

CHAPTER 9

FLANDERS

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9.1. General Introduction

9.1.1. Country description

Belgium consists of two linguistic communities – Flemish and French. The Flemish linguistic community lives mainly in the region of Flanders (the western rather flat countryside of Belgium) and to a small extent also in the Brussels capital region (about 10-12% of the population). They form altogether 60% of the Belgian population (58.8% in 2002), amounting to about 6 million people in the Flanders region (5,940,251 in 2000, with a 1% increase in population every 4 years, amounting to 6,021,771 in 2004). The Flemish population is an increasingly elderly population with one quarter above 60 years, while half (56%) is between 20 and 60 years; in 5 years the ratio of 60+/20-59 years old increased from 40% to 50% in Flanders (against a smaller increase in mean age in the French-speaking part: 7% ratio increase from 40% to 47%).

9.1.2. Alcohol consumption

Alcohol consumption is highest in the middle-aged group, amounting to a mean of 10 glasses a week for men between 35 and 55 years¹. The percentage of daily drinkers increases steadily from 8% among men 25 years of age to 20% between 65 and 70. According to health surveys in 1997¹ and 2001², women between 45 and 55 showed the highest percentages of daily drinkers (10%). Overconsumption (defined as more than 6 glasses per day at least once a month) is estimated by these surveys at 19.7% of the adult population. Hazardous use thus defined is present in one-quarter of the age-group 15 to 54 years of age².

Using the CAGE questionnaire as a basis, the health survey in 2001² identified 6.7% of men as ‘problem drinkers’ and 2% of women. These data are probably an underestimate by a factor of two or three when compared with calculations based on household budget analyses^{3,4}. According to the latter studies, per capita consumption above 15 years of age is highest in the French-speaking part of Belgium (see Table 9.1). This difference is mainly related to higher wine and aperitif use by the French-speaking compared to the Flemish-speaking population.

However it should be noted that Flanders has twice as many cafés and restaurants serving alcohol as the French region². Also, among Flemish boys 15-16 years of age, 8% have already been drunk more than 20 times compared to 6% in the Walloon region⁵.

9.1.3. Burden of alcohol use

Based on data collected by the Commission of Distilled Spirits⁶, there has been a slow but steady decrease in overall alcohol consumption from 9.1 litres of pure alcohol in 1995 to 7.9 litres in 2002. By contrast, there has been a significant increase in excessive alcohol use among youth (13-18 years) in Belgium and, more particularly so, in Flanders compared to the Walloon

region^{6,7}. The mean age for starting to drink alcohol is younger than for tobacco and other drugs² and the number of regular drinkers in all the younger age-groups is higher than for other drugs⁸.

TABLE 9.1.

Alcohol consumption based on household budget analysis in different regions

	L/pure alc/p >15y/yr	% wine
Walloni	6.1	63
Brussels	5.8	70
Flanders	5.0	58
Belgium	5.5	62

The prevalence of hazardous alcohol use based on screening studies is estimated as 9% of the adult population⁹.

More than 50% of mental health care for drugs relates to alcohol problems¹⁰ and about 10% of avoidable death is estimated to be alcohol-related¹¹. One in twelve accidents (8.5%) and 10% of all major accidents on the road are related to alcohol use¹². Moreover, one-third of accidents at home among men and one in 8 among women are related to alcohol or drugs¹³. Depression and suicide have been demonstrated to relate to hazardous alcohol use in Belgian society¹⁴, and intentional violence is related to alcohol equally among perpetrators and victims¹⁵.

Recently a university-based study estimated that work-related problems due to alcohol were comparable with data from other countries (10% of the costs of criminality and exclusion and 5% of police costs)¹³.

9.1.4. Health services dealing with alcohol problems

Belgian health organisation is characterised by a liberal system based on fee-for-service payments and free choice of physician. More than 80% of the population see their general practitioner yearly but direct access to specialist and hospital care is possible. GPs function mainly as sole physicians, although a slight increase in two-partner and group practices occurred recently. This is partly due to links between practitioners and their tutors after vocational training and partly to an increase in female physicians. No special fee exists for the provision of more lengthy mental health counselling. The mean time for consultation among GPs in Belgium (15 minutes) is estimated to be higher than in surrounding countries.

In mental health care different facilities co-exist financed by the linguistic communities and the federal health insurance system. On the one hand, ambulatory care provided by psychiatrists and private psychologists is regular practice. Psychiatrists generally function also as consultants to either regional mental health hospitals or psychiatric services linked to general hospitals; they are reimbursed, as are GPs, by health insurance which covers almost the entire Belgian population. On the other hand, centres for mental health deal with ambulatory mental health care, either autonomously or after referral by GPs. Such centres are financed on a salary basis by the linguistic communities and provide a variety of services, of which drug counselling and prevention is one.

GPs are organised in local circles that arrange after-hours services on a collaborative roster and sometimes co-ordinate home care and continuing medical education (CME) in addition. GPs are further organised in local quality circles, being groups of 8-24 GPs who meet 4 times a year. Historically these activities developed differently in the two main linguistic communities in Belgium but CME and quality assurance are endorsed by the scientific societies of both communities and the universities. Because of this different organisation and the responsibility for prevention assumed by the linguistic communities, the development of an implementation strategy for Belgium needed to include two customisation projects, one Flemish and the other French. The French-speaking customisation project is summarised in Appendix 9.1.

9.2. The Flemish Phase IV Project

The aim of the Flemish arm of the WHO project is to develop a cost-effective, GP-oriented quality assurance programme for early identification and brief intervention (EIBI) embedded in a health promotion policy initiated by the Flemish community through the creation of local health promotion groups (LOGOs) in 1998. Specific aims are:

- To develop a strategy promoting municipality and LOGO action to stimulate (i) safe alcohol use and (ii) enduring delivery in primary health care of EIBI for hazardous and harmful drinking;
- To evaluate the cost and outcomes of a primary care-oriented quality assurance project embedded in a regional (municipality and provincial levels) and nationwide (i.e. Flemish) implementation strategy.

9.2.1. Project development

At the start of the project the coordinating team made requests at the federal state and Flemish community levels for specific funding for research and developmental costs of the programme but did not succeed due to competing priorities in the ministerial budgets at that time. Due to lack of specific funding, the project was embedded in the regular health promotion strategy of the *Scientific Society of Flemish General Practitioners* and into other Flemish initiatives for health promotion. The WHO Phase III and IV studies started as a research programme of the Flemish Institute of General Practitioners (VHI, grouping WVVH and 4 university centres in general practice) which during the time of the study became the Research Department of the *Wetenschappelijke Vereniging voor Vlaamse Huisartsen* (WVVH).

In the Flemish community health promotion is co-ordinated by voluntary groupings of municipality representatives, health care institutions, preventive care organisations and associations of health professionals in areas of about 300,000 people (i.e., LOGOs). The aim is the accomplishment of health targets defined by the Flemish Parliament; a LOGO can however add its own local targets. Alcohol is not a formal health target but actions against drug and alcohol problems are supported by the Flemish Ministry department responsible for health by a convention with an NGO association (VAD) combining specialised services and a large number of Centres of Mental Health. This association prepares the policy and training of prevention and municipality workers and this is coordinated at a provincial level in preventive drug platforms.

Through “reflective participation”¹⁶ the project coordinator and municipality prevention workers were able to put the target of ‘safe alcohol use among adults’ on the agenda of a number of municipalities and proposed it as provincial policy in Flemish Brabant through the

provincial prevention platform for drugs. This policy was endorsed for 2003 to 2006 by the provincial deputation (i.e. the elected district board).

9.3. Customisation

9.3.1. Defining targets for QA and CME (Strand 1)

Focus group research among GPs

This began by adding to the WHO Phase III focus group research on habitual care by GPs the adaptations needed by those who used the Drink-less package and the early detection and brief intervention strategy that was being followed. Focus groups on strategies for collaboration with mental health care were added¹⁷.

Focus groups taught us that the hidden character of alcohol and the social and economic background of alcohol misuse and dependence strongly influence the views of practitioners. This gives GPs a major emotional burden in dealing with alcohol problems, expressed as “workload” or “lack of time”. (The same phenomena was found in other countries taking part in the ECATOD training project). In the focus groups feelings were expressed of ineffectiveness, powerlessness and deception after major efforts to help people. Generally GPs are neither trained nor feel they have the time to deal with ongoing counselling of patients with alcohol misuse. On the other hand, a tension exists between the perceived responsibility on the part of the GP to remain available and supportive to alcohol patients and specific lack of public support for such this continuing work. In Flanders the relationship with specialists is coloured by the GP’s fear of “loosing” patients. GPs also complained of inadequate training and insufficient facilities.

GP who were provided with the Drink-less package in Flanders expressed similar views and feelings of deception in the focus groups but these were mixed with new ideas on the possibilities of the tools provided, although questionnaires for detection and counselling are not regularly used.

The actual clinical approach to alcohol problems consists mainly of blood testing and repeatedly confronting patients with the negative consequences of alcohol use. This is complicated by a lack of clear distinction between hazardous alcohol use and harmful use or dependency. Flemish practitioners believe that dealing with dependent alcohol users is a task for specialised services. Hazardous alcohol use does not constitute an easily demonstrable “disease entity” and GPs have some difficulty dealing with deviant behaviour when disease is still absent.

On the one hand, the suggested early identification is welcomed as a strategy to deal with alcohol before major problems occur. The family support role of general practitioners is seen as an advantage of GPs over specialists in dealing with alcohol counseling. On the other hand, use of screening questionnaires differs fundamentally from the curative approach GPs are trained for. GPs who took part in the WHO Phase III study recommended initial training in local QA groups followed by ongoing support for implementation.

It was concluded that any promotional strategy towards Flemish GPs should stress:

- the clear distinction between hazardous drinking, harmful alcohol use and dependency;

- allowing cumulative positive experiences with new tools to promote an approach linked to the medical model highlighting the negative effects of alcohol misuse as a cause of disease;
- acknowledging the time and psychological burdens facing GPs involved in dealing with patients and families with alcohol problems and providing peer group support for this;
- providing an official support strategy at national and local levels for reducing advertising and decreasing the accessibility of alcohol.

Delphi study

Based on the problems identified in focus groups, a Delphi study was carried out from April to June 1999 to develop a consensus on collaboration between primary care and mental health care¹⁷.

The consensus statement considers the role of the GP in Flanders to:

- act as a central key person due to easy accessibility
- provide motivating and supporting interpersonal counseling
- refer complicated patients (defined in terms of comorbidity) and dependent patients
- assess the fulfilment of an agreed and developed therapeutic plan
- arrange hospitalisation when required and check for compliance after release
- provide biomedical aftercare
- monitor relapse

To take the role as coordinator of care for alcohol problems, GPs need to develop a better knowledge of social services.

Pretesting quality assurance in local QA groups

These findings were integrated into an experimental package of 3 sessions for local quality assurance groups and CME. The sessions provide an introduction to forms of alcohol use and EIBI (Session 1), discussion of experiences with EIBI and a more comprehensive motivational exercise related to different stages for change (Session 2) and a follow-up and discussion about collaboration with mental health care (Session 3). This approach was tested in 13 local groups of GPs (supported by an unconditional grant by Merck, formerly LIPHA) and some undergraduate and vocational training sessions¹⁷. This appeared to be too lengthy and we have decided to reduce the sessions to two at the most. Materials for AUDIT and short advice cards were adapted from the original Drink-less package to include new ideas about GP involvement with dependent drinkers and reduced, more sophisticated strategies. A similar programme was developed for tobacco.

Additionally training of local prevention delegates and QA-group facilitators was tested in a joint effort between WVVH and the health district prevention authority, called 'Centrumlogo', responsible for a population of 320.000 people living north-east of the Brussels capital region. Although this was embedded in an international conference with Phase IV collaborators (October 2001), it did not provide the expected stimulus for interest among LOGO workers nor QA groups in training for health behaviour change (tobacco and alcohol). This may be partly explained by the English language training sessions, partly because only tobacco has been officially retained as a health target for health promotion teams.

9.3.2. Embedding EIBI within the strategy of the Scientific Society of Flemish GPs

A problem occurring as a result of the origin of our project outside the Scientific Society was the testing of a quality assurance package and materials before the development of an officially authorised recommendation. Development of a Flemish recommendation was started according to the usual policy of the Scientific Society of Flemish GPs (Task Group Prevention of WVVH). A recent study⁹ indicated the usefulness of reduced questionnaires for screening. However, the evidence-base for counselling after such a questionnaire is not well-established. Discussion of the state of the art within the Task Group led to the decision to develop this simplified screening and advice strategy integrated in a more comprehensive view of behavioural change. A simplified screening procedure is now proposed for evaluation and a new working group has been created within the Scientific Society to support GP promotion of behavioural change (Working Group on Behavioural Change, WVVH). This EIBI approach will be embedded into a 4-year strategy developed by this working group based on an “ABC” philosophy¹⁸. The three main clinical approaches proposed for health behaviour change are:

- A: Anamnesis - ‘ask’ and ‘assess alcohol use’
- B: Begeleiding (guidance) - ‘advice’, ‘agree’ about targets and ‘assist’ according to stage of change
- C. Continuity of care – record-keeping or ‘annotate’ and ‘assure follow-up’

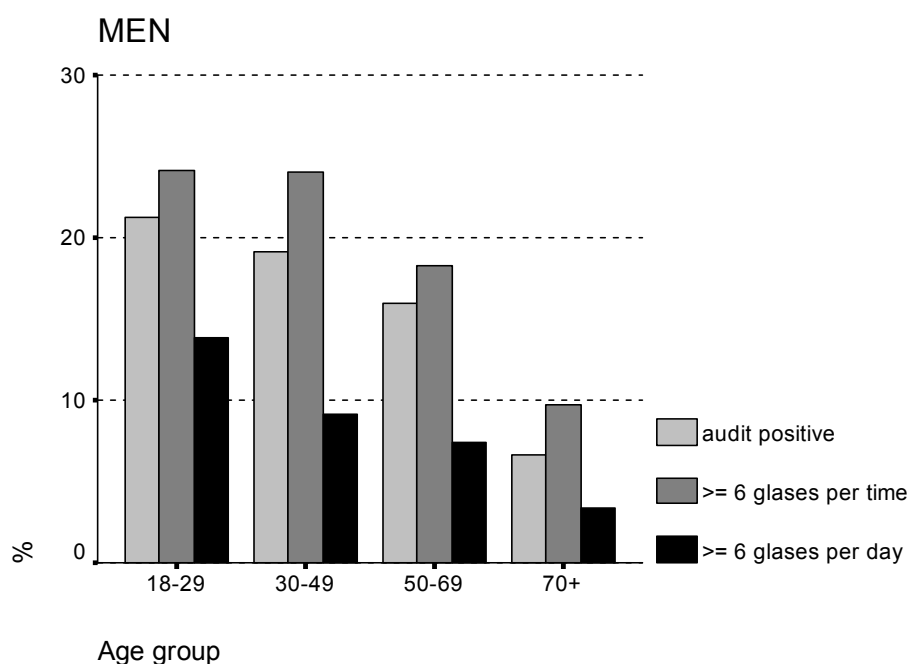
7.3.3. Embedding the primary care-oriented action into community health promotion

Community survey

To promote discussion with local municipalities on health promotion policy, a population survey was developed in Centrumlogo (Flemish Brabant), one of the LOGOs mentioned above.

This survey was designed to test the feasibility of including AUDIT questions in a general population survey. Figure 9.1 compares the results of regular health survey measures in Belgium for problematic alcohol use with measures based on the AUDIT questions.

FIGURE 9.1
Comparison of audit results for men to regularly used measures according to health survey in Centrumlogo (May 2000)



Cases weighted by municipality and 5 years age groups

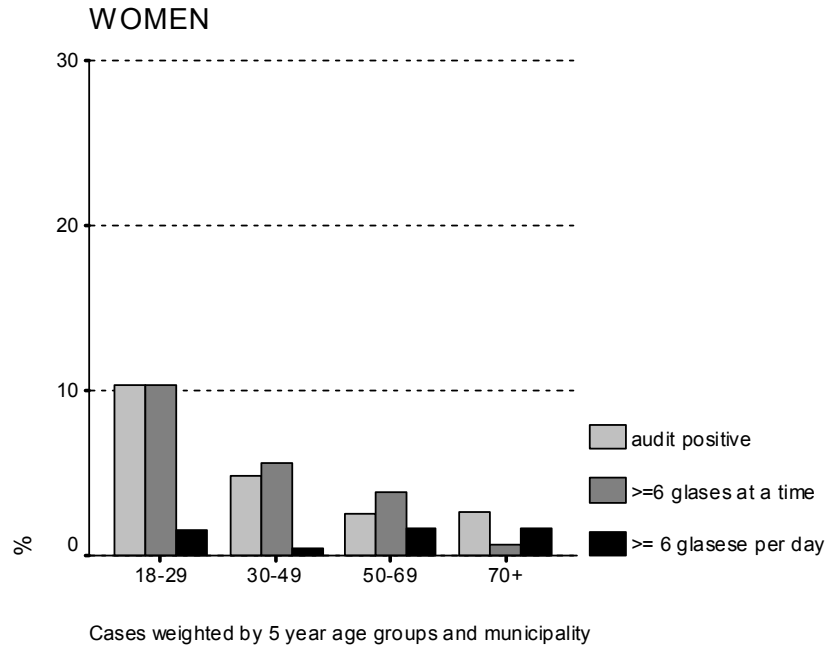


FIGURE 9.1 ABOUT HERE

Questions from a reduced psychosocial well-being scale¹⁹ were added to the health survey. Results allowed us to exclude this questionnaire as a pre-screening test for detection of mental health problems, including alcohol as illustrated in Table 9.2.

TABLE 9.2
Comparison of AUDIT results and Depcare Well-being scores

Audit results		Depcare Wellbeing score		
		bad	good	
normal alcohol use	n=	52	806	858
	%	81,3	87,1	
hazardous use	n=	7	85	92
	%	10,9	9,2	
harmfull use	n=	5	34	39
	%	7,8	3,7	
Total		n= 64	925	989

PPV= 18,6 NPV= 12,9 sens=9,2 spec=6,1

Differences between municipalities in alcohol use were discussed with interested local boards. The attention of regional GP representatives was directed to the low involvement of practitioners and other primary health care workers in preventive advice for alcohol (Figure 9.2).

FIGURE 9.2
Percentage of drinkers counseled in primary health care in Centrumlogo about alcohol
according to results on AUDIT questionnaire (Y-axis) included in health survey.

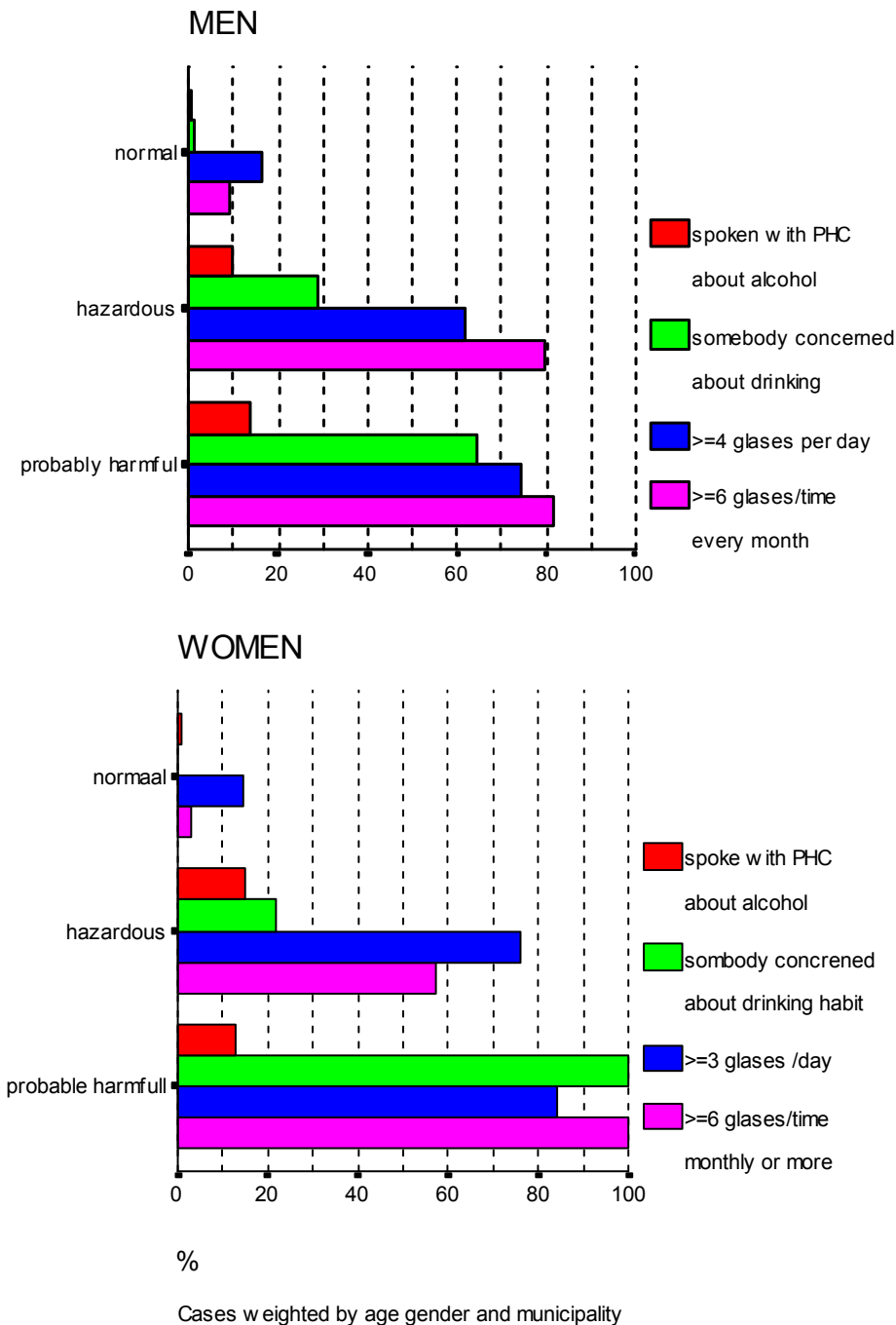


FIGURE 9.2 ABOUT HERE

These results were submitted to local GP representatives, municipality discussion groups and the so-called ‘Provincial Prevention Platform on Drugs’ (co-ordination the work of local prevention workers on alcohol and drug issues). A number of municipalities decided to run

specific actions on alcohol and tobacco in 2003. Furthermore, data from the survey contributed to the establishment of an official provincial strategy towards alcohol misuse in the adult population.

9.4. Communications Strategy

At the end of 2002 a working group was created to develop a population communications strategy directed towards the adult population, in collaboration with municipality workers in the province of Flemish Brabant. Four key messages were retained:

- Safe use for whole population (folder, poster, gadget for measurement of own consumption);
- Referring and discussing problems related to alcohol in primary and mental care. The same folder and poster will be used and training is provided to a wide range of primary care workers. Trainees include general practitioner co-ordinators of local QA groups, health care and social welfare workers integrated into collaborative groups for home care, the so-called “SITS” (collaborative groups for home care: nurses and social workers, pharmacists, physiotherapists, policemen). Training was provided by mental health care prevention workers to such groups in 2004-2005 in a number of pilot training groups for motivational approaches;
- The promotion of the role model or exemplary role of specific groups such as parents, teachers, GPs, police etc.;
- Countering social pressure to drink.

The province of Flemish Brabant will produce all needed materials and the communication is scheduled to start at the end of 2005 with new promotion of training in QA groups of GPs and home-care staff. Additionally, materials will be distributed to all participants and all municipalities in the province will be approached and invited to join. A number of municipalities have agreed to pilot the strategy (Tienen, Dilbeek, Vilvoorde, Kraainem and Wezembeek). Several of these municipalities usually run an information campaign about safe use linked to the so-called ‘BOB campaign’, a successful annual campaign around Christmas with road controls for the prevention of drink driving.

The messages now initiated will indicate that safe use is always necessary. Other messages will be used to sustain public attention and activate the campaign.

Finally, the Flemish Association against Alcohol and Drug Problems (VAD) will run a new nationwide (Flemish) communications policy aimed at adult safe use which will start at the end 2005 and will be launched together with the provincial communication strategy described above. This information policy was prepared during an action year 2004 dealing mainly with the relationships between sport and alcohol, and pregnancy and alcohol. It is the last step in a 4-year plan to run a public alcohol campaign which first targets youth and then adds adult alcohol use to the messages at the end.

9.5. Alliance Building

9.5.1. Integration of primary care actions for hazardous alcohol use into drug policy

A report on the WHO Phase III project together with a new proposal was sent in 1999 to the Minister of Health for the Flemish Community, with a request for support for a demonstration project. This was not accepted. It was hoped that tobacco as a health target would be replaced by health behaviour change in 2003 for the new 5-year programme but this was not the case.

A proposal was submitted in 2000 jointly with VAD to the Secretariat for Scientific Research (Department of the Prime Minister) for a cost-benefit analysis of reimbursement to GPs. This was not successful due to competing priorities, although it was well scored.

We tried to establish a joint policy document with VAD for the federal state during elections in April 2003, in collaboration with French-speaking Belgian colleagues. In the end the document was not signed and was withdrawn by VAD due to their aim of obtaining support for a comprehensive drug and alcohol policy and not a specific alcohol plan.

We conclude that a further major effort is needed to set alcohol as a specific target for health promotion on the political agenda. As part of the PHEPA project we succeeded in two successful large-scale national meetings in reaching agreement on a consensus statement on the priority of an alcohol policy with a large number of French and Flemish speaking bodies (NGOs, public officers of regional governments, provincial delegates, scientific institute delegates). Screening and brief intervention in primary care was defined as one of the major cornerstones for such a policy in conjunction with local community networking and actions embedded in a large scale public information policy.

One consequence of this country team work was the alliance building with the sister organisation SSMG, extending customisation efforts for training to the French-speaking GP community in Belgium (see Appendix 1).

9.5.2. Guideline development and integration into the policy of WVVH Taskforce Prevention

The collaborative WHO project, including the development of practice tools and the package for quality assurance, preceded the development of a formal guidelines authorised by the official Belgian committee set up for this purpose. The Taskforce Prevention of WVVH required the development of a formal guideline before further implementation in the field. A first version was developed in 1999-2000 by the research team.

In a thesis at one of our major universities⁹, the AUDIT was validated as the best screening instrument for the Flemish-speaking population, using lower cut-off points than normal. However, the study also pointed to the advantages of using simpler screening tests (5-shot, AUDIT-C) as very good alternatives.

Our analysis of Phase III Strand 3 results and focus groups showed that Flemish GPs did indeed request a choice of screening strategies adapted to their own motivations and practice feasibility.

The development of a formal guideline was therefore postponed to allow for adaptation of an early identification strategy and to coincide with a review of Dutch Recommendations on Alcohol²⁰ planned at the beginning of 2004. As a result, development of the new Flemish guideline will run in parallel with the guideline development in the PHEPA project which the WVVH joined in 2003. A new version of the Flemish draft guidelines was submitted to the Task Force on Guideline Development of the Flemish Scientific Society in April 2005 and has now been adapted according to their comments. Pre-testing in local quality groups of GPs is planned for the beginning 2006.

It has been agreed with WVVH to enter the recommendation for alcohol to the formal authorisation committee (CEBAM) in March 2006 at the latest. This committee, situated at the Catholic University of Leuven, verifies the quality and evidence-base of all recommendations for good practice in primary care. This allows us to run the planned demonstration project in a local area in 2006-2007 using quality assurance to test the draft of the recommendations and before widespread use in Flanders.

9.5.3. Introducing adult alcohol use as a topic for local health promotion activities

Presentation of the strategy to selected Health Promotion Boards, called LOGO teams and created recently in Flanders (Autumn 1999), did not lead to a formal collaboration. Joint training involving foreign experts was set up between WVVH and Centrumlogo and open to other LOGO teams in October 2000.

Results of the health survey carried out by Centrumlogo were published in a widely distributed newsletter to all possible workers in health promotion, including municipality representatives in this LOGO. Data were presented to a number of these municipalities in detail and some chose alcohol policy as their priority for 2003.

Alcohol was also proposed as a local target to be added to the five Flemish targets for health promotion in 2003 for the whole Centrumlogo. However, the Health Promotion Board changed and expanded this choice in a submission for financial support to the Province of Flemish Brabant to drug addiction policy (including tobacco, alcohol and drugs). We disagreed with this procedure and withdrew from the LOGO team. A limited number of the 17 communities still planned a specific alcohol policy. Their efforts will be reiterated through the launch of the provincial policy on alcohol at the end of 2005. Indeed, a number of specifically interested prevention workers continued to develop an alcohol communications strategy, co-ordinated by the Provincial Platform on Drug Use for the whole province and some municipalities, and now plan a community information strategy which addresses municipalities as a specific target for action.

9.6. Further Planning

9.6.1. Development of national and regional alcohol policies

Primary care-oriented actions embedded in a formal policy

As part of the PHEPHA project, the research group of WVVH held 3 major meetings to sensitise local authorities and scientific bodies for jointly designing a specific Alcohol Action Plan. This should enhance the involvement of the different levels of responsibility in Flanders and Belgium more generally.

- i.* A meeting was organised by the country-based PHEPHA team (VAD, Province Flemish Brabant, WVVH, VVGG, SSMG) at the start of 2004 to provide the scientific evidence on safe use, the effectiveness of EIBI and task definitions in primary and mental health care. The debate defined better the complementarity of an alcohol policy at provincial, linguistic and federal levels and tried to put alcohol higher on the political agenda for the Flemish Elections in June 2004.
- ii.* A further meeting was proposed to the Working Party for Alcohol of the provincial drug platform of Flemish Brabant in 2004 to involve local municipalities and LOGOs in launching the key messages defined for the provincial communications strategy on alcohol. In this approach mental health care will be specifically involved in sensitisation

of intermediate health workers (pharmacists, nurses, home care, physiotherapists, school medicine, child medicine, social services etc.). This will allow us to define the subsidiarity of involvement of local prevention and community workers in Flanders. The launch of this plan is scheduled for November 2005.

- iii. Finally, a second PHEPHA meeting took place in November 2004, paying particular attention to the possibilities for an enhanced federal policy on EIBI in primary care.

The main effort of the WVVH research team from 2000 to 2005 was to try to orient different actors towards a common goal of developing a local alcohol action. The procedure followed was “reflective participation” in health promotion planning at provincial, LOGO and municipality levels.

In the meantime, active participation in local mental health projects and dialogue with prevention teams made the team known in the province of Flemish Brabant and more recently at federal level. (We worked successively on: detecting alcohol misuse in primary care; dealing with dependence through GPs in collaboration with mental health care; developing a consensus on dealing with violence and showing its relationship to alcohol abuse). The core of the original project team for WHO Phases III and IV is now working on a project on depression and suicide and was involved in a working group of a Flemish health conference on the relationship between alcohol and drug abuse with depression and suicide). Alcohol has been integrated as one of the 5 topics in a comprehensive pilot programme which is aiming at continuing professional development in mental health (i.e. training coupled with quality assurance). As a result, local quality assurance groups of GPs are already being trained in EIBI on a regular basis at their own request.

The workplace as a complementary target

An active policy towards companies and factories has been piloted mainly through mental health centre collaborators and prevention workers and coordinated at VAD which published a guidebook for such a strategy at the end of 2002. In this philosophy, the municipality itself is seen as an important company. It would be possible to include this in the local strategy if specific financial support can be obtained.

We also considered the development of a parallel policy for EIBI at the workplace level. This has not been realised owing to an ongoing debate on reorientation of the formal policy of the Ministry of the Flemish Community towards prevention in the workplace. However, a recent study on the impact of alcohol on work may reactivate this debate in Flanders²¹.

It should be noted that this workplace approach is part of a more comprehensive community action policy called *Schakel Jezelf In* launched in 1998 by VAD for both alcohol and drug problems. Until recently this policy has given priority to strategies for youth (school-based evaluations and school and youth organisation-based actions) together with the workplace policy. It is well supported by the networks of provincially coordinated municipality workers for prevention on alcohol and drugs use, partly working from Centres of Mental Health and partly from a variety of municipality departments or social services

Provincial action plan for drugs as a basis for further strategies

In 2003 the Province of Flemish Brabant made safe alcohol use among adults one of its priorities for prevention policy. In this province a number of municipalities are considering development of alcohol action plans, or more comprehensive drug strategies with special attention to alcohol, in municipalities with special prevention workers coordinated by the Provincial Platform on Drugs or as a result of coordination efforts in Centrumlogo. In these municipalities WVVH has suggested supporting quality assurance for GPs according to the model developed and customised by the Research Group of WVVH in collaboration with WHO Phase IV. The promotion of this could be left to LOGOs and municipality working groups supported by WVVH and Centres of Mental Health care. Municipality actions are also supported by regional coordinators of prevention workers based in the Mental Health Care Centres.

Such efforts towards an adult alcohol policy should be co-ordinated in a stepwise planned and complementary programme. This can be pursued at provincial level. A remaining difficulty is the diverse aims of all actors in this process. The provincial initiative in Flemish Brabant was planned as a pilot phase upon which the later VAD action can build nationally. Delay in development of the population communication strategy postponed the provincial programme however to coincide with the Flemish VAD information action towards adult alcohol use. It has the additional advantage of directly addressing local communities.

9.6.2. Proposal for a demonstration project

As no specific funds were available for a formal demonstration project in 2004, the project will be embedded into the actual planning of the different groups involved. It will thus consist of:

- Guideline submission and associated quality assurance for GPs in Flemish Brabant by the Task Group Prevention WVVH in collaboration with the Province of Flemish Brabant;
- Reframing understandings of other health care and social welfare workers regionally through Centres of Mental Health in the Province of Flemish Brabant;
- Results measured for costs and effects using existing data sources (sentinel network of GP, police data, national health survey) by comparing dissemination of EIBI in the strategy followed in Flemish Brabant with the national strategy of guideline dissemination and the VAD communication policy in Flanders as a whole.

The development of indicators for good GP preventive performance has been recently undertaken by the WVVH Task Group Prevention and should allow us to collect baseline and follow-up data on adequate GP preventive care in the future, including EIBI.

Other issues, in particular cost-utility evaluation, will depend on further financial resources.

9.6.3. Customising alcohol measures for evaluation purposes

Data collection on alcohol-related problems was proposed to the sentinel GP network in 2003. Instead, however, a register of intentional violence was started in collaboration with the Research Group of WVVH. This includes particular attention to the relationship between violence and alcohol abuse. The pilot register was completed in 2001 and the formal register which started in 2002 ran till 2004. During the program 2004-2005 no data on alcohol will be collected in this registry but from 2007 onwards crisis interventions by GPs, including alcohol intoxications and social problems related to alcohol, will be prepared by our Institute in collaboration with the Institute of Public Health. In the meanwhile a web-based case

management tool will be lunched in 2006 and will be linked to problem identification when dealing with psychosocial problems in primary care.

Road accidents are regularly registered at police and federal level and followed up annually. Data were analysed by Centrumlogo and sent to 17 municipalities in Flemish Brabant, linked to survey results, to draw their attention to alcohol as a major health topic. These data are readily available at national level and can be further followed up without problems.

FIGURE 9.3
Distribution among local municipalities of the percentage (X-axis)
of road accidents under influence of alcohol in Belgium.
(Data kindly provided by National Institute for Road Safety, 2004)

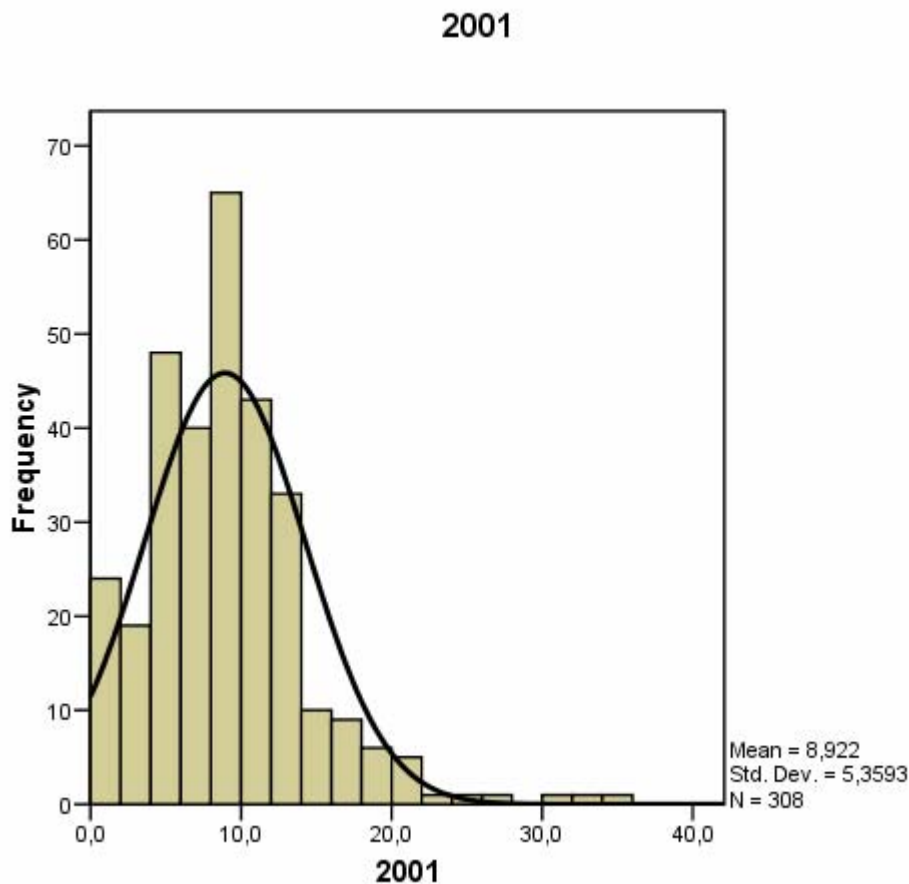


FIGURE 9.3 ABOUT HERE

Health promotion surveys were carried out in 1997 and 2001 and were repeated in 2004. Questions measure problematic alcohol use in the Belgian population, such as drinking above 6 glasses a day. We have proposed a slightly modified approach based on the results of the Centrumlogo survey.

A procedure has now been initiated by the Task Force Prevention of WVVH to develop a consensus on Flemish indicators for primary preventive care. We favoured the inclusion of alcohol-related process measures. Alcohol-related measures were not retained by the expert review committee for large scale use. The proposed parameters will be used, however, in the demonstration project.

9.7. Funding

The WVVH/VAD project proposal could not be developed as a project in its own right, although several attempts were made to raise funds for a cost utility analysis and the demonstration project. (The last proposal made to the National Knowledge Centre in May 2005 was refused in October 2005 because of ‘too many competing other offers’.) Most work was therefore carried out on a voluntary basis by the research team of WVVH involved in other projects, as highlighted above.

Specific project money was linked to the WHO Phase III study in 1998 (e.g., testing the Drink-less programme) and is available for guideline development (Flemish Community sponsorship by Task Force Prevention WVVH). The philosophy followed by the research group aims to integrate EIBI into regular local and regional prevention plans for which budgets are readily available in Flanders. Supportive scientific activities were financed by the WVVH Research Department or sponsored through participation in international projects (first ECATOD, than PHEPHA).

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- Regional health survey in 2000 (Centrumlogo)
- Community action support: municipalities and Province of Flemish Brabant
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APPENDIX 9.1 French-speaking Customisation Programme

Lead organisation:

Société Scientifique de Médecine Générale (SSMG)

Coordinator:

Bernard Dor, MD for the “SSMG Commission Alcoology”.

Start date: 1999

Introduction:

To study the feasibility of extending experiences of the Flemish Phase III and IV into the French-speaking community, the SSMG (Scientific Society of French-speaking General Practitioners) started a project in 1998.

The overall aim of the French-speaking working group on alcohol of the SSMG is to promote integration of screening and brief interventions for hazardous and harmful alcohol use into primary health care in the French-speaking community. A customisation and feasibility study of training and screening was performed among 40 GPs and 500 additionally trained physicians.

Customisation of training strategy in the French region:

Customisation was performed by organising and evaluating results of the training of GPs for screening for hazardous and harmful drinkers and in the brief interventions techniques (EIBI).

This training took part in SSMG’s regular meetings on continuing medical education, with no initial intention in 1998 to extend this into a broader policy of continuing education to all primary care workers, nor by including a “community enhancement” dimension.

This project in 1998 was the first attempt to integrate dealing with hazardous and harmful drinking in the French-speaking community. Earlier initiatives were related only to dealing with alcohol addiction, and mainly based on hospital or the specialised sector.

Feasibility of screening by French speaking GP - the PROBEX Study:

In 1998 an enquiry was carried out among 300 GPs to study their view on dealing with alcohol problems.

In 1999 the SSMG joined an action research project (PROBEX) in partnership with the School for Public Health of the University of Liège (Prof. Gosset) and with financial support from the Belgian French Community Government and the regional government of the Walloon Region. This action research project was carried out with nearly 40 general practitioners with following aims:

- to study and evaluate the relevance and acceptability of a number of intervention tools put at the disposal of the participating doctors in order
- to disseminate the tools as well as
- to evaluate the impact of the training of GPs in the effective management of this category of drinkers.

No such study existed in French-speaking Belgium at that time.

The training module was adapted to the needs of the participating doctors. The tools developed by the French Phase IV team were used and adapted to the needs of Belgian French-speaking GPs after evaluation of relevance and acceptability by a small experimental group of GPs.

The above-mentioned political authorities gave their financial support to the PROBEX project which was planned over a period of 39 months, with an end initially projected for the Autumn of 2003 but eventually deferred to the Spring of 2004.

Training of the PROBEX practitioners was performed in November 2001 (two days).

Evaluation: Data were collected on the tools, doctors and patients included from November 2001 to September 2003.

One focus group with 10 PROBEX fellow-practitioners was organised in the Spring of 2002. It showed that there was little perceived need, motivation and preparation among GPs in the practice for networking around alcohol; in particular, the main obstacle was lack of financial valorisation of preventive care in Belgium.

Probex results:

After 18+ months (September 2003) 2096 patients had been recorded by trained GP and had completed the AUDIT. Of these 421 (20.1%) proved positive. At 18 months a follow-up of 268 was available. Of these, 32 % had reduced their consumption; the doctor-patient relationship was improved in 16% of cases; global health, as estimated by the GP, was improved in 22% of cases, stable in 25% of cases and deteriorated in only 10%.

Customisation of materials:

PROBEX's results allowed the improvement of the quality of continuing training aimed at disseminating EIBI. For instance, among the documents (booklets and support sheets) offered to pilot practitioners, some are far more utilised than others; diagnostic categories will be more clearly defined and promoted. In the course of the research many practitioners persisted in considering hazardous drinkers as the main problem compared to dependent drinkers.

Extension of training through SSMG's continuing training groups (dodecagroups and workshops). In 2003 more than 500 Belgian French-speaking GPs (members of the SSMG), meeting in small groups of 15 to 20 general practitioners each, were trained using the developed educational module ("quality assurance package") (CD-ROM; paper documents; down-loadable on SSMG's website : www.ssmg.be).

Further planning:

At the beginning of 2004 SSMG continued the distribution programme started in 2003 to adapt it according to experience in the PROBEX-study and to integrate those efforts into a broader concept with community implications. Collaboration between WVVH and SSMG work is now activated through joint participation in the PHEPA network supported by the European Union.

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