



Alcohol Measures for Public Health Research Alliance (AMPHORA)

**Report on the mapping of European need and service
provision for early diagnosis and treatment of alcohol use
disorders**

Deliverable 2.5, Work Package 6

**The public health impact of individually directed brief
interventions and treatment for alcohol use disorders in
European countries**

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AMPHORA Project

Workpackage 6: The public health impact of individually directed brief interventions and treatment for alcohol use disorders in European countries

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Table of Contents

1. Introduction	4
1.1 The AMPHORA Project	
1.2 Work package 6 of the AMPHORA project	
1.3 Workpackage 6 – workplan	
1.4 A description of alcohol intervention systems	
1.5 Survey of primary health care and accident and emergency service providers	
1.6 Study of the gap between need and access to treatment	
2. Overall conclusions and recommendations	8
2.1 Conclusions from the descriptive study of alcohol service provision	
2.2 Conclusions from the survey of primary care and accident and emergency service providers	
2.3 Conclusions from the study of the gap between need and access to treatment	
3. Description of treatment systems for alcohol use disorders across six European countries	12
3.1 Introduction	
3.2 Methods	
3.3 Results	
3.4 Discussion	
4. Survey of primary health care and accident and emergency service providers	32
4.1 Introduction	
4.2 Methods	
4.3 Results	
4.4 Discussion	
5. Study of the gap between need and access to treatment	45
5.1 Introduction	
5.2 Methods	
5.3 Results	
5.4 Discussion	
6. References	54
7. Annexes	58
Annex 1: Definitions and abbreviations	58
Annex 2: List of key informants for country surveys	62
Annex 3: Key informant questionnaire	67
Annex 4: Primary health care survey questionnaire	69
Annex 5: Accident and Emergency survey questionnaire	75

1. INTRODUCTION

1.1 The AMPHORA Project

In 2006 the European Commission adopted an EU strategy to support its Member States in reducing harm caused by alcohol and fostering related research. AMPHORA (Alcohol Public Health Research Alliance) is a four-year €4million project co-financed by the Seventh Framework Programme (FP7) of research of the European Commission and is coordinated by the Hospital Clinic de Barcelona (FCRB), in Spain. Thirty-three partner organisations from 14 European countries through this project, aim to add knowledge across a wide range of public health alcohol policy measures, and to disseminate this knowledge to those engaged in making alcohol policy.

AMPHORA aims to contribute to new evidence on alcohol consumption and alcohol-related harm in Europe. This knowledge will be disseminated to those engaged in policy-making for development and implementation of more effective public health measures. AMPHORA consists of nine work packages, each one tackling a different aspect of alcohol consumption, related harm and treatment provision.

1.2 Work package six of the AMPHORA project

Work package six (WP6) of the AMPHORA project is entitled “The public health impact of individually directed brief interventions and treatment for alcohol use disorders in European countries”.

1.2.1 Work package six - outline

This research takes as its starting point the existing extensive international research that has been carried out on brief interventions and treatment for alcohol use disorders over the past 20 years, much of it pioneered in Europe. The WHO Collaborative research programme on identification and management of alcohol problems concluded recently with a Phase IV international project on implementation of screening and brief interventions (SBI) for hazardous and harmful drinkers involving several European countries: the *Primary Health Care European Project on Alcohol* (PHEPA), on implementing brief interventions in Europe (PHEPA, 2007). This work built on earlier phases which variously identified a valid screening tool for alcohol use disorders: the AUDIT questionnaire (Babor et al., 2001), in addition to identifying studies of the efficacy and effectiveness of SBI as an intervention, and research on optimal methods for its implementation.

There is an extensive international literature on the effectiveness of SBI. Most recently a Cochrane review (Kaner et al., 2007) confirmed that SBI is highly effective in reducing hazardous and harmful alcohol consumption and health costs in primary health care (PHC) settings. There is also growing evidence of effectiveness in other health settings including accident and emergency departments (Dinh-Zarr et al., 2004; Crawford et al., 2005; Kaner et al., 2007), and growing evidence of cost-effectiveness of these interventions (Chisholm et al., 2004; NICE, 2010). This and other evidence has recently led to the UK National Institute for Healthcare and Clinical Effectiveness (NICE) to recommend widespread implementation of SBI in the National Health Service (NICE, 2010).

Most research on the implementation of alcohol interventions in Europe has been restricted to SBI (Drummond et al., 2011), however several reviews have taken place of the international literature on effectiveness of specialist treatment for people with alcohol dependence. A recent review of the international literature by NICE in England concluded that various forms of specialist treatment (including psychosocial and pharmacological interventions) are both effective and cost-effective in harmful drinking and alcohol dependence (NICE, 2011). This review also emphasised the need for coordinated systems of care for people with alcohol use disorders (AUD), offering a stepped care approach to deliver the most appropriate interventions to the in-need population in a cost effective way. Therefore across the spectrum of severity of alcohol problems, there is clear evidence of the effectiveness of these interventions, at an individual level.

However three clear gaps exist in understanding the contribution of individually directed alcohol interventions as a public health measure to reduce harm caused by alcohol:

a) Alcohol treatment system characteristics

Health care utilisation varies greatly across European countries, as does the nature of services (European Commission, 2004). These differences in implementation and utilisation are likely to be due to political, financial, practical and ethical considerations; however there is a lack of comparative data on variations in alcohol treatment systems across European countries (Drummond et al., 2011). A comparative study of characteristics of treatment systems across European countries, and the country-specific factors facilitating or hampering implementation, could lead to improved guidance on optimal implementation methods.

b) Barriers and facilitators to implementation of SBI at the practitioner level

There is evidence that implementation of SBI is related to practitioners' attitudes, and that these attitudes can be influenced by appropriate training and support (Anderson et al, 2003; 2004). Attitudes to SBI and managing patients with AUDs may vary from one country to another across Europe, though commonalities are also expected. Identification of barriers and facilitators is the

first step to developing optimal methods of implementation. This study builds on previous studies and reports of attitudes towards and practices of SBI among GPs and primary care nurses in England (Deehan et al., 1998; Kaner et al., 1999; Lock et al., 2002; McAvoy et al., 1999) and in Europe (Anderson et al., 2003; 2004).

c) Prevalence of alcohol dependence across European countries and the gap between need and access to interventions for alcohol dependence.

The findings of a recent literature review of existing research on the prevalence of AUD and availability of interventions across Europe, has pointed to key gaps in knowledge relating to the availability and provision of alcohol interventions in Europe, including a lack of comparative data on the prevalence of AUDs across countries and the relative gap between need and access to treatment (Drummond et al., 2011). Despite validated methodology for carrying out gap analyses between need for interventions and access to treatment (Rush 1990), very few national needs assessments, if any, have been carried out nationally in European countries, and nor has a purpose designed EU-wide alcohol needs assessment been conducted.

WP6 of the AMPHORA project was designed to address all three of these areas.

1.3 Work package six - work plan

The work plan had four Elements split across 48 months including report preparation. The fieldwork element took place over the first 36 months. Six core European partners participated in the work package (Germany, Italy, Spain, Switzerland, Austria, England) taking part in all elements of the work. The number of core participating countries was limited by the available resources and the logistics of coordination and data collection. Additional interest was expressed in participating in some elements of the work package by scientists in Bulgaria, Poland, Greece (Crete), Netherlands, Sweden, however this would have been on an unfunded basis, and was not in the end feasible. Definitions and abbreviations used in this report are to be found at Annex 1.

1.4 Description of alcohol intervention systems

Element One of WP6 was a descriptive study of alcohol intervention systems across six European countries. It sought to describe the systems of early intervention and treatment for alcohol use disorders, and the overarching health care system settings. This in turn provided comparative information on the extent of implementation of these approaches across a sample of six European countries. Information collected was both qualitative and quantitative and provided a context for subsequent elements of the work package. This work built on previous similar research including the PHEPA project. An analysis of similarities and differences between

countries has been made, where possible, in order to assist in identifying factors which appear to facilitate or hinder the public health impact of brief and specialist alcohol interventions.

1.5 Survey of primary health care and accident and emergency service providers

Element Two of WP6 aimed to provide new data on aspects affecting the implementation of SBI in both Primary Health Care (PHC) setting and accident and emergency (A&E) departments. This study built on previous studies and reports of attitudes towards and practices of SBI among GPs and primary care nurses in England (Deehan et al., 1998; Kaner et al., 1999; Lock et al., 2002; McAvoy et al., 1999) and in Europe (Anderson et al, 2003; Anderson et al., 2004). There is evidence that implementation of SBI is related to practitioners' attitudes, and that these attitudes can be influenced by appropriate training and support. Identification of barriers and facilitators is the first step to developing optimal methods of implementation.

A parallel series of national surveys were conducted of alcohol intervention service providers across the six countries. This included medical practitioners in primary health care settings (PHC) and accident and emergency departments (A&E). The data were then analysed to identify common factors and trends in the experiences and attitudes of practitioners, and similarly identify any country specific differences.

1.6 Study of the gap between need and access to treatment

Element 3 aimed to provide estimates of the prevalence of alcohol dependence in the six participating countries, and use these to conduct a needs assessment to estimate the gap between need for, and actual access to specialist alcohol treatment in each country. Available data on the prevalence of alcohol dependence and alcohol related morbidity and mortality was identified, mainly from the data collected in element one, but occasionally from other published sources. Data was also collected on numbers receiving treatment in order to develop a standardised measure of the gap between need and access, the prevalence-service utilisation ratio (PSUR), for each country.

2. OVERALL CONCLUSIONS AND RECOMMENDATIONS

2.1 Conclusions from the descriptive study of alcohol service provision

In all areas of the research we identified considerable between-country variation in the organisation and provision of alcohol interventions. Countries that had more developed national alcohol strategies in relation to individually directed alcohol interventions appeared to achieve higher levels of implementation of both SBI and specialist treatment than countries without such strategies. The devolution of health care management and funding to a local level appeared to hamper implementation of effective public health strategies, although they may be more effective for other types of health care delivery for other disease conditions.

Since alcohol places a considerable health, social and economic burden on Europe, there is a need for a more concerted effort to implement SBI and treatment strategies as part of the overall public health response. In order to assess the public health impact of these interventions and make comparisons between countries, there is a need for improved, and up-to-date, data on prevalence and service utilisation to support rational and cost-effective health care planning. Currently implementation appears to be based on relatively poor quality data, which is largely not comparable between countries in Europe, hampering meaningful evaluation of effectiveness and impact. A common standard of identified indicators would enable a better evaluation of the impact of alcohol interventions across countries.

As this project was conducted in some of the more developed countries in Europe, the situation in less developed countries with less data availability may be even more difficult to assess.

KEY RECOMMENDATIONS:

The implementation and monitoring of individually directed alcohol interventions across all EU member states, including SBI and specialist treatment, should be considered at the European Commission and WHO Europe level to develop an improved public health response to alcohol. High on the list of priorities will be a harmonised Europe-wide system of estimating prevalence of alcohol use disorders and monitoring implementation of SBI and specialist alcohol treatment.

There is a need for clear clinical guidance on evidence-based specialist interventions for alcohol dependence to guide implementation across Europe. There is a need for greater training for health professionals in alcohol clinical management of alcohol use disorders from the undergraduate curriculum through to continuing medical education.

2.2 Conclusions from the survey of primary care and accident and emergency service providers

In summary, several points of interest emerged from the between country and health setting comparisons of attitudes and practices of primary care practitioners and accident and emergency staff.

In particular, GPs reported very low screening activity with an average of five patients screened positive for and alcohol use disorder (AUD) over a four-week period, representing only 0.8% of their patients. This is considerably lower than the actual prevalence of AUD in primary care. GPs did however have a fairly high level of knowledge and understanding of screening tools and brief interventions, although with some variations across countries. GPs in England and Catalonia appeared to be more familiar with SBI compared with GPs in the other countries.

In contrast, the actual use of screening tools and offering of brief interventions was lower than their level of knowledge across all countries. GPs reported 'time constraints', 'risk of upsetting the patient' and 'lack of training' to be the main barriers to both alcohol screening and offering of SBI.

GPs from the participating countries did not differ in their sense of legitimacy and security in carrying out SBI or in their therapeutic commitment. However, when compared with the A&E staff, they showed significantly more positive attitudes towards working with alcohol misusers.

Conducting the surveys of A&E staff was considerably more challenging, and in some countries this required more time and effort than anticipated, based on experience with the survey of GPs. Key stakeholders and A&E staff in Germany, Austria and Italy showed considerable resistance in responding to the survey. This resistance is also consistent with the less positive attitudinal findings in these countries compared to practitioners in the other participating countries. In particular, A&E staff in England, Catalonia and Switzerland had a greater knowledge of and familiarity with standardised alcohol SBI. As emerged in the GP survey findings, there were barriers that limit the implementation of alcohol screening and brief interventions. 'Time constraints' and 'lack of training' were the most cited reasons.

England, Catalonia and Switzerland also reported a higher proportion of people screened positive for AUD in A&E each week, and interestingly A&E staff across the six countries screened and identified 4.5 times more AUD positive individuals than their GPs counterparts, probably reflecting the higher prevalence of AUD in the A&E setting.

KEY RECOMMENDATIONS:

There is a need for greater training and support for primary care practitioners to deliver SBI as part of wider public health approaches to alcohol across countries in Europe. Since the extent of implementation of SBI varies across countries and even in the most active countries, the proportion of the in need population reached by SBI is considerably lower than the prevalence rates of AUD, there is a need to set implementation targets and monitor progress towards implementation across all European countries.

Each country should have an implementation strategy for SBI in primary care which includes training, active provision and promotion of SBI tools, ongoing support for practitioners to facilitate continued implementation, and monitoring of implementation of SBI against set targets.

Implementation of SBI in accident and emergency is more challenging than in primary care and there are questions about the relative effectiveness of SBI in accident and emergency compared to primary care: greater evidence of effectiveness of SBI exists in primary care. Consideration should be given to improved methods of implementation of SBI in A&E which takes into account the busy and challenging nature of this clinical setting.

2.3 Conclusions from the study of the gap between need and access to treatment

Alcohol dependence prevalence rates vary across the countries studied, but it is not clear that comparisons are meaningful due to the different methods used to achieve these estimates. Given the convergence of other alcohol related indicators (e.g. per capita alcohol consumption, alcoholic liver disease mortality) between European countries over the last 20 years the reported variance in prevalence of alcohol dependence is surprising. Rather than being a true reflection of variation in prevalence of alcohol dependence, it is probably more likely to be an indication of the differences in methods of estimating prevalence.

Countries with large general household surveys (e.g. England and Italy) probably have more reliable estimates than those without, but even then, different measures have been used to estimate alcohol dependence.

Italy and Spain both have surprisingly low prevalence rates of alcohol dependence compared to the four more northern European countries. It is known that alcohol consumption in southern European, predominantly wine-drinking “Mediterranean”, countries is such a culturally integrated norm that dependence can be under-detected and under-reported, and also as a result, be more of a social stigma.

Similarly, there were problems in obtaining comparable estimates of the number of people entering specialist alcohol treatment. The majority of countries had a method of monitoring that allowed for data on access to treatment to be provided. However methodological differences in the collection of this data again diminish its suitability for direct comparisons.

In addition to hospital admission or discharge diagnostic data, provided by some countries as a proxy for actual specialist alcohol treatment access. Data on actual access to specialist treatment would provide a more reliable estimate of the reach of alcohol interventions. Diagnosis upon hospital admission or discharge does not necessarily indicate that that individual will go on to receive a comprehensive package of alcohol treatment appropriate to their needs.

Although “access to treatment” is a better indicator there is a need for a standardised definition and method of measuring access across countries. Data may vary due to other factors, such as the effectiveness of treatment systems and care pathways to channel less severely dependent patients into outpatient care, which may be less well measured than inpatient treatment provision.

Prospective treatment access data in the form of a national alcohol treatment monitoring system is likely to be more reliable than those based on hospital discharge diagnosis. Such a system would also enable more recent and up-to-date data to provide regular monitoring reports. The most recent data provided for national prevalence of alcohol dependence ranged from two to ten years old, which clearly has limitations.

KEY RECOMMENDATIONS:

Given the importance of alcohol dependence to European public health, there is a need for more reliable Europe-wide measures of alcohol dependence prevalence, preferable household surveys, to estimate comparative prevalence rates using the same time frame and survey instruments. This would be essential to the rational planning of alcohol treatment provision and benchmarking across Europe. It would also provide a more reliable estimate of trends and patterns, which in turn may assist with the effective evaluation of policies and treatment implementation.

There is a need to develop harmonisation between European countries on the collection of prospective specialist alcohol treatment monitoring data and data on the delivery of SBI in primary care, using a common methodology. Again this would be helpful in estimating the relative public health impact of alcohol treatment across Europe, and identifying areas where greater implementation is required. Prospective data collection and monitoring should be encouraged and promoted as the gold standard.

3. DESCRIPTIONS OF TREATMENT SYSTEMS FOR ACOHOL USE DISORDERS ACROSS SIX EUROPEAN COUNTRIES

3.1 Introduction

This element of the workpackage sought to describe the systems of early intervention and specialist treatment for alcohol use disorders (AUD), in order to provide comparative information on approaches and the extent of implementation across the six participating countries. Data collected identified similarities and differences in the systems of provision of SBI and specialist treatment for AUD. Systemic factors promoting or hindering the effective implementation and public health impact of alcohol interventions were also identified, in order to inform future European public health action on alcohol. Information obtained was both qualitative and quantitative and provided a context for subsequent elements of this work package.

3.2 Methods

3.2.1 Aims and objectives

With particular focus on both screening and brief intervention (SBI) and specialist treatment, the main aims of this particular study were:

- to identify similarities and differences in systems for the provision of SBI and specialist treatment for AUD across Europe, and
- to identify system level factors contributing to the effective implementation and public health impact of individually directed alcohol interventions.

The objectives were:

- to conduct a comparative study of SBI and specialist alcohol treatment systems for AUD across 6 countries
- to identify key informants in public health and treatment provision for each participating country to gather data on current and historical provision and implementation
- to identify key official and published data sources on provision of individually directed alcohol interventions across participating European countries
- to conduct a comparative analysis of typical care pathways across participating countries, particularly highlighting organisational, administrative, fiscal and cultural differences

3.2.2 Country level methodology

Data were gathered on the current and historical provision and implementation of alcohol interventions in each of the participating countries by conducting interviews with relevant national experts, and studying key official and published data sources and literature on the provision of alcohol interventions. This work was done following guidelines and a questionnaire was developed at the start of the project by the coordinating centre at the Institute of Psychiatry, King's College London in conjunction with the partners in the other countries.

Key informants were identified in each participating country within the alcohol field, with clinical and policy backgrounds. Interviews with key informants were conducted using a semi-structured questionnaire. To facilitate the interviews, the questionnaire was sent to the experts via email together with a summary of the AMPHORA project and an outline of the Models of Care for Alcohol Misusers Service Tiers (DH, 2006) in advance of the interview.

In addition to the information from the interviews, a literature search of available published and unpublished documentation on the provision of alcohol interventions in the participating countries was conducted, supplemented by advice from the key informants.

Each participating country conducted interviews with the relevant national experts identified, then analysed the responses and produced a country specific report on the findings (Gual & Robles, 2011; Zois et al., 2011; Gandin & Scafato, 2011; Keundig & Gmel, 2011; Goos & Strizek, 2011; Davey et al., 2011). The six country reports were then collated by the WP6 coordinating centre.

3.2.3 Sampling

Key informants were selected from each participating country from the following categories: government officials responsible for implementation of alcohol interventions; senior public health specialists and epidemiologists responsible for alcohol policy in relation to alcohol interventions; senior alcohol treatment service providers; senior primary health practitioners involved in implementation of SBI for hazardous and harmful drinkers. This process was assisted by named core AMPHORA investigators and additional collaborators, as well as making use of contacts within PHEPA, European Working Group on Treatment of Alcohol Dependence, and the World Health Organisation.

Table 3.1 – Summary of interviews conducted

COUNTRY	NUMBER OF EXPERTS	COVERAGE	PERIOD OF TIME	Comments on willingness to participate
Austria	8	Included practitioners working in specialist institutions, scientists working in the fields of epidemiology and public health as well as policy makers	Nov '09 – Mar '10	Satisfactory
England	7	Included practitioners working in specialist institutions, scientists working in the fields of epidemiology and public health as well as policy makers	Apr '10 – Jan '11	Satisfactory
Germany	5 (out of 10)	Specialist addiction scientists in academic institutions as well as addiction policy makers were among those selected to be interviewed	--	Only half of those contacted participated
Italy	10	General practitioners, scientists in epidemiology and public health, clinicians from Alcohol Units and Drug Units, experts from Italian Society on Alcoholology, President of Alcoholic Clubs and policy makers	May '10 – Nov '10	--
Spain	10	Selected based on their expertise in the alcohol treatment field, and to cover a large range of perspectives such as practitioners working in primary health care and specialist institutions as well as public health experts	Feb '10 – Oct '10	--
Switzerland	11 (9 face-to-face and 2 telephone)	Selected based on their expertise in the alcohol treatment field and cover a large range of perspectives such as practitioners working in specialist institutions, researchers working in the field of epidemiology and public health experts. Based on their reputation. Two were recommendations of other key informants	Feb '10 – Oct '10	High

The criteria for inclusion of informants took into account the relevance of their contribution, experience and reputation to the alcohol research, policy and practice areas. In some cases, the questionnaires were divided into separate sections to complete for different key informants with different expertise. Some later interviews took place with colleagues who had been recommended by earlier interviewees as more appropriate to deal with the questions. See Annex 2 for a full list of experts interviewed.

3.2.4 Tools

A semi-structured questionnaire was developed to collect comparable information from the key informants. These were based on previous published and ongoing work on mapping of provision of alcohol interventions (including PHEPA; Klingemann et al., 1992; UK National Audit Office, 2008, Babor & Poznyak, 2010). The tools sought to obtain qualitative and quantitative data on:

- 1) Present and historical provision of alcohol interventions
- 2) Policy initiatives designed to increase implementation of alcohol interventions and their impact
- 3) Comparable data on annual spending on different elements of alcohol interventions across the spectrum of care provision, based on the intervention categories (“service tiers”) identified in Models of Care for Alcohol Misusers (Department of Health, 2006). This included provision from primary care through to specialist treatment.
- 4) Comparable data on numbers of individuals identified and receiving alcohol interventions.
- 5) Information on available materials and methods to deliver alcohol interventions including: number of service providers engaged in delivery of interventions, both statutory and non-statutory; pharmaceutical products licensed for treatment of alcohol use disorders; available psychological interventions including information on extent of trained workforce; availability of protocols and tools for screening and brief intervention; internet based interventions; support for professionals, and the extent and nature of mutual aid and/or self help alcohol organisations (e.g. Alcoholics Anonymous, family clubs, religious organisations).
- 6) Descriptive information on typical care pathways for hazardous, harmful and dependent drinkers across participating countries
- 7) Identification of barriers and facilitators to implementation of alcohol interventions including: fiscal, administrative, organisational, training, workforce development, attitudinal (both professional and public).
- 8) Key informants’ perceptions of the extent to which alcohol intervention has been successfully implemented or otherwise in their respective countries, and reasons for this.

The questionnaire and criteria for alcohol treatment services is provided in Annex 3.

3.2.5 Combining data across countries

Findings from the six reports were combined and analysed by the WP6 workpackage coordinating centre. This required an initial assessment of all the data provided, cross-

referencing for differences in format, availability and methodology. Meaningful comparisons between countries were drawn where possible.

Any missing information was proactively sought first by the coordinating team, and then directly with the relevant country teams. The final cross-country report was then circulated to all six partner countries for comments, accompanied with a checklist of further country-specific data missing or other clarifications required.

Consistency has remained a priority throughout this process, both in language and format of country responses. However due to the individual nature of the six original country reports, and the variety of health care systems, treatment approaches, terminology, and methodology, consistency has sometimes been difficult to achieve.

In the following section results summarised, comparing and analysing the findings from all countries, to give an overview of the findings. Country-specific results are available in the individual country reports (Gual & Robles, 2011; Zois et al., 2011; Gandin & Scafato, 2011; Keundig & Gmel, 2011; Goos & Strizek, 2011; Davey et al., 2011).

3.3 Results

3.3.1 Summary of present and historical provision of alcohol interventions

There was considerable variation in both the health care systems in each of the six countries studied, and the corresponding approaches to implementing interventions for AUD within these systems. Most countries were well along a modernisation path towards evidence-based treatment systems. Austria – which remained largely focussed on long-stay residential treatment models until recently – was progressing to more evidence based, shorter, community (outpatient) models of treatment.

Sources of funding were generally either from government through taxation alone (England, Spain), or a mixture of tax and social insurance systems (Italy), all supported by co-payments to some degree. Most were free at the point of use to the patient.

Table 3.2 summarises the health system characteristics and treatment provision for AUD across the six countries, based on the descriptions provided in the six country reports. All countries were able to report having a service mapping mechanism in place, to describe current alcohol service provision, although the comprehensiveness of this varied depending on whether participation by all service providers is mandatory. This was the case in Switzerland, where

participation was not mandatory, and therefore coverage was incomplete. The federal structure was an added barrier to achieving nationally applicable initiatives.

Germany and Austria had the lowest reported SBI activity. In Germany this was felt by experts to be due to insufficient support and drive from the centre, and Austrian experts identified the focus on specialist residential treatment as the cause.

Two thirds of the countries had a formal national alcohol strategy, and of those there was little reference to service provision – comments included “none” and “little, if any”. Italy was the only country confirming service provision as a significant aspect of their strategy. Where alcohol strategies existed (England, Spain, Italy), they tended to identify subgroups and other at risk groups to target, such as young people, binge drinkers and high risk drinkers rather than an overall implementation plan. Prevention and education were generally the main focus. More recently in England attention has been paid to the evidence base on the introduction of public health measures such as minimum alcohol unit pricing, restriction of bulk buying offers, and screening and brief intervention (SBI). However England’s alcohol strategy (Home Office, 2012) contained very little direct reference to treatment improvement. Experts in England noted that the introduction of a national alcohol strategy was significantly behind that of a drugs strategy, felt to be an indication of a lower priority afforded to alcohol. Italy’s strategy was comprehensive, ranging from education to tackling drink driving laws. Spain’s strategy covered aspects of prevention and behaviour change as well as targeting subgroups of the drinking population. In Switzerland, an alcohol strategy was preceded by a national alcohol programme, which similarly focused on education and prevention for young people and other at risk groups.

In countries where a strategy did not yet exist, a high degree of federalism was cited as a contributing factor in the barriers to developing an overarching national strategy that would have any impact. Plans were being developed in Austria and Switzerland to rectify this, though there remained some doubts amongst respondents about whether this can be successfully achieved, or even be advantageous. Some experts were concerned about over-generalisation and lack of local relevance. However most of the experts interviewed also acknowledged the potential difficulties in coordination and implementation, service-mapping and treatment-monitoring, due to the fragmentation of the system. Spain and Italy appeared to oversee implementation of alcohol intervention policy at a national level more cohesively, despite a high level of autonomy in their regions.

Table 3.2 – Health systems and treatment for AUD (of the six participating WP6 partner countries)

	Provision of screening and brief interventions, for hazardous/harmful drinking	Provision of specialist treatment for alcohol dependence	Health system funding sources	Treatment monitoring systems in place	Availability of a national alcohol strategy (including aspects of service provision)	Existence of decentralisation in the health system
Austria	No	Yes: mainly residential setting (units/hospitals), though moving towards outpatient	Social insurance, Government / tax (local, regional, national), private insurance and co-payments	Not specifically mentioned, but hospital discharge data available	No: moves afoot to develop but still some way off	Yes: 9 Länder and very decentralised. Plus multi-layered health systems.
England	Yes: primary Health Care, A&E and out of hours	Yes: community based or residential - psychosocial, detoxification and stepped care - some also treat physical and mental comorbidity	Government / tax: and out-of-pocket/ copayments	Yes NATMS	Yes: little if any service provision	Yes: strategic Health Authorities, and potentially more so with new structures due in the present reorganisation of National Health Service
Germany	SBI programmes do exist but are rarely implemented	Yes: outpatient, inpatient and rehabilitation. Past decade has changed to shorter and more intensive package of care	Social insurance	Yes	No	Yes: 16 Bundesländer
Italy	Yes: primary health care – GPs only, but rarely implemented	Yes: mainly outpatient: Specialist addictions clinics, departments or hospital - medically assisted and psychosocial. Inpatient by not for profit orgs recognised by NHS	National and regional taxes, and co-payments. Private insurance does not play a significant role due to the universal coverage of the NHS	Yes	Yes: including aspects of service provision	Yes: 21 Regions and 145 Local Health Authorities (ASLs)
Spain	Yes: primary Health Care and increasingly in other medical settings, and outpatient and inpatient units in mental health units	Yes: outpatient and inpatient . Therapeutic communities. Mutual aid and self help connect with health care institutions	Tax	Yes	Yes: but contains nothing on service provision	Yes: 17 autonomous communities
Switzerland	Yes: widespread, undertaken by most disciplines, but not officially driven	Yes: range of inpatient, outpatient, medical and psychosocial. Demand for large scale treatment has reduced and system of care has updated over past 10yrs	Tax, health insurance, and a mixture of other funding sources (depends on the particular service and setting) Access at almost no cost to patient	In some single Cantons only	Yes (in the form of a national program, which is the forerunner to a strategy. But not much by way of service provision e	Yes: 26 Cantons This is a big factor in the variation and fragmentation of the treatment on offer

3.3.2 Summary of policy initiatives designed to increase implementation of alcohol interventions

All countries were able to provide examples of initiatives designed to increase implementation of alcohol interventions. These ranged from prevention and primary health care, to research programmes, needs assessments, and the dissemination of information, tools and resources.

However there was a lack of formal evaluation processes in place, and despite some published work on individual initiatives, the methods and indicators were very specific to the initiative in question, and it was therefore not possible to make firm conclusions about how such approaches work in different countries. Results did not always show improvements. The most common benchmarks for assessing successful activity, tended to be those linked to the alcohol strategies, where available, or outlined in more overarching government health plans.

Not all of the initiatives appear to fit easily with the health care systems in which they are set, particularly where part of the funding comes from social insurance, which raises issues of anonymity and subsequent impact on entitlement to support, or insurance-funded treatment.

RECOMMENDATIONS

Over and above reporting on the success rate or otherwise of these initiatives, the European Commission should examine the reasons why certain approaches and strategies are easier to implement and work more effectively than others, and learn from this, in order that other countries do not spend time repeating the failed experiments. A central source of recommended action and evidence-based policy initiatives should be created to inform European countries of what works, what is cost-effective and where the best policy areas for future investment are.

3.3.3 Summary of comparable data on annual spending on different elements of alcohol interventions.

Different methodologies have been used, limiting any meaningful cross-country comparison. Funding sources, commissioning systems, and even different understandings of which factors should feed into this calculation added to the inconsistency. In addition, it was sometimes not possible to accurately determine alcohol treatment expenditure from that of illicit drugs due to the way in which monitoring methods or funding were administered.

Austria calculated an average cost per inhabitant by taking the average cost per hospital admission, multiplying it by the number of alcohol related admissions, and dividing it by the population. Better estimates were later acquired using more recently introduced performance

based clinical funding data, which records the actual cost of treatments. England presented three different estimation approaches: one calculated the total cost to the health service of alcohol, based on premature deaths, A&E admissions, and chronic liver disease; another came from the first national needs assessment, which estimated spending on specialist treatment in total, and a cost per dependent drinker, and the third looked at expenditure on commissioning alcohol services, and percentage of total expenditure per local health authority (Primary Care Trust) area. Italy is able to provide costs per capita for community semi-residential and residential care aimed at the treatment of drug and alcohol dependence. Spain assessed inpatient and outpatient cost estimates from a study carried out some years ago, and Switzerland was unable to produce any estimates. Each individual country report strongly emphasises the limitations of the estimates provided.

There is clearly no uniform methodology to recording and collating this type of information on a national or a European level, and there is hence a limited understanding of the real expenditure. Some vital factors appear to be missing from the calculations in order to make them more practicable. Few countries mention actual treatment provision costs, patient numbers, trends, staff time or training costs.

RECOMMENDATIONS

There is a need to identify specific cost categories that should be considered, and guidance on methodology, if data on spending is to be meaningfully compared across Europe in the future. An ability to present estimates of these for each country would at the very least provide a formula for comparison in the future. As with many other aspects of this report, it is possible that with proactive recording of information, following a specified format, more useful cross-country comparisons could be made.

Costs have been separated into specialist treatment and non-specialist, however in most cases, spending on non-specialist interventions such as SBI is more difficult to quantify, due to its opportunistic and brief nature, and the multiple settings in which it takes place.

3.3.4 Summary of comparable data on numbers of individuals identified and receiving alcohol interventions.

Most countries were able to provide an estimate of the number of individuals receiving specialist treatment, but there was little recorded or monitored information on SBI activity within non-specialist settings. Mechanisms were more firmly in place for recording the delivery and provision of more structured, time and resource-intensive specialist care. Indeed it is essential to

do so to ensure adequate provision of treatment and services, and for planning, funding and management.

Problems again arose from the variation between countries in the methodology used to record, calculate and report the numbers in need of treatment and numbers receiving treatment. This was further affected by the availability and quality of data. Austria provided data drawn from hospital statistics, which are ICD-10 diagnoses of alcohol dependence upon discharge (both as a primary and secondary diagnosis), stating that while ideally all those identified should go on to receive specialist treatment, this could not be taken as an accurate representation of numbers in specialist alcohol treatment. Italy also provided data on hospital discharge diagnosis and from specialist alcohol services for alcohol dependence, but data for patients receiving interventions in non-specialist settings were not available. England drew initially from a needs assessment, however this has been superseded by a new national monitoring system providing more accurate data generated from initiation into treatment. Germany reported on the number of inpatient and outpatient treatment provisions granted, and Spain's annual report also indicated numbers treated.

As has already been stated, caution should be exercised when interpreting this data. The diagnosis of alcohol dependence at the point of hospital admission or discharge does not necessarily provide an accurate representation of numbers in receipt of treatment. It is unclear whether those discharged from hospital with a diagnosis of alcohol dependence received treatment or went on to receive treatment. Switzerland in particular stated that it too collates hospital admission and discharge diagnosis data, but respondents felt it to be inappropriate to provide these data to estimate the number of individuals in receipt of treatment. Some countries appeared to have more information on the different types of treatment provision within specialist settings. Those providing less detail may have underestimated a significant proportion individuals in receipt of treatment.

RECOMMENDATIONS

- There is a need for a more prescriptive methodology to estimate the number of people identified and needing alcohol interventions to allow meaningful cross-country comparisons in Europe to assess the reach impact of alcohol interventions as part of countries' overall public health alcohol strategy
- Alcohol needs assessments should be undertaken using validated and comparable methodologies across European countries
- Greater information on the nature of treatment interventions provided would be useful to assess the impact of alcohol interventions in Europe. This would provide a baseline measure against which the impact of future alcohol strategies can be measured.

3.3.5 Summary of available materials and methods for implementation of interventions

The emerging picture across Europe was that a wide range of materials and methods to deliver evidence based individually directed alcohol interventions were available in all the countries studied (Table 3.3). However these varied in terms of specific methods and materials and the extent to which their implementation has been actively promoted varies across countries.

In terms of SBI, a wide range of screening tools was available in most countries but there was a lack of consensus about the most appropriate tools to be applied in specific settings. Thus there was the potential for practitioners to be confused about which tools to apply. The AUDIT questionnaire (and its shorter variants) was the most commonly reported approach. AUDIT was developed by WHO and actively promoted internationally as the most validated screening tool. However in many countries the choice of screening tool seemed to be largely left to individual practitioner preferences. This would be unusual in many other areas of clinical practice. Similarly there was a lack of consensus on the most appropriate brief intervention methods both within and across countries. Both of these findings are likely to be related to a lack of concerted national policies and guidelines to promote implementation of SBI.

In the case of specialist alcohol treatment, again a wide range of intervention approaches were available and provided across countries, with little consensus both within and across countries on the most appropriate approaches to treat people with alcohol dependence. Few countries were able to identify national clinical guidelines on alcohol treatment. Only one country (England) has produced official national clinical guidelines on specialist alcohol treatment (NICE, 2011). However, even there, it was reported that there has been limited effort to implement the guidelines into practice. The resulting picture across Europe was of a patchwork of services and interventions driven largely by historical provision and individual practitioner preferences rather than being driven by research evidence on effectiveness or national or European guidelines for best practice.

For example in Austria and Germany it was reported that there has been an over-reliance on inpatient treatment compared to outpatient or community based approaches in spite of a lack of evidence to support the former as the most appropriate approach for most patients. However, there was some evidence that this situation is changing in both countries in recent years.

Table 3.3: summary of availability of materials and methods to deliver alcohol interventions: information/examples provided

Tools	Austria	England	Germany	Italy	Spain	Switzerland
a) Materials, methods, screening tools	YES	YES	YES	YES	YES	YES – to some degree, but not promoted
b) Interventions: used & promoted in practice	YES	YES	YES	YES	YES	YES (available & used, but not actively promoted)
c) Number of service providers delivering alcohol interventions (stat/non-stat)	YES	YES	YES	YES	YES	YES
d) Pharma products: licensed and available	YES	YES	YES	YES	YES	YES
e) Psychological interventions available	YES	YES	YES	YES	YES	YES
f) Service provider workforce training (& any national initiatives to promote training)	NO/ Very small number	YES	YES	YES	YES (see 5b)	YES
g) Protocols or tools, promoted to deliver effective alcohol interventions	YES	YES	YES	YES	YES	YES
h) National review of effectiveness of treatment, or published national standards in treatment delivery	NO	YES	NO	YES	NO	NO
i) Internet based interventions	YES	YES, but not to a great extent	YES	NO	YES	YES
j) Internet based resources for professionals	YES	YES	YES	YES	YES	YES
k) Extent of role of mutual aid and/or self-help	YES	YES	YES	YES	YES	YES

In terms of the number and range of service providers delivering specialist alcohol treatment again the picture was mixed across countries. First there was a variation in the extent to which the range of specialist service provision has been mapped across countries. Those countries with national treatment databases (Germany, England) were able to provide a detailed breakdown of service providers as well as the number of patients entering alcohol treatment. Countries without such a facility were only able to provide a partial picture of service provision. In particular countries with decentralised service administration and funding were able to provide the least information as this information was not collated nationally.

A wide range of licensed pharmacological agents for use in the treatment of alcohol dependence was available across countries. The newer relapse prevention medications (acamprosate, naltrexone) were licensed in most countries but there were important exceptions (e.g. naltrexone is not licensed for use in alcohol dependence in England but can be used on an individual patient basis at the discretion of the practitioner). In some countries there was a clinical preference for older medications such as disulfiram, although the evidence base for this is less than for the newer relapse prevention medications. As with alcohol treatment generally there was considerable variation in practice across countries but most countries noted a lack of active promotion of relapse prevention medications, a lack of national clinical guidelines, and consequently a low level of prescribing by practitioners.

Psychological interventions were commonly used in specialist treatment across countries, but again there was considerable variation between countries in terms of the methods used. There was a preponderance of behavioural, motivational and cognitive behavioural approaches, which is encouraging, as these have the strongest evidence base.

Most countries reported a lack of active training for practitioners to deliver alcohol interventions. But there were some examples of good practice. In England the Department of Health and the Royal College of General Practitioners has been promoting learning tools and courses, including online learning for primary care doctors and the Medical Council on Alcohol has been promoting alcohol education in medical schools. A similar programme exists in Italy via the PHEPA project and in Catalonia. However most countries did not actively promote SBI training on a national level. Similarly all countries commented on the lack of emphasis on alcohol training in the undergraduate medical curriculum in spite of various initiatives to improve this. Also a lack of funding for alcohol training initiatives for practitioners in continuing medical education was noted in most countries.

There was limited uptake of the opportunities provided by the growth of the internet both in terms of alcohol self help websites and online access to appropriate alcohol information and tools for practitioners, although this was viewed to be gradually improving. The Alcohol Learning Centre in England was regarded by respondents as a useful resource, and has been promoted by the Department of Health. Also several countries reported access to SBI tools and training on the internet, but this is not universally available or widely promoted.

Mutual aid groups were reported to be fairly widespread in most countries with Alcoholics Anonymous being more active in northern European countries. In Catalonia the "Catalan Rehabilitated Alcoholic Federation" (*Federació Catalana d'Alcohòlics Rehabilitats*) is active and in Italy the Club of Alcoholics in Treatment was mentioned as an important source of support. However the extent to which these organisations are integrated into, or actively collaborate with, specialist treatment providers varied across countries.

As with treatment provision, typical care pathways for people who are alcohol dependent were varied. Several countries had difficulty in identifying “typical” care pathways as systems of care tend to be more *ad hoc* and less nationally directed. This is likely to be partly related to a lack of clear national guidelines on care pathways in many countries.

RECOMMENDATIONS

- There is a need for national and international guidelines to promote implementation of alcohol interventions in Europe both in terms of the SBI and specialist alcohol treatment
- There is a need for national and European alcohol strategies that give appropriate emphasis to individually directed alcohol interventions as part of an overall public health approach to alcohol
- There is a need for greater resources for training practitioners and supporting implementation of alcohol interventions
- Improving implementation of alcohol interventions would benefit from learning across countries on examples of good practice and sharing of tools and methods

3.3.6 Summary of reported barriers and facilitators to implementation of alcohol interventions:

The issues identified as barriers to implementation of intervention outweighed the number of facilitators identified. Factors that affected the ease with which treatment can be implemented mostly relate to either systemic and policy issues, or societal and cultural issues.

Financial, organisational and political barriers to implementing alcohol interventions are all considered to restrict implementation in England, while Germany cites poor support from both the government and insurance companies. Germany’s social insurance system is felt to be highly disruptive to continuity of care, and indeed is viewed by key informants as being responsible for a higher rate of relapse along the rehabilitation pathway. Switzerland lacks funding for initiatives beyond the pilot stage (specifically for brief interventions), making implementation a continuing struggle. There is a lack evaluation of existing treatment in Switzerland. Implementation is also hampered by the simple lack of a billing code for alcohol treatment related activity.

Italy has had to overcome a lack of consistent support for GPs’ work with brief interventions, in addition to lack of resources, including training and staff. Spain also cited competing pressures medical care and staff burn out, a lack of motivation for staff to carry out SBI, and an underlying doubt in the minds of practitioners as to its effectiveness. Further, a lack of coordination between primary care and specialist care providers has been a barrier, but is beginning to

improve in Spain. In Austria an over-emphasis on inpatient treatment has created a mistaken belief that AUDs are not a health priority as treatment is focused only on the more severe cases.

Fragmentation due to a federalised system was cited by Switzerland as a barrier to successful implementation, but this may also apply to Austria, Germany and to a lesser extent, Spain. Reformation of Germany's addiction care service in particular was reported to suffer from too many players, responsible for only part of the system.

In Italy patients were reluctant to discuss alcohol related problems with the family doctor for cultural reasons, nor were they confident to authorise the use of their records for the purposes of research. Similarly, Austria suffered from an over-normalisation of heavier drinking patterns, and a lack of understanding of the potential health problems. However in England, an increasing societal awareness of potential harms associated with alcohol misuse has been observed as a facilitator to implementation. In Switzerland increased coverage in the media, and more realistic media portrayals, have helped to raise awareness. Spain has encountered difficulties due to the cultural associations of alcohol and leisure, particularly with young people.

Research is viewed as a facilitator in England, developing and making available service models of brief interventions, extended interventions and more intensive treatment. And in Spain, the implementation of programmes which directly promote the early detection of alcohol misuse were seen as having had a positive impact. A lack of training and education of health professionals was noted to some extent in Austria and Italy. Spain cited recent improvements in training as a facilitator.

3.3.7 Summary of key informants' perceptions of the extent to which alcohol intervention has been successfully implemented and their recommendations for improvement.

Because the perceptions varied considerably across countries and recommendations made by informants were relatively country specific, they are presented here on a country-by-country basis.

AUSTRIA

Key informants felt that the provision of services was currently of a high quality, with easy access and short waiting times, but many felt there was too much emphasis on inpatient treatment, and the duration of that treatment was too long compared to that which can be supported by the evidence base. Equally, there was too little interest in SBI in primary care. Most believed the lack of services provided in community settings was a major problem within treatment system.

KEY RECOMMENDATIONS FROM AUSTRIA:

- An extended provision of psychological help and low-threshold services is needed. To achieve these objectives, support from social insurance (as the main source of funding) would be required.
- A more diverse provision of care is needed. Some efforts are underway to run “qualified detoxification” programmes, which offers a shorter stay and cooperation with associated outpatient services ensures a more flexible service provision. It is also better adapted to specific indications - an extension of this kind of service provision would also reduce pressures on acute psychiatric care and would constitute an essential addition to the existing range of inpatient services.

ENGLAND

Feedback from key informants identified that alcohol related issues, including alcohol treatment and intervention have moved up the political and health agenda over the past decade, including national alcohol strategy development, a national needs assessment, effectiveness reviews, and data monitoring systems. Meanwhile, voluntary guidance, poor financial investment and a lack of cohesion across services and sectors has limited the extent to which the implementation of alcohol interventions has been successful. Some comments included “haphazard” and “not a lot” has been done, and recommendations for specialist services have not been implemented “at all”. Successes were often attributable to local champions rather than national initiatives. It should be noted that the majority of stakeholders were interviewed prior to the NHS health reforms and new government’s alcohol strategy being released. One of the few who had the opportunity to comment on this said that movement towards outcome focussed commissioning and ‘payment by results’, combined with the increased integration of alcohol service provision (and funding) that is anticipated from the new ‘recovery agenda’ will be positive. However it is not yet known how diversity of local provision will be managed in this new context, particularly as the plans for NHS reform are likely to put more emphasis on local commissioning and decision making which may hamper implementation of national alcohol strategy on SBI and treatment.

KEY RECOMMENDATIONS FROM ENGLAND:

- There is a need for greater investment in cost-effective treatments and better integration of policy and practice.
- There is a need for balanced treatment systems across primary, acute and specialist care. This should include formalised incentives for alcohol interventions in primary care and other non-specialist settings and adequate funding of specialist care

- There is a need for implementation of existing national guidance and better monitoring of the impact of alcohol misuse and elements of service provision, particularly in relation to SBI
- Further education, training, infrastructure, and research are needed to support effective implementation.

The All Party Parliamentary Group on Alcohol Misuse Inquiry into the future of alcohol treatment services (Alcohol Concern, 2009), are similar to those provided by expert respondents. Its key recommendations included:

- The need for clear cross-departmental leadership from the government
- Improved measurement of alcohol related harms
- Improved capacity in primary health care for the delivery of SBI
- Accessible specialist alcohol services in all local areas
- Regional needs assessments and shared data sources
- Clear protocols and pathways for clients with complex needs
- Clear and updated clinical guidance
- Improved training for practitioners
- Better integration of services

GERMANY

In Germany outpatient counselling, detoxification, inpatient rehabilitation, outpatient aftercare, and self-help have been implemented for several decades. However in 2001 only 7% of all patients with AUD were treated in a specialised outpatient counselling centres (5.1% in community psychiatric service centres, and 3.7% in psychiatric hospitals, and 1.7% in specialised institutions for inpatient alcoholism therapy). Most of these patients have not been identified by professionals, but have initiated their own participation in addiction treatment.

KEY RECOMMENDATIONS FROM GERMANY:

- There is a need for implementation of SBI in routine primary health and non-specialist settings
- There is a need for development of integrated treatment approached for people with alcohol dependence, including intensive integrated outpatient long-term alcoholism treatment approaches

- Both pension and health insurance companies should finance these innovative interventions – they have to be obliged to finance effective innovative therapy approaches and to reduce unnecessary inpatient rehabilitation hospitals.
- More specific training of GPs and nursing staff is needed in order to deliver specific interventions incorporating such interventions in the standard routine medical care they provide.

ITALY

Key informants considered that Italy has benefited from an increased focus over the past few years on improving capacity to deal with AUD. This has in turn focussed attention on the need for standardised approaches, and on the development of local capacity planning to involve all possible stakeholders in community strategies that are not only limited to primary care. The need for a more formalised approach towards alcohol related problems and the possibility to implement SBI into the daily work of GPs by using validated instruments has started to become a priority in terms of public health strategy. The reported feeling and perception of GPs in implementing SBI, is influenced by the burden of the pilot testing procedures. This should be taken into account and accurately evaluated together with the other countries experiences, in order to try to find a way to tailor new and effective strategy that could help in reduce alcohol risk and harm.

KEY RECOMMENDATIONS FROM ITALY:

- Development of a model of training for the professionals involved in SBI is a priority together with a major effort to implement a common standard
- The outgoing national adaptation of the SBI will be a challenge for the forthcoming years together with the need to implement methodologies and specific approaches on early detection and consequent interventions aimed at preventing people from becoming alcohol dependent
- A careful reading of the needs of the GPs is required in terms of implementation of the SBI strategy, particularly of those related to the adaptation of the AUDIT in Italian primary care settings
- Development of projects aimed at the evaluation of the influence of SBI within the general population will be instrumental to full implementation
- There is a need for specific approaches, particularly for young people and the elderly, and widening the SBI approach focusing on particular settings such as schools, working places, hospitals

SPAIN

Stakeholders in Spain considered it difficult to quantify the success of preventive interventions although they recognised improvement in the public's and professionals' risk perceptions of consumption, relating to specific populations and situations. They highlighted the importance of the development and implementation of programmes focused on training medical staff on alcohol interventions (such as Drink Less), and initiatives devoted to disseminating information about alcohol related problems in different settings (e.g. primary care, schools, mass media, such as the "To Act Is Possible" [Actuar es posible] series of publications).

Catalan stakeholders said that although the Drink Less programme is widely available in Catalonia, and those interviewed viewed it as positive, the rate of identification of heavy drinkers has not increased sufficiently. The programme has improved implementation in routine consultations, providing information for professionals, altering attitudes towards alcohol, and the provision of support for more dependent drinkers. The creation of addiction networks to support medical staff, providing them with appropriate guidelines and tools, has been helpful. GenCat is now working on other collaborations with the Catalan Society Family and Community Medicine (CAMFiC) and the Association of Nursing Family and Community Medicine (AIFICC).

KEY RECOMMENDATIONS FROM SPAIN:

- Raise medical staff awareness of consequences of alcohol consumption
- Provide continuity to the existing projects and increase coordination between settings
- Create a supportive environment for professionals and improve the quality of the screening and interventions
- Implementation of programmes such as Drink Less in the health system to become part of routine care
- Development of online SBI tools
- At the specialist level, integration between addiction centres and mental health centres in order to provide a better treatment, and increase the number of available centres providing these services
- Combination of the prevention effort with fiscal measures (increasing taxes on alcoholic beverages, educational and legal restrictive measures in respect with nightlife and health)

SWITZERLAND

Key informants in Switzerland welcomed the efforts made in some regions to standardise the treatment process and the adoption of patient-treatment matching principles. Yet the fact that almost no evaluation studies have been conducted revealed an important flaw in the evolution of the current care system, suggesting that it was difficult to argue for successful implementation of *best practice* approaches. However the current treatment provided did appear to be responsive to actual needs, and improvement in the organisational network would be beneficial. The absence of strong financial support and government will at a national level were suggested reasons for overall inertia in the treatment system.

Yet important improvements have taken place in early intervention based on recent developments of internet based “prevention” intervention tools (e.g. in the work environment), and broader media coverage of “addiction” themes. These elements have provided easier access to information, a better knowledge of treatment issues, and earlier recognition of alcohol problems. Also, better training of GPs during medical training may facilitate earlier identification of alcohol problems, and probably result in overall improvement in the treatment system.

KEY RECOMMENDATIONS FROM SWITZERLAND

- Better collaboration between prevention and treatment stakeholders, which would assist more effective implementation and resource allocation
- More multidisciplinary (e.g. medical, psychosocial) and multicentre collaboration should take place, not only to improve the treatment network, but also promote a common understanding and definition of alcohol dependence.
- Efforts towards better “patient-treatment matching” should be prioritised at national level
- Cost-effectiveness should not be the only element to be considered, as the patient experience is also known to influence outcome
- In-depth evaluation of the standardised systems recently implemented in some states are urgently needed
- Incorporating ‘alcohol medicine’ into a more comprehensive framework of addiction medicine in the development of an official alcohol treatment system is needed, as only minor focus is given to alcohol
- Spreading of available intervention tools through national level initiatives to promote uptake throughout whole healthcare system.

4. Survey of primary health care and accident and emergency service providers

4.1 Introduction

Element 2 of WP6, comprises two surveys of services providing alcohol interventions at different levels of the health system, namely primary care settings, and accident and emergency departments. These surveys were carried out on a randomly selected sample of services in six European countries (Italy, Germany, England, Spain, Austria and Switzerland). In Spain the surveys focused only on Catalonia, whereas in the remaining 5 countries, surveys were conducted on a national level. It was originally intended that national surveys of specialist alcohol treatment providers would need to be carried out in order to estimate national service capacity. However, this data was obtained through other available sources and is described in Section 5 below. This section of the report describes the surveys of primary health care and accident emergency (A&E) department providers.

4.2 Methods

4.2.1 Aims

- 1) To identify barriers and facilitators to service provision in primary care settings, A&E departments
- 2) To provide an improved understanding of alcohol interventions in primary care and A&E across European countries
- 3) To identify the proportion of people treated in each of these settings in different countries

4.2.2 Survey of primary care staff

Sampling

We aimed to survey a random sample of 100 primary care staff (general practitioners – one from each practice) in each of the six countries using national databases and registers of primary care practitioners, or from the relevant professional organisations. Table 4.1 summarises the number of respondents for each country, the sampling frame and methods used to collect this data. This yielded a total of 683 primary care staff respondents across the six participating countries.

Table 4.1 – Summary of the Primary health care survey methods

Country	Method/s	Sampling	Completed
Austria	Email/online	5,000	103
Germany	Letter (and email)	800	103
Italy	Online	1,300	198
Spain (Catalonia)	Online	100 (centres)	74
Switzerland	Postal	500	102
UK (England)	Online/Phone	300	103
Total			683

Survey tools

A survey tool was developed based on the recent UK (Kaner et al., 2009; Coulton et al., 2009) and WHO surveys of health professionals on the identification and management of AUDs, and included the Short Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ; Anderson and Clement, 1987). The survey tool can be found in Annex 4.

The SAAPPQ is a 10 item, 7-point Likert-type questionnaire measuring the attitudes of professionals towards the provision of care to people with alcohol use disorders. The SAAPPQ is a shorter version of the original AAPPQ (Cartwright, 1980). The SAAPPQ measures two attitudinal dimensions – ‘role legitimacy’ and ‘therapeutic commitment’. ‘Role legitimacy’ refers to the way in which professionals perceive the adequacy of their skills and knowledge in relation to problem drinkers and how appropriate it is for them to work with such clients. ‘Therapeutic commitment’ refers to the extent to which professionals seek to engage drinkers in treatment and the extent that they find the work rewarding on both a professional or personal level (Gorman and Cartwright, 1991). Additional information was collected about the practitioners’ characteristics and activity in relation to patients with AUDs.

Once finalised, the survey (see annex 4) was adapted and translated to meet different national languages and contexts (translated versions available on request).

Participating staff either completed the survey online, received an electronic version via email, received a printed copy by post, or were interviewed by phone, in order to achieve the sample size as quickly and efficiently as possible. Data collected from each partner country was entered into a single SPSS file for analysis.

4.2.3 Accident and Emergency (A&E) staff survey

Sampling

For A&E staff, we aimed to interview 100 members of staff from a sample of randomly selected A&E departments in each country (600 in total). Staff members in each department were invited to complete an online survey, complete a postal survey, or were interviewed by phone. Table 4.2 summarises the number of respondents for each country, the sampling frames and methods used to collect this data. This provided a total of 468 A&E staff respondents across the six participating countries.

In England, the target A&E departments were identified using the national Hospital Episode Statistics data for Accident & Emergency Departments in England. A total of 20 A&E departments were randomly selected, stratified geographically and by acute and foundation NHS trusts. For each A&E department, senior and junior medical and nursing staff were identified through service managers, and invited to complete a short online survey which was distributed to work email accounts. In total, email addresses were sought for 250 staff members to allow for non-response.

Once identified, participating staff were invited to complete a web based survey (provided at Annex 5) via a hyperlink in the email. The email was sent directly to the A&E staff member or forwarded by the service manager on behalf of the research team. Each participant was issued an identification code to track response progress in addition to maintaining anonymity and confidentiality. A participant information sheet was also attached to the email, describing the purpose of the study and contact details of the research team. Participants were informed that taking part in the survey would be taken as consent to participate and participants were still free to leave any questions blank or withdraw at any time and without giving a reason. A gift voucher for a high street retailer worth the equivalent of £10 was offered as an incentive for completion of the survey.

In Italy, recruitment was impaired by external factors including changes in the Italian National Health Service. During the period when the survey has been carried out A&E departments faced major and ongoing structural changes due to the governmental spending review with consequent overcrowding, personnel reduction, strikes that influenced the possibility to select a random sample of units to be involved in the survey. Notwithstanding this difficult background, the Italian collaborators have managed, with the support of key stakeholders, to collect 88 completed questionnaires.

In Germany, lack of time and interest for the survey topic amongst A&E staff were mentioned as the main reasons for lack of responses. Out of 40 A&E departments selected at random only 10 members of staff from 4 sites responded.

In Austria, A&Es were selected from a list of over 300 hospitals. All general hospitals with A&E departments were selected as eligible for the survey. Based on this list, a random selection of A&E departments was made (no stratification was applied) and contacted by telephone. Five out of 30 contacted hospitals agreed to participate in the survey. Additionally experts in emergency care helped to identify five additional hospitals with extensive experience in emergency care which agreed to take part in the survey.

In Switzerland a first selection was made of A&Es with full diagnostic facilities in the hospital and/or related to the largest hospital of each state; facilities located in the smaller Italian speaking part of the country were excluded. Based on this list, a blind selection of 6 A&Es was made based on the list of A&Es with full emergency care facilities, with stratification between large scale cities (four) and smaller one (two, for covering more rural areas) and between the two main linguistic parts of the country (four A&Es in the German speaking part, and two in the French speaking part). Among the six originally selected A&Es, one immediately agreed to participate, another agreed three months later and after repeated contacts (one in each region). When refusals were recorded, alternative A&Es with similar characteristics were contacted. Over the second phase of sampling, six other A&Es refused to take part to the survey, and only two accepted. In total, four A&Es accepted to take part to the survey, and 10 refused, with a total of 14 A&Es contacted. Two of the four participating A&Es were affiliated to university hospitals, the other two being located in smaller cities (one of them being multi-site, with respondents from two/both emergency wards taking part in the survey).

In Catalonia, five large general hospitals in Catalonia were selected: Hospital Vall d'Hebron, Hospital Sant Pau, Hospital del Mar, Hospital de Bellvitge and Hospital Clinic. Doctors working in A&E departments from all medical specialties, whether staff or external consultants, could participate in the study. The collection of responses was carried out by the hospitals themselves, coordinated by the local research team. The contact was made through the head of the psychiatry unit of each hospital who was requested to distribute, mainly through a psychiatrist working in the emergency unit, and collect at least 20 completed questionnaires.

Ethical and data protection issues

Personal identifiable information was collected from participants who consented to take part in the surveys. The collected data was stored on a secure server based at King's College London. However, personally identifiable data was stored separately from survey responses. King's College London is regularly inspected by research governance to ensure it complies with all data management regulations. All data collected was only accessible to the scientists managing the surveys. Analysis was conducted using anonymised data. At the end of the study all personal identifiable data was deleted from the dataset. All relevant data protection laws were observed, including the UK Data Protection Act. The study was awarded ethical approval by the relevant

ethical committees in the participating countries according to local legal and ethical requirements.

Table 4.2 – Summary of the Emergency Department survey methods

Country	Methods	Number of A&E departments	Completed
Austria	In person, paper copy, email/online	35	96
Germany	Online, postal (and email)	40	10
Italy	Online, postal	16	88
Catalonia	Paper copy	5	97
Switzerland	Postal	14	71
England	Online	20	106
Total		130	468

4.3 GP survey results

Table 4.3 shows the gender and mean age of the respondents across the six countries. The gender of respondents varied between countries, with the percentage of male GPs varying between 74.2% in Italy to 23.3% in Catalonia. The mean age of respondents also varied from 56.2 years in Italy to 46.5 years in England.

Table 4.3 – Sample demographics and patients seen and screened positive for AUD per week.

Country	Gender of respondents(% males)	Mean age of respondents	Patients per week	Patients screen +ive/4 weeks (%)
Austria	46.5%	55.2	285	6.54 (0.5%)
Germany	53.4%	53.8	203	7.76 (0.9%)
Italy	74.2%	56.2	117	5.18 (1.1%)
Catalonia	23.3%	47.3	149	4.14 (0.7%)
Switzerland	61.8%	52.5	98	4.40 (1.1%)
England	52.4%	46.5	110	3.87 (0.8%)
Mean across countries	56.3%	52.7	154	5.34 (0.8%)

The total number of patients seen each week by each individual general practitioner was highest in Austria (n=285) and lowest in Switzerland (n=98). The largest number of patients screened positive for AUD in a 4-week period was highest in Germany (mean= 7.76) and lowest England

(mean= 3.87). However, when adjusted for the total number of people seen, GPs in Switzerland and Italy were able to identify a higher proportion of people with AUDs (1.1%) than GPs from any other country (Table 4.3 above).

Figure 4.1 shows the proportion of GPs who were familiar with and used standardised alcohol screening tools such as FAST or AUDIT across the six countries. Catalonia and England had the highest proportion – with 94.6% and 88.2% respectively – of GPs who were aware of these screening tools. GPs in Italy were the least aware of standardised tools for the identification of AUD. Actual use of these tools followed a similar trend, albeit with fewer people using these screening tools in all countries. Table 4.4 lists the main barriers to implementation of SBI with ‘time constraints’ and ‘risk of upsetting the patient’ cited as the most important barriers to alcohol screening in their clinical setting.

Figure 4.1 – Are GPs familiar with and use standardized alcohol screening tools?

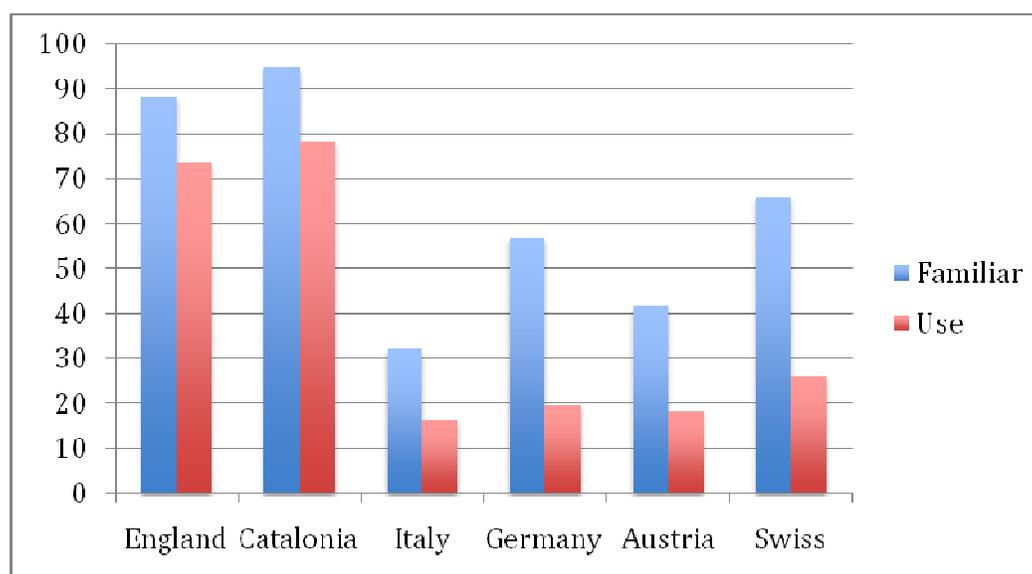


Table 4.4 – Main barriers to alcohol screening in primary care

Reason	N of responses	Percent of cases
Time constraints	209	70.6
Lack of financial incentives	87	29.4
Risk of upsetting the patient	147	49.7
Lack of training	60	20.3
Lack of services to refer patient to	67	22.6
Other reasons	81	27.4
Total	651	

Similarly GPs in Catalonia and England were more familiar with alcohol brief interventions than in other countries. It was specified in the questionnaire that we were referring to interventions carried out in non-specialist settings, by non-specialist personnel, and directed at hazardous and harmful drinkers who are not typically complaining about or seeking help for an alcohol problem. These interventions might vary in length from five minutes to 30/40 minutes, and from a single session to repeated sessions. Actual provision of brief interventions showed a similar pattern (see Figure 4.2 below). However as already reported with alcohol screening activities, fewer GPs reported offering alcohol brief interventions in their clinical setting, with ‘Time constraints’ and ‘Lack of training’ mentioned as the most important barriers (see also table 4.5).

Figure 4.2 – Are GPs familiar with and use brief interventions?

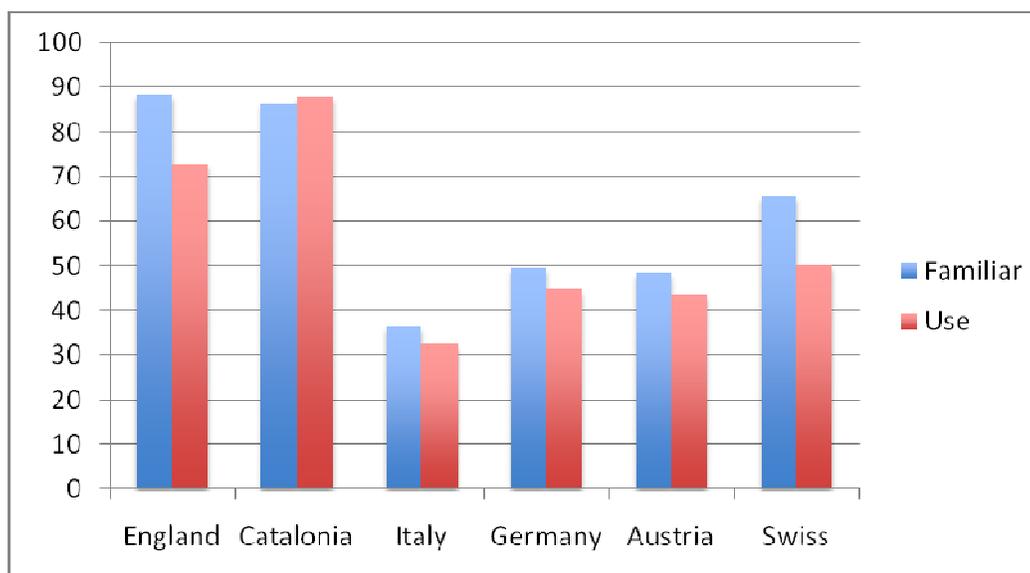


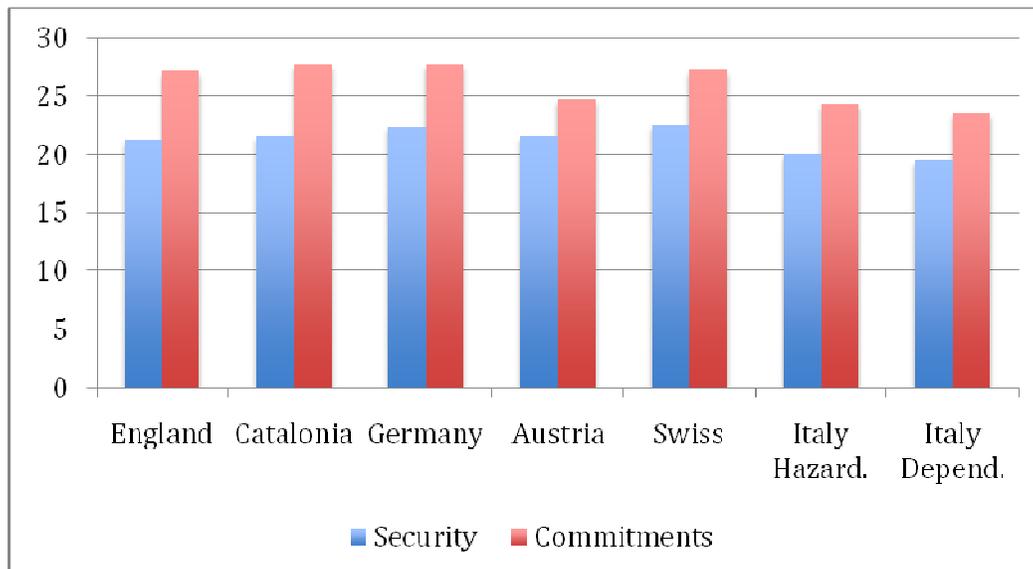
Table 4.5 – Main barriers to alcohol brief interventions in primary care

Reason	N of responses	Percent of cases
Time constraints	224	72.0
Lack of financial incentives	97	31.2
Risk of upsetting the patient	87	28.0
Lack of training	125	40.2
Lack of services to refer patient to	68	21.9
Other reasons	33	10.6
Total	634	

Figure 4.3 compares the subscale-scores of the SAAPPQ relating to Role legitimacy / Role security and Therapeutic commitment. These showed no statistically significant differences between the respondents across countries. Further, Role security, Therapeutic commitment and total score of the SAAPPQ did not differ significantly between male and female responders across

all countries (respectively M=21.4 F=21.4; M=25.9 F=26.8; M=47.2 F=4.9; $p > 0.05$). However, Therapeutic commitment did significantly inversely correlate with age ($p=0.001$) indicating that younger GPs are more positive about working with AUD patients.

Figure 4.3 – GPs SAAPPO scores by country



4.4 Accident and Emergency Department survey results

Table 4.6 shows the gender and mean age of the respondents across the six countries. The gender of respondents varied between countries, with the percentage of male ED staff varying between 69.3% in Italy to 38.9% in Catalonia. The mean age of respondents also varied from 49.1 years in Italy to 34.7 years in Catalonia.

The total number of patients seen each week by each individual A&E staff member was highest in Austria ($n=117$) and lowest in Catalonia ($n=40$). The largest number of patients screened positive for AUD in a 4-week period was highest in England (mean= 14.2) and lowest in Italy (mean= 4.7). However, when adjusted for the total number of people seen, A&E staff in Switzerland were able to identify a higher proportion of people with AUDs (6.6%) than A&E staff in other countries (Table 4.6).

Table 4.6 – Sample demographics and patients seen and screened positive for AUD per week.

Country	Gender of respondents(% males)	Mean age of respondents	Patients per week	Patients screen +ive/4weeks (%)
Austria	39.6%	38.3	117	13.1 (2.8%)
Germany	80.0%	39.6	58	8.4 (3.6%)
Italy	69.3%	49.1	78	4.7 (1.5%)
Catalonia	38.9%	34.7	40	6.9 (4.3%)
Switzerland	43.7%	36.2	36	9.5 (6.6%)
UK (England)	49.1%	42.7	64	14.2 (5.5%)
Mean across countries	48.7%	40.3	68	9.89 (3.6%)

Figure 4.5 shows the proportion of A&E staff who were familiar with and used standardised alcohol screening tools such as FAST or AUDIT across the countries. England and Switzerland had the highest proportion, with 78.1% and 57.7% respectively. A&E staff in Austria were the least aware of standardised tools for the identification of people with AUDs. Actual use of standardised tools was highest in England (53.8%) and lowest in Germany (0%). A&E staff mentioned ‘Time constraints’ and ‘Lack of training’ as the most important barriers to screening in this clinical setting (see also table 4.7).

Figure 4.5 – Are A&E staff familiar with and/or use standardized alcohol screening tools?

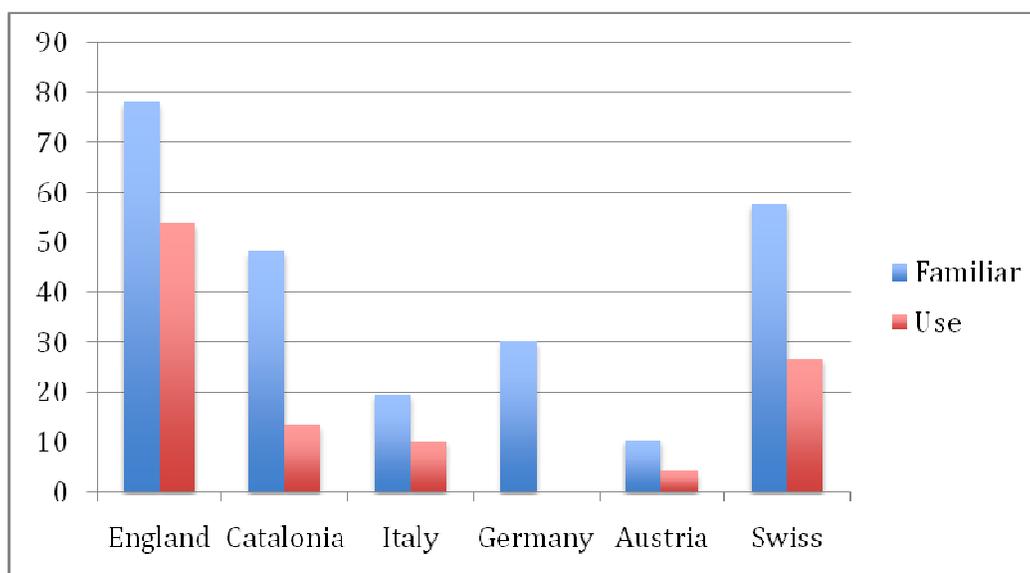


Table 4.7 – Main barriers to alcohol screening in Accident and Emergency

Reason	N of responses	Percent of cases
Time constraints	275	77.7
Lack of financial incentives	33	9.3
Risk of upsetting the patient	75	21.2
Lack of training	123	34.7
Lack of services to refer patient to	119	33.6
Lack of familiarity	98	27.7
Other reasons	47	13.3
Total	770	

Similarly A&E staff in England and Catalonia were more familiar with alcohol brief interventions than A&E staff in other countries. As with the GP survey, this term is used to refer to intervention carried out in non-specialist settings, by non-specialist personnel and directed at hazardous and harmful drinkers who are not typically complaining about, or seeking help for, an alcohol problem. Of the A&E staff that responded, 45.3% in England also offered brief interventions to patients in their clinical setting whilst in the other participating countries this percentage is lower. Provision of brief interventions reflects the use of standardised screening tool as reported earlier with England having the highest percentage and Germany the lowest reported level of use (see Figure 4.6 below). ‘Time constraints’ and ‘lack of training’ were again mentioned as the most important barriers to offering alcohol brief interventions in A&E.

Figure 4.6 – Are A&E staff familiar with and/or provide brief interventions?

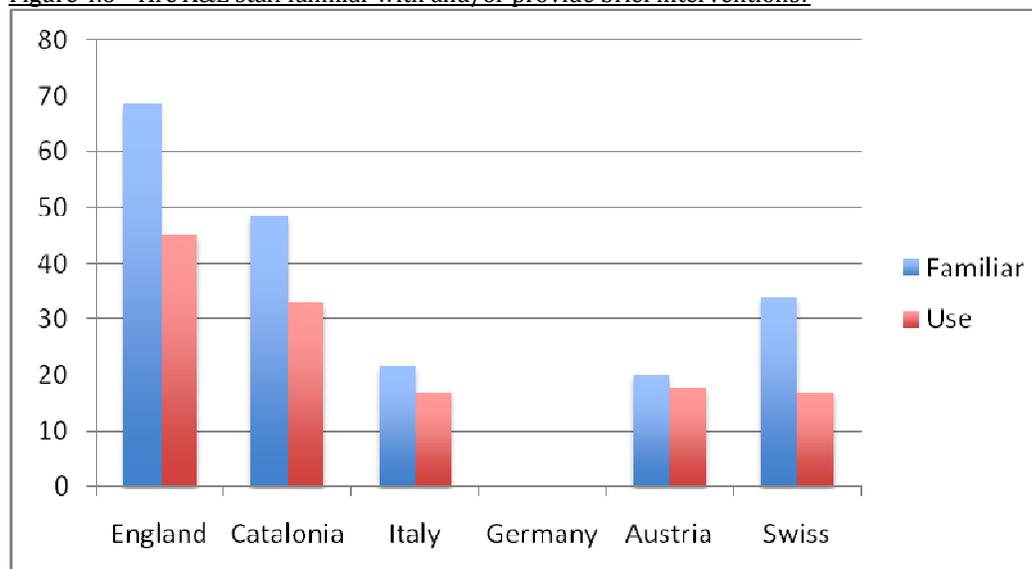


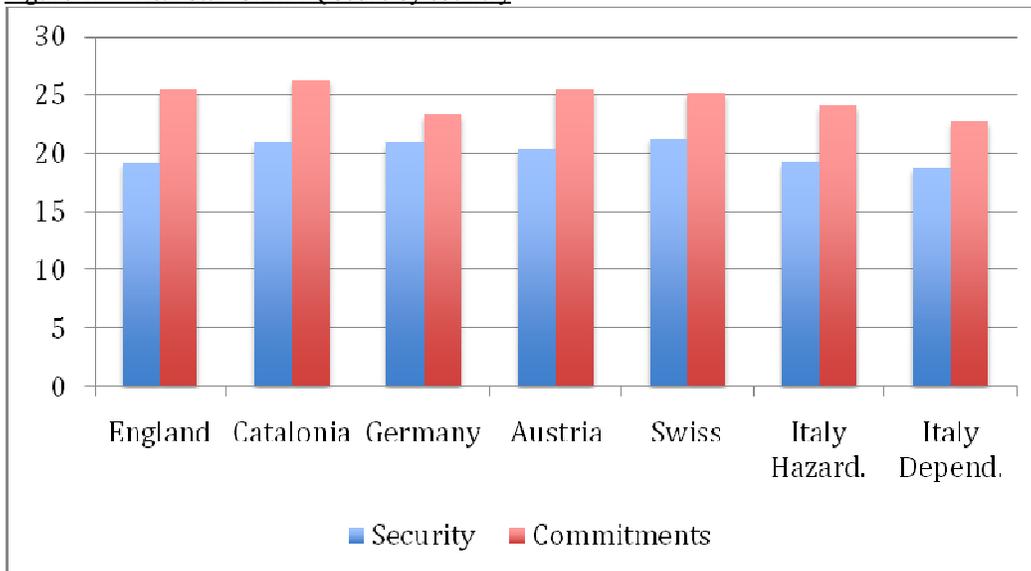
Table 4.8 – Main barriers to alcohol brief interventions in Accident & Emergency

Reason	N of responses	Percent of cases
Time constraints	269	76.9
Lack of financial incentives	38	10.9
Risk of upsetting the patient	57	16.3
Lack of training	175	50.0
Lack of resources	140	40.0
Other reasons	44	12.6
Total	723	

The SAAPPQ measures two attitudinal dimensions – ‘role legitimacy’ and ‘therapeutic commitment’. ‘Role legitimacy’ refers to the way in which professionals perceive the adequacy of their skills and knowledge in relation to problem drinkers and how appropriate it is for them to work with such clients. ‘Therapeutic commitment’ refers to the extent to which professionals seek to engage drinkers in treatment and the extent that they find the work rewarding on both a professional or personal level.

Figure 4.7 compares the subscale-scores of the SAAPPQ relating to Role legitimacy / Role security and Therapeutic commitment. These showed no statistically significant differences between the respondents across the six participating countries. In Italy, A&E staff were administered the SAAPPQ twice, first referring to hazardous and harmful drinkers, and subsequently referring to dependent drinkers. Total scores from those two sets of questions were highly correlated (0.961 $p < 0.001$).

Figure 4.7 – A&E staff SAAPPQ score by country



Role security, Therapeutic commitment and total score of the SAAPPQ did not differ significantly between male and female responders across all countries (respectively $M=20.5$ $F=19.7$; $M=24.6$ $F=25.9$; $M=45.2$ $F=45.7$; $p > 0.05$). However, Therapeutic commitment and SAAPPQ total score did significantly inversely correlate with age (respectively, $p=0.001$ and $p=0.003$). Therefore younger A&E staff had a greater therapeutic commitment and overall SAAPPQ score than older respondents.

Finally, a t-test analysis comparing SAAPPQ scores between GPs and A&E staff showed significant differences across the role security subscales (Mean=21.3; Mean=20.1; $p < 0.001$), therapeutic commitment (Mean=26.2; Mean=25.3; $p < 0.005$) and total SAAPPQ score (Mean=47.6; Mean=45.5; $p < 0.001$) indicating GPs scored significantly more positively than A&E staff.

4.4 Conclusions

In summary, several points of interest emerged from the between country and setting comparisons of attitudes and practices of GPs and A&E staff, aside from demographic differences.

In particular, GPs reported very low screening activity with an average of five patients screened positive over a four-week period, representing 0.8% of their patients. GPs did however have a relatively high level of knowledge and understanding of screening tools and brief interventions, although with some variations across countries. GPs in England and Catalonia reported being more familiar with SBI compared with GPs in the other countries.

In contrast, the actual use of screening tools and provision of brief interventions was lower than the proportion who reported familiarity with these methods across all countries. GPs reported 'time constraints', 'risk of upsetting the patient' and 'lack of training' to be the main barriers to both alcohol screening and offering of brief alcohol interventions.

GPs from the participating countries did not differ on the subscale-scores of the SAAPPQ relating to Role legitimacy / Role security and Therapeutic commitment. However, when compared with the A&E staff they showed a significantly more positive attitudes towards working with patients with AUDs.

Conducting the surveys of A&E staff was considerably more challenging, and in some countries this required more time and effort than anticipated based on experience with the survey of GPs. Key stakeholders and A&E staff in Germany, Austria and Italy showed considerable resistance in responding to the survey. This may be a reflection of the more negative attitudes towards working with AUD patients. In particular, A&E staff in England, Catalonia and Switzerland had greater knowledge of and familiarity with standardised alcohol screening tools and alcohol brief interventions. As emerged in the GP survey findings, there were barriers that limit the

implementation of alcohol screening and brief interventions. 'Time constraints' and 'Lack of training' were the most cited reasons.

England, Catalonia and Switzerland respondents also reported a higher proportion of people screened positive each week, and interestingly, A&E staff across the six countries screen and identify 4.5 times more AUD positive individuals than their GPs counterparts which may be a reflection of higher prevalence rates of AUD amongst A&E compared to primary care attenders.

5. Study of the gap between need and access to treatment.

5.1 Introduction

5.1.1 Overview of needs assessment in a European context

Healthcare needs assessments are a systematic approach to ensuring that health service resources are most efficiently used to meet the health needs of the population. There has been growing interest in the question of how well health services meet the alcohol needs of the community in Europe (Drummond et al., 2011). A number of recent studies, particularly the WHO global burden of disease studies and initiatives such as the WHO ministerial conference on mental health, and the creation of networks such as the European Network on Mental Health, have led to an increased interest in mental health as a public health priority.

Alcohol needs assessment methodology has been developed but there has been no Europe-wide alcohol needs assessment conducted to establish this measurement in different countries using a common methodology (Drummond et al., 2011). Very few countries are known to have conducted previous alcohol needs assessments (Drummond et al., 2005; Drummond et al., 2009). Hence there is a lack of comparative data on prevalence (or need) and access to services for AD across European countries, and the gap between these. This hampers an ability to make useful Europe-wide comparison, develop relevant policy and ensure it is targeted appropriately.

5.1.2 Aims and Objectives

The aim of this workstream was to estimate the prevalence of alcohol dependence in the six participating WP6 countries, and to conduct a needs assessment to estimate the gap between alcohol-related need and access to specialist alcohol treatment in each country. Available data on the prevalence of alcohol dependence and alcohol related morbidity and mortality was identified in each country, and the prevalence compared to access to treatment for people with alcohol dependence in all six countries. The ratio between prevalence and access to treatment was calculated for each country as a prevalence-service utilisation ratio (PSUR).

Aims:

- 1) To estimate the prevalence of alcohol use disorders (alcohol dependence) across 6 European countries.
- 2) To conduct a needs assessment to estimate the gap between alcohol related need and provision of services across 6 European countries.

Objectives:

- 1) To identify available data on the prevalence of alcohol use disorders in six European countries.
- 2) To compare the gap between prevalence and service utilisation of people with alcohol dependence in six European countries by calculating a prevalence-service utilisation ratio.

5.2 Methods

5.2.1 Data collection

A semi-structured questionnaire was developed to collect a broad range of information from experts working within the alcohol field (Annex 3). All data relating to prevalence of alcohol dependence and access to treatment was extracted from these reports for the purpose of the gap analysis. Where this data was not available, alternative sources of information were sought including national statistical websites and other published resources.

5.2.2 Prevalence of alcohol dependence and need for treatment

All information available on prevalence of alcohol dependence was extracted from the country reports. Where only percentages were available, population figures for the same or nearest possible year was used to calculate an estimate of numbers of alcohol dependent individuals for each country. Where no prevalence data was available in the country reports, alternative or less recent data was first sought with the relevant country's research team. In the case that no appropriate data could be directly sourced, prevalence rates were taken from a recently published report (Rehm et al., 2012). This report presents the most recent European country prevalence estimates. The report used large general population surveys as its main source of data, where available, and WHO regional office data and other discrete studies where population surveys were unavailable.

Population data was also sought for the corresponding year of the prevalence data, in order to a) provide a context for the need and access to treatment figures, and b) allow for any further prevalence estimates to be made.

5.2.3 Access to treatment

All available national data on patients accessing specialist treatment were identified from the country reports, and extracted for this exercise. Most countries routinely collected data that, to some extent informs on numbers accessing treatment, despite differences in methodology and robustness. One country felt none of the data collected was sufficiently representative of

numbers accessing treatment, citing the devolved health care administration and the involvement of health social insurance as barriers to obtaining comprehensive national level data.

As far as possible, treatment access data related to the same year as the prevalence estimates being used. Only data on treatment episodes funded by state or social insurance were included. Data on self-help and mutual aid organisations was not included, as these are not statutorily provided and hence are less directly affected by government policy. However in some countries, particularly Italy, this was noted to be a significant contributor to the overall service provision.

Where data were unobtainable, substitute data was again sourced from the recently published European study (Rehm et al., 2012). The Rehm study uses estimates comprising one set of data for access to inpatient treatment, and usually two estimates (upper and lower) for access to outpatient treatment; thus providing an upper and lower total estimate in total when combined. Most of this data was originally sourced from the WHO European Hospital Morbidity Database (EHMD).

5.2.4 Data types

Qualitative information from the country reports provided a useful insight to the diversity with which access to treatment figures are obtained and recorded (Gual & Robles, 2011; Zois et al., 2011; Gandin & Scafato, 2011; Keundig & Gmel, 2011; Goos & Strizek, 2011; Davey et al., 2011). Austria's recording system used ICD-10 diagnosis of alcohol dependency upon hospital discharge. Systematic documentation of outpatient care did not exist, but general patient records were kept by individual providers and have been added together to provide a crude figure, albeit 1) different methodology has been used by providers, 2) different packages of care are being provided, 3) patient target groups differ (addictions, but not all alcohol), and 4) data are not all from the same year.

England has had a National Alcohol Treatment Monitoring System since 2008, which records data on treatment access contemporaneously. Italy collected data on the number of alcohol patients who received a community intervention at specialist alcohol services, but also offered data collected on hospital discharge ICD-9 diagnosis. Germany produced an annual statistical report whose methodology has apparently improved over the years, however the methodology and measurements are not described in any further detail. Further, it was stated that data are not sufficiently differentiated with regard to numbers on early interventions and non-specialist settings to be able to isolate and identify those in receipt of specialist treatment alone. Spain produced annual reports detailing numbers treated in outpatient units, hospital settings and non-hospital residential facilities.

Switzerland on the other hand was not able to provide reliable national estimates of treatment access, as data tended to be collected locally or via multiple health insurance providers, so it is

highly likely that the access level is higher than the data suggest. Experts stated that medical care funded by basic medical health insurance would first need to be taken into account i.e. hospital medical statistics, however these only consider primary alcohol diagnoses and not as a secondary underlying cause, such as in alcohol related injury or suicidal ideation.

5.2.5 Data verification by country

Where possible the data provided by the country reports were used, as these were generally deemed to be the most recent available, and the best representation of the current picture. Some issues arose requiring further refining of data, in order to achieve the most meaningful calculations. These included:

- Incomplete or unobtainable data
- Prevalence and access to treatment figures referring to different years
- Prevalence and population data incompatible e.g. prevalence presented as a percentage of males and a percentage of females, and population only available as a total, or not available specifically for the 15 years+ age group
- Non-specific data e.g. prevalence data not fully referenced or anchored in a specific year

In the first instance, more compatible data was requested from the relevant country team, as summarised in sections 3.3.2 and 3.3.3. However where no further data could be provided, measures were undertaken to maximise data compatibility through searches carried out on the internet for official data provided by domestic statistical organisations and other published data.

5.2.6 Gap analysis

The gap between the need for alcohol interventions (number of people who are alcohol dependent in the general population) and access to specialist treatment services (including inpatient and outpatient services) was analysed to produce a prevalence-service utilisation ratio (PSUR) for each country. The methodology followed that of a recent national alcohol needs assessment study in England (Drummond et al., 2005).

5.3 Results

5.3.1 Prevalence of alcohol dependence and access to treatment

The data used to calculate prevalence of alcohol dependence and the gap analysis are shown in Table 5.1. It can be seen that the prevalence of alcohol dependence based on the available data varied considerably across the six countries. Italy had the lowest male prevalence rate (0.7%)

and Spain had the lowest female prevalence rate (0.2%). Switzerland had the highest male prevalence rate (7.2%) and Austria had the highest female prevalence rate (2.5%).

Prevalence Service Utilisation Ratios also vary widely across Europe, and this appears to be a consequence of the differences in prevalence rates. Given that Rush's model (Rush, 1990) suggested that 10% of those in need of alcohol treatment gaining access to treatment per annum is regarded as "low" and 20% is regarded as "high", we can see that Austria, England, Germany and Switzerland are relatively low, with Italy and Spain high. Italy had the highest level of access with 1 in 4.2 (23.3%) people with alcohol dependence accessing treatment per annum. Germany had the lowest level of access with just 1 in 28 (3.6%) people with alcohol dependence accessing treatment per annum.

In contrast, there was less variance between countries regarding estimated numbers accessing treatment, which could suggest that there is less between-country variation in prevalence of alcohol dependence than the available data suggest. England had the highest number of people accessing specialist alcohol treatment (111,381) and Switzerland had the lowest (23,589 – 39,000), followed closely by Austria.

5.3.2 Trends

Not all countries were able to provide 10 year longitudinal data, or analyses of trends. Of those available, Austria showed a slight decrease in hospital admissions with the diagnosis "alcohol dependence", but within that, an increase in the proportion that were women. However it was acknowledged that the diagnostic tool had changed during that time period from ICD-9 to ICD-10, limiting the relevance of these findings.

Italy did not have recent prevalence data, but was able to report that the rate of alcohol attributable diseases diagnosed upon discharge from hospital has been on a downward trend since 2000. The total number of alcohol patients who received a specialist community intervention in 2009 was also slightly down from the previous year's figures.

The number of people being treated for alcohol problems in Spain had increased over the past ten years – patients being mainly treated in outpatient settings, which runs in parallel with a small decrease of patients treated in inpatient facilities. The proportion of patients treated in non-hospital residential centres matched the proportion of patients being treated in inpatient settings. In 1999 only a small portion of patients were treated in non-hospital residential centres, but progressively the number of patients treated by them had increased. In 2008, the number of patients treated in non-hospital residential centres was very similar that the treated in inpatient settings.

In Catalonia since 2004 there has been an increase of patients being treated for alcohol problems, parallel to an increase of the use of screening tools in primary health care. It is likely that increased numbers in treatment are due to greater availability and use of screening tools in

primary care, but yet screening is still considered to identify a small proportion of those in need of treatment. Stakeholders interviewed considered there to be an under-estimation of hazardous drinking, so the quality of screening was being assessed. It is not unrealistic to conclude therefore that prevalence rates for alcohol dependence also suffer from underestimation.

Table 5.1 – Gap analysis of specialist treatment for alcohol dependence

	General population (full & aged 15yrs+) T-Total M- Male F- Female	Prevalence rate (% of population aged 15yrs+): M=male, F=female, T=Total population, if figure provided	Number of adults with AD (n) (aged 15yrs+, England 16yrs+)	Access to treatment (n) (aged 15yrs+, England 18yrs+)	PSUR (% of in need population accessing treatment)
Austria ¹ 2010	7,148,204	M: 7.5% F: 2.5% T: 5%	357,410	39,814	9.0 (11.1%)
England ² 2007 (& '11)	T: 53,013,000 43,682,712 (15yrs+)	M: 6% F: 2% T: 4%	1,572,577	111,381	14.1 (7.1%)
Germany ³ 2007 (& '11)	T: 81,902,000 70,845,230 (15yrs+)	Approx: 2.3%	1,600,000 (no age group specified)	57,259	28.0 (3.6%)
Italy ⁴ 2009	T: 60,045,068 M: 24,818,220 F: 26,798,140 = 51,616,360 (15yrs+)	M: 0.7% F: 0.4%	280,921	65,360	4.3 (23.3%)
Spain ⁵ 2008	M: 22,978,661 F: 23,264,850 T: 46,063,511 (14.7% under 15yrs 39,289,174 (15yrs+))	M: 1.2% F: 0.2%	M: 273,583 F: 46,529 T: 320,112	49,036	6.5 (15.3%)
Switzerland ⁶ 2007	T: 7,551,000 6,373,044 (15yrs+)	M: 7.2% F: 1.4%	M: 206,800 F: 42,300 T: 249,100	39,000 - 23,589	6.4 - 10.6 (15.7% - 9.5%)

FOOTNOTES ON DATA SOURCES:

1. AUSTRIA: All data presented are for 2010, and for a population, aged 15yrs+. Population data was taken from Statistik Austria. Prevalence data rates were from assumptions made by Uhl et al (2009), and access to treatment data combined “main” and “secondary” alcohol dependence hospital diagnoses (31,218), monitored by Statstik Austria and the Federal Institute for health

(Bundesinstitut für Gesundheit, ÖBIG). These have been added to outpatient figures (8,765) from the country report spanning different years between 2002 & 2009.

2. ENGLAND: Population data is from the 2011 census (Office for National Statistics, 2012) available for age 15yrs+. A new PSUR has been calculated using the 2007 APMS prevalence rate (4%) based on an AUDIT score of 16 or more (McManus et al, 2009), which refers to adults aged 16yrs+. Access to treatment data was taken from the most recent NATMS report available (for 2009-10) and refers to adults aged 18yrs+ that presented for treatment with alcohol as the primary substance of misuse.

3. GERMANY: Population was for 2009 from the OECD, and 15yrs+ calculated based on the percentages provided. Prevalence rates and number of population with alcohol dependence were provided in the WP6 German country report (Zois et al., 2011). Data for access to treatment is for 2007, from the same WP6 report (Zois et al., 2011), and is described as inpatient and outpatient treatment “provisions granted”.

4. ITALY: Population figures are for 2009, males and females 15yrs+ and were from the Istat website. Prevalence is for adults aged 15yrs+ in 2001-03, taken from Rehm et al. 2012, and originally from the European Study of the Epidemiology of Mental Disorders (ESEMeD) (De Girolamo et al, 2006). These are the most recent rates available and have been used to calculate an updated estimate for the “in need” population using the 2009 population data. Access to treatment figures are for 2009, in an updated addendum for the Italy report (Gandin & Scafato, 2011). Data from the Italian monitoring system describes “the total number of alcoholics who received a community treatment at a specialist service” (65,360) for outpatient treatment, and number of fully alcohol attributable diseases upon hospital discharge (87,287)

5. SPAIN: Main population data (total and aged 15yrs+) was taken from 2008 (OECD, 2012) with age 15yrs +, calculated from the percentages provided on the OECD website (85.3% of population in 2008). However this could not be combined with a male/female population, which was required due to prevalence rates being presented in this way. Therefore numbers with alcohol dependence based on prevalence rates provided are for whole population, rather than the age range 15yrs +. Prevalence rates are from Rehm et al., (2012), and refer to those aged 15yrs+ in 2000-01. These data were originally sourced from the WHO world mental health surveys Kessler & Üstün (2008). Access to treatment data is from the PNSD 2008 and refers to outpatient, hospital and non-hospital data for 2008.

6. SWITZERLAND: Population figures are for 2007 (OECD, 2012) and adults 15yrs + have been calculated based on percentages provided on the same OECD website. Alcohol dependence prevalence rates and numbers of individuals with alcohol dependence were for adults aged 15yrs+, sourced from Rehm et al (2012), and originally from Kuendig (2010). Access to treatment was provided in higher and lower estimates for 2004, and originally taken from the WHO European Hospital Morbidity Database ((HMDB

<http://data.euro.who.int/hmdb/index.php>.) and accessed August 2, 2011 (see methods section for more information).

5.4 Conclusions

The results of the gap analysis should be interpreted with caution, due to the high levels of heterogeneity of methods used to estimate prevalence and access across countries.

Alcohol dependence prevalence rates varied, but it is not clear that comparisons of these are meaningful, due to the different methods used to achieve these estimates. Given the convergence of other alcohol related indicators (e.g. per capita alcohol consumption, alcoholic liver disease mortality) between European countries over the last 20 years the reported variance in prevalence is surprising. So rather than being a true reflection of prevalence variation, it is probably more likely to be an indication of the differences in methods of estimating prevalence of alcohol dependence.

Countries with large general household surveys (e.g. England) probably had more reliable estimates than those without, but even then, different measures have been used to estimate alcohol dependence (e.g. the Adult Psychiatric Morbidity survey in England used the AUDIT questionnaire, which is not ideal for estimating prevalence of alcohol dependence as it was designed as a screening tool for hazardous and harmful drinking).

Italy and Spain both had markedly lower prevalence rates compared to the other four more northern European countries. As Rehm et al (2012) argue alcohol consumption in southern European, predominantly wine-drinking “Mediterranean” countries is such an entrenched cultural norm, that dependence will tend to be under-detected and under-reported, and as such, is also more of a social stigma.

Similarly, there were problems in obtaining comparable estimates of the number of people entering specialist alcohol treatment. The majority of countries had some form of monitoring system that enabled reporting on access to treatment, but gaps in the understanding of this still exist, and the comprehensiveness and robustness of the country specific data was difficult to ascertain. Not all data is available for the same years, and methodological differences in its collection further diminish its suitability for direct comparisons.

Although “access to treatment” is an essential marker to look at, it is not sufficiently exacting in its detail, and there is a need to be more prescriptive about what this means i.e. which types of treatment, which patient population it applies to and whether treatment is completed or otherwise. Access data may also vary due to factors such as the effectiveness of treatment systems and care pathways to channel less severely dependent patients into outpatient care, which may be less well monitored than inpatient care provision. Prospective treatment access

data (e.g. England's NATMS) is more reliable than those based on hospital discharge diagnosis, which by no means an indicator, nor a guarantee of receiving a comprehensive package of specialist treatment appropriate to need.

The UK is observed to have the highest number of individuals in treatment, yet also registers as "low" in terms of the Rush model of assessing PSURs. By the same standards, Italy and Spain appear to have high access and PSUR value, however these are the two countries with possibly the greatest underestimate of prevalence, so this estimate of service access may be misleading. Switzerland's "high" access and PSUR rating was necessarily based on older estimates of access to treatment, due to none of sufficient reliability or comprehensiveness being able to be produced more recently.

RECOMMENDATIONS:

Given the importance of alcohol dependence to European public health, there is a clear need for Europe-wide surveys to estimate comparative prevalence rates using the same time frame and survey instruments. This would be essential to the rational planning of alcohol treatment provision, and meaningful benchmarking across Europe. It would also provide a more reliable picture of trends and patterns, which in turn may assist with the effective evaluation of policies and treatment implementation.

There is a need to develop harmonisation between European countries on the collection of specifically prospective treatment monitoring data, and a common methodology employed. Again this would be helpful in estimating the relative potential public health impact of alcohol treatment across Europe, and identifying areas where more policy and implementation may be required.

Prospective data collection and monitoring should be encouraged and promoted as the gold standard. It is essential that alcohol treatment is separable from that of other substances for the purpose of accurate reporting. Further detail is also required within this, such as types of treatment provided and new cases versus those returning to treatment, which may in turn allow for more targeted provision of services, and more cost-effective and efficient systems altogether.

Until such times as the cross-country data can at least be presented for the same time period, and with comparable methodology, these PSUR estimates, will not provide a valid comparative estimate of treatment access rates across countries. This will require coordination at a European level.

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7. Annexes

ANNEX 1:

Definitions and abbreviations:

Definitions

We have used the World Health Organisation's ICD-10 classification of alcohol use disorders in this project which includes:

- a. Hazardous drinking: alcohol consumption at a level likely to cause harm in the future
- b. Harmful drinking: drinking at a level currently causing harm but not including alcohol dependence
- c. Alcohol dependence: alcohol consumption leading to meeting the clinical criteria for alcohol dependence including tolerance, withdrawal, impaired control.

In terms of interventions we have used the following terms:

- a. Screening and brief intervention: is taken to mean early identification of hazardous and harmful drinkers using a screening method (questionnaire, interview) in a non-alcohol-specialist health or social care setting and the provision of at a minimum a single session of advice or intervention.
- b. Specialist treatment: is taken to mean a range of publicly funded interventions provided either in the community or residential settings for people seeking help for alcohol dependence, and delivered by a specialist treatment provider
- c. Access to specialist treatment: is taken to mean the number of individuals with alcohol dependence accessing treatment in a given year.

Abbreviations (general)

AA	Alcoholics Anonymous
AUD	Alcohol Use Disorders
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood Alcohol Concentration
GPs	General Practitioners
NGOs	Non-Governmental Organizations
OTC drugs	Over-the-counter drugs
WHO	World Health Organization

Abbreviations (country specific)**Austria**

Alkohol Forum Policy initiative – focuses mainly on primary prevention, but secondary and tertiary prevention also covered. Its main task is to prepare an analysis of the present situation and to develop recommended background policy papers for the Ministry of Health

EDOLKI Inheitliche Dokumentation der Klientinnen und Klienten der Drogeneinrichtung (comprehensive registration system for people with substance misuse disorders)

OBIG Austrian Health Institute

Österreichischer Strukturplan für Gesundheit – Austrian Structure Plan for Health

AKIS

Landesgesundheitsfond – State level public funds

MALT Münchner Alkoholismus Test

BRIEF Brief Alcohol Screening Instrument in Medical Care (A)

German Institute ZUMA Zentrum für Umfragen, Methoden und Analysen

Sociale Krankenversicherung – social health insurance system

England

ANARP Alcohol Needs Assessment Research Project

DH Department of Health in England

NATMS National Alcohol Treatment Monitoring System

NICE National Institute for Health and Clinical Excellence

MoCAM Models of Care for Alcohol Misusers

NTA National Treatment Agency for Substance Misuse

Germany

Arbeiterwohlfart National Association for Workers' Welfare

DHS German Centre for Addiction Issues

BMG	Federal Ministry of Health
BZGA	Federal Centre for Health Education
AWMF	Scientific Medical Societies in Germany
DG Sucht	German Association for Addiction Research and Therapy

Italy

AICAT	Clubs of the Alcoholics in treatment – <i>Associazione Italiana Club Alcolisti in Trattamento</i>
AO	Hospital enterprise - <i>Azienda ospedaliera</i>
ASLs	Local health units - <i>Aziende Sanitarie Locali</i>
CCM	Centre for Diseases Control – <i>Centro Controllo Malattie</i>
CNESPS	National Center on Epidemiology, Surveillance and Health Promotion
CUP	Central booking point - <i>Centro Unico di Prenotazione</i>
ECM	Continuous National training programme – <i>Educazione Continua in Medicina</i>
EIBI	Early Identification and Brief Intervention
GDP	Gross Domestic Product
INRAN	National Research Institute on Foods and Nutrition - <i>Istituto Nazionale di Ricerca per gli Alimenti e la Nutrizione</i>
ISS	National Health Institute - <i>Istituto Superiore di Sanità</i>
LEA	Standard/minimum health care provision - Livelli Essenziali di Assistenza
NHS	National Health Service
NOA	National Observatory on Alcohol - <i>Osservatorio Nazionale Alcohol</i>
PHEPA	Primary Health care European Project on Alcohol
PNAS	National Alcohol and Health Plan - <i>Piano Nazionale Alcol e Salute</i>
PRISMA	Italian project on Prevention, Identification and Strategies Management for Alcohol - related problems in primary health care
PSN	National Health Plan – <i>Plano Sanitario Nazionale</i>
RBT	Random Breath Testing
RSA	Residential (semi-residential) facilities – <i>Residenza Sanitaria Assistita</i>
Ser.T.S.	Public drug treatment units
SIA	Italian Society of Alcoholology - <i>Società Italiana di Alcolologia</i>
SIMG	Italian Society of general medicine - <i>Società Italiana di Medicina Generale</i>

Spain

XAD Network of Care for Drug Addiction of Catalonia - *Xarxa d'atenció a les drogodependències*

Switzerland

FOPH Federal Office of Public Health

ANNEX 2:

List of key experts and stakeholders interviewed

AUSTRIA

Dr. Ursula HÖRHAN (24.11.2009)

Suchtkoordinatorin des Landes Niederösterreich, Leiterin der Fachstelle für Suchtvorbeugung, Koordination und Beratung
(Coordinator Addictions, State of Lower Austria, Chief Executive Prevention, Coordination and Treatment)

Dr. Doris KOHL (08.01.2010)

Fachexpertin für fachliche und juristische Angelegenheiten von Missbrauch und Abhängigkeitserkrankungen hinsichtlich Alkohol und Fragen der Alkoholstrategie
(National and international alcohol issues, Chair of Senate III of Equal Treatment Commission, Federal Ministry of Health, Family and Youth)

Prim. ao. Univ. Prof. Dr. Martin KURZ

Leiter der Abteilung für Abhängigkeitserkrankungen an der Landesnervenklinik Sigmund Freud Graz
(Director, Department of Addictions and Related Disorders, State Psychiatric Hospital Sigmund Freud, Graz)

a.o. Uni. Prof. Dr. Otto-Michael LESCH

Head of the Alcohol Research Group at the University of Psychiatry and Psychotherapy
President of the Austrian Society of Addiction Medicine (AUSAM)
Board Member of the International Society for Biomedical Research on Alcoholism

Dr. Roland MADER (13.11.2009)

Oberarzt am Anton-Proksch-Institut
(Senior Physician, Anton Proksch Institute, Vienna)

Univ. Prof. Dr. Michael MUSALEK (10.11.2009)

Ärztlicher Leiter des Anton-Proksch-Instituts
(Medical Director, Anton Proksch Institute, Vienna)

Dr. Thomas DORNER MSc (13.01.10)

Assistent an der Abteilung für Allgemeinmedizin, Zentrum für Public Health, Medizinische Universität Wien mit Zuteilung an das Institut für Sozialmedizin
(Staff member, Department of General Medicine, Center for Public Health, Medical University, Vienna)

Dr. Alfred UHL (03.11.2009)

Koordinator Suchtpräventionsdokumentation – Alkohol am Anton-Proksch-Institut
(Coordinator of Addiction Prevention Research and Documentation, (formerly LBISucht and AKIS) of the Anton-Proksch-Institute (API)

ENGLAND

Linda Harris (6 January 2011)

Addiction Lead, Royal College of General Practitioners

Professor Mike Farrell (12 April 2010)
Addiction Lead, Royal College of General Practitioners

Kevin Shelton (tbc)
Treatment Information Manager, NATMS, National Treatment Agency (NTA)

Professor Colin Drummond
Professor of Addiction Psychiatry, Institute of Psychiatry/Specialist Clinical Addiction Network

Mr Adam Marr (28 April 2010)
North West Manager, National Drug Treatment Monitoring System (NDTMS)

Mr David Sheehan (23 November 2010)
Development Manager, Public Health Group South East, Department of Health

Mr Don Lavoie (19 March 2010)
Alcohol Lead, Department of Health, Alcohol Policy Team

Dr Nick Sheron (22 June 2010)
Consultant Hepatologist, Royal College of Physicians

Professor Robin Touquet (30 March 2010)
Professor of Emergency Medicine, St Mary's Hospital London

Helen Young (6 January 2011)
Manager, Alcohol Learning Centre, Alcohol Improvement Programme

Mr Don Shenker (tbc)
Chief Executive, Alcohol Concern

GERMANY

Frau Bartsch

Referentin für Grundsatzfragen, stellvertretende Geschäftsführerin Deutsche Hauptstelle für Suchtfragen (DHS) e.V.

Prof. Gerhard Bühringer

Wissenschaftlicher Leiter, Institut für Therapieforschung

Dr. Tilmann Holzer

Referent für Alkoholpolitik - Geschäftsstelle der Drogenbeauftragten der Bundesregierung im BMG

Dr. Hans-Jürgen Rumpf

Klinik für Psychiatrie und Psychotherapie Universität Lübeck

Dr. Dilek Sonntag

Institut für Therapieforschung, Ltg. Klinische Psychologie

Prof. Claudia Spies

Universitätsklinikum Charité, Klinik für Anästhesie + operative Medizin

Prof. Karl Mann

Central Institute of Mental Health Department of Addictive Behavior and Addiction Medicine

Prof. Falk Kiefer

Central Institute of Mental Health Department of Addictive Behavior and Addiction Medicine

Dr. Volker Weissinger

Fachverband Sucht e.V.

Dr. Norbert Wodarz

Klinik und Poliklinik für Psychiatrie und Psychotherapie der Universität Regensburg

ITALY

Maria Francesca Amendola

Alcohol Unit, ASL Cosenza, Italian Society of Alcoholology -SIA

Nello Baselice

President AICAT

Vanna Cerrato

Researcher, ASL 16, Padova, SERT, Padova

Tiziana Codenotti

Vice-President, EUROCARE Italia

Ilaria Londi

Centro Alcologico Regionale -CAR, Regione Toscana

Franco Marcomini

Chair of Alcohol Unit, ASL 16, Padova, ASL Padova, Department of addiction

Bastiana Pala

Alcohol Policy team, Ministry of Health, Department of Prevention

Valentino Patussi

Director, Centro Alcologico Regionale -CAR, Regione Toscana

Raffaella Rossin

Coordinator of Alcohol services, ASL Milano, Italian Society of Alcoholology –SIA

Pierluigi Struzzo

General Practitioner, Regional Centre for Primary Care training Monfalcone –Gorizia, CEFORMED

SPAIN

Aubà, Josep

Primare care practicioner, Catalonia

Bastida, Núria

Primare care practitioner, Catalonia

Bobes, Julio

Chair of Psychiatry Department – Universidad de Oviedo, President of Socidrogalcohol

Casas, Miquel

Chair of Psychiatry Department – Universitat Autònoma de Barcelona. Head department of Addictive Behaviours – Hospital de Sant Pau i la Santa Creu

Colom, Joan

General Subdirector of Substance Abuse – Subdirecció General de Drogodependències, Departament de Salut, Generalitat de Catalunya

Gual, Antoni

Head of Alcohol Unit – Hospital Clinic de Barcelona

Laso, Javier

Chair of Internal Medicine Department – Universidad de Salamanca - Head department of Internal Medicine – Hospital Universitario de Salamanca

Lizarbe, Vicenta

Chief of Prevention Area - Dirección General de Salud Pública y Sanidad Exterior, Ministerio de Sanidad y Política Social

Segura, Lidia

Coordinator of the Alcohol Team - Subdirecció General de Drogodependències, Departament de Salut, Generalitat de Catalunya

Verdager, Jordi

Psychologist CAS, Catalonia

SWITZERLAND

AA - *Services Généraux des Alcooliques Anonymes de Suisse Romande et Italienne (AASRI)*, Anonymous member of the organization « Alcoholics Anonymous » in the French speaking part of Switzerland.

Prof. Jacques BESSON - *Psychiatry department, Lausanne University Hospital (CHUV)*

Head of the community psychiatry section of the CHUV and « creating member » of the *Swiss Society of Addiction Medicine (SSAM)*.

Prof. Jean Bernard DAEPEN - *Alcohol Treatment Center, Department of Community Medicine and Health, Lausanne University Hospital (CHUV)*

Head of the *Alcohol Treatment Center* of the CHUV and expert in the field of brief alcohol interventions.

Marina DELGRANDE JORDAN - *Addiction Switzerland*

Project manager of the Swiss substance-related residential treatment monitoring systems (*act-info RESIDALC*).

Michel GRAF - *Addiction Switzerland*

Head of the main national NGO working on alcohol prevention and participant to numerous boards on this matter in Switzerland.

Etienne MAFFLI - *Addiction Switzerland*

Project manager of the Swiss substance-related ambulatory treatment monitoring systems (*act-info SAMBAD*).

Viviane PRATS - *Haute école de travail social et de la santé (EESP) Lausanne*

President of the *GREA*, key institution involved in the addiction treatment network of the French speaking part of Switzerland.

Jean-Félix SAVARY - *Groupement Romand d'Etudes des Addictions (GREA)*

Secretary-general of the *GREA*, key institution involved in the addiction treatment network of the French speaking part of Switzerland.

Gabriela SCHERER - *Federal office of Public Health*

Scientific collaborator at the alcohol and tobacco section of the *Federal office of Public Health*.

Barbara WEIL - *Swiss Medical Association (FMH)*

Head of the division Health and Prevention of the *Swiss Medical Association*.

Ana ZUMBINO - *Service d'application des peines et mesures (SAPEM), Geneva canton*

Head of the *Service of sentencing and measure* of Geneva canton (*Service d'application des peines et mesures, SAPEM*).

ANNEX 3:

WP6 Activity 1: Descriptive study of alcohol intervention systems across 6 collaborating European countries

Key Informant Questionnaire (V2 09-02-2010)

- 1) Present and historical provision of alcohol interventions
 - a. What is the current provision of services for alcohol use disorders in your country? (this includes specialist treatment and early interventions in primary care and other non-specialist settings)
 - b. Do you have any national service mapping exercises which describe the alcohol service provision?
 - c. Do you have a national strategy to combat alcohol problems which includes an element of service provision?
 - d. Can you provide any historical information on the above relating to the last 10 years?
- 2) Policy initiatives designed to increase implementation of alcohol interventions and their impact
 - a. Can you identify any policy initiatives over the past 10 years designed to implement or increase the provision of alcohol interventions (including specialist alcohol treatment and early interventions in non-specialist settings)?
 - b. Do you have any data or other information on the impact of specialist alcohol interventions?
- 3) Comparable data on annual spending on different elements of alcohol interventions across the spectrum of care provision (based on the intervention categories (service tiers) identified in Models of Care for Alcohol Misusers (DH, 2006). This will include provision from primary through to secondary care.
 - a. Can you provide any data on spending on alcohol services in your country both in terms of specialist alcohol treatment and early interventions in non-specialist settings? (Refer to Models of Care for Alcohol Misusers classification of alcohol services: see annex).
 - b. How robust are the spending estimates on alcohol interventions?
- 4) Comparable data on numbers of individuals identified and receiving alcohol interventions.
 - a. What data is available nationally on the level of activity in terms of individuals age 16 years and over who are identified and receiving alcohol interventions?
 - b. Ideally data should include the last 10 years but at a minimum the current level of provision is requested (i.e. the past full financial or calendar year).
 - c. This should be classified in terms of numbers receiving specialist alcohol treatment and early alcohol interventions in non-specialist settings.
- 5) Information on available materials and methods to deliver alcohol interventions including: number of service providers engaged in delivery of interventions, both statutory and non-statutory; pharmaceutical products licenced for treatment of alcohol use disorders; available psychological interventions including information on extent of trained workforce; availability of screening and brief intervention protocols and tools; internet based interventions and support for professionals; extent and nature of mutual aid and/or self help alcohol organisations (e.g. Alcoholics Anonymous, family clubs, religious organisations)
 - a. What information can you provide on the available materials and methods to deliver early alcohol interventions in your country? This should include which screening tools are available, used or promoted in practice.
 - b. What interventions are available, used or promoted in practice to enable service providers to deliver alcohol interventions?

- c. How many service providers are engaged in delivering alcohol interventions including both statutory, and non-statutory providers?
 - d. What pharmaceutical products are licenced and available for treatment of alcohol use disorders in your country?
 - e. What psychological interventions are available for treatment of alcohol use disorders in your country?
 - f. To what extent is the service provider workforce trained to deliver alcohol interventions? Are there any national initiatives to promote training and delivery of alcohol interventions and if so, what is the nature of these?
 - g. Are there any national protocols or tools which have been promoted to deliver effective alcohol interventions in your country?
 - h. Has there been a national review of effectiveness of treatment for alcohol use disorders or published national standards for treatment delivery?
 - i. Are there any internet based alcohol interventions available in your country?
 - j. Are there any internet based resources for professionals to deliver alcohol interventions in your country?
 - k. What is the extent and nature of mutual aid and/or self help alcohol organisations (e.g. Alcoholics Anonymous, family clubs, religious organisations)
- 6) Descriptive information on typical care pathways for hazardous, harmful and dependent drinkers across participating countries
- a. What are the typical care pathways for hazardous, harmful and dependent drinkers in your country?
 - b. Are any of these nationally published or promoted?
- 7) Identification of barriers and facilitators to implementation of alcohol interventions including: fiscal, administrative, organisational, training, workforce development, attitudinal (both professional and public).
- a. What are the barriers and facilitators to implementation of alcohol interventions in your country including specialist alcohol treatment and early intervention in non-specialist settings? These can include: fiscal, administrative, organisational, training, workforce development, attitudinal (both professional and public), other.
- 8) Key informants perceptions of the extent to which alcohol intervention has been successfully implement or otherwise in their respective countries, and reasons for this.
- a. To what extent have alcohol interventions been successfully implemented in your country?
 - b. Can you identify the reasons behind successful implementation or otherwise?
 - c. What more needs to be done or is currently planned?

ANNEX 4:

WP6 Activity Two – Services surveys (updated 01/03/11)



Survey of Primary Care Staff

Instructions:

Please complete the entire questionnaire. Most questions can be answered by checking the box next to your response. These questions are important for our research so we would appreciate it if you would please complete the entire questionnaire. Note also that the questionnaire is anonymous and only aggregate data will be used in reporting the results of the surveys.

Definitions:

1) Hazardous drinking and alcohol use disorders: Here we refer to three categories: Hazardous drinking, Harmful drinking, and Dependent drinking which are based on the WHO ICD-10 categorization of alcohol use disorders.

Hazardous drinking, is defined by the WHO as, “a pattern of substance use that increases the risk of harmful consequences for the user [physical or mental...]. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user”.

Harmful drinking, is defined as in the WHO ICD-10 as, “a pattern of psychoactive substance use that is causing damage to health...The damage may be physical or mental”. Unlike in hazardous drinking, there will be evidence of alcohol-related problems but often without this having resulted in seeking treatment.

Dependent drinking, this category refers to drinking associated with an established moderate or severe level of dependence on alcohol. Dependence being, “a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state” (WHO ICD-10 definition of *dependence syndrome*).

2) Systematic screening: Refers to the regular use of a, paper or electronic based, **standardized screening tool**, such as the AUDIT, brief AUDITs (e.g., AUDIT-C), CAGE, FAST, SASQ or others, for the identification of people with alcohol problems (see above).

3) Brief intervention: With this term we refer to intervention carried out in non specialist settings, by non-specialist personnel and are directed at hazardous and harmful drinkers who are not typically complaining about or seeking help for an alcohol problem. These interventions

might vary in length from 5 minutes to 30/40 minutes, from a single session to more repeat sessions.

1. ID Number (online version will also record date and time of submission)

2. Place of work/location: _____

3. In which year were you born?

4. What is your gender? (please tick a box)

Male
Female

5. In total, how many hours of post-graduate or in service training, continuing medical education or clinical supervision on alcohol and alcohol-related problems have you ever received?

None	<input type="checkbox"/>
Less than 4 hours	<input type="checkbox"/>
4 - 10 hours	<input type="checkbox"/>
11 - 40 hours	<input type="checkbox"/>
More than 40 hours	<input type="checkbox"/>
Don't know/Can't remember	<input type="checkbox"/>

6. How many years have you worked in primary health care?

Years Months

7. How many hours per week do you work in your primary care practice?

8. How many patients would you personally see in an average week?

[If relevant to a specific country there is the option to include the following question: What is your yearly patient quota (i.e., how many patients are you supposed to see in one year)?]

9. How many patients have approached you about their drinking in the last 4 weeks?

(we understand that this will be an approximation but please try to give a total figure)

10. In addition to this number, in the last 4 weeks how many patients have you identified as hazardous, harmful, or dependent drinkers, when this was not their presenting problem?

(We understand that this will be an approximation but please try to give a total figure)

11. In addition to this number, how many patients have approached you in the last 4 weeks about a family member's (or other affiliated person's) drinking?

Paper or electronic based standardized screening tools include the AUDIT, brief AUDITs (e.g., AUDIT-C), CAGE, FAST, SASQ or others, for the identification of people with hazardous, harmful, and dependent drinking (see intro).

12. Are you familiar with any standardized alcohol screening tool(s) to identify hazardous, harmful, and dependent drinking (e.g., AUDIT, brief AUDITs, AUDIT-C, CAGE, FAST, SASQ)?

Yes
No (go to question 13)

12a. If yes, do you use any standardized alcohol screening tool(s) to identify hazardous, harmful, and dependent drinking?

Yes
No (go to question 13)

12b. If yes, do you use any in the following cases (please select all that apply)

...in routine medical check ups	<input type="checkbox"/>
...on suspicion	<input type="checkbox"/>
...in general	<input type="checkbox"/>
...when I see a patient for the first time	<input type="checkbox"/>
...if they present with specific conditions	<input type="checkbox"/>
... other (please state)_____	

12c. Which one(s) do you use?

13. On the scale of 1-5 below, please indicate how useful you think it is to offer alcohol screening to patients in your clinical setting (please circle a number).

20. The questions in this section are designed to explore the attitudes of staff working with people with hazardous drinking patterns or alcohol use disorders. There are no right or wrong answers. Please indicate the extent to which you agree or disagree with the following statements:

		Strongly agree	Quite strongly	Agree	Neither agree or	Disagree	Quite strongly	Strongly disagree
		1	2	3	4	5	6	7
1	I feel I know enough about causes of drinking problems to carry out my role when working with harmful, hazardous, or dependent drinkers							
2	I feel I can appropriately advise my patients about drinking and its effects							
3	I feel I do not have much to be proud of when working with harmful, hazardous, or dependent drinkers.							
4	All in all I am inclined to feel I am a failure with harmful, hazardous, or dependent drinkers							
5	I want to work with harmful, hazardous, or dependent drinkers							
6	Pessimism is the most realistic attitude to take towards harmful, hazardous, or dependent drinkers							
7	I feel I have the right to ask patients questions about their drinking when necessary							
8	I feel that my patients believe I have the right to ask them questions about drinking when necessary							
9	In general, it is rewarding to work with harmful, hazardous, or dependent drinkers							
10	In general I like harmful, hazardous, or dependent drinkers							

Additional questions to be added by Spain and Italy:

If you were to make rough estimates of the proportions of persons with alcohol problems in your practice whom you have referred to specialised institutions and whom you have treated yourself it would be approximately:

..... % referred to specialised treatment centres

..... % treated myself

.....% other]

20. Are there any other comments that you would like to make

Thank you for taking the time to complete this survey

ANNEX 5:

WP6 Activity Two – Services surveys (updated 15/02/12)



Survey of Accident and Emergency Department Staff

Instructions:

Please complete the entire questionnaire. Most questions can be answered by checking the box next to your response. These questions are important for our research so we would appreciate it if you would please complete the entire questionnaire. Note also that the questionnaire is anonymous and only aggregate data will be used in reporting the results of the surveys.

Definitions:

1) Hazardous drinking and alcohol use disorders: Here we refer to three categories: Hazardous drinking, Harmful drinking, and Dependent drinking which are based on the WHO ICD-10 categorization of alcohol use disorders.

Hazardous drinking, is defined by the WHO as, “a pattern of substance use that increases the risk of harmful consequences for the user [physical or mental...In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user”.

Harmful drinking, is defined as in the WHO ICD-10 as, “a pattern of psychoactive substance use that is causing damage to health...The damage may be physical or mental”. Unlike in hazardous drinking, there will be evidence of alcohol-related problems but often without this having resulted in seeking treatment.

Dependent drinking, this category refers to drinking associated with an established moderate or severe level of dependence on alcohol. Dependence being, “a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state” (WHO ICD-10 definition of *dependence syndrome*).

2) Systematic alcohol screening: Refers to the regular use of a, paper or electronic based, **standardized alcohol screening tool**, such as the AUDIT, brief AUDITs (e.g., AUDIT-C), CAGE, FAST, SASQ or others (amend list if needed), for the identification of people with hazardous, harmful or dependent drinking (see above).

3) Brief intervention: With this term we refer to intervention carried out in non specialist settings (eg your setting), by non-specialist personnel (eg not alcohol treatment specialists) and are directed at hazardous and harmful drinkers who are not typically complaining about or seeking help for an alcohol problem. These interventions might vary in length from 5 minutes to 30/40 minutes, from a single session to more repeat sessions.

1. ID Number (online version will also record date and time of submission)

2. Place of work/location: _____

3. In which year were you born?

4. What is your gender? (please tick a box)

Male
Female

5a. What is your qualification? _____ (eg nurse/doctor)

5b. What is your specialty?

5e. Number of years since qualifying: _____

6. In total, how many hours of post-graduate or in service training, continuing medical education or clinical supervision on alcohol and alcohol-related problems have you ever received?

None	<input type="checkbox"/>
Less than 4 hours	<input type="checkbox"/>
4 - 10 hours	<input type="checkbox"/>
11 - 40 hours	<input type="checkbox"/>
More than 40 hours	<input type="checkbox"/>
Don't know/Can't remember	<input type="checkbox"/>

7. How many years have you worked in accident and emergency departments?

Years Months

8. How many hours per week do you work in accident and emergency departments?

9. How many patients would you personally see in an average week?

10. How many patients have approached you about their drinking in the last 4 weeks?

(we understand that this will be an approximation but please try to give a total figure)

11. In addition to this number, in the last 4 weeks how many patients have you identified as hazardous, harmful, or dependent drinkers, when this was not their presenting problem?

(We understand that this will be an approximation but please try to give a total figure)

Paper or electronic based standardized alcohol screening tools include the AUDIT, brief AUDITs (e.g., AUDIT-C), CAGE, FAST, SASQ or others (amend if needed), for the identification of people with hazardous, harmful, and dependent drinking (see intro).

12. Are you familiar with any standardized alcohol screening tool(s) to identify hazardous, harmful, and dependent drinking (e.g., AUDIT, brief AUDITs, AUDIT-C, CAGE, FAST, SASQ)?

Yes

No (go to question 13)

12a. If yes, do you use any standardized alcohol screening tool(s) to identify hazardous, harmful or dependent drinking?

Yes

No (go to question 13)

12b. If yes, How often do you use standardised screening tools in the following cases

...as a point of general practice

... if I suspect hazardous drinking or alcohol use disorder

...if they present with specific conditions

... other (please state) _____

1

2

3

4

5

"never "

"sometimes"

" always"

12c. Which one(s) do you use?

13. On the scale of 1-5 below, please indicate how useful you think it is to offer systematic alcohol screening to patients in your clinical setting (please circle a number).

1

2

3

4

5

not at all useful

Moderately
useful

highly useful

20. The questions in this section are designed to explore the attitudes of staff working with people with hazardous drinking patterns or alcohol use disorders. There are no right or wrong answers. Please indicate the extent to which you agree or disagree with the following statements:

		Strongly agree	Quite strongly	Agree	Neither agree or	Disagree	Quite strongly	Strongly disagree
		1	2	3	4	5	6	7
1	I feel I know enough about causes of drinking problems to carry out my role when working with harmful, hazardous, or dependent drinkers							
2	I feel I can appropriately advise my patients about drinking and its effects							
3	I feel I do not have much to be proud of when working with harmful, hazardous, or dependent drinkers.							
4	All in all I am inclined to feel I am a failure with harmful, hazardous, or dependent drinkers							
5	I want to work with harmful, hazardous, or dependent drinkers							
6	Pessimism is the most realistic attitude to take towards harmful, hazardous, or dependent drinkers							
7	I feel I have the right to ask patients questions about their drinking when necessary							
8	I feel that my patients believe I have the right to ask them questions about drinking when necessary							
9	In general, it is rewarding to work with harmful, hazardous, or dependent drinkers							
10	In general I like harmful, hazardous, or dependent drinkers							

Additional questions to be added:

After question 19. Spain and Italy to suggest exact wording in their own language

If you were to make rough estimates of the proportions of persons with alcohol problems in your practice whom you have referred to specialised institutions and whom you have treated yourself it would be approximately:

..... % referred to specialised treatment centres

..... % treated myself

.....% other]

21. Are there any other comments that you would like to make

Thank you for taking the time to complete this survey