohol policy in the Communities of Leuven , Halle, Diest. The Phepa project team will also endorse the strategy proposed for the roll out of EIBI in Emergency departments in the city of Brussels which was proposed by a local Drug policy group in collaboration with the drug prevention worker appointed by the Flemish community for Brussels.
B Garmyn entered a pilot project for EIBI in occupational health.

A discussion of such strategies is planned as satellite meeting to the annual conference of the DOMUS MEDICA and INEBRIA on 17 th of November.

Belgium : contribution to the development of a Belgian Federal strategy on Alcohol.

L Pas has participated as expert for the Flemish Community in the ongoing development meetings organised by the drugscel coordinated from the Federal Agency on Health.

Guidelines were distributed to all members of this committee.

At two sessions in May 2007 specific attention to hazardous alcohol use as a major target and the need for stepped care were included in the documents at our request.

On 25th September 2007 the proposal of the new Alcohol Action Plan was again reviewed and finalising meetings are planned in October and November. It was suggested to redefine objectives better for this national strategy and to mention early detection and brief intervention more specifically as well.

Attention was also drawn to the need for conditions for widespread application of proposed actions.

International: Dissemination at conferences and training workshops of Phepa proposals.

At the special request of the Phepa project and preparing in the mean time for this Flemish strategy and an implementation programme L Pas participated in the Bridging the Gap conference in Helsinki in November 2006.

L Pas presented the Phepa project and provided interactive training to Hungarian GPs in April 2007.

Through the Europrev group L Pas has further introduced together with T Drenthen (Nl), K Seppa (Fi) and M Kolsek a workshop proposal on Alcohol to update and disseminate towards European academies and colleges of general practice the Phepa implementation in several countries (planned paris 20/10).

Adaptation of guidelines

The Domus Medica Steering group on Recommendation for good clinical practice decided in June 2006 to review several guidelines before finalising the Flemish recommendation prepared by L Pas and B Garmyn. This review includes the Phepa Alcohol and Primary Care Clinical Guidelines on Identification and brief Intervention.

Reviewed were :

1. NHG-Standaard Problematisch alcoholgebruik - Problematic Alcohol Consumption (NHG- M10)
2. The management of harmful drinking and alcohol dependence in primary care (SIGN 74)
3. Prodigy Guidance 'Alcohol – Drinking Problem'
4. Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care (NZGG),

5. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse (U.S. Preventive Services Task Force),
6. Evidence-based guidelines for the pharmacological management of substance misuse, addiction and co-morbidity : recommendations from the British Association for Psychopharmacology (BAP)
7. Anderson P, Gual A, Colom J. Alcohol and Primary Health Care: Clinical Guidelines on Identification and Brief Interventions. Departement of Health of the Government of Catalonia: Barcelona, 2005. (PHEPA).

8 meetings were held between September 2006 and now in which the 'Adapt strategy' was applied by Domus Medica collaborators. On the 4th of October a further meeting will be held before submitting the proposals to an expert committee.

Chairman of steering committee : Prof P Van Royen.
Coordinator of meetings : Dr J Michels

Adaptation of training manual and creation of teaching faculty

From Nov 06- Feb 2007 Claudia Put was specially appointed to review the training manuals form earlier
projects of DOMUS MEDICA on alcohol (formerly WVVH) and the Phepa training manual. A short presentation was developed to integrate Phepa slides and the need to deal specifically with resistant attitudes towards health behaviour change on alcohol.

The adapted presentation was tested in several Local quality cricels of Flemish GP.

In parallel, a special training session of GP's was devoted to discuss the models for dealing with more complex problems behind alcohol on a Flemish Session. Brief interventions were discussed in the context of the strategy of health behaviour change developed by our society (ABC on prevention), 'Solution oriented counseling' (Dr AM Frisque) and cognitive behavioral support (Roland Rogiers).
These GP's are involved in transmitting psychosocial models for counseling to GP groups.

The roll out of a larger scaled 'train the trainers' strategy is foreseen based on these experiences between November 2007 and June 2008, hopefully within the new Flemish Strategy for alcohol and with particular attention to GP and pharmacies in municipalities of Flemish Brabant were other alcohol actions are planned.

Bulgaria

A set of activities have been implemented so far within workpackages 1, 4 and 7 of the project, as follows:

Horizonti 21 foundation has translated and adapted the *Clinical Guidelines on Identification and Brief Interventions* and *Training Programme on Identification and Brief Interventions* manuals and held negotiations with a pharmaceutical company ready to offer financial support for their publishing.

The project team has also held a series of meetings with the heads of the departments of Psychiatry and General Medicine at the Medical University – Sofia, aimed at recognition of the training course within their academic curricula.

A network team has been formed and gradually involved in the project activities through a series of individual meetings and one general team meeting (Blagoevgrad, April 11th-12th, 2007) for the purpose of creation of a national platform within the country. The network team consists of 8 experts in the field of substance abuse, representatives of 4 major Bulgarian regions, as follows:

Daniela Alexieva, MD – Project Coordinator, President of *Horizonti 21* foundation
Georgi Vassilev, MD – Expert, Trainer
Malen Malenov – Assistant Coordinator
Georgi Dimitrov, MD – Blagoevgrad
Marian Silianovski, MD – Sofia
Nikolai Markov, MD – Plovdiv
Nikolai Tomov, MD – Sofia
Tsvetelina Doncheva, MD – Varna

A training seminar has been held in Sofia (January 19th–21st, 2007), offering 16 medical experts in the field of addictions with specialized knowledge and skills for leading training courses on the implementation of *Clinical Guidelines* manual. The training has been lead by Dr Daniela Alexieva and Dr Georgi Vasilev, substance abuse experts and members of PHEPA.

The local project coordination team (Dr Daniela Alexieva and Malen Malenov) has coordinated all project activities and provided proper financial documentation for the implemented activities at country level so far.

Czech Republic

The Czech Republic participated in the PHEPA I Project as an observer. Because of this fact, we did not prepare any country report during that phase. The Country profile focused on the policies on the management of alcohol use disorders and Assessment questionnaire as a tool to assess the available services for the management of alcohol problems at the country level were completed in 2004.

Now, we are in the process of collecting data and all relevant information needed for writing the national Country report and updating information gathered in 2004 (Assessment tool).

The cross-sectional population surveys focused on drinking patterns of the Czech adult population (15+) was conducted at the end of 2005 and 2006. Questionnaires were administered to a representative sample of the adult population. Results show the unfavourable status of the extent of hazardous and harmful consumption of alcoholic beverages especially in younger male population groups. In cooperation with the Professional Society of General Practitioners, these research results will contribute to the execution of methodological recommendations for brief intervention in cases of high-risk and harmful drinking.

As regards the Phase II, we did a lot of work using outputs of the PHEPA Phase I, especially the Training manual on identification and brief interventions and Clinical Guidelines on identification and brief interventions.

During last two years, both materials were translated into the Czech language and they were submitted for approval to professional organisations of GPs´ and psychiatrists.

The model of the training on early identification and brief intervention was approved by the Czech Ministry of Health and accredited for postgraduate education of health professionals.

Using the Training manual, the first training on early identification and brief interventions was conducted in November 2006 for public health professionals from regional Institutes of Public Health, and it was a great success. We plan to organise this training for general practitioners in 2008.

Both Training manual and Clinical guidelines (Czech versions) are available on PHEPA Website and they are also distributed on CD-ROMs to participants of the EIBI training.

The Working group of experts was established, and it is working in the framework of the Coordination, monitoring and research unit for alcohol and tobacco, based at the National Institute of Public Health. Representatives from the health care sector (public health, health care), education, and transportation – road safety unit, work together to prepare recommendations for policy makers and other relevant professionals from all sectors involved in the activities of the Working group.

Evaluation of the Assessment Questionnaire 2004 indicated the unsatisfactory measures in relation to hazardous and harmful drinking and the need of action.

Analysis of research confirmed the applicability of used tools (AUDIT, CAGE) in the Czech context and helped us to determine the optimal indication range for brief intervention.

In order to launch a broad implementation of the PHEPA results, it is necessary to ensure on-going systematic education of general practitioners and other health professionals. In cooperation with the Professional Societies of health professionals, results of the PHEPA project will contribute to the execution of methodological recommendations for EIBI in cases of high-risk and harmful drinking. Our recommendation is to include EIBI as part of the regular courses offered both for pre- and post-graduate education for GPs and other health professionals.

Denmark

The majority of Danish patients find it OK that their GP raises life style issues during consultation if it seems relevant to the problem presented.

The GPs are willing to discuss life style issues if they can be trained in raising the subject and coping with the patients resistance. The GPs don't want to discuss alcohol as the only theme but want to include other issues like smoking, diet, weight, lack of exercise. But alcohol care in the GP's clinic is now the subject of an article in a handbook and an another article is accepted of the journal of CME for GPs.

The Danish National Board of Health

The overall aim for the Danish National Board of Health is explained at their website www.sst.dk :

- To reduce alcohol consumption, especially the number of risky drinkers and the amount of alcohol related harm by information on alcohol and by preventing alcohol problems
- To put off the first experience of children with alcohol and reduce the consumption among youngsters
- To promote alcohol policy in workplaces, schools, et cetera
- To develop methods of identification and early intervention towards alcohol problems.

Concerning primary health care The National Board of Health until now has not had any resources to put into the subject. But the consultant specialist of alcohol in The National Board of Health is willing to cooperate and work for financial support producing a clinical guideline of handling alcohol problems in general practice. Presumably this is a necessary base for developing consciousness by GPs on the matter as most of the GPs base their CME-activities on such guidelines.

The Danish government

1.The Ministry of the Interior and Health has focused on 12 public health issues, none of them is alcohol.

2. The Ministry has started an investigation into mapping the habits of the Danes concerning the risk factors diet, smoking, alcohol and exercise. The project runs until the end of 2008 and 13 of 99 municipalities are included.

3. Reform of infrastracture. Both before and after the reform of infrastructure in Denmark on Jan. 1st 2007 there is a big gap between the possibilities of treatment in different regions.

On Jan. 1st 2007 the 15 counties changed into 5 regions, and 220 municipalities of very different sizes (both area and population) changed into 99 more even municipalities.
Before the reform the counties were responsible for managing alcohol problems and out patient clinics were the usual institution. They worked well.
After the reform the municipalities have the responsibility but the most of them (especially the smaller ones) have refused to commit themselves on this "new" topic. That means that the skilled staff in the clinics now look for other jobs. In patient treatment is threatened because it expensive. The budgets of 2008 are in progress and will include alcohol managing at some degree. Meanwhile some private institutions have closed because of lack of funding.

There is still no coordination between hospitals (managed by the regions) and the municipalities concerning alcohol habits of patients.
Only a few of the municipalities have a written policy on managing alcohol problems.

Current activities

Continuous medical education
Developing a declaration of quality for general practice is rather difficult but progress is Being made. So, during the last few years the *Danish Regions* (Amtsrådsforeningen) have
established five committees on different areas of quality assurance in general practice.
The aim is to coordinate this with the continuous medical education (CME) of GPs.
The importance is stressed on the breadth of the offers of the CME including involvement of the clinical staff.
The National Board of Health has initiated some projects involving the staff of the clinics in advising the patients. Because of the lack of GPs more advice in the future will be given by the staff. Some GPs are very interested in this, others are more reluctant.
Most recently, the director of department of prevention under the National Board of Health has accepted the idea of a clinical guideline and in a few months we will see if she includes this project in the budget for activities in 2008.

Meanwhile I have asked the Danish university institutes of general practice and the three Danish research units of general practice for suggestions for members of the editorial board. We have three names now and seek a non-GP specialist to incorporate the opinions of the secondary health care.

In GP's clinic
The National Board of Health has published a catalogue of ideas on preventive work in general practice with reports form clinics active in the preventive field, from doctors *and* staff.
Concerning alcohol problems the catalogue mentioned detection and referral but it is well known that GPs do not always *want* to refer. As seen above not many municipalities have specialists or out patient clinics to whom GPs can refer. It is still quite uncertain how the municipalities will solve this problem.
Hence general practice - including the staff - should have tools also for *treatment* including skills in motivational interviewing.

Referral
The contact between the GPs and the out-patients' clinics of alcohol *after* referral is nonexistent in almost all Denmark and improving this contact is very important, especially by systematic information procedures.

Conclusion:

1. The reform of infrastructure by January 1st 2007 has brought treatment of alcohol problems to a standstill.
2. The National Board of Health (Centre of Prevention) received the PHEPA Training
Programme in May 2005 but it is still uncertain if the Board wishes to use
PHEPA material (in some way) concerning the alcohol issue. There are plans for writing a clinical guideline for primary health care.
3. The CME of GPs is administered by quality assurance committees in the regions. Only a few of these groups are engaged with the alcohol issue.
It has been essential to combine the skills of motivational interviewing in the programs but because of lack of manpower it has not been possible to educate GPs as trainers in the different regions as wished.

England

Based on the Strategy for England prepared for PHEPA I, the following developments have taken place since the beginning of PHEPA II on 01/04/2006:

1. A screening and brief intervention (SBI) package has been developed, entitled *How Much Is Too Much?* This includes Worksheets on two levels of intervention, *Simple Structured Advice* and *Extended Brief Intervention,* which can be used by practitioners and patients. Also included in the package are a *Guide for Primary Care Clinicians on Brief Alcohol Intervention*, a document giving guidance on screening tools for alcohol-related risk, a poster for display in waiting rooms and a self-help booklet for the patient to take away. See http://tinyurl.com/269b75

2. A training programme has also been developed to support the *How Much Is Too Much?* package. For Simple Structured Advice, the training programme consists of one PowerPoint presentation giving information on SBI and another incorporating experiential exercises in raising the topic of alcohol consumption with patients and other interactive aspects of the intervention. The training programme for Extended Brief Intervention was developed by a company specialising in training for general medical practitioners (*Effective Professional Interactions*) and involves intensive, half-day training in interpersonal skills relevant to SBI. See http://tinyurl.com/269b75

3. The *How Much Is Too Much?* package and the associated training programme will be used in a project designed to support the national *Alcohol Harm Reduction Strategy for England* which has called for "more information…on the most effective methods of targeted screening and brief interventions, and whether the successes shown in research studies can be replicated within the health system in England." This project has three linked sub-studies designed to address these issues: primary health care; accident and emergency services; criminal justice system.

   The primary health care (PHC) study uses a pragmatic cluster randomised design to evaluate the impact and cost-effectiveness of implementing different models of alcohol screening and brief intervention piloted in 80 typical primary health care practices in three English regions. The study will test four models of implementation: a control group receiving a patient information leaflet, brief advice provided by PHC staff, brief lifestyle counselling provided by PHC staff, and brief lifestyle counselling provided by an alcohol health worker. Two screening methods of different complexity will be compared. 1000 hazardous or harmful drinking patients will be recruited for the study. PHC study outcomes will include measures of implementation, attitudinal and organisation predictors of implementation and patient outcomes, which will include drinking behaviour and health economic outcomes. The PHC study is designed to answer key policy questions concerning the implementation of screening and brief intervention in PHC.

   The whole project will take place over a period of two years and results are expected in 2008. The project will address key gaps in the current evidence base on screening and brief intervention and should provide invaluable information to guide further development and implementation of SBI in England.

4. At the same time as the above project is in progress, the Department of Health intends to roll out SBI across England. The results of the randomised trial will be relevant to the way in which this implementation is effected. The first event in this process is a workshop at the Department of Health in London on 10/12/07 at which attendees from regions of England will discuss the best options for SBI

implementation in the light of the research programme and their local experiences. The specific objectives of the workshop are: (i) to share progress in terms of the literature review and research programme; (ii) to discuss research in the light of pilot project experience; (iii) to recognise the barriers to local progress and consider how local initiatives can be established and best supported; (iv) to understand how learning can be shared in the future. Attendees will be asked to think about local networks and structures that could improve health service delivery, both those that have been or are being successful and those that have been less successful.

The PHEPA II project will support this meeting by reimbursing the travel and *per diem* expenses of 8 experts attending the meeting.

5. Further meetings and events are planned to assist training and dissemination of SBI in the English regions and these will be supported by PHEPA II.

6. Efforts in 2006 to obtain agreement to the inclusion of SBI in the *Quality and Outcomes Framework* of the new General Practice Contract were unsuccessful but these efforts will continue when the contract is under review in future years. If this effort is eventually successful, PHC services will be paid for the delivery of SBI and a significant increase in routine SBI activity could therefore be expected.

Estonia

Estonia did not participate in the first phase I project. We have been working towards the creation of the country based team.

Planned activities

December 2007 – January 2008 translation and adaptation of the CG and TM developed by PHEPA

January - February 2008 several consensus meetings, with family doctors, addiction specialists and psychiatrist preparing guidelines. Preparing concepts with sick-fund for quality bonus system for later financing in routine everyday work. It may take a lot of time to find a consensus and working system. But it is an important aspect for better results.

February - March 2008 printing in practical size book with guidelines. Useful in everyday work. About 40-50 pages, 1000 copies

March - June 2008 Training courses for family physicians, general practitioners, family nurses. Duration about 8 hour with breaks. 2-3 lecturers. Control of knowledge and certification.

September - November 2008 Training courses for family physicians, general practitioners, family nurses. Duration about 8 hour with breaks. 2-3 lecturers. Control of knowledge and certification

It is planned to arrange 10-15 training courses in each county-centre.

December 2008 conclusion of year 2008 and preparation of next steps.

Finland

In Finland alcohol consumption and its consequences are growing. The recent decrease in 2004 especially in spirit taxation, and the decrease of import regulations increased the rate of this growth. Between the years 1999 - 2005 for example the number of deaths due to alcoholic liver cirrhosis has doubled. The weakening of the possibilities for strong policy actions was challenging to other preventive policy measures and it has led to decisions on alcohol policy. The Ministry of Social Affairs and Health was charged with the preparation and implementation of a comprehensive alcohol programme for the years 2004-2007. The Alcohol Programme is about to continue during the new four-year governmental period starting in 2007. Also, there is now legislation to add warnings of alcohol-related health risks on labels.

During the past government period, there was a rather strong political support to implement brief intervention in primary health care in Finland. The basis for the Finnish implementation strategy lay in Clinical Guidelines, two implementation projects (National Brief Intervention Project VAMP (Valtakunnallinen Mini-interventioProjekti) and National Occupational Brief Intervention Project). These two projects were supplemented by a nationwide training programme organized by the Society for Municipal Physicians. All the three projects were funded by the Ministry of Social Affairs and Health. Clinical Guidelines by the Finnish Medical Society Duodecim were used with the PHEPA guidelines in all programmes.

The government-based funding for the VAMP, the biggest of the projects, was 2,4 million €. Additionally, the project had a national co-ordinator for the nationwide project. Altogether, 46 regions' primary health care covering about a quarter of the Finnish population participated to this 4-year project. There have been 14 regional co-ordinators, nurse-GP couples, in doing the implementation. The specific features of the project have been education and training of professionals, flexibility, focus on early identification and brief intervention; not on treating alcoholics, communication with leaders, general public and with media. The project has also organised big educational sessions for a wider range of professionals and educated trainers for other projects. In collaboration with the Alcohol Programme, VAMP has produced the material needed for implementation: This material is based on WHO Phase I and PHEPA materials and tailored for national needs.

The end-point measurements of the VAMP project are on-going. The preliminary results show that the number of those doing brief intervention permanently in Finland has doubled and the number of those who do it not permanently but 'sometimes' has increased with 10%. This can be considered a good result in circumstances where the lack of professionals in primary health care is big. Brief intervention is widely considered important among health care leaders and its further implementation is included in the new government programme. This means that targeted funding to increase and maintain brief intervention in health care will be guaranteed. However, to reach wide implementation several years of work and collaboration are still needed, as are changes in legislation related to adding preventive actions in patient documents.

Greece

1) Translation and circulation of the "Training Programme on Identification and Brief Interventions" power-point slides.
2) Finishing of translation of the "Clinical Guidelines on Identification and Brief Interventions" book (within the next weeks we will be ready to circulate it).
3) We worked with the training program on Identification and Brief Intervantion as a pilot with psychiatry residents (of the 3rd psychiatric dept. of AHEPA University Hospital).
4) We are contacting the military force, since we think that at least all males who are joining the army could benefit from brief interventions. So we are willing to implement education to the military doctors and nursing staff that provide health services to that interesting target group of young people from all over the country, at the time of their service and in the future.
5) Since we have an elective lesson on drug and alcohol abuse for medical university students, we want to extend it, including the brief intervention programme.
6) The day after tomorrow we are meeting the person responsible for alcohol from Ministry of Health, in order to discussing policies, needs, education etc. We give big attention to Brief Intervention, which is an important one, since it is something that can be applied on some populations eg. general doctors in rural areas.
7) We have already planned two training programmes for the medical and nursing stuff of AHEPA University Hospital of Thessaloniki and 424 General Military Hospital of Thessaloniki for the year 2008.

Germany

The PHEPA project is devoted to promoting the integration of health promotion interventions for hazardous and harmful alcohol consumption (screening and brief intervention – SBI) into primary health care (PHC) settings through a pan-European platform of experts with representatives in all partner countries, especially to ensure quality and harmonisation throughout Europe. The German team has carried out several measures in order to contribute to the goals of PHEPA 2 which are specified according to the PHEPA work packages:

WP1 Coordination of the project

After the German partner in PHEPA 1 (Michael Smolka) left the project due to occupational changes early in 2007, the German group was re-established in summer 2007 (new German PHEPA partner is Karl Mann). The necessary documentation as well as the documentation of financial issues was sent to the PHEPA coordination in Barcelona.

WP2 Dissemination of the results

In June 2007 PHEPA's aims and structure as well as the products from PHEPA 1, completed with a special view on the German situation were reported at the Conference of the German Centre for Addiction Issues in Tutzing, Bavaria, in order to disseminate knowledge about PHEPA and it's products. Participants of this conference were health professionals, government representatives and scientists. The report was evaluated informative and relevant for practice. There was a special interest in PHEPA products. Their availability (internet resource) was appreciated.
After that, we decided to prepare a publication on SBI in primary health care as a special issue of the journal *"Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen, ZEFQ"* (Journal on Evidence, Education and Quality in Health Care). One of the PHEPA group members (Martin Härter) is a current member of the editorial board of this journal. A description of PHEPA and its products – based on an up-dated version of the German Country Report – is planned to represent the core of this special issue. Other potential contributions: German guidelines on SBI, results from regional projects, results from health economic research. The time frame for preparation is the first half of 2008.

WP4 European Platform

Members of the German group attended the European platform meetings in Tallinn and Istanbul (Thomas Hintz, Michael Berner). In Istanbul, Michael Berner gave a report on experiences of disseminating SBI in PHC settings from a regional German project.
The national group was re-established in summer 2007. Up to now one meeting of this group was organised in September 2007. As a result of this meeting, the German group agreed on aims and measures in accordance with the overall PHEPA goals:

1) Updating the Country Report and dissemination of knowledge (see WP2)
2) Translation and Adaptation of PHEPA materials (see WP7)

WP7 Country Roll Out

Against the background of the overall PHEPA goal to harmonise standards of SBI practice throughout Europe and the fact that clinical guidelines on SBI are already available in Germany, the German team decided to concentrate on the training manual as in Germany is no widely accepted training program available to date. It is planned to translate the programme during the first half of 2008 and to adapt it to German needs. The overheads were already translated into German during PHEPA 1. As further steps, the translated training manual should be published on the PHEPA homepage as well as on homepages of participating institutions. It should be also available in a print version and

it is also planned to organise two trainings based on this manual. An important step is to provide the manual to appropriate institutions in order to assure its dissemination, e.g. DEGAM – the German Association for General Practitioners, the Institute for continued medical education for GP's (IHF), Departments for General Medicine at Universities or professional Chambers of Physicians.

Hungary

There are 7 large regions in Hungary, so we have decided first of all to educate and train 7 substance abuse managers.

There are 7 head physicians also in the substance abuse field. They have been working for years in their region for alcoholic patients, but in the past they only got together for serious cases. I am the head physician of the central part of Hungary (Budapest, and Pest county) and besides the regional substance abuse managers, I have trained 2 persons at the university hospital, and we made the program together. We have educated 24 primary care physicians. The training was 5 days, 8 hours/day, and there was an exam at the end, and the participants were given a certificate at then end. We are continually in touch with the "old" students - participants of the training program, we try to help and encourage them to continue the work. We give them literature, we invite them to national meetings of the Hungarian Association of Addictologists, where I have also given talks and short trainings about Alcohol and Primary Health Care. They may get to know and practice the early identification and brief intervention (EIBI) program and method. The EIBI is the only way to prevent the developing of the real addiction, which in many cases causes irreversible social and physical destruction and in many cases tragedy in their individual lives.

We have experienced in our practice that the GP's role is very important in recognising the alcohol problem at an early stage and giving a brief intervention program.

The 24 general practitioners (GPs) have started and continued educating primary care physicians, nurses and assistants in their own region. The basis of the method is the early identification of alcohol misuse and brief intervention. According to the program the GPs use the AUDIT-C screening test, and in some cases the nurses and the assistants (who are educated) mean great help in this work. While the patients are sitting in the waiting-room the patients have a possibility to receive the screening test from the assistant, who usually creates a friendly, empathic atmosphere in which the patients are able to cooperate (if they have understood the behaviour part of the program).

There are some regions, for example in ours, where the patients can answer for not only addictological questions, but physical questions too. The wider risk questions include the AUDIT-C as well. The general experience is that the patients who are unwilling to answer straight questions about their alcohol consumption become more cooperative when the screening test also contains questions about physical risk-factors (e.g.: hypertonia, diabetes, osteoporoses, arterioscleroses, overweight, smoking, sleeping disorders or headaches).

According to our plans by the end of this year there will be in every region 8-10 GPs individually using the EIBI program in their practice. During the next year we will ensure that all the GPs can have the Hungarian version of the PHEPA books: "Clinical Guidelines on Identification and Brief Interventions" and the "Training Program on Identification and Brief Interventions" or the shorter version of it.

Last year we translated the Clinical Guidelines and the Training Book is under consultation and in November it will be published.

Recognising the seriousness of alcohol problem in Hungary we consider it that it is very important that during the next years most of the GPs in Hungary acknowledge at least the basic concept of EIBI in the field of alcohol consumption. We hope, that in this way, we will be able to decrease the 11 natural alcohol (100%) consumption, and the great mortality due to drinking behaviour.

Plans for the future:

- 22-24. November 2007. National Congress on Alcological and, addictological disorders (in it Phepa program in Hungary, Initial steps with the EIBI among the Hungarian GPs in practice)
- Edition of Clinical Guidlines and Training Book at the end of the year, or at the beginning of 2008.
- Go ahead with training of the trainers (GPs)
- Local, regional conferences focus to the EIBI of GPs
- To finish and send the Grate National Program on Alcohol Policy to the PHEPA switchboard
- Another National Congress on Alcohol and Alcohol Policy in 2008

Ireland

The situation regarding the style in which we drink in Ireland has not altered much and various reports still sadly place us at the top of the binge drinking league in Europe. Most worryingly there are increases in the rates of suicide and alcohol is clearly implicated in these tragic figures. It would appear from recent research that suicide has been underestimated. While there are varying estimates it would appear that at least one third of those who die from suicide meet the criteria for an alcohol related disorder.

There are also reports that consumption rates have fallen and there is certainly evidence of a reduction in the number of public houses. This situation has been explained by the impact of the smoking ban and improvements in detection of drink driving with the introduction of random breath testing. Ireland was the first country to introduce the smoking ban in public places in March 2004. However, it would appear that there has also been a large increase in home drinking.

Experts in the field of health care continue to be very concerned by the manner in which we are drinking and the knowledge that a significant percentage are drinking at hazardous and harmful levels. Heavy drinking has been normalised in Ireland and there are few curbs on advertising despite many calls for a total ban and specific protection for children. The advertising of alcohol is still self-regulated by the drinks industry. The industry also provides wide scale sponsorship of sport, television programmes, musical and other events. Counter-advertising by the drinks industry continues to be very common. In the opinion of this author it often amounts to little more than pure advertising of their products. A worrying development is counter-advertising by the industry in the media by 'Drink Aware' which is developed by Meas (social responsibility organisation funded by the industry). The concern is that it is not clear that they are the source of the advertisements and the public may believe that the advertising and the elaborate website has been developed by the government or by health professionals.

There is an increasing interest in training for brief interventions across the board but particularly for Primary Care professionals in Ireland. This has been encouraged by a number of initiatives and by overwhelming international evidence on the efficacy of brief interventions. Two training courses are in the advanced stages of planning for October and November 2007. These will be one day courses and the participants will be GPs and Practice Nurses. Both are organised by the ICGP and one will be in conjunction with the Health Service Executive (HSE; Government funded and responsible for all public health services). Four more courses are already planned for the next 18 months. The Alcohol Aware Practice Service Initiative (AAPS) 2005-2006 which built on the success of the Alcohol Aware Practice study (2002-2003) involved 26 GPs, four Practice Nurses and eight Counsellors on site. The study was funded by the HSE. It provided further valuable information and statistics on all aspects of alcohol in primary care in Ireland. Over 4,000 patients took part and were screened to be low risk, hazardous, harmful or dependent. Referral was available, when necessary, to professional alcohol Counsellors on site. This was a vital element in attracting participants as referral sources particularly for public patients are very thin on the ground. Patients were screened on the basis of random, targeted or help seeking criteria. The results indicated that 61% of patients were in 'low risk', 22% 'hazardous' and 17% 'harmful/dependent'. In 2006 the Irish College of GPs also launched an Alcohol Guidelines document and in the previous year a module on 'Alcohol and Growing Older' for primary care professionals. These documents have made a positive difference for patients and have improved the ability of primary care professionals to intervene effectively. They are also of great assistance in training. More progress needs to be made on providing modules for trainee GPs and for those established GPs via the Continuing Medical Education Network.

Italy

According to the previous PHEPA experience and the Country strategy implementation already outlined for Italy and in line with the new PHEPA aims the national working team at the Istituto Superiore di Sanità started in April 2006 to prepare and organize all the project's activities included in the workplan.

Building and consolidating alliances has been necessary at the political, scientific, administrative national and, in some cases, local level. Creating partnership between the ISS and the Ministry of Health, the Italian Society of Alcohology-SIA, with universities (such as the Florence university), with Eurocare Italia and GPs representatives and alcoholics associations (AA, AICAT etc.) has been basic to ensuring the full participation of the professionals working within the National Health System (Local Health Units and Services) at the already organized first National training course on Early Identification and Brief Intervention (Identificazione Precoce e Intervento Breve – IPIB) to be held on October 17th and 18th in Rome at the National Centre of Epidemiology, Suirveillance and Health Promotion of the Istituto Superiore di Sanità.

The preparation, translation and adaptation of the PHEPA English documentation and related materials and the organizations of a few well-managed meetings has been aimed at optimizing the presentation and the starting of the training programme as well as the dissemination and the promotion and implementation in Primary Health Care settings. It has been, perhaps, a priority to develop a good communication strategy and to organise local conferences to announce and promote the programme. The web page of the Istituto Superiore di Sanità has published the call for selection of candidate to the first training programme IPIB (http://www.iss.it/binary/esps/cors/scheda%20corso%20ott%2007%20scafato.1185442119.pdf) as well as the programme of the course (http://www.iss.it/binary/esps/cors/locandina%20programma%20corso%20ipib%20PDF.1189778413.pdf) that will allow 24 participants for each of the planned courses to be trained to train other professionals themselves.

The course has received the credit and a small funding from the Ministry of Health and of the Continuous National Training Programme, compulsory for the professionals of the National Health System. The training course has been opened to GPs and generally speaking to all the physicians involved in the Primary Health Care as well as (something new in Italy) to the psychologists.

This has been made possible by the institutional role of the Istituto Superiore di Sanità, the scientific and technical advisory body of the National Health System, of the Ministries, of the Regions.

The training standard PHEPA has been approved and formally recommended by the National Committee on Alcohol set by the law 125/2001 and the Istituto Superiore di Sanità indicated as the national provider of the training activities in close connection with the SIA and the Regions (see http://www.solidarietasociale.gov.it/NR/rdonlyres/CCA57828-3C95-4568-9D25-9E22395E862F/0/Formazionedelpersonale.doc):

6) sulla base dello standard europeo delineato dal progetto comunitario PHEPA - Primary Health care European Project on Alcohol - e delle esigenze di formazione specifica del personale sanitario operante nel settore di prevenzione primaria, è raccomandabile un'implementazione nazionale e regionale delle attività preventive alcol-correlate attraverso l'attuazione di corsi specifici volti a garantire la formazione dei Medici

di Medicina generale e l'aggiornamento continuo. Per tale compito l'Istituto Superiore di Sanità si è già proposto di coordinare e promuovere tali attività in concertazione con le Regioni ed in collaborazione con Società professionali (SIMG) e scientifiche (SIA).

The need for the specific training standard and consequent activities outlined by the PHEPA/IPIB Country strategy found a relevant inclusion among the activities of the Alcohol National Strategy 2007-2010
(Piano Nazionale Alcol e Salute – PNAS) (http://www.ministerosalute.it/imgs/C_17_pubblicazioni_623_allegato.pdf) as follows:

Area "Trattamento del consumo alcolico dannoso e dell'a/co/dipendenza"

Risultati attesi
-Disponibilità per i singoli e per le famiglie di un trattamento accessibile ed efficace per tutto l'arco dei problemi alcolcorrelati, dal consumo a rischio e dannoso all' alcoldipendenza.

Azioni
-Provvedere al coinvolgimento e alla formazione degli operatori della medicina di base, e in particolare dei Medici di Medicina Generale, Pediatri e Medici dei Dipartimenti di Prevenzione, per l'identificazione precoce dei soggetti a rischio, anche tramite strumenti di screening comportamentale mirati e attendibili, nonché per 1' intervento breve nei confronti del consumo alcolico nocivo

It has been also possible to let the PHEPA/IPIB approach included into the National Governmental Programme "Gaining Health" (Guadagnare Salute) (http://www.ministerosalute.it/imgs/C_17_pubblicazioni_605_allegato.pdf) as follows:

5 RAFFORZARE GLI INTERVENTI DI PREVENZIONE PRIMARIA E SECONDARIA NELLA MEDICINA DI BASE

• Provvedere alla sensibilizzazione e formazione degli operatori della medicina di base, e in particolare dei Medici di Medicina Generale, per consentire l'identificazione precoce dei soggetti a rischio nonché la pratica dell'intervento breve e del counselling nei confronti del consumo alcolico nocivo. A tale fine dovrebbero essere sostenute nuove e adeguate strategie contrattuali e stanziate risorse finanziarie che consentano i la più ampia disponibilità, accessibilità e produttività degli operatori e dei servizi di base in merito ai suddetti interventi.
• Favorire un approccio integrato che coinvolga nella individuazione precoce dei casi di abuso, oltre ai servizi e agli operatori sanitari, anche i servizi sociali, i gruppi di auto-aiuto, le istituzioni scolastiche, giudiziarie, il mondo del lavoro e le altre istituzioni interessate.

One more initiative is related to the opportunity given by a recent agreement signed by Alcoholics Anonymous – AA and the Italian Federation of General Practitioners to promote joint activities related to a management programme of alcoholics and problematic drinkers that may include the training of GPs by means of the training programme and the competencies of the Istituto Superiore di Sanità. Furthermore a series of meetings could be arranged involving all the possible stakeholders at the local level; in this field Italy has since 2002 organized the Alcohol Prevention Day in April, actually promoted by the Italian Society of Alcohology (SIA) and the Italian Club of Alcoholics and Treament (AICAT) as a yearly occasion to spread alcohol-related health aimed at the reduction of alcohol-related harm.

The Alcohol Prevention Day 2008, organized yearly in Italy by the Osservatorio Nazionale Alcol and the WHO CC for research and health promotion on alcohol and alcohol-related problems will focus on the IPIB approach and the National implementation of the early identification of alcohol abuse and brief intervention with the support and acknowledgment of the Minister of Health.

As a final consideration we may say that the possibility to improve the capacity to deal with alcohol problems by means of the PHEPA project seems to receive new strength from the above reported experience. The Italian experience was extremely important to focus the attention on the need for standardised instruments and methodology and on the development of the local capacity to involve all the possible stakeholders into a community strategy that cannot be limited to the Primary Health Care settings. The need for a much more formalised approach on alcohol-related problems and diseases and the possibility to implement the early detection of alcohol abuse into the daily work of General practitioners by mean validated instruments has start to become formally a priority in terms of the National Public Health Strategy even if many obstacles have to be overcome and many efforts to be done to convince that the common practice will not be affected by difficult screening procedures test and that the cost-benefit ratio will be higher than today. The Country adaptation of the EIBI has been so far and still remains a challenge for the forthcoming years together with the need to improve and simplify the methodologies and the specific procedures. A general remark must be made on the opportunity to spread the short-Audit (3 items) as a quick screening tool for the general population level.

In terms of implementation of the PHEPA approach and standards the current experience require a possible further adaptation and dissemination across the different sectors of the Primary Health Care settings in Italy including the professionals working in the workplaces (in which a very recent pilot initiative has been performed with interesting results) and the local prevention services.

Regarding the web activities, these are in progress and the set-up of a specific page on the web site of the Instituto Superiore di Sanità is close to being finalised following a formal procedure.

Lithuania

Projeci activities in the year 2006 (actions carried out from 01/04/2006 to 30/09/2007)

1. One member from Vilnius Centre for Addictive Disorders took part in the PHEPA meeting in Tallinn (Estonia) in June 2006.
2. Vilnius Centre for Addictive Disorders prepared and presented to the State Mental Health Center project on translation and trainings for general practitioners about Brief intervention in order to get funding, but Project was not confirmed.

Project activities are planning for year 2008

Country Roll out

1. Translation of "Training Programme on Identification and Brief Intervention"
2. Experts meeting for adaptation of "Training Programme on Identification and Brief Intervention" on the country level
3. To present "Training Programme on Identification and Brief Intervention" to the Vilnius University in order to confirm it as the doctors' postgraduate training program
4. Delivery of two trainings for general practitioners per country

- Organize two trainings at national level

5. Dissemination of training program to participants of trainings and faculties of Medical Universities (for example as a booklet or in CD form)

Portugal

Current activities of Phepa Project in Portugal concerning alcohol related problems

1. Introduction
2. Policy related to alcohol problems
3. Phepa Project in Portugal
4. Plan and implementation- outcomes of the project – PHEPA I
5. Dissemination of the Phepa Project – PHEPA II

1. Introduction

Portugal is one of the countries with the highest alcohol consumption in Europe and Alcohol Related Problems constitute an important Public Health problem in this country.
Alcohol consumption is directly related with social behaviour patterns, part of the "life-styles" and influenced by cultural context. A number of reputed international studies have shown a dose-response relationship between alcohol consumption and the frequency and severity of several illnesses. In this sense, the high levels of alcohol consumption relate with higher mortality and morbidity rates in what concerns liver cirrhosis, cancer, accidents and other.
The aims of Portugal's alcohol policy are similar to those of the European Union and the World Health Organisation, and give special priority to prevention and treatment of harm done by alcohol and a good availability of services to manage this important problem.
The scientific knowledge of the disease risk factors and their consequences justify that the current policy related with alcohol problems gives priority to the need of a population-based approach to alcohol abuse prevention complemented by the intervention to reduce excessive consumers, namely at the primary care level.

2. Policy related to alcohol problems
2.1 Action Plan against Alcohol Related Problems
Approved by Government in 2000, defines the development of Projects such as:

- Health Promotion and Education
- Research and Clinical issues
- Legislation and Fiscal monitoring
- National Network on Alcohol Problems

2.2 National Program of Alcohol Related Problems
This national program includes a National Project concerning "Treatment of excessive consumption of alcohol – Brief interventions in Primary Health Care".
Participation of Portugal in the European Project of " Phepa Project- Integrating Health promotion interventions for Hazardous and Harmful Alcohol Consumption into Primary Care Professional's Daily Work"

Goals:

- Elaboration of a National Inquiry to collect Data on Alcohol related problems in Primary Health Care.
- Development of Health Professional training program for Hazardous and Harmful drinking in Primary Health Care based on brief interventions.
- Target trainees:
    - Professionals of Health Care such as General Practitioners, nurses, psychologists and nutritionists.
    - The issue of alcohol prevention will be raised both with health care providers and with the professional organizations and involves different levels of care.

2.3 National Health Plan 2004-2010

- Framework to all these initiatives integrated in Healthy Life Style Programs. Sedentary life, unhealthy diet, tobacco use and risky drinking are responsible for disease and disability. This National Health Plan gives particular importance to effective interventions for modifying these risk factors.
- The importance of epidemiology of alcohol's role in health and illness; the treatment of alcohol use disorders in a public health perspective and policy research options are considered in this framework. The evidence based preventive measures at both individual and population levels such as alcohol taxes, restrictions on alcohol availability and drink driving countermeasures are also recommended.

3. Phepa Project in Portugal
Early Identification and Brief alcohol Intervention in Primary Health Care

3.1 General description of the Project

Portugal has the highest levels of alcohol consumption worldwide and the highest rates of alcohol related problems. Consumption levels are high among young people.
The Action Plan against Alcoholism, approved by Government, defines the development of projects that include training of health professionals particularly those who work in the area of the Primary Health Care. Those professionals are in a privileged position to deal with alcohol problems. They are the first level of attendance in national health care, and they have a permanent contact with the population that habitually uses the primary health centres. The high consumption of alcohol is responsible for the development of physical, psychological and social problems. In Portugal, approximately 7,000 annual deaths are related to alcohol consumption. The high prevalence of excessive alcohol consumption and the high economic, social and health costs, are important reasons to justify the implementation of projects concerning alcohol related problems in Primary Health Care in Portugal.

3.2 Goals of the Project

- National Survey to identify and assess the health institutions (health coordinators) involved in the care delivery to people with alcohol related problems
- Apply another National Survey to evaluate the capacities of Primary health care professionals (General practitioners) to deal with the Alcohol Related problems. Increase skills to do early identification of and brief alcohol interventions in primary Health Care.
- Supply training materials and a training program to primary health care professionals about alcohol consumption and how to reduce it.

PHEPA PROJECT IN PORTUGAL

Phase 1 (PHEPA I) -2004	**Phase 2 (PHEPA I)- 2005-06**	**Phase 3 (PHEPA II) 2007-08**
2.1.1.1 Plan **2.1.1.2 Methodology** Preparation of the national Survey about alcohol related problems **2.2 (Done)** Preparation of the materials for trainers and training programs for health professionals. **2.3 (Done)**	**Implementation** National Survey to identify and assess the health institutions (health coordinators) involved in the care delivery to people with alcohol related problems Survey about alcohol related problems and needs assessments was prepared and has been answered by health professionals in Primary Health Care. Distribution of the surveys and evaluation of the answers **2.4 (Done)**	**Dissemination** 2.5 Training program in brief intervention based on the motivational interview for trainers **(In progress)** Training of professional Primary Health Care conducted by the trainers prepared in the beginning of this project **(In progress)** Monitor implementation Evaluation of the outcomes of the project

3.3 Description of the Project

The project includes:

- Elaboration of a National Survey to collect data on Alcohol related problems in primary health care.
- Development of a health professional training program for hazardous and harmful drinking in primary Health Care with brief interventions.
- Production of videos with motivational approach and booklets about drinking problems.
- Production of a manual about motivational techniques to promote changes in behaviour, such as motivational interview.
- Elaboration of a guide for development of this program in primary health care.
- The National Project "Treatment of excessive consumption of alcohol – Brief interventions in Primary Health Care" - includes a module of training in the identification and management of alcohol hazardous and harmful consumption and referral of alcohol dependent patients.
- The package can be delivered in two days, with a follow-up of another two days six month later. Trainers are health professionals whose profile and interest in alcohol problems is relevant. They can be GP, Psychiatrist, nurses or psychologist.
- Addresses professionals of Health Care such as General practitioners, Psychiatrists, Nurses, Psychologists and Nutritionists.

4. Plan and implementation- outcomes of the project -PHEPA I

Preparation of national surveys about alcohol related problems (needs assessment)

4.1 We have done two national surveys:

- National Survey to identify and assess the health institutions (health coordinators)
- National Survey about alcohol related problems and needs assessments of general practitioners

The **National Survey to identify and assess the health institutions (health coordinators)** involved in the care delivery to people with alcohol related problems. This Survey has been done and now it is possible to have information of all the technical and professional resources existing in the public health system.
Some national results are:

Hospital Based Care (Public Sector)

36 Public Healthcare Services answered to the Survey (85%)

- 50% of those Public health care services have specific team for Alcohol Related Problems
- 53% have some implemented programs
- 34% have research programs
- 39% have training programs
- 72% liaise with Primary health care

Primary Health care services

11 Sub-regional health authorities answered to the Survey (61% of total)

- 55% have Alcohol Related Problems intervention
- 45% have Alcohol Related programs
- 55% have specific teams
- 90% liaise with Mental Health Services
- 50% have Alcohol training programs
- Only a very small number of PHC have research programs

It is now possible to:

- Identify the *key persons* in those process at each level of care delivery
- To make a better liaison between different levels of care
- To identify and assess the health institutions involved in the care delivery to people with alcohol related problems
- It is possible now to have information on all the technical and professional resources existing in the public health system

The **National Survey about alcohol related problems and needs assessments of general practitioners** was prepared and has been answered by health professionals in Primary Health Care.

Aims
Apply a national questionnaire to evaluate capacities of General Practitioners to deal with Alcohol Related Problems.
Increase skills among General Practitioners for the early identification of hazardous and harmful alcohol consumption and the performance of brief interventions to reduce consumption levels and promote healthier life styles.
Identify the priorities of a program of detection and intervention in Alcohol Related Problems at Primary Health Care.

Methods
A structured questionnaire about attitudes and capacities to deal with ARP was sent to all GP in Portugal through eighteen health coordinators.

Results
In all five health regions of Continental Portugal, 2193 answers to the questionnaire were obtained. This sample of general practitioners is distributed by 350 Health Centres in 18 health sub-regions. Concerning gender, 53,7% of the sample were women and 46,3% were men. The results show that the average age was 48,1 years old, with around 18,9 average years of clinical activity. The great majority of the general practitioners (GP) who have answered to the questionnaire consider that ARP are very important (48,3%) or important (41,1%); they are interested to be trained (82,3%); 88,7% of GP think that new types of interventions in alcohol consumption are necessary in primary health care centres although they are not familiar with brief interventions (80,5%).

4.2Preparation of the materials for trainers and training programs for health professionals.

- Supply training materials and a training program to primary health care professionals about alcohol consumption and how to reduce it.
- Production of a manual about motivational techniques to promote changes in behaviour, such as motivational interview.
- Elaboration of a guide for development of this program in primary health care.

5. Dissemination of the Phepa Project– PHEPA II
5.1 The main goals are:

- Practice based guidelines: are now being translated but not yet printed
- Continuing the Training of professional in Primary Health Care (in progress)
- Programmed sessions and follow-up for group of PHC professionals
- Loco-regional support of the training program
- We have Specialist support from alcohol centers when patients with alcohol related problems need to be referred
- Engaging Health care providers: Discuss local project, goals, barriers, strategies

With the support of trainers from the Health institutions of Alcohology, the Regional Health Administrations are implementing the training program in the three major regions of Portugal (North, Center and South)

5.2 Points of Intervention of Phepa II (2008)
Dissemination

Key points

- Monitor implementation of the training program
- Evaluate outcomes in some specific regions
- Reassess and modify interventions if there is some local difficulties
- Support for increased allocation of resources and infrastructure capacity
- how to put the best transfer of knowledge and skills of the training program into practice

5.3 Other developments related to national project in Alcohol Related Problems

- There's now interest in alcohol related problems and brief interventions in pre-graduate Primary Health Care curricula at University

- There is now interest in alcohol related problems and brief interventions in post-graduate internal Primary Health Care programs
- There is now interest in alcohol related problems and brief interventions in groups of "tobacco and smoking intervention" in Primary Health Care
- There's also interest on the project Phepa in Primary Health Care conferences and Institute on Drugs and Drug Addiction and alcohol national meetings with specific workshops on brief interventions and alcohol related problems.

5.4 Conclusions

- *ongoing* process and an *adaptive* process in Primary Health Care
- *Integration of EIBI* into daily routine requires *adequate infrastructure* capacity
- It also requires *commitment* and support from institutions from primary and secondary level of care

Building the capacity to continue the program

Slovakia

1. Overall background of the project:

Slovakia declared its interest in taking part in the second phase of the Phepa in the Autumn of 2005 and the beginning of 2006, and re-confirmed this definitively in May 2006 at the Barcelona conference. A Slovakian representative took part in the first meeting of the Phepa II in Vilnius, Estonia, where a preliminary plan of activities was outlined, as the dissemination of early identification and brief intervention against hazardous and harmful drinking among upper primary and secondary school students.
Project Phepa II in Slovakia should contribute to solving the growing problem of risk and harmful drinking among youths still at school, which has unacceptably high prevalence among 15 – 19 years old students. For example recent representative survey TAD (TAD: Tobacco, Alcohol, Drugs Scale) had shown problem drinking and first signs of psychological and physical dependence on alcohol (comparable with the concepts of hazardous and harmful drinking) in 24,7 % (CAGE) and 21,7 % (ADS) among students aged 15 to 19 in 2006 (see Annex 1). The same estimates will soon be available from the ESPAD2007 representative sample from the last grade of upper primary and four grades of secondary schools (15 – 19 years old students).
This nation-wide mapping of target population was carried out because of intention to translate and to adapt for practical use the Clinical Guidelines and Training manual, created during Phepa I, in which Slovakia did not take part because in the second half of the 1980s and during the 1990s the author of this paper adapted and then standardized tools for screening and detection of alcohol problems and dependence, like ADS[7] but also MAST, CAGE and Trauma Scale. Also Audit and MALT were tried in the clinical population, but not standardized, and the same was true for the Stages of Change Questionnaire (SCS) and the Processes of Change Scale (PCQ) original versions, which we were allow to use for research purposes by their author J.O. Prochaska. Finally two screening scales, adapted and standardized for the clinical population were considered for usage along TAD2006 and ESPAD2007.
ADS and CAGE items were used as an addendum to the TAD in recent survey in March 2006, and results had shown that amount of risk drinking among Slovakian youth in very high[8]. Because of these empirical findings, supported by epidemiological and also clinical data, we decided to act, instead of the usual pointing out of an "alarming situation" and doing nothing. Fortunately, the project of participation of Slovakia in the second phase of Phepa was in line with priorities of main funding institution, Anti-drug Fund in the field of education and prevention, as well as with the EU health policy, hence we applied both for funding in Slovakia, and for the status of co-beneficiary in EU framework.

2. Goals of the project in 2007:

The main goal is to translate and to adapt for practical use the Clinical guidelines on Identification and Brief Interventions and related Training Programme. Another sub-goals are as follows:

- To adapt, with regards to Slovak conditions, clinical and training manuals, which were created during previous part of the Phepa I.;
- To enable psychologists and educators in general to acquire basic skills in screening and brief intervention at detection of risk drinking of students;
- To prepare these methods and methodical approach for the dissemination throughout their network in Slovakia;

[7] Nociar, A. et al.: Škála alkoholovej závislosti – ADS [Alcohol Dependence Scale; Test and Manual]. Bratislava, Psychodiagnostické a didaktické testy, š.p., 1990, pp. 1-51.

[8] See graphical annex to this material

- To prepare materials for inclusion of this method in the pool of accepted methods for post-graduate education of school and clinical psychologists;

    - **Goals of the project in 2008:**
- To involve in the second phase key experts from Centers of educational and psychological prevention within the Psychological counseling centers, and eventually also to engage one group of school psychologists;
- To carry out a minimum of four training events with selected groups of experts, who might be trained as trainers;
- To consider the possibility of introducing this topic into the curricula for post-graduate education of general practitioners.

4. Resources of the project

During the year 2007 this project will be oriented mainly at the adaptation and translation of main textbooks, and to inclusion of our own results, relevant for the target population of secondary school students. The financial source shall be mainly the grant from Anti-drug Fund, awarded in the half of 2007 (225,000 Slovak koruna; approximately 6700 Euro, according to the current rate). There will be also added value of co-financing from the EU funds.

Practical-training part of the project will start only at the beginning 2008. We plan to start as early as possible, using EU funds untill new grant from the Anti-drug Fund is awarded (because of procedural reasons it can not be earlier then in April or May 2008) Practical-training part of the project will be carried out in the network of selected Centres of educational and psychological prevention, which are parts of Educational and Psychological counselling centers. The project will be implemented by OZ Prevencia V & P, with cooperation of the Research Institute of Child Psychology and Pathopsychology.

Slovenia

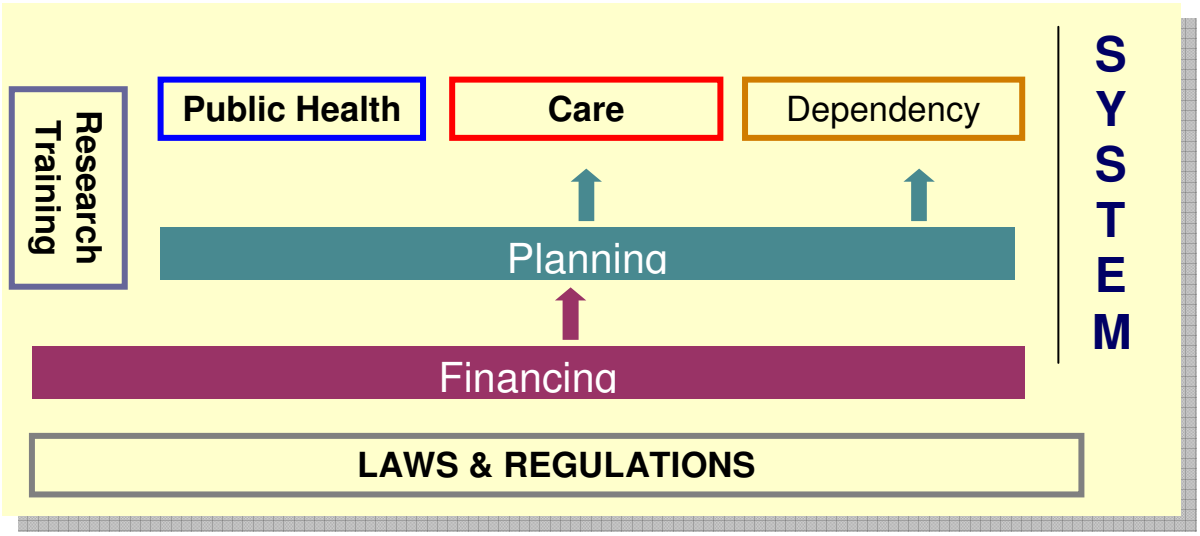
Following the Phepa I project the activities on implementing of early identification and brief interventions for hazardous and harmful drinking have been continued. The introduction of the Phepa II project was warmly welcomed by our team and we were satisfied to join this new project which continues the work done in Phepa I. We are collaborating also with some other organizations in our country (e.g. CINDI Slovenia) that are interested in health prevention to establish a national network which could continue activities when the Phepa II project finishes.

Since April 2006 we have done some work that fulfils the tasks in the workpackages of the Phepa II project:

-Attended the meeting of the European platform in Tallinn, Estonia – June 2006
-we are preparing the meeting of professionals involved in the project activities to maintain of a national platform within our country
-we completed the adaptation of clinical guidelines at country level and the files of the translated and adapted documents were sent to the main beneficiary
-we completed the adaptation of training manual at country level and the files of the translated and adapted documents were sent to the main beneficiary
-adapted guidelines has been endorsed by the members of the national professional society of family physicians and we are waiting for the official endorsement
-we published adapted guidelines and training manual and disseminate them (medical professional bodies, the Ministry of health, primary health centres all over the country, all hospitals in the country, public health centres, all medical high schools, medical colleges and universities, medical libraries, some experts and professionals)
we organized training of trainers and we prepared 4 training programs

Spain (Catalonia)

1) In Catalonia, we are orienting our health system towards prevention and promotion of public health



2) We have linked the alcohol policy to Public Health Policy

Launch of the **Catalan Public Health Agency**, in charge of
the design and implementation of programs incorporating effective strategies of health promotion & protection, and disease prevention, with the support of epidemiology, monitoring and research.
providing support to policy formulation and planning
monitoring changes in key determinants and outcome indicators

Development of a **regional strategy on mental health promotion and mental disorder prevention** in the framework of a global reorganisation of the public health policies and resources.

Complement the medical approach with **population-based public health interventions** to address the broad dimensions of alcohol problems at the community level.

Health Plan 2002-2005 - Alcohol Chapter

Operational targets (of a total of 10):

- Complete dissemination of the EIBI in the Primary Health Care
- Train other professionals (paediatricians, etc) with screening and brief intervention strategies on alcohol

Also the inclusion of the continuity of the actions in the Health Plan 2005-2010

3) The Program on Substance Abuse has produced a Drug Plan in which:

- Addictions are diseases and must be treated within the Health System
- The Drugs Plan must deal with all drugs, including alcohol and tobacco
- Drug and alcohol related problems must be viewed from a Public Health perspective

4) EIBI is part of the drug/alcohol strategy

- Legislative activities
- Prevention activities
- Treatment of addictions. Creation of a network of specialized centers (XAD)
- Harm reduction activities
- Introduction of alcohol related issues in Primary Health Care.
- Strategy to introduce programs of Drugs at Work

5) The Catalan experience shows that International collaboration is crucial

- In 1995, we joined the Phase III Of the World Health Organisation Collaborative Project and Primary Health Care
- In the framework of the Phase IV of the WHO Project we started in 2002 the dissemination of the "Beveu Menys" in all the Primary Health Centres
- We entered the iteration/implementation phase in december 2005
- International collaboration within the PHEPA I and PHEPA II project and the INEBRIA network has provided an important support for the continuity of the strategy and the maintenance of the implementation activities

6) **Learning from experience is essential (2002-2005)**
- 70 training the trainers from specialized treatment centres
- 340 (98%) PHC centres trained
- 6000 PHC professionals trained

Activities carried out in the framework of the PHEPA project

- Use Phepa to influence national guidelines on alcohol
- Reach a consensus with the PHC professionals
- Inclusion in the Health Plan for Catalonia
- Inclusion in the Master Plan on Mental Health & Addiction
- Alcohol screening in the providers' contract
- Adaptation of Medical Records to PHEPA standards
- Development of on-line tools (course, bulletin, drinking measurement tool)
- Expansion to other health settings (hospitals, occupational health, etc)
- The PHEPA recommendations and training program are being translated and edited and also adopted.
- PHEPA recommendations have been included in the Director Plan of Mental Health and Addictions and
- Train increasing numbers of XaROH members from PHC (alcohol referents)

2006

Training the trainers	April and November 10 hours each course	34 participants
Motivational techniques in patients with alcohol related problems in Primary Health Care	October 10 hours	38 participants
The role of the Nurse	June 10 hours	15 participants

2007

Training the trainers	April, May, September 10 hours of formation each course	59 participants
Motivational techniques in patients with alcohol related problems in Primary Health Care	December 10 hours of formation	30 participants
The role of the Nurse	June, October 10 hours of formation each course	51 participants

Sweden

In Sweden there is a large government project called Riskbruksprojektet (The risk drinking project in Sweden) that stimulates and partially finances BI in Sweden. This was in 2006 the responsibility of the FHI (The State Institute of Public health). This project operates all over the country, in separate projects run by the 24 regions). Financially the local authorities are obliged to take half of the financial responsibility, mainly the salary of staff attending courses, and their later treatment activities. Several evaluations of these projects are currently running or have been started recently. A summary of all those evaluations is currently being carried out by some of the Swedish PHEPA members under supervision of Fredrik Spak. We are currently developing an evaluation form which it should be possible to use in these projects, and that also shall include the first period of institutionalization. We will check how much of the PHEPA assessment tool can be used for this purpose. Another important activity is an ongoing project, with delivery deadline 2009, of working out guidelines for how PHC will deal with unhealthy lifestyles concerning alcohol, tobacco, overweight and exercise. PHEPA member Preben Bendtsen leads the scientific group on alcohol.

The PHEPA members of Sweden are several researchers in the field as well some practitioners who have been involved in the earlier stages of development in this field. Some BI activities started in the 90s, with scattered projects also having been done in the 80s; meaning that present activities are building on a long period of implementation.

The Swedish situation also means that the PHEPA contribution to BI probably have less significance than in some other countries where the development has been started lately, and often also on a smaller scale. Furthermore, it also means that the interest of the Swedish PHEPA group lies more in "late" implementation issues that in the earlier stages of implementation, where construction of instruments and formation of strategies play a larger role.
As the practical BI policy is decided at local level, several pathways of implementation are adopted in Sweden. Basic activities are opportunistic screening, mainly with AUDIT, or AUDIT-C, and motivational sessions, mainly with MI or short versions thereof. Very many courses in BI have been given.

The main arenas of these activities are Family Practice centers (FPC), Maternity care units (MUC) and, recently started, in Child care units (CCU). MCU activities started in the 80s, had a decline in the 90s and a revival in the 2000´s. These activities are presently rather effective and widespread, maybe partially because the non- drinking message used in this context is less controversial than the moderate drinking concept used in a FPC-setting, and also because the alcohol message concerns a restricted period in a person's life. There may be yet another reason that is less investigated; the message in MUC mainly concerns women, among whom health work generally is easier to carry out.
In FPC is has been difficult to involve the GP's, and thus nurses are often the most active profession in this regard. GPs have, through their professional organization, held Risk Use Workshops (Riskbruksverkstäder in Swedish) over many years. These, however, have been directed only to GP's.
The risk drinking project in Sweden also now works with CCU. The message to the parents of infants and young children have been more difficult for the professions to unify around, and this work is so far mainly in it's infancy.
Lastly The risk drinking project in Sweden also deals with SBI in the occupational health sector, and these activities are widespread and gaining strength after a decline in the latter part of the 90s. PHEPA members are involved also in this sector, mainly in research and evaluation.

So what is the contribution of the PHEPA group?

1. Meetings have been initiated by the Swedish PHEPA group with all of the most influential national authorities in Sweden (Social board of health and Welfare), The State Institute of Public health, The social ministry (The Alcohol Committee), Representatives of the two largest regions in Sweden, SoRAD (Centre of Social alcohol research on alcohol and drugs), The PHEPA groups etc. One meeting was held in Dec 20 2006 and one in June 14 2007. As this body has no formal status it has mainly served as a vehicle for information exchange. The PHEPA project and its products have been presented and distributed. The forthcoming meeting will have evaluation as the main theme.
2. In collaboration with the PHEPA group a national survey of BI activities was done among GP's and PHC nurses of Sweden in 2006 was done financed by The risk drinking project in Sweden. Some results have been presented in Sweden, a first scientific article is accepted for publication, and more results will be presented at the INEBRIA-4 meeting Nov 2007. Likely this survey will be repeated in 2008.
3. PHEPA group members are active as researchers in several projects around this issue, and contribute to a better scientific standing of BI activities of Sweden...
4. As the various regions adopt their implementation strategies autonomously, there will be different strategies and methods used. The PHEPA group members raise awareness of the international activities and where Swedish BI agents may best pick up such knowledge.
5. PHEPA group members play a major role in the ongoing effort to increase the use of EBM in this field.