Optimizing Delivery of Health Care Interventions (ODHIN)

Survey of attitudes and managing alcohol problems in general practice in Europe – Final Report

Deliverable 4.1, Work Package 4

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1. WP4 OBJECTIVES

The main objectives of ODHIN's Work Package 4 were:

1. To consolidate and update knowledge of potential barriers and facilitators for general practitioners to implementing Identification and Brief Intervention (IBI) programmes;

2. To increase the understanding of factors that affect whether clinicians will use the IBI intervention;

3. To compare attitudes and experiences in delivering IBI in participating European countries with differing cultures, and organization and funding of Primary Health Care services.

2. WP4 METHODS

Work Package 4 included several consecutive tasks undertaken in the months 1-24: construction of the instrument, adaptation of the instrument, writing the protocol of the survey, implementation of the survey in the 9 European countries, data collection, data cleaning, and statistical analyses.

A. Construction of the survey instrument

The survey questionnaire was primarily based on the instrument used in the WHO Phase III strand I study in 1999 (Anderson et al., 2003) and later on the survey of GP attitudes to primary care alcohol intervention in 2009 in England (Wilson et al., 2011). The semi-structured questionnaire (Appendix 1) consists of 28 questions with the ability for each of the participating countries to supplement with up to three country-specific additional questions.

The questionnaire includes questions on demographic information about doctors and practices, the attitudes of doctors working with patients who drink alcohol, their beliefs about their own activities in working with drinkers, extent of academic education and postgraduate training on alcohol received by general practitioners, their views and attitudes towards management of alcohol problems, their diagnostic performance and their reported management of alcohol problems during the past year, including number of patients managed in the previous year, working environment and its impact on intervening for alcohol problems.

The Shortened Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ) (Anderson and Clement, 1987) is included to assess GPs' inclination towards intervening for alcohol problems; 10-item instrument measures adequacy, task-specific self-esteem, motivation, legitimacy and satisfaction of physicians (Anderson et al., 2004). The SAAPPQ items are used separately in respect of hazardous or harmful ('problem') drinkers and dependent drinkers.

In the subsequent section, respondents indicate their agreement on a scale of one to four ('not at all' to 'very much'), with 18 suggested barriers and 11 suggested incentives to early intervention for alcohol in general practice. In addition, to gauge the influence of policy change on attitudes and behaviour GPs are expected to rate the effectiveness of 10 European public policies and 12 suggested policy measures in each country to tackle alcohol problems on a scale from one to five (1 = no opinion, 2 = ineffective, 3 = slightly effective, 4 = quite effective, 5 = very effective). Finally, an open-ended question is included at the end of the questionnaire to collect individual experiences or comments of the surveyed physicians.

The content of the questionnaire was discussed in detail at the partner meeting (ODHIN Kick-off Meeting, Barcelona, 21-23.02.2011), and the final version of the instrument approved was later approved by all the partners after a series of email exchange.

B. Writing the survey protocol

The flow of the study and the assumptions for the protocol of the survey was discussed at the partner meeting (ODHIN Kick-off Meeting, Barcelona, 21-23.02.2011) and further developed by the WP4 leader with close consultation with the ODHIN project leaders. The final version of the protocol (Appendix 2) was presented, discussed, and approved by all partners across the series of email communication and at the ODHIN Partner Meeting in Barcelona (14-15.02.2012).

C. Adaptation of the instrument

The final English version of the questionnaire was translated in each country to the native language and the translation was later validated by back translation into English and confirmed by an English native speaker in terms of language accuracy and appropriateness for primary care (Peter Anderson, M.D. validated the back-translations). Where available, a translated copy of the original WHO questionnaire from 1999 was used as a master in the process of translation. In such a case, only newly added questions were translated and back translated. All 9 national versions of the survey instrument are attached to this report (Appendix 1).

D. Ethical approval

Depending on country law and regional regulations, the ethical approval by the Bioethics Committees (Institutional Review Boards) was received before the study started in the UK, Poland, and Slovenia.

E. Sampling

In each country, an accessible database of general practitioners was sought and used to draw a sample (see Table 1). In most of the countries, these databases were used to obtain the information on sex, age, address, type and location of practices. According to this data, a representative sample of minimum 250 physicians per country was drawn randomly where possible after stratification for sex, age, geographic location. If a group practice was drawn, only one GP per practice was selected. The sample size was adjusted accordingly to the response rate, so that a final number of returned questionnaires fit the minimum sample size of 250. Only in Sweden, due to problems with recruitment, only 90 GPs took part in the study, which cannot be considered a representative sample for the country.

In Catalonia, email invitations were sent to all members of the Catalan Society of Family and Community Medicine. Measures were taken to ensure the representativeness by sex, age group and geographic location of the final convenience sample obtained. In Slovenia, the paper version was mailed along with the invitation letter to all GPs in the country. In Portugal, a representative sample of total family physicians registered in the Health System Central Administration was stratified by gender, age group and Health Region. In the Netherlands, a representative sample, concerning sex, age, situation and degree of urbanization, of 1,600 GPs from the whole country was drawn. In the UK, all PC practices were identified in 6 Primary Care Trusts in Leicestershire, Derbyshire and Nottinghamshire. One GP randomly was sampled from each of 419 selected PC practices. In Italy, a database of Italian GPs having telephone numbers and email addresses was used. Altogether 647 questionnaires were sent out through email to reach the 250 physicians. In Poland, two main associations of Primary care physicians were approached and selected members from several regions in the country were invited

participate in the survey. In the Czech Republic the data set of all registered GPs in the country was used to select randomly 361 practitioners using quotas representative by region, gender and age. In Sweden, all approachable general practitioners working in 4 different counties were approached and surveyed.

Table 1. Sampling and survey implementation by country.

	Ethical approval	Participants	Method of sampling	Method of survey implementation	Additional measures
Catalonia	Not needed	The Catalan Association of General Practitioners	All members of the association (3,457 GPs)	Online questionnaire (http://enquestaodhinproject.net/); email invitations sent to all GPs with valid emails	Survey incentivised by raffling an Apple IPAD between those who completed the survey. A reminder was sent to participants on the 2nd of the 3 week survey period
Czech Republic	Not needed	GPs from the Register of the Czech General Practitioners	Random selection using quotas representative by region, gender and age.	Paper version of the questionnaire; research assistants personally contacting GPs	A total of 361 GPs were asked to take part in the survey; 66 GPs (18.3%) refused to participate. Reasons for refusal to participate: lack of time - 52.5%; lack of interest in participating - 33.3%, excessive length of the questionnaire - 7.1%, essentially does no complete any questionnaire - 7.1%.
UK	Received	419 PC practices identified in 6 Primary Care Trusts in Leicestershire, Derbyshire and Nottinghamshire	One GP principal from each of PC practices; a final sample of 385 eligible GPs selected	Postal survey – a paper copy of the questionnaire mailed to selected GPs	Personalized prenotification and follow-up letters signed by the GP member of the research team, telephone calls to non-responders to ask whether they would return the questionnaire and an unconditional £10 voucher to compensate GPs for their time
Italy	Not needed	A Database of Italian GPs having telephone numbers and email addresses	647 questionnaires were sent out through email to reach the 250 physicians	Online questionnaire; GPs contacted first by telephone to explain the idea of the study and to confirm the participation; link to the Q sent by email	Reminder phone calls will also be made after a couple of weeks after the first mailing in order to recruit the national sample of 250
Netherlands	Not needed	A representative sample of 20% of Dutch GPs (8,000)	1,600 GPs randomly selected. Representativeness concerning sex, age, situation and degree of urbanization was checked and assured	Paper version; mailed by post office with a reply-paid return envelope	To ensure adequate response rate one reminder was sent to non-responders
Poland	Received	Members of the College of Family Physicians, "Zielonogórskie Alliance"	Members of the associations were invited to participate in the study in several regions in the country	Online questionnaire http://odhin.wum.edu.pl/ ; GPs were contacted and invited via emails and advertisements in Journals.	
Portugal	Not needed	General and Family Medicine doctors /General	Random sample of 850 GPs from the 5527 GPs	Online questionnaire http://www.createsurvey.com/s/oeBywF/; GPs	The list of selected GPs in each Group of Health Centres was sent to their Executive Director and

	Ethical approval	Participants	Method of sampling	Method of survey implementation	Additional measures
		Practitioners (MGF/CG) working in the Portuguese National Health Service (SNS)	registered in the Health System Central Administration stratified by sex, age group and Health Region	contacted via email	President of the Clinical Council in order to inform about the study and to encourage filling Questionnaires
Slovenia	Received	All GPs registered in Slovenia	All 820 general practitioners were invited to participate in the survey	Paper version mailed to all physicians	Questionnaire was not sent to few GPs that were on a sick leave for a longer period.
Sweden	Not needed	General Practitioners working in different counties; 4 counties chosen in first pass	All reachable GPs approached	Paper and online questionnaire, depending of distribution method. Direct contact with GPs (through internal internet discussion groups and through the PHC directors)	

F. Implementation of the survey

The survey was carried out in all 9 countries (Catalonia, Czech Republic, Italy, Netherlands, Poland, Portugal, Slovenia, Sweden and UK) separately by the group of researchers or a survey company (see Table 2 for data collection period). The questionnaires were mailed by post office (Slovenia, Netherlands, UK, partly Sweden), e-mailed or the questionnaire was made accessible online on a special website that GPs could access (Catalonia, Poland, Italy, Portugal, and partly in Sweden). In such cases, electronic mail was sent containing the relevant information about the study, encouragement and the link to this website with the proposed login name and password was sent. If the copy of questionnaire was mailed by post, the reply paid envelope was included in the mail. In the Czech Republic, paper version was used and research assistants interviewed GPs face-to face.

To ensure an adequate response rate, in some cases additional techniques were utilised. In Italy, GPs were first contacted by telephone, the study was explained and an e-mail address requested. In Portugal, the list of selected doctors in each Group of Health Centres was sent to their Executive Director, jointly with a letter asking for support of the dissemination and encouragement of selected doctors to fill the questionnaire. In the Netherlands, one reminder with a new questionnaire including a reply paid envelope was sent to non-responders. In Sweden the low participation rate has led to a stepwise change in the procedure. At first, a postal invitation to four regions in different parts of the country was sent. This was followed by an e-mail invitation in most other regions of the country, and finally was followed by an invitation by postal mail in the rest of Sweden. In the last round, lottery tickets to enhance the response rate were offered. In Catalonia, an incentive was offered by raffling an Apple IPAD to those who completed the survey and a reminder was sent to participants on the 2nd of the 3-week survey period. The incentive had been used in previous similar occasions by the Catalan Society.

In the UK, the survey was performed in 2009. Two weeks prior to sending questionnaires, GPs were posted a pre-notification letter informing them about the study and alerting them to the forthcoming questionnaire. Questionnaires were mailed via first class recorded delivery.

Enclosed with the questionnaire was an unconditional £10 voucher to compensate GPs for their time, a covering letter encouraging GPs to respond, and an addressed envelope for return of completed questionnaire. Non-responders were telephoned two weeks later to encourage them to respond. Two further reminder questionnaires were posted to non-responders at two weekly intervals, comprising revised letters further encouraging GPs to respond and an addressed return envelope. All letters were personalised, printed on university headed paper and individually signed by the practicing study GP.

After return of filled questionnaires, completeness of answers was checked, allowing no more than 5% of missing data. If there was more missing answers, the respective GP was re-contacted where possible with a request to supplement the answers.

G. Data collection and analysis

The information from the questionnaires was put into the data collection form and then typed or transferred into the database. The template for the data set (MS Excel file) was designed and prepared in the leader centre (Medical University of Warsaw, Poland). Final statistical analysis and comparisons of a combined data from all countries were conducted as the collection process was completed.

For the main analyses several domains were selected:

The number of patients managed for alcohol problems in the previous year was classified on a self-reported ordinal scale, none, 1-6, 7-12, 13-24, 25-49 and 50 or more (Question 23 of Appendix 1). Following the method adopted by Anderson (1985), general practitioners were grouped into those who managed seven or more patients in the previous year and those who managed less than seven patients in the previous year, including non-respondents. The number of patients managed was also recoded from the ordinal scale into none, 3, 9, 18, 37 and 60.

Education and training was classified on a self-reported ordinal scale, none, less than 4 hours, 4-10 hours, 11-40 hours and more than 40 hours (Question 9 of Appendix 1). Following the method adopted by Anderson (1985), general practitioners were grouped into those with four or more hours of education on alcohol and those with less than 4 hours, including non-respondents and those who indicated 'don't know'. Hours of education were also recoded from the ordinal scale into none, 2, 7, 25 and 50 hours.

Role security and therapeutic commitment were measured by responses to the short form of the Alcohol and Alcohol Problems Perception Questionnaire (Anderson & Clement 1987; see Question 20 of Appendix 1). The questionnaire included five domains, two of role security and three of therapeutic commitment. General practitioners were grouped into those with higher role security and therapeutic commitment (a score higher than the median value for each scale) and those with lower role security and therapeutic commitment (a score including and lower than the median value for each scale).

Analysis

The whole dataset was combined and analyzed at the level of the individual general practitioner. Mixed models were used to estimate coefficients, their 95% confidence intervals and statistical significance of a range of independent variables on a range of dependent variables, using different models, explained in the results section (procedure mixed in SPSS,

version 21, using subcommand RANDOM intercept | subject (country) to account for the clustered nature of the data within country).

Achieved Milestones

Core group workshops on the design of the implementation methodology of the developed survey questionnaire took place during the consecutive ODHIN Partner Meetings in Barcelona (21-23.02.2011 and 14-15.02.2012).

Publications and dissemination

No publications have been submitted so far, few of them are in preparation. A conference paper was presented at the 9th Conference of INEBRIA: *From Clinical practice to Public Health: the two dimensions of Brief Interventions*; 27-28.09.2012, Barcelona, Spain: **Marcin Wojnar, Andrzej Jakubczyk, Antoni Gual, Peter Anderson**. *Implementing IBI in everyday practice of general practitioners. What are the GP's attitudes towards prevention of alcohol drinking and alcohol related problems.*

A conference paper was presented at the 10th Conference of INEBRIA: *"Brief interventions on alcohol and other drugs: improving health and the quality of health services provision"*; 19-20.09.2013, Rome, Italy: **Marcin Wojnar, Andrzej Jakubczyk, Peter Anderson, Antoni Gual, Eileen Kaner, Marko Kolsek, Miranda Laurant, Dorothy Newbury-Birch, Cristina Ribeiro, Gaby Ronda, Lidia Segura, Hana Sovinova, Fredrik Spak, Pierluigi Struzzo**. *Attitudes and managing alcohol problems in general practice in Europe: results from the European ODHIN survey of general practitioners* (http://www.inebria.net/Du14/pdf/2013_09_19_31.pdf).

3. WP4 SURVEY RESULTS

The survey of attitudes and experiences of general practitioners was performed in 9 European countries: Catalonia, Czech Republic, Italy, Netherlands, Poland, Portugal, Slovenia, Sweden, and UK/England. A total of 2435 European physicians were surveyed with an average response rate of 39.6% (10-82) as shown in Table 2.

Table 2. Basic demographic characteristics of European general practitioners participating in the survey, by country.

Country	Time of conducting the survey	Number of GPs sampled	Number of actual responses from GPs	Response rate	Mean age (SD)	Females (N, %)	Number of years in general practice (SD)
Catalonia	III.2012	3457	360	10.4%	43.4 (9.0)	267 (74.2)	16.3 (8.8)
Czech Republic	I-IV.2012	361	294	81.4%	47.4 (11.4	160 (54.4)	15.7 (10.6)
Italy	IV-VIII.2012	647	250	38.6%	56.2 (6.1)	68 (27.2)	25.1 (8.4)
Netherlands	II-VI.2012	1600	312	19.5%	51.2 (8.1)	111 (35.7)	18.7 (8.9)
Poland	III-X.2012	552	276	50%	48.5 (10.0)	198 (72.0)	14.5 (8.9)
Portugal	II-III.2012	850	234	27.5%	52.3 (8.7)	150 (64.1)	22.9 (9.4)
Slovenia	II-IV.2012	820	337	41.1%	50.6 (7.8)	243 (72.1)	21.6 (9.6)
Sweden	IV-XI.2012	600	90	15%	48.7 (11.1)	38 (43.7)	14.2 (9.8)
UK/England	II.2009	385	282	73.2%	47 (9.3)	121 (42.9)	16.2 (9.2)
Total/Mean (SD)	-	9125	2435	39.6%	49.2 (9.7)	1356 (55.8)	18.5 (9.9)

Characteristics of the GPs

The average age of GPs was 49.2 (SD: 9.7) years; the majority were females (55.8%; n=1356). Mean number of years in primary care practice was 18.5 (SD: 9.9). Over half of the GPs worked in urban practices (n=1261, 51.9%), 18.5% (n=449) worked in rural practices and 29.6% (n=720) in mixed-area practices.

Male GPs were older (mean 51.7 yrs, SD: 9.3 vs. 47.3 yrs, SD: 9.6), and had significantly more years in practice (mean 20.7 yrs, SD: 9.9) than female GPs (mean 16.8 yrs, SD: 9.5), ($t(2420)=9.85$, $p<0.0005$). As shown in Table 2, there were significant differences between countries in respect of mean age of GPs, with youngest physicians in Catalonia (mean: 43 yrs) and oldest in Italy (mean: 56 yrs). In Catalonia, Slovenia, Poland, Portugal and Czech Republic women were more common; in Italy, the Netherlands, England and Sweden majority were male GPs. Also, number of years in general practice was different among all countries: more experienced GPs were surveyed in Italy, Portugal, Slovenia and the Netherlands. Physicians from Poland, Sweden, England, Czech Republic and Catalonia had shorter experience working in general practice.

The majority of respondents worked at group practices (62%), with median of 4 (2-6) FTE physicians in the practice. Only 37.6% GPs had their individual practices and worked as sole practitioners. The average number of days per week in general practice was 4.7 (SD: 0.8); 75.4% (n=1828) of respondents worked 5 days or more days per week. The modal response for number of patients seen each week was 101-150 (38%); 22% said they saw 51-100 patients, 35% GPs had seen more than 150 per week (Figure 1). Number of patients seen per week differed significantly between male and female GPs ($\chi 2(3)=8.52$, $p=0.036$), with a trend for male GPs to see more patients.

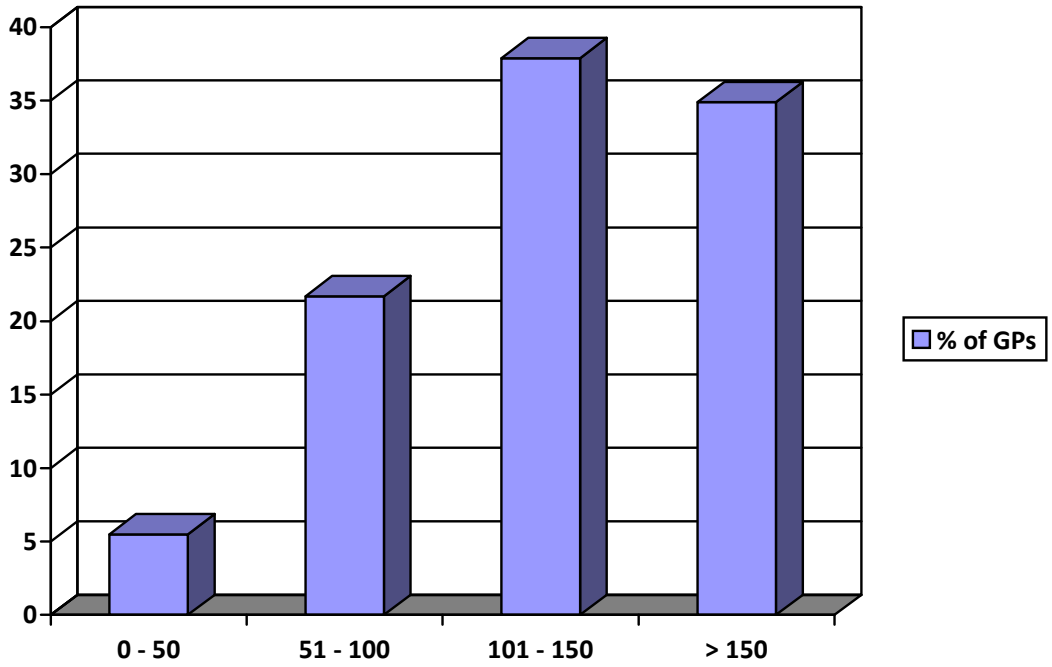

Figure 1. Number of patients seen per week by the general practitioners in Europe.

Emphasis on disease prevention

Seventy seven per cent of GPs declared that they placed 'somewhat high' or 'very high' their priority on disease prevention. Less than 4% indicated a 'very low' priority for disease prevention. Sixty three per cent said that they placed 'somewhat more' priority on disease prevention than other medical practitioners; a further 13% said that they placed much more priority. There were significant differences by country as shown in Table 3. In Catalonia perception of GPs about prioritizing preventive activity was very low (25-20%), while in Czech Republic, Italy and Portugal – very high (85-98%).

Table 3. Priorities of general practitioners in Europe in respect of disease prevention by country.

Country	N	'Very high' or 'somewhat high' priority on disease prevention	More priority on disease prevention compared to other practitioners
Catalonia	360	25.6%	20.0%
Czech Republic	294	87.8%	85.0%
Italy	250	95.6%	94.8%
Netherlands	312	76.4%	69.6%
Poland	276	79.3%	88.0%
Portugal	234	98.3%	97.2%
Slovenia	337	82.8%	87.5%
Sweden	90	76.5%	75.6%
UK/England	282	89.4%	91.7%
Total	2435	77.1%	76.5%

Table 4. Summary of current practices of general practitioners in Europe in respect of disease prevention by country: mean ratings of extent to which information is obtained on (using a scale of 1-4 from 'rarely/never' to 'always')

Country	N	Not smoking	Exercising regularly	Alcohol consumption	Diet/nutrition	Stress level	Use of prescription drugs	Illicit drug use
Catalonia	360	3.3	2.7	2.8	2.5	2.2	2.8	2.6
Czech Republic	294	3.3	2.4	2.9	2.6	2.7	3.4	2.8
Italy	250	3.5	3.2	2.9	2.9	2.8	3.1	2.5
Netherlands	312	3.3	3.0	2.9	2.9	2.8	3.1	2.7
Poland	276	3.4	2.8	2.7	2.8	2.6	3.5	2.6
Portugal	234	3.5	3.1	3.1	3.1	2.9	3.3	2.9
Slovenia	337	3.5	3.0	3.0	2.9	2.8	3.3	2.7
Sweden	90	1.5	1.9	2.0	2.4	2.3	2.1	2.5
UK/England	282	3.6	2.9	3.0	2.8	2.6	3.0	2.7
Total	2435	3.3	2.8	2.9	2.8	2.6	3.1	2.7

GPs were also asked how often they obtained information from their patients in relation to various aspects of health on a scale of 1-4 from 'rarely/never' to 'always'. Ninety per cent of GPs indicated that they obtained information about smoking; 75% gave these responses 'always' or 'as indicated' about alcohol consumption. Responses to questions on attitudes about prevention and obtaining information on lifestyle behaviours are summarised in Tables 4 - 8. In a separate question, GPs were asked whether they enquired about alcohol if a patient did not mention it, using a scale of 1-4 ('all the time', 'most of the time', some of the time', 'rarely or never'). The largest proportion of GPs (43%) said that they enquired about alcohol 'some of the time' if the patient did not volunteer information. Frequency of inquiring about alcohol did not differ significantly between male and female GPs ($\chi 2(3)=6.37$, $p=0.095$) and between older and younger GPs ($p=0.05$), with a trend for older GPs to ask more frequently than younger GPs.

Table 5. Summary of attitudes of general practitioners in Europe by country: mean ratings of indicated importance of selected behaviours in promoting the health of the average person (using a scale of 1-4 from 'rarely/never' to 'always')

Country	N	Not smoking	Regular exercise	Reducing alcohol consumption	Avoiding excess calories	Reducing stress	Responsible use of prescribed drugs	Not using illicit drugs
Catalonia	360	3.9	3.5	3.1	3.4	3.2	3.5	3.7
Czech Republic	294	3.6	3.0	3.1	3.1	3.2	3.6	3.5
Italy	250	3.9	3.5	3.4	3.5	3.2	3.5	3.8
Netherlands	312	3.9	3.6	3.2	3.3	3.0	3.2	3.4
Poland	276	3.9	3.5	3.2	3.3	3.1	3.7	3.8
Portugal	234	3.9	3.7	3.7	3.6	3.5	3.6	3.9
Slovenia	337	3.9	3.7	3.6	3.6	3.5	3.7	3.8
Sweden	90	1.0	1.22	1.6	2.4	2.0	1.5	1.2
UK/England	282	3.9	3.6	3.4	3.4	3.0	3.3	3.6
Total	2435	3.8	3.4	3.3	3.4	3.2	3.4	3.6

Table 6. Summary of attitudes of general practitioners in Europe by country: mean ratings of perceived preparedness for counselling patients in selected areas (using a scale of 1-4 from 'rarely/never' to 'always')

Country	N	Not smoking	Exercise regularly	Reducing alcohol consumption	Avoiding excess calories	Reducing stress	Responsible use of prescribed drugs	Not using illicit drugs
Catalonia	360	3.2	3.0	2.9	2.9	2.5	3.1	2.7
Czech Republic	294	3.2	3.0	3.1	3.0	3.0	3.5	3.0
Italy	250	3.0	3.1	3.0	3.0	2.8	3.2	2.8
Netherlands	312	3.4	3.3	3.1	3.1	3.1	3.3	2.9
Poland	276	3.2	3.2	3.0	3.2	2.7	3.5	2.8
Portugal	234	3.1	3.3	3.0	3.2	2.9	3.4	2.8
Slovenia	337	3.2	3.2	3.1	3.2	2.8	3.4	2.8
Sweden	90	1.3	1.3	1.5	1.8	1.8	1.6	2.1
UK/England	282	3.6	3.5	3.3	3.2	3.0	3.4	3.0
Total	2435	3.2	3.1	3.0	3.0	2.8	3.3	2.8

Table 7. Summary of attitudes of general practitioners in Europe by country: mean ratings of perceived effectiveness in helping patients achieve change in selected areas (using a scale of 1-4 from 'rarely/never' to 'always')

Country	N	Not smoking	Exercise regularly	Reducing alcohol consumption	Avoiding excess calories	Reducing stress	Responsible use of prescribed drugs	Not using illicit drugs
Catalonia	360	2.8	2.6	2.6	2.4	2.3	2.8	2.3
Czech Republic	294	2.8	2.6	2.7	2.6	2.7	3.2	2.8
Italy	250	2.6	2.8	2.6	2.6	2.4	3.0	2.5
Netherlands	312	3.1	3.1	2.8	2.8	2.9	3.1	2.6
Poland	276	2.7	2.5	2.3	2.6	2.2	3.1	2.4
Portugal	234	2.7	2.9	2.6	2.7	2.5	3.1	2.5
Slovenia	337	2.6	2.7	2.4	2.4	2.3	3.0	2.3
Sweden	90	2.1	2.1	2.4	2.6	2.3	2.3	2.7
UK/England	282	3.0	2.5	2.6	2.4	2.5	3.0	2.3
Total	2435	2.8	2.7	2.6	2.5	2.5	3.0	2.5

Table 8. Summary of attitudes of general practitioners in Europe by country: mean ratings of potential effectiveness in helping patients achieve change in selected areas given adequate information and training (using a scale of 1-4 from 'rarely/never' to 'always')

Country	N	Not smoking	Exercise regularly	Reducing alcohol consumption	Avoiding excess calories	Reducing stress	Responsible use of prescribed drugs	Not using illicit drugs

Catalonia	360	3.3	3.0	3.1	3.0	2.8	3.2	2.9
Czech Republic	294	3.3	3.0	3.1	3.1	3.1	3.5	3.2
Italy	250	3.1	3.2	3.1	3.1	2.9	3.3	2.9
Netherlands	312	3.3	3.2	3.2	3.2	3.1	3.3	3.1
Poland	276	3.4	3.2	3.2	3.2	3.0	3.5	3.0
Portugal	234	3.3	3.3	3.3	3.3	3.1	3.4	3.0
Slovenia	337	3.0	3.1	3.0	3.0	2.9	3.3	2.9
Sweden	90	1.7	1.8	1.8	2.1	2.0	1.9	2.2
UK/England	282	3.3	3.1	3.1	3.0	3.0	3.3	3.0
Total	2435	3.2	3.1	3.1	3.1	3.0	3.3	3.0

Summarizing the mean scores from the above tables, ratings related to the issue of alcohol consumption showed that general practitioners in Europe value more questioning and preventive activities for smoking, exercise or responsible use of prescribed drugs than significance of reduction of alcohol use for health. However, the GPs perceive their effectiveness in intervention for alcohol problems equally to preventive activities towards other risky behaviours.

Sensible drinking limits

Most GPs reported the upper limit for alcohol consumption before advising to cut down in terms of drinks or units per day or week. The mean responses for men were 15.6 units per week (SD 9.2) and 2.5 units per day (SD 2.2) and for non-pregnant women - 10.2 units per week (SD 6.8) and 1.7 units per day (SD 1.5). Median responses were 14 units per week (2 per day) for men and 8.5 units per week (1 per day) for women. Those accepted limits were very different by country as shown in Table 9. Very high limits were reported by GPs in Catalonia and England, while very low in Poland, Sweden and Slovenia.

Table 9. Perceived upper limits for alcohol consumption before GPs would advise a patient to cut down drinking, by country.

Country	N	Men		Women	
		Alcohol units per week	Alcohol units per day	Alcohol units per week	Alcohol units per day
Catalonia	360	23.2	4.5	15.0	2.7
Czech Republic	294	14.9	2.8	10.8	2.0
Italy	250	-	2.1	-	1.4
Netherlands	312	15.8	2.7	10.8	1.9
Poland	276	8.6	2.2	4.9	1.3
Portugal	234	14.4	2.2	9.1	1.4
Slovenia	337	11.1	2.1	6.3	1.3
Sweden	90	10.2	2.4	6.9	1.7
UK/England	282	22.8	3.5	15.7	2.3
Total	2435	15.6	2.5	10.2	1.7

Training and education

Alcohol-related Continuing Medical Education (CME) training was reported by 2429 GPs. 14.7% GPs (n=358) declared they received no training, 25.2% (n=611) less than 4 hours, 31.4% (n=763) between 4 to 10 hours, 16.5% (n=401) between 11 to 40 hours, and 6% (n=146) more than 40 hours. Additional 6.2% (n=150) of GPs could not recollect whether or not they received CME training on alcohol-related problems, and were not included in the subsequent analyses.

Among those who remembered (n=2279), low levels of alcohol-related CME (0 to less than 4 hours) was declared by 42.5% (n=969) and high levels by 57.5% (n=1310). Levels of alcohol-related CME by country are shown in Table 10.

Table 10. Reported experience of low or high levels of alcohol-related CME by country.

Country	Number of GPs responded	Low CME	High CME	Do not remember
Catalonia	360	107 (29.7%)	248 (68.9%)	5 (1.4%)
Czech Republic	294	152 (51.7%)	114 (38.8%)	28 (9.5%)
Italy	250	118 (47.2%)	119 (47.6%)	13 (5.2%)
Netherlands	312	84 (27.0%)	205 (65.9%)	22 (7.1%)
Poland	276	135 (49.1%)	110 (40.0%)	30 (10.9%)
Portugal	234	127 (54.3%)	93 (39.7%)	14 (6.0%)
Slovenia	337	72 (21.5%)	247 (73.7%)	16 (4.8%)
Sweden	90	28 (31.8%)	54 (61.4%)	6 (6.8%)
UK/England	282	146 (51.8%)	120 (42.6%)	16 (5.7%)
Total	2435	969 (39.9%)	1310 (53.9%)	150 (6.2%)

There was a significant difference between countries in proportion of GPs who had experienced high or low levels of alcohol-related CME ($\chi2(16)=212.7$, $p<0.0005$). Countries with the highest reported levels of CME were Slovenia, Catalonia, Netherlands, and Sweden.

Impact of CME on GPs' attitudes

Generally, there was no significant relationship between experience of alcohol-related CME and views about the importance of reduction of alcohol use for to promote good health. However, those GPs who reported higher levels of alcohol-related CME considered themselves more frequently (61.7%) to be prepared for counselling in reducing alcohol consumption than those who received less CME training (38.3%; $\chi2(3)=55.1$, $p<0.0005$). There was also a significant relationship between alcohol-related CME experience and GP's perception of their effectiveness at reducing alcohol consumption in patients – GPs who received more CME training more frequently (61.2%) felt that they are effective or very effective in helping their patients to reduce alcohol use compared to GPs with less training (38.8%; $\chi2(3)=35.5$, $p<0.0005$).

Practice attitudes and behaviour

The estimated mean number of patients managed for heavy drinking during the previous year ranged from 5.2 (Italy) to 21.2 (Portugal), Table 11. The reported received hours of postgraduate education on alcohol ranged from 7.2 (Czech Republic) to 14.8 (Slovenia). In all countries, except Sweden, which had an aberrant unexplained finding, the mean score for role security was above the neutral score of 16, ranging from 19.8 (Catalonia) to 21.8 (Slovenia). In contrast, in all countries, except Catalonia, England, and Netherlands, the mean score for therapeutic commitment was below the neutral score of 24, ranging from 20.1 (Sweden) to 26.4 (Catalonia).

GP demographics Controlling for country, neither age nor sex of the GP was related to role security. However, male GPs were more therapeutically committed than female GPs (B =0.73; 95%CI 0.28 to 1.18; $p<0.001$) and younger GPs were marginally more therapeutically committed than older GPs (B =0.04; 95%CI 0.02 to 0.06; $p<0.001$).

Education on alcohol Providers reporting having received more postgraduate education on alcohol reported marginally higher role security (B =0.05; 95%CI 0.03 to 0.06; p<0.001), and higher therapeutic commitment (B =0.07; 95%CI 0.05 to 0.08; p<0.001).

Table 11. Reported number of patients managed for heavy drinking, received level of alcohol-related CME, role security and therapeutic commitment, by country.

	Mean number patients managed for heavy drinking last year	Hours of postgraduate education on alcohol	Role Security[1]	Therapeutic Commitment[2]
Catalonia	6.7 (2.9)	12.8 (4.6)	19.8 (3.1)	26.4 (4.3)
England	11.5 (4.4)	7.9 (3.6)	21.2 (2.8)	24.3 (5.2)
Czech Republic	8.8 (4.3)	7.2 (3.9)	20.8 (3.3)	23.8 (3.7)
Italy	5.2 (2.2)	9.6 (5.0)	20.8 (3.3)	23.5 (4.3)
Netherlands	8.0 (3.0)	10.6 (3.9)	21.0 (2.2)	24.4 (3.7)
Poland	11.6 (5.7)	9.3 (4.9)	20.3 (3.3)	23.1 (5.1)
Portugal	21.2 (8.6)	7.7 (4.6)	21.0 (3.0)	23.3 (4.8)
Slovenia	14.8 (6.1)	14.8 (5.2)	21.8 (2.7)	22.9 (5.0)
Sweden[3]	10.9 (4.3)	13.1 (5.7)	8.2 (2.5)	20.1 (6.1)
Total	10.7 (4.9)	10.3 (4.7)	20.4 (3.8)	23.9 (4.8)

[1] Neutral score=16

[2] Neutral score=24

[3] Sweden excluded from some of the subsequent analysis due to unexplained aberrant results

GP demographics Neither age nor sex of the GP was related to the reported number of patients managed for heavy drinking.

Education Controlling for providers' age, sex, consultation rate and country, providers reporting having received more postgraduate education on alcohol reported managing a higher number of patients with heavy alcohol use (B =0.243; 95%CI 0.201 to 0.2850; p<0.001).

Role security and therapeutic commitment Providers with higher values of role security (B =0.683; 95%CI 0.498 to 0.867; p<0.001) and higher values of therapeutic commitment (B =0.616; 95%CI 0.492 to 0.739; p<0.001) reported managing a higher number of patients with heavy alcohol use. When controlling for providers' age, sex, consultation rate and country, both education on alcohol (B =0.222; 95%CI 0.180 to 0.265; p<0.001) and role security (B =0.506; 95%CI 0.324 to 0.689; p<0.001) had independent relationships with reported number of patients managed, when included in the same model, with part of the impact of role security being mediated by education, but the impact of education not mediated by role security. Likewise, both education on alcohol (B =0.209 95%CI 0.167 to 0.251; p<0.001) and therapeutic commitment (B =0.500; 95%CI 0.366 to 0.613; p<0.001) had independent relationships with reported number of patients managed, when included in the same model, with part of the impact of therapeutic commitment being mediated by education, but the impact of education not mediated by therapeutic commitment.

Perceived barriers to early alcohol intervention

To consider potential barriers to early intervention in general practice, European GPs were asked to indicate their agreement on a scale of 1-4 ('not at all' to 'very much') with 18 suggested barriers. Table 12 presents their agreement with these items. Agreement was highest for the statements suggesting that were just "too busy" (64%); that doctors were not trained in counselling for reducing alcohol consumption (52%); that doctors believe that alcohol counselling involves family and wider social effects, and is therefore too difficult (50%); and that general practices are not organised to do preventive counselling (49%). The lowest rates of agreement were with statements that alcohol is not an important issue in general practice (33%); that doctors themselves have a liberal attitude to alcohol (28%); and that doctors believe that patients would resent being asked about their alcohol consumption (26%).

Table 12. Perceived barriers to early alcohol intervention by European general practitioners.

Statement	Agreement
Doctors are just too busy dealing with the problems people present with	64.3%
Doctors are not trained in counselling for reducing alcohol consumption	52.1%
Doctors believe that alcohol counselling involves family and wider social effects, and is therefore too difficult	49.7%
General practices are not organised to do preventive counselling	48.6%
Doctors do not believe that patients would take their advice and change their behaviour	47.6%
Doctors do not have suitable counselling materials available	46.8%
Government health policies in general do not support doctors who want to practise preventive medicine	45.4%
The government health scheme does not reimburse doctors for time spent on preventive medicine	42.7%
Doctors have a disease model training and they don't think about prevention	40.7%
Doctors do not know how to identify problem drinkers who have no obvious symptoms of excess consumption.	41.6%
Doctors do not have a suitable screening device to identify problem drinkers who have no obvious symptoms of excess consumption	41.3%
Doctors feel awkward about asking questions about alcohol consumption because saying someone has an alcohol problem could be seen as accusing them of being an alcoholic	36.0%
Private health insurance does not reimburse patients for alcohol counselling by doctors in general practice	35.0%
Doctors themselves may have alcohol problems	34.6%
Doctors think that preventive health should be the patients' responsibility not theirs	33.7%
Alcohol is not an important issue in general practice	32.5%
Doctors themselves have a liberal attitude to alcohol	28.1%
Doctors believe that patients would resent being asked about their alcohol consumption	25.7%

Perceived facilitators for early alcohol intervention

To consider potential incentives to early intervention in general practice, European GPs were asked to indicate their agreement on a scale of 1-4 ('not at all' to 'very much') with 11 suggested incentives. Table 13 presents their agreement with these items. Most statements were strongly endorsed by GPs. Agreement was highest that readily available support services (84%), patients requesting health advice about alcohol (80%), quick and easy counselling materials as well as training programs for early intervention for alcohol (75%) were available, proving the success of early intervention (73%) were incentives to early intervention; the lowest rating was for patients willing to pay a fee for alcohol counselling as an incentive (27%).

Table 13. General practitioners' agreement on impact of selected public policies on reducing alcohol-related harm in Europe.

Statement	Agreement
Support services (self-help/counselling) were readily available to refer patients to	83.7%
Patients requested health advice about alcohol consumption	80.1%
Quick and easy counselling materials were available	75.4%
Training programs for early intervention for alcohol were available	75.3%
Early intervention for alcohol was proven to be successful	73.2%
Quick and easy screening questionnaires were available	70.6%
Public health education campaigns in general made society more concerned about alcohol	69.4%
Salary and working conditions were improved	57.2%
Training in early intervention for alcohol was recognised for continuing medical education credits	48.0%
Providing early intervention for alcohol was recognised for quality assurance credits	37.6%
Patients were willing to pay a fee for alcohol counselling	26.9%

Further analyses of barriers and facilitators for alcohol intervention

The 18 items that measured barriers and the 11 items that measured facilitators were each subject to factor analysis to achieve a small number of domains. The correlation matrices produced were examined and those statements, which inter-correlated with a coefficient of more than 0.7 were extracted. The variable, which was judged more meaningful, was returned and the analysis repeated with the smaller number of items (12 for barriers and 6 for facilitators). The factor analysis was repeated with an oblique rotation, choosing factors with an eigenvalue of more than 1.00. This resulted in two domains for barriers (termed 'doctors have a disease model', and 'do not regard prevention as a medical responsibility') and two facilitators (termed 'availability of support materials and training', and 'availability of financial incentives'). The items in each domain were summed.

Table 14. Views on barriers and facilitators for early alcohol intervention.

	Reasons for low intervention		What would encourage more intervention	
	Disease rather than prevention model	Do not regard prevention as medical responsibility	Provide materials and training	Provide financial incentives
Catalonia	7.1 (1.8)	6.1 (1.7)	12.8 (1.9)	6.9 (2.3)
England	7.2 (2.0)	6.2 (1.8)	12.2 (2.6)	6.9 (3.2)
Czech Republic	7.3 (2.2)	7.5 (1.9)	11.6 (2.6)	8.2 (2.2)
Italy	8.2 (2.1)	6.5 (2.1)	13.2 (2.0)	7.7 (2.3)
Netherlands	6.5 (2.0)	7.0 (1.7)	11.1 (2.0)	7.4 (2.1)
Poland	9.1 (1.8)	7.1 (1.7)	13.2 (2.2)	8.7 (1.9)
Portugal	7.5 (1.9)	8.4 (2.9)	13.0 (2.0)	8.4 (2.9)
Slovenia	7.3 (2.1)	7.7 (2.2)	11.9 (2.2)	7.7 (2.2)
Sweden	5.9 (1.9)	7.1 (1.7)	7.1 (2.7)	7.9 (1.8)
Total	7.4 (2.1)	6.6 (1.9)	12.2 (2.5)	7.7 (2.4)

Disease: range 3-12 (7.5); Not responsible: 3-12 (7.5); Materials: 4-16 (10); Financial incentives: 3-12 (7.5)

There was not a clear picture that providers considered doctors having a disease rather than a prevention model or not regarding prevention as a medical responsibility were important reasons for low identification and brief advice rates, with views on both issues ranging from 5.9 to 9.1 and 6.1 to 8.4 respectively around a neutral score of 7.5, Table 14. Providers considered providing materials and training would encourage more intervention (range from

7.1 to 13.2, compared with a neutral score of 10.0), but were less certain about the impact of providing financial incentives (range 6.9 to 8.7, around a neutral score of 7.5).

Impediments and encouragers for brief advice activity

Controlling for providers' age, sex, consultation rate and country, providers who agreed that doctors having a disease model would impede brief advice activity had lower values of role security and therapeutic commitment, Table 15. Providers who regarded prevention as not a medical responsibility had lower therapeutic commitment, but not role security. Providers who agreed that providing support would encourage their own brief advice activity had higher role security and therapeutic commitment, and providers who agreed that providing financial incentives would encourage their own brief advice activity had higher role security, but lower therapeutic commitment.

Table 15. Predictors of role security and therapeutic commitment.

	Role Security			Therapeutic commitment		
Predictor variable	B	95% Wald Confidence Interval		B	95% Wald Confidence Interval	
		Lower	Upper		Lower	Upper
Doctors have a disease rather than a prevention model	-.169***	-.235	-.103	-.350***	-.451	-.249
Do not regard prevention as a medical responsibility'	-.078	-.147	.009	-.462***	-.574	-.350
Availability of support materials and training	.113**	.054	.172	.133**	-.36	.231
Availability of financial incentives	.076**	.022	.130	-.078*	-.157	-.000

Separate models for each predictor variable, controlling for providers' age, sex, consultation rate and country

***p<0.001; **p<0.01; *p<0.05

Controlling for providers' age, sex, consultation rate and country, only providers who agreed that doctors having a disease model would impede brief advice activity was related to reported number of patients managed for heavy drinking in a negative direction (B =-0.509; 95%CI -0.784 to -0.233; p<0.001), a relationship that was reduced when including role security and therapeutic commitment in the model. The more hours of postgraduate education received on alcohol, the less likely were providers to agree that doctors having a disease model would impede brief advice activity (B =-0.018; 95%CI -0.025 to -0.011; p<0.001).

Significance of public policies for reducing alcohol-related harm in Europe

To consider potential significance of public policies on reducing alcohol-related harm in Europe, GPs were asked to indicate their agreement on a scale of 1-5 ('strongly disagree' to 'strongly agree) with 10 suggested policies. Table 16 presents their agreement with these policies. Most statements were strongly endorsed by GPs. Agreement was highest for subsequent public policies: alcohol advertising targeting young people should be banned in all EU (86%), selling and serving alcohol to people under the age of 18 years should be banned (85%), warnings should be placed on alcohol adverts (75%) or bottles (74%) with the purpose to warn pregnant women and drivers of dangers of drinking alcohol; the lowest rating was for statement that individuals are responsible enough to protect themselves from alcohol related harm (38%).

Table 16. General practitioners' agreement with selected public policies that might have impact on reducing alcohol-related harm in Europe.

Statement	Agreement
Individuals are responsible enough to protect themselves from alcohol related harm	37.6%
Public authorities have to intervene in order to protect individuals from alcohol related harm	68.4%
Young and heavy drinkers would buy less alcoholic beverages like beer, wine or spirits if the price was increased by 25%	47.3%
Random police alcohol checks on EU roads would reduce people's alcohol consumption before driving	73.3%
Blood alcohol levels (BAC) for young and novice drivers should be placed at 0.2g/l in all 27 European Union Member States	70.4%
Selling and serving alcohol to people under the age of 18 years should be banned in all EU Member States	84.7%
Alcohol advertising targeting young people should be banned in all EU Member States	85.5%
Warnings should be placed on alcohol bottles with the purpose to warn pregnant women and drivers of dangers of drinking alcohol	73.5%
Warnings should be placed on alcohol adverts with the purpose to warn pregnant women and drivers of dangers of drinking alcohol	78.7%
People would buy more alcoholic beverages like beer, wine or spirits if the price was decreased by 25%	50.6%

Perceived effectiveness of public policies for reducing alcohol-related harm in Europe

To evaluate potential effectiveness of public policies in reducing alcohol-related harm in Europe, GPs were asked to indicate their opinion on a scale of 1-5 ('Ineffective' to 'Very effective') with 12 suggested policies. Table 17 presents their assessment of proposed policies. Not all items were strongly endorsed by the GPs. Several public policies were perceived as most effective: improving alcohol education in schools (81%), increasing restrictions on alcohol advertising (69%), and introducing obligatory programmes of early identification and brief intervention for individuals with hazardous and harmful alcohol consumption in primary care (61%); the lowest effectiveness was attributed to introducing government monopoly of retail sales of alcohol (27%) or introducing minimum pricing for units of alcohol (31%).

Table 17. General practitioners' evaluation of potential effectiveness of selected public policies that might have impact on reducing alcohol-related harm in Europe.

Statement	Agreement
Raise minimum legal age for drinking alcohol	46.4%
Raise minimum legal purchase age of alcohol for all beverage categories	52.8%
Reduce the legal BAC level for drinking and driving for all drivers	57.9%
Improve alcohol education in schools	80.6%
Increase restrictions on alcohol advertising	68.6%
Keep or introduce government monopoly of retail sales of alcohol	27.1%
Institute minimum pricing for units of alcohol	31.4%
Increase alcohol price through taxation	44.7%
Reduce the density and opening hours for alcohol sales outlets	38.7%
Further regulation of alcohol off-sales (e.g. supermarkets, off-licences)	45.1%
Make public health a criterion for giving and renewing licenses for the sale of alcohol	46.6%
Introduce obligatory programmes of early identification and brief intervention for individuals with hazardous and harmful alcohol consumption in primary care	60.6%

Further analyses of alcohol policies

The 10 items measuring views on alcohol policies and the 12 items measuring views on effective policies were managed in the same way as the barriers and facilitators above, resulting in three domains for views on alcohol policies (termed 'should restrict advertising and place warning labels'; 'price influences consumption'; and, 'individuals should be responsible for managing their own drinking') and two domains on effective policies (termed 'regulatory policies work'; and, 'youth oriented policies work'). For all domains, missing values for any items in the domain were assigned the mean score of the remaining items in the domain.

Excluding Sweden, which had unexplained aberrant findings, providers generally agreed that advertising should be restricted and warning labels placed (range 7.8 to 9.2 around a neutral score of 6.0), that price influences consumption (range 6.6 to 7.2 around a neutral score of 6.0), but mixed as to whether or not individuals are responsible for their own consumption (range 2.3 to 4.7 around a neutral score of 3.0), Table 18. Providers did not generally agree that regulatory policies were effective policies (range 6.7 to 7.8 around a neutral score of 7.5) but that policies that focus on youth were (range 5.6 to 7.1 around a neutral score of 5).

Table 18. Views on barriers and facilitators and on alcohol policy issues.

	Views on alcohol policies			Effective policies	
	Should restrict advertising and place warning labels	Price influences consumption	Individuals are responsible	Regulatory policies	Focus on youth
Catalonia	8.5 (1.3)	7.1 (1.7)	2.6 (0.98)	6.9 (2.3)	6.1 (1.3)
England	Na	Na	Na	7.8 (3.1)	5.6 (1.6)
Czech Republic	7.8 (1.7)	6.6 (2.0)	3.9 (0.9)	6.7 (2.6)	5.6 (1.5)
Italy	8.8 (1.4)	6.6 (1.9)	4.7 (0.5)	7.8 (2.4)	7.1 (1.0)
Netherlands	8.3 (1.6)	6.6 (1.7)	2.7 (0.9)	6.8 (2.5)	6.5 (1.4)
Poland	8.9 (1.3)	6.8 (1.9)	2.3 (0.96)	6.8 (2.5)	6.5 (1.4)
Portugal	Na	Na	Na	6.8 (2.7)	6.6 (1.3)
Slovenia	9.2 (1.2)	7.2 (1.8)	2.5 (1.0)	7.4 (2.5)	6.3 (1.4)
Sweden	2.7 (1.1)	4.0 (1.8)	3.0 (1.1)	6.5 (2.4)	2.8 (1.1)
Total	8.3 (1.9)	6.7 (1.9)	3.0 (1.2)	7.0 (2.6)	6.1 (1.5)

Disease: range 3-12 (7.5); Not responsible: 3-12 (7.5); Materials: 4-16 (10); Financial incentives: 3-12 (7.5); Warning: range 2-10 (6); Price: range 2-10 (6); Individuals: range 1-5 (3); Regulatory: range 3-12 (7.5); Youth: range 2-8 (5)

Public policies and effective policies and brief advice activity

Controlling for providers' age, sex, consultation rate and country, providers who agreed that price influences alcohol consumption, that regulatory policies are effective, and that policies should focus on youth tended to have higher role security, but not therapeutic commitment, Table 19. Providers who believed that individuals should be responsible for managing their own drinking had lower therapeutic commitment, but not role security.

Controlling for providers' age, sex, consultation rate and country, providers who agreed that individuals are responsible enough to protect themselves from alcohol-related harm was related to reported number of patients managed for heavy drinking in a negative direction (B =-0.949; 95%CI -1.544 to -0.354; $p<0.01$). The degree to which providers agreed that

individuals are responsible enough to protect themselves from alcohol-related harm was not related to education on alcohol.

Table 19. Predictors of role security and therapeutic commitment.

	Role Security			Therapeutic commitment		
Predictor variable	B	95% Wald Confidence Interval		B	95% Wald Confidence Interval	
		Lower	Upper		Lower	Upper
Restrict advertising and place warning labels	.003	-.104	.109	-.086	-.060	.231
Price influences consumption	.036	-0.047	.128	.078	-.035	.192
Individuals are responsible	-.002	-1.478	.145	-.390***	-.609	-.172
Regulatory policies effective	.092*	.033	.152	.037	-.047	.120
Policies should focus on youth	.087	-.021	.196	.094	-.060	.248

Separate models for each predictor variable, controlling for providers' age, sex, consultation rate and country

***p<0.001; **p<0.01; *p<0.05

4. SUMMARY AND RECOMMENDATIONS

SUMMARY

In the ODHIN survey of general practitioners in Europe over half of doctors (54%) reported having received 4 or more hours of education and training on managing alcohol problems, and under half of GPs (43%) reported managing seven or more patients for alcohol problems in the previous year. One half of the general practitioners felt that they were working in a supportive environment, two out of five felt secure in their role in managing alcohol problems and under half (44%) felt committed to providing help for alcohol problems.

In the ODHIN survey, both education on alcohol and a supportive working environment were independently related to the number of patients managed for alcohol-related harm. Role security, which was influenced by both education on alcohol and a supportive working environment, was independently related to the number of patients managed. Therapeutic commitment was not influenced by education on alcohol and did not impact on the number of patients managed.

The six top barriers to early intervention expressed by the general practitioners were: Doctors are just too busy dealing with the problems people present with; Doctors are not trained in counselling for reducing alcohol consumption; Doctors believe that alcohol counselling involves family and wider social effects, and is therefore too difficult; General practices are not organised to do preventive counselling; Doctors do not believe that patients would take their advice and change their behaviour; Doctors do not have suitable counselling materials available, and the six top facilitators for undertaking early intervention were: Support services (self-help/counselling) were readily available to refer patients to; Patients requested health

advice about alcohol consumption; Quick and easy counselling materials were available; Training programs for early intervention for alcohol were available; Early intervention for alcohol was proven to be successful; and Quick and easy screening questionnaires were available.

Even though European general practitioners reported receiving relatively little postgraduate education on alcohol and alcohol problems (average of ten hours in total), overall they felt secure in their role in managing patients with hazardous and harmful alcohol use, but they did not feel therapeutically committed to do so. On average, they reported managing a relatively small number of patients (eleven) for alcohol and alcohol problems during the previous year.
Doctors who reported receiving more education on alcohol and doctors who were more secure in their role (but not more therapeutically committed) reported managing a higher number of patients for alcohol and alcohol problems. Education was weakly associated with increased role security, but not therapeutic commitment.

When considering potential impediments and facilitators to implementing brief advice programmes, the only significant finding was an impediment, in which GPs who agreed that doctors having a disease model would impede brief advice activity, reported a lower number of patients managed for alcohol and alcohol problems. Similarly, GPs who agreed that individuals are responsible enough to protect themselves from alcohol-related harm reported a lower number of patients managed for alcohol and alcohol problems.

RECOMMENDATIONS
Three important conclusions for policy and future research derive from this survey.

1. Increased education seems to be related to increased role security, and each increase of education and role security was associated with a reported increase in patients managed for heavy drinking. This would suggest the importance of scaled-up education and training for managing heavy drinking patients in primary health care settings.
2. A belief in the importance of a disease model in reducing brief advice activity seemed to impair role security (but not therapeutic commitment) and management activity. This would suggest a disease-based approach linking alcohol to other physical comorbidities (such as high blood pressure) or the use of pharmacotherapies might be considered and studied. It would also be important to increase the understanding of a non-medical approach, e.g. a broader public health perspective including health promotion and preventive care.
3. A belief in individual patient responsibility seemed to impair management activity. This would suggest that patient owned identification and brief advice technologies that could be explored and developed might broaden the number of heavy drinkers exposed to actions to reduce their drinking.

Overall, the recommendations for improving the delivery of early alcohol intervention and the management of alcohol problems in general practice are simple and straightforward:

1. Provide training to general practitioners to deliver early alcohol interventions. There is a lot of scope for improvement here, given that only 54% of practitioners reported having received only four or more hours of such training.
2. Provide the infrastructure to deliver early alcohol interventions. The infrastructure is very simple - the availability of screening and counselling materials, and the availability of help to handle difficult cases. Again, there is a lot of scope for improvement here, given that only 44% of practitioners felt that they were in receipt of such infrastructure.

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6. APPENDICES

I. The survey questionnaire (English and translated versions)

II. Survey Protocol

Survey of General Practitioners' Attitudes to Prevention: Repeat of a World Health Organisation Collaborative Study Questionnaire

Primary Care Research Network
East Midlands and South Yorkshire

Please tick the box corresponding to your answer or write your answer where indicated.
All answers to this questionnaire will be treated in confidence.

OFFICE USE ONLY

ID no

1. How many years have you been practising as a general practitioner?

☐ years

1 ☐

2. In which year were you born

19☐

2 ☐

3. What is your gender?

Male ☐
Female ☐

3 ☐

4. Is your practice a:

Urban practice? ☐
Rural practice? ☐
Mixed Urban/Rural practice? ☐

4 ☐

5. Is it a:

Solo practice? ☐
Group practice? ☐

5 ☐

6. How many full time equivalent (FTE) general practitioners are there in the practice, including yourself?

☐

6 ☐

7. How many days per week do you work in general practice?

☐

7 ☐

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

0 – 50 ☐
50 – 100 ☐
101 – 150 ☐
More than 150 ☐

8 ☐

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

None ☐
Less than 4 hours ☐
4-10 hours ☐
11-40 hours ☐
More than 40 hours ☐
Don't know/Can't remember ☐

9 ☐

10. At the present time, taking into consideration all your current responsibilities with patients, how high a priority do you place on disease prevention as an aspect of your practice?

Very high ☐
Somewhat high ☐
Somewhat low ☐
Very low ☐

10 ☐

11. Compared to other medical practitioners you know, how much emphasis do you place on disease prevention in your practice?

Much more	
Somewhat more	
Somewhat less	
Much less	

11 ☐

12. If the patient doesn't ask you about alcohol, do you ask about it?

All the time	
Most of the time	
Some of the time	
Rarely or never	

12 ☐

13. Please list the typical conditions which elicit your talking about alcohol

13 ☐

14. The following are behaviours that some health professionals believe to be related to health. How important do you think each of the following behaviours are in **promoting the health of the average person?** *(Please circle one number for each)*.

Behaviour	Very important	Important	Somewhat important	Unimportant	
a. Not smoking	4	3	2	1	14 ☐
b. Exercise regularly	4	3	2	1	15 ☐
c. Drinking alcohol moderately	4	3	2	1	16 ☐
d. Avoiding excess calories	4	3	2	1	17 ☐
e. Reducing stress	4	3	2	1	18 ☐
f. Responsible use of prescription drugs	4	3	2	1	19 ☐
g. Not using illicit drugs	4	3	2	1	20 ☐

15. Please indicate **the extent to which you obtain information** on your patients in each of the following areas: *(Please circle one for each).*

Behaviour	Always	As indicated	Occasionally	Rarely/Never	
a. Not smoking	4	3	2	1	21 ☐
b. Exercise regularly	4	3	2	1	22 ☐
c. Drinking alcohol moderately	4	3	2	1	23 ☐
d. Avoiding excess calories	4	3	2	1	24 ☐
e. Reducing stress	4	3	2	1	25 ☐
f. Responsible use of prescription drugs	4	3	2	1	26 ☐
g. Not using illicit drugs	4	3	2	1	27 ☐

16. Doctors vary in their counselling skills and training. How **prepared** do you feel when counselling patients in each of these areas: *(Please circle one for each).*

Behaviour	Very Prepared	Prepared	Unprepared	Very Unprepared	
a. Not smoking	4	3	2	1	28 ☐
b. Exercise regularly	4	3	2	1	29 ☐
c. Reducing alcohol consumption	4	3	2	1	30 ☐
d. Avoiding excess calories	4	3	2	1	31 ☐
e. Reducing stress	4	3	2	1	32 ☐
f. Responsible use of prescription drugs	4	3	2	1	33 ☐
g. Not using illicit drugs	4	3	2	1	34 ☐

17. How **effective** do you feel you are in helping patients achieve change in each of the following areas? *(Please circle one number for each).*

Behaviour	Very Effective	Effective	Ineffective	Very Ineffective	
a. Not smoking	4	3	2	1	35
b. Exercise regularly	4	3	2	1	36
c. Reducing alcohol consumption	4	3	2	1	37
d. Avoiding excess calories	4	3	2	1	38
e. Reducing stress	4	3	2	1	39
f. Responsible use of prescription drugs	4	3	2	1	40
g. Not using illicit drugs	4	3	2	1	41

18. In general, **given adequate information and training**, how effective do you feel general practitioners **could** be in helping patients change behaviour in each of the following areas? *(Please circle one number for each)*.

Behaviour	Very Effective	Effective	Ineffective	Very Ineffective	
a. Not smoking	4	3	2	1	42
b. Exercise regularly	4	3	2	1	43
c. Reducing alcohol consumption	4	3	2	1	44
d. Avoiding excess calories	4	3	2	1	45
e. Reducing stress	4	3	2	1	46
f. Responsible use of prescription drugs	4	3	2	1	47
g. Not using illicit drugs	4	3	2	1	48

19. For a healthy adult man, what would you consider the upper limit for alcohol consumption before you would advise him to cut down?

Please record as …… standard drinks/units* per week 49

or as …… standard drinks/units* per day 50

For a healthy adult woman, who is not pregnant, what would you consider the upper limit for alcohol consumption before you would advise her to cut down? 51

Please record as …….. standard drinks/units* per week

or as …….. standard drinks/units* per day 52

*1 standard drink = ½ pint of beer = 1 small glass of wine = 1 small glass of sherry = 1 measure of spirits

20. Indicate how much you agree or disagree with each of the following statements about working with "problem drinkers". For this part of the question, "problem drinkers" refers to people with **hazardous or harmful alcohol use,** but excludes those dependent on alcohol.

Statement	Strongly agree	Quite strongly agree	Agree	Neither agree or disagree	Dis-agree	Quite strongly disagree	Strongly disagree	
a. I feel I know enough about the causes of drinking problems to carry out my role when working with problem drinkers	7	6	5	4	3	2	1	53
b. I feel I can appropriately advise my patients about drinking and its effects	7	6	5	4	3	2	1	54
c. I feel I do not have much to be proud of when working with drinkers	7	6	5	4	3	2	1	55
d. All in all I am inclined to feel a failure with drinkers	7	6	5	4	3	2	1	56
e. I want to work with drinkers	7	6	5	4	3	2	1	57
f. Pessimism is the most realistic attitude to take towards problem drinkers	7	6	5	4	3	2	1	58
g. I feel I have the right to ask patients questions about their drinking when necessary	7	6	5	4	3	2	1	59
h. I feel that my patients believe I have the right to ask them questions about drinking when necessary	7	6	5	4	3	2	1	60
i. In general it is rewarding to work with drinkers	7	6	5	4	3	2	1	61
j. In general, I like problem drinkers	7	6	5	4	3	2	1	62

21. Indicate how much you agree or disagree with each of the following statements about working with people who are **dependent on alcohol or have a severe problem with alcohol ("alcoholics").**

Statement	Strongly agree	Quite strongly agree	Agree	Neither agree or disagree	Dis-agree	Quite strongly disagree	Strongly disagree	
a. I feel I know enough about the causes of drinking problems to carry out my role when working with problem drinkers	7	6	5	4	3	2	1	63
b. I feel I can appropriately advise my patients about drinking and its effects	7	6	5	4	3	2	1	64
c. I feel I do not have much to be proud of when working with drinkers	7	6	5	4	3	2	1	65
d. All in all I am inclined to feel a failure with drinkers	7	6	5	4	3	2	1	66
e. I want to work with drinkers	7	6	5	4	3	2	1	67
f. Pessimism is the most realistic attitude to take towards problem drinkers	7	6	5	4	3	2	1	68
g. I feel I have the right to ask patients questions about their drinking when necessary	7	6	5	4	3	2	1	69
h. I feel that my patients believe I have the right to ask them questions about drinking when necessary	7	6	5	4	3	2	1	70
i. In general it is rewarding to work with drinkers	7	6	5	4	3	2	1	71
j. In general, I like problem drinkers	7	6	5	4	3	2	1	72

22. In the last year, how many times have you taken or requested a blood test (*eg blood alcohol, MCV, GGT)* **because of concern** about alcohol consumption? *(Please circle one number).*

Never	1	73
1 – 2 times	2	
3 – 5 times	3	
6 – 12 time	4	
more than 12 times	5	

23. In the last year, about how many patients have you managed specifically for their hazardous drinking or alcohol-related problems?

None	1	74
1 – 6 patients	2	
7 – 12 patients	3	
13 – 24 patients	4	
25 – 49 patients	5	
50 or more patients	6	

24. The next two questions are about early intervention for hazardous alcohol consumption. This involves screening patients to identify those whose alcohol consumption places them at increased risk of disease, and then counselling identified problem drinkers about reducing their alcohol consumption.

Inquiries in a number of countries have revealed that many doctors in general practice spend very little or no time at all on early intervention for alcohol. A variety of reasons have been suggested as to why this might be so. For each one please indicate to what extent you think that reason applies by circling the appropriate number.

Statement	Very much	Quite a bit	Little	Not at all	Don't know	
a. Alcohol is not an important issue in general practice	5	4	3	2	1	75
b. Doctors are just too busy dealing with the problems people present with	5	4	3	2	1	76
c. Doctors have a disease model training and they don't think about prevention	5	4	3	2	1	77
d. Doctors think that preventive health should be the patients' responsibility not theirs	5	4	3	2	1	78
e. Doctors are not sufficiently encouraged to work with alcohol problems in the current GMS contract	5	4	3	2	1	79
f. Doctors feel awkward about asking questions about alcohol consumption because saying someone has an alcohol problem could be seen as accusing them of being an alcoholic	5	4	3	2	1	80
g. Doctors do not know how to identify problem drinkers who have no obvious symptoms of excess consumption.	5	4	3	2	1	81
h. Doctors do not have a suitable screening device to identify problem drinkers who have no obvious symptoms of excess consumption	5	4	3	2	1	82
i. Doctors do not have suitable counselling materials available	5	4	3	2	1	83
j. Doctors are not trained in counselling for reducing alcohol consumption	5	4	3	2	1	84
k. Doctors believe that alcohol counselling involves family and wider social effects, and is therefore too difficult	5	4	3	2	1	85
l. Doctors do not believe that patients would take their advice and change their behaviour	5	4	3	2	1	86
m. Doctors themselves have a liberal attitude to alcohol	5	4	3	2	1	87
n. Doctors themselves may have alcohol problems	5	4	3	2	1	88
o. Doctors believe that patients would resent being asked about their alcohol consumption	5	4	3	2	1	89

25. Doctors in a number of countries have suggested a variety of things that could lead to more doctors doing early intervention for hazardous alcohol consumption. Please indicate for each item to what extent it **would** encourage you personally to do more early intervention for hazardous alcohol consumption, by circling the appropriate response.

Statement	Very much	Quite a bit	Little	Not at all	Don't know		
a. Public health education campaigns in general made society more concerned about alcohol	5	4	3	2	1	90	
b. Patients requested health advice about alcohol consumption	5	4	3	2	1	91	
c. Quick and easy screening questionnaires were available	5	4	3	2	1	92	
d. Quick and easy counselling materials were available	5	4	3	2	1	93	
e. Early intervention for alcohol was proven to be successful	5	4	3	2	1	94	
f. Training programs for early intervention for alcohol were available	5	4	3	2	1	95	
g. Providing early intervention for alcohol was included in the Quality in Outcomes Framework (QOF)	5	4	3	2	1	96	
h. General support services (self-help/counselling) were readily available to refer patients to	5	4	3	2	1	97	
i. Salary and working conditions were improved	5	4	3	2	1	98	

26. Over the past 10 years, how effective do you think the following government policies have been in reducing alcohol-related harm in England? *(Please circle one number for each)*.

Statement	Very effective	Quite effective	Slightly effective	In-effective	No opinion		
a. Promotion of a 'sensible drinking' culture	5	4	3	2	1	99	
b. Promotion of recommended guidelines on drinking limits and health information	5	4	3	2	1	100	
c. Introduction of more flexible opening hours licensed premises	5	4	3	2	1	101	
d. Stricter rules for the content of alcohol advertisements	5	4	3	2	1	102	
e. More extensive considerations when granting licenses	5	4	3	2	1	103	
f. Increased powers to enforce and penalise breach of licence conditions	5	4	3	2	1	104	
g. Introduction of powers to ban anti-social drinking in areas	5	4	3	2	1	105	
h. Introduction of powers to ban individuals from premises or areas following alcohol-related ASB	5	4	3	2	1	106	
i. Sharpened criminal justice for drunken behaviour	5	4	3	2	1	107	
j. Increased provision for brief interventions to prevent alcohol problems	5	4	3	2	1	108	
k. Increased provision for treatment of alcohol problems	5	4	3	2	1	109	
l. Introduction of local alcohol strategies	5	4	3	2	1	110	

27. How effective do you think the following policy measures might be in reducing alcohol-related harm in England? *(Please circle one number for each)*.

Statement	Very effective	Quite effective	Slightly effective	In-effective	No opinion	
a. Raise minimum legal age for drinking alcohol	5	4	3	2	1	111
b. Raise minimum legal age for purchasing alcohol	5	4	3	2	1	112
c. Lower BAC limit for drivers	5	4	3	2	1	113
d. Improve alcohol education in schools	5	4	3	2	1	114
e. Increase restrictions on TV & cinema alcohol advertising	5	4	3	2	1	115
f. Government monopoly of retail sales of alcohol	5	4	3	2	1	116
g. Institute minimum pricing for units of alcohol	5	4	3	2	1	117
h. General changes in alcohol price through taxation	5	4	3	2	1	118
i. Further regulation of alcohol off-sales (e.g. supermarkets, off-licences)	5	4	3	2	1	119
j. Make public health a criterion for licensing decisions	5	4	3	2	1	120
k. Statutory regulation of alcohol industry	5	4	3	2	1	121

28. Can you recall filling out an earlier version of this questionnaire from our team about 10 years ago?

Yes ☐
No ☐ 122

29. If you would like to express further opinions or comment on the questionnaire or any other aspect of alcohol problems, please use the space below

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Please return this questionnaire in the postage paid envelope provided to:

Beth Edgar, Institute of Health & Society, Newcastle University, William Leech Building, Framlington Place, Newcastle upon Tyne, NE2 4HH

If you require another envelope please contact 0191 2226260

Odhin project

VRAGENLIJST VOOR HUISARTSEN

Europese studie naar de ervaringen van huisartsen bij de zorg voor mensen met riskant alcoholgebruik

IQ Scientific Institute for Quality of Healthcare
Radboud University Nijmegen Medical Centre

Maastricht University Leading in Learning.

caphri School for Public Health and Primary Care

VRAGENLIJST VOOR HUISARTSEN

Deze vragenlijst begint met algemene vragen over uw achtergrond en uw attitude ten aanzien van gezondheidsbevordering. Daarna volgen er vragen over uw ervaringen, uw vaardigheden, en de belemmerende en bevorderende factoren die u ervaren hebt of verwacht, bij het implementeren van vroege interventie programma's bij riskant alcoholgebruik. Deze vragenlijst wordt afgenomen in negen landen in Europa, waaronder Nederland.

Gelieve het vakje dat overeenkomt met uw antwoord aan te kruisen of uw antwoord op te schrijven waar dit gevraagd wordt. Alle gegevens worden anoniem en vertrouwelijk behandeld.

ALGEMEEN

1 **Hoeveel jaar werkt u als huisarts?**

☐☐ jaar

2 **In welk jaar bent u geboren?**

19 ☐☐

3 **Wat is uw geslacht?**

- ☐ Man
- ☐ Vrouw

4 **Is uw praktijk een:**

- ☐ Stadspraktijk
- ☐ Plattelandspraktijk
- ☐ Gemengd

5 **Is uw praktijk een:**

- ☐ Solopraktijk
- ☐ Duo- of groepspraktijk

6 **Hoeveel full time equivalent (FTE) huisartsen werken er in de praktijk, inclusief uzelf?** *(Bijvoorbeeld: in uw praktijk werken inclusief uzelf 3 huisartsen; 2 huisartsen werken 0,8 fte en 1 huisarts werkt 0,7 fte. U vult in:* ☐**2**, **3** **fte***).*

☐☐, ☐ **fte**

7 **Hoeveel dagen per week werkt u in de huisartspraktijk?**

. . . dag(en)

8 **Hoeveel patiënten ziet u gemiddeld in een normale week?**

- ☐ 0 – 50
- ☐ 51 – 100
- ☐ 101 – 150
- ☐ Meer dan 150

9 **In totaal, hoeveel uren nascholing, training of supervisie heeft u ooit over alcohol en aan alcohol gerelateerde problemen gehad?**

- ☐ Geen
- ☐ Minder dan 4 uur
- ☐ 4 -10 uur
- ☐ 11 - 40 uur
- ☐ Meer dan 40 uur
- ☐ Weet niet / Kan me niet herinneren

10 **Welke prioriteit geeft u op dit moment, al uw verantwoordelijkenheden ten aanzien van uw patiënten in acht nemend, aan ziektepreventie als onderdeel van uw werk als huisarts?**

- ☐ Zeer hoge prioriteit
- ☐ Tamelijk hoge prioriteit
- ☐ Tamelijk lage prioriteit
- ☐ Zeer lage prioriteit

11 **Hoeveel nadruk legt u op ziektepreventie in uw huisartspraktijk in vergelijking met andere huisartsen die u kent?**

- ☐ Veel meer
- ☐ Iets meer
- ☐ Iets minder
- ☐ Veel minder

12 **Als een patiënt niet over alcohol begint, vraagt u er dan toch naar?**

- ☐ Altijd
- ☐ Meestal
- ☐ Soms
- ☐ Zelden of nooit

13 **Hoeveel full time equivalent (FTE) (verpleegkundige) ondersteuning is er in de praktijk?**

☐☐,☐ fte Praktijkondersteuners chronische/ouderen zorg

☐☐,☐ fte Praktijkondersteuners GGZ

☐☐,☐ fte Verpleegkundig Specialisten /Physician Assistants

☐☐,☐ fte Praktijk assistenten

ATTITUDE T.A.V. GEZONDHEIDSBEVORDERING

14 **De volgende gedragingen zijn volgens sommige zorgverleners gerelateerd aan gezondheid.**
Hoe belangrijk denkt u dat de volgende gedragingen zijn voor het bevorderen van de gezondheid van een doorsnee persoon?
(Gelieve telkens een nummer te omcirkelen)

GEDRAG	Heel belangrijk	Belangrijk	Enigszins belangrijk	Onbelangrijk
a Niet roken	4	3	2	1
b Regelmatig bewegen	4	3	2	1
c Matig alcoholgebruik	4	3	2	1
d Overmatige calorie-inname vermijden	4	3	2	1
e Stress verminderen	4	3	2	1
f Verantwoord gebruik van voorgeschreven medicijnen	4	3	2	1
g Geen drugs gebruiken	4	3	2	1

15 **Geef aan in welke mate u informatie verzamelt over uw patiënten op elk van de volgende gebieden.**
(Gelieve telkens een nummer te omcirkelen)

GEDRAG	Altijd	Als er een indicatie voor is	Soms	Zelden/ nooit
a Niet roken	4	3	2	1
b Regelmatig bewegen	4	3	2	1
c Matig alcohol drinken	4	3	2	1
d Overmatige calorie-inname vermijden	4	3	2	1
e Stress verminderen	4	3	2	1
f Verantwoord gebruik van voorgeschreven medicijnen	4	3	2	1
g Geen drugs gebruiken	4	3	2	1

16 **Huisartsen verschillen wat betreft counselingvaardigheden en training in deze vaardigheden. In hoeverre voelt u zich voorbereid om uw patiënten te adviseren op elk van de volgende gebieden?** ***(Gelieve telkens een nummer te omcirkelen)***

GEDRAG	Zeer voorbereid	Voorbereid	Onvoor-bereid	Zeer on-voorbereid
a Niet roken	4	3	2	1
b Regelmatig bewegen	4	3	2	1
c Matig alcohol drinken	4	3	2	1
d Overmatige calorie-inname vermijden	4	3	2	1
e Stress verminderen	4	3	2	1
f Verantwoord gebruik van voorgeschreven medicijnen	4	3	2	1
g Geen drugs gebruiken	4	3	2	1

17 **Hoe bekwaam voelt u zich om patiënten te helpen om hun gedrag te veranderen op de volgende gebieden?**
(Gelieve telkens een nummer te omcirkelen)

GEDRAG	Zeer bekwaam	Bekwaam	Onbekwaam	Zeer onbekwaam
a Niet roken	4	3	2	1
b Regelmatig bewegen	4	3	2	1
c Matig alcohol drinken	4	3	2	1
d Overmatige calorie-inname vermijden	4	3	2	1
e Stress verminderen	4	3	2	1
f Verantwoord gebruik van voorgeschreven medicijnen	4	3	2	1
g Geen drugs gebruiken	4	3	2	1

18 **Hoe bekwaam denkt u dat huisartsen in het algemeen zouden kunnen zijn, ervan uitgaande dat ze adequate informatie en training hebben ontvangen, bij het helpen van patiënten om hun gedrag te veranderen op de volgende gebieden?**
(Gelieve telkens een nummer te omcirkelen)

GEDRAG	Zeer bekwaam	Bekwaam	Onbekwaam	Zeer onbekwaam
a Niet roken	4	3	2	1
b Regelmatig bewegen	4	3	2	1
c Matig alcohol drinken	4	3	2	1
d Overmatige calorie-inname vermijden	4	3	2	1
e Stress verminderen	4	3	2	1
f Verantwoord gebruik van voorgeschreven medicijnen	4	3	2	1
g Geen drugs gebruiken	4	3	2	1

VRAGEN OVER ALCOHOLGEBRUIK

19 **Wat beschouwt u als uiterste limiet van alcoholgebruik voor een gezonde volwassen man tot 65 jaar voordat u hem zou aanraden te minderen?**

☐☐ standaard glazen / eenheden per week*

of

☐☐ standaard glazen / eenheden per dag*

Wat beschouwt u als uiterste limiet van alcoholgebruik voor een gezonde volwassen (niet zwangere) vrouw voordat u haar zou aanraden te minderen?

☐☐ standaard glazen / eenheden per week*

of

☐☐ standaard glazen / eenheden per dag*

* *1 standaard glas/eenheid =*
1 normaal glas bier = › 250cc
1 glas wijn = › 100cc
1 glas sherry = › 80cc
1 borrel = › sterke drank van 35% alcohol = › 35cc

20 **Geef aan in hoeverre u het eens of oneens bent met elk van de volgende uitspraken over het werken met 'probleemdrinkers'. De term 'probleemdrinkers' verwijst naar mensen met een riskant of schadelijk alcoholgebruik, maar die niet verslaafd zijn aan alcohol.** ***(Gelieve telkens een nummer te omcirkelen)***

UITSPRAAK	Zeer sterk mee eens	Sterk mee eens	Mee eens	Niet eens/ niet oneens	Oneens	Sterk mee oneens	Zeer sterk mee oneens
a Ik vind dat ik voldoende weet over de oorzaken van drankproblemen om mijn taak uit te voeren bij het werken met probleemdrinkers.	7	6	5	4	3	2	1
b Ik vind dat ik mijn patiënten naar behoren kan adviseren over drankgebruik en de gevolgen ervan.	7	6	5	4	3	2	1
c Ik vind dat het werken met probleemdrinkers mij weinig aanleiding geeft om trots op te zijn.	7	6	5	4	3	2	1
d Over het algemeen vind ik mezelf tekort schieten in mijn begeleiding van probleemdrinkers.	7	6	5	4	3	2	1
e Ik wil werken met probleemdrinkers.	7	6	5	4	3	2	1
f Pessimisme is de meest realistische attitude die je ten opzichte van probleemdrinkers kunt aannemen.	7	6	5	4	3	2	1
g Ik vind dat ik het recht heb patiënten vragen te stellen over hun drankgebruik als ik dat nodig acht.	7	6	5	4	3	2	1

UITSPRAAK	Zeer sterk mee eens	Sterk mee eens	Mee eens	Niet eens/ niet oneens	Oneens	Sterk mee oneens	Zeer sterk mee oneens
h Ik heb het gevoel dat mijn patiënten vinden dat ik het recht heb om ze vragen te stellen over hun drankgebruik, als ik dat nodig acht.	7	6	5	4	3	2	1
i Over het algemeen is het een dankbare taak om met probleemdrinkers te werken.	7	6	5	4	3	2	1
j Over het algemeen vind ik probleemdrinkers aardige mensen.	7	6	5	4	3	2	1

21 **Geef aan in hoeverre u het eens of oneens bent met elk van de volgende uitspraken over het werken met mensen die verslaafd zijn aan alcohol of ernstige problemen hebben door de alcohol (alcoholisten).**
(Gelieve telkens een nummer te omcirkelen)

UITSPRAAK	Zeer sterk mee eens	Sterk mee eens	Mee eens	Niet eens/ niet oneens	Oneens	Sterk mee oneens	Zeer sterk mee oneens
a Ik vind dat ik voldoende weet over de oorzaken van drankproblemen om mijn taak uit te voeren bij het werken met alcoholisten.	7	6	5	4	3	2	1
b Ik vind dat ik mijn patiënten naar behoren kan adviseren over drankgebruik en de gevolgen ervan.	7	6	5	4	3	2	1
c Ik vind dat het werken met alcoholisten mij weinig aanleiding geeft om trots op te zijn.	7	6	5	4	3	2	1
d Over het algemeen vind ik mezelf tekort schieten in mijn begeleiding van alcoholisten.	7	6	5	4	3	2	1
e Ik wil werken met alcoholisten.	7	6	5	4	3	2	1
f Pessimisme is de meest realistische attitude die je ten opzichte van alcoholisten kunt aannemen.	7	6	5	4	3	2	1
g Ik vind dat ik het recht heb patiënten vragen te stellen over hun drankgebruik als ik dat nodig acht.	7	6	5	4	3	2	1
h Ik heb het gevoel dat mijn patiënten vinden dat ik het recht heb om ze vragen te stellen over hun drankgebruik, als ik dat nodig acht.	7	6	5	4	3	2	1

UITSPRAAK	Zeer sterk mee eens	Sterk mee eens	Mee eens	Niet eens/ niet oneens	Oneens	Sterk mee oneens	Zeer sterk mee oneens
i Over het algemeen is het een dankbare taak om met probleemdrinkers te werken.	7	6	5	4	3	2	1
j Over het algemeen vind ik probleemdrinkers aardige mensen.	7	6	5	4	3	2	1

22 **Hoe vaak heeft u in het afgelopen jaar een screeningstest afgenomen of aangevraagd (bijvoorbeeld: alcoholgehalte in het bloed, MCV, γ-GT, AUDIT, 5 SHOT test) vanwege ongerustheid over alcoholgebruik?**

- ☐ nooit
- ☐ 1 - 2 keer
- ☐ 3 - 5 keer
- ☐ 6 - 12 keer
- ☐ Meer dan 12 keer

23 **Hoeveel patiënten heeft u in het afgelopen jaar behandeld specifiek voor hun riskant alcoholgebruik of voor hun alcoholgerelateerde klachten?**

- ☐ geen enkele patiënt
- ☐ 1 - 6 patienten
- ☐ 7 - 12 patienten
- ☐ 13 - 24 pateinten
- ☐ 25 - 49 patienten
- ☐ 50 of meer patienten

24 **De volgende twee vragen gaan over vroege interventies bij riskant alcoholgebruik. Dit omvat het door screening opsporen van patiënten die vanwege hun alcoholgebruik een verhoogd risico hebben om ziek te worden en het counselen van de opgespoorde probleemdrinkers om hun alcoholconsumptie te verminderen.**

Navraag in een aantal landen heeft geleerd dat veel huisartsen over het algemeen zeer weinig of helemaal geen tijd besteden aan vroege interventies voor alcoholmisbruik. Hiervoor werden verschillende redenen aangevoerd. Geef voor elk van onderstaande redenen aan in hoeverre die volgens u van toepassing is.
(Gelieve een nummer te omcirkelen.)

STELLING	Zeer toepasselijk	Tamelijk toepasselijk	Weinig toepasselijk	Helemaal niet toe-passelijk	Weet niet
a Alcohol is geen belangrijk issue in de huisartspraktijk	5	4	3	2	1
b Huisartsen hebben het eenvoudigweg te druk met de problemen die de patiënten presenteren	5	4	3	2	1
c Huisartsen zijn getraind in het 'ziektemodel' en ze denken niet aan preventie	5	4	3	2	1

	STELLING	Zeer toepasselijk	Tamelijk toepasselijk	Weinig toepasselijk	Helemaal niet toe-passelijk	Weet niet
d	Huisartsen denken dat een gezonde levenswijze niet hun verantwoordelijkheid maar die van de patiënt zou moeten zijn	5	4	3	2	1
e	Huisartspraktijken zijn wat organisatie betreft niet ingericht om aan preventieve begeleiding te doen	5	4	3	2	1
f	Huisartsen voelen zich ongemakkelijk bij het vragen naar alcohol-gebruik omdat het benoemen van iemands alcoholprobleem gezien kan worden als een beschuldiging van alcoholisme	5	4	3	2	1
g	Huisartsen weten niet hoe ze probleemdrinkers die geen duidelijke symptomen hebben van overmatig alcoholgebruik kunnen herkennen	5	4	3	2	1
h	Huisartsen hebben geen geschikt screeningsinstrument om probleemdrinkers die geen duidelijke symptomen van een overmatig alcoholgebruik vertonen te kunnen herkennen	5	4	3	2	1
i	Huisartsen hebben geen geschikte counselingmaterialen tot hun beschikking	5	4	3	2	1
j	Huisartsen zijn niet getraind in counseling voor vermindering van alcoholgebruik	5	4	3	2	1
k	Huisartsen geloven dat alcoholcounseling ook het betrekken van familie en sociale netwerk inhoudt, en dat het daarom te moeilijk is	5	4	3	2	1
l	Huisartsen geloven niet dat patiënten hun advies zullen opvolgen en hun gedrag veranderen	5	4	3	2	1
m	Huisartsen zelf hebben een liberale houding ten aanzien van alcohol	5	4	3	2	1
n	Huisartsen kunnen zelf ook alcoholproblemen hebben	5	4	3	2	1
o	Huisartsen geloven dat patiënten het hen kwalijk zullen nemen wanneer er naar hun alcoholgebruik wordt gevraagd	5	4	3	2	1
p	De overheid geeft geen vergoeding voor de tijd die huisartsen aan preventieve geneeskunde besteden	5	4	3	2	1
q	In het algemeen worden dokters die preventieve geneeskunde in praktijk brengen niet ondersteund door het nationale gezondheidsbeleid	5	4	3	2	1
r	Zorgverzekeraars geven geen vergoeding aan patiënten voor alcoholcounseling door huisartsen	5	4	3	2	1

25 **(Huis)artsen uit verschillende landen hebben een aantal voorstellen gedaan die er toe kunnen leiden dat meer artsen vroegtijdig gaan interveniëren bij riskant alcoholgebruik. Geef bij elk voorstel aan in welke mate het u persoonlijk zou stimuleren om meer vroege interventies te doen bij riskant alcoholgebruik, door het meest passende antwoord te omcirkelen.**

UITSPRAAK	Zeer veel	Tamelijk veel	Weinig	Helemaal niet	Weet niet
a Als publieke voorlichtingscampagnes in het algemeen de gemeenschap meer bezorgd zouden maken over alcohol	5	4	3	2	1
b Als patiënten om gezondheidsadvies over alcoholgebruik zouden vragen	5	4	3	2	1
c Als patiënten bereid waren om een vergoeding te betalen voor alcoholcounseling	5	4	3	2	1
d Als er snelle en eenvoudige screeningsvragenlijsten beschikbaar waren	5	4	3	2	1
e Als er snelle en eenvoudige counselingmaterialen beschikbaar waren	5	4	3	2	1
f Als er bewijs was dat vroege interventie bij alcoholproblemen succesvol is	5	4	3	2	1
g Als er trainingsprogramma's voor vroege interventie bij alcoholproblemen beschikbaar waren	5	4	3	2	1
h Als training in vroege interventie bij alcoholproblemen als nascholing geaccrediteerd werd	5	4	3	2	1
i Als het geven van vroege interventies bij alcoholproblemen als kwaliteitsindicator gemeten en beloond werd (pay for performance)	5	4	3	2	1
j Als ondersteunende diensten (zelfhulp/counseling) om patiënten naar te verwijzen direct beschikbaar waren	5	4	3	2	1
k Als salaris en werkomstandigheden verbeterd werden	5	4	3	2	1

26 **Geef aan in hoeverre u het eens of oneens bent met elk van de volgende uitspraken over het publieke beleid om alcoholgerelateerde schade in Europa te verminderen**
(Gelieve telkens een nummer te omcirkelen)

		Helemaal eens	Eens	Niet eens/ niet oneens	Oneens	Helemaal oneens
a	Mensen hebben verantwoordelijkheid genoeg om zichzelf te beschermen tegen alcoholgerelateerde schade	5	4	3	2	1
b	De overheid moet ingrijpen om individuen te beschermen tegen alcoholgerelateerde schade	5	4	3	2	1
c	Jonge en zware drinkers zouden minder alcoholische drank zoals bier, wijn of sterke drank kopen als de prijs met 25% verhoogd zou worden	5	4	3	2	1
d	Door willekeurige alcoholcontroles door de politie op de Nederlandse (EU) wegen zal het alcoholgebruik voordat men gaat rijden afnemen	5	4	3	2	1
e	Het maximale alcoholpromillage in het bloed voor jonge en beginnende chauffeurs zou op 0,2g/l moeten worden gezet in alle 27 Europese lidstaten	5	4	3	2	1
f	Het verkopen en schenken van alcohol aan personen onder de 18 jaar zou verboden moeten worden in alle EU-lidstaten	5	4	3	2	1
g	Alcoholreclame gericht op jongeren zou verboden moeten worden in alle EU-lidstaten	5	4	3	2	1
h	Op flessen met alcoholhoudende drank zouden waarschuwingen moeten worden gezet om zwangere vrouwen en bestuurders te wijzen op de gevaren van alcoholgebruik	5	4	3	2	1
i	Op alcoholreclame zouden waarschuwingen moeten worden gezet om zwangere vrouwen en bestuurders op de gevaren van alcoholgebruik te wijzen	5	4	3	2	1
j	Mensen zouden meer alcoholhoudende drank zoals bier, wijn of sterke drank kopen als de prijs met 25% verlaagd zou worden	5	4	3	2	1

27 **Hoe effectief denkt u dat de volgende beleidsmaatregelen zouden kunnen zijn in het verminderen van alcoholgerelateerde schade in Nederland?**

	Zeer effectief	Nogal effectief	Een beetje effectief	Niet effectief	Geen mening
a Verhoog de wettelijke minimum leeftijd voor het drinken van alcohol	5	4	3	2	1
b Verhoog de wettelijke minimum leeftijd voor het kopen van alcohol voor alle soorten alcoholhoudende drank	5	4	3	2	1
c Verlaag het wettelijke toegestane alcoholpromillage in het bloed voor alle bestuurders	5	4	3	2	1
d Verbeter de voorlichting over alcohol op scholen	5	4	3	2	1
e Verhoog de beperkingen op alcoholreclame	5	4	3	2	1
f Handhaven of invoeren van een overheidsmonopolie op de detailhandel van alcoholhoudende dranken	5	4	3	2	1
g Stel een minimum verkoopprijs per eenheid alcohol vast	5	4	3	2	1
h Verhoog de prijs van alcoholhoudende dranken door middel van belasting	5	4	3	2	1
i Verminder de concentratie en de openingstijden van alcohol verkooppunten	5	4	3	2	1
j Verdere regulering voor de verkoop van alcoholhoudende dranken (bijvoorbeeld supermarkten, slijterijen)	5	4	3	2	1
k Maak aandacht voor de volksgezondheid een criterium voor het verlenen en verlengen van vergunningen voor de verkoop van alcoholhoudende drank	5	4	3	2	1
i Introduceer verplichte programma's voor de vroege opsporing van en korte interventies voor mensen met riskant en schadelijk alcoholgebruik in de eerste lijn	5	4	3	2	1

28 **Kunt u zich herinneren of u ongeveer 12 jaar geleden een eerdere versie van deze vragenlijst heeft ingevuld?**

- ☐ Ja
- ☐ Nee

29 **Hoe vaak zijn uw ondersteuners (bv. uw praktijkondersteuners, verpleegkundig specialisten, physician assistants, praktijkassistenten) betrokken bij de screening van patiënten met problematisch alcoholgebruik?**

- ☐ Altijd
- ☐ Vaak
- ☐ Soms
- ☐ (Bijna) nooit

30 **Hoe vaak zijn uw ondersteuners (bv. uw praktijkondersteuners, verpleegkundig specialisten, physician assistants, praktijkassistenten) betrokken bij de behandeling/ begeleiding van patiënten met problematisch alcoholgebruik?**

- ☐ Altijd
- ☐ Vaak
- ☐ Soms
- ☐ (Bijna) nooit

31 **Als u uw mening over, of commentaar op de vragenlijst wilt geven of over ieder ander aspect van de alcoholproblematiek, gebruik dan de ruimte hieronder.**

Tot slot willen we u vragen of u geïnteresseerd bent om deel te nemen aan een implementatiestudie waarbij we met behulp van verschillende strategieën zoals training en support, financiële vergoeding en/of inzet van e-health interventies de zorg voor patiënten met problematisch alcoholgebruik willen verbeteren. Indien u hierin geïnteresseerd bent wilt u dan uw naam en praktijkadres hieronder invullen. We nemen dan contact met u op om de studie verder toe te lichten, zodat u op basis van die informatie kunt besluiten of u wel of niet wilt deelnemen.

Naam: _____

Praktijkadres: _____

Telefoon: _____

Email: _____

HARTELIJK DANK
VOOR HET INVULLEN VAN DEZE VRAGENLIJST

Wij vragen u vriendelijk
om de vragenlijst naar ons terug te sturen
in de bijgevoegde retourenvelop

Estudi col·laboratiu de la Unió Europea

ODHIN (Optimizing delivery of Healthcare Interventions)

Qüestionari per a metges/ses de la AP

camfic
societat catalana de medicina familiar i comunitària

Generalitat de Catalunya
Departament de Salut

CLÍNIC
BARCELONA
Hospital Universitari

Benvolgut/da
Has estat seleccionat/da per respondre un qüestionari al voltant de la intervenció precoç en el consum de risc d'alcohol a Catalunya. Aquesta activitat s'emmarca en les accions previstes en el Projecte ODHIN en què participa el Departament de Salut i l'Hospital Clinic. Aquesta enquesta també es durà a terme, entre d'altres, a Itàlia, Anglaterra, Polònia, Portugal i Països Baixos, entre metges i metgesses de l'atenció primària. Llegiu les instruccions amb deteniment abans de començar.

Instruccions

El qüestionari està organitzat en 6 apartats i respondre'l no us suposarà més de 15 minuts. Responeu totes les preguntes del qüestionari, fins al final, a poder ser en una sola vegada per evitar que es perdi la informació. La majoria de preguntes es poden respondre marcant la casella que hi ha al costat de la resposta. Fixa't que n'hi ha algunes de resposta múltiple. Aquest qüestionari és anònim; totes les respostes seran tractades de manera confidencial i als informes sobre els resultats de l'estudi només hi apareixerà la informació agregada. Llegeix les definicions que apareixen a continuació abans de respondre.

Definicions

1. Consum de risc i trastorns per consum d'alcohol: fan referència a tres categories: consum de risc, consum perjudicial i consum dependent, basats en la classificació dels trastorns per consum d'alcohol de la CIM-10 de l'Organització Mundial de la Salut (OMS).

   L'OMS defineix el consum de risc com "un patró de consum d'una substància que eleva el risc de patir conseqüències perjudicials (físiques o mentals) per al consumidor [...]. A diferència del consum perjudicial, el consum de risc fa referència a patrons de consum que, tot i que no produeixen cap trastorn en el consumidor, tenen importància per a la salut pública".

   A la CIM-10 de l'OMS, el consum perjudicial es defineix com "un patró de consum d'una substància psicoactiva que perjudica la salut […]. Els danys causats poden ser físics o mentals". A diferència del consum de risc, en aquest cas hi ha evidències de problemes relacionats amb el consum d'alcohol, però el consumidor no sol seguir cap tractament.

   El consum dependent és una categoria que fa referència a un determinat consum d'alcohol que es relaciona amb un nivell de dependència de l'alcohol moderat o greu. La dependència es defineix com "un conjunt de fenòmens comportamentals, cognitius i fisiològics que es produeixen després del consum repetit d'una substància i que solen incloure un fort desig de consumir-la, dificultats per controlar-ne el consum, persistència en el consum malgrat les conseqüències perjudicials que comporta, més prioritat per al consum de la substància que per a altres activitats i obligacions, augment de la tolerància i, en alguns casos, un estat d'abstinència física" (definició de síndrome de dependència de la CIM-10 de l'OMS).

2. Identificació sistemàtica del consum d'alcohol: fa referència a l'ús regular d'una eina d'identificació del consum d'alcohol estandarditzada en suport paper o electrònic, com l'AUDIT, els AUDIT breus (per exemple, AUDIT-C), ISCA, CAGE, FAST, o d'altres per a la identificació de pacients amb un consum de risc, perjudicial o dependent d'alcohol (vegeu més amunt).

3. Intervenció breu: aquest terme fa referència a les intervencions que es duen a terme en centres no especialitzats (per exemple, el vostre centre), amb la intervenció de personal no especialitzat i adreçades a pacients amb un patró de consum d'alcohol de risc o perjudicial que no solen buscar ajuda per al seu problema amb l'alcohol. La durada d'aquestes intervencions pot variar de 5 a 30-40 minuts, i poden incloure una sola sessió o més d'una.

Si té qualsevol dubte o consulta pel que fa l'enquesta, posi's en contacte escrivint al odhin@odhinproject.eu

BLOC 1. DADES GENERALS

1. Quants **anys fa que exerceixes** com a metge/ssa?

☐ anys

2. Quin any **vas néixer**?

19--

3. **Ets**?

Home ☐
Dona ☐

4. Exerceixes en un **entorn**:

Urbà? ☐
Rural? ☐
Urbà / rural? ☐

5. Especifica la teva **província de residència:**

Barcelona ☐
Girona ☐
Lleida ☐
Tarragona ☐

6. Quants **facultatius a temps complet** exerceixin en el teu CAP, si t'hi comptes?

☐

7. **Quants dies** a la setmana **treballes** com a facultatiu/va?

☐

8. Com a facultatiu/va, **quants pacients de mitjana visites** a la setmana?

0 – 50 ☐
51 – 100 ☐
101 – 150 ☐
Més de 150 ☐

BLOC 2. ACTIVITAT PREVENTIVA

9. En total, quantes **hores de formació** de postgrau, educació mèdica contínua o supervisió clínica **sobre l'alcohol i els problemes relacionats** amb l'alcohol has rebut ?

Cap ☐
Menys de 4 hores ☐
4-10 hores ☐
11-40 hores ☐
Més de 40 hores ☐
No ho sé / No ho recordo ☐

10. En l'actualitat, tenint en compte totes les teves responsabilitats actuals amb els pacients, quina **prioritat** dónes a la **prevenció de la malaltia** en la teva pràctica clínica?

Molt alta ☐
Força alta ☐
Una mica baixa ☐
Molt baixa ☐

11. En comparació amb d'altres facultatius/ves que coneixes, quin **èmfasi fas en la prevenció de la malaltia** en la teva pràctica?

Molt més	
Una mica més	
Una mica menys	
Molt menys	

12. Si el pacient no et pregunta sobre l'alcohol, tu **li preguntes sobre el tema**?

Sempre	
Gairebé sempre	
Algunes vegades	
Gairebé mai o mai	

13. A continuació es presenten conductes que alguns professionals sanitaris creuen que tenen relació amb la salut. **Quina importància penses que tenen** cadascuna de les conductes següents en la **promoció de la salut d'una persona estàndard**? *(Marca un número per cadascuna).*

Conducta	Molta	Força	Poca	Cap
a) No fumar	4	3	2	1
b) Fer exercici regularment	4	3	2	1
c) Beure alcohol moderadament	4	3	2	1
d) Evitar l'excés calòric	4	3	2	1
e) Reduir l'estrès	4	3	2	1
f) Fer un ús responsable dels medicaments	4	3	2	1
g) No consumir drogues il·legals	4	3	2	1

14. Indica **el grau en què obtens informació** sobre els teus pacients en cadascuna de les àrees següents *(Marca un número per cadascuna).*

Conducta	Sempre	Tal com s'indica*	Algunes vegades	Gairebé mai / mai
a) No fumar	4	3	2	1
b) Fer exercici regularment	4	3	2	1
c) Beure alcohol moderadament	4	3	2	1
d) Evitar l'excés calòric	4	3	2	1
e) Reduir l'estrès	4	3	2	1
f) Fer un ús responsable dels medicaments	4	3	2	1
g) No consumir drogues il·legals	4	3	2	1

*** Es a dir "segons les recomanacions o guíes clíniques"**

15. Les habilitats i la formació dels facultatius i de les facultatives pel que fa l'aconsellament varia d'una persona a una altra. Com de **preparat/ada et sents quan aconselles pacients** en cadascuna d'aquestes àrees *(Marca un número per cadascuna).*

Conducta	Molt preparat/ada	Preparat/ada	Poc preparat	Gens preparat
a) No fumar	4	3	2	1
b) Fer exercici regularment	4	3	2	1
c) Reduir el consum d'alcohol	4	3	2	1
d) Evitar l'excés calòric	4	3	2	1
e) Reduir l'estrès	4	3	2	1
f) Fer un ús responsable dels medicaments	4	3	2	1
g) No consumir drogues il·legals	4	3	2	1

16. Com d'**efectiu/va** et sents **a l'hora d'ajudar els pacients a aconseguir canviar** en cadascuna de les àrees següents? *(Marca un número per cadascuna).*

Conducta	Molt efectiu/va	Efectiu/va	Inefectiu/va	Molt inefectiu/va
a) No fumar	4	3	2	1
b) Fer exercici regularment	4	3	2	1
c) Reduir el consum d'alcohol	4	3	2	1
d) Evitar l'excés calòric	4	3	2	1
e) Reduir l'estrès	4	3	2	1
f) Fer un ús responsable dels medicaments	4	3	2	1
g) No consumir drogues il·legals	4	3	2	1

17. En general, **amb una informació i formació adequades**, com d'efectius creus que els facultatius i les facultatives **podríeu** ser a l'hora d'ajudar els pacients a canviar en cadascuna de les àrees següents? *(Marca un número per cadascuna).*

Conducta	Molt efectius/ves	Efectius/ves	Inefectius/ves	Molt inefectius/ves
a) No fumar	4	3	2	1
b) Fer exercici regularment	4	3	2	1
c) Reduir el consum d'alcohol	4	3	2	1
d) Evitar l'excés calòric	4	3	2	1
e) Reduir l'estrès	4	3	2	1
f) Fer un ús responsable dels medicaments	4	3	2	1
g) No consumir drogues il·legals	4	3	2	1

BLOC 3. ACTIVITAT PREVENTIVA ALCOHOL

18. En el cas d'un **home adult sà**, quin consideraries que és el **límit màxim per al consum d'alcohol** abans d'aconsellar-li reduir-lo?

Registreu com …… unitats de beguda estàndard UBE* per setmana

o com ……..…unitats de beguda estàndard UBE* per dia

En el cas d'una **dona sana adulta**, que **no està embarassada**, quin consideraries que és el **límit màxim per al consum d'alcohol** abans d'aconsellar-li reduir-lo?

Registreu com …… unitats de beguda estàndard UBE* per setmana

o com ……..unitats de beguda estàndard UBE* per dia

*1 unitat de beguda estàndard (UBE)= ½ got de cervesa = 1 got petit de vi = 1 got petit de xerès = 1 copa de licor

19. Indica el teu **grau d'acord o desacord** amb cadascuna de les següents afirmacions sobre el fet de treballar amb "bevedors problematics". S'entén per "bevedors problemàtics" les persones que fan un **consum d'alcohol de risc o perjudicial,** però n'exclou les persones dependents de l'alcohol. *(Marca un número per cadascuna).*

Afirmació	Molt d'acord	Força d'acord	D'acord	Ni d'acord ni en desacord	En desacord	Força en desacord	Molt en desacord
a)Sento que sé prou sobre les causes dels problemes de la beguda per dur a terme la meva tasca quan treballo amb bevedors	7	6	5	4	3	2	1
b) Sento que puc aconsellar adequadament els meus pacients sobre la beguda i els seus efectes	7	6	5	4	3	2	1
c) Sento que no tinc gaires motius per estar orgullós/a quan treballo amb bevedors	7	6	5	4	3	2	1
d) En general m'inclino a pensar que sóc un fracàs amb els bevedors	7	6	5	4	3	2	1
e) Vull treballar amb bevedors	7	6	5	4	3	2	1

f) El pessimisme és l'actitud més realista que es pot adoptar respecte als bevedors	7	6	5	4	3	2	1
g) Sento que tinc dret de preguntar els pacients sobre el consum d'alcohol quan és necessari	7	6	5	4	3	2	1
h) Sento que els meus pacients creuen que tinc el dret de preguntar-los sobre la beguda quan és necessari	7	6	5	4	3	2	1
i) En general, és gratificant treballar amb bevedors	7	6	5	4	3	2	1
j) En general, em cauen bé els bevedors	7	6	5	4	3	2	1

20. Indica el teu **grau d'acord o desacord** amb cadascuna de les següents afirmacions sobre el fet de treballar amb persones que són **dependents de l'alcohol o tenen un problema greu amb l'alcohol ("alcohòlics").** *(Marca un número per cadascuna).*

Afirmació	Molt d'acord	Força d'acord	D'acord	Ni d'acord ni en desacord	En desacord	Força desacord	Molt en desacord
a) Sento que sé prou sobre les causes dels problemes de la beguda per dur a terme la meva tasca quan treballo amb bevedors	7	6	5	4	3	2	1
b) Sento que puc aconsellar adequadament els meus pacients sobre la beguda i els seus efectes	7	6	5	4	3	2	1
c) Sento que no tinc gaires motius per estar orgullós/a quan treballo amb bevedors	7	6	5	4	3	2	1
d) En general m'inclino a pensar que sóc un fracàs amb els bevedors	7	6	5	4	3	2	1
e) Vull treballar amb bevedors	7	6	5	4	3	2	1
f) El pessimisme és l'actitud més realista que es pot adoptar respecte als bevedors	7	6	5	4	3	2	1
g) Sento que tinc dret de preguntar els pacients sobre el consum d'alcohol quan és necessari	7	6	5	4	3	2	1
h) Sento que els meus pacients creuen que tinc el dret de preguntar-los sobre la beguda quan és necessari	7	6	5	4	3	2	1
i) En general, és gratificant treballar amb bevedors	7	6	5	4	3	2	1
j) En general, em cauen bé els bevedors	7	6	5	4	3	2	1

21. En el darrer any, quantes vegades has utilizat o ha sol·licitat **un test de cribratge** (p. ex. *prova d'alcoholèmia en sang, MCV, GGT, AUDIT) degut a estar* **preocupat/da** pel consum d'alcohol d'algun/a pacient? *(Marca una única resposta).*

Mai 1
D'1 a 2 vegades 2
De 3 a 5 vegades..... 3
De 6 a 12 vegades..... 4
Més de 12 vegades 5

22. En el darrer any, aproximadament **quants/es pacients ha tractat específicament** pel seu consum de risc o pels problemes relacionats amb l'alcohol? *(Marca una única resposta).*

Cap 1
D'1 a 6 pacients 2
De 7 a12 pacients..... 3

De 13 a 24 pacients..... 4
De 25 a 49 pacients 5
De 50 pacients o més 6

BLOC 4 ACTITUDS VERS LA INTERVENCIO PRECOÇ EN EL CONSUM DE RISC D'ALCOHOL

23. Les dues properes preguntes són sobre la intervenció precoç en el consum de risc d'alcohol. Això comporta fer un cribratge de pacients per identificar aquells que tenen un consum d'alcohol que n'incrementa el risc de malaltia, i l'aconsellament als bevedors problemàtics identificats sobre la reducció del consum d'alcohol.

Estudis en tot un seguit de països mostren que molts facultatius en la pràctica general destinen **molt poc temps –o gens– a la intervenció precoç de l'alcohol**. S'han indicat tot un seguit de motius que ho explicarien. Per cada afirmació, **indica en quin grau penses que el motiu al·ludit l'explica** *(Marca un número per cadascuna).*

Afirmació	**Molt**	**Força**	**Poc**	**Gens**	**No ho sé**
a) L'alcohol no és un problema important en l'especialitat de medicina de família	5	4	3	2	1
b) Els/les metges/ses estan massa ocupats/des tractant els problemes amb què es presenten els pacients	5	4	3	2	1
c) Els/les metges/ses tenen un model de formació en malaltia i no pensen en la prevenció	5	4	3	2	1
d) Els/les metges/ses pensen que la salut preventiva hauria de ser responsabilitat dels pacients, no la seva	5	4	3	2	1
e) Les pràctiques generals no estan organitzades per fer aconsellament preventiu	5	4	3	2	1
f) Els/les metges/ses se senten incòmodes quan fan preguntes sobre el consum d'alcohol perquè es pot entendre que quan es diu que algú té un problema amb l'alcohol se l'està acusant de ser alcohòlic	5	4	3	2	1
g) Els/les metges/ses no saben com identificar els bevedors problemàtics que no tenen símptomes evidents d'un consum excessiu	5	4	3	2	1
h) Els/les metges/ses no tenen una eina o test de cribratge adequat per identificar els bevedors problemàtics que no tenen símptomes evidents d'un consum excessiu	5	4	3	2	1
i) Els/les metges/ses no disposen de materials d'aconsellament adequats	5	4	3	2	1
j) Els/les metges/ses no estan formats/des en aconsellament per reduir el consum d'alcohol	5	4	3	2	1
k) Els/les metges/ses pensen que l'aconsellament sobre l'alcohol abasta la família i efectes socials més amplis, i per tant és massa difícil	5	4	3	2	1
l) Els/les metges/ses no pensen que els pacients segueixin els seus consells i canviïn la seva conducta	5	4	3	2	1
m) Els/les metges/ses mateixos tenen una actitud lliberal amb l'alcohol	5	4	3	2	1
n) Els/les metges/ses mateixos podrien tenir problemes amb l'alcohol	5	4	3	2	1
o) Els/les metges/ses pensen que als pacients els molestaria que se'ls preguntés sobre el consum d'alcohol	5	4	3	2	1
p) El pla de salut del govern no remunera els/les	5	4	3	2	1

metges/ses pel temps que destinen a fer medicina preventiva					
q) Les polítiques de salut del govern en general no donen suport als/a les metges/ses que volen exercir la medicina preventiva	5	4	3	2	1
r) L'assegurança mèdica privada no reemborsa els pacients per l'aconsellament sobre alcohol per part dels metges en l'especialitat de medicina de família	5	4	3	2	1

24. Els/les metges/ses de diversos països han indicat tot un seguit de qüestions que podrien **portar a més metges/ses a fer intervenció precoç per al consum de risc d'alcohol**. Indica per cada ítem **en quina mesura podria animar-te** personalment **a fer més intervenció** precoç per al consum de risc d'alcohol *(Marca un número per cadascuna).*

Afirmació	**Molt**	**Força**	**Poc**	**Gens**	**No ho sé**
a) Que les campanyes d'educació en salut pública en general augmentin la preocupació de la societat sobre l'alcohol	5	4	3	2	1
b) Que els pacients sol·licitessin consell sanitari sobre el consum d'alcohol	5	4	3	2	1
c) Que els pacients estiguessin disposats a pagar per a l'aconsellament sobre l'alcohol	5	4	3	2	1
d) Que es disposés de qüestionaris ràpids i fàcils sobre cribratge	5	4	3	2	1
e) Que es disposés de materials sobre aconsellament ràpids i fàcils	5	4	3	2	1
f) Que estigués provat que la intervenció en l'alcohol és un èxit	5	4	3	2	1
g) Que es disposés de programes de formació per a la intervenció precoç	5	4	3	2	1
h) Que la formació en intervenció precoç per a l'alcohol estigués reconeguda amb crèdits de formació continuada	5	4	3	2	1
i) Que el fet de proporcionar intervenció precoç per a l'alcohol estigués reconegut en la direcció per objectius (DPO)	5	4	3	2	1
j) Que es disposés immediatament de serveis de suport (autoajuda / aconsellament) per a la derivació de pacients	5	4	3	2	1
k) Que es milloressin les condicions salarials i laborals	5	4	3	2	1

BLOC 5. ACTITUDS VERS POLIITIQUES RELACIONADES AMB L'ALCOHOL

25. Indica en quin **grau estàs d'acord o en desacord** amb cadascuna de les afirmacions següents sobre les **polítiques públiques de reducció del dany relacionat amb l'alcohol**. *(Marca un número per cadascuna).*

Afirmació	Molt d'acord	D'acord	Ni d'acord ni en desacord	En desacord	Molt en desacord
a) Les persones són prou responsables per protegir-se elles mateixes del dany relacionat amb l'alcohol	5	4	3	2	1
b) Les autoritats públiques han d'intervenir per protegir les persones del dany relacionat amb l'alcohol	5	4	3	2	1
c) Els/les joves i els/les grans bevedors/es comprarien menys begudes alcohòliques com cervesa, vi o licor si el preu s'incrementés un 25%	5	4	3	2	1
d) Els controls d'alcohol aleatoris per part de la policia en les carreteres de la UE reduirien el consum d'alcohol de les persones abans de la conducció	5	4	3	2	1
e) Els nivells d'alcohol en sang per als/les conductors/es joves i els/les novells s'hauria de situar en el 0,2 g/l en tots els 27 estats membres de la Unió Europea	5	4	3	2	1
f) La venda i el servei d'alcohol als/les menors de 18 anys s'haurien de prohibir en tots els estats membres de la UE	5	4	3	2	1
g) La publicitat sobre l'alcohol adreçada als/les joves hauria d'estar prohibida en tots els estats membres de la UE	5	4	3	2	1
h) S'han de col·locar etiquetes d'advertiment en les ampolles d'alcohol amb la finalitat d'informar a les embarassades i els conductors dels perills de beure alcohol	5	4	3	2	1
i) S'han de col·locar advertiments en els anuncis sobre alcohol per tal d'informar les embarassades i els conductors dels perills de beure alcohol	5	4	3	2	1
j) Les persones comprarien més begudes alcohòliques com la cervesa, el vi o licors si el preu baixés un 25%	5	4	3	2	1

26. **Com d'efectives creus** que podrien ser les següents **mesures** per tal de reduir els danys relacionats amb l'alcohol **a Catalunya**? *(Marca un número per cadascuna).*

Afirmació	Molt efectiva	Força efectiva	Lleugerament efectiva	Inefectiva	Sense cap opinió
a) Augmentar l'edat mínima legal per beure alcohol	5	4	3	2	1
b) Augmentar l'edat mínima legal per comprar alcohol per a tots els tipus de begudes alcohòliques	5	4	3	2	1
c) Baixar els nivells permesos d'alcohol en sang per a tots els conductors	5	4	3	2	1
d) Millorar l'educació sobre l'alcohol a les escoles	5	4	3	2	1
e) Augmentar les restriccions sobre la publicitat d'alcohol	5	4	3	2	1
f) Mantenir o introduir el monopoli del govern en la venda al detall d'alcohol	5	4	3	2	1
g) Establir la fixació d'un preu mínim per l'alcohol	5	4	3	2	1
h) Augmentar els preus de l'alcohol per mitjà dels impostos	5	4	3	2	1
i) Reduir el nombre i l'horari comercial dels establiments amb llicència de venda i consum de begudes alcohòliques	5	4	3	2	1
j) Augmentar la regulació de les vendes d'alcohol en establiments només amb llicència de venda (p. ex. supermercats, establiments sense llicència de consum)	5	4	3	2	1

k) Fer de la salut pública un criteri per a l'atorgament i la renovació de llicències per a la venda d'alcohol	5	4	3	2	1
l) Introduir programes obligatoris per a la identificació precoç i la intervenció breu de les persones amb un consum d'alcohol de risc i perjudicial en l'atenció primària	5	4	3	2	1

BLOC 6. CATALUNYA

27. **Recordes** haver emplenat una **versió anterior d'aquest qüestionari**?

Sí ☐
No ☐

28. **Coneixes algun programa preventiu a Catalunya** relacionat amb l'alcohol a l'Atenció Primària?

Sí ☐ Indica el nom: ☐
No ☐ (Passar a la P30)

29. Valora la **utilitat global d'aquest programa** preventiu.

No gaire útil 1
Una mica útil 2
Mitjanament útil 3
Bastant útil..... 4
Molt útil 5

30. Ets **referent** del Beveu Menys?

Sí ☐
No ☐

31. Si vols expressar **la teva opinió o fer algun comentari** sobre el qüestionari o qualsevol altre aspecte dels problemes d'alcohol, utilitza l'espai següent:

GRÀCIES PER EMPLENAR AQUEST QÜESTIONARI

Ministério da Saúde

Optimização nas Intervenções em Cuidados de Saúde no contexto dos Problemas Ligados ao Álcool

Questionário sobre as Atitudes dos Médicos de Família na Prevenção

Projeto Europeu ODHIN - Optimizing Delivery of Healthcare Interventions

European Union Collaborative Project

Grupo Técnico para o Desenvolvimento dos Cuidados de Saúde Primários
IDT (Instituto da Droga e da Toxicodependência) / SICAD (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências)

Assinale, por favor, a opção correspondente à sua resposta ou escreva a sua resposta no local indicado. Todas as respostas a este questionário são confidenciais.

1. Há quantos anos exerce Medicina Geral e Familiar (MGF)?

2. Em que ano nasceu?

3. Qual o seu sexo?
Por favor, seleccione

4. A sua prática clínica insere-se num contexto:
Por favor, seleccione

5. Exerce a sua prática clínica:
Por favor, seleccione

6. Para além de si, quantos médicos de família (MF) se encontram a exercer a tempo inteiro, no seu local de trabalho?

7. Quantos dias por semana exerce a prática clínica de MGF?

8. Quantos doentes de MGF atende em média por semana?
Por favor, seleccione

9. No total, quantas horas recebeu de formação pós-graduada, de educação médica contínua ou supervisão clínica nas áreas do álcool e problemas relacionados?
Por favor, seleccione

10. Atualmente, tendo em consideração todas as suas responsabilidades para com os doentes, qual o grau de prioridade que atribui à prevenção de doenças na sua prática clínica?
Por favor seleccione

11. Comparado com outros MF que conheça, quanto ênfase coloca na prevenção de doenças, na sua prática clínica?
Por favor, seleccione

12. Se o doente não o/a questiona sobre questões ligadas ao álcool, questiona-o / costuma questioná-lo?
Por favor, seleccione

13. Enumere, por favor, as situações típicas que o/a levam a falar sobre álcool.

14. Alguns profissionais de saúde crêem que os comportamentos seguintes estão relacionados com a saúde. Qual a importância que atribui a cada um deles na promoção da saúde da maioria dos indivíduos? *(por favor, assinale o número pretendido para cada opção)*

	Muito Importante (4)	Importante (3)	Pouco Importante (2)	Sem Importância (1)
a. Não fumar	○	○	○	○
b. Exercício físico regular	○	○	○	○
c. Reduzir o consumo de bebidas alcoólicas	○	○	○	○
d. Evitar calorias em excesso	○	○	○	○
e. Reduzir o stress	○	○	○	○
f. Uso responsável de fármacos prescritos	○	○	○	○
g. Não consumir drogas ilícitas	○	○	○	○

15. Indique por favor a frequência com que obtém informação dos seus doentes sobre cada uma das áreas seguintes: *(por favor, assinale o número pretendido para cada opção)*

	Sempre (4)	Quando indicado (3)	Ocasionalmente (2)	Raramente/Nunca (1)
a. Não fumar	○	○	○	○
b. Exercício físico regular	○	○	○	○
c. Reduzir o consumo de bebidas alcoólicas	○	○	○	○
d. Evitar calorias em excesso	○	○	○	○
e. Reduzir o stress	○	○	○	○
f. Uso responsável de fármacos prescritos	○	○	○	○
g. Não consumir drogas ilícitas	○	○	○	○

16. Os médicos apresentam diferenças no seu treino e aptidão para fazer aconselhamento. Explicite o nível de preparação que sente para aconselhar doentes em cada uma das áreas seguintes: *(por favor, assinale o número pretendido para cada opção)*

	Bem preparado (4)	Preparado (3)	Mal preparado (2)	Muito mal preparado (1)
a. Não fumar	○	○	○	○
b. Exercício físico regular	○	○	○	○
c. Reduzir o consumo de bebidas alcoólicas	○	○	○	○
d. Evitar calorias em excesso	○	○	○	○
e. Reduzir o stress	○	○	○	○
f. Uso responsável de fármacos prescritos	○	○	○	○
g. Não consumir drogas ilícitas	○	○	○	○

17. Quão **eficaz** sente que é ao ajudar os seus doentes a modificar cada um dos comportamentos seguintes? *(por favor, assinale o número pretendido para cada opção)*

	Muito eficaz (4)	Eficaz (3)	Ineficaz (2)	Muito ineficaz (1)
a. Não fumar	○	○	○	○
b. Exercício físico regular	○	○	○	○
c. Reduzir o consumo de bebidas alcoólicas	○	○	○	○
d. Evitar calorias em excesso	○	○	○	○
e. Reduzir o stress	○	○	○	○
f. Uso responsável de fármacos prescritos	○	○	○	○
g. Não consumir drogas ilícitas	○	○	○	○

18. Em geral, **sendo dados informação e treino adequados**, qual considera ser o nível de eficácia que os MF **poderiam** obter no auxílio a doentes para que modifiquem cada um dos comportamentos seguintes? *(por favor, assinale o número pretendido para cada opção)*

	Muito eficaz (4)	Eficaz (3)	Ineficaz (2)	Muito ineficaz (1)
a. Não fumar	○	○	○	○
b. Exercício físico regular	○	○	○	○
c. Reduzir o consumo de bebidas alcoólicas	○	○	○	○
d. Evitar calorias em excesso	○	○	○	○
e. Reduzir o stress	○	○	○	○
f. Uso responsável de fármacos prescritos	○	○	○	○
g. Não consumir drogas ilícitas	○	○	○	○

19. Para um adulto saudável, qual considera ser o limite máximo de consumo de álcool antes de o aconselhar a reduzir?
Indique por favor em número de bebidas padrão/unidades* por semana **ou** em número de bebidas padrão/unidades* por dia.

**1 bebida padrão = 3 dl de cerveja = 1,65 dl de vinho = 0,5 dl de um aperitivo/aguardente*

	Número de bebidas padrão/unidades* por semana	Número de bebidas padrão/unidades* por dia
Homem		
Mulher que não está grávida		

20. Indique o seu nível de concordância com cada uma das seguintes afirmações sobre como lidar com "consumidores de bebidas alcoólicas problemáticos", expressão que se refere a pessoas que **têm um consumo de risco ou nocivo**, mas exclui aqueles que são dependentes do álcool. *(por favor, assinale o número pretendido para cada opção)*

	Concordo plenamente (7)	Concordo bastante (6)	Concordo (5)	Não concordo nem discordo (4)	Discordo (3)	Discordo bastante (2)	Discordo plenamente (1)
a. Sinto que sei o suficiente acerca das causas dos problemas ligados ao álcool para desempenhar o meu papel quando lido com consumidores de bebidas alcoólicas problemáticos	○	○	○	○	○	○	○
b. Sinto que consigo aconselhar apropriadamente os meus doentes acerca do consumo de álcool e dos seus efeitos	○	○	○	○	○	○	○
c. Sinto que não tenho muitos motivos de orgulho quando lido com consumidores de bebidas alcoólicas	○	○	○	○	○	○	○
d. Tendo tudo em consideração, sinto-me inclinado a sentir insucesso quando lido com consumidores de bebidas alcoólicas	○	○	○	○	○	○	○
e. Quero trabalhar com consumidores de bebidas alcoólicas	○	○	○	○	○	○	○
f. Pessimismo é a atitude mais realista a adoptar perante consumidores de bebidas alcoólicas problemáticos	○	○	○	○	○	○	○
g. Sinto que tenho o direito de questionar os doentes acerca dos seus hábitos alcoólicos, quando necessário	○	○	○	○	○	○	○
h. Sinto que os meus doentes acreditam que tenho o direito de os questionar sobre os seus hábitos alcoólicos, quando necessário	○	○	○	○	○	○	○
i. Em geral, é gratificante trabalhar com consumidores de bebidas alcoólicas	○	○	○	○	○	○	○
j. Em geral, gosto de lidar com consumidores de bebidas alcoólicas problemáticos	○	○	○	○	○	○	○

21. Indique o seu nível de concordância com cada uma das seguintes afirmações sobre como lidar com **pessoas dependentes de álcool ou com graves problemas relacionados com o consumo de álcool ("doentes alcoólicos")**. *(por favor, assinale o número pretendido para cada opção)*

	Concordo plenamente (7)	Concordo bastante (6)	Concordo (5)	Não concordo nem discordo (4)	Discordo (3)	Discordo bastante (2)	Discordo plenamente (1)
a. Sinto que sei o suficiente acerca das causas dos problemas ligados ao álcool para desempenhar o meu papel quando lido com alcoólicos problemáticos	○	○	○	○	○	○	○
b. Sinto que consigo aconselhar apropriadamente os meus doentes acerca do consumo de álcool e dos seus efeitos	○	○	○	○	○	○	○
c. Sinto que não tenho muitos motivos de orgulho quando lido com doentes alcoólicos	○	○	○	○	○	○	○
d. Tendo tudo em consideração, sinto-me inclinado a sentir insucesso quando lido com doentes alcoólicos	○	○	○	○	○	○	○
e. Quero trabalhar com doentes alcoólicos	○	○	○	○	○	○	○
f. Pessimismo é a atitude mais realista a adoptar perante doentes alcoólicos	○	○	○	○	○	○	○
g. Sinto que tenho o direito de questionar os doentes acerca dos seus hábitos alcoólicos, quando necessário	○	○	○	○	○	○	○
h. Sinto que os meus doentes acreditam que tenho o direito de os questionar sobre os seus hábitos alcoólicos, quando necessário	○	○	○	○	○	○	○
i. Em geral, é gratificante trabalhar com doentes alcoólicos	○	○	○	○	○	○	○
j. Em geral, gosto de lidar com doentes alcoólicos	○	○	○	○	○	○	○

22. No último ano, quantas vezes realizou ou requisitou análises sanguíneas (por exemplo, taxa de alcoolemia, VGM, g-GT) **por estar preocupado(a)** com o consumo de bebidas alcoólicas? *(por favor, assinale a opção pretendida)*

- ○ Nunca
- ○ 1 – 2 vezes
- ○ 3 – 5 vezes
- ○ 6 – 12 vezes
- ○ Mais de 12 vezes

23. No último ano, cerca de quantos doentes aconselhou/orientou especificamente devido ao seu consumo perigoso de bebidas alcoólicas ou a problemas relacionados com o álcool? *(por favor, assinale a opção pretendida)*

- Nenhum
- 1 – 6 doentes
- 7 – 12 doentes
- 13 – 24 doentes
- 25 - 49 doentes
- 50 ou mais doentes

As próximas duas perguntas são acerca da intervenção precoce sobre o consumo de risco e nocivo de bebidas alcoólicas, o que implica rastrear os doentes para identificar os indivíduos cujo consumo de álcool os coloca em risco aumentado de doença e, consequentemente, aconselhar os consumidores de bebidas alcoólicas, identificados como problemáticos, a reduzirem o seu consumo.

24. Inquéritos em vários países revelaram que muitos médicos de MGF investem muito pouco ou nenhum tempo na intervenção precoce sobre o consumo de bebidas alcoólicas. Várias razões foram sugeridas para explicar este desinvestimento. Indique, por favor, em que medida, na sua opinião, cada uma das razões se aplica, assinalando o número apropriado.

	Muito (5)	Bastante (4)	Pouco (3)	Nada (2)	NS/NR (1)
a. O álcool não é uma questão importante em MGF					
b. Os médicos já estão demasiado ocupados com a resolução dos problemas que lhes são apresentados pelos doentes					
c. Os médicos foram treinados num modelo centrado nas doenças e não pensam na prevenção					
d. Os médicos pensam que a prevenção é responsabilidade do doente e não deles					
e. Os médicos não são suficientemente incentivados a trabalharem as questões ligadas ao álcool no modelo de contratualização actual em MGF					
f. Os médicos sentem desconforto ao colocarem perguntas sobre o consumo de álcool porque dizer a alguém que tem um problema com o álcool tende a ser interpretado como estar a acusar essa pessoa de ser alcoólica					
g. Os médicos não sabem identificar consumidores problemáticos que não exibam sintomas óbvios de consumo excessivo de bebidas alcoólicas					
h. Os médicos não dispõem de uma ferramenta de rastreio adequada para identificar consumidores problemáticos que não exibam sintomas óbvios de consumo excessivo de bebidas alcoólicas					
i. Os médicos não têm disponíveis materiais de apoio apropriados para o aconselhamento					
j. Os médicos não são treinados no aconselhamento para a redução do consumo de bebidas alcoólicas					
k. Os médicos acreditam que o aconselhamento em questões ligadas ao álcool envolve efeitos familiares e sociais mais alargados e que é, por isso, demasiado difícil					
l. Os médicos não acreditam que os pacientes seguiriam os seus conselhos e alterariam o seu comportamento					
m. Os próprios médicos têm uma atitude permissiva em relação ao álcool					
n. Os próprios médicos podem ter problemas de consumo de bebidas alcoólicas					
o. Os médicos acreditam que os pacientes ficariam ressentidos se fossem interrogados sobre o seu consumo de bebidas alcoólicas					

25. Médicos em vários países têm sugerido diversas medidas que poderiam levar mais médicos a intervir precocemente sobre o consumo excessivo de bebidas alcoólicas. Indique, por favor, para cada afirmação, em que medida esta o(a) levaria a realizar um maior número de intervenções precoces sobre o consumo excessivo de bebidas alcoólicas, assinalando o número apropriado.

	Muito (5)	Bastante (4)	Pouco (3)	Nada (2)	NS/NR (1)
a. Campanhas educativas de saúde pública que, em geral, aumentaram a preocupação da sociedade sobre o álcool					
b. Pedido de aconselhamento, por parte dos doentes, sobre o consumo de bebidas alcoólicas					
c. Disponibilidade de questionários de rastreio de preenchimento rápido e simples					
d. Disponibilidade de materiais de aconselhamento de exposição rápida e simples					
e. Comprovação do sucesso da intervenção precoce sobre o consumo de bebidas alcoólicas					
f. Disponibilidade de programas de treino relativos à intervenção precoce sobre o consumo de bebidas alcoólicas					
g. Atribuição de incentivos financeiros pela intervenção precoce sobre o consumo de bebidas alcoólicas					
h. Disponibilidade de serviços de apoio geral (auto-ajuda/aconselhamento) para os quais os doentes podem ser rapidamente encaminhados					
i. Melhoria do salário e condições de trabalho					

26. Nos últimos dez anos, quão eficazes considera terem sido/poderiam ter sido as seguintes medidas governamentais para reduzir os malefícios relacionados com o álcool em Portugal? *(por favor, assinale o número pretendido para cada opção)*

	Muito eficaz (5)	Bastante eficaz (4)	Ligeiramente eficaz (3)	Ineficaz (2)	NS/NR (1)
a. Promoção de uma cultura de "consumo responsável" de bebidas alcoólicas	○	○	○	○	○
b. Promoção de guidelines recomendadas relativas aos limites do consumo de bebidas alcoólicas e educação para a saúde	○	○	○	○	○
c. Instituição de horários de abertura mais flexíveis em estabelecimentos com licença para venda de bebidas alcoólicas	○	○	○	○	○
d. Regras mais restritas relativamente ao conteúdo da publicidade a bebidas alcoólicas	○	○	○	○	○
e. Controle mais rigoroso na atribuição de licenças para venda de bebidas alcoólicas	○	○	○	○	○
f. Aumento dos poderes legais para fazer cumprir e penalizar os incumprimentos da lei	○	○	○	○	○
g. Proibição do consumo de bebidas alcoólicas em locais públicos ou abertos ao público por quem se apresente notoriamente embriagado	○	○	○	○	○
h. Possibilidade de recusar o acesso ou permanência nos estabelecimentos a quem provoque distúrbios ou estragos devido ao consumo de bebidas alcoólicas	○	○	○	○	○
i. Aplicação de sanções mais severas do ponto de vista judicial sobre o comportamento embriagado	○	○	○	○	○
j. Aumento do acesso a intervenções breves para prevenção de problemas relacionados com o consumo de bebidas alcoólicas	○	○	○	○	○
k. Aumento do acesso ao tratamento de problemas relacionados com o consumo de bebidas alcoólicas	○	○	○	○	○
l. Introdução de estratégias locais relativas ao consumo nocivo de bebidas alcoólicas	○	○	○	○	○

27. Na redução dos malefícios relacionados com o álcool em Portugal, quão eficazes considera que poderiam ser as medidas seguintes? *(por favor, assinale o número pretendido para cada opção)*

	Muito eficaz (5)	Bastante eficaz (4)	Ligeiramente eficaz (3)	Ineficaz (2)	NS/NR (1)
a. Aumentar a idade legal mínima para o consumo de bebidas alcoólicas	○	○	○	○	○
b. Aumentar a idade legal mínima para a compra de bebidas alcoólicas	○	○	○	○	○
c. Diminuir o limite da taxa de alcoolémia autorizada nos condutores	○	○	○	○	○
d. Melhorar a educação sobre o álcool nas escolas	○	○	○	○	○
e. Aumentar as restrições para a publicidade de bebidas alcoólicas na televisão e no cinema	○	○	○	○	○
f. Monopólio estatal sobre a venda de retalho de bebidas alcoólicas	○	○	○	○	○
g. Instituir um preço mínimo na venda de unidades de álcool	○	○	○	○	○
h. Mudança geral do preço de bebidas alcoólicas através do aumento dos impostos sobre estas	○	○	○	○	○
i. Regulação adicional sobre a venda de bebidas alcoólicas em estabelecimentos onde não é permitido o seu consumo (por exemplo, supermercados)	○	○	○	○	○
j. Valorizar a saúde pública como um critério para a decisão de atribuição de licenças de venda de bebibas alcoólicas	○	○	○	○	○
k. Regulação prevista por lei da indústria relacionada com o álcool	○	○	○	○	○

28. Recorda-se de ter preenchido uma versão anterior deste questionário há dez anos?

Por favor, seleccione

29. Se desejar expressar outras opiniões ou deixar algum comentário sobre o questionário ou qualquer outro aspecto dos problemas relacionados com o álcool, utilize, por favor, o espaço abaixo.

OBRIGADO POR PREENCHER ESTE QUESTIONÁRIO!

Submeter

Page **1** of **1**

ODHIN - Společná studie Evropské unie
Dotazník pro praktické lékaře

Identif

Vážená paní doktorko, vážený pane doktore,

dovolujeme si Vás požádat o účast ve výzkumu, který probíhá v devíti zemích Evropské unie. Jeho cílem je optimalizovat úlohu praktických lékařů ve formování zdravého životního stylu populace. Účast ve výzkumu je anonymní, proto nikde neuvádějte své jméno. Všechny Vaše odpovědi v tomto dotazníku jsou považovány za důvěrné. Prosím, zaškrtněte políčko, které odpovídá Vaší odpovědi, nebo svoji odpověď zapište do označeného místa. Státní zdravotní ústav, Lékařské informační centrum

1

2

3

1. Kolik let pracujete jako praktický lékař?

☐ let

2. **V kterém roce jste se narodil/a**

☐ 19___

4

3. Jste:

muž ☐
žena ☐

5

4. Svoji praxi vykonáváte:

ve městě? ☐
na venkově? ☐
jak ve městě, tak na venkově? ☐

5.

Jste: Samostatně pracující praktický lékař ☐
Praktický lékař -zaměstnanec ☐

6

6. Kolik praktických lékařů přepočtených na plný pracovní úvazek působí včetně vás ve vašem zařízení? (Nepočítejte samostatně působící PL ve stejné budově.)

☐

7

7. Kolik dnů v týdnu pracujete v ordinaci praktického lékaře?

☐

8

8. Kolik pacientů přibližně vyšetříte během průměrného týdne v ordinaci praktického lékaře?

0 – 50 ☐
51 – 100 ☐
101 – 150 ☐
Více než 150 ☐

9. Kolik hodin postgraduálního školení, kontinuálního zdravotnického vzdělávání nebo klinické supervize o alkoholu a problémech spojených s alkoholem jste celkem absolvoval/a?

Žádné ☐
Méně než 4 hodiny ☐
4-10 hodin ☐
11-40 hodin ☐
Více než 40 hodin ☐
Nevím/nepamatuji se ☐

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10. Pokud vezmete v úvahu všechny vaše současné povinnosti vůči pacientům, jak vysokou prioritu přisuzujete v současné době **prevenci onemocnění** jako jednomu z aspektů vaší praxe?

Hodně vysokou	
Poměrně vysokou	
Poměrně nízkou	
Velmi nízkou	

11

11. Jak velký důraz kladete ve své praxi na prevenci onemocnění v porovnání s jinými lékaři, které znáte?

Mnohem více	
Poněkud více	
Poněkud méně	
Mnohem méně	

12

12. Pokud se vás pacient nezeptá na alkohol sám, zeptáte se na něj vy?

Pokaždé	
Většinou	
Někdy	
Zřídka nebo nikdy	

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14. Níže jsou uvedeny typy chování, které podle názoru některých odborníků souvisejí se zdravím. Jakou důležitost podle vás má každý z následujících typů chování při **podpoře zdraví u průměrné osoby?** *(Prosím, zakroužkujte jedno číslo u každého výroku)*

Chování	**Velmi důležité**	**Důležité**	**Poměrně důležité**	**Nevýznamné**
a. Nekuřáctví	4	3	2	1
b. Pravidelné cvičení	4	3	2	1
c. Pití alkoholu s mírou	4	3	2	1
d. Vyhýbání se nadměrným kaloriím	4	3	2	1
e. Snižování stresu	4	3	2	1
f. Odpovědné užívání léků na předpis	4	3	2	1
g. Neužívání zakázaných drog	4	3	2	1

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15. Prosím, označte **rozsah, v jakém získáváte informace** od svých pacientů v každé z následujících oblastí: *(Prosím zakroužkujte jedno číslo u každého výroku).*

Chování	**Vždy**	**Jak je požadováno**	**Občas**	**Zřídka/nikdy**
a. Nekuřáctví	4	3	2	1
b. Pravidelné cvičení	4	3	2	1
c. Pití alkoholu s mírou	4	3	2	1
d. Vyhýbání se nadměrným kaloriím	4	3	2	1
e. Snižování stresu	4	3	2	1
f. Odpovědné užívání léků na předpis	4	3	2	1
g. Neužívání zakázaných drog	4	3	2	1

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16. Lékaři se liší ve svých poradenských dovednostech a odborné přípravě. Jak **připravený/á** se cítíte pro poskytování poradenství pacientům v každé z následujících oblastí: *(Prosím, zakroužkujte jedno číslo u každého výroku)*.

Chování	**Velmi připravený/á**	**Připravený/á**	**Nepřipravený /á**	**Velmi nepřipravený/ á**
a. Nekuřáctví	4	3	2	1
b. Pravidelné cvičení	4	3	2	1
c. Omezování spotřeby alkoholu	4	3	2	1
d. Vyhýbání se nadměrným kaloriím	4	3	2	1
e. Snižování stresu	4	3	2	1
f. Odpovědné užívání léků na předpis	4	3	2	1
g. Neužívání zakázaných drog	4	3	2	1

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17. Jak **efektivní** jste, podle vlastního mínění, při pomoci pacientům dosáhnout změny v každé z následujících oblastí? *(Prosím zakroužkujte jedno číslo u každého výroku)*

Chování	**Velmi efektivní**	**Efektivní**	**Neefektivní**	**Velmi neefektivní**
a. Nekuřáctví	4	3	2	1
b. Pravidelné cvičení	4	3	2	1
c. Omezování spotřeby alkoholu	4	3	2	1
d. Vyhýbání se nadměrným kaloriím	4	3	2	1
e. Snižování stresu	4	3	2	1
f. Odpovědné užívání léků na předpis	4	3	2	1
g. Neužívání zakázaných drog	4	3	2	1

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18. Jak efektivní by praktičtí lékaři **mohli** obecně být v úsilí pomoci pacientům změnit chování v každé z následujících oblastí, **pokud by dostali odpovídající informace a výcvik?** *(Prosím zakroužkujte jedno číslo každého výroku)*.

Chování	**Velmi efektivní**	**Efektivní**	**Neefektivní**	**Velmi neefektivní**
a. Nekuřáctví	4	3	2	1
b. Pravidelné cvičení	4	3	2	1
c. Omezování spotřeby alkoholu	4	3	2	1
d. Vyhýbání se nadměrným kaloriím	4	3	2	1
e. Snižování stresu	4	3	2	1
f. Odpovědné užívání léků na předpis	4	3	2	1
g. Neužívání zakázaných drog	4	3	2	1

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19. Co považujete za horní hranici spotřeby alkoholu u zdravého dospělého muže, abyste mu doporučil/a spotřebu omezit?

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Prosím uveďte jako počet …… standardních nápojů* za týden

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nebo jako jako počet …… standardních nápojů* za za den

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Co považujete za horní hranici spotřeby alkoholu u zdravé dospělé ženy, která není těhotná, abyste jí doporučil/a spotřebu omezit?

52

Prosím uveďte jako počet …… standardních nápojů* za týden

nebo jako jako počet …… standardních nápojů* za za den

*1 standardní nápoj = 0,5 litru piva = 1 sklenka vína (2 dl) 1 sklenka tvrdého alkoholu (0,5 dl)

20. Uveďte, do jaké míry souhlasíte nebo nesouhlasíte s každým z následujících výroků o práci s „problémovými pijáky“. Termínem „problémoví pijáci“ se v této otázce rozumí lidé, kteří alkohol konzumují **rizikovým nebo škodlivým** způsobem, ale nepatří sem lidé, kteří jsou na alkoholu závislí.

Výrok	**Silně souhlasím**	**Poměrně silně souhlasím**	**Souhlasím**	**Nemohu ani souhlasit, ani nesouhlasit**	**Nesouhlasím**	**Poměrně silně nesouhlasím**	**Silně nesouhlasím**
a. Domnívám se, že příčiny potíží s nadměrným pitím alkoholu znám natolik, abych mohl/a pracovat s pijáky.	7	6	5	4	3	2	1
b. Domnívám se, že umím svým pacientům poskytnout náležité rady, pokud se týká pití alkoholu a jeho účinků.	7	6	5	4	3	2	1
c. Domnívám se, že pokud se týká práce s pijáky, není toho moc, na co bych mohl/a být hrdý/á	7	6	5	4	3	2	1
d. Celkem vzato mám pocit, že se mi s pijáky pracovat nedaří	7	6	5	4	3	2	1
e. Chci pracovat s pijáky	7	6	5	4	3	2	1
f. Pesimismus je nejvíce realistický přístup, který je třeba k pijákům zaujmout	7	6	5	4	3	2	1

53 54 55 56 57 58 59 60 61 62

g. Domnívám se, že mám právo se pacientů na pití alkoholu v případě potřeby zeptat	7	6	5	4	3	2	1
h. Domnívám se, že mí pacienti mají za to, že mám právo se jich na pití alkoholu v případě potřeby zeptat	7	6	5	4	3	2	1
i. Obecně stojí za to s pijáky pracovat	7	6	5	4	3	2	1
j. Celkem vzato mám pijáky rád/a	7	6	5	4	3	2	1

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21. Uveďte, do jaké míry souhlasíte nebo nesouhlasíte s každým z následujících výroků o práci s lidmi, kteří jsou **závislí na alkoholu nebo mají s alkoholem vážné problémy („alkoholiky").**

Výrok	**Silně souhlasím**	**Poměrně silně souhlasím**	**Souhlasím**	**Nemohu ani souhlasit, ani nesouhlasit**	**Nesouhlasím**	**Poměrně silně nesouhlasím**	**Silně nesouhlasím**
a. Domnívám se, že příčiny potíží s nadměrným pitím alkoholu znám natolik, abych mohl/a plnit svoji roli při práci s alkoholiky.	7	6	5	4	3	2	1
b. Domnívám se, že mohu svým pacientům poskytnout náležité rady, pokud se týká pití alkoholu a jeho účinků	7	6	5	4	3	2	1
c. Domnívám se, že pokud se týká práce s alkoholiky , není toho moc, na co bych mohl/a být hrdý/á	7	6	5	4	3	2	1
d. Celkem vzato mám pocit, že se mi s alkoholiky pracovat nedaří	7	6	5	4	3	2	1
e. Chci pracovat s alkoholiky	7	6	5	4	3	2	1
f. Pesimismus je nejvíce realistický přístup, který je třeba k alkoholikům zaujmout	7	6	5	4	3	2	1
g. Domnívám se, že mám právo se pacientů na pití alkoholu v případě potřeby zeptat	7	6	5	4	3	2	1
h. Domnívám se, že mí pacienti mají za to, že mám právo se jich na pití alkoholu v případě potřeby zeptat	7	6	5	4	3	2	1
i. Obecně stojí za to s alkoholiky pracovat	7	6	5	4	3	2	1
j. Celkem vzato mám alkoholiky rád/a	7	6	5	4	3	2	1

73

22. Kolikrát jste za poslední rok využil/a nebo zažádal/a o nějaký ***screeningový nástroj*** *(např. na zjištění alkoholu v krvi, MCV, GGT, dotazník AUDIT)* **kvůli podezření** na konzumaci alkoholu? *(Prosím, zakroužkujte jedno číslo).*

Nikdy 1
1x – 2x 2
3x – 5x 3
6x – 12x 4
více než 12x 5

74

23. Kolik pacientů jste za poslední rok vyšetřil/a konkrétně v souvislosti s jejich rizikovým pitím nebo problémy souvisejícími s alkoholem?

Žádné 1
1 – 6 pacientů 2
7 – 12 pacientů 3
13 – 24 pacientů 4
25 – 49 pacientů 5
50 nebo více pacientů..... 6

24. Následující dvě otázky se týkají časné intervence u rizikové konzumace alkoholu. Patří sem screening pacientů za účelem zjištění těch, které konzumace alkoholu vystavuje zvýšenému riziku onemocnění, a následné lékařské poradenství poskytované identifikovaným problémovým pijákům zaměřené na snižování jejich konzumace alkoholu.
Dotazníková šetření v řadě zemí zjistila, že mnoho praktických lékařů ve své praxi obecně věnovalo časné intervenci týkající se alkoholu velice málo času nebo vůbec žádný čas. Byly uváděny různé důvody, proč by tomu tak mohlo být. U každého důvodu zakroužkováním odpovídající číslice uveďte prosím, do jaké míry podle vás platí.

Výrok	**Hodně**	**Po-měr-ně hodně**	**Málo**	**Vůbec ne**	**Nevím**		
a. Alkohol není v praxi všeobecného lékaře důležitou problematikou	5	4	3	2	1		
b. Lékaři jsou jenom příliš zaneprázdněni řešením problémů, se kterými za nimi lidé přicházejí	5	4	3	2	1	75	
c. Vzdělání lékařů je založeno na modelu nemoci, takže o prevenci nepřemýšlejí	5	4	3	2	1	76	
d. Lékaři si myslí, že za prevenci týkající se zdraví nesou odpovědnost pacienti, nikoliv oni	5	4	3	2	1	77	
e. Ordinace všeobecných lékařů nejsou zařízeny na poskytování preventivního poradenství	5	4	3	2	1	78	
f. Lékaři jsou na rozpacích, když se mají pacienta zeptat na konzumaci alkoholu, protože kdyby řekli, že někdo má problém s alkoholem, mohlo by se to vnímat jako obvinění z alkoholismu	5	4	3	2	1	79	
g. Lékaři nevědí, jak identifikovat problémové pijáky, kteří nemají žádné zjevné symptomy související s nadměrným pitím.	5	4	3	2	1	80	
h. Lékaři nemají vhodný screeningový nástroj pro identifikaci problémových pijáků, kteří nemají žádné zjevné symptomy související s nadměrným pitím.	5	4	3	2	1	81	
i. Lékaři nemají k dispozici vhodné poradenské materiály	5	4	3	2	1	82	
j. Lékaři nejsou školeni, jak poskytovat poradenství o snižování konzumace alkoholu	5	4	3	2	1	83	
k. Lékaři jsou přesvědčeni, že poradenství týkající se konzumace alkoholu zahrnuje rodinu a širší sociální vlivy, a proto je příliš obtížné	5	4	3	2	1	84	
l. Lékaři nejsou přesvědčeni, že by pacienti jejich radu přijali, a změnili své chování	5	4	3	2	1	85	
m. Lékaři samotní mají k alkoholu liberální postoj	5	4	3	2	1	86	
n. Lékaři samotní mohou mít problémy s alkoholem	5	4	3	2	1	87	
o. Lékaři se domnívají, že by pacienti nelibě nesli, pokud by se jich někdo zeptal na konzumaci alkoholu	5	4	3	2	1	88	
p. Státní systém zdravotní péče lékařům nehradí čas, který věnují preventivní medicíně	5	4	3	2	1	89	
q. Politika vlády v oblasti zdravotní péče obecně nepodporuje lékaře, kteří chtějí vykonávat preventivní medicínu	5	4	3	2	1	90	
r. Soukromé zdravotní pojištění nehradí pacientům poradenství PL související s konzumací alkoholu	5	4	3	2	1	91	
						92	

25. Lékaři v řadě zemí navrhli různá opatření, v jejichž důsledku by se více lékařů mohlo zabývat časnou intervencí u rizikové konzumace alkoholu. Uveďte zakroužkováním odpovídající odpovědi u každé položky, do jaké míry **by vás osobně** povzbudily k zvýšenému provádění časné intervence u rizikové konzumace alkoholu.
(Prosím, zakroužkujte jedno číslo u každého výroku).

Výrok	**Hodně**	**Poměrně hodně**	**Málo**	**Vůbec ne**	**Nevím**
a. Kdyby veřejné zdravotní osvětové kampaně obecně vedly společnost k většímu zájmu o otázky související s konzumací alkoholu	5	4	3	2	1
b. Kdyby pacienti požadovali zdravotní poradenství o konzumaci alkoholu	5	4	3	2	1
c. Kdyby pacienti byli ochotni uhradit poplatek za poradenství týkající se alkoholu	5	4	3	2	1
d. Kdyby byly k dispozici rychlé a snadné screeningové dotazníky	5	4	3	2	1
e. Kdyby byly k dispozici rychlé a snadné poradenské materiály	5	4	3	2	1
f. Kdyby se prokázala úspěšnost časné intervence u případů konzumace alkoholu	5	4	3	2	1
g. Kdyby byly k dispozici vzdělávací programy o časné intervenci u případů konzumace alkoholu	5	4	3	2	1
h. Kdyby školení v časné intervenci u případů konzumace alkoholu bylo započítáno do kreditů za kontinuální zdravotnické vzdělávání	5	4	3	2	1
i. Kdyby poskytování časné intervence u případů konzumace alkoholu bylo započítáno do kreditů za zajištění kvality péče	5	4	3	2	1
j. Kdyby byly k dispozici podpůrné služby (svépomoc/poradenství), na které by bylo možné pacienty odkázat	5	4	3	2	1
k. Kdyby se zlepšil plat a pracovní podmínky	5	4	3	2	1

26. Uveďte, do jaké míry souhlasíte nebo nesouhlasíte s každým z následujících výroků o veřejných politikách týkajících se snižování škod souvisejících s alkoholem v Evropě. *(Prosím, zakroužkujte jedno číslo u každého výroku).*

Výrok	**Silně souhlasím**	**Souhlasím**	**Nemohu ani souhlasit, ani nesouhlasit**	**Nesouhlasím**	**Silně nesouhlasím**	
a. Jednotlivci jsou dostatečně odpovědní, aby se před škodami souvisejícími s alkoholem ochránili sami	5	4	3	2	1	93
b. Státní orgány musí zasahovat, aby jednotlivce ochránily před škodami souvisejícími s alkoholem	5	4	3	2	1	94
c. Mladí lidé a těžcí pijáci by si kupovali **méně** alkoholických nápojů jako pivo, víno nebo tvrdý alkohol, pokud by se jejich cena **zvedla** o 25 %	5	4	3	2	1	95
d. Namátkové kontroly alkoholu prováděné policií na silnicích v EU by u lidí snížily konzumaci alkoholu před jízdou	5	4	3	2	1	96
e. Hladina alkoholu v krvi u mladých a začínajících řidičů by se měla snížit na 0,2g/l ve všech 27 členských státech Evropské unie *(pokud už není nižší)*	5	4	3	2	1	97
f. Prodej a podávání alkoholu osobám mladším 18 let by se mělo zakázat ve všech členských státech Evropské unie	5	4	3	2	1	98
g. Propagování alkoholu prostřednictvím reklamy zaměřené na mladé lidi by se mělo zakázat ve všech členských státech Evropské unie	5	4	3	2	1	99
h. **Lahve** s obsahem alkoholu by se měly opatřit varováním, které by těhotné ženy a řidiče upozorňovalo na nebezpečí související s pitím alkoholu	5	4	3	2	1	100
i. **Reklamy** na alkohol by se měly opatřit varováním, které by těhotné ženy a řidiče upozorňovalo na nebezpečí související s pitím alkoholu	5	4	3	2	1	101
j. Lidé by si kupovali **více** alkoholických nápojů jako pivo, víno nebo tvrdý alkohol, pokud by se jejich cena **snížila** o 25 %	5	4	3	2	1	102
						103

27. Jak účinná mohou být podle vašeho mínění následující opatření v oblasti politik při snižování škod souvisejících s alkoholem **ve vaší zemi?** *(Prosím, zakroužkujte jedno číslo u každého výroku)*

Výrok	**Velmi účinná**	**Poměrně účinná**	**Mírně účinná**	**Neúčinná**	**Bez názoru**	
a. Zvýšení právní plnoletosti pro konzumaci alkoholu	5	4	3	2	1	104
b. Zvýšení právní plnoletosti pro nákup alkoholu u všech kategorií nápojů	5	4	3	2	1	105
c. Snížení zákonem povolené hladiny alkoholu v krvi v případech řízení po požití alkoholu u všech řidičů	5	4	3	2	1	106
d. Zlepšení osvěty ve školách zaměřené na konzumaci alkoholu	5	4	3	2	1	107
e. Zvýšení omezení reklamy na alkohol	5	4	3	2	1	108
f. Zachování nebo zavedení monopolu státu na maloobchodní prodej alkoholu	5	4	3	2	1	109
g. Zavedení stanovení minimálních cen za jednotky alkoholu	5	4	3	2	1	110
						111
						112
						113

h. Zvýšení ceny alkoholu prostřednictvím daní	5	4	3	2	1
i. Omezení hustoty a otevírací doby prodejen alkoholu	5	4	3	2	1
j. Další regulace výprodeje alkoholu (např. supermarkety, obchody s lihovinami)	5	4	3	2	1
k. Veřejné zdraví zařadit jako kritérium pro udělování a obnovování licencí na prodej alkoholu	5	4	3	2	1
l. Zavedení povinných programů časné identifikace a krátké intervence u osob s rizikovou a škodlivou konzumací alkoholu v primární péči	5	4	3	2	1

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31. Pokud byste chtěl/a vyjádřit další názory nebo komentáře k dotazníku nebo jakémukoliv aspektu problémů s alkoholem, použijte prosím níže uvedené řádky

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DĚKUJEME ZA VYPLNĚNÍ DOTAZNÍKU

STÁTNÍ ZDRAVOTNÍ ÚSTAV
SZÚ

ODHIN

Kolaborativna raziskava Evropske unije

Vprašalnik za zdravnike družinske medicine

Prosimo, označite kvadratek, ki ustreza vašemu odgovoru, ali vpišite odgovor, kjer je tako navedeno.
Vse odgovore v tem vprašalniku bomo obravnavali zaupno.

ID no

1. Koliko let delate kot zdravnik družinske medicine? 1

☐ let

2. Katerega leta ste se rodili? 2

19☐

3. Katerega spola ste? 3

Moški ☐
Ženska ☐

4. Ali je vaša ambulanta: 4

mestna? ☐
podeželska? ☐
mešano mestna/podeželska? ☐

5. Ali je na lokaciji: 5

samo ena ambulanta? ☐
več ambulant? ☐

6. Koliko »full time equivalent - FTE« zdravnikov družinske medicine <u>vključno z vami</u> dela na tej lokaciji? (*FTE = 1, če nekdo dela polni delovni čas; FTE = 0,5, če nekdo dela skrajšan delovni čas po 4 ure in sta dva takšna kolega skupaj 1 cel FTE*) 6

☐ 7

7. Koliko dni v tednu delate v ambulanti?

☐

8. Koliko bolnikov imate povprečno na teden? 8

0 – 50 ☐
50 – 100 ☐
101 – 150 ☐
Več kot 150 ☐

9. Koliko ur podiplomskega izobraževanja, stalnega strokovnega izobraževanja ali kliničnega svetovanja o alkoholu in z alkoholom povezanih težavah ste bili skupno deležni doslej? 9

Nič ☐
Manj kot 4 ure ☐
4-10 ur ☐
11-40 ur ☐
Več kot 40 ur ☐
Ne vem / ne spomnim se ☐

10. Dandanes, upoštevajoč vse vaše sedanje obveznosti glede bolnikov, kakšno prioriteto dajete **preprečevanju bolezni** kot delu vašega dela z bolniki? 10

Zelo veliko ☐
Relativno veliko ☐
Relativno majhno ☐
Zelo majhno ☐

11. Kolikšen poudarek pri svojem delu dajete preventivi bolezni v primerjavi z drugimi zdravniki, ki jih poznate? 11

Veliko večji	
Nekoliko večji	
Nekoliko manjši	
Veliko manjši	

12. Če vas bolnik sam ne vpraša glede pitja alkohola, ali ga vprašate vi? 12

Vedno	
Večinoma	
Včasih	
Redko ali nikoli	

13. Če vas bolnikov sorodnik vpraša glede pitja alkohola bolnika, ali mu svetujete? 13

Vedno	
Večinoma	
Včasih	
Redko ali nikoli	

14. V nadaljevanju so našteta vedenja, za katera nekateri medicinski strokovnjaki menijo, da so povezana z zdravjem. Kako pomembna so po vašem mnenju naslednja vedenja pri **promociji zdravja pri povprečnem posamezniku?** *(Prosimo, pri vsaki točki obkrožite po eno številko).*

Vedenje	**Zelo pomembno**	**Pomembno**	**Nekoliko pomembno**	**Nepomembno**	
a. Nekajenje	4	3	2	1	14
b. Redna telesna vadba	4	3	2	1	15
c. Malo tvegano pitje alkohola	4	3	2	1	16
d. Izogibanje presežku zaužitih kalorij	4	3	2	1	17
e. Zmanjševanje stresa	4	3	2	1	18
f. Odgovorna raba predpisanih zdravil	4	3	2	1	19
g. Izogibanje rabi nedovoljenih drog	4	3	2	1	20

15. Označite, **v kakšnem obsegu pridobite informacije** o vaših bolnikih na naslednjih področjih: *(Prosimo, pri vsaki točki obkrožite po eno številko).*

Vedenje	**Vedno**	**Kadar je potrebno**	**Občasno**	**Redko/Nikoli**	
a. Nekajenje	4	3	2	1	21
b. Redna telesna vadba	4	3	2	1	22
c. Malo tvegano pitje alkohola	4	3	2	1	23
d. Izogibanje presežku zaužitih kalorij	4	3	2	1	24
e. Zmanjševanje stresa	4	3	2	1	25
f. Odgovorna raba predpisanih zdravil	4	3	2	1	26
g. Izogibanje rabi nedovoljenih drog	4	3	2	1	27

16. Zdravniki se razlikujejo po sposobnostih svetovanja in po usposabljanju. Kako **pripravljenega,-o** se počutite vi za svetovanje na naslednjih področjih: *(Prosimo, pri vsaki točki obkrožite po eno številko).*

Vedenje	**Zelo pripravljen,-a**	**Pripravljen,-a**	**Nisem pripravljen,-a**	**Povsem nepripravljen,-a**	
a. Nekajenje	4	3	2	1	28
b. Redna telesna vadba	4	3	2	1	29
c. Malo tvegano pitje alkohola	4	3	2	1	30
d. Izogibanje presežku zaužitih kalorij	4	3	2	1	31
e. Zmanjševanje stresa	4	3	2	1	32
f. Odgovorna raba predpisanih zdravil	4	3	2	1	33
g. Izogibanje rabi nedovoljenih drog	4	3	2	1	34

17. Kako **učinkoviti** ste po vašem mnenju pri pomoči bolnikom, da spremenijo vedenje na naštetih področjih? *(Prosimo, pri vsaki točki obkrožite po eno številko).*

Vedenje	**Zelo učinkovit,-a**	**Učinkovit,-a**	**Neučinkovit,-a**	**Zelo neučinkovit,-a**
a. Nekajenje	4	3	2	1
b. Redna telesna vadba	4	3	2	1
c. Malo tvegano pitje alkohola	4	3	2	1
d. Izogibanje presežku zaužitih kalorij	4	3	2	1
e. Zmanjševanje stresa	4	3	2	1
f. Odgovorna raba predpisanih zdravil	4	3	2	1
g. Izogibanje rabi nedovoljenih drog	4	3	2	1

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18. Če gledate na splošno, kako učinkoviti **bi lahko bili** po vašem mnenju zdravniki družinske medicine pri pomoči bolnikom, da bi spremenili sovje vedenje, **če bi imeli zadosti informacij in usposabljanja**? *(Prosimo, pri vsaki točki obkrožite po eno številko).*

Vedenje	**Zelo učinkoviti**	**Učinkoviti**	**Neučinkoviti**	**Zelo neučinkoviti**
a. Nekajenje	4	3	2	1
b. Redna telesna vadba	4	3	2	1
c. Malo tvegano pitje alkohola	4	3	2	1
d. Izogibanje presežku zaužitih kalorij	4	3	2	1
e. Zmanjševanje stresa	4	3	2	1
f. Odgovorna raba predpisanih zdravil	4	3	2	1
g. Izogibanje rabi nedovoljenih drog	4	3	2	1

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19. Kakšna je po vašem mnenju zgornja meja pitja alkohola za zdravega odraslega moškega, preden bi mu svetovali zmanjšanje pitja alkohola?

49

…… standardnih meric / enot* na teden

50

…… standardnih meric / enot* na dan

Kakšna je po vašem zgornja meja pitja alkohola za zdravo odraslo žensko, preden bi ji svetovali zmanjšanje pitja alkohola?

51

…… standardnih meric / enot* na teden

52

…… standardnih odmerkov / enot* dnevno

**1 standardna merica/enota = 2,5 dcl piva = 1 dcl vina = 1 mali kozarec šerija = 1 šilce žgane pijače*

20. Označite, v kolikšni meri se strinjate ali ne strinjate z naslednjimi trditvami o delu s "problematičnimi pivci". Pri tem se izraz "problematični pivci" nanaša na ljudi, ki alkohol **pijejo tvegano ali škodljivo**, izključuje pa zasvojene z alkoholom (alkoholike).

Trditev	**Močno se strinjam**	**Kar močno se strinjam**	**Strinjam se**	**Niti se strinjam niti se ne strinjam**	**Ne strinjam se**	**Kar močno se ne strinjam**	**Močno se ne strinjam**
a. Menim, da vem dovolj o vzrokih za težave s pitjem, da lahko odigram svojo vlogo pri delu s pivci	7	6	5	4	3	2	1
b. Menim, da svojim bolnikom lahko ustrezno svetujem glede pitja in njegovega učinka	7	6	5	4	3	2	1
c. Menim, da ne morem biti ponosen na svoje delo s pivci	7	6	5	4	3	2	1
d. Na koncu koncev se mi dozdeva, da mi s pivci res ne gre	7	6	5	4	3	2	1
e. Želim delati s pivci	7	6	5	4	3	2	1
f. Pesimizem je najbolj realističen odnos do pivcev	7	6	5	4	3	2	1

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g. Menim, da imam pravico svoje bolnike vprašati o pitju alkohola, kadar je potrebno	7	6	5	4	3	2	1
h. Zdi sem mi, da moji bolniki menijo, da jih imam pravico vprašati o pitju alkohola, kadar je potrebno	7	6	5	4	3	2	1
i. Na splošno je delo s pivci v zadovoljstvo	7	6	5	4	3	2	1
j. Na splošno so mi pivci všeč	7	6	5	4	3	2	1

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21. Označite, v kolikšni meri se strinjate ali ne strinjate z naslednjimi trditvami o delu z ljudmi, ki so **zasvojeni z alkoholom ali imajo resne težave z alkoholom ("alkoholiki")**.

Trditev	**Močno se strinjam**	**Kar močno se strinjam**	**Strinjam se**	**Niti se strinjam niti se ne strinjam**	**Ne strinjam se**	**Kar močno se ne strinjam**	**Močno se ne strinjam**
a. Menim, da vem dovolj o vzrokih za težave s pitjem, da lahko odigram svojo vlogo pri delu z alkoholiki	7	6	5	4	3	2	1
b. Menim, da svojim bolnikom lahko ustrezno svetujem glede pitja in njegovega učinka	7	6	5	4	3	2	1
c. Menim, da ne morem biti ponosen na svoje delo z alkoholiki	7	6	5	4	3	2	1
d. Na koncu koncev se mi dozdeva, da mi z alkoholiki res ne gre	7	6	5	4	3	2	1
e. Želim delati z alkoholiki	7	6	5	4	3	2	1
f. Najbolj realističen odnos do alkoholikov je pesimizem	7	6	5	4	3	2	1
g. Menim, da imam svoje bolnike pravico spraševati o pitju alkohola, kadar je potrebno	7	6	5	4	3	2	1
h. Zdi se mi, da moji bolniki menijo, da jih imam pravico spraševati o pitju alkohola, kadar je potrebno	7	6	5	4	3	2	1
i. Na splošno je delo z alkoholiki v zadovoljstvo	7	6	5	4	3	2	1
j. Na splošno so mi alkoholiki všeč	7	6	5	4	3	2	1

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22. Kolikokrat ste v zadnjem letu naredili ali naročili **presejalno orodje** (npr. analiza alkohola v krvi*, MCV,gama-GT, AUDIT vprašalnik)* **zaradi zaskrbljenosti** o pitju alkohola vaših bolnikov?

Nikoli 1
1 – 2 krat 2
3 – 5 krat 3
6 – 12 krat 4
Več kot 12 krat 5

74

23. Koliko bolnikov ste v zadnjem letu obravnavali posebej zaradi njihovega tveganega pitja ali z alkoholom povezanih problemov?

Nobenega 1
1 – 6 bolnikov 2
7 – 12 bolnikov 3
13 – 24 bolnikov 4
25 – 49 bolnikov 5
50 ali več bolnikov 6

24. Naslednji dve vprašanji se nanašata na zgodnje ukrepe pri tveganem pitju alkohola. To vključuje presejanje bolnikov, da bi odkriti tiste, ki jih njihovo pitje uvršča med ogrožene za razvoj bolezni, in nato svetovanje odkritim problematičnim pivcem za zmanjšanje pitja alkohola.

Raziskave v številnih državah so odkrile, da zdravniki družinske medicine posvetijo zelo malo ali skoraj nič časa zgodnjim ukrepom pri alkoholu. Ugotovili so različne razloge, zakaj naj bi bilo tako. Za vsak razlog označite, do katere mere se strinjate s trditvijo.

Trditev	**Zelo**	**Kar močno**	**Malo**	**Sploh ne**	**Ne vem**	
a. Alkohol v družinski medicini ni pomemben problem	5	4	3	2	1	75
b. Zdravniki so že tako preveč zaposleni s težavami, s katerimi prihajajo bolniki	5	4	3	2	1	76
c. Zdravniki so izobraženi bolj za kurativo in ne razmišljajo o preventivi	5	4	3	2	1	77
d. Zdravniki menijo, da bi preventiva morala biti bolnikova odgovornost ne pa zdravnikova	5	4	3	2	1	78
e. Ambulante družinske medicine niso organizirane na način, ki bi omogočal preventivno svetovanje	5	4	3	2	1	79
f. Zdravniki se pri spraševanju o pitju alkohola počutijo nelagodno, ker bi bolnik izjavo, da ima nekdo težave z alkoholom, lahko razumel kot obtožbo, da je alkoholik	5	4	3	2	1	80
g. Zdravniki ne znajo identificirati problematičnih pivcev, ki nimajo očitnih znakov pretiranega pitja	5	4	3	2	1	81
h. Zdravniki nimajo primernega orodja za presejanje, ki bi omogočalo identificiranje problematičnih pivcev, ki nimajo očitnih znakov pretiranega pitja	5	4	3	2	1	82
i. Zdravniki nimajo na voljo ustreznega materiala za svetovanje	5	4	3	2	1	83
j. Zdravniki niso usposobljeni za svetovanje za zmanjševanje pitja alkohola	5	4	3	2	1	84
k. Zdravniki menijo, da svetovanje v zvezi z alkoholom vključuje družine in širše družbene vplive, in je zato prezahtevno	5	4	3	2	1	85
l. Zdravniki ne verjamejo, da bodo bolniki upoštevali njihove nasvete in spremenili vedenje	5	4	3	2	1	86
m. Zdravniki sami imajo liberalna odnos do alkohola	5	4	3	2	1	87
n. Zdravniki sami imajo lahko težave z alkoholom	5	4	3	2	1	88
o. Zdravniki menijo, da bi bolniki zamerili, če jih bodo spraševali o pitju alkohola	5	4	3	2	1	89
p. Način financiranja v zdravstvu ne plačuje zdravnikov za čas, ki ga namenijo preventivnim dejavnostim	5	4	3	2	1	90
q. Vladna zdravstvene politika na splošno ne podpira zdravnikov za izvajanje preventivne medicine	5	4	3	2	1	91
r. Zasebna zdravstvena zavarovanja ne krijejo stroškov zdravnikom družinske medicine za svetovanja bolnikom glede alkohola	5	4	3	2	1	92

25. Zdravniki so v številnih državah predlagali različne stvari, ki bi več zdravnikov spodbudilo k zgodnjim ukrepom pri tveganem pitju. Prosimo, da za vsako trditev obkrožite številko, v kolikšni meri **bi vas spodbudila**, da bi izvajali več zgodnjih ukrepov pri tveganih pivcih.

Trditev	***Zelo***	***Precej***	***Malo***	***Sploh ne***	***Ne vem***	
a. Javnozdravstvene izobraževalne kampanje so na splošno naredile družbo bolj zaskrbljeno v zvezi z alkoholom	*5*	*4*	*3*	*2*	*1*	
b. Če bi bolniki zahtevali svetovanje glede pitja alkohola	*5*	*4*	*3*	*2*	*1*	
c. Če bi bili bolniki pripravljeni plačati takšno svetovanje	5	4	3	2	1	*93*
d. Če bi bili na voljo hitri in enostavni presejalni vprašalniki	5	4	3	2	1	*94*
e. Če bi bila na voljo hitra in enostavna gradiva za svetovanje	5	4	3	2	1	*95*
f. Če bi dokazali, da so zgodnji ukrepi pri alkoholu uspešne	5	4	3	2	1	*96*
g. Če bi bili na voljo programi usposabljanja za zgodnje intervencije	5	4	3	2	1	*97*
h. Če bi bile za usposabljanje za zgodnje ukrepe priznane kreditne točke stalnega strokovnega usposabljanja	5	4	3	2	1	*98*
i. Če bi bili zgodnji ukrepi pri alkoholu priznanni za kreditne točke pri zagotavljanju kakovosti	5	4	3	2	1	*99*
j. Če bi bile stalno na voljo podporne službe (za samopomoč/svetovanje), kamor bi lahko napotili bolnike	5	4	3	2	1	*100*
k. Če bi imeli boljšo plačo in delovne pogoje	5	4	3	2	1	*101*
						102
						103

26. Navedite, v kolikšni meri se strinjate ali ne strinjate z navedenimi trditvami o javni politiki glede zmanjšanja škode zaradi pitja alkohola v Evropi? *(Prosimo, pri vsaki trditvi obkrožite po eno številko).*

Trditev	**Močno se strinjam**	**Strinjam se**	**Niti se strinjam, niti se ne strinjam**	**Ne strinjam se**	**Močno se ne strinjam**	
a. Posamezniki so dovolj odgovorni, da se obvarujejo pred škodo, ki jo povzroča alkohol	5	4	3	2	1	*104*
b. Javne oblasti morajo ukrepati, da bi posameznike zaščitile pred škodo, povezano z alkoholom	5	4	3	2	1	*105*
c. Mladi in hudi pivci bi kupili **manj** alkoholnih pijač, kot so pivo, vino ali žgane pijače, če bi se cena dvignila za 25 %	5	4	3	2	1	*106*
d. Naključna policijska preverjanja alkoholiziranosti na EU cestah bi zmanjšale pitje alkohola pred vožnjo	5	4	3	2	1	*107*
e. Dovoljena raven alkohola v krvi za mlade in nove voznike bi morala biti v vseh 27 članicah evropske unije do 0,2 g/l	5	4	3	2	1	*108*
f. Prodaja in strežba alkohola osebam mlajšim od 18 let bi morala biti prepovedana v vseh državah EU	5	4	3	2	1	*109*
g. Oglaševanje alkohola usmerjeno na mlade bi moralo biti prepovedano v vseh državah članicah EU	5	4	3	2	1	*110*
h. Opozorila o nevarnostih pitja alkohola za nosečnice in voznike bi morala biti na vseh **steklenicah** z alkoholom	5	4	3	2	1	*111*
i. Opozorila o nevarnostih pitja alkohola za nosečnice in voznike bi morala biti na vseh **oglasih** za alkohol	5	4	3	2	1	*112*
j. Ljudje bi kupili **več** alkoholnih pijač, kot so pivo, vino ali žgane pijače, če bi cene **znižali** za 25 %	5	4	3	2	1	*113*

27. Kako učinkoviti bi po bili sledeči politični ukrepi pri zmanjševanju z alkoholom povezane škode **v vaši državi**? *(Prosimo, pri vsakem ukrepu obkrožite eno številko).*

Trditev	Zelo učinkoviti	Kar učinkoviti	Nekoliko učinkoviti	Neučinkoviti	Nimam mnenja	
a. Dvig najnižje starosti za pitje alkohola	5	4	3	2	1	114
b. Dvig najnižje starosti za nakup alkohola za vse alkoholne pijače	5	4	3	2	1	115
c. Znižanje dovoljene ravni alkohola v krvi za vse voznike	5	4	3	2	1	116
d. Izboljšanje izobraževanja o alkoholu v šolah	5	4	3	2	1	117
e. Povečanje omejitev za oglaševanje alkohola	5	4	3	2	1	118
f. Uvedba državnega monopola nad prodajo alkohola	5	4	3	2	1	119
g. Uvedba minimalne cene za enoto alkohola	5	4	3	2	1	120
h. Zvišanje cen alkohola z večjo obdavčitvijo	5	4	3	2	1	121
i. Zmanjšanje števila prodajaln alkohola in skrajšanje odpiralnega časa za prodajo alkohola	5	4	3	2	1	122
j. Dodatna regulativa za prodajalne alkohola, kot so n.pr. supermarketi, druga mesta, kjer prodajajo alkohol	5	4	3	2	1	123
k. Pri podeljevanju in obnovi licence za prodajo alkohola naj bo merilo javno zdravje	5	4	3	2	1	124
l. Uvedba obveznega progama v osnovnem zdravstvu za zgodnje odkrivanje in kratke ukrepe za posameznike, ki pijejo tvegano ali škodljivo	5	4	3	2	1	125

28. Ali se spomnite, da ste pred 12 leti izpolnili podoben vprašalnik?

Da ☐ 126
Ne ☐ 127

Sedaj bi radi še nekoliko bolj podrobno razčlenili vaša odgovora na vprašanji številka 22 in 23.

29. Kolikokrat ste v zadnjem letu **zaradi zaskrbljenosti** glede pitja alkohola vaših bolnikov naredili ali naročili: *(Prosimo, v vsaki vrstici vpišite število, kolikokrat ste kaj naredili ali naročili.)*

analizo alkohola v krvi ……. ___ krat 128
gamaGT in/ali MCV ……. ___ krat 129
AUDIT dolgi vprašalnik …….. ___ krat 130
AUDIT-C kratki vprašalnik …….. ___ krat 131
drugo: _____ ….. ___ krat 132

30. Koliko bolnikov ste v zadnjem letu obravnavali posebej zaradi njihovega *(Prosimo, v vsaki vrstici vpišite število.)*:

tveganega pitja …….. ____ bolnikov 133
škodljivega pitja …….. ____ bolnikov 134
alkoholizma …….. ____ bolnikov? 135

31. Če nam želite zaupati vaše mnenje ali pripombe glede tega vprašalnika ali glede katerega koli drugega vidika alkoholne problematike, uporabite prostor spodaj ali pa nam pišite.

NAJLEPŠA HVALA, DA STE IZPOLNILI VPRAŠALNIK

ODHIN

Europejski Projekt Badawczy

Kwestionariusz dla lekarzy rodzinnych

Szanowna Pani Doktor, Szanowny Panie Doktorze,

Warszawki Uniwersytet Medyczny zaprasza do wzięcia udziału w europejskim projekcie ODHIN, dotyczącym profilaktyki uzależnienia od alkoholu. Badanie ma charakter międzynarodowy i jest prowadzone równocześnie w 9 krajach Unii Europejskiej. Spośród państw Europy środkowo-wschodniej biorą w nim udział jedynie Polska oraz Czechy.

Celem projektu jest ocena doświadczeń oraz postaw lekarzy rodzinnych w kontekście pracy z osobami nadużywającymi alkoholu. Większość pytań kwestionariusza dotyczy zagadnień związanych z szeroko rozumianą profilaktyką, a także pracą z pacjentami pijącymi alkohol w sposób szkodliwy lub ryzykowny.

Udział w badaniu jest całkowicie dobrowolny i anonimowy. Zależy nam na zaproszeniu do projektu i poznaniu opinii jak największej liczby lekarzy rodzinnych w Polsce. Dlatego zwracamy się do Państwa z serdeczną prośbą o wzięcie udziału w badaniu i udzielenie odpowiedzi na zawarte w kwestionariuszu pytania. Wypełnienie ankiety trwa około 20 minut, prosimy o odpowiedź na wszystkie poniższe pytania.

prof. dr hab. n. med. Marcin Wojnar

Prosimy o zaznaczanie lub wpisywanie odpowiedzi we wskazanych miejscach.
Wszystkie odpowiedzi na pytania zawarte w kwestionariuszu mają charakter poufny.

1. Ile lat Pan/Pani pracuje jako lekarz rodzinny?

☐ lat

2. W którym roku Pan/Pani się urodził/a?

19☐

3. Proszę podać swoją płeć:

Męska ☐
Żeńska ☐

4. Czy poradnia, w której Pan/Pani pracuje ma charakter:

Miejski? ☐
Wiejski? ☐
Przyjmuje Pan/Pani pacjentów zarówno z terenów miejskich jak i wiejskich? ☐

5. Czy jest to praktyka?

jednoosobowa? ☐
grupowa? ☐

6. Ilu pełnoetatowych lekarzy rodzinnych (wliczając Pana/Panią) pracuje w poradni?

☐

7. Ile dni w tygodniu pracuje Pan/Pani w poradni podstawowej opieki zdrowotnej?

☐

8. Ilu przeciętnie pacjentów przyjmuje Pan/Pani tygodniowo w poradni podstawowej opieki zdrowotnej?

0 – 50 ☐
50 – 100 ☐
101 – 150 ☐
Ponad 150 ☐

9. W ilu (w sumie) godzinach szkoleń dotyczących alkoholu oraz problemów związanych z piciem (w ramach realizacji programu specjalizacji, obowiązku kształcenia ustawicznego lub zajęć klinicznych) uczestniczył/a Pan/Pani?

Ani jednej ☐
Mniej niż 4 godzinach ☐
4-10 godzinach ☐
11-40 godzinach ☐
Ponad 40 godzinach ☐
Nie wiem/nie pamiętam ☐

10. W chwili obecnej, uwzględniając wszystkie Pana/Pani obowiązki związane z opieką nad pacjentami, jak duży nacisk kładzie Pan/Pani na **profilaktykę chorób** jako elementu Pana/Pani praktyki?

Bardzo duży ☐
Dość duży ☐
Mały ☐
Bardzo mały ☐

11. W porównaniu z innymi lekarzami, których Pan/Pani zna, jak dużą wagę przywiązuje Pan/Pani do profilaktyki chorób w swojej praktyce?

Znacznie większą ☐
Nieco większą ☐
Nieco mniejszą ☐
Znacznie mniejszą ☐

12. Jeżeli pacjent nie zadaje Panu/Pani pytań dotyczących picia alkoholu, czy Pan/Pani to robi?

Zawsze ☐
Zazwyczaj ☐
Czasami ☐
Rzadko lub nigdy ☐

13. Jaką specjalizację posiada Pan/Pani poza medycyną rodzinną?

☐

14. Poniżej znajduje się lista zachowań, które specjaliści od ochrony zdrowia uważają za istotne. Jak ważne według Pana/Pani są poszczególne zachowania dla **utrzymania stanu zdrowia przeciętnej osoby?** *(prosimy o zaznaczenie jednej odpowiedzi w każdym wierszu)*

Zachowanie	Bardzo ważne	Ważne	Dość ważne	Nieważne
a. Niepalenie papierosów	4	3	2	1
b. Regularne ćwiczenia fizyczne	4	3	2	1
c. Picie alkoholu w ilościach umiarkowanych	4	3	2	1
d. Unikanie pokarmów wysokokalorycznych	4	3	2	1
e. Unikanie stresów	4	3	2	1
f. Przyjmowanie leków zgodnie z zaleceniami lekarskimi	4	3	2	1
g. Nieprzyjmowanie narkotyków	4	3	2	1

15. Jak często **uzyskuje Pan/Pani od pacjentów informacje** dotyczące poniższych zachowań: *(Prosimy o zaznaczenie jednej odpowiedzi w każdym wierszu)*

Zachowanie	Zawsze	Jeżeli jest to wskazane	Sporady-cznie	Rzadko/ nigdy
a. Niepalenie papierosów	4	3	2	1
b. Regularne ćwiczenia fizyczne	4	3	2	1
c. Picie alkoholu w ilościach umiarkowanych	4	3	2	1
d. Unikanie pokarmów wysokokalorycznych	4	3	2	1
e. Unikanie stresów	4	3	2	1
f. Przyjmowanie leków zgodnie z zaleceniami lekarskimi	4	3	2	1
g. Nieprzyjmowanie narkotyków	4	3	2	1

16. Lekarze różnią się w zakresie przygotowania i umiejętności udzielania porad. Jak ocenia Pan/Pani swoje **przygotowanie** do udzielania porad w zakresie niżej wymienionych zagadnień: *(Prosimy o zaznaczenie jednej odpowiedzi w każdym wierszu)*

Zachowanie	Bardzo dobrze przygotowany	Przygo-towany	Nieprzy-gotowany	Zupełnie nieprzygo towany
a. Niepalenie papierosów	4	3	2	1
b. Regularne ćwiczenia fizyczne	4	3	2	1
c. Ograniczenie ilości spożywanego alkoholu	4	3	2	1
d. Unikanie pokarmów wysokokalorycznych	4	3	2	1
e. Unikanie stresów	4	3	2	1
f. Przyjmowanie leków zgodnie z zaleceniami lekarskimi	4	3	2	1
g. Nieprzyjmowanie narkotyków	4	3	2	1

17. Jak ocenia Pan/Pani swoją **skuteczność** w pomaganiu pacjentom w osiąganiu zmian w zakresie poniższych zachowań? *(Prosimy o zaznaczenie jednej odpowiedzi w każdym wierszu)*

Zachowanie	Bardzo skuteczny	Skutecz-ny	Nieskutecz ny	Bardzo nieskute-czny
a. Niepalenie papierosów	4	3	2	1
b. Regularne ćwiczenia fizyczne	4	3	2	1
c. Ograniczenie ilości spożywanego alkoholu	4	3	2	1
d. Unikanie pokarmów wysokokalorycznych	4	3	2	1
e. Unikanie stresów	4	3	2	1

Zachowanie	Bardzo skuteczny	Skuteczny	Nieskuteczny	Bardzo nieskuteczny
f. Przyjmowanie leków zgodnie z zaleceniami lekarskimi	4	3	2	1
g. Nieprzyjmowanie narkotyków	4	3	2	1

18. **Zakładając odpowiednie przygotowanie merytoryczne i praktyczne**, jak skuteczni Pana/Pani zdaniem **mogliby być** lekarze rodzinni w udzielaniu pomocy pacjentom w osiąganiu zmian w zakresie poniższych zachowań? *(Prosimy o zaznaczenie jednej odpowiedzi w każdym wierszu)*

Zachowanie	Bardzo skuteczni	Skuteczni	Nieskuteczni	Bardzo nieskuteczni
a. Niepalenie papierosów	4	3	2	1
b. Regularne ćwiczenia fizyczne	4	3	2	1
c. Ograniczenie ilości spożywanego alkoholu	4	3	2	1
d. Unikanie pokarmów wysokokalorycznych	4	3	2	1
e. Unikanie stresów	4	3	2	1
f. Przyjmowanie leków zgodnie z zaleceniami lekarskimi	4	3	2	1
g. Nieprzyjmowanie narkotyków	4	3	2	1

19. W przypadku zdrowego, dorosłego mężczyzny, jaką ilość alkoholu uznałby/łaby Pan/Pani za górną dopuszczalną granicę, po przekroczeniu której zaleciłby/łaby Pan/Pani ograniczenie picia?

Prosimy o zapisanie w postaci …… porcji standardowych*/ tydzień

lub jako …… porcji standardowych* na dobę

W przypadku zdrowej, dorosłej i niebędącej w ciąży kobiety, jaką ilość alkoholu uznałby/łaby Pan/Pani za górną dopuszczalną granicę, po przekroczeniu której zaleciłby/łaby Pan/Pani ograniczenie picia?

Prosimy o zapisanie w postaci…… porcji standardowych*/ tydzień

lub jako …… porcji standardowych* na dobę

***1 porcja standardowa = ½ butelki piwa (250ml) = 1 kieliszek wina (100ml) = 1 kieliszek wódki (25g)**

20. Prosimy o zaznaczenie, w jakim stopniu zgadza się Pan/Pani z wymienionymi poniżej stwierdzeniami dotyczącymi pracy z osobami „pijącymi problemowo". W tym punkcie pytamy o osoby pijące w sposób **ryzykowny lub szkodliwy;** pytanie nie dotyczy pacjentów uzależnionych od alkoholu. *(Prosimy o zaznaczenie jednej odpowiedzi w każdym wierszu)*

Stwierdzenie	Całkowicie się zgadzam	Prawie całkowicie się zgadzam	Zgadzam się	Nie mam zdania	Nie zgadzam się	Prawie zupełnie się nie zgadzam	Zupełnie się nie zgadzam
a. Uważam, że wiem wystarczająco dużo na temat przyczyn problemów związanych z piciem alkoholu i potrafię wywiązać się ze swoich zadań w pracy z osobami pijącymi	7	6	5	4	3	2	1
b. Uważam, że jestem w stanie udzielić kompetentnej porady na temat picia alkoholu i jego następstw	7	6	5	4	3	2	1
c. Uważam, że nie mam się czym pochwalić, jeżeli chodzi o pracę z osobami pijącymi	7	6	5	4	3	2	1
d. Ogólnie mówiąc, jestem skłonny przyznać, że zupełnie nie radzę sobie w pracy z osobami pijącymi	7	6	5	4	3	2	1
e. Chcę pracować z osobami pijącymi	7	6	5	4	3	2	1
f. Pesymizm to najbardziej realistyczne nastawienie w pracy z osobami pijącymi	7	6	5	4	3	2	1
g. Uważam, że kiedy jest to uzasadnione, mam prawo zadawać pacjentom pytania dotyczące picia alkoholu	7	6	5	4	3	2	1
h. Uważam, że moi pacjenci przyznają mi prawo do zadawania pytań dotyczących picia alkoholu	7	6	5	4	3	2	1
i. Ogólnie mówiąc, praca z osobami pijącymi daje dużo satysfakcji	7	6	5	4	3	2	1
j. W sumie lubię osoby pijące	7	6	5	4	3	2	1

21. Prosimy o zaznaczenie, w jakim stopniu zgadza się Pan/Pani z wymienionymi poniżej stwierdzeniami dotyczącymi pracy z osobami **uzależnionymi od alkoholu lub mającymi poważny problem z piciem alkoholu („alkoholikami”).** *(Prosimy o zaznaczenie jednej odpowiedzi w każdym wierszu)*

Stwierdzenie	Całkowicie się zgadzam	Prawie całkowicie się zgadzam	Zgadzam się	Nie mam zdania	Nie zgadzam się	Prawie zupełnie się nie zgadzam	Zupełnie się nie zgadzam
a. Uważam, że wiem wystarczająco dużo na temat przyczyn problemów związanych z piciem alkoholu i potrafię wywiązać się ze swoich zadań w pracy z osobami uzależnionymi	7	6	5	4	3	2	1
b. Uważam, że jestem w stanie udzielić kompetentnej porady na temat picia alkoholu i jego następstw	7	6	5	4	3	2	1
c. Uważam, że nie mam się czym pochwalić, jeżeli chodzi o pracę z osobami uzależnionymi od alkoholu	7	6	5	4	3	2	1
d. Ogólnie mówiąc, jestem skłonny przyznać, że zupełnie nie radzę sobie w pracy z osobami uzależnionymi	7	6	5	4	3	2	1
e. Chcę pracować z osobami uzależnionymi od alkoholu	7	6	5	4	3	2	1
f. Pesymizm to najbardziej realistyczne nastawienie w pracy z osobami uzależnionymi	7	6	5	4	3	2	1
g. Uważam, że kiedy jest to uzasadnione, mam prawo zadawać pacjentom pytania dotyczące picia alkoholu	7	6	5	4	3	2	1
h. Uważam, że moi pacjenci przyznają mi prawo do zadawania pytań dotyczących picia alkoholu	7	6	5	4	3	2	1
i. Ogólnie mówiąc, praca z osobami uzależnionymi daje dużo satysfakcji	7	6	5	4	3	2	1
j. W sumie lubię pacjentów uzależnionych od alkoholu	7	6	5	4	3	2	1

22. Ile razy, w okresie ostatniego roku, wykonał/a Pan/Pani lub zlecił/a **badanie przesiewowe** (stężenie alkoholu w surowicy, MCV, GGT, test AUDIT) **w związku z obawą** o nadmierne picie alkoholu przez pacjenta?
(Prosimy o zaznaczenie jednej odpowiedzi)

Ani razu 1
1 – 2 razy 2
3 – 5 razy 3
6 – 12 razy 4
więcej niż 12 razy 5

23. W okresie ostatniego roku, w przypadku ilu pacjentów Pana/Pani interwencja miała związek z piciem ryzykownym lub problemami związanymi z alkoholem?
(Prosimy o zaznaczenie jednej odpowiedzi)

Ani jednego 1
1 – 6 pacjetów 2
7 – 12 pacjentów 3
13 – 24 pacjentów 4
25 – 49 pacjentów 5
50 lub więcej pacjentów..... 6

24. Kolejne dwa pytania dotyczą prowadzenia wczesnej interwencji u osób pijących alkohol w sposób ryzykowny. Wczesna interwencja oznacza badanie przesiewowe pacjentów w celu identyfikacji tych osób, u których wysokie spożycie alkoholu może wiązać się ze szkodami zdrowotnymi, a następnie udzielenie tym osobom porad dotyczących ograniczenia ilości spożywanego alkoholu.

Badania przeprowadzone w wielu krajach wykazały, że lekarze rodzinni bardzo mało czasu poświęcają na prowadzenie wczesnej interwencji u osób pijących w sposób problemowy lub nie stosują takich interwencji w ogóle. Sytuacja taka może wynikać z różnych przyczyn, które wymieniono poniżej. Prosimy o zaznaczenie (poprzez zakreślenie odpowiedniej odpowiedzi w <u>każdej</u> kolumnie), jak bardzo, według Pana/Pani oceny, dana przyczyna wpływa na rzadkie stosowanie wczesnej interwencji.

Przyczyna	**Bardzo**	**Zna-cząco**	**Mało**	**Wcale**	**Nie wiem**
a. Alkohol nie jest ważnym problemem w praktyce lekarza rodzinnego	5	4	3	2	1
b. Lekarze są po prostu zbyt zajęci zajmowaniem się innymi problemami, z którymi zgłaszają się pacjenci	5	4	3	2	1
c. Lekarze zostali wykształceni w modelu nastawionym na leczenie chorób, a nie zapobieganie im	5	4	3	2	1
d. Lekarze uważają, że profilaktyka chorób nie jest ich obowiązkiem, ale zadaniem pacjentów	5	4	3	2	1
e. Poradnie podstawowej opieki zdrowotnej nie są	5	4	3	2	1

Przyczyna	Bardzo	Zna-cząco	Mało	Wcale	Nie wiem
odpowiednio zorganizowane dla udzielenia porad w zakresie profilaktyki					
f. Lekarze czują się niezręcznie zadając pytania dotyczące picia alkoholu, ponieważ stwierdzenie, że pacjent ma problem alkoholowy może zabrzmieć jak oskarżenie o bycie alkoholikiem	5	4	3	2	1
g. Lekarze nie wiedzą, w jaki sposób identyfikować osoby, które piją w sposób problemowy, a u których nie stwierdza się ewidentnych oznak nadmiernego spożycia alkoholu	5	4	3	2	1
h. Lekarze nie mają odpowiednich narzędzi przesiewowych do identyfikowania osób, które piją w sposób problemowy, a u których nie stwierdza się ewidentnych oznak nadmiernego spożycia alkoholu	5	4	3	2	1
i. Lekarze nie mają dostępu do odpowiednich materiałów edukacyjnych przeznaczonych dla pacjentów	5	4	3	2	1
j. Lekarze nie są szkoleni w prowadzeniu poradnictwa dotyczącego ograniczenia ilości spożywanego alkoholu	5	4	3	2	1
k. Lekarze uważają, że poradnictwo w zakresie picia alkoholu wymaga włączenia rodziny oraz szerszych oddziaływań społecznych i w związku z tym jest zbyt trudne do zrealizowania	5	4	3	2	1
l. Lekarze nie wierzą, aby ich porady mogły zostać przyjęte przez pacjenta i przynieść zmianę jego zachowań	5	4	3	2	1
m. Lekarze sami mają liberalny stosunek do alkoholu	5	4	3	2	1
n. Lekarze sami mogą mieć problem alkoholowy	5	4	3	2	1
o. Lekarze uważają, że pacjenci mogą poczuć się urażeni pytaniami o picie alkoholu	5	4	3	2	1
p. System opieki zdrowotnej nie przewiduje wynagrodzenia za czas poświęcony przez lekarzy na działania związane z profilaktyką	5	4	3	2	1
q. Generalnie polityka zdrowotna rządu nie wspiera lekarzy chcących zająć się profilaktyką	5	4	3	2	1
r. Prywatne ubezpieczenia zdrowotne nie pokrywają kosztów uzyskania od lekarza rodzinnego porady w zakresie używania alkoholu	5	4	3	2	1

25. Lekarze z różnych krajów zaproponowali szereg rozwiązań, których celem miało być zwiększenie częstości prowadzenia wczesnej interwencji u osób pijących alkohol w sposób ryzykowny. Prosimy o zaznaczenie przy każdym rozwiązaniu (przez zakreślenie odpowiedniej odpowiedzi), w jakim stopniu **zachęciłoby** ono **Pana/Panią osobiście** do zwiększenia liczby wczesnych interwencji w piciu ryzykownym.

Rozwiązanie	**Bardzo**	**Zna-cząco**	**Mało**	**Wcale**	**Nie wiem**
a. Ogólna świadomość społeczna na temat używania alkoholu zostałaby zwiększona przez prozdrowotne kampanie społeczne	5	4	3	2	1
b. Pacjenci sami prosiliby o poradę na temat używania alkoholu	5	4	3	2	1
c. Pacjenci płaciliby za udzielenie porady na temat używania alkoholu	5	4	3	2	1
d. Dostępne byłyby krótkie i proste kwestionariusze przesiewowe	5	4	3	2	1
e. Dostępne byłyby krótkie i przystępne materiały edukacyjne dla pacjentów	5	4	3	2	1
f. Skuteczność wczesnej interwencji zostałaby udowodniona	5	4	3	2	1
g. Dostępne byłyby warsztaty dotyczące przeprowadzania wczesnej interwencji w piciu ryzykownym	5	4	3	2	1
h. Za odbycie szkolenia w zakresie wczesnej interwencji byłyby przyznawane punkty edukacyjne	5	4	3	2	1
i. Prowadzenie wczesnej interwencji byłoby finansowane ze środków przeznaczonych na zapewnienie jakości usług medycznych.	5	4	3	2	1
j. Byłyby dostępne ośrodki wsparcia (samopomocowe, konsultacyjne), do których bezpośrednio możnaby kierować pacjentów	5	4	3	2	1
k. Nastąpiłby wzrost wynagrodzenia oraz poprawa warunków pracy	5	4	3	2	1

26. Prosimy o zaznaczenie, w jakim stopniu zgadza się Pan/Pani z wymienionymi poniżej stwierdzeniami dotyczącymi stosowanych w Europie strategii ograniczania szkód związanych z piciem alkoholu? *(Prosimy o zaznaczenie jednej odpowiedzi w każdym wierszu)*

Stwierdzenie	**Całkowicie się zgadzam**	**Zgadzam się**	**Nie mam zdania**	**Nie zgadzam się**	**Zupełnie się nie zgadzam**
a. Ludzie są wystarczająco odpowiedzialni, aby ochronić się przed szkodami związanymi z piciem alkoholu	5	4	3	2	1
b. Władze publiczne powinny interweniować w celu ochrony obywateli przed szkodami związanymi z piciem alkoholu	5	4	3	2	1
c. Młode oraz pijące intensywnie osoby kupowałyby **mniej** produktów alkoholowych takich jak piwo, wino czy wódka, jeżeli ich ceny zostałyby **podwyższone** o 25%	5	4	3	2	1
d. Częste kontrole policyjne na drogach krajów Unii Europejskiej zmniejszyłyby liczbę osób prowadzących pojazdy pod wpływem alkoholu	5	4	3	2	1
e. Dozwolone stężenie alkoholu we krwi dla kierowców młodych oraz z małym doświadczeniem powinno wynosić 0,2g/l we wszystkich 27 krajach należących do Unii Europejskiej	5	4	3	2	1
f. Sprzedaż alkoholu osobom, które nie ukończyły 18-go roku życia powinna być zabroniona we wszystkich krajach Unii Europejskiej	5	4	3	2	1
g. Reklama alkoholu ukierunkowana na młodych odbiorców powinna być zabroniona we wszystkich krajach Unii Europejskiej	5	4	3	2	1
h. Na **opakowaniach (butelkach)** produktów zawierających alkohol powinny znaleźć się ostrzeżenia informujące o zagrożeniach dla kobiet w ciąży oraz kierowców	5	4	3	2	1
i. **Reklamy** produktów alkoholowych powinny zawierać ostrzeżenia skierowane do kobiet w ciąży oraz kierowców	5	4	3	2	1
j. Ludzie kupowaliby **więcej** produktów alkoholowych takich jak piwo, wino czy wódka, jeżeli ich ceny zostałyby **obniżone** o 25%	5	4	3	2	1

27. Jak skuteczne według Ciebie, byłyby poniżej wymienione strategie ograniczania szkód związanych z piciem alkoholu, jeżeli zostałyby one zastosowane w **Pana/Pani kraju**? *(Prosimy o zaznaczenie jednej odpowiedzi w każdym wierszu)*

Stwierdzenie	Bardzo skute-czne	Dość skute-czne	Znikomo skuteczne	Nieskute-czne	Nie mam zdania
a. Podwyższenie prawnej granicy wieku dla spożywania alkoholu	5	4	3	2	1
b. Podwyższenie prawnej granicy wieku dla zakupu wszystkich rodzajów produktów alkoholowych	5	4	3	2	1
c. Obniżenie dopuszczalnego stężenia alkoholu w surowicy dla osób prowadzących samochody	5	4	3	2	1
d. Poprawa edukacji szkolnej dotyczącej problemów związanych z piciem alkoholu	5	4	3	2	1
e. Wprowadzenie ograniczeń dotyczących reklamowania produktów alkoholowych	5	4	3	2	1
f. Utrzymanie lub wprowadzenie państwowego monopolu na detaliczną sprzedaż alkoholu	5	4	3	2	1
g. Wprowadzenie cen minimalnych dla produktów alkoholowych	5	4	3	2	1
h. Zwiększenie ceny alkoholu przez nałożenie dodatkowych podatków	5	4	3	2	1
i. Zmniejszenie liczby i skrócenie czasu pracy sklepów monopolowych	5	4	3	2	1
j. Wprowadzenie dodatkowych regulacji dla innych miejsc prowadzących dystrybucję produktów alkoholowych (supermakety itp.)	5	4	3	2	1
k. Uwzględnienie zdrowia publicznego w kryteriach wydawania i odnawiania licencji na sprzedaż produktów alkoholowych	5	4	3	2	1
l. Wprowadzenie w systemie podstawowej opieki zdrowotnej obowiązkowych programów wczesnego wykrywania i krótkiej interwencji wobec osób pijących alkohol ryzykownie lub szkodliwie	5	4	3	2	1

28. Czy przypomina Pani/Pan sobie wypełnianie podobnego kwestionariusza około 13 lat temu?

Tak	
Nie	

29. Jeżeli chciałby/łaby Pan/Pani wyrazić swoją opinię na temat kwestionariusza lub podzielić się swoim zdaniem na temat jakiegokolwiek aspektu problemów związanych z alkoholem, prosimy o wpisanie komentarza poniżej.

BARDZO DZIĘKUJEMY ZA WYPEŁNIENIE KWESTIONARIUSZA!

ODHIN

Studio collaborativo dell'Unione Europea

Questionario per i Medici di Medicina Generale

Contrassegnare la casella corrispondente alla vostra risposta o scrivete la vostra risposta dove indicato.

Tutte le risposte al presente questionario verranno trattate con la massima riservatezza.

1. Da quanti anni esercita come medico di medicina generale?
   _____ anni

2. In che anno è nato/a?
   19

3. Sesso
   Maschile
   Femminile

4. Svolge la sua professione
   In un'area urbana
   In un'area rurale
   In un'area mista (urbana e rurale)

5. Esercita
   Da solo/ a
   In medicina di gruppo

6. Quanti medici a tempo pieno lavorano nel suo studio, compreso lei stesso/a ?
   _____

7. Quanti giorni alla settimana dedica alla medicina generale?
   _____ giorni

8. Quanti pazienti frequentano il suo ambulatorio in una settimana mediamente?
   0-50
   50-100
   101-150
   Più di 150

9. In totale, quante ore di formazione post-universitaria, di educazione medica continua (ECM) o di supervisione clinica ha frequentato su alcol e problemi alcol-correlati?
   Nessuna
   Meno di 4 ore
   4-10 ore
   11-40 ore
   Più di 40 ore
   Non lo so/ non ricordo

10. Al momento, rispetto alle sue responsabilità verso i pazienti, quale priorità dà alla prevenzione delle malattie nella sua pratica?
    Molto alta
    Abbastanza alta
    Bassa
    Molto bassa

11. Rispetto ad altri medici generici di sua conoscenza, quanta importanza dà alla prevenzione delle malattie nella sua pratica?
    Molto di più
    Leggermente di più
    Di meno
    Molto di meno

12. Se il paziente non le rivolge domande sull'alcol, prende lei l'iniziativa?
    Tutte le volte
    La maggior parte delle volte
    Qualche volta
    Raramente o mai

13. Al momento, rispetto ai bisogni dei pazienti, quale priorità dà alla prevenzione delle malattie nella sua pratica?
    Molto alta
    Abbastanza alta
    Bassa
    Molto bassa

14. I seguenti sono comportamenti che gli operatori sanitari ritengono correlati allo stato di salute.
    Quanto ritiene importante ciascuna delle seguenti scelte comportamentali nel migliorare e promuovere la salute di un individuo? *(cerchiare un numero per ogni risposta)*

Comportamento	Molto importante	Importante	Abbastanza importante	Per nulla importante
a. Non fumare	4	3	2	1
b. Fare regolare esercizio fisico	4	3	2	1
c. Bere alcol moderatamente	4	3	2	1
d. Evitare eccessi di calorie	4	3	2	1
e. Ridurre lo stress	4	3	2	1
f. Uso responsabile dei medicinali prescritti	4	3	2	1
g. Non usare sostanze illegali	4	3	2	1

15. Indichi in che misura riesce ad ottenere informazioni dai suoi pazienti sui seguenti comportamenti: *(cerchiare un numero per ogni risposta)*

Comportamento	Sempre	Regolarmente secondo necessità	Occasionalmente	Raramente/ Mai
a. Non fumare	4	3	2	1
b. Fare regolare esercizio fisico	4	3	2	1
c. Bere alcolici moderatamente	4	3	2	1
d. Evitare eccessi di calorie	4	3	2	1
e. Ridurre lo stress	4	3	2	1
f. Uso responsabile dei medicinali prescritti	4	3	2	1
g. Non usare sostanze illegali	4	3	2	1

16. I medici hanno formazione e capacità diverse nel counselling. Quanto si sente preparato nel conselling ai pazienti in ciascuno dei seguenti comportamenti? *(cerchiare un numero per risposta)*

Comportamento	Molto preparato/a	Preparato /a	Impreparato/a	Molto impreparato/a
a. Non fumare	4	3	2	1
b. Fare regolare esercizio fisico	4	3	2	1
c. Bere alcolici moderatamente	4	3	2	1
d. Evitare eccessi di calorie	4	3	2	1
e. Ridurre lo stress	4	3	2	1
f. Uso responsabile dei medicinali prescritti	4	3	2	1
g. Non usare sostanze illegali	4	3	2	1

17. Quanto pensa che il suo intervento sia efficace nel facilitare i pazienti nel cambiamento in ciascuna delle seguenti aree? *(cerchiare un numero per risposta)*

Comportamento	Molto efficace	Efficace	Inefficace	Molto inefficace
a. Non fumare	4	3	2	1
b. Fare regolare esercizio fisico	4	3	2	1
c. Bere alcolici moderatamente	4	3	2	1
d. Evitare eccessi di calorie	4	3	2	1
e. Ridurre lo stress	4	3	2	1
f. Uso responsabile dei medicinali prescritti	4	3	2	1
g. Non usare sostanze illegali	4	3	2	1

18. In generale, se adeguatamente formati ed informati, quanto pensa possano essere efficaci i medici generici nel facilitare i pazienti nel cambiamento di stili di vita in ciascuna delle seguenti aree? *(cerchiare un numero per risposta)*

Comportamento	Molto efficace	Efficace	Inefficace	Molto inefficace
a. Non fumare	4	3	2	1
b. Fare regolare esercizio fisico	4	3	2	1
c. Bere alcolici moderatamente	4	3	2	1
d. Evitare eccessi di calorie	4	3	2	1
e. Ridurre lo stress	4	3	2	1
f. Uso responsabile dei medicinali prescritti	4	3	2	1
g. Non usare sostanze illegali	4	3	2	1

19. Qual è secondo Lei il limite massimo di consumo di alcolici per una uomo adulto, sano prima di consigliargli di calarne l'assunzione?
Indicare…….. il numero di unità o bicchieri standard * alla settimana
oppure…… ……il numero di unità o bicchieri standard * al giorno

Qual è secondo Lei il limite massimo di consumo di alcolici per una donna adulta, sana, non in gravidanza prima di consigliarle di calarne l'assunzione?
Indicare…….. il numero di unità o bicchieri standard * alla settimana
oppure…… ……il numero di unità o bicchieri standard * al giorno

*1 unità o bicchiere standard = 330 ml di birra (4.5°) = 125 ml di vino (12°) = 80 ml di aperitivo (18°) = 40 ml di cocktail alcolico (36°)

20. Indichi quanto è d'accordo o in disaccordo con ciascuna delle seguenti affermazioni riguardanti il lavoro con "bevitori problematici". *(Bevitori problematici sono soggetti con un consumo rischioso o dannoso di alcol ma non alcoldipendenti).*

Affermazione	Molto d'accordo	Abbastanza d'accordo	D'accordo	Né d'accordo né in disaccordo	In disaccordo	Abbastanza in disaccordo	Fortemente in disaccordo
a. Penso di saperne abbastanza sulle cause dei problemi legati al consumo di alcol da poter svolgere il mio ruolo con i bevitori problematici	7	6	5	4	3	2	1
b. Penso di poter informare in modo adeguato i miei pazienti sul consumo di alcolici ed i suoi effetti	7	6	5	4	3	2	1
c. Penso di non aver niente di cui andar fiero/a quando lavoro con i bevitori problematici	7	6	5	4	3	2	1
d. Tutto sommato credo di essere incapace a lavorare con i bevitori	7	6	5	4	3	2	1
e. Voglio lavorare con i bevitori problematici	7	6	5	4	3	2	1
f. Il pessimismo è l'atteggiamento più realistico da adottare nei confronti dei bevitori problematici	7	6	5	4	3	2	1

g. Credo di avere il diritto di fare domande ai pazienti in merito al loro consumo di alcol quando necessario	7	6	5	4	3	2	1
h. Credo che i miei pazienti pensino che io abbia il diritto di far loro domande in merito al consumo di alcol quando necessario	7	6	5	4	3	2	1
i. In generale, è appagante lavorare con i bevitori problematici	7	6	5	4	3	2	1
j. In generale, mi piacciono i bevitori problematici	7	6	5	4	3	2	1

21. Indichi quanto è d'accordo o in disaccordo con ciascuna delle seguenti affermazioni riguardanti il lavoro con soggetti alcoldipendenti o che hanno gravi problemi con l'alcol.

Affermazione	Molto d'accordo	Abbastanza d'accordo	D'accordo	Né d'accordo né in disaccordo	In disaccordo	Abbastanza in disaccordo	Fortemente in disaccordo
a. Penso di saperne abbastanza sulle cause dei problemi legati al consumo di alcol da poter svolgere il mio ruolo con i bevitori problematici	7	6	5	4	3	2	1
b. Penso di poter informare in modo adeguato i miei pazienti sul consumo di alcolici ed i suoi effetti	7	6	5	4	3	2	1
c. Penso di non aver niente di cui andar fiero/a quando lavoro con i bevitori problematici	7	6	5	4	3	2	1
d. Tutto sommato credo di essere incapace a lavorare con i bevitori	7	6	5	4	3	2	1
e. Voglio lavorare con i bevitori problematici	7	6	5	4	3	2	1
f. Il pessimismo è l'atteggiamento più realistico da adottare nei confronti dei bevitori problematici	7	6	5	4	3	2	1
g. Credo di avere il diritto di fare domande ai pazienti in merito al loro consumo di alcol quando necessario	7	6	5	4	3	2	1
h. Credo che i miei pazienti pensino che io abbia il diritto di far loro domande in merito al consumo di alcol quando necessario	7	6	5	4	3	2	1
i. In generale, è appagante lavorare con i bevitori problematici	7	6	5	4	3	2	1
j. In generale, mi piacciono i bevitori problematici	7	6	5	4	3	2	1

22. Quante volte ha fatto o richiesto esami di screening (ad es. controllo del tasso alcolemico, MCV, GGT, il test AUDIT) sul consumo di alcol durante lo scorso anno? (Cerchiare un numero)

Mai…… 1
1- 2 volte…… 2
3- 5 volte…… 3
6- 12 volte…… …. 4
Più di 12 volte…… …. 5

23. Quanti pazienti ha trattato nello specifico per un consumo rischioso di alcol o per problemi alcol-correlati durante lo scorso anno? (Cerchiare un numero)

Nessuno…… …….. 1
1-6 pazienti…… … 2
7- 12 pazienti…… 3
13-24 pazienti…… …….. 4
25- 49 pazienti…….. 5
50 o più pazienti…….. 6

24. Le prossime due domande sono legate all'intervento breve sul consumo rischioso di alcol; ciò comprende l'identicazione dei pazienti ad alto rischio e l'effettuazione di un intervento di counselling per la riduzione del consumo.

Alcuni sondaggi svolti in vari paesi hanno dimostrato che molti medici di base dedicano pochissimo tempo o per niente all'intervento breve; a tal proposito, le suggeriamo una serie di motivazioni per cercare di spiegarne le ragioni. Indichi fino a che punto, secondo lei, la motivazione è applicabile cerchiando il numero adeguato.

Affermazione	Molto	Abbastanza	Poco	Per nulla	Non so
a. L'alcol non è considerato un problema importante in medicina generale	5	4	3	2	1
b. I medici sono troppo impegnati a occuparsi dei problemi posti dai pazienti	5	4	3	2	1
c. I medici hanno una formazione centrata sulla malattia e non sulla prevenzione	5	4	3	2	1
d. I medici ritengono che la prevenzione della salute sia una responsabilità del paziente stesso e non la loro	5	4	3	2	1
e. Gli ambulatori dei medici di base non sono organizzati per effettuare il counselling in materia di prevenzione	5	4	3	2	1
f. I medici sono restii a porre domande sul consumo di alcol, perché questo potrebbe essere interpretato come un'accusa di alcolismo	5	4	3	2	1
g. I medici non sono in grado di individuare i bevitori problematici che non presentano sintomi evidenti di consumo eccessivo	5	4	3	2	1
h. I medici non hanno adeguati strumenti di screening in grado di identificare i bevitori problematici che non presentano sintomi evidenti di consumo eccessivo	5	4	3	2	1
i. I medici non hanno a disposizione materiale per il counselling.	5	4	3	2	1
j. I medici non possiedono una formazione al counselling per la riduzione del consumo di alcol	5	4	3	2	1
k. I medici pensano che il counselling coinvolga anche la famiglia e la società, e pertanto troppo difficile da realizzarsi.	5	4	3	2	1
l. I medici non credono che i pazienti seguirebbero i loro consigli e cambierebbero i propri comportamenti	5	4	3	2	1
m. I medici stessi hanno un atteggiamento positivo nei confronti dell'alcol	5	4	3	2	1
n. I medici stessi potrebbero avere problemi rispetto al consumo di alcol	5	4	3	2	1
o. I medici sono convinti che i pazienti si risentirebbero se fossero loro poste domande relative al loro consumo di alcol	5	4	3	2	1
p. Non sono previsti rimborsi per i medici che lavorano nella medicina preventiva	5	4	3	2	1
q. Le politiche sanitarie nazionali, in generale, non offrono sostegno ai medici che vogliono praticare la medicina preventiva	5	4	3	2	1
r. Le assicurazioni sanitarie private non offrono rimborsi ai pazienti che hanno ricevuto counselling per il consumo di alcol in medicina generale	5	4	3	2	1

25. I medici di alcuni paesi hanno proposto una serie di suggerimenti che potrebbero incoraggiare un numero maggiore di medici a praticare la prevenzione del consumo

rischioso di alcol. Indichi per ciascuna affermazione quanto la incoraggerebbe personalmente a fare più prevenzione rispetto al consumo rischioso di alcol.

Affermazione	Molto	Abbastanza	Poco	Per nulla	Non so
a. Se le campagne pubbliche di promozione alla salute sensibilizzassero di più la società sull'alcol	5	4	3	2	1
b. Se i pazienti richiedessero informazioni sul consumo di alcol	5	4	3	2	1
c. Se i pazienti fossero disposti a pagare per un servizio di counselling sull'alcol					
d. Se fossero disponibili questionari di screening semplici	5	4	3	2	1
e. Se fosse disponibile materiale di supporto di rapida e facile consultazione	5	4	3	2	1
f. Se esistessero prove tangibili sull'efficacia dell'intervento breve sull'alcol	5	4	3	2	1
g. Se fossero disponibili programmi di formazione sull'intervento breve per l'alcol	5	4	3	2	1
h. Se la formazione sull'intervento breve sull'alcol ottenesse crediti nell'educazione continua in medicina (ECM)	5	4	3	2	1
i Se il fornire un intervento breve sull'alcol fosse ufficialmente riconosciuto	5	4	3	2	1
j Se esistessero servizi di supporto a cui indirizzare agevolmente i pazienti (gruppi di counselling di auto aiuto)	5	4	3	2	1
k. Se fossero migliorati i salari e le condizioni di lavoro	5	4	3	2	1

26. Quanto siete d'accordo sulle seguenti politiche dalla UE per la riduzione dei danni alcol-correlati in Europa? *(Cerchiare un numero per ogni affermazione)*

Affermazione	Molto utile	Abbastanza utile	Poco utile	Per niente utile	Non so
a. La promozione di una cultura orientata al consumo responsabile di alcolici	5	4	3	2	1
b. Le Autorità locali dovrebbero intervenire per proteggere le persone dai danni dell'alcol	5	4	3	2	1
c. I giovani e i forti bevitori comprerebbero meno alcolici se si aumentasse il prezzo del 25%	5	4	3	2	1
d. Controlli random della polizia stradale in Europa ridurrebbe il consumo di alcol prima di mettersi alla guida	5	4	3	2	1
e. I livelli di alcool nel sangue per i giovani e neopatentati dovrebbe essere di 0,2g/l in tutti i 27 Paesi europei	5	4	3	2	1
f. Somministrare e vendere alcol ai minori di anni 18 anni dovrebbe essere proibito in tutti i paesi europei	5	4	3	2	1
g. Bisognerebbe bandire la pubblicità di alcolici rivolta ai giovani	5	4	3	2	1
h. .Bisognerebbe scrivere sull'etichetta i rischi del consumo di alcol per le donne in gravidanza ed i guidatori	5	4	3	2	1
i Bisognerebbe mettere degli avvisi anche sulla pubblicità con lo scopo di tutelare le donne in gravidanza ed i guidatori	5	4	3	2	1
j. Le persone comprerebbero più alcolici se il prezzo fosse ridotto del 25%	5	4	3	2	1

27. Quanto pensa che l'adozione delle seguenti politiche potrebbe essere efficace nel ridurre i danni legati all'abuso di alcolici in Italia? *(Cerchiare una risposta per ogni affermazione)*

Affermazione	Molto utile	Abbastanza utile	Poco utile	Per niente utile	Non so
a. Aumento dell'età minima legale per il consumo di alcol	5	4	3	2	1
b. Aumento dell'età minima legale per l'acquisto di tutte le bevande alcoliche	5	4	3	2	1

c. Diminuzione dell'alcolemia (BAC) per tutti coloro che guidano	5	4	3	2	1
d. Miglioramento dell'educazione all'alcol nelle scuole	5	4	3	2	1
e. Aumento delle restrizioni per quanto riguarda la pubblicizzazione di bevande alcoliche	5	4	3	2	1
f. Monopolio di stato per la vendita di alcolici	5	4	3	2	1
g. Istituire un prezzo minimo legale per unità di alcol	5	4	3	2	1
h. Aumentare il prezzo delle bevande alcoliche attraverso un aumento della tassazione	5	4	3	2	1
i Ridurre il numero di rivendite di bevande alcoliche e gli orari di vendita	5	4	3	2	1
j. Ulteriore regolamentazione per le rivendite di alcolici (es. supermercati, negozi, pub, eccetera)	5	4	3	2	1
k. Rendere la Salute Pubblica un criterio da tenere in considerazione per il rilascio/rinnovo delle licenze	5	4	3	2	1
l. Introdurre programmi obbligatori di identificazione precoce ed intervento breve nell'assistenza sanitaria primaria per i soggetti con consumo rischioso e dannoso di alcol	5	4	3	2	1

28. Riesce a ricordare di aver compilato una versione precedente di questo questionario redatto dal nostro gruppo circa 12 anni fa?
    Si
    No

29. Quanto è d'accordo con le seguenti affermazioni riguardo all'integrazione con amministrazioni e servizi locali?

Affermazione	Molto d'accordo	Abbastanza d'accordo	Poco d'accordo	Per niente d'accordo	Non so
I problemi alcol correlati non possono essere di pertinenza esclusiva dei servizi territoriali deputati alle dipendenze che hanno come mandato prioritario la gestione dell'alcoldipendenza	5	4	3	2	1
Molti pazienti che hanno problemi con l'alcol, ma non sono alcol dipendenti, non si avvalgono delle necessarie cure mediche perché dovrebbero recarsi presso un SERT alla pari di un tossicodipendente	5	4	3	2	1
E' indispensabile creare o rafforzare la rete di servizi alcologici per l'identificazione precoce del consumo rischioso o dannoso di alcol includendo sia le competenze sanitarie che sociali	5	4	3	2	1
Per ridurre l'impatto e migliorare la gestione dei problemi alcol correlati è indispensabile integrare le competenze di promozione della salute e di prevenzione nei contesti di assistenza sanitaria primaria con quelle dei servizi per le dipendenze riconoscendo e valorizzando il ruolo dell'approccio di popolazione accanto a quello della gestione clinica	5	4	3	2	1
Mi piacerebbe collaborare in rete con gli amministratori locali anche senza remunerazione	5	4	3	2	1
Sono disponibile a collaborare con gli amministratori locali se questo porta al miglioramento della qualità del mio lavoro	5	4	3	2	1
Sono favorevole alla creazione di una figura intermedia di medico di medicina generale con competenze sugli stili di vita e sul	5	4	3	2	1

counselling					

30. Se desidera aggiungere ulteriori commenti od opinioni in merito al presente questionario o a qualsiasi altro aspetto legato ai problemi alcol-correlati, può utilizzare lo spazio sottostante

GRAZIE PER AVER COMPLETATO IL PRESENTE QUESTIONARIO

ODHIN

En samarbets studie i Europeiska Unionen

Frågeformulär för allmänläkare

Kryssa i rutan för ditt svar eller skriv ditt svar där det anges. Alla svar i detta frågeformulär kommer behandlas konfidenttiellt.

OFFICE USE ONLY

1. Hur många år har du arbetat som allmänläkare?

☐ år

1 ☐

2. Vilket årtal är du född?

19☐

2 ☐

3. Kön

Man ☐
Kvinna ☐

3 ☐

4. Var är din arbetsplats lokaliserad?

Stad? ☐
Landsbygd? ☐
Blandat stad/landsbygd? ☐

4 ☐

5. Är vårdcentralen/mottagningen:

Ensam - praktik/mottagning? ☐
Grupp - praktik/mottagning? ☐

5 ☐

6. Hur många allmänläkare, motsvarande heltidstjänster, arbeta på vårdcentralen, inkluderat dig.

☐

6 ☐

7. Hur många dagar i veckan arbetar du på mottagningen?

☐

7 ☐

8. Hur många patienter träffar du i medeltal på mottagningen varje vecka?

0 – 50 ☐
50 – 100 ☐
101 – 150 ☐
Mer än 150 ☐

8 ☐

9. Sammanlagt, hur många timmar vidarutbildning eller klinisk handledning i alkohol eller alkohol relaterade problem har du fått?

Ingen ☐
Mindre än 4 timmar ☐
4-10 timmar ☐
11-40 timmar ☐
Mer än 40 timmar ☐
Vet ej, kommer inte ihåg ☐

9 ☐

10. Med hänsyn till dina nuvarande ansvarsområden med patienter, hur högt prioriterar du i nuläget arbete med **förebyggande sjukdomar** som en del av din mottagning?

Mycket hög ☐
Något hög ☐
Något låg ☐
Mycket låg ☐

10 ☐

11. Jämfört med andra medicinska mottagningar som du känner till, hur mycket vikt lägger du på sjukdomsförebyggande arbete på din mottagning?

Mycket mer		11
Något mer		
Något mindre		
Mycket mindre		

12. Om patienten inte tar upp frågan om alkohol, frågar du om det?

Hela tiden		12
För det mesta		
En del av tiden		
Sällan eller aldrig		

14. Följande är beteenden som en del av vårdpersonalen anser vara relaterade till hälsa. Hur viktigt tror du varje av följande beteende är att främja **hälsan hos en vanlig människa?** *(Vänligen ringa in en siffra för varje del).*

Beteende	Mycket viktigt	Viktigt	Relativt viktigt	Oviktigt	
a. Inte röka	4	3	2	1	13
b. Fysisk aktivitet	4	3	2	1	
c. Måttlig alkoholkonsumtion	4	3	2	1	
d. Högt kaloriintag	4	3	2	1	14
e. Minska stress	4	3	2	1	15
f. Ansvarsfull användning beroende framkallande läkemedel	4	3	2	1	16
g. Inte använda narkotika	4	3	2	1	17

15. Ange i vilken **utsträckning du efterfrågar information** av dina patienter i varje av följande områden: *(Vänligen ringa in en siffra för varje del).*

Beteende	Alltid	Vid behov	Ibland	Sällan/Aldrig	
a. Rökning	4	3	2	1	18
b. Fysisk aktivitet	4	3	2	1	19
c. Alkoholkonsumtion	4	3	2	1	20
d. Högt kaloriintag	4	3	2	1	21
e. Stress	4	3	2	1	22
f. Användning av beroende framkallande mediciner	4	3	2	1	23
g. Narkotika	4	3	2	1	24

16. Läkare varierar i komptens och utbildning avseende rådgivning. Hur **redo** känner du dig för att ge råd till patienter på följande områden *(Vänligen ringa in en siffra för varje del).*

Beteende	Mycket redo	Redo	Inte redo	Inte alls redo	
a. Rökning	4	3	2	1	25
b. Fysisk aktivitet	4	3	2	1	26
c. Alkoholkonsumtion	4	3	2	1	27
d. Högt kaloriintag	4	3	2	1	28
e. Stress	4	3	2	1	29
f. Användning av beroende framkallande mediciner	4	3	2	1	30
g. Narkotika	4	3	2	1	31

32
33
34

17. **Hur effektiv** anser du att du är i att hjälpa patienter att åstadkomma en förändring på följande områden? *(Vänligen ringa in en siffra för varje del).*

Beteende	Mycket effektiv	Effektiv	Ineffektiv	Mycket ineffektiv	
a. Rökning	4	3	2	1	35
b. Fysisk aktivitet	4	3	2	1	36
c. Alkoholkonsumtion	4	3	2	1	37
d. Högt kaloriintag	4	3	2	1	38
e. Stress	4	3	2	1	39
f. Användning av beroendeframkallande mediciner	4	3	2	1	40
g. Narkotika	4	3	2	1	41

18. I allmänhet, **om du fick adekvat information och utbildning,** hur effektiva känner du att allmänläkare **skulle kunna bli i att** hjälpa patienter att förändra sina vanor? *(Vänligen ringa in en siffra för varje del).*

Beteende	Mycket effektiv	Effektiv	Ineffektiv	Mycket ineffektiv	
a. Rökning	4	3	2	1	42
b. Fysisk aktivitet	4	3	2	1	43
c. Alkoholkonsumtion	4	3	2	1	44
d. Högt kaloriintag	4	3	2	1	45
e. Stress	4	3	2	1	46
f. Användning av beroendeframkallande mediciner	4	3	2	1	47
g. Narkotika	4	3	2	1	48

19. För en frisk vuxen man, vad skulle du överväga för övre gräns för alkoholkonsumtion innan du skulle råda honom att skära ner? 49

Vänligen skriv ned……..standardglas per vecka 50
och ……standardglas per dag

För en frisk vuxen kvinna, vad skulle du överväga för övre gräns för alkoholkonsumtion innan du skulle råda henne att skära ner? 51

Vänligen skriv ned……..standardglas per vecka 52
och ……standardglas per dag

Ett standard glad består av antingen av 45 cl folköl, 33 cl starköl, 15 cl vin, 8 cl starkvin, eller 4 cl sprit
s

20. Ange hur mycket du instämmer eller avstår i vart och ett av följande påståenden om att arbeta med människor med alkoholproblem. För denna fråga avses **riskfylld eller skadlig alkoholkonsumtion,** men inte beroende av alkohol.

Påstående	Instämmer helt	Instämmer i hög grad	Instämmer delvis	Varken instämmer el tar avstånd	Tar avstånd delvis	Tar avstånd i hög grad	Tar helt avstånd	
a. Jag känner att jag kan tillräckligt mycket om alkoholproblem för att arbeta med aptietner med alkohol problem	7	6	5	4	3	2	1	53
b. Jag känner att jag på ett bra sätt kan informera mina patienter om alkohol och dess följder	7	6	5	4	3	2	1	54
c. Jag känner att jag inte har så mycket att vara stolt över när jag arbetar med patienter	7	6	5	4	3	2	1	55
								56
								57
								58
								59
								60
								61
								62

med alkoholproblem							
d. På det hela taget känner jag mig misslyckad när det gäller att arbeta med patienter med alkoholproblem	7	6	5	4	3	2	1
e. Jag vill arbeta mer patienter som har alkoholproblem	7	6	5	4	3	2	1
f. Pessimism är det mest realistiska attityden i arbete med patienter med alkoholproblem	7	6	5	4	3	2	1
g. Jag känner att jag har rätt att fråga patienten om sina alkoholkvanor när det behövs	7	6	5	4	3	2	1
h. Jag tycker mina patienter anser att jag har rätt att fråga dem frågor om alkohol när det behövs	7	6	5	4	3	2	1
i. I allmänhet är det givande att arbeta med patienter som har alkoholproblem	7	6	5	4	3	2	1
j. I största allmänhet tycker jag om patienter med alkoholproblem	7	6	5	4	3	2	1

63
64
65
66
67
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71
72

21. Ange hur mycket du instämmer eller tar avstånd till i följande påståenden, att arbeta med **patienter beroende av alkohol eller har stora problem med alkohol** (“alkholister”).

Påstående	Instäm merhelt	Instäm mer i hög grad	Instäm mer delvis	Varken instämmer el tar avstånd	Tar avstånd delvis	Tar avstånd i hög grad	Tar helt avstånd
a. Jag känner att jag kan tillräckligt mycket om alkoholproblem för att arbeta med patienter med alkohol problem	7	6	5	4	3	2	1
b. Jag känner att jag på ett bra sätt kan informera mina patienter om alkohol och dess följder	7	6	5	4	3	2	1
c. Jag känner att jag inte har så mycket att vara stolt över när jag arbetar med patienter med alkoholproblem	7	6	5	4	3	2	1
d. På det hela taget känner jag mig misslyckad när det gäller att arbeta med patienter med alkoholproblem	7	6	5	4	3	2	1
e. Jag vill arbeta mer patienter som har alkoholproblem	7	6	5	4	3	2	1
f. Pessimism är det mest realistiska attityden i arbete med patienter med alkoholproblem	7	6	5	4	3	2	1
g. Jag känner att jag har rätt att fråga patienten om sina alkoholkvanor när det behövs	7	6	5	4	3	2	1
h. Jag tycker mina patienter anser att jag har rätt att fråga dem frågor om alkohol när det behövs	7	6	5	4	3	2	1
i. I allmänhet är det givande att arbeta med patieneter som har alkoholproblem	7	6	5	4	3	2	1
j. I största allmänhet tycker jag om patienter med alkoholproblem	7	6	5	4	3	2	1

73
74

22. Under det senaste året, hur många gånger har du tagit eller beställt en **screening undersökning** (t.ex. alcohol I blodet, MCV, GGT, AUDIT) **på grund av bekymmer** för alkoholkonsumtionen? *(Vänligen ringa in en siffra för varje del).*

Aldrig	1
1 – 2 gånger	2
3 – 5 gånger	3
6 – 12 gånger.....	4
Fler än 12 gånger	5

23. Under det senaste året, hur många patienter har du speciellt behandlat för deras skadliga drickande eller alkoholproblem.

Ingen.....	1
1 – 6 patienter.....	2
7 – 12 patienter.....	3
13 – 24 patienter	4
25 – 49 patienter	5
50 eller fler patienter	6

24. Följande två frågor handlar om tidig intervention för skadlig konsumtion. Det inkluderar screening av patienter för att identifiera de med alkoholkonsumtion som gör att de löper en ökad risk för sjukdom, och sedan att ge råd för att minska sin alkoholkonsumtion.

Undersökningar i ett antal länder har visat att många läkare i allmänmedicin använder väldigt lite tid eller ingen på tidiga insatser av alkohol. Olika skäl har föreslagits varför det kan vara så. Ange i vilken utsträckning du tror att anledningen gäller genom att ringa in en lämplig siffra.

Påstående	**Stämmer helt och hållet**	**Stämmer ganska bra**	**Stämmer någorlunda**	**Stämmer inte**	**Vet ej**
a. Alkohol är ingen viktig fråga på vårdcentral	5	4	3	2	1
b. Läkare har fullt upp med att hantera det folk söker över	5	4	3	2	1
c. Läkare har en utbildning att ta hand om sjukdomar och att de inte fokuserar på förebyggande arbete	5	4	3	2	1
d. Läkare anser att den förebyggande hälsoåtgärder skulle vara patientens ansvar, inte deras	5	4	3	2	1
e. Läkare i primärvården har inte resurser på förebyggande rådgivning	5	4	3	2	1
f. Läkare känner sig obekväma att ställa frågor kring alkohol konsumtion eftersom om någon påpekar att någon har alkoholproblem kan det ses att man anklagar dem för att vara alkholister.	5	4	3	2	1
g. Läkare vet inte hur de skall identifiera personer som har alkoholproblem men som inte har några tydliga symtptom med hög konsumtion	5	4	3	2	1
h. Läkare har inga lämpliga screening instrument för att identifiera personer med alkoholproblem som inte har några uppenbara symptom av hög konsumtion	5	4	3	2	1
i. Läkare har inte tillgång till lämpligt rådgivnings material	5	4	3	2	1
j. Läkare har inte utbildning i hur man ger råd för att minska alkohol	5	4	3	2	1

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k. Läkare tror att alkohol rådgivning innebär att familjen involveras och måste ta hänsyn till sociala konsekvenser och därför också svårt	5	4	3	2	1
l. Läkare tror inte att patienter skulle lyssna på deras råd och förändra sitt beteende	5	4	3	2	1
m. Läkare har själva en liberal attityd till alkohol	5	4	3	2	1
n. Läkare har själva kanske alkoholproblem	5	4	3	2	1
o. Läkare tror att patienter skulle bli kränkta att bli tillfrågade om deras alkoholkonsumtion	5	4	3	2	1
p. Den offentliga hälso- och sjukvården har inte betalt läkare för primärpreventiva åtgärder	5	4	3	2	1
q. Den offentliga vården uppmuntrar i allmänhet inte läkare som vill syssla med primärpreventiva åtgärder	5	4	3	2	1
r. Privata hälso försäkringar ger inte ersättning till patienter för alkoholrådgivning hos privata läkare TA BORT???	5	4	3	2	1

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25. Läkare i ett antal länder har föreslagit en mängd saker som kan leda till att fler läkare gör tidiga insatser för riskfylld alkoholkonsumtion. Ange för varje påstående i vilken utsträckning det **skulle** uppmuntra att du själv gör mer tidiga interventioner för riskfylld alkoholkonsumtion, ringa in lämpligt svar.

Påstående	**Stämmer helt och hållet**	**Stämmer ganska bra**	**Stämmer någorlunda**	**Stämmer inte**	**Vet ej**
a. Folkhälsokampanjer har gjort människor mer bekymrade om alkohol	5	4	3	2	1
b. Patienter efterfrågar rådgivning i alkohol	5	4	3	2	1
c. Patienter är villiga att betala för alkoholrådgivning	5	4	3	2	1
d. Snabba och lätta screenings frågeformulär var tillgängliga	5	4	3	2	1
e. Snabba och lätta rådgivningsmaterial var tillgängliga	5	4	3	2	1
f. Tidig intervention har visat sig vara framgångsrik	5	4	3	2	1
g. Utbildnignsprogram för tidiga insatser för alkohol fanns tillgängliga	5	4	3	2	1
h. Utbildning i tidiga interventioner för alkohol var en kontinuerlig medicinsk utbildning	5	4	3	2	1
i. Utbildning i tidiga interventioner för alkohol redovisas som medicinska efterutbildnignspoäng	5	4	3	2	1
j. Stödjande tjänster (självhjälp/rådgivning) finns som det är enkelt att hänvisa patienter till	5	4	3	2	1
k. Lön och arbetsvillkor förbättras	5	4	3	2	1

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26. Ange hur mycket du instämmer eller tar avstånd ifrån i vart och ett av följande påståenden om följande politiska strategier för att minska de alkoholrelaterade skadorna i Europa? *(Vänligen ringa in en siffra för varje del).*

Påstående	Instämmer helt	Instämmer delvis	Varken instämmer el tar avstånd	Tar avstånd delvis	Tar avstånd helt
a. Individer är ansvariga nog att skydda sig från alkoholrelaterade skador	5	4	3	2	1
b. Offentliga myndigheter måste agera för att skydda individer från alkoholrelaterade skador	5	4	3	2	1
c. Unga och storkonsumenter skulle köpa **mindre** alkoholhaltiga drycker som öl, vin, och sprit om priset **höjdes** med 25 %	5	4	3	2	1
d. Om polisen gör slumpmässiga alkoholtester på vägarna I EU skulle det minska människors alkoholkonsumtion innan de kör bil	5	4	3	2	1
e. Unga och oerfarna förare bör max ha 0.2 promille I blodet i alla 27 EU medlemsstater	5	4	3	2	1
f. Försäljning och servering av alkohol till personer under 18 år bör förbjudas i alla EU medlemsstater	5	4	3	2	1
g. Alkoholreklam som riktar sig till unga människor bör förbjudas i alla EU medlemsstater	5	4	3	2	1
h. Varningar bör finnas på alkohol **flaskor** med syfte att varna gravid kvinnor och förare av farorna med att dricka alkohol	5	4	3	2	1
i. Varningar bör finnas **i alkoholreklam** med syfte att varna gravid kvinnor och förare av farorna med att dricka alkohol	5	4	3	2	1
j. Folk skulle köpa mer alkoholhaltiga drycker som öl, vin eller sprit om priset **sänktes** med 25 %	5	4	3	2	1

27. Hur effektiva tror du att följande politiska åtgärder kan vara att minska alkoholrelaterade skador **i ditt land?** *(Vänligen ringa in en siffra för varje del).*

Påstående	Mycket effektivt	Ganska effektivt	Något effektivt	Ineffektivt	Ingen åsikt
a. Hög lägsta lagliga åldern för att dricka alkohol	5	4	3	2	1
b. Höj minsta lagliga åldern för att köpa alkoholhaltiga drycker	5	4	3	2	1
c. Minska den rättsliga blodalkohlkoncentrationen för rattfylleri för alla förare	5	4	3	2	1
d. Förbättra alkohol utbildning i skolor	5	4	3	2	1
e. Öka restriktioner för alkoholreklam	5	4	3	2	1
f. Behålla eller införa statligt monopol på detaljhandeln för alkohol	5	4	3	2	1
g. Inför en minimumpris för försäljning av alkohol	5	4	3	2	1
h. Öka alkoholpriset genom skatter	5	4	3	2	1
i. Minska densitet (täthet) för försäljningsställen för alkohol	5	4	3	2	1
j. Ytterligare reglering för försäljningsställen (stormarknad)	5	4	3	2	1

k. Väga folkhälsoaspekter för att ge och förnya tillstånd av alkoholförsäljning	5	4	3	2	1
l. Införa obligatoriska program för tidig uttäckt och tidig intervention för personer med riskfylld eller skadlig alkoholkonsumtion i primärvården	5	4	3	2	1

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28. Har du tidigare fyllt i ett frågeformlär för 12 år sedan?

Ja ☐
Nej ☐

31. Om du vill fylla i fler åsikter eller kommentarer på frågeformuläret eller andra aspekter på alkohol problem, använd raderna nedan

Tack för att du fyllde i formuläret!

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PROJECT ODHIN

WORK PACKAGE 4

SURVEYS

PROTOCOL

A field survey in primary health care will be performed in 9 countries from the European Union: Catalonia, Czech Republic, England, Italy, the Netherlands, Poland, Portugal, Slovenia and Sweden. The national data will be collected and combined to consolidate and update knowledge of potential barriers and facilitators for general practitioners to implement Identification and Brief Intervention (IBI) for hazardous and harmful drinking programs. Also, the study aims to increase the understanding of factors that affect whether clinicians will use the IBI intervention. In addition, the survey will allow comparing attitudes towards patients who drink alcohol excessively, and experiences in delivering IBI in participating European countries with differing cultures, organization and funding of Primary Health Care services. The study will use a comparable method to the Strand I of the third phase of the WHO Collaborative Study on Brief Interventions for Hazardous and Harmful Alcohol Use (Anderson, 1996; Monteiro and Gomel, 1998).

1. Participants

In most countries, a representative sample of General Practitioners (Family Physicians) will be invited to participate in the survey. General practices will be taken directly by selection from databases of practitioners maintained by national or regional health authorities and/or associations of Family Physicians in each of the countries. In each participating country at least 250 physicians will be surveyed. In Slovenia, all General Practitioners (Family Physicians) will be requested to participate.

2. Survey Instrument

The survey questionnaire will consist of 28 questions with the ability for each of the participating countries to add up to three further country-specific additional questions. The semi-structured questionnaire will be based on the instrument used in the WHO Phase III strand I study in 1999 (Anderson et al., 2001) and later on the survey of GP attitudes to primary care alcohol intervention in 2009 in England (Wilson et al., 2011).

The questionnaire includes questions on demographic information about doctors and practices, the attitudes of doctors working with patients who drink alcohol, their beliefs about their own activities in working with drinkers, extent of academic education and postgraduate training on alcohol received by general practitioners, their views and attitudes towards management of alcohol problems, their diagnostic performance and their reported management of alcohol problems during the past year, including number of patients managed in the previous year, working environment and its impact on intervening for alcohol problems.

The Shortened Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ) (Anderson and Clement, 1987) will be included to assess GPs' inclination towards intervening for alcohol problems; 10-item instrument measures adequacy, task-specific self-esteem, motivation, legitimacy and satisfaction of physicians (Anderson et al., 2004a). The SAAPPQ items will be used separately in respect of hazardous or harmful ('problem') drinkers and dependent drinkers.

In the subsequent section, respondents will indicate their agreement on a scale of one to four ('not at all' to 'very much'), with 18 suggested barriers and 11 suggested incentives to early intervention for alcohol in general practice.

In addition, to gauge the influence of policy change on attitudes and behaviour, GPs will rate the effectiveness of 10 European public policies and 12 suggested policy measures in each country to tackle alcohol problems on a scale from one to five (1 = no opinion, 2 = ineffective, 3 = slightly effective, 4 = quite effective, 5 = very effective).

Finally, an open-ended question will be included at the end of the questionnaire to collect individual experiences or comments of the surveyed physicians.

Translation and back-translation

The final English version of the questionnaire will be translated in each country to the native language and the translation will be later validated by back translation into English and confirmed by an English native speaker in terms of language accuracy and appropriateness for primary care. Where available, a translated copy of the original WHO questionnaire from 1999 will be used as a master in the process of translation. In such a case, only newly added questions will be translated and back translated.

3. Procedures

Ethical Approval

Depending on country law and regional regulations, the ethical approval of the Bioethics Committee (Institutional Review Board) will be received before the study started.

4. Sampling

In each country, an accessible database of general practitioners will be sought and used to draw a sample. In most of the countries, these databases will be used to obtain the information on sex, age, address, type and location of practices. According to this data, a representative sample of minimum 250 physicians per country will be drawn randomly where possible after stratification for sex, age, geographic location. In Catalonia and Poland the email invitations will be sent to all members of associations of Family Physicians. In the case of the Catalonian online survey, measures will be taken to ensure the representativeness by sex, age group and geographic location of the final sample obtained. In Slovenia the paper version will be mailed along with the invitation letter to all GPs in the country. In Portugal, a representative sample of total family physicians registered in the Health System Central Administration will be stratified by gender, age group and Health Region. In the Netherlands, a representative sample, concerning sex, age, situation and degree of urbanization, of 1,600 GPs from the whole country will be drawn.

If a group practice is drawn, only one GP per practice will be selected. The sample size will be adjusted accordingly to the response rate, so that a final number of returned questionnaires fit the minimum sample size of 250.

5. Implementation of the survey

The survey will be carried out in each country separately by the group of researchers or a survey company. The questionnaires will be mailed by post office, e-mailed or the questionnaire will be put on a special website that GPs will be able to access with a unique login name and password that was sent by e-mail. In such cases, electronic mail will be sent containing the relevant information about the study, encouragement and the link to this website. If the questionnaire is mailed by post, a reply paid envelope will be included in the mail. In the Czech Republic, research assistants will interview GPs face-to face.

To ensure an adequate response rate, in some cases additional techniques will be utilised. In Italy GPs will be first contacted by telephone, the study will be explained and an e-mail address requested. In Portugal the list of selected doctors in each Group of Health Centres will be sent to their Executive Director, jointly with a letter asking for support of the dissemination and encouragement of selected doctors to fill the questionnaire. In the Netherlands one reminder with a new questionnaire including a reply paid envelope will be sent to non-responders. In Sweden (expecting a low participation rate) a stepwise procedure is planned. At first, a postal invitation to four regions in different parts of the country will be sent. This will be followed by an e-mail invitation in most other regions of the country, and finally will be followed by an invitation by postal mail in the rest of Sweden. In the last round, lottery tickets to enhance the response rate will be offered. In Catalonia, an incentive will be offered by raffling an Apple IPAD to those who complete the survey and a reminder will be sent to participants on the 2nd of the 3 week survey period.

After return of filled in questionnaires, completeness of answers will be checked, allowing no more than 5% of missing data. If there are more missing answers, the respective GP will be re-contacted where possible with a request to supplement the answers.

The information from the questionnaires will be put into the data collection form and then typed/transferred into the database. Final statistical analysis and comparisons of a combined data from all countries will be conducted in the leader centre (Medical University of Warsaw, Poland).