Optimizing Delivery of Health care INterventions

ODHIN ASSESSMENT TOOL –REPORT

A description of the available services for the management of hazardous and harmful alcohol consumption

Edited by:
Claudia Gandin and Emanuele Scafato
Istituto Superiore di Sanità (ISS)
Rome, Italy
2013

This document has been prepared by the authors on behalf of the ODHIN Work Package WP6 "Assessment tool" network and is a result of the ODHIN project.
The ODHIN project has been financed by the European Commission's –Seventh Framework Programme - HEALTH.2010.3.1-1 (Better understanding of dissemination and implementation strategies).
For more information and the electronic version of the document, see: www.odhinproject.eu/

ODHIN WP6 PARTNERS

Emanuele Scafato, Claudia Gandin
Istituto Superiore di Sanità (ISS)
Rome, Italy

Antoni Gual, Silvia Matrai, Jillian Reynolds
Fundacio Privada Clinic per a la Recerca Biomedica (FCRB) / Hospital Clinico Provincial de Barcelona (HCPB), Spain

Miranda Laurant, Myrna Keurhorst
Radboud University Nijmegen Medical Centre (RUNMC)
The Netherlands

Pierluigi Struzzo
Centro Regionale di Formazione per l'Area delle Cure Primarie (Ceformed)
Italy

Eileen Kaner, Dorothy Newbury Birch, Peter Anderson
Newcastle University, Institute of Health and Society (NU)
Newcastle, United Kingdom

Colin Drummond, Paolo De Luca, Paul Cassidy
King's College London (KCL)
London, United Kingdom

Fredrik Spak
University of Gothenburg (UGOT)
Gothenburg, Sweden

Preben Bendtsen
Linkoping University (LIU)
Sweden

Joan Colom, Lidia Segura
Department de salut – Generalitat de Catalunya (GENCAT)
Barcelona, Spain

Brzozka Krzysztof
Polish State Agency for Prevention of Alcohol-related Problems (PARPA)
Poland

Marko Kolsek
Univerza V Ljubljani (UL)
Slovenia

Cristina Ribeiro

Istituto da droga e da toxicodependencia (IDT)
Portugal

Van Schayck Onno, Gaby Ronda
Universiteit Maastricht (UM)
The Netherlands

Hana Sovinova
Statni Zdravotni Ustav (SZU)
Czech Republic

Artur Mierzecki
Pomeranian Medical University in Szczecin (PAM)
Poland

ACKNOWLEDGEMENTS

The authors wish to acknowledge the support in the document of experts from other participating countries:

Capouet Mathieu
Tobacco and alcohol political expert
FPS Public health
Bruxelles, Belgium

Lampros Samartzis
Cyprus Mental Health Services, Athalassa Hospital
Nicosia, Cyprus

Marina Kuzman
Croatian National Institute of Public Health
Service for Youth Health Care and Drug Addiction Prevention
Zagreb, Croatia

Triinu Täht
Ministry of Social Affairs
Tallinn, Estonia

Maris Jesse
National Institute for Health Development
Tallinn, Estonia

Iisi Saame
Department of Public Health
Tartu University

Tartu, Estonia

Sandra Dybowski
Federal Ministry of Health
Bonn, Germany

Aija Pelne
The Center for Disease Prevention and Control of Latvia
Addiction disease risk analysis unit
Riga, Latvia

Manuel Mangani
Alcohol Services, Sedqa
Malta

Monika Rueegg
Federal Department of Home Affairs (DHA)
Federal Office of Public Health (FOPH)
Berne, Switzerland

Ioanna Siamou
Greek REITOX Focal Point
Athens, Greece

Melpomeni Malliori
Greek Organisation against Drugs (OKANA)
Athens, Greece

Ismo Tuominen, Helena Vorma
Ministry of Social Affairs and Health
Finland

Pia Makela
National Health Institute
Finland

Liam McCormack
Health Promotion Unit
Dept of Health
Ireland

Ruth Armstrong
Alcohol Health Service Executive (HSE)
Ireland

Joe Barry

Department of Public Health and Primary Care, Trinity College Centre for Health Sciences
Ireland

Rafn M Jonsson
Directorate of Health
Reykjavik, Iceland

Tomus Ioana
Alianta pentru Lupta Impotriva Alcoolismului si Toxicomaniilor (ALIAT)
Bucarest, Romania

Pavlina Vaskova
Psychiatric Hospital "Skopje"
Skopje, FYROM

INDEX

INTRODUCTION

Alcohol is the world's third largest risk factor for disease burden, and the second largest in Europe. In the EU in 2004, almost 95,000 men and more than 25,000 women, aged 15 to 64, died of alcohol-attributable causes (total 120,000). This means that 1 in every 7 deaths in men and 1 in every 13 deaths in women in the group aged 15–64 years is related to alcohol consumption (1).

Harmful drinking, recognized by the World Health Organization (WHO) as a specific disorder, is defined as 'a pattern of drinking that causes damage to health, either physical (such as hepatitis) or mental' (e.g. episodes of depressive disorder), while hazardous drinking (not included as a diagnostic term in the 10 edition of the International Classification of Diseases-ICD-10), despite the absence of any current disorder in the individual user, is an advisory term recommended by WHO that refers to regular average patterns of consumption of public health significance (2), to a consumption of more than 40g alcohol a day for women and more than 60g a day for men (3) that is likely to result in harm should present drinking habits persist.

Over the past decade there have been numerous European initiatives on alcohol (European Commission-EC, 2006; WHO, Regional Office for Europe, 2011) (4-5) supported globally by the *"Global strategy to reduce the harmful use of alcohol"* (WHO, 2010) (6) and the *"Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Disease 2008-2013"* (WHO, 2008) (7). The communication of the Commission of the European Communities in 2006 (4) has been the first specific strategy aimed at reducing alcohol-related harm in Europe before the end of 2012, highlighting the need to put in place legislation and policies related to Hazardous and Harmful Alcohol Consumption (HHAC), to allocate resources to identify and treat HHAC in Primary Health Care (PHC) and to provide training health care professionals on Early Identification and Brief Intervention (EIBI).

In daily professional practice, PHC operators frequently encountered patients with HHAC. Of utmost importance for programs of EIBI is the fact that individuals who have not yet developed alcohol dependence can reduce or stop drinking receiving adequate assistance, and ensuring appropriate support can prevent the onset of alcohol-related diseases; once the addiction has been established, to deal with alcohol consumption is more difficult and may require specialist treatment. Thus, EIBI for HHAC in PHC is an opportunity to communicate to patients the risks and propose ways of consumption compatible with a state of good health. There is considerable evidence that EIBI programs are effective and cost-effective in reducing alcohol consumption either in PHC than in other health settings by an extensive international literature confirmed by a recent Cochrane review (8). However, many PHC operators are reluctant to identify and advise patients in relation to alcohol consumption and such interventions have rarely been integrated into routine clinical practice. Among the reasons most often cited are lack of time, inadequate training, fear of antagonizing patients, the perceived incompatibility of EIBI with PHC, and the belief that those who are dependent on alcohol do not respond to interventions. Thus, the challenge is to integrate these interventions into professionals' daily clinical work.

According to the WHO strategies to reduce HHAC, adequate mechanisms for regular assessment, reporting and evaluation are necessary for monitoring progress at different levels, and special efforts are needed to formulate a comprehensive healthcare sector response to alcohol-related problems, with particular emphasis on PHC interventions.

In the Framework of the European ODHIN Project (Optimizing Delivery of Health Care Interventions), an assessment tool to test the implementation and the extent of EIBIs for HHAC throughout PHC settings has been developed to provide a measurement of services for managing HHAC (current status), identifying areas where services require development or strengthening (limitations or barriers in the main health care system domains); to provide a mechanism for monitoring service provision over time and to allow sharing of information and examples of good practices between countries.

METHODOLOGY

2.1. Development of the questionnaire

The questionnaire is an adaptation of a tool to assess the services for the management of HHAC in the PHC sector, developed by Peter Anderson in 2004 with the partners of the Primary Health Care European Project on Alcohol (PHEPA) (9). The ODHIN WP6 "assessment tool" has been conceived as an instrument for the identification of the state of the art, gaps and areas in the country that need further work and strengthening; to monitor the adequacy of brief intervention programmes for HHAC in order to provide recommendations to improve and optimize delivery of health care interventions.

Particularly, the ODHIN "assessment tool" collects elements enabling the research group:

- to provide a measurement of services for managing HHAC (current status), identifying areas where services require development or strengthening (limitations or barriers in the main health care system domains);
- to provide a mechanism for monitoring service provision over time;
- to allow sharing of information and examples of practice between countries;
- to provide a mechanism for coalitions or partnerships to discuss and share view on services for managing HHAC (if not available).

The ODHIN research group started the activities on the identification of the best fitting format for an effective description of the variables that allow to provide a good estimate of the implementation and the extent of EIBI for HHAC throughout PHC settings. The collection of information in the ODHIN WP6 "assessment tool" includes all the elements that are required for effective dissemination of brief interventions within a health care systems' perspective, including the domains of organization of health care, support for providing brief interventions, availability of brief interventions, provision of effective brief interventions by health care providers and uptake of effective brief interventions by the general population.

For the development of the questionnaire, the main tasks have been the following:

- the revision of the PHEPA questionnaire and the description of the final ODHIN assessment tool from consensus building involving all ODHIN WP6 partners;
- the translation of the questionnaire (where judged appropriate);
- the identification of key informants and stakeholders.

The ODHIN "assessment tool" team includes 15 European scientific partners from 9 countries (Czech Republic, Italy, Portugal, Slovenia, England, Poland, Sweden and the Netherlands) and nearby 25 scientists. Furthermore, a contact has been also planned with the project leaders of selected EU Projects and Networks on alcohol such as AMPHORA, PHEPA II, VINTAGE and with WHO national counterpart European experts on alcohol in order to involve other European countries other than the ODHIN partners, contributing to improve the results. Thus, other 14 European countries (and nearby 20 scientists) shared their national qualified experience with the ODHIN collaborating countries reaching a total 23 European countries collected data.

The revision of the PHEPA "assessment tool" by the ODHIN WP6 research team started during the ODHIN kick off meeting held in Barcelona on February 2011. After that, each partner was provided, by email, with a copy of the draft tool discussed in Barcelona and they were asked to read the new draft, to consider each item in terms of its apparent relevance and comprehensibility, and to provide their views and feedback on the overall content and organisation of the assessment tool. A fruitful and interesting discussion concerning the assessment tool was followed up by various email contacts between the ODHIN WP6 partners and the WP6 leaders. The core version of the PHEPA questionnaire has been supplemented with questions specific for the culture or system of each country or of interest to the participating partners. Questions considered useful or relevant for the participating partners have been added maintaining the original frame and the progressive number of questions. The final version of the questionnaire has been approved by all partners. In some cases (Czech Republic, Slovenia and Portugal) it has been judged appropriate to translate into the native language of the partner.

2.2. Description of the questionnaire

The ODHIN WP6 Assessment Tool has been conceived as a semi-structured questionnaire. It analyses 24 questions distributed across 7 key sections, covering the following topics:

1. Presence of a country coalition or partnership.
2. Community action and media education.
3. Health care services and infrastructure for harmful / hazardous alcohol use management (integrated health care system, structures for quality of care, research and knowledge for health, health care policies and strategies, structures to manage the implementation of treatment within health services, and funding health service and allocating resources).
4. Support for treatment provision (screening and quality assessment systems, protocols and guidelines, reimbursement for health care providers).
5. Intervention and treatment (availability and accessibility).
6. Health care providers (clinical accountability and treatment provision).
7. Health care users (knowledge and help seeking behaviour).

2.3. Data collection

The ODHIN participating countries were requested to complete the questionnaire and to indicate the source of some data provided, if available, by the end of March 2012. Within each participating countries, it has been suggested to select up to 10 key informants for the specific task activities. Key informants have been selected based on their expertise in the alcohol field, covering a large range of perspective such as general practitioners, scientists working in the field of epidemiology and public health, clinicians from alcohology units, experts from the national society on alcohology and policy makers. It has been suggested that the tool has to be completed by country or regional coalitions or partnerships, playing a central role in supporting the development, the dissemination and the implementation of services for managing HHAC. If no such coalition or partnership exists, it has been suggested to use the opportunity of the ODHIN project to solicit the creation of a collaborating group with its first task to complete the tool.

It has been agreed:

- to send the tool by post (or email) to selected key informants or to complete it through the organization of ad hoc meetings with individual key informants;
- to divide the tool (if necessary) into separate sections to be completed by different key informants according to each different expertise;
- to achieve a national consensus through meetings of coalitions or partnerships for certain questions which require opinion or expert judgment;
- to collect the information from different key informants into only one final questionnaire.

As mentioned before, during this period, a contact has been also activated with the project leaders of selected EU Projects and Networks on alcohol such as AMPHORA, PHEPA II, VINTAGE and with WHO in order to involve other European countries other than the ODHIN partners and contribute to improve the results.

The following 23 European countries participated into the ODHIN assessment tool analysis:

- 9 ODHIN partners (Spain/Catalonia, The Netherlands, Italy, United Kingdom, Sweden, Poland, Slovenia, Portugal, Czech Republic);
- 14 European additional countries (Belgium, Cyprus, Croatia, Estonia, Germany, Latvia, Malta, Switzerland, Greece, Finland, Ireland, Iceland, Romania, and Fyrom -Ex Macedonia).

A preliminary analysis and overview of the collected data was carried out and presented in a ODHIN meeting on the 27th and 28th of September 2012. This first draft of the report is now circulating among all the participants and we are requesting for your feedback.

2.4. Data analysis

The data were introduced in SPSS. Descriptive statistics and graphs were calculated. The information was also reported qualitatively with comments from the partners, which are also reported.

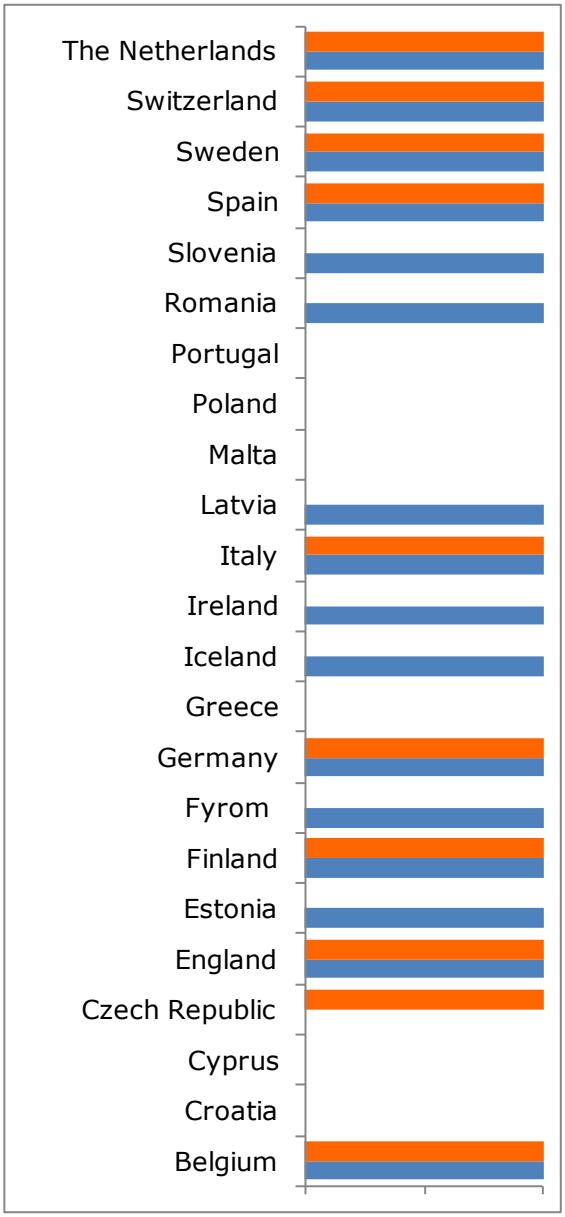
RESULTS

3.1. European overview across 23 countries in 2012

In this section, both a general overview across all the countries, but also the specific situation reported by the partners on their national/regional assessment tool questionnaires (in italics), are reported.

3.1.1. Presence of a country coalition or partnership

In 2012, most of the countries (73.9%) have a country and/or regional coalition for the management of HHAC. Particularly, 16 (69.6%) have a country-wide coalition, while only 47.6% have a region-wide formal or informal coalition or partnership that deals with the management of hazardous and harmful alcohol consumption (Figure 1).



Country coalition (69.6%)
Yes: Belgium, England, Estonia, Finland, Fyrom, Germany, Iceland, Ireland, Italy, Latvia, Romania, Slovenia, Spain/Catalonia, Sweden, Switzerland, The Netherlands.
No: Croatia, Cyprus, Czech Republic, Greece, Poland.
No, but in process of definition: Malta and Portugal.

Regional coalition (47.6%)
Yes: Belgium, Czech Republic, England, Finland, Germany, Italy, Spain/Catalonia, Switzerland, Sweden, The Netherlands.
No: Cyprus, Estonia, Fyrom, Greece, Ireland, Iceland, Latvia, Malta, Poland, Portugal, Romania.
Missing data: Croatia and Slovenia.

Figure 1. Is there a country-wide and a regional-wide formal or informal coalition or partnership that

deals with the management of hazardous and harmful alcohol consumption?

Figures 2 and 3 show the names, year of creation and objectives of the country-wide and regional-wide coalitions respectively.

COUNTRY	NAME	YEAR OF CREATION	AIM OF THE COUNTRY-WIDE COALITION
Belgium	1. On policy level: General Drug Policy Level –GDPC 1. On practitioners level: IDA	1. 2009	1. GDPC: establishing a global and integrated alcohol and drug policy (www.drugpolicy.be); 2. IDA: dissemination of information on research, good practices, overview of available specialised treatment and prevention (www.ida-web.be)
England	Department of Health – Substance Misuse Policy unit		The Department of Health – Substance Misuse Policy unit – is tasked with developing and implementing policies to reduce alcohol consumption including the dissemination and implementation of strategies to reduce hazardous and harmful drinking.
Estonia	Task Force 1 for the Green Book of Alcohol Policy	2011	To design the system of treatment, rehabilitation and counseling.
Finland		2004	The National Institute for Health and Welfare-THL coordinates the National Alcohol Programme activities. The Alcohol Programme was launched by the Government in 2004. A new programme period runs from 2012.
Fyrom	Expert group for alcohol related problems, Ministry of Health	2010	The aim of the coalition is preparing the strategy and action plan for HHAC.
Germany	Die Deutsche Hauptstelle für Suchtfragen - DHS (German Centre for Addiction Issues)	1947	The DHS has the aim of informing people about addiction-related problems, advising them and drawing their attention to support provision. A priority of the work is the development of effective strategies to reduce the harmful consequences of alcohol and illicit drugs. In addition, the DHS member organisations offer dependent people and their families concrete support and help towards self-help. This enables sufferers to find ways out of their dependency. The DHS promotes the constant qualitative development of counselling and treatment for people with addiction problems and is committed to ensuring the availability of such provision.
Iceland	Directorate of Health	2007	The directorate of Health published in the year 2007 clinical guidelines on how to screen and treat alcohol problems in the PHC.

Italy	The coalition has no name but ISS, SIA and AICAT network has been established since 2001 as a steering group mainly orienting the Alcohol Prevention Month, the Alcohol Prevention Day. ISS is the advisory board of the National Health System dealing with the National Alcohol and Health Plan and Strategies issues providing formal advise. ALIA is the recent National Alliance on Alcohol gathering several realities and representatives belonging to the different areas of citizenship, families, scientific societies. 1. Istituto Superiore di Sanità- ISS-CNESPS 2. Società Italiana di Alcologia- SIA 3. Italian Association of Territorial Club alcoholism-AICAT 4 ALIA 5 Italian Collaborating network on Alcohol - ICON	1. 2000 2. 1979 3. 1989 4. 2008 5. 2012	1. ISS – CNESPS: Since year 2000 Population Health Unit (PHU) at the CNESPS has received the governmental mandate to deal with the identification and implementation of strategies aimed at curbing under-age drinking, HHAC preventive programmes providing scientific evidence for the policy decision-makers and for the implementation of the National Alcohol and Health Plan. PHU is the National Focal point, the scientific and technical expert and advisor appointed by the MoH and the Government representative on policy, research, prevention and health promotion on alcohol and alcoholism. On 2007 PHU adapted and implemented the PHEPA programme in Italy; 2. S.I.A.: Italian Society on Alcohology promotes scientific activities as well as preventive programmes, treatment, rehabilitation and epidemiology on alcohol; 3. AICAT: a non-profit social organization to promote and coordinate the activities of the Regional Club alcoholism (CAT), according to the principles of the Social Ecological alcohol-related problems (by Prof. Vladimir Hudolin); 4. ALIA: the alliance devotes attention to the increasing levels of alcohol related harm; propose evidence based solutions to reduce it; influence decision makers to take positive action to address the damage caused by alcohol misuse. It brings together research, social and medical bodies, patient representatives and alcohol-related stakeholders; 5. ICON: The Italian Collaborating network on Alcohol is a formal network created between the ONA-CNESPS, WHO CC for Research on Alcohol and the CARs of Tuscany and Liguria at the ISS deserving attention to the specific workplan of activities agreed between the WHO and the ISS complementing competences and professionalities in the field of epidemiology, prevention, training and treatment.
Ireland	HSE (Health Service Executive)	2005	HSE is the National Organization responsible for providing Health and Personal Social Services for everyone living in the Republic of Ireland.
Latvia	1.National Board for the Restriction of Alcohol 2.Latvian National Coalition on Tobacco and Alcohol Control	1. 2003 2. 2009	1.National Board for the Restriction of Alcohol. Aim: co-ordination of the work of central and local governments in restricting and combating alcohol addiction. 2.Latvian National Coalition on Tobacco and Alcohol Control. Aim: the Coalition's mission is to support the WHO and EU health policies on tobacco and alcohol harm prevention and mitigation of Latvian and Baltic States.
Malta			There is not coalition. However, virtually all the functions are performed by SEDQA, the National Agency against Drug and Alcohol abuse and Compulsive Gambling.

Romania	Informal technical group	2013	In 2013 a technical group was set in place at the initiative of the National Institute for Public Health and Asociatia Libera Initiativa si Antreprenoriat Tismana -ALIAT, in order to work at the future National Alcohol Strategy and the following Action Plan. At the moment the group has generated a document which aims at creating a common framework, of approaching this topic both in policy and in actions. The technical group is an informal one, its constituents being specialists from NGOs, public and also private sector.
Slovenia	Council for alcohol politics at the Ministry of Health	2004	It aims at planning and approval of effective politics and interventions at alcohol field. Members are from different political, professional and economic fields - stakeholders including alcohol industry, so compromises are needed.
Spain (Catalonia)	Programa de Actividades Preventivas y de Promoción de la Salud - PAPPS (Health Promotion and Prevention Activities Programme)	1991	-Working group of the Spanish Society of GPs that deals with preventive activities and developed SBI in PHC setting; -Working group of the Spanish Society of GPs that promotes preventive activities in PHC; -Prevention and education.
Sweden	ANDT, SKL, Socialstyrelsen	2010	During 2004-2010 there was a formal organization promoting the work called Riskbruksprojektet "Risk Drinking Project". It has since been replace by several bodies with prime coordination from Socialstyrelsen (National board of Health and Social Welfare). Otherwise the regions are each responsible for treatment provision.
Switzerland	The coalition has no name.	2008	Dissemination and implementation of the management of HHAC is coordinated by the National Programme Alcohol (NPA). The implementation of the programme is controlled by the NPA Strategic Directorate. This group comprises representatives of the Federal Office of Public Health, the Swiss Alcohol Board, the Federal Commission for Problems linked to Alcohol and the Swiss Conference of the Cantonal Ministers of Public Health. The implementation partners (organizations which implement activities/projects within the scope of the NPA) meet approx. twice annually to exchange information and make use of synergies.
The Netherlands	Partnership Vroegsignalering Alcohol PVA (Partnership Early Identification Alcohol)	2005	PVA aims at early detection and intervention of hazardous or harmful alcohol consumption. (www.vroegsignaleringalcohol.nl).

Figure 2. Name, year of creation and objectives of the country-wide coalitions.

COUNTRY	NAME	YEAR OF CREATION	AIM OF THE REGIONAL-WIDE COALITION
Belgium	1. Vereniging voor Alcohol en andere Drugproblemen 2. Fedito Wallonne and Fedito Bruxelles		Federations for institutions for alcohol and drug treatment and prevention. 1. www.vad.be 2. www.feditobruxelles.be

Czech Republic	National network of health promotion	2004	To promote health of the Czech population in an evidence-based way. Operates in several regions of the CR.
England	Balance	2009	BALANCE – is a regional office based in the North East of England whose remit is to implement alcohol policies in this area. There is a similar structure in the North West – called Our Life. Whilst there are coordinators in other regional areas but they do not have the same level of organization or infrastructure. There are a number of these organizations and forums across the country and across specialties. For instance the Eastern Alcohol Leads Forum, and the Hospital Alcohol Liaison Forum to cite just two examples.
Finland	Regional State Administrative Agencies		Regional State Administrative Agencies coordinate the activities in social and health services.
Germany	Centers for addiction issues		Centers for addiction issues are in the 16 Federal Länder (aim s.o.)
Italy	1. Regional public alcohology services within the NHS 2. CAT-Country association of territorial Club in every regions and autonomous province of Italy 3. CAR- Centro Alcologico Regionale Toscano 4. CAR – Centro Alcologico Regionale Ligure 5. CRARL – Centro di Riferimento Alcologico Regione Lazio	1. State-Region agreement (21.01.1999) on drug dependency 2. 1989 3. 2000 4. 2012 5. 2006	1. Regional public alcohology services within the NHS: Prevention, treatment, rehabilitation, monitoring on HHAC and alcohol dependency; 2. CAT are communities made up of no more than 12 families and a servant, teacher, that promote the change of lifestyle that tends to sobriety, through growth and maturation of the multidimensional person (emotional, cultural, spiritual, relational); 3-4. CAR is the formal Regional Coordination Centre in Tuscany and in Liguria with a mandate to harmonize the prevention and treatment activities in alcohol field in the Region. It deals with the National Health System Units; 5 CRARL is the formal Regional Coordination Centre in Latium with a mandate to harmonize the prevention and treatment activities in alcohol field in the Region. It deals with the National Health System Units.
Spain (Catalonia)	Drink Less	1996	Implementation of the "Drink less" programme, WHO, in the PHC.
Sweden	Country office with area name, eg. Skane Scania)		To 90 percent generic treatment provision. Health promotion is mandatory as part of the services.
Switzerland			Most of the 26 Swiss cantons have their own strategy or programme (either formally published as a programme or as part of their daily work) for the management of HHAC; coordination and exchange with the National Programme Alcohol takes place.

The Netherlands	Some examples: 1. PVA Limburg 2. Projectgroep alcoholmatiging jeugd (project group alcohol moderation youth) in Achterhoek (2006) and Stedendriehoek (2008). 3. A coalition between Maastricht University and the Mondriaan zorggroep. 4. Different regional or municipality alcohol prevention networks coordinated by addiction services. 5. SRE (coalition region Eindhoven). 6. Collaboration of municipalities in the region West-Friesland.	1. 2007	1. The aim of PVA-Limburg project is to improve the practice of early detection of General Practitioners in the Province of Limburg. 2. The aim is to reduce alcohol consumption and its impact among youngsters. 3. The aim is to initiate research contributing to prevention of addiction or treatment of addiction and to implement evidence based interventions in the practice of prevention and treatment. 5. www.sre.nl

Figure 3. Name, year of creation and objectives of the regional-wide coalitions.

3.1.2. Community action media and education

This section explores whether there have been public education campaigns implemented, in the 24 months before the completion of the questionnaire, that provide information about why heavy drinkers should reduce their alcohol consumption and how to reduce it. Where possible, it is indicated whether the campaign was publicly funded.

Figure 4 shows that implemented media education campaigns on alcohol consumption, in general are not widely available or not reported especially in some countries. The results show that the most common education campaigns are reported on the website (65.2%) followed by newspaper / magazines (47.8%) and radio (39.1%). Between the media, billboards and TV are the least used for community action and education campaigns about HHAC. When available, they are generally fully publicly funded (F) from those campaigns where the type of funded was reported, with a minor proportion of those being partially funded (P) and no funded (N).

EDUCATION CAMPAIGNS ON MEDIA ABOUT HHAC REDUCTION – AVAILABILITY AND FUNDING	TV [1 = Why reduce; 2 = How]	Publicly funded-TV [F=Full; P=Partial]	Level of implementation [R=Regional; C=Country-Wide; B=Both]	RADIO [1 = Why reduce; 2 = How]	Publicly funded-TV [F=Full; P=Partial]	Level of implementation [R=Regional; C=Country-Wide; B=Both]	NEWSPAPER/ MAGAZINES [1 = Why reduce; 2 = How]	Publicly funded-TV [F=Full; P=Partial]	Level of implementation [R=Regional; C=Country-Wide; B=Both]	BILLBOARDS [1 = Why reduce; 2 = How]	Publicly funded-TV [F=Full; P=Partial]	Level of implementation [R=Regional; C=Country-Wide; B=Both]	WEB SITE [1 = Why reduce; 2 = How]	Publicly funded-TV [F=Full; P=Partial]	Level of implementation [R=Regional; C=Country-Wide; B=Both]
Belgium															
Croatia															
Cyprus															
Czech Republic													2	P	C
England	1 - 2	F	C	1	F	R				1	N	C			
Estonia	1 - 2	F	C	1 - 2	F	B	1 - 2	F	B	1 - 2	F	C	1 - 2	F	C
Finland													1 - 2	F	C
Fyrom	1 - 2	F	C	1 - 2	F	C	1 - 2	N	C	1 - 2	P	R	1 - 2	N	C
Germany							1	P	C	1	P	C	1 - 2	F	C
Greece													1	N	C
Iceland	1	P	C				1	P	C				1 - 2	F	C
Ireland															
Italy							1	F	B				1 - 2	F	B
Latvia															
Malta	1	P	C	1	P	C	1	N	C				1	F	C
Poland	1 - 2	F	R	1 - 2	F	C	1 - 2	F	B	1 - 2	F	B	1 - 2	F	C
Portugal				1 - 2			1 - 2	P	C				1 - 2	F	C
Romania															
Slovenia	1	F	C	1	F	C	1 - 2	P	C	1	F	C	1 - 2	P	C
Spain (Catalonia)				1		C				1	F	C	1 - 2	F	R
Sweden							1 - 2	N	B						
Switzerland													2	F	C
The Netherlands	1 - 2	P	B	1 - 2	P	B	1 - 2	P	B	1 - 2	F	B	1 - 2	F	B
Percentage (%)	34.8			39.1			47.8			34.8			65.2		
Fully publicly funded (%)	62.5			71.4			27.3			62.5			73.3		

Figure 4. Implemented media education campaigns with information about why heavy drinkers should reduce their alcohol consumption and how to reduce it.

3.1.3. Health care infrastructures

3.1.3.1. Integrated Health Care System

This section explores to what extent the management of HHAC 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. Partners were asked to give their opinion to this issue, in a scale from 0 to 10. Caution is recommended in the use of this information for official purposes, since it reflects a consensus opinion given the difficulty to measure the question with objective data, but it can be helpful as an orientation towards the issue. According to personal opinions, the integration of the management of HHAC in the primary and secondary health care is considered quite low in most of the participating countries, with great differences between countries (See Figure 5 and 5a). Only 11 out of 23 countries in a scale from 0, no integrated, to 10, fully integrated, pointed the integration of the management of HHAC in the PHC system over the average of 5.4 points (Figure 5a).

Integration of the management of HHAC in the primary and secondary health care system (scale 0-10)	Primary	Secondary
Belgium	6	6
Croatia	10	10
Cyprus	8	8
Czech Republic	2	3
England	5	6
Estonia	1	1
Finland	5	5
Fyrom	8	8
Germany	8	9
Greece	4	7
Iceland	5	4
Ireland	3	3
Italy	5	4
Latvia	3	3
Malta	5	7
Poland	1	0
Portugal	6	7
Romania	3	3
Slovenia	6	5
Spain (Catalonia)	8	8
Sweden	10	4
Switzerland	6	9
The Netherlands	7	4
Mean±SD	5.4±2.5	5.4±2.6

Figure 5. Integration of the management of HHAC in the primary and secondary health care system. The question is pointed in a scale from 0 (no integrated, the lighter) to 10 (fully integrated, the darker), and the intensity of the colour on the scale column is degraded according to the score.

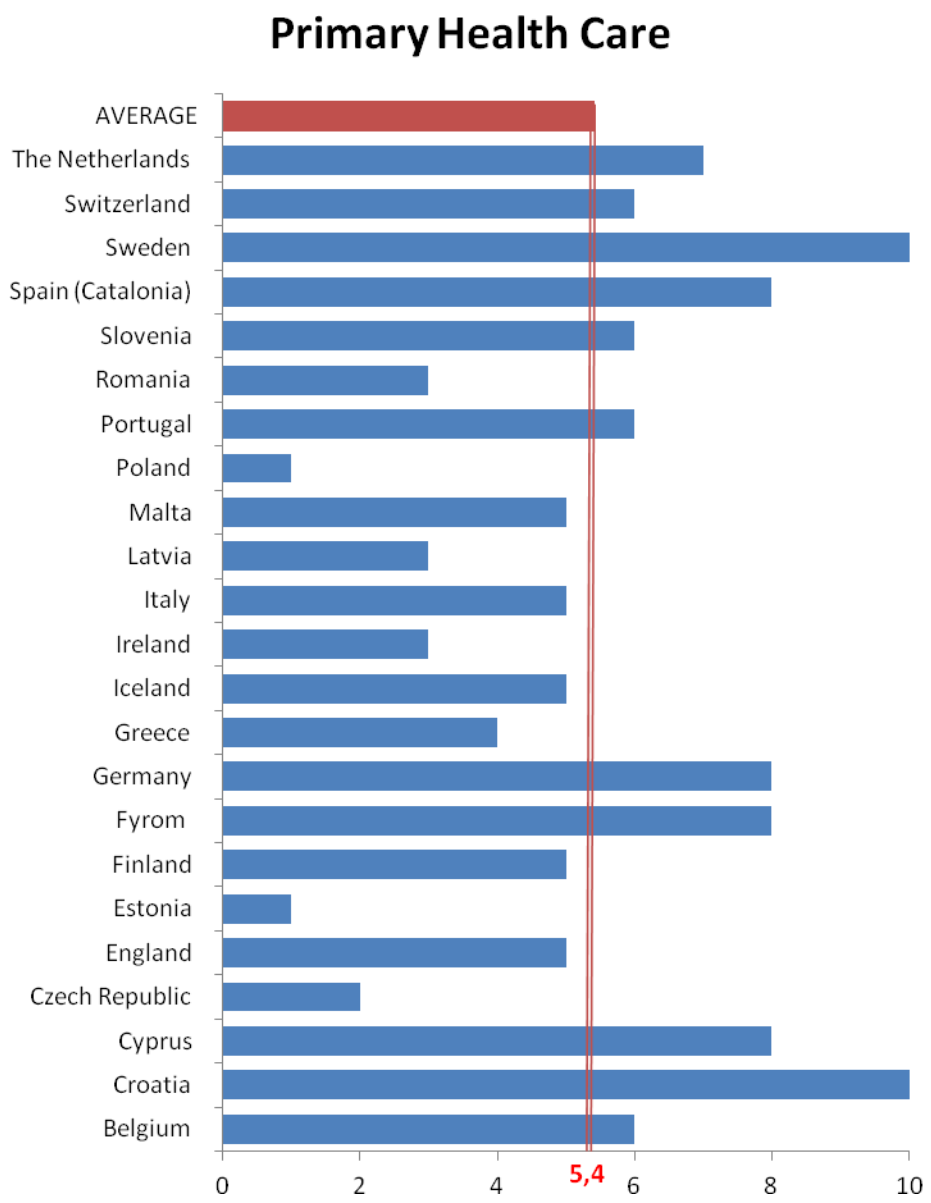


Figure 5a. Integration of the management of HHAC in the primary health care system. The question is pointed in a scale from 0 (no integrated) to 10 (fully integrated). The average of 5.4 points is also indicated.

Further support for the information of Figure 5 regarding the integration of the management of HHAC in the primary health system can be found in the following paragraphs:

Belgium	*The ASSIST (Alcohol Smoking and Substance Involvement Screening Test) of the WHO was translated and adapted for use in PHC practice; a training program for GP's and welfare workers was set up to use the screening instrument and implement a brief intervention/advice or referral.*

Croatia	*The treatment and rehabilitation of persons with HHAC is fully integrated in the health care system and financed by the basic national health insurance. The PHC practitioners follow these patients during hospital and out-patient treatment. The rehabilitation is very well developed, consisting of the more than 250 "clubs for treated alcoholics", lead by professionals and involving the family members as well.*
Czech Republic	*Based on time-limited projects/grants.*
England	*The links between alcohol and areas of chronic disease management in primary care remain relatively weak. There is some work on trying to persuade GPs to put alcohol SBI into the Quality and Outcomes Framework and the national screening committee to include alcohol as a must-screen condition, without success so far. Implementation largely voluntary.*
Estonia	*The process of integrating EIBI to PHC has started in 2009, the concept and guidelines are developed and published, the piloting of the service is going on. The present project's funding is secured until the end of 2013, the funding will be revised and probably reorganized (to the more permanent basis) after the end of the pilot project.*
Fyrom	*During 2012, we organised 4 educative seminars and 1 regional conference under Macedonian doctors's chambers and macedonian doctor's organization for doctors in primary and secondary health care.*
Germany	*Specialised outpatient care for dependence is very well developed in Germany with the outpatient counseling addictions services. They exist as a parallel system to PHC, but they operate with very low threshold and refer patients to specialized care.*
Iceland	*There is a lack of implementation and follow-up on the implementation of the clinical guidelines. However we have established a webpage and short seminars for healthcare professionals on how to use Motivational Interview and Brief intervention. The infant and maternity service is doing well in monitoring alcohol consumption of the mother.*
Ireland	*A steering group report on a National Substance Misuse Policy was published in February 2012 and will be implemented shortly.*
Italy	*- In the last years an increased interest arose in Italy in relationship with the need to develop, validate and implement instruments and methodologies for the EIBI of HHAC in the PHC settings. The ISS played a pivotal role in carrying out a formal activity in preparing a country strategy aimed at the implementation and dissemination of a common standard of training and at the coherent application of the EIBI. According to the PHEPA standard, the national working teams of the ONA-CNESPS and the WHO CC on Alcohol at ISS started in April 2006 to deliver a communication strategy and to organise conferences to announce, promote and disseminate the IPIB training programme. IPIB (Identificazione Precoce e Intervento Breve) is actually the formal institutional standard of training in Italy funded by the MoH and by the Presidency of the council, DPA. At the moment, this activity is waiting to receive fundings for its implementation.* *-"Progressi delle Aziende Sanitarie per la Salute in Italia" – PASSI, 2009.*
Poland	*There is no formal integration of management of HHAC to the health care system in Poland. No national guidelines as to management HHAC. However, some GPs (only a few really trained) include HHAC management in practice.*
Portugal	*We have a National Alcohol Plan and a treatment referral network with oriented procedures to clinical referral.*
Spain (Catalonia)	*Introduced in the contractual incentives with the PHC provider and the Direction for Objectives of the Professional; Services of drug dependency is not near of the Primary Health Care; Difficulty for coordination.*

Sweden	*It is integrated in the health care system but not always carried out in implementation had been graded here, we would give it a 6.*

Further support for the information of Figure 5 regarding the integration of the management of HHAC in the secondary health system can be found in the following paragraphs:

Belgium	*IDA-web (www.ida-web.be) offers a referral system for GPs and PHC towards the more specialized treatment center.*
Czech Republic	*Limited extent, rather locally. Mainly referral to specialized clinics.*
England	*There is increasing integration of alcohol management in the hospital system via the development of the alcohol liaison nurse role – which bridges emergency care to inpatient hospital care. This effort to integrated alcohol treatment systems across the whole country have been partially successful. But evidence from the Alcohol Needs Assessment Research Project (ANARP) and National Audit Office (NAO) show it is very patchy.*
Estonia	*The Task Force for the Green Book of Alcohol Policy is about to design the system of service provision; currently there is no systematic approach.*
Germany	*Specialised medical services for alcohol dependence is integrated part of the health care system.*
Iceland	*This is especially for psychiatry departments, but also other departments.*
Ireland	*A steering group report on a National Substance Misuse Policy was published in February 2012 and will be implemented shortly.*
Italy	*Alcohol consumption is considered just an addiction yet.*
Portugal	*At present there is an integration of services for treatment of alcohol related problems in the National Health Care System to guarantee a better intervention from PHC to other levels of care. We have an Alcohol Directory where we provide information at: http://directorioalcool.com.pt/Paginas/HomePage.aspx.*
Spain (Catalonia)	*Some improvements are still possible.*
Sweden	*Not at all carried to the same extent as in PHC.*
Switzerland	*We understand secondary health care here as expert addiction support.*

3.1.3.2. Structures for quality care

In Figure 6, the results to the question: "is there a formal governmental organization, or organization appointed or contracted by the government that with responsibility of managing HHAC?" are provided.

In most of the countries, there are structures in charge for monitoring health outcomes at the population level from HHAC (18 out of 23, in 78.3% of the countries), and to a lesser extent for reviewing the safety of pharmacological treatments for managing alcohol dependence (15 out of 22, 68.2%) and for providing information on managing HHAC to health care providers (14 out of 22, 63.6%). In nearby half of the countries there are structures in charge for the monitoring of the quality of care provided for managing HHAC (12 out of 21, 57.1%) and for preparing clinical guidelines (13 out of 23, 56.5%). The structures for reviewing the cost effectiveness of interventions for managing HHAC are unavailable in almost all the countries but not in England, Finland, Portugal, Sweden and The Netherlands (21.7%) (Figure 6).

EXISTENCE OF FORMAL GOVERNMENTAL ORGANIZATION, APPOINTED OR CONTRACTED BY THE GOVERNMENT, WITH RESPONSIBILITIES FOR MANAGING HHAC IN:	Preparing clinical guidelines	Monitoring health outcomes	Monitoring the quality of care	Cost-effectiveness review of interventions	Reviews the safety of pharmacological treatments	Provides information to health care providers
Belgium		■			■	■
Croatia	■	■			■	
Cyprus	■	■	■			
Czech Republic		■				
England	■	■	na	■	na	■
Estonia					■	■
Finland	■	■	■	■	■	■
Fyrom (Ex Macedonia)						
Germany		■	■		■	■
Greece						
Iceland	■	■	■		■	■
Ireland	■	■			■	■
Italy	■	■	■		■	■
Latvia	■	■	■		■	
Malta	■	■	■			■
Poland		■	■		■	■
Portugal	■	■	■	■	■	■
Romania						
Slovenia						
Spain (Catalonia)	■	■	■	na	■	■
Sweden	■	■	■	■	■	■
Switzerland		■	na		■	na
The Netherlands	■	■	■	■	■	■
PERCENTAGE (%)	**56.5**	**78.3**	**57.1**	**21.7**	**68.2**	**63.6**

Figure 6. Structures for quality of care for the managing of HHAC

■ **:YES;** **na** **:Not available**

The names of the structures for each country is listed in the following paragraph:

	Preparing clinical guidelines	*Monitoring health outcomes*	*Monitoring the quality of care*	*Cost-effectiveness review of interventions*	*Reviews the safety of pharmacological treatments*	*Provides information to health care providers*
Croatia	*Croatian society for alcoholism and other dependencies*	*Croatian National Institute of Public Health*	*NO*	*NO*	*Refent centre for alcoholism of Ministry of Health*	*NO*
Cyprus	*Cyprus Antidrug Council (www.ask.org.cy)*	*Cyprus Antidrug Council (www.ask.org.cy)*	*Cyprus Antidrug Council (www.ask.org.cy)*	*NO*	*NO*	*NO*
Czech Republic	*NO*	*NIPH-Coordination,*	*NO*	*NO*	*NO*	*NO*

		monitoring and research centre for alcohol issues				
England	*National Institute for Health and Clinical Excellence (NICE)*	*North West Public Health Observatory;* *NHS Information Centre*	*-*	*The Department of Health Substance Misuse Policy unit has carried out some of this work;* *NICE*	*-*	*Department of Health Alcohol Learning Centre;* *NICE*
Estonia	*NO*	*NO*	*NO*	*NO*	*State Agency of Medicines*	*National Institute for Health Development*
Finland	*http://www.kaypahoito.fi/web/english/home*	*The National Institute of Health and Welfare (THL) maintains national health registers. Statistical database "Sotkanet" includes the most important health indicatiors (http://uusi.sotkanet.fi/portal/page/portal/etusivu/hakusivu?group=340)*	*The National Supervisory Authority for Welfare and Health (Valvira) and Regional State Administrative Agencies supervise health and social care services. (http://www.valvira.fi/en/)*	*Finnish Office for Health Technology Assessment - Finohta (http://www.thl.fi/fi_FI/web/fi/organisatio/rakenne/yksikot/meka/finohta)*	*(http://www.fimea.fi/frontpage)*	*THL (http://www.thl.fi/fi_FI/web/fi/tutkimus/ohjelmat/alkoholiohjelma, only in Finnish)*
Germany	*NO*	*Robert Koch-Institut (www.rki.de)*	*Institute for Therapy Research (IFT)*	*NO*	*Federal Institute of Drugs and Medical Devices (BfArM)*	*Federal Centre for Health Education (BZgA)*
Iceland	*Department of Health*	*Department of Health*	*Department of Health*	*NO*	*Icelandic Medicines Agency (www.imca.is)*	*Department of Health*
Ireland	*Health Service Executive*	*Health Research Board*	*NO*	*NO*	*Irish Medicines Executive*	*Health Service Executive*
Italy	*ISS-ONA CNESPS;* *Presidency of the Council of the Ministries, Dept of anti drugs policies*	*ISS-ONA CNESPS;* *Presidency of the Council of the Ministries, Dept of anti drugs policies*	*ISS-ONA CNESPS;* *Sistema di Sorveglianza PASSI "Progressi delle Aziende Sanitarie per la Salute in Italia", ISS*	*NO*	*ISS;* *Agenzia Italiana del Farmaco (AIFA)*	*ISS-ONA CNESPS;* *SIA;* *WHO CC - ISS*
Latvia	*Prepared by medical institutions or health care practitioners but approved by The National Health Service*	*The Ministry of Health and The Center for Disease Prevention and Control of Latvia*	*The Ministry of Health and the Health Inspectorate*	*NO*	*The State Agency of Medicines*	*NO*
Malta	*Sedqa – the National Agency Against Alcohol and Drug Abuse www.sedqa.gov.mt*	*Public Health Department, Ministry of Health, Valletta, Malta*	*Department of Standards, Centru Hidma Socjali, St. Joseph High Road, Hamrun*	*NO*	*NO*	*Sedqa – the National Agency Against Alcohol and Drug Abuse www.sedqa.gov.mt*
Poland	*NO*	*PAŃSTWOWA*	*www.parla.pl*	*NO*	*Institute of*	*www.parla.pl*

		AGENCJA ROZWIĄZYWANIA PROBLEMÓW ALKOHOLOWYCH (PARPA) www.parpa.pl			*Psychiatry and Neurology (www.ipin.edu.pl);* *Agency for Health Technology Assessment (www.aotm.gov.pl)*	
Portugal	*Institute on Drugs and drug Addiction (IPDT);* *General Directorate of Health*	*Institute on Drugs and drug Addiction (IPDT);* *Ministry of Health*	*Institute on Drugs and drug Addiction (IPDT);* *Regional Health Administration*	*Institute on Drugs and drug Addiction (IPDT)*	*Infarmed (Autoridade Nacional do Medicamento e Produtos de Saude)*	*National Authority of Medicines and Health Products (IPDT);* *General Directorate of Health*
Spain (Catalonia)	*Spanish Drug Agency (http://www.agemed.es)*	*Health Plan Unit of the Department of Health*	*Institute of Health Studies (http://www.ieasalut.es/)*	-	*Spanish Drug Agency (http://www.agemed.es)*	*Health Department of the Government of Catalonia*
Sweden	*Socialstyrelsen as well as the regions*	*It has recently started*	*But not in all counties*	*To at least a minimal extent*	-	-
Switzerland	*NO*	*Swiss Addiction Monitoring (Federal Office of Public Health)*	-	*NO*	*Swissmedic*	-
The Netherlands	*Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling in de GGZ (National Steering Committee Development Guidelines in mental health care);* *Scoring Results;* *Trimbos Institute*	*Municipal health organizations;* *National Drug Monitor (including tabacco and alcohol);* *RIVM (National Institute for Public Health and the Environment);* *Nemesis onderzoek (Netherlands Mental Health Survey and Incidence Study);* *University projects*	*Scoring Results; Trimbos Institute; Inspection Ministry of Health; Health Care Inspectorate (IGZ)*	*Universities;* *Netherlands Economic Institute*	*Surgeon General Health;* *Inspection Ministry of Health*	*Trimbos Institute: drug education by department of addiction care;* *PVA*

Further details can be found in the following paragraphs:

Estonia	*National Institute for Health Development provides information on early identification and brief intervention.*
England	*Regarding "monitors the quality of care provided for managing HHAC", the national Audit Office has had one go – but it is being disbanded. NICE has developed quality standards but yet to be implemented.* *For "reviewing the safety of pharmacological treatments for managing alcohol dependence", it is possibly done by the Medicines and Health Regulatory Authority (MHRA).*

Germany	*With reference of "preparing clinical guidelines for managing HHAC", by definition of clinical guidelines they are done by Scientific Medical Societies, which define their self as independent from governments.*
Italy	*At national level, the monitoring and reporting on the activities of the structures devoted to care and rehabilitation of alcohol dependents is set by a law decree that establish a common standard of data collection. Different sources of information are taken into account to monitor and report the impact of alcohol on the population and to assess the performance of the treatment systems in reply to the changing trends observed by the monitoring system. Together with the specific treatment system evaluation (structures) the MoH evaluates and reports on alcohol consumption patterns, alcohol mortality, alcohol attributable hospital discharges and other quantitative as well as qualitative data coming from the regional monitoring and reporting activities set by law. Data are elaborated and reported by a yearly formal report of the MoH to the Parliament on the implementation of the 125/2001 frame law on alcohol, the national frame law on alcohol. All the reports are public and fully disseminated on the institutional web site. The ISS-CNESPS contributes to the elaboration of the yearly report to the Parliament.*
Portugal	*We have an Alcohol Directory where we provide the important information related to Alcohol (http://www.diretorioalcool.pt/Paginas/HomePage.aspx*
Spain	*There are agencies but mainly for other topics. Not yet on alcohol.*
Switzerland	*Regarding "monitors the quality of care provided for managing HHAC", there is not a comprehensive national monitoring, but partial/voluntary initiatives with a high coverage:* *(1) the quality norm „QuaTheDA" has been developed for the area of expert addiction support (including alcohol) and ensures the quality of structures and processes. (www.quatheda.ch);* *(2) Infodrog maintains a database where all addiction support services in Switzerland can be found: www.suchtindex.ch* *Regarding "provides information on HHAC to health care providers", there are some further organisations that provide information (partly funded by the Federal Office of Public Health): Addiction Switzerland, Infodrog, www.praxis-suchtmedizin.ch, SSAM, www.infoset.ch*
The Netherlands	*For each topic there is an organization and they receive partly money from the government.*

3.1.3.3. Research and knowledge for health

3.1.3.3.1. Formal research programme

In this section it explored whether there have been a research call during the last 10 years managing HHAC with specifically allocated funding from governmental, government appointed or non-governmental organizations (excluding the pharmaceutical companies and the alcohol industry). Nearby half of the countries have not a formal research programme (13 out of 23 countries, 56.5%). Those who have formal research programme are always, at least in part, from a governmental organizations (Figure 7).

Yes, from governmental organizations (Czech Republic, England, Germany, Iceland, Italy, Poland, Spain – Catalonia, Sweden, Switzerland, The Netherlands)

Yes, from governmental appointed organizations (Czech Republic, England, Italy, Poland, Sweitzerland, The Netherlands)

Yes, from non governmental organizations (England, Germany, Iceland, The Netherlands)

No (Belgium, Croatia, Cyprus, Estonia, Finland, Fyrom, Greece, Ireland, Latvia, Malta, Portugal, Romania, Slovenia)

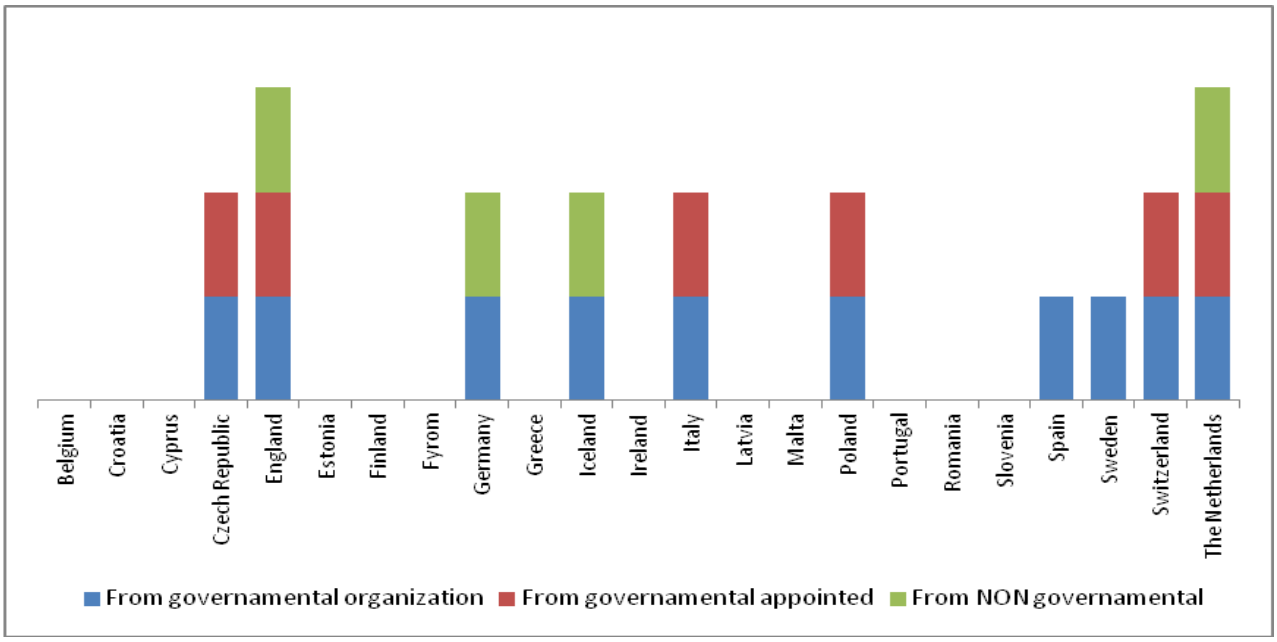


Figure 7. Formal research programmes

3.1.3.3.2. Education in the curriculum of professional training

The estimation of the formal inclusion of education on managing HHAC in the curriculum of undergraduate/basic professional training of several health care providers is considered in this section (See Figure 8, 8a and 8b).

There are great differences among countries in all the estimations. According to participants opinions, there is a lack of formal education on managing HHAC in all the educational level and health care providers considered, particularly for pharmacists, dentists and obstetricians (Figure 8b). For all the health care providers considered here (but not for dentists, obstetricians and pharmacists), taking into account the media values, it seems that there is a tendency to have more formal education on the managing of HHAC in the curriculum of postgraduate and continuing professional training compared to the undergraduate curriculum. However, the data provided are only estimation; therefore it should be only considered as a suggestion to explore deeply the question.

	PHYSICIANS			NURSES			PHARMACISTS			SOCIAL WORKERS			PHYCHOLOGIST		
	U	P	CE	U	P	CE	U	P	CE	U	P	CE	U	P	CE
Belgium	3	4	4	1			1			3			5		
Croatia	6	9	9	6	8	8	6	6	6	8	8	8	6	6	6
Cyprus	8	8	8	8	8	8	7	7	7	8	8	8	8	8	8
Czech Republic	2	2	2	1	2	2	1	1	0	1	2	0	0	1	0
England	3	3	3	4	4	4	2	2	2	4	4	4	2	2	2
Estonia	5	7	6	3	5	6	1	1	1	1	2	3	5	7	7
Finland	8	8	2	7	6		4	0		5	5		6	6	
Fyrom	7	8	7	7	7	7	5	5	5	7	8	7	7	8	7
Germany	6			4			3			6	8				
Greece	5	6	5	3	5	5	0	0	0	3	4	4	4	6	5

Iceland	3	3	4	4	4	4				4	5	6	3	5	5
Ireland	5	5	7	5	5	7	4	4	4	4	4	4	5	5	5
Italy	4	5	6	2	3	3	1	2	1	1	2	2	2	3	4
Latvia	3	3	4	3	4	4	2	2	2	5	5	5	5	5	5
Malta	8	8	8	5	5	5	5	5	5	2	2	2	6	6	6
Poland	1	1	1	0	0	0	0	0	0	0	0	0	1	2	2
Portugal	5	7	6	4	6	4	4	4	4	5	6	6		7	7
Romania	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Slovenia	5	10	5	3	3	4	1	1	1	3	3	3	2	3	4
Spain - Catalonia	3	5	8	5	5	8	2	1	1	5	7	7	5	8	6
Sweden	5	4	6	2	4	6	4			1	1	5	1	1	5
Switzerland															
The Netherlands	3	5	4	3	5	5	3	3	4	5	6	5	3	4	4

Figure 8. Education on managing HHAC in the curriculum of undergraduate (U), postgraduate (P) and continuing professional training (CE). The question is pointed in a scale from 0 (no included) to 10 (fully included).

	DENTISTS			OBSTETRICIANS			COUNSELLORS		
	U	P	CE	U	P	CE	U	P	CE
Belgium	0			2					
Croatia	5	5	5	6	7	8	8	8	8
Cyprus	7	7	7	8	8	8	8	8	8
Czech Republic	2	2	1	2	2	1	3	3	2
England	2	2	2	1	1	1	4	4	4
Estonia	3	0	0	3	2	2	*	*	*
Finland	6	6		8	6		*	*	*
Fyrom	5	5	5	5	5	5	3	3	3
Germany	1			4					
Greece	0	0	0	0	0	0	4	6	5
Iceland	1	1	1	4	4	4			
Ireland	4	4	4	6	6	6	7	7	7
Italy	1	2	1	1	2	2	2	3	3
Latvia	3	3	3	4	4	4	3	3	3
Malta	7	7	7	7	7	7	5	7	7
Poland	0	0	0	0	0	0	2	2	2
Portugal	4	4	4	4	4	4			
Romania	0	0	0	1	0	0	1	0	0
Slovenia	1	0	0	1	1	1	*	*	*
Spain - Catalonia	3	2	2	3	2	2	5	7	7
Sweden				5	4	6			
Switzerland									
The Netherlands	3	3	3	3	2	2	4	5	5

Figure 8a. Education on managing HHAC in the curriculum of undergraduate (U), postgraduate (P) and continuing professional education (CE). The question is pointed in a scale from 0 (no included) to 10 (fully included). *Not Applicable: Estonia, Finland and Slovenia have not the professional title of counsellor

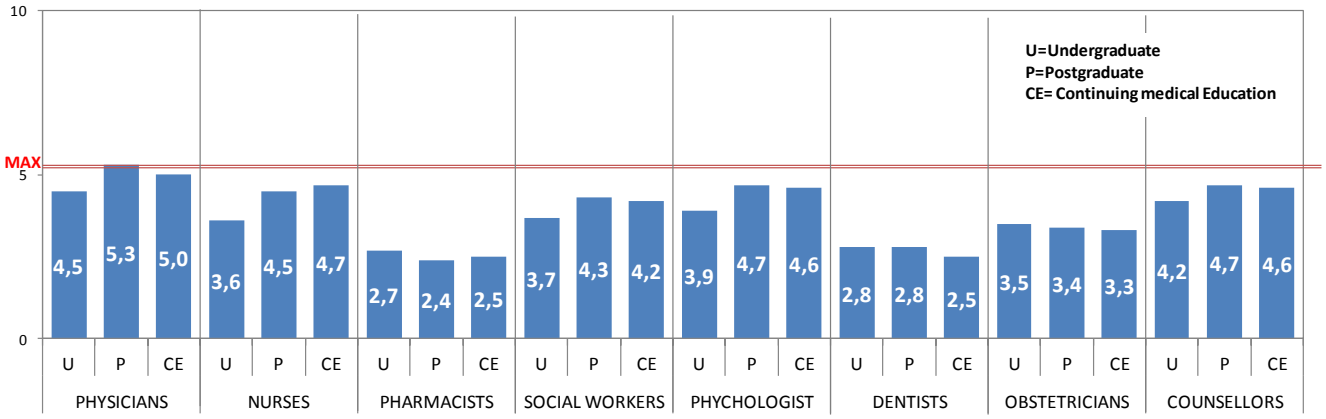


Figure 8b. Education on managing HHAC in the curriculum of undergraduate (U), postgraduate (P) and continuing professional education (CE) as average values (in a scale from 0, no included, to 10, fully included by health care providers and educational levels

Further details can be found in the following paragraphs:

Belgium	*Postgraduate and continuing education is available, but it depends on the individual whether he or she is attending these trainings. As a result, it is difficult to score.*
England	*No national strategy as yet apart from undergraduate medical curriculum: Department of Health had a project which is coming to an end shortly. Medical Council on Alcohol has been promoting this for about 25 years and has a network of regional coordinators who coordinate training in medical schools. Almost full national coverage and a medical students' handbook provided free to all medical students nationally.*
Estonia	*"Counsellors" is not applicable. We do not have this specialty.*
Finland	*It is possible to perform a two-year training program for Addiction Medicine Special Competence authorized by the Finnish Medical Association. The program has attracted only about 100 doctors. Counsellor is no professional title in Finland.*
Germany	*Curricula for the education varies depending on "Bundesland" and depending on University. Therefore a general answers to these question often not possible. Particular postgraduate professional training is and further training is so broad that the question can't be answered.*
Greece	*Substance addiction / use where alcohol addiction / use is part of the lessons of the course, is included in the undergraduate / postgraduate curriculums of medical school, school of nursing, school of social work, school of psychology and dental school. Continuing medical education is mainly related to seminars, conferences on alcohol use/abuse.*
Iceland	*Not quite sure what is referred to by "counsellors" so leave that as NA. There is a special diploma education with focus on alcohol and drug use – counseling at the social workers unit, but all students can apply.*
Italy	*1.At the University of Florence, Toscana Region, there is a post graduated course (from the second half of 90s) on "alcohology and life style". About 170 operators have been attended it (country wide level). In the latest years physicians are a minority.* *2.In Perugia, Umbria Region, training courses have been carried out for physicians, psychologists, nurses and social workers.*

Romania	*In 2011 ALIAT has initiated the first national study that evaluates the specialized medical services for people with problematic alcohol consumption shows the need of dedicated medical and social services for this risk group. One of the main conclusion of the study was the lack of training programs, compulsory and continuous within the university and post university curricula. Overall, physicians that are part of the target groups follow none, or very few training programs in the area of prevention/treatment of alcohol abuse/addiction.*
Portugal	*There are training programs to stop smoking, reducing alcohol consumption, doing exercise regularly and avoiding excess calories that are covered at undergraduate level. On public health system there are also post graduate training programs on alcohol consumption.*
Slovenia	*We do not have health counsellors.*
Spain	*Doctors and nurses who specialize in Family and Community Medicine are getting more training on alcohol.*
Sweden	*Improvement is underways at least among nurses and physicians in general, and among GPs in particular.*
Switzerland	*In most of the curriculums education on managing hazardous and harmful alcohol consumption is formally part for the mentioned professional groups. However there is no systematic overview, and curriculums differ from university to university /school to school. Currently, a project aims at the concerted integration of relevant content on the topic of addiction into basis moduls of the education of relevant professional groups.*

3.1.3.4. Health care policies and strategies

In 2012, an official written policy on managing HHAC from the Government or Ministry of Health is reported in 78.3% of the countries, mostly as a part of a more general alcohol policy strategy (See Figure 9).

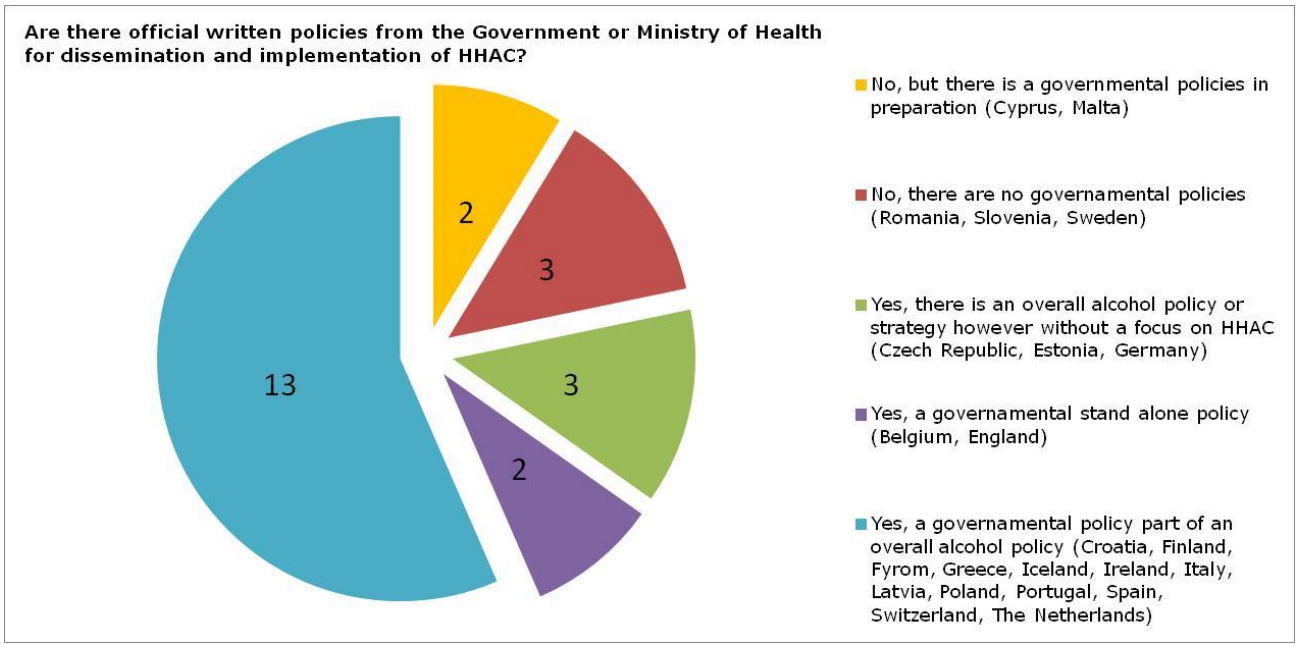


Figure 9. Policies on managing HHAC from the Government or Ministry of Health

Further details can be found in the following paragraphs:

Belgium	*Common Declaration of the Interministerial Conference on Health on the future alcohol policy.*

Croatia	*Croatian Strategy on prevention of harmful use of alcohol and alcohol-related harm 2011-2016 (www.vlada.hr)*
Czech Republic	*1. Long-term program of improving the health status of the population - Health 21 (12, 12.1) (www.mzcr.cz)* *2. National strategy of anti-drug policy (www.drogy-info.cz)*
England	*1. Models of Care for Alcohol Misusers 2006/7 produced by the Department of Health;* *2. Public Health Outcomes Framework (Jan 2012);* *3. Awaiting Government strategy on alcohol.*
Estonia	*There is a concept of integrating EIBI of harmful use of alcohol prepared by National Institute of Health Development, acknowledged by Ministry of Social Affairs.* *The Green Book of Alcohol Policy, under development, will include a chapter envisaging the future system of treatment, rehabilitation and counseling for harmful use of alcohol.*
Finland	*http://www.thl.fi/fi_FI/web/fi/tutkimus/ohjelmat/alkoholiohjelma*
Fyrom	*Strategy, intended for reduction of the alcohol misuse consequences on the health of the population in R. of Macedonia (2008-2012).*
Greece	*National Action Plan on Alcohol Harm Reduction 2008-2012 (www.ygeianet.gov.gr)*
Iceland	*A comprehensive policy on alcohol and other substances was written for the Ministry of Welfare and the government late in the year 2012. Is not formally approved yet by the government. There is a plan to write the policy as a parliament bill. The strategy and implementation is to be written in 2013.*
Italy	*1.Italy. Frame law 125, 30 march 2001 on alcohol and alcohol related problems (http://www.salute.gov.it/imgs/C_17_normativa_452_allegato.pdf);* *2.Ministry of Health, National Alcohol and Health Plan 2007-2010 (PNAS) (http://www.salute.gov.it/imgs/C_17_pubblicazioni_623_allegato.pdf);* *3.Ministry of Health, Gain Health 2007-2010 (http://www.salute.gov.it/stiliVita/paginaMenuStiliVita.jsp?menu=programma&lingua=italiano)* *4.Ministry of Health, National Prevention Plan 2010-12 (PNP) (http://www.ccm-network.it/Pnp_2010-2012);* *5.Ministry of Health, National Health Plan 2011-2013 (PSN) (www.salute.gov.it/imgs/C_17_pubblicazioni_1454_allegato.pdf)*
Latvia	*1.From 2005-2008 "Program for Reduction of Alcohol Consumption and Restriction of Alcohol Addiction for 2005-2008".* *2.Currently in the process of elaboration "Action plan for reduction of alcohol consumption and alcoholism 2012-2014".*
Malta	*The draft document is not available to the general public.*
Ireland	*A steering group report on a National Substance Misuse Strategy 2012 (http://healthupdate.gov.ie/wp-content/uploads/2012/02/Steering-Group-Report-on-a-National-Substance-Misuse-Strategy-7-Feb-11.pdf)*
Poland	*National Program for Prevention of Alcohol-Related Problems 2011-2015 (http://fas.nazwa.pl/parpa_en/images/stories/NPPiRPA 2011 2015 eng.pdf)*
Portugal	*1.Ministry of Health, PLANO NACIONAL PARA A REDUÇÃO DOS PROBLEMAS LIGADOS AO ÁLCOOL 2009-2012 (http://www.min-saude.pt/NR/rdonlyres/DFF7BEF4-9F5F-4470-B058-8376F8644B16/0/PlanoNacionalPLA202009II.pdf)* *2.There is a new document being prepared after 2012.*
Spain	*White paper on Drug Prevention*
Sweden	*"Socialstyrelsen riktlinjer för missbruk och beroende 2007" and "Socialstyrelsen riktlinjer för sjukdomsframkallande levandsvanor 2011" (www.socialstyrelsen.se)*
Switzerland	*1.English, short version available at: http://www.bag.admin.ch/themen/drogen/00039/00596/index.html?lang=en*

	2.Italian, long version (Programma nazionale Alcol 2008-12) available at: http://www.bag.admin.ch/themen/drogen/00039/00596/index.html?lang=it
The Netherlands	*http://www.rijksoverheid.nl/ministeries/vws/documenten-en-publicaties/notas/2011/05/25/landelijke-nota-gezondheidsbeleid.html*

When the policy is available (n=18), an intensive support for managing alcohol dependence in specialised treatment facilities is included in 88.9% of the countries and to a lesser extent (66.7%) a strategy on training for health professionals and a strategy to support interventions in primary care (61.1%). A national funded research strategy is included in 38.9% of the policies (analysis to be confirmed after completing the table) (See Figure 10).

IF WRITTEN POLICIES ARE AVAILABLE, THE GOVERNMENTAL POLICIES ON MANAGING HHAC INCLUDES:	Policy for the management of HHAC	Strategy on training health professionals	National funded research strategy	Strategy to support interventions by primary care professionals	Intensive support for managing SDA in specialised treatment facilities
Belgium		?	?	?	?
Croatia					
Cyprus					
Czech Rep					
England		?	?	?	?
Estonia		?	?	?	?
Finland					
Fyrom					
Germany					
Greece					
Iceland					
Ireland					
Italy					
Latvia					
Malta					
Poland					
Portugal					
Romania					
Slovenia					
Spain					
Sweden		?	?	?	?
Switzerland					
The Netherlands					
Percentages (%)					

Figure 10. Areas included in the policies on managing HHAC from the Government or Ministry of Health. The first column shows the countries with the existence (or not) of a policy (coloured), following the colour criteria of Figure 9.

Belgium, England, and Estonia: please specify; Sweden: conflicting data. Please check it.

3.1.3.5. Structures to manage the implementation of treatment within health services

In 43.5% of the countries (Cyprus, Czech Republic, England, Italy, Latvia, Portugal, Romania, Spain, Sweden and the Netherlands) there is 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 HHAC.

Further details can be found in the following paragraphs:

Cyprus	*The Mental Health Services of the Ministry of Health are responsible for managing services for HHAC. The Cyprus Antidrug Council is responsible for the provision of treatment guidelines, approval and monitoring.*
England	*The new alcohol strategy is: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98121/alcohol-strategy.pdf*
Germany	*In Germany it is not the responsibility of the government to oversee any health care services directly. Health-care in Germany is self-administered by physicians and statutory health insurance.*
Ireland	*Under the strategy, a new clinical directorate that includes alcohol is to be established.*
Romania	*The only governmental specialists that tackle the issue of alcohol misuse and the needed policy the coordinate the field are the experts from the National Institute for Public Health. Within the Ministry of Health there is one expert who deals, but in a broader manner, with this issue, but without a specific portofolio of activities.*
Portugal	*Now each Regional Health Administration is responsible for implementation according to New Organic Law (http://www.sg.min-saude.pt/NR/rdonlyres/065B7F96-F9E1-4E18-AD3C-9E9425DF78FC/28477/DecLei_17_2002depe.pdf , Decreto-Lei n.º 17/2012, de 26 de janeiro)*
Sweden	*Getting tougher after some years of intensive stimulation.*
Switzerland	*Infodrog maintains a database where all addiction support services in Switzerland can be found and they provide a minimal standard of quality control (www.suchtindex.ch).* *In Switzerland, the 26 Cantons are in charge for the controlling of addiction facilities.*
The Netherlands	*There are several identified persons within the Department of Health. (www.loketgezondleven.nl)*

3.1.3.6. Funding health service and allocating resources

In 19 of the countries (82.6%%) there is government funding for services for the management of HHAC (See Figure 11). In these cases, the amount of funding is usually reviewed from time to time. There is only one country, Switzerland, where a proportion of alcohol taxes (10%) is specifically allocated to fund the costs of services for managing HHAC.

GOVERNMENTAL FUNDING FOR HHAC	GOVERNMENTAL FUNDING	REVISION OF FUNDING	PROPORTION OF TAXES FOR HHAC SERVICES
Belgium		Yes	No
Croatia		n.a.	No
Cyprus		Yes, annually	No
Czech Republic	No		No
England	No		No
Estonia		Yes, project based	No
Finland		Yes, annually	No
Fyrom		Yes, annually	No
Germany		Yes, annually	No
Greece	No		No
Iceland		Yes, annually	No
Ireland		n.a.	No
Italy		Yes, annually or more	No
Latvia		Yes, annually	No
Malta		Yes, annually	No
Poland		No	No
Portugal		Yes, annually	No
Romania	No		No
Slovenia		No	No
Spain		Yes, annually	No
Sweden		Yes	No
Switzerland		Yes, annually	
The Netherlands		Yes, annually ore more	No
MEAN	19 out of 23 (82.6%)	15 out of 17 (88.2%)	1 out of 23 (4.3%)

Figure 11. Governmental funding health service and allocating resources

Further details can be found in the following paragraphs:

England	*No specific ring-fenced funding – this work is supposed to occur via generally allocated funding.*
Estonia	*Currently funding is project-based, more permanent funding is envisaged.*
Finland	*Equalization payment made by the government to municipalities to compensate basic social and health services.*
Fyrom	*By financing project applications.*
Germany	*The answer is:* *1.Yes: Local communities fund the outpatient addiction counseling services;* *2.No: Medical treatment is fully paid by the statutory health insurances and the statutory pension insurance (not by government directly). Therefore the services receive - as any other medical service - funding per patient.*
Greece	*According to the Action Plan on Alcohol Harm Reduction (2008-2012), government funding for the development of such services has been provided. However, in all probability the funding of the services has been slashed.*
Italy	*Reviewed annually or every 2 or 5 years, depending on what is funded. Funding for the implementation of the frame law on alcohol 125/2001 are allocated on annual basis, but resources are limited. Other funding could be allocated every three years by the MoH under the frame of the National*

	Prevention Plan - Piano Nazionale Prevenzione – PNP.
Malta	*The funding is handed over in the form of an annual budget to sedqa - the National Agency against Alcohol abuse, drug abuse and problem gambling, utilized for a number of initiatives/projects including the management of HHAC.*
Slovenia	*EIBI is a part of regular work of family physicians that is financed by National Health Insurance Fund (85% for primary health care services, 15% by additional voluntary individual insurance). Nearby 95% of population have it.*
Sweden	*To a certain extent sometimes it is stimulated by the government. Swedish health care is run by the counties not by the state. State supervises, and sometimes stimulates sector of health care. The funding is generic, but in some counties there is now a specific part of the budget that is directed towards generic health promotion. This includes hazardous alcohol consumption.*
Switzerland	*Ten % of taxes on spirits are allocated to the 26 Swiss cantons. Cantons must use these funds for the fight against / management of substance abuse (legal and illegal drugs). Cantons are required to annually report on how they use these funds.*
The Netherlands	*Reviewed annually or every 2 or 5 years, depending on what is funded.*

3.1.4. Support for treatment provision.

3.1.4.1. Screening and quality assessment systems.

In this section, partners were again asked their opinion on a scale from 0 to 10, about to what extent they consider that the following screening and support systems are available for PHC providers in managing HHAC. Results are reported in Figure 12.

The results show a great difference between countries. In general, they considered more available the screening instruments to identify at risk drinkers, case notes or computer record to record alcohol risk status, facilitators or advisors for HHAC consumption, follow up system for monitoring and advice patients and finally, with the lowest level of agreement, protocol charts or diagrams for HHAC consumption.

SUPPORT FOR TREATMENT PROVISION	Screening instruments to identify at risk drinkers	Case notes or computer records to record alcohol risk status	Protocol charts or diagrams for HHAC consumption	Facilitators or advisors for HHAC consumption	Follow up systems for monitoring and advice patients
Belgium	**2**	**1**	**3**	**3**	**4**
Croatia	**5**	**5**	**1**	**8**	**8**
Cyprus	**1**	**8**	**1**	**9**	**9**
Czech Republic	**5**	**1**	**0**	**2**	**1**
England	**5**	**5**	**5**	**2**	**2**
Estonia	**10**	**10**	**5**	**4**	**3**
Finland	**10**	**10**	**10**	**5**	**5**
Fyrom	**8**	**8**	**3**	**4**	**8**
Germany	**9**	**9**	**5**	**9**	**5**
Greece	**0**	**0**	**0**	**0**	**4**
Iceland	**9**	**6**	**7**	**5**	**3**
Ireland	**8**	**8**	**7**	**6**	**4**
Italy	**5**	**2**	**5**	**3**	**3**
Latvia	**7**	**6**	**1**	**5**	**3**

Malta	**1**	**1**	**1**	**8**	**2**
Poland	**8**	**1**	**0**	**3**	**0**
Portugal	**6**	**5**	**5**	**4**	**4**
Romania	**2**	**0**	**0**	**1**	**0**
Slovenia	**10**	**10**	**5**	**3**	**2**
Spain - Catalonia	**9**	**9**	**9**	**8**	**8**
Sweden	**10**	**7**	**4**	**4**	**10**
Switzerland	**10**	**3**	**3**	**4**	**3**
The Netherlands	**8**	**7**	**8**	**6**	**4**
MEAN	**6.4**	**5.3**	**3.8**	**4.6**	**4.1**
STANDARD DEVIATION	**3.3**	**3.5**	**3.0**	**2.5**	**2.8**

Figure 12. Availability of support systems for PHC providers in managing HHAC. The intensity of the colour on the scale column is degraded according to the score

Further details can be found in the following paragraphs:

Estonia	*There is a great scarcity of addiction specialists, the treatment of dependence is mainly privately funded.*
Portugal	*There are some experimental models of computer records being tested and the new action plan for alcohol will propose protocols and other kind of supports for PHC Providers.*
Romania	*The lack of a referral mechanism is currently felt by service providers, both public and private, when trying to link different services that patients need, without much success. Usually when a patient has an alcohol related problem if the services are not one stop shop the patient gets lost in the health and social work system.*
Sweden	*This was very efficient during the "risk drinking project" time, but has not yet become institutionalized.*
Switzerland	*Screening instruments are available at:www.praxis-suchtmedizin.ch; if other instruments are known (and used) is not known.*

3.1.4.2. Protocols and guidelines

Multidisciplinary guidelines

Most of the countries (69.6%) have already developed multidisciplinary guidelines, while one more is developing them (Greece). The majority are stand alone guidelines as opposed to a part of other clinical guidelines. However, there is still a great lack of studies about their adherence and implementation (just in 25% of the countries who reported having clinical guidelines).

PROTOCOLS AND GUIDELINES	MULTIDISCIPLINARY CLINICAL GUIDELINES FOR MANAGING HHAC	STUDIES ON ITS IMPLEMENTATION OR ADHERENCE
Belgium	Yes	Yes
Croatia	Yes, as part of other clinical care guidelines	No
Cyprus	No	
Czech Republic	Yes, stand alone guidelines	No
England	Yes, stand alone guidelines	No
Estonia	No	
Finland	Yes, as part of other clinical care guidelines	No

Fyrom	No	
Germany	Yes, as part of other clinical care guidelines	No
Greece	No, but under development	
Iceland	Yes, stand alone guidelines	No
Ireland	Yes, stand alone guidelines	No
Italy	Yes, stand alone guidelines	Yes
Latvia	Yes, as part of other clinical care guidelines	No
Malta	No	
Poland	No	
Portugal	Yes, stand alone guidelines	No
Romania	No	
Slovenia	Yes, stand alone guidelines	No
Spain	Yes, stand alone guidelines	No
Sweden	Yes	Yes
Switzerland	Yes, stand alone guidelines	No
The Netherlands	Yes, stand alone guidelines	Yes
MEAN	**16 out of 23 (69.6%)**	**4 out of 16 (25.0%)**

Figure 13. Availability of protocol and guidelines for managing HHAC approved or endorsed

Further details can be found in the following paragraphs:

Belgium	*www.domusmedica.be/.../709-problematisch-alcoholgebruik-aanpak-door-de -huisarts.html*
Czech Republic	*Guidelines - based on PHEPA II project –Czech version by NIPH at:http://www.gencat.cat/salut/phepa/units/phepa/pdf/czechguidelines.pdf*
England	*Three sets of NICE guidance were published in 2010:* *1. NICE. Alcohol-use disorders: preventing harmful drinking at http://guidance.nice.org.uk/PH24/Guidance/pdf/English;* *2. NICE. Alcohol dependence and harmful alcohol use at http://guidance.nice.org.uk/CG115/NICEGuidance/pdf/English;* *3. NICE. Alcohol-use disorders: physical complications at http://guidance.nice.org.uk/CG100/NICEGuidance/pdf/English*
Estonia	*The health care providers develop and apply their own guidelines.*
Finland	*http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/tunnus/hoi50028* *Treatment of Alcohol Abuse, Current Care Summary: http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/tunnus/ccs00005*
Germany	*Clinical guidelines are under preparation.*
Greece	*Guidelines for treatment of alcoholism have been recently developed (i.e. guidelines for clinical evaluation, for withdrawal syndrome treatment, for alcoholic intoxication, for relapse prevention and so on). http://www.eof.gr/c/document_library/get_file?p_l_id=34765&folderId=236302&name=DLFE-1701.pdf*
Italy	*Guidelines - based on PHEPA II project – Italian version by Scafato E., Gandin C., Patussi E. Alcol ed assistenza sanitaria primaria. Linee guida cliniche per l'identificazione precoce e l'intervento breve 2010, PHEPA-ISS at: http://www.epicentro.iss.it/temi/alcol/linee/linee_guida_cliniche.pdf*
Latvia	*Narcologic patient treatment guidelines.*

Portugal	*1.Guidelines - based on PHEPA II project – Portuguese version by The Portuguese Association of Family Medicine and the Institute on Drugs and Drug Addiction at: http://www.apmgf.pt/index.php?section=publications&f=cdi 2.Stand alone guidelines for managing HHAC and as a part of other clinical care guidelines at: http://www.apmgf.pt/index.php?section=publications&f=cdi*
Slovenia	*Guidelines - based on PHEPA II project – Slovenian version by Kolšek Marko (ed.&adapt.). Klinične smernice za zgodnje odkrivanje tveganega in škodljivega pitja in kratki ukrepi : alkohol in osnovno zdravstvo : evropski projekt za obravnavo alkoholne problematike v osnovnem zdravstvu (PHEPA). Ljubljana: Medicinska fakulteta, Katedra za družinsko medicino, 2006. (str. 159) ISBN 961-6264-77-X.*
Spain-Catalonia	*PHEPA guidelines, Socidrogallcohol guideline, Pla director.*
Switzerland	*www.praxis-suchtmedizin.ch offers guidelines, information, instruments, tools, advice and support for the PHC settings (especially physicians); the available information has been reviewed by experts and is regularly updated.*
The Netherlands	*1.Stand alone: CBO (Dutch Institute for Healthcare Improvement) richtlijn stoornissen in het gebruik van alcohol (guideline disorders in the use of alcohol), see: http://www.cbo.nl/Downloads/206/rl_alcohol_09.pdf, or http://www.trimbos.nl/webwinkel/productoverzicht-webwinkel/behandeling-en-re-integratie/af/af0857-multidisciplinaire-richtlijn-alcohol. 2.Part of: Scoring Results, see: www.resultatenscoren.nl.*

3.1.4.3. Reimbursement for health care providers

A small proportion of addition specialists (41.2%), general practitioners (35.3%), psychiatrists (35.3%) are reimbursed for managing HHAC (See Figure 14). The most common practice, however, is reimbursement as a part of their normal salary (See Figure 15).

REIMBURSEMENT OF HEALTH CARE PROVIDERS FOR MANAGING HHAC WITHIN TERMS OF SERVICE (CONTRACT)	General practitioners	Doctor in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospitals	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium							0		0	0	0	
Croatia												
Cyprus												
Czech Republic	0	0			0	0	0	0		0	0	
England												
Estonia	0	0			0	0	0	0	0	0	0	n.a.
Finland												n.a.
Fyrom	0	0	0	0	0	0	0	0	0	0	0	0
Germany												
Greece	0	0	0	0	0	0	0	0	0	0	0	0

Iceland	0	0	0	0	0	0	0	0	0	0	0	0
Ireland	0	0	0	0	0	0	0	0	0	0	0	0
Italy	0	0	0	0	0	0	0	0	0	0	0	
Latvia	0	0		0	0	0	0	0	0	0	0	0
Malta												
Poland	0	0	0	0	0	0	0	0	0	0	0	
Portugal	0	0	0	0	0	0	0	0	0	0	0	0
Romania	0	0	0	0	0	0	0	0	0	0	0	0
Slovenia		0	0	0	0	0	0	0	0	0	0	n.a.
Spain		0	0	0		0	0	0	0	0	0	0
Sweden		0				0	0	0		0		
Switzerland							0			0		
The Netherlands												
PERCENTAGES	**35.3**	**17.6**	**41.2**	**35.3**	**20.0**	**12.5**	**0.0**	**12.5**	**23.5**	**0.0**	**6.7**	**33.3**

Figure 14. Reimbursement of health care providers for managing HHAC

:YES; **Missing or not applicable (please, complete it)**

REIMBURSEMENT OF HEALTH CARE PROVIDERS FOR MANAGING HHAC AS A PART OF NORMAL SALARY	**General practitioners**	**Doctor in hospital**	**Addiction specialists**	**Psychiatrists**	**Nurses in general practice**	**Nurses in hospitals**	**Pharmacists**	**Social workers**	**Psychologists**	**Dentists**	**Obstetricians**	**Counsellors**
Belgium												
Croatia												
Cyprus												
Czech Republic			0	0								0
England												
Estonia							0			0		n.a.
Finland							0			0		
Fyrom							0			0	0	0
Germany					0	0	0			0		
Greece					0	0	0	0	0	0	0	0
Iceland												
Ireland	0	0	0	0	0	0	0	0	0	0	0	
Italy					0	0	0					
Latvia							0			0		
Malta												
Poland	0	0	0		0	0	0	0	0	0	0	
Portugal												
Romania												
Slovenia										0		n.a.

Spain							0			0	0	
Sweden						0	0			0	0	
Switzerland												
The Netherlands												
PERCENTAGES	**90.0**	**89.5**	**83.3**	**88.9**	**72.2**	**70.0**	**42.1**	**85.0**	**85.7**	**42.1**	**68.4**	**78.6**

Figure15. Reimbursement as a part of normal salary of health care providers for managing HHAC

:YES; **Missing or not applicable (please, complete it)**

Further details can be found in the following paragraphs:

Belgium	*Refunding of general consultations, but there don't exist refunding of specific consultations alcohol.*
England	*There have been localized initiatives to incentivize GPs to do more SBI, especially screening, with extra incentives eg Directed Enhanced Services (DES) and Local Enhanced Services (LES).*
Germany	*Social workers, counselors and psychologists: It depends in which institution they work.*
Ireland	*This work would form part of the general clinical services they provide.*
Poland	*In terms of funding/reimbursing managing hazardous and harmful alcohol consumption is not distinguished from alcohol dependence.*
Portugal	*A specific PHC reform was implemented and there are PHC professionals that receive an extra payment for providing services in areas such as tobacco and we are preparing a specific additional service for alcohol problems. But concerning detection and early intervention of alcohol consumption it will be included in the basic services in PHC.*
Slovenia	*Family physicians get a small extra payment for 5 consultations with one patient with HHAC (less than 5 consultations are not paid).*
Switzerland	*Reimbursement by KVG (=Federal Health Insurance Act) for professionals working in medical settings; professionals working in other settings are financed by public funds.*

Protocols, policies and training for professionals

In most of the countries (See Figure 16), there are specialized guidelines or protocols for managing HHAC for addiction specialists (81.8%), general practitioners (65.2%), psychiatrists (59.1%), doctors in hospital (55.0%) On the contrary, guidelines or protocols are uncommon for all the rest of professionals, particularly for pharmacists (11.1%) and dentists (6.3%).

SPECIALIZED GUIDELINES OR PROTOCOLS FOR MANAGING HHAC	General practitioners	Doctors in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospital	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Croatia	0				0	0						
Cyprus							0			0	0	

Czech Republic		0		0	0	0	0	0	0	0	0	0
England												
Estonia	0	0	0	0	0	0	0	0	0	0	0	n.a.
Finland							0			0		n.a.
Fyrom	0	0	0	0	0	0	0	0	0	0	0	0
Germany												
Greece	0	0	0	0	0	0	0	0	0	0	0	0
Iceland						0						
Ireland					0	0	0	0	0	0	0	
Italy					0	0	0	0		0	0	0
Latvia	0	0		0	0	0	0	0	0	0	0	0
Malta	0	0		0	0	0	0	0		0	0	0
Poland	0	0		0	0	0	0			0	0	
Portugal												
Romania	0	0	0	0	0	0	0	0	0	0	0	0
Slovenia		0			0	0	0	0	0	0	0	n.a.
Spain							0			0	0	
Sweden				0			0				0	
Switzerland												
The Netherlands							0			0		
PERCENTAGES	**65.2**	**55.0**	**81.8**	**59.1**	**36.8**	**31.6**	**11.1**	**41.2**	**50.0**	**6.3**	**17.6**	**46.2**

Figure 16. Specialized guidelines or protocols for managing HHAC

In few countries (See Figure 17), there are written policies by professional associations for managing HHAC for all professionals. No written policies are indicated by all countries for dentists and only one country for obstetricians and pharmacists (The Netherlands).

WRITTEN POLICIY BY PROFESSIONAL ASSOCIATION FOR MANAGING HHAC	General practitioners	Doctors in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospital	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Croatia	0	0	0	0	0	0						
Cyprus	0	0			0	0	0	0		0	0	0
Czech Republic	0	0	0	0	0	0	0	0	0	0	0	0
England												
Estonia												n.a.
Finland	0	0	0	0	0	0	0	0	0	0	0	n.a.
Fyrom	0	0	0	0	0	0	0	0	0	0	0	0

Germany												
Greece	0	0	0	0	0	0	0	0	0	0	0	0
Iceland					0	0						
Ireland										0		
Italy	0	0		0	0	0	0	0	0	0	0	0
Latvia	0	0	0	0	0	0	0	0	0	0	0	0
Malta	0	0	0	0	0	0	0	0	0	0	0	0
Poland	0	0	0	0	0	0	0	0	0	0	0	0
Portugal												
Romania												
Slovenia	0	0	0	0	0	0	0	0	0	0	0	n.a.
Spain							0			0	0	
Sweden				0			0				0	
Switzerland												
The Netherlands										0		
PERCENTAGES	**31.3**	**26.7**	**35.7**	**31.3**	**20.0**	**20.0**	**7.7**	**23.1**	**30.8**	**0.0**	**7.7**	**20.0**

Figure 17. Written policies for managing HHAC.

In most of the countries (See Figure 18), there is training for managing HHAC within professional vocational training for addiction specialists (88.2%), general practitioners (82.4%), psychologists (80.0%), psychiatrists (76.5%), and to a lesser extent for social workers (73.3%), doctors in hospital (71.4%) and counsellors (58.3%); training is particularly uncommon for obstetricians (28.6%) pharmacists (26.7%) and for dentists (23.1%).

TRAINING FOR MANAGING HHAC WITHIN PROFESSIONAL VOCATIONAL TRAINING	General practitioners	Doctors in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospital	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Croatia					0	0						
Cyprus	0	0			0	0	0	0		0	0	0
Czech Republic							0					
England												
Estonia												n.a.
Finland							0					n.a.
Fyrom (Ex Macedonia)	0	0	0	0	0	0	0	0	0	0	0	0
Germany												
Greece					0		0			0	0	
Iceland					0	0						

Ireland										0		
Italy					0	0	0	0		0	0	0
Latvia				0			0			0	0	0
Malta					0	0						
Poland	0	0	0	0	0	0	0	0	0	0	0	0
Portugal												
Romania												
Slovenia		0			0	0	0		0	0	0	n.a.
Spain							0			0	0	
Sweden				0			0				0	
Switzerland												
The Netherlands										0	0	
PERCENTAGES	**82.4**	**71.4**	**88.2**	**76.5**	**43.8**	**50.0**	**26.7**	**73.3**	**80.0**	**23.1**	**28.6**	**58.3**

Figure 18. Training for managing HHAC within professional vocational training

The availability of training for managing HHAC within accredited continuing medical education is inferior to the training for managing HHAC within professional vocational training, for all professionals but not for doctors in hospitals (See Figure19).

TRAINING FOR MANAGING HHAC WITHIN ACCREDITED CONTINUING MEDICAL EDUCATION	General practitioners	Doctors in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospital	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Croatia	0				0	0						
Cyprus	0	0	0	0	0	0	0	0	0	0	0	0
Czech Republic							0	0	0	0	0	0
England												
Estonia												n.a.
Finland												n.a.
Fyrom					0	0	0			0	0	0
Germany												
Greece	0	0	0	0	0	0	0	0	0	0	0	0
Iceland					0	0						
Ireland										0	0	0
Italy					0	0	0	0		0	0	0
Latvia							0			0		

Malta								0				
Poland	0	0	0	0	0	0	0	0	0	0	0	0
Portugal												
Romania												
Slovenia		0			0	0	0	0	0	0	0	n.a.
Spain							0			0	0	
Sweden	0			0			0					
Switzerland												
The Netherlands										0	0	
PERCENTAGES	**70.6**	**73.3**	**80.0**	**76.5**	**42.9**	**42.9**	**23.1**	**41.7**	**58.3**	**8.3**	**16.7**	**36.4**

Figure 19. Training for managing HHAC within accredited continuing medical education

Further details can be found in the following paragraphs:

Belgium	*The training protocols are available but are not made compulsory.*
England	*Three sets of NICE guidance covers all these groups of professionals:* • *http://www.sips.iop.kcl.ac.uk/documents/factsheets/SIPS_factsheet_ED.pdf;* • *http://www.sips.iop.kcl.ac.uk/documents/factsheets/SIPS_factsheet_PHC.pdf;* • *http://www.sips.iop.kcl.ac.uk/documents/factsheets/SIPS_factsheet_CJS.pdf;* *Some local training programmes provide training, but no national strategy for postgraduate training apart from GPS through Royal College of General Practitioners and alcohol treatment part of core curriculum for psychiatrists in training.*
Greece	*Training is related to seminars, conferences on alcohol use/abuse and so on.*
Germany	*It all depends on regions, professions, and institutions. The options not crossed do not mean that do not exist.*
Iceland	*For addiction specialists and counselors working at the main treatment hospital, private owned but partially publically funded, they have their own guidelines.*

Italy	*The implementation of EIBI PHEPA II programme started at the CNESPS-ISS, on 2007 with the first formal training course; from that time many courses have been carried by the ISS funded by the MoH and by the Presidency of the Council of the Ministries, Dept of anti drugs policies. The national EIBI working team at the ISS- "Gruppo IPIB-Identificazione Precoce Intervento Breve" started its activities in April 2006 to deliver a communication strategy and to organise conferences to announce, promote and disseminate the training programme. IPIB is actually the formal institutional standard of training in Italy according to the PHEPA standard approved by the National Committee on Alcohol (set by the frame law on alcohol 125/2001). The ISS has been indicated as the national provider of the training activities in tight connection with the SIA (Italian Society of Alcohology) and the Regions. The training course has received a good evaluation in terms of credits to be earned through the Continuous National Training Programme (ECM), compulsory for the professionals of the National Health System.* *In Perugia, Umbria Region, training for managing HHAC has been carried out also for nurses, pharmacists and obstetricians.*
Sweden	*1. We still lack a system for accreditation in Sweden.* *2.The national guidelines are generic, and not directed towards any particular professional group. At least for nurses one is underways. Please observe that concerning nurses and physicians must is done in Occupational health care, which may be the group that presently does most work with HHAC among it's clients.*
Switzerland	*1.Information on www.praxis-suchtmedizin.ch* *2.Guidelines for midwives (see below).* *3.QuaTheDA – quality norm in expert addiction support.*

3.1.5. Intervention and treatment: availability and accessibility

In this section, partners were again asked about their opinion on a scale from 0 to 10, about how much they consider that patient help for HHAC is accessible in different settings. Results are reported in Figure 20.

PATIENT HELP FOR HHAC IS ACCESSIBLE IN DIFFERENT SETTINGS	General/family practice	Hospital clinics	Pharmacies	Specialist clinics	Addiction services

Figure 20. Patients help for HHAC obtainable in different settings. The intensity of the colour on the scale column is degraded according to the score

Patients help for HHAC is considered accessible in addition services and to a lesser extent in specialists clinics, general/family practice and hospital clinics, with the lowest percentage in pharmacies.

Further details can be found in the following paragraphs:

Belgium	*Accessibility does not mean that there are no waiting lists.*

Italy	*It is important to take into account that not all addiction public services are engaged on EIBI of HHAC: this task is mainly carried out in specialist alcohol services only.*
Poland	*Rehabilitation clinics don't exist in Poland.*
Portugal	*There is a specific training program in hospitals, in addiction units and also in undergraduate medical settings. See at: http://www.acss.min-saude.pt/Projectos/ProjectoQRENPOPH/tabid/223/language/pt-PT/Default.aspx?PageContentMode=1 , http://www.acss.min-saude.pt/Portals/0/ANEXO%20IX%20-%20FormacaoProblAlcDepend.pdf , http://www.fm.ul.pt/#3278*
Romania	*In the same study mentioned earlier another problematic issue was the health services in the area of problematic/hazardous alcohol consumption. The services fail to reach the younger sections of the population with less severe issues. Women are strongly sub-represented among the beneficiaries of health services. Over 80% of the people with problematic alcohol consumption from within the general population and that have never resorted to specialized services know of no institutions/specialized services in treating problems of abuse and addictions in their county. People resorting to these services tend to be over 50 years of age (over 50%), when presumably they have reached a greater stage of alcohol addiction. Family physicians fail to discern, in the early stages, disorders regarding alcohol consumption; they rather asses them in advanced stages. Thus, 55% of people that have had treatment for a problem related to alcohol consumption have received information from their family physician, and 44% were directed to a specialized service, compared to just 2%, respectively 3% of people that never received any treatment. In conclusion, in the lack of training, physicians rarely recognize minimal cases of alcohol abuse, with people reaching hospital treatment being rather older patients where we can suppose a greater stage of alcohol addiction. The study shows that another aspect important to the specialists interviewed is that of the absence of guidebooks and work protocols agreed at a national level in the area of specialized interventions for the treatment of alcohol consumption disorders. The sole official document developed at a national level regarding specialized services in this area is framed within the National Antidrug Strategy. Currently, in Romania, the main specialization addressing interventions related to alcohol consumption is psychiatry, with interventions in this field being very appreciated by those struggling with problematic alcohol consumption, over 50% of them considering them very useful. The same positive note is being said about self-help groups such as Alcoholics Anonymous or socio-medical intervention centers developed in this field.*
Sweden	*These fairly low figures are explained by practical reason, not by formal accessibility. The shortcomings are both due to lack of attention to this issue, and inconvenience in working with alcohol issues.*

3.1.6. Health care providers.

3.1.6.1. Clinical accountability.

In this section, participants were asked about their opinion on a scale from 0 to 10, about how much they estimate that different health care professionals consider advices for HHAC as part of their routine clinical practice. Results are reported in Figure 21.

…….

ESTIMATION OF THE EXTENT TO WHICH THE FOLLOWING CARE PROFESSIONALS DO CONSIDER ADVICE FOR HHAC AS PART OF THEIR ROUTINE CLINICAL PRACTICE	General/family practice	Doctors in hospital	Addiction specialists	Psychiatrists	Nurses working in general practice	Nurses woking in hospitals	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium	4	3	10	7	3	2	2	2	5	1	2	
Croatia	7	7	10	10	5	5	3	7	6	2	7	8
Cyprus	10	10	10	10	10	10	10	10	10	10	10	10
Czech Republic	2	1	8	7	2	1	1	1	2	1	1	5
England	4	3	7	6	5	5	2	6	3	1	3	5
Estonia	5	3	10	5	5	3	0	3	5	0	4	
Finland	7	3	10	8	8	6	0	8	6	2	8	
Fyrom	4	4	9	8	2	2	0	9	9	0	0	0
Germany	5	4	10	8	2	2	2	3	2	1	3	3
Greece	4	7	9	9	2	6	3	3	6	2	2	6
Iceland	8	7	10	10	8	7	7	9	9	4		9
Ireland	7	7	8	7	6	6	5	7	3	3	6	8
Italy	4	3	6	4	2	2	1	4	4	1	3	3
Latvia	6	7	10	9	7	7	4	9	6	5	6	8
Malta	6	7	10	9	5	6	5	6	7	6	8	7
Poland	1	1	8	3	0	0	0	0	3	0	0	5
Portugal	5	6	8	8	6	6		6	8	3	5	7
Romania	2	1	3	4	1	1	0	2	4	0	0	3
Slovenia	8	3	9	8	4	3	2	5	5	1	2	
Spain	8	5	8	6	7	5	3	6	6	2	3	6
Sweden	5				4		0				8	
Switzerland	7	5	10	8		6	2	8	5	4	9	
The Netherlands	5	4	9	6	5	5	3	6	6	3	3	6
MEAN	5,4	4,6	8,7	7,3	4,5	4,4	2,5	5,5	5,5	2,4	4,2	5,8

Figure 21. Estimation of advices for HHAC as part of the routine clinical practice

Further details can be found in the following paragraphs:

Czech Republic	*Training in brief intervention - PILOT PROJECT NIPH - launched in 2010 - slower implementation into clinical practice - lack of motivation of health professionals.*
England	*SIPS "Screening and Intervention Programme for Sensible drinkers" reports cover General Practitioners and Emergency Departments.* • *Primary Health Care results: http://www.bmj.com/content/346/bmj.e8501 ;* • *Criminal Justice Service Protocol: http://www.biomedcentral.com/1471-2458/9/418/;*

	• *Accidents and Emergency Departments Protocol: http://www.biomedcentral.com/1472-6963/9/114*
Fyrom	*Alcohol related problems in Republic of Macedonia;* *Why young people should not drink alcohol;* *Alcoholism and deviated behaviour;* *Alcoholism, recovery and sober life*
Germany	*Social worker and counselors: It varies a lot where they work. If they work in specialized addiction services it is certainly 10*
Ireland	*Health Service Executive 2011. A guiding framework for education and training in screening and brief intervention for problem alcohol use. Dublin: HSE available online (http://www.hse.ie/eng/services/Publications/topics/alcohol/interventionforproblemalcoholabuse.pdf)*
Switzerland	• *General practitioners and others:* *www.praxis-suchtmedizin.ch;* *http://www.fosumos.ch/images/stories/pdf/risikotrinken_dt_web_verschlsselt.pdf;* • *Midwives:* *http://www.hebamme.ch/x_data/lit_pdf/Guideline%20zu%20Screening%20und%20Beratung%20bei%20Zigaretten-%20und%20Alkoholkonsum.pdf*

3.1.6.2. Treatment provision.

In this section a summary of the main findings reported on different areas is provided in the tables.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	PATIENTS ARE ASKED OR SCREENED ABOUT THEIR ALCOHOL CONSUMPTION		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	Y	2008	Health interview survey, Belgium
Croatia	N		
Cyprus	N		
Czech Republic	Y	2011	Almost 30% of young men drink in an hazardous way. Sovinová H et al. The Czech Audit: Internal consistency, latent structure and identification of risky alcohol consumption. Cent Eur J Public Health 2010; 18 (3): 127 – 131
England	Y	2011	Occurs sporadically. AMPHORA in the latest. Wilson G, Lock C, Heather N, Cassidy P, Christie M, Kaner E. Intervention against excessive alcohol consumption in primary health care: a survey of GPs attitudes and practices in England ten years on. Alcohol and Alcoholism 2011: doi: 10.1093/alcalc/agr067; Drummond C, Gual A, Goos C, Godfrey C, Deluca P, et al. Addiction 2011;106:31-36
Estonia	Y		Adult health behavior survey available at: http://www.tai.ee/et/terviseandmed/uuringud?limit=10&filter_catid=17&filter_year=0&filter_pubid=0&filter_languageid=0&filter_order=p.publish_year&filter_order_Dir=DESC&start=10
Finland	Y	2008	makela et al_2011_addiction_brief intervention.docx
Fyrom	N		
Germany	Y	2011	Frühintervention bei Patienten mit Alkoholproblem in

			Arztpraxen FrühA
Greece	Y	2006	1.Aim: The detection of alcohol addiction/abuse among patients with psychiatric problems visiting the Emergency Psychiatric Department (EPD) of a General Public Hospital. Method: For a period of 3 months all adult patients were asked to answer the CAGE TEST. Sample: 220 patients with mean age 41 years (± 14.4). Results: Men showed statistically higher values in CAGE TEST compared to women (t-test p <0.05) as well as the divorced patients compared to unmarried and married patients (ANOVA Test p <0.05). Conclusions: Alcohol abuse appears to be increasing among individuals with psychiatric problems compared to those of general population. Alcohol abuse as a comorbid factor should be further investigated. Moussas G et al. Alcoholism in the Emergency Department of the Psychiatric clinic of the Public General Hospital: An epidemiological study of comorbidity (In: 19th National Congress of Psychiatry, 4-8 May 2006, Athens, Greek Psychiatric Association), Psychiatry, v.17 (1), p.200; 2. Method: Method: Data on sex, age, city, substance use, psychiatric comorbidity, medication, number of admissions, number of relapses and number of visits derived from the data collected by the Outpatient's Substance Department of the hospital. Sample: 183 new patients who participated in 800 scheduled sessions. Results: The patients who were alcohol and poly-drug users outnumbered. The majority of them were men. The low rate of relapses and hospital admissions is attributed to the regular attendance of the scheduled sessions. Conclusions: The Outpatient's Substance Department seems to meet the need for evaluation and health care of substance dependent patients visiting the hospital. It is also stressed the need of such interventions being further developed in public hospitals. Diakogiannis I et al. Clinical – epidemiological study of the Patients of the Outpatient's Substance Department of the Psychiatric Clinic of AXEPA University General Hospital: Three-year operation (In: 19th National Congress of Psychiatry, 4-8 May 2006, Athens, Greek Psychiatric Association.
Iceland	Y	2009	15% of doctors ask, if patient have no symptoms. 84% ask if patient have symptoms. Prevention in the PHC. The findings we have on SBI are mainly from a master thesis from the year 2009. In that thesis a comparison was done on changes in doctors attitude on smoking prevention in the PHC. Data from the year 2000 was compared with data from 2009. In addition, questions regarding alcohol were added in 2009 data collection.
Ireland	Y	2006	4,584 patients were screened. The results show that 61% of these patients were in the 'low/no risk' categories, while 22% were in the 'hazardous' zone and 17% were 'harmful/dependent'. Irish College of General Practitioners. (2006) Alcohol Aware Practice Pilot Study 2005-2006. Dublin: ICGP Publications.
Italy	Y	2006	No difficulties for about 60% of GPs http://www.who.int/substance_abuse/publications/id

			entification_management_alcoholproblems_phaseiv.pdf
Latvia	Y		The most frequent issues caused by alcohol consumption was the inability to stop drinking, higher than planned amount of consumption, hangovers, and attempts to fight them by continuing drinking of the following day. 28% of the population (15-64 yrs) faced various alcohol related problem during last year period, but CIDI test criteria confirm this for 12.5% of the population. These indicators point out that drinking habits in Latvia exhibit major similarities to those in Finland and United Kingdom, thus it might be important to give thorough consideration to evidences found in similar to Latvia countries. Snikere.S. et al. "Addiction inducing substance use among general population". Survey results.
Malta	N		
Poland	N		
Portugal	Y	2009	Rev Port Clin Geral 2009;25:281-304 "Hábitos alcoólicos e protecção cardiovascular no Centro de Saúde de Barão do Corvo" at http://www.rpmgf.pt/ojs/index.php?journal=rpmgf&page=article&op=view&path%5B%5D=4610
Romania			
Slovenia	Y	2006	1. Only 50% of patients have ever been asked about their alcohol drinking (2006). SIMONIČ R. Osveščenost odrasle populacije o učinkih uživanja alkohola na telesno zdravje ter poznavanje sodobnih meril za tvegano pitje; specialistična naloga. Ljubljana: Medicinska fakulteta, 2010. 2. 95% of patients aged: men 35 – 65, women 45 – 70 has been asked about their alcohol drinking (2006). FRAS, Z. et al. Prevalence of arterial hypertension, its awareness and control in the adult population of the Ljubljana area of Slovenia. Results of WHO's countrywide integrated non communicable diseases intervention (CINDI) program survey 2002/2003 = Prevalenca arterijske hipertenzije, njenega zavedanja in urejenosti pri odraslih prebivalcih ljubljanske regije. Rezultati raziskave CINDI (WHO countrywide integrated non communicable diseases intervention) program survev 2002/2003. Slov. Kardiol, 2006;3(2):106-14.
Spain	Y	2010	45% of patients are asked about alcohol consumption. Not published
Sweden	Y	2008 2011	Staff in PHC recorded strong increase in asking patients between 2006 and 2009, not confirmed in studies with patients, these report being asked 12-15%. 1. Holmqvist M et al. Alcohol Prevention Activity in Swedish PHC and Occupational Health Services. Asking patients about their drinking. Nordic Studies on alcohol and drugs. 2008;25:489-504. 2. Geirsson M et al. The impact of the Swedish Risk Drinking Project on clinical practice in primary Care. In dissertation Geirsson M 2011 Alcohol prevention in Sweden primary health care at http://hdl.handle.net/2077/26274
Switzerland	Y	2010	Group brief interventions proved significant for participants in the risk group (3-4 binge drinking events

			in the previous month). However no such effect for the high risk group (more than 4 binge drinking events) (Gmel, 2010, S. 49); Interventions for the group with the higher drink amount led to a greater reduction of the drink amount and the number of excessive drinking events compared to the control group (no intervention). G.Gmel et al (2010) in: http://www.sucht-info.ch/fileadmin/user_upload/Images/Abschlussbericht_Z%C3%BCrich_Kurzinterventionen.pdf; Daeppen JB., Bertholet N., Gaume J., Fortini C., Faouzi M., Gmel G. (2010). Efficacy of brief motivational intervention in reducing binge drinking in young men: A randomized controlled trial. Drug and Alcohol Dependence 113, 69-75
The Netherlands	Y	1995 2009	- GP-standard for recognizing alcoholics is not adequate; - NEMESIS (Netherlands Mental Health Survey and Incidence Study) - Cornel et al. Alcohol and Alcoholism 1995; 30: 651-659; - www.trimbos.nl
PERCENTAGE	73.9%		

Figure 22. Studies, surveys or publications in primary health care about patients screened about their alcohol consumption.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	PATIENTS WITH HHAC ARE GIVEN ADVICE		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England	Y	2012	AMPHORA. The SIPS Team. Primary Health Care. SIPs Factsheet 2.2012
Estonia	Y		Adult health behavior survey available at: http://www.tai.ee/et/terviseandmed/uuringud?limit=10&filter_catid=17&filter_year=0&filter_pubid=0&filter_languageid=0&filter_order=p.publish_year&filter_order_Dir=DESC&start=10
Finland	Y		makela et al_2011_addiction_brief intervention.docx
Fyrom	N		
Germany	Y	2011 2009	Frühintervention bei Patienten mit Alkoholproblem in Arztpraxen FrühA; Reis O, Pape M, Häßler F (2009): Ergebnisse eines Projektes zur kombinierten Prävention jugendlichen Rauschtrinkens. Sucht 2009; 55: 347-356.
Greece			
Iceland	Y		81% give advice to change lifestyle

Ireland	N		
Italy	Y		http://www.who.int/substance_abuse/publications/identification_management_alcoholproblems_phaseiv.pdf
Latvia	N		
Malta	N		
Poland	N		
Portugal	Y		Patients accept screening of alcohol consumption by their physician. Patients are also open to advice regarding their alcohol intake. RASTREIO DO CONSUMO DE ÁLCOOL NOS CUIDADOS DE SAÚDE PRIMÁRIOS - ATITUDES DOS UTENTES – Campos – Master degree at: http://repositorio.ul.pt/handle/10451/6768
Romania	N		
Slovenia	N		
Spain	Y	2010	Not published
Sweden	Y		See above
Switzerland	Y		Gmel G et al (2010) in: http://www.sucht-info.ch/fileadmin/user_upload/Images/Abschlussbericht_Z%C3%BCrich_Kurzinterventionen.pdf; Daeppen JB., Bertholet N., Gaume J., Fortini C., Faouzi M., Gmel G. (2010). Efficacy of brief motivational intervention in reducing binge drinking in young men: A randomized controlled trial. Drug and Alcohol Dependence 113, 69-75.
The Netherlands	Y		Pilots and research
PERCENTAGE	47.8%		

Figure 23. Studies, surveys or publications in primary health care about patients with HHAC given advice.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	THE USE OF AUDIT QUESTIONNAIRE		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	Y	2008	Occupational health:13% van de werknemers gebruikt alcohol op een onveilige manier (categorieën samengeteld: risicogebruik + schadelijk gebruik + risico op afhankelijkheid). Er zijn significant meer mannen (18%) met een onveilig alcoholgebruik dan vrouwen (6%). Daarbij kan ruim 1 op 100 werknemers. Securex (2008). White paper 'Het alcoholgebruik van de Belgische werknemer'
Croatia	N		
Cyprus	N		
Czech Republic	Y	2010	Experience with Czech AUDIT is promising. Csémy L., Sovinová H., Procházka B.: Risky and harmful alcohol consumption in young adults: social and demographic context. Prakticky lekar 2011, 91, (10): 655 - 660
England	Y	2012	The SIPS Team. Primary Health Care. SIPs Factsheet 2.2012
Estonia	N		
Finland	Y	2008	http://www.thl.fi/thl-client/pdfs/185cd443-0aa9-4bb7-8755-7a98bcfaaed7 Table (taulukko) 20a. Kaikki=all, Miehet=men, Naiset=women
Fyrom	N		
Germany			
Greece			
Iceland	N		
Ireland	Y	2006	4,584 patients were screened. The results show that 61% of these patients were in the 'low/no risk' categories, while 22% were in the 'hazardous' zone and 17% were 'harmful/dependent'. Irish College of General Practitioners. (2006) Alcohol Aware Practice Pilot Study 2005-2006. Dublin: ICGP Publications.
Italy	Y	1997 2006	1. The AUDIT has been validated in Italy in 1997 (Piccinelli M. et al, 1997. BMJ, 314:420-424) 2. A study aimed to evaluate the feasibility of adapting a shorter version of the WHO AUDIT (AUDIT-C) in a setting of PHC in an Italian context. It examined 232 questionnaires previously administered to an opportunistic sample of GPs patients to verify the internal validity of the first three items of the AUDIT questionnaire in comparison to the full set of ten questions. It revealed that the short-AUDIT is predictive of the same results obtained by the ten questions-AUDIT. 2. Struzzo P. et al (2006). Bollettino per le Farmacodipendenze e l'Alcolismo at: http://www.unicri.it/wwk/publications/dacp/journal/2006_12/j%20xxix%202006_12%206_Struzzo.pdf
Latvia	N		
Malta	N		
Poland	N		

Portugal	Y		A Medicina Geral e Familiar e a Abordagem do Consumo de Álcool Detecção e Intervenções Breves no âmbito dos Cuidados de Saúde Primários Cristina Ribeiro at: http://repositorio.ul.pt/handle/10451/2733
Romania	N		
Slovenia	N		
Spain	Y	2002 2010 2011	15% of prevalence more or less. Several references.
Sweden	Y		More patients identified with screening that without. Please, check references not clear in the questionnaire
Switzerland	Y	2010	Based on the AUDIT: G.Gmel et al in: http://www.sucht-info.ch/fileadmin/user_upload/Images/Abschlussbericht_Z%C3%BCrich_Kurzinterventionen.pdf; Daeppen JB., Bertholet N., Gaume J., Fortini C., Faouzi M., Gmel G. (2010). Efficacy of brief motivational intervention in reducing binge drinking in young men: A randomized controlled trial. Drug and Alcohol Dependence 113, 69-75 .
The Netherlands	Y		
PERCENTAGE	47.8%		

Figure 24. Studies, surveys or publications in primary health care about the use of AUDIT questionnaire.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	**ADVICE MEETS QUALITY CRITERIA**		
	Y/N	**YEAR**	**MAIN FINDINGS - REFERENCE**
Belgium	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England			
Estonia	N		
Finland			
Fyrom	N		
Germany			
Greece			
Iceland	N		
Ireland	N		
Italy	N		
Latvia	N		
Malta	N		
Poland	N		
Portugal	N		
Romania	N		
Slovenia	N		
Spain	Y	2010	

Sweden	N		
Switzerland			
The Netherlands	Y		Only pilot, regional application
PERCENTAGE	8.7%		

Figure 25. Studies, surveys or publications in primary health care about advice meet quality criteria.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	PRACTICE PROTOCOLS AND GUIDELINES ARE FOLLOWED		
	Y/N	**YEAR**	**MAIN FINDINGS - REFERENCE**
Belgium	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England			
Estonia	N		
Finland			
Fyrom			
Germany			
Greece			
Iceland	N		
Ireland	N		
Italy	Y	2007	EIBI PHEPA programme implemented by ISS from 2007. 1. Scafato E. et al (Eds), (2008). Programma di formazione IPIB-PHEPA Identificazione Precoce e Intervento Breve dell'abuso alcolico in Primary Health Care. Alcol e Prevenzione nei contesti di Assistenza Sanitaria Primaria, at: http://www.gencat.cat/salut/phepa/units/phepa/pdf/italian_training_programme.pdf ; 2. Scafato E. et al (Eds), (2010). L'alcol e l'assistenza sanitaria primaria. Linee guida cliniche per l'identificazione e l'intervento breve, at: http://www.epicentro.iss.it/temi/alcol/linee/linee_guida_cliniche.pdf
Latvia	N		
Malta	N		
Poland	N		
Portugal	Y	2009	Do not recommend alcohol consumption for cardiovascular benefits and recommend less alcohol consumption. Rev Port Clin Geral 2009;25:281-304 "Hábitos alcoólicos e protecção cardiovascular no Centro de Saúde de Barão do Corvo" at http://www.rpmgf.pt/ojs/index.php?journal=rpmgf&page=article&op=view&path%5B%5D=4610
Romania	N		
Slovenia	N		
Spain	N		ECAP and guidelines (YES or NO? Please, check it)
Sweden	N		
Switzerland			

The Netherlands	Y		There are, but application is uncertain. www.nhg.artsennet.nl
PERCENTAGE	13.0%		

Figure 26. Studies, surveys or publications in primary health care about practice protocols and guidelines.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	EFFECTIVENESS OF INTERVENTIONS FOR HHAC		
	Y/N	**YEAR**	**MAIN FINDINGS - REFERENCE**
Belgium	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England	Y	2007	Brief intervention effective. SIPS. Kaner E et al (2007). Brief interventions for excessive drinkers in PHC settings (Full Review). Cochrane Database of Systematic Reviews 2007, Issue 2. Art No.: CD04148
Estonia	N		
Finland			
Fyrom	N		
Germany			
Greece	Y		Aim: The Outpatients' Alcohol Department (Gastroenterology Clinic, University General Hospital of Crete) has been operating since 2004. It provides health care (medical and psychiatric care, counseling and motivation interviewing) to patients with alcoholic liver damage. It cooperates with family clubs for the support of the family members of the patients. Outcome of the patients attending the programme of the Outpatients' Alcohol Department for 1 month to 5 years: 104 of 227 patients abstained from alcohol use and 20 of 227 reported occasional use of alcohol without loss of control (54.6%). Of those (104 individuals), 54% abstained from alcohol use for less than 3 months, 23.4% for 3-6 months, 7.2% for 6-12 months and 15.3% for more than 1 year. Conclusion: The disciplinary approach of a sensitized health professional group in cooperation with family club volunteers is related to the fact that a significant proportion of patients (over 50%) abstained from alcohol use for a short/long period of time. Koulentaki M et al (2010). Outpatients' Alcohol Department: Five-year Experience from Crete. 30th Panhellenic Congress of Gastroenterology, Athens, 11-14 November 2010.
Iceland	N		
Ireland	N		

Italy	Y		1. Aims, methodology and preliminary results of a national pilot study are described. Mezzani et al, 2007 2. A randomized controlled non-inferiority trial is ongoing in PHC in the Friuli Venezia Giulia Region aimed at evaluating whether facilitated access to an alcohol reduction website for at-risk drinkers is not inferior to the face-to-face brief intervention in primary care. Wallace et al, 2013
Latvia	N		
Malta	N		
Poland	Y	2009 2010	At 3 and 12 month follow ups, intervention and assessment groups compared to screened only group showed significant decreases in alcohol consumption. Cherpitel C.J.; Moskalewicz J., Świątkiewicz G., Ye Y. (2009): Screening, brief intervention, and referral to treatment (SBIRT) in a Polish Emergency Department: three-month outcomes of a randomized, controlled clinical trial. J. Stud. Alcohol. Drugs, Vol.70, No.6, pp.982-990; Cherpitel C.J.; Korcha R.A., Moskalewicz J., Świątkiewicz G., Bond J. (2010): Screening, brief intervention, and referral to treatment (SBIRT): 12-month outcomes of a randomized controlled clinical trial in a polish emergency department. Alcohol. Clin. Exp. Res., Vol.34, No.11, pp.1922-1928
Portugal	Y		Decrease in consumption was observed patients followed by physicians of the experimental group. Results concerning the relationship demonstrates that a better attitude of physicians in can influence the decrease alcohol. Ribeiro C. A Medicina Geral e Familiar e a Abordagem do Consumo de Álcool Detecção e Intervenções Breves no âmbito dos Cuidados de Saúde Primários.
Romania	N		
Slovenia	N		
Spain	Y	2003	IB reduced significantly alcohol consumption (d=-0.46; IC95%, -0.29 to -0,63; p<0,0005) and prevalence of risky drinkers (OR=1,55; IC 95%, 1.06-2.26; p=0.02. Gaceta sanitaria 2003
Sweden	Y	1989	At the one-year follow-up there were greater, however not significant, reduction in GGT-level, in self-reported alcohol consumption and in a 'problem index' in the minimal intervention group than in the comparison group. Romelsjo A, Andersson L, Barrner H, Borg S, Granstrand C, Hultman O, et al. A randomized study of secondary prevention of early stage problem drinkers in primary health care. Br J Addict. 1989;84:1319-27
Switzerland			
The Netherlands			
PERCENTAGE	30.4%		

Figure 27. Studies, surveys or publications in primary health care about effectiveness of interventions for HHAC.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	COST-EFFECTIVENESS OF INTERVENTIONS FOR HHAC		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England	Y		SIPS
Estonia	N		
Finland			
Fyrom	N		
Germany			
Greece			
Iceland	N		
Ireland	N		
Italy	Y	2013	In press. Colin et al. Modelling the Cost-Effectiveness of Screening and Brief Interventions in Italy. An Adaptation of the Sheffield Alcohol Policy Model
Latvia	N		
Malta	N		
Poland	N		
Portugal	N		
Romania	N		
Slovenia	N		
Spain	N		
Sweden	N		
Switzerland			
The Netherlands	N		
PERCENTAGE	8.7%		

Figure 28. Studies, surveys or publications in primary health care about cost-effectiveness of interventions for HHAC.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	THE ATTITUDES OF HEALTH CARE PROVIDERS TO MANAGING HHAC		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England	Y	2011	SIPS and ANARP. Wilson G et al (2011) Alcohol and Alcoholism 2011: doi: 10.1093/alcalc/agr067. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122341
Estonia	Y		
Finland			
Fyrom	N		
Germany	Y	2011	Frühintervention bei Patienten mit Alkoholproblem in Arztpraxen FrühA available at: http://tannenhof.de/fileadmin/user_upload/download/pdf/THBB%20Projekt%20Fr%C3%BCh%20-%20A%20%20Abschlussbericht%2030.06.2011.pdf
Greece			
Iceland	Y	2009	Want to refer patient to other professionals. Want to gain more training in BI. Prevention in the primary health care.
Ireland	N		

Italy	Y	2000 2003 2006 2003 2007	1. Within proposed disincentives to a sample of 800 GPs, the most serious barriers: the availability of adequate support structures, health policies and lack of availability of adequate training programmes; within the proposed incentives: the access to a national network of specialised services, voluntary associations - self-help groups, available screening material and training programmes. Polvani S, et al. (2000) at: http://www.unicri.it/min.san.bollettino/bulletin/2000-1e/art3.html 2. Focus groups with GPs concerning the principal barriers to implement EIBI, regarding how to involve GPs into preventive approach on alcohol, the need to obtain a package suitable to clinical practice; the formalization of their role on primary prevention and the needs for possible incentives, specific training needs in terms of communication skills, counselling techniques, EIBI instruments. Patussi V, et al. (2003) at: http://www.unicri.it/wwk/publications/dacp/journal/2003_4/j%20xxvi%202003%204%20prevenzione%20alcol%20medicina%20generale%20progetto%20who.pdf 3. GPs suggested also 3 types of interventions into their general daily's practice: information to the general population, diagnosis and brief intervention for risky drinkers, motivational interview for alcohol dependence and to refer them to specialized centres. Some more problems have been underlined by GPs, linked to their working settings such as young people rarely go to see their GPs, women tend to hide problems related to their alcohol consumption, the tendency to minimize alcohol consumption by patients and the fact that GPs themselves have difficulties in asking their patients questions on alcohol consumption. Scafato E, et al. (2006) at: http://www.who.int/substance_abuse/publications/identification_management_alcoholproblems_phaseiv.pdf 4. A survey in two areas of northern Italy, to assess GPs basic knowledge of risky drinking and their attitude towards performing routine BI. Most of the respondents (60%) have no difficulties in talking about these issues with their patients, while only the 23% have some difficulty. The three most important things to increase the success of SBI for them are: specific information, more practical and personal training. Struzzo P, et al. (2003) at: http://www.priory.com/fam/italgp.htm 5. The protocol of a national pilot study. Mezzani L, et al. (2007). Establishing an Italian general practitioner brief intervention pilot project for problem drinkers. Substance Use and Misuse, 42:12-13.
Latvia	N		

Malta	N		
Poland	N		
Portugal	Y		Not yet published. Working with hazardous and harmful drinkers: derivation and validation of a model for predicting distinct general practitioners groups.
Romania	N		
Slovenia	N		
Spain	Y		2003, improvement. Not published.
Sweden	Y	2008 2011	1. Holmqvist M et al (2008). Alcohol Prevention Activity in Swedish Primary Health Care and Occupational Health Services. Asking patients about their drinking. Nordic Studies on alcohol and drugs. 2008;25:489-504. 2. Geirsson M et al (2011). The impact of the Swedish Risk Drinking Project on clinical practice in primary Care. In dissertation Geirsson M. Alcohol prevention in Swedish primary health care (http://hdl.handle.net/2077/26274)
Switzerland	Y	2006	Factors: Addressing the topic of alcohol (the necessary skills and competencies are a prerequisite, otherwise the topic is avoided by many health care providers). Generally, patients accept questions regarding their alcohol consumption in the interest of their health. (vgl. Daeppen & Gaume, 2006, S. 5-9). Daeppen Daeppen J.-B. & Gaume J. (2006). Implémentation et dissémination de l'intervention brève pour la consommation d'alcool à risque en médicine de premiers recours: évaluation du projet partiel „médecins" du programme national alcool „Ca débouche sur quoi". Travail réalisé sous mandat de l'Office Fédéral de la Santé Publique. Centre de traitement en Alcoologie, Lausanne.
The Netherlands			
PERCENTAGE	39.1%		

Figure 29. Studies, surveys or publications in primary health care about the attitudes of health care providers to managing HHAC.

STUDIES, SURVEYS OR PUBLICATIONS IN PRIMARY HEALTH CARE	**INCREASING THE INVOLVEMENT OF HEALTH CARE PROVIDERS IN MANAGING HHAC**		
	Y/N	**YEAR**	**MAIN FINDINGS - REFERENCE**
Belgium	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England	Y	2013	SIPS Kaner E, Bland M, Cassidy P, Coulton S, et al Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial at: http://www.bmj.com/content/346/bmj.e8501 , 2013
Estonia	Y		

Finland			
Fyrom	N		
Germany			
Greece	Y	2011	Mouzas, I. (2011). Care devices for alcoholic patients in Southern Europe» Alcoholism: Clinical and Experimental Research 2011 35: 22 A.
Iceland	N		
Ireland	N		
Italy	Y	2000 2003 2006 2007 2013	Focus groups to collect information about their experience, knowledge and needs; distribution of brochure and other information materials; providing support staff; providing specific training and incentives. Polvani et al., 2000; Patussi et al., 2003; Scafato et al. 2006; Struzzo et al., 2003; Mezzani et al. 2007 ; Struzzo et al., 2013
Latvia	N		
Malta	N		
Poland	N		
Portugal	N		We have in this report the national and epidemiologic studies concerning alcohol and also the developing of political strategies that facilitates the screening and brief interventions on alcohol at health care level at: http://www.euro.who.int/en/what-we-publish/abstracts/status-report-on-alcohol-and-health-in-35-european-countries-2013 , Pges 104-107-Portugal
Romania	N		
Slovenia	N		
Spain	Y	2003	Improvement. Not published.
Sweden	Y	2011	Geirsson M et al. (2011). The impact of the Swedish Risk Drinking Project on clinical practice in primary care. http://hdl.handle.net/2077/26274
Switzerland			There are a variety of projects and programmes in Switzerland with the aim of increasing the involvement of health care providers in managing HHAC however there's no or only partial evaluation intended.
The Netherlands	Y		
PERCENTAGE	30.4%		

Figure 30. Studies, surveys or publications in primary health care about increasing the involvement of health care providers in managing HHAC.

3.1.7. Health care users.

3.1.7.1. Knowledge

In this section a summary of the main findings reported on studies about people knowledge on the danger of HHAC to their health is provided in the table.

STUDIES, SURVEYS OR PUBLICATIONS	PEOPLE KNOW THAT HHAC CAN BE DANGEROUS TO THEIR HEALTH		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Croatia	N		
Cyprus	N		

Czech Republic	Y	2010	Respondents underestimate harmful effects. Eurobarometer 2010.
England	Y	2003	Low knowledge. This was referred to in recent House of Commons Science Technology committee. A published review of sensible drinking guidelines in Feb 2012. The recommendations was to send out to an Expert Committee. Minister's Strategy Unit, Cabinet Office Alcohol Project (2003): Interim Analytical Report.Cabinet Office, London, UK
Estonia	Y		Not published.
Finland	N		
Fyrom	N		
Germany			
Greece	N		
Iceland	N		
Ireland	Y	2012	In general, there is good knowledge about the common diseases associated with alcohol consumption such as its effects on the liver, pancreas and blood pressure. Knowledge about the association with breast cancer and bowel cancer is less well understood. There are mistaken beliefs about its association with stomach ulcers and to a lesser extent, skin cancer. Health Research Board (2012) Alcohol: Public Knowledge, Attitudes and Behaviours available at: http://www.hrb.ie/uploads/tx_hrbpublications/Alcohol_-_Public_Knowledge_Attitudes_and_Behaviours_Report.pdf
Italy	Y	2010	High level of risk awareness for liver diseases, lower for heart disease, depression, risk of birth defects and cancer. Eurobarometer 2010
Latvia	N		
Malta	N		
Poland	N		
Portugal	N		
Romania	N		
Slovenia	Y	2006	96% of patients are aware that HHAC is risky for their health. SIMONIČ, Rahela. Osveščenost odrasle populacije o učinkih uživanja alkohola na telesno zdravje ter poznavanje sodobnih meril za tvegano pitje; specialistična naloga. Ljubljana: Medicinska fakulteta, 2010
Spain	Y	2003	People does not know the limits. Not published.
Sweden	Y	2006 2009	High awareness of social consequences, low on cancer association. Eurobarometer 2006, 2009.
Switzerland			
The Netherlands	N		
PERCENTAGE	34.8%		

Figure 31. Studies, surveys or publications in primary health care about people knowledge on the danger of HHAC to their health.

3.1.7.2. Help seeking behaviour

In this section a summary of the main findings reported on studies about people knowledge on

help seeking methods to reduce HHAC is provided in the tables.

STUDIES, SURVEYS OR PUBLICATIONS	PEOPLE KNOW ABOUT EFFECTIVE METHODS TO REDUCE HHAC		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England	Y	2004	Little awareness. Prime Minister's Strategy Unit, Cabinet Office Alcohol Harm Reduction Strategy for England (2004). Cabinet Office, London, UK
Estonia	N		
Finland	N		
Fyrom	N		
Germany			
Greece	N		
Iceland	N		
Ireland			
Italy	N		
Latvia	N		
Malta	N		
Poland	N		
Portugal	N		
Romania	N		
Slovenia	N		
Spain	N		
Sweden	N		
Switzerland			
The Netherlands	N		
PERCENTAGE	4.3%		

Figure 32. Studies, surveys or publications in primary health care about effective methods to reduce HHAC.

STUDIES, SURVEYS OR PUBLICATIONS	PROVIDE INFORMATION ON THE PROPORTION OF HHAC USERS WHO HAVE EVER USED ONE METHODS* TO REDUCE THEIR ALCOHOL CONSUMPTION		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Croatia			
Cyprus	N		
Czech Republic	N		
England	N		
Estonia	N		
Finland	N		

Fyrom	N		
Germany			
Greece	N		
Iceland	N		
Ireland	N		
Italy	Y	2012	Help from self help groups: Carlesso L et al (Ed.). La banca dati dei Club Alcologici Territoriali in Italia, Anno 2010. Associazione Italiana dei Club Alcologici territoriali (AICAT); 2012.
Latvia	N		
Malta	N		
Poland	N		
Portugal	Y		Help from a doctor are effective. See the Alcohol Directory collecting studies related to those aspects at: http://directorioalcool.pt/Paginas/HomePage.aspx
Romania	N		
Slovenia	Y		Help from the internet: not published yet.
Spain	N		
Sweden	Y		Help from specialist clinics: ? Please Fredrik, help us to complete this box
Switzerland	Y		From a specialist clinic: Siehe Alkoholismus Therapieforschung Schweiz atf Schweiz – Forschungsverbund der Forel Klinik und Klinik Südhang. Laufende Projekte:http://www.atf-schweiz.ch/forschung/aktuelle_projekte.htm abgeschlossenen Projekte:http://www.atf-schweiz.ch/forschung/abgeschlossene_projekte.htm Publikationen:http://www.atf-schweiz.ch/forschung/forschungs_publikationen.htm Help from willpower alone: Selbstheilung von der Sucht von Harald Klingemann und Linda Sobell von VS Verlag für Sozialwissenschaften (Taschenbuch - 13. Juni 2006).
The Netherlands	Y		Help from the internet: www.brijder.nl Help from specialist clinics: www.brijder.nl
PERCENTAGE	26.1		

*Methods include the followings: help from a doctor, nurse, pharmacist, dentist, friends or family; advice from the internet; specialist clinic, self-help group; help line service; or willpower alone.

Figure 33. Studies, surveys or publications in primary health care about proportion of HHAC users using methods to reduce their alcohol consumption.

CONCLUSIONS

- Most of the countries (73.9%) have a country and/or regional coalition for the management of HHAC.
- Implemented media education campaigns on alcohol consumption in general are not widely available or not reported especially in some countries. The most common education campaigns are reported on the website followed by newspaper/magazines and radio. When available, they are generally fully publicly funded.
- According to personal opinions, in most of the countries the integration of the management of HHAC in the health care system is quite low with great differences between countries.
- Most of the countries have formal governmental organizations in charge for monitoring health outcomes at the population level from HHAC (78.3%), for reviewing the safety of pharmacological treatments for managing alcohol dependence (68.2%) and for providing information on managing HHAC to health care providers (63.6%). About half of the countries have structures in charge for the monitoring of the quality of care provided for managing HHAC (57.1%) and for preparing clinical guidelines (56.5%). The structures for reviewing the cost effectiveness of interventions for managing HHAC are unavailable in almost all the countries but not in England, Finland, Portugal, Sweden and The Netherlands (21.7%).
- In 2012, nearby half of the countries have not a formal research programme for managing HHAC with specifically allocated funding (56.5%). Those who have a formal research programme are always, at least in part, from governmental organizations.
- There is a lack of formal education on managing HHAC for health care professionals, (particularly for pharmacists and dentists) in all the educational levels, with great differences among countries. There is a tendency for most of the professionals (but not for dentists, obstetricians and pharmacists) to have more formal education on the managing of HHAC in the curriculum of postgraduate and continuing professional training compared to the undergraduate curriculum.
- In 2012, an official written policy on managing HHAC from the Government or Ministry of Health is reported in 78.3% of the countries, mostly as a part of a more general alcohol policy strategy. In the countries where such a policy exists, an intensive support for managing alcohol dependence in specialised treatment facilities is included in most of the countries (88.9%) and to a lesser extent a strategy on training for health professionals (66.7%) and a strategy to support interventions in primary care (61.1%). A national funded research strategy is included in 38.9% of the policies.
- In about half of the countries there is an identified person within the Department of Health or Government who oversees or manages services for HHAC.
- In most of the countries (82.6%) there is government funding for services for the management of HHAC. In the countries where governmental funding for services is available, the amount of funding is usually reviewed from time to time.
- In almost none of the countries (but not for Switzerland) a proportion of alcohol taxes is specifically earmarked or allocated to fund the costs of services for managing HHAC.
- Nearby three out of four of the countries (73.9%) have already developed or are developing multidisciplinary guidelines for managing HHAC. The majority are stand alone guidelines as opposed to a part of other clinical guidelines. However, there is a great lack of studies about their adherence and implementation.
- About 30% of addition specialists, general practitioners and psychiatrists are reimbursed for managing HHAC. The most common practice, however, is reimbursement as a part of their normal salary, especially for general practitioners, psychologists, doctors in hospitals and social workers.
- In most of the countries there are specialized guidelines or protocols for managing

HHAC for addiction specialists (78.3%), general practitioners (65.2%), psychiatrist (56.5%), doctors in hospital (47.8%) On the contrary, guidelines or protocols are uncommon for all the rest of professionals, particularly for pharmacists (8.7%) and dentists (4.3%).

- The training for managing HHAC within professional vocational training is available in more than half of the countries and for different professionals, but still uncommon for pharmacists, obstetricians and dentists and in some countries. The availability of training for managing HHAC within accredited continuing medical education is inferior to the training for managing HHAC within professional vocational training for all professionals but not for doctors in hospitals and psychiatrists.
- Regarding treatment provision in primary care, there are many studies, surveys or publications on patients screened about alcohol consumption (in 73.9% of the countries) followed by studies on patients with HHAC are given advice and on the use of AUDIT questionnaire (47.8%), on the attitudes of health care providers to managing HHAC (39.1%), increasing the involvement of health care providers in managing HHAC and the effectiveness of interventions for HHAC (30.4%). Few studies, survey or publications have been carried out on advice meets quality criteria (8.7%) and on cost-effectiveness of interventions for HHAC (8.7%).
- Regarding health care users there are studies, surveys or publications on people knowledge that HHAC can be dangerous to their health in 34.8% of the countries, while few studies on people knowledge about effective methods to reduce HHAC (4.3%).

DISCUSSION

To be done

RECOMMENDATIONS

To be done after a common discussion

REFERENCES

1. Rehm J, Shield KD, Rehm MX, Gmel G, Frick U (2012). Alcohol consumption, alcohol dependence and attributable burden of disease in Europe: Potential gains from effective interventions for alcohol dependence. Centre for Addiction and Mental Health, at: www.camh.net

2. World Health Organization. International Classification of Diseases (ICD), at: http://www.who.int/classifications/icd/en/

3. Rehm J, Room R, Monteiro M, Gmel G, Graham K, Rehn T, Sempos CT, Frick U, Jernigan D. (2004). Alcohol. In: WHO (ed), Comparative quantification of health risks: Global and regional burden of disease due to selected major risk factors. Geneva: WHO.

4. European Commission. (2006). Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions. An EU strategy to support Member States in reducing alcohol-related harm. Brussels, Commission of the European Communities, at: http://eurlex.europa.eu/LexUriServ/ site/en/com/2006/com2006_0625en01.pdf

5. World Health Organization Regional Office for Europe (2011). European Alcohol Action Plan to reduce the harmful use of alcohol 2012-2020. WHO, at: http://www.euro.who.int/__data/assets/pdf_file/0006/147732/RC61_wd13E_Alcohol_111372_ver2012.pdf

6. World Health Organization (2010). Global strategy to reduce the harmful use of alcohol. WHO, Geneva, at: http://www.who.int/substance_abuse/msbalcstragegy.pdf

7. World Health Organization (2008). 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases. WHO, at: http://www.who.int/nmh/publications/9789241597418/en/

8. Kaner E, Dickinson H, Beyer F, Pienaar E, Campbell F, Schlesinger C, et al. (2007). Effectiveness of brief alcohol interventions in primary care populations (Review). Cochrane Database of Systematic Reviews, CD004148.DOI:10.1002/14651858.CD4148.pub3.

9. Primary HEalth Project on Alcohol (PHEPA) (2004). Assessment tool for hazardous and harmful alcohol consumption, at: http ://www .gencat.cat/salut/phepa/units/phepa/html/en/dir360/index. Html