



**Optimizing Delivery of Health Care Interventions  
ODHIN (2011-2014)  
Project no. 259268**

**SECOND PERIODIC REPORT  
Period: 01/07/2012 – 31/12/2013**



## PROJECT PERIODIC REPORT

**Grant Agreement number:** 259268  
**Project acronym:** ODHIN  
**Project title:** Optimizing Delivery of Health Care Interventions  
**Funding Scheme:** FP7 Collaborative project  
**Date of latest version of Annex I against which the assessment will be made:** 2012-07-01  
**Periodic report:** 2<sup>nd</sup> Periodic report  
**Period covered:** From 01/07/2012 to 31/12/2013  
**Name, title and organisation of the scientific representative of the project's coordinator:**  
Dr. Antoni Gual  
Head of the Addictions Unit  
Hospital Clínic i Provincial de Barcelona (HCPB)  
**Tel:** +34932279923  
**Fax:** +34932271750  
**E-mail:** [tgual@clinic.ub.es](mailto:tgual@clinic.ub.es)  
**Project website address:** [www.odhinproject.eu](http://www.odhinproject.eu)



## DECLARATION BY THE SCIENTIFIC REPRESENTATIVE OF THE PROJECT COORDINATOR

I, as scientific representative of the coordinator of this project and in line with the obligations as stated in Article II.2.3 of the Grant Agreement declare that:

- The attached periodic report represents an accurate description of the work carried out in this project for this reporting period;
- The project (tick as appropriate):
  - has fully achieved its objectives and technical goals for the period;
  - has achieved most of its objectives and technical goals for the period with relatively minor deviations.
  - has failed to achieve critical objectives and/or is not at all on schedule.
- The public website,
  - is up to date
  - is not up to date
- To my best knowledge, the financial statements which are being submitted as part of this report are in line with the actual work carried out and are consistent with the report on the resources used for the project (section 3.4) and if applicable with the certificate on financial statement.
- All beneficiaries, in particular non-profit public bodies, secondary and higher education establishments, research organisations and SMEs, have declared to have verified their legal status. Any changes have been reported under section 3.2.3 (Project Management) in accordance with Article II.3.f of the Grant Agreement.

Name of scientific representative of the Coordinator: Dr. Antoni Gual

Date: 1/04/2014

**Signature:**





## INDEX

|   |    |
|---|----|
| 1. LIST OF BENEFICIARIES .....  | 5  |
| 2. PUBLISHABLE SUMMARY .....  | 6  |
| 3. PROJECT OBJECTIVES, WORK PROGRESS AND ACHIEVEMENTS DURING THE PERIOD ..... | 9  |
| WP2 – KNOWLEDGE BASE .....  | 10 |
| WP3 – COST EFFECTIVENESS .....  | 20 |
| WP4 – SURVEYS .....   | 24 |
| WP5 – STEPPED CLUSTER RCT .....   | 32 |
| WP6 – ASESMENT TOOL .....   | 47 |
| WP7 – FROM SCIENCE TO POLICY.....   | 57 |
| 4. PROJECT MANAGEMENT DURING THE PERIOD .....                                 | 70 |
| 5. DELIVERABLES AND MILESTONES TABLES.....                                    | 70 |
| 1. TABLE OF DELIVERABLES .....  | 70 |
| 2. TABLE OF MILESTONES.....   | 72 |



## **1. LIST OF BENEFICIARIES**

| <b>Beneficiary number</b> | <b>Beneficiary short name</b> | <b>Beneficiary organisation name</b>                                  | <b>Country</b> |
|---------------------------|-------------------------------|---|----------------|
| 1                         | FCRB                          | FUNDACIO PRIVADA CLINIC PER A LA RECERCA BIOMEDICA                    | Spain          |
| 2                         | RUNMC                         | STICHTING KATHOLIEKE UNIVERSITEIT                                     | Netherlands    |
| 3                         | USFD                          | THE UNIVERSITY OF SHEFFIELD   | United Kingdom |
| 4                         | UoY                           | UNIVERSITY OF YORK  | United Kingdom |
| 5                         | Ceformed                      | AZIENDA PER I SERVIZI SANITARI n°2 ISONTINA                           | Italy          |
| 6                         | NU                            | UNIVERSITY OF NEWCASTLE UPON TYNE                                     | United Kingdom |
| 7                         | KCL                           | KING'S COLLEGE LONDON   | United Kingdom |
| 8                         | UGOT                          | GOETEBORGS UNIVERSITET  | Sweden         |
| 9                         | LIU                           | LINKOPINGS UNIVERSITET  | Sweden         |
| 10                        | GENCAT                        | DEPARTAMENT DE SALUT - GENERALITAT DE CATALUNYA                       | Spain          |
| 11                        | PARPA                         | PANSTWOWA AGENCJA ROZWIĄZYWANIA PROBLEMÓW ALKOHOLOWYCH                | Poland         |
| 12                        | UCL                           | UNIVERSITY COLLEGE LONDON   | United Kingdom |
| 13                        | UL                            | UNIVERZA V LJUBLJANI  | Slovenia       |
| 14 (UTRO)                 | IDT (UTRO)                    | INSTITUTO DA DROGA E DA TOXICODEPENDENCIA (UTRO)                      | Portugal       |
| 14                        | SICAD                         | SERVICO DE INTERVENCAO NOS COMPORTAMENTOS ADITIVOS E NAS DEPENDENCIAS |                |
| 15                        | ISS                           | ISTITUTO SUPERIORE DI SANITA  | Italy          |
| 16                        | UM                            | UNIVERSITEIT MAASTRICHT   | Netherlands    |
| 17                        | SZU                           | STATNI ZDRAVOTNI USTAV  | Czech Republic |
| 18                        | PAM                           | POMORSKI UNIWERSYTET MEDYCZNY W SZCZECINIE                            | Poland         |
| 19                        | MUW                           | WARSZAWSKI UNIWERSYTET MEDYCZNY                                       | Poland         |



## 2. PUBLISHABLE SUMMARY

### 2.1. SUMMARY DESCRIPTION OF THE PROJECT CONTEXT AND THE MAIN OBJECTIVES

The European Union is the region of the world with the highest levels of per-capita alcohol consumption. There are many drinkers who regularly consume amounts of alcohol that put their health at considerable risk; according to the latest estimates for Europe, this applies to some 15% of the adult population. A vast body of scientific research has found that brief advice in health care settings can reduce the prevalence of hazardous and harmful drinking and their associated problems by up to 20%. Such advice, if extensively delivered is an important tool, among others, in reducing the negative health impacts of alcohol at the population level.

ODHIN is using the implementation of identification and brief intervention programmes (IBI) for hazardous and harmful alcohol consumption (HHAC) in primary health care (PHC) as a case study to better understand how to translate the results of clinical research into every day practice. Systematic reviews investigating the impact of different behavioural, organisational and financial strategies in changing provider behaviour have been undertaken across a range of clinical lifestyle interventions; a baseline measurement of services for managing hazardous drinking in PHC available in European countries has been carried out; a cluster randomised controlled trial is being performed to test the incremental effect of a range of strategies to improve the delivery of screening and brief advice for HHAC in primary health settings; and ODHIN is developing an evidence-based database on effective and cost-effective IBI measures for use in PHC.

The general objective of the project is to improve the delivery of health care interventions by understanding how to better translate the results of clinical research into everyday clinical practice. The ODHIN project aims to improve screening and brief interventions in primary care to reduce hazardous drinking.

The **scientific objectives** of ODHIN include the study of a number of aspects relating to the effectiveness and cost-effect of identification and brief interventions for harmful and hazardous alcohol consumption:

- the impact of different behavioural, organizational and financial strategies in changing provider behaviour across a range of clinical lifestyle interventions, explored through a series of systematic reviews.
- potential barriers and facilitators to dissemination and implementation processes for identification and brief intervention programmes for hazardous and harmful alcohol consumption in primary health care within current organisational arrangements.
- modelling studies test the impact of different identification and brief intervention approaches on changes in alcohol consumption and the resulting impacts on healthcare costs and health-related quality of life will provide evidence for both methodologies and measures to investigate the dissemination and implementation processes.
- A stepped cluster randomised controlled trial methodology is used to test the incremental effect of strategies that raise awareness, insight, acceptance of and performance of IBI programmes, and that improve acceptance, change and maintenance of implementation with financial and organisational strategies, with the intent to spread knowledge and the associated evidence-based interventions, and the adoption and integration of evidence-based health interventions in primary health care settings.
- the extent of current provision of clinical practice for IBI programmes for hazardous and harmful alcohol consumption in PHC settings is being assessed in order to measure the sustainability of effective dissemination and implementation processes.



## **2.2. DESCRIPTION OF THE WORK PERFORMED SINCE THE BEGINNING OF THE PROJECT AND THE MAIN RESULTS ACHIEVED SO FAR**

WP1 – Coordination - is in charge of the coordination and management of ODHIN both at administrative, financial and scientific level. Creating and maintaining efficient communication channels between the project participants has enabled collaboration and exchange of ideas, and also continuous support and follow-up of the different tasks. Such are the project website, regular e-mail exchange and rounds of conference calls. In addition, 3 plenary meetings and two WP-specific meetings have been held so far.

WP2 – Knowledge base – The overall objective was to add to the knowledge base on how IBI approaches for lifestyle issues can be successfully disseminated and implemented in everyday routine PHC practice. This has been achieved through a 3-step review methodology, which has found that implementation strategies have a statistically significant effect on the provision of prevention and health promotion activities of care providers, although, only some implementation strategies have proven effects on changing patient lifestyles. Multi-component implementation strategies tailored at identified implementation barriers seem to have positive effects on the healthcare provider as well as on patients, whereas evidence indicates that professional education is effective, but the effect size varies per lifestyle topic. A clear knowledge gap exists concerning the effectiveness of financial oriented implementation strategies.

WP3 - Cost effectiveness – has adapted the Sheffield Alcohol Policy Model from the UK context, and modelled the cost-effectiveness of screening and brief interventions (SBI) in the Netherlands, Poland and Italy. These adaptations show that national programmes of SBI are estimated to be highly cost-effective in all three countries. We have also devised a framework to allow these results to be generalised to estimate the costs and health benefits of such programmes in other EU countries.

WP4 – Surveys – has assessed provider attitudes and the experience of implementation of IBI programmes in 9 different European countries, based on the responses of 2,435 European physicians. A comparative report on attitudes, barriers and facilitators in regards to IBI programmes for hazardous drinking has been produced. The findings indicate that education on alcohol, a supportive working environment, and role security (influenced by education and a supportive work environment) were independently related to the number of patients managed for alcohol-related harm. The top two barriers for delivering IBI were lack of time and the lack of a specific training in counselling for reducing alcohol consumption.

WP5 – A Stepped cluster RCT in 5 countries is being used to study factors which could increase the implementation of evidence-based IBI methods. The RCT has been designed and carried out following a comprehensive study protocol, recruiting over 700 providers. Data collection for all measurement periods is due to be completed in Spring 2014, and will be analysed following an agreed analysis plan. A preliminary analysis of the baseline measurement shows that the recruited providers undertook alcohol screening in 1 in 14 of their consultations.

WP6 - Assessment tool –The assessment tool developed under the Primary Health Care European Project on Alcohol (PHEPA project) has been formalised, operationalised and tested, gathering information from 23 European countries in order to assess the extent of implementation of IBIs for hazardous and harmful alcohol consumption throughout PHC settings. A comprehensive report has been produced.

WP7 - From science to policy –The work package aims to disseminate the findings of the project amongst the scientific community, forming a network of IBI implementation researchers and translating science into easily understandable conclusions and recommendations. Over 50 dissemination activities have been carried out across the project, and a round of national policy dialogues has taken place.



### 2.3. EXPECTED FINAL RESULTS AND THEIR POTENTIAL IMPACTS AND USE

The project has so far produced 5 of the 8 expected deliverables: a knowledge base of successful implementation of screening and brief intervention for lifestyle issues in every day routine primary health care practice; a report on the adaptation of the cost-effectiveness of IBI model to 3 European countries and its generalisation to Europe; a report describing the attitudes and managing alcohol problems in general practice in Europe; a protocol of the RCT to study factors which could increase the implementation of evidence-based IBI methods; and a report describing the available services for the management of hazardous and harmful alcohol consumption in Europe.

During the last 12 months of the project, ODHIN partners' work will concentrate on two main areas: the analysis of WP5's RCT results, elaborating a final report presenting the results of the trial (D5.2) and an implementation guide for policy makers (D5.3); and the dissemination of the overall project findings using a variety of tools including a series of factsheets, a final policy dialogue, an evidence-based database on IBIs, and a future challenges guidance (D7.1) for the governance of delivering screening and brief intervention programmes for hazardous and harmful alcohol consumption.

Thus, research work will be translated into easily understandable conclusions and recommendations concerning effective approaches to adopting IBI into daily practice. All final outputs will be developed in a clear and intelligible language, so that findings may be used by decision-makers in the design and implementation of IBI programmes and made available to the general population.

The ODHIN project aims to have a twofold socio-economic impact: the evidence provided on the cost-effectiveness of policy measures designed to promote the implementation of IBI programmes can be used to optimise public expenditure in this field, and therefore potentially improve the coverage and/or the intensity of the identification and clinical management of harmful alcohol consumption. In parallel, the project's implementation will act as a sensitizing force towards the relevance of identifying and managing harmful alcohol consumption (i.e. through surveys with general practitioners (WP4), training and support courses in primary health care settings (WP5) or dissemination activities (WP7)). In the long term, the wider potential societal impacts would be an improvement in the health and well-being of European citizens, and a reduction of alcohol-related costs in society (avoidable mortality and disease, loss of productivity, damage to interpersonal relationships, etc.), thanks to an improvement in the delivery of alcohol-related health care interventions.





### **3. PROJECT OBJECTIVES, WORK PROGRESS AND ACHIEVEMENTS** **DURING THE PERIOD**

|            |                               |
|------------|-------------------------------|
| <b>WP2</b> | <b>Knowledge base</b>         |
| <b>WP3</b> | <b>Cost effectiveness</b>     |
| <b>WP4</b> | <b>Surveys</b>                |
| <b>WP5</b> | <b>Stepped cluster RCT</b>    |
| <b>WP6</b> | <b>Assessment tool</b>        |
| <b>WP7</b> | <b>From science to policy</b> |



## WP2 – KNOWLEDGE BASE

### **1. WP LEADER:**

RUNMC (RADBOD UNIVERSITY NIJMEGEN MEDICAL CENTRE, NETHERLANDS)

### **2. OTHER PARTNER INSTITUTIONS INVOLVED:**

NU (NEWCASTLE UNIVERSITY, INSTITUTE OF HEALTH AND SOCIETY, NEWCASTLE, UNITED KINGDOM)

### **3. DESCRIPTION OF WP OBJECTIVES (OVERALL AND FOR MONTHS 19-36)**

The overall objective is to bridge the gap between evidence base clinical research and everyday clinical practice by building a knowledge base on how identification and brief interventions (IBI) for lifestyle issues can be successfully disseminated and implemented in everyday routine practice. The focus of the application and this WP is on primary health care and on hazardous and harmful alcohol consumption, nonetheless the hypothesis is that this knowledge base can be translated to the dissemination and implementation of IBI for other lifestyle issues and in other healthcare settings. This overall aim is specified in the following two objectives:

1. To identify effective strategies to disseminate and implement IBI in primary care settings.
2. To identify factors that foster or limit dissemination and implementation IBI in primary care settings.

In months 1 to 18 we focused on objective 1 to identify (effective) strategies for disseminating and implementing IBI in primary care settings. The identification of factors was based on the extraction of studies and was primarily carried out in the next 18 months.

In months 19 to 36 we focused on completing objective 2 to identify (effective) strategies for disseminating and implementing IBI in primary care settings. The identification of factors was based on finalizing the extraction of and analysis of studies. Furthermore, the focus was on finalizing the deliverable report.

### **4. DESCRIPTION OF THE PROGRESS TOWARDS OBJECTIVES, INCLUDING DETAILS FOR EACH OF THE WP'S TASKS**

It is important to note that WP2 is subdivided in three steps:

1. Firstly, the (cost-) effectiveness of professional educational and reimbursement strategies on lifestyle and prevention targeted at health professionals were reviewed (review of reviews) as well as the (cost-) effectiveness of e-health strategies on lifestyle and prevention targeted at patients/citizens.
2. Secondly, a review and meta-regression of trials on implementing screening and brief interventions for hazardous and harmful alcohol consumption in primary healthcare was completed.
3. Thirdly, results of the review of trials were compared with other reviews on lifestyle issues such as smoking, non-exercise and unhealthy diet.

The three steps have different tasks, which we will describe below. However, all tasks were carried out through an iterative process with various tasks and different timelines per approach (where relevant we specify the task per approach).

In months 1-18 we focused on steps 1 and 2, in months 18-36 we focused on steps 2 and 3:



### Task 1: Protocol

- In months 1-4 a protocol was written describing the 3 steps. The protocol was completed in April 2011, and in June 2011 an amendment was incorporated (attached to the 1st periodic report).

### Task 2: Searches

- How
  - i. Searching computerized databases:

Step 1 was carried out and completed: search for references and data-extraction.

Step 2 was carried out and completed: Search for relevant papers: Medline, EMBASE, Cinahl and CCTR database of the Cochrane Library. First an adequate search strategy was developed. The search strategy included terms related to primary healthcare (set A), related to alcohol drinking (set B), to dissemination and implementation strategies or interventions (set C) and to study design (set D). The strategy developed by EPOC was used as the starting point. We used the pre-2008 EPOC search template as well as the current (post-2008) EPOC search template for all four libraries (pre-2008 was attached to 1st periodic report; post-2008 attached as “OD\_WP2\_AP2\_EPOC post-2008 search template”). This strategy included terms related to set A, C and D. Set B was based on search strategy developed by the Drug and Alcohol group combined with terms used within the WHO international collaborative project implementing IBI. The search strategy was discussed amongst the participants and a pilot search was conducted to assure that the strategy was both sensitive and specific enough to cover all relevant papers. Next, the final strategy was adopted to the specific databases and run. The search was updated in March 2013.

Step 3 was carried out and completed: Pubmed and the Cochrane Library were searched with a pre-defined search strategy. The search was split up and combined into four sets by the Boolean operator AND: Set 1: primary health care; Set 2: systematic reviews; meta-analysis; Set 3: smoking; exercise; diet; (food; nutrition); Set 4: 5 year limitation (see “OD\_WP2\_AP3\_WP2 search strategy step 3”)
  - ii. Searching clinical trial databases (e.g. clinical trial.gov). Step 2: These databases were searched to identify ongoing research and unpublished research.
  - iii. Contacting experts in the field. Step 1, 2 and 3: All participants in ODHIN project, as well as other experts in the field were contacted to identify ongoing trials, unpublished papers and grey literature (reports, policy papers, etc).
  - iv. Searching reference lists. Step 1, 2 and 3: Finally, the reference lists of papers included were hand - searched to identify additional papers.
- When:

Step 1: Months 3 - 16

Step 2: Months 4 – 28

Step 3: Months 30-35

### Task 3: Endnote X3

- How: Identified references were entered into Endnote X3 and an Excel-file. The Excel-file has been used as a logbook to identify included and excluded references and reasons for exclusion. Full text copies of potentially relevant papers were obtained and archived.
- When: Months 3-35

### Task 4: Identification of relevant papers

- How: A short checklist to identify relevant papers was developed. Next, the title and abstracts of the paper identified by the searches are screened for inclusion independently by two reviewers. Disagreements between reviewers were resolved by a third reviewer.
- When:

Step 1: Months 6 - 18



Step 2: Months 8 – 29 (this is a continuous task as new papers will still be identified in the next months, although this WP has formally ended in month 36).

Step 3: Months 33-35

#### Task 5: Data collection

- How:

Step 1: A data extraction form was developed and tested on 2-3 papers. Papers were extracted by two reviewers independently. Any disagreement was to be resolved by discussion. The data-extraction template was attached to the 1st periodic report.

Step 2: A data extraction form was developed and tested on 4 to 6 papers. Each identified paper was extracted by two independent reviewers. Eight independent reviewers completed data-extraction. The data-extraction template was attached to the 1st periodic report.

Step 3: A data extraction form was applied based on step 1. Data were captured on first author, aim of the review, implementation strategy, participants, number of studies included, results, conclusions of authors and our own remarks for this work package (see “OD\_WP2\_AP4\_WP2 data-extraction form step 3”).

- When:

Step 1: month 7-18

Step 2: month 15 – 31

Step 3: month 33-35

#### Task 6: Data analysis

- How:

Step 1: All data were entered in an electronic database (excel), see “OD\_WP2\_AP5\_WP2 data-extracted step 1”. Due to substantial heterogeneity formal meta-analyses were not possible, and a qualitative analyses has been undertaken. The results are described in the deliverable report (see “OD\_WP2\_AP1\_D2.1 Knowledge base”).

Step 2: All data were entered in an electronic database (excel), see “OD\_WP2\_AP6\_WP2 data-extracted step 2”. Meta-analysis and meta-regression analysis were carried out. Meta-analyses were executed with the MetaEasy version 1.0.4. program. Standardised effect sizes were calculated, both for dichotomous and continuous outcomes. A fixed effects model was applied for all meta-analyses. The data-set of MetaEasy is available upon request. Meta-regression analyses were executed with SPSS version 20. This dataset is available upon request.

Step 3: All papers were assessed with narrative analyses. In more detail, papers were first assessed on a) general study characteristics; b) the method of reporting effectiveness, c) key findings and, if applicable, outcomes for which an effect and statistical significance could be calculated; d) effects for subgroups or subcomponents of reviewed implementation strategies outcomes and in the absence of an overall effect; see “OD\_WP2\_AP4\_WP2 data-extraction form step 3”.

- When:

Step 1: Month 15-20

Step 2: Month 20-34

Step 3: Month 34-35

#### Task 7: Conference meeting

- How:

Step 1: The results of our analysis were discussed at a conference meeting with the ODHIN participants and in particular with the participants involved in the development and conduction of the RCT (WP5).

Step 2: The results of our narrative analyses, and planned quantitative analyses were discussed at an ODHIN meeting with the ODHIN partners and in particular with the participants involved in the development and conduction of WP2.



Step 3: The planned search and narrative analyses were discussed at an ODHIN meeting with the ODHIN partners and in particular with the participants involved in the development and conduction of WP2.

- When:

Step 1: Month 13: preliminary results of the first approach were discussed at ODHIN meeting in Barcelona, February 2012 (attached to the 1st periodic report).

Step 2: Month 33: Preliminary results from step 1 and step 2 were presented in a plenary session at the INEBRIA conference in Rome September 20, 2013 (see “OD\_WP2\_AP7\_WP2 presentation INEBRIA”).  
Month 34: results of our narrative analyses, and planned quantitative analyses were discussed at the ODHIN meeting October 2013 (see “OD\_WP2\_AP8\_WP2 presentation ODHIN meeting Oct 2013”).

Task 8: Writing a series of scientific papers

This will be carried out from month 36 onwards

Task 9: Writing a guide for dissemination and implementation

The report, which serves as a Deliverable, was delivered early January 2014 (see “OD\_WP2\_AP1\_D2.1\_Knowledge base”)

The present status of the Work Package is as follows:

Step 1: completed, results are written in the Deliverable report

Step 2: completed, results are written in the Deliverable report

Step 3: completed, results are written in the Deliverable report

Currently we have started writing a manuscript for peer reviewed journals. In the upcoming months the manuscripts will be submitted for publication.

## 5. SIGNIFICANT RESULTS ACHIEVED SO FAR

The **Deliverable 2.1 report** *Knowledge base of successful implementation of screening and brief intervention for lifestyle issues in every day routine primary health care practice* has been completed and delivered (see “OD\_WP2\_AP1\_D2.1\_Knowledge base”). Below is a summary of the work performed.

Objective: To complete literature reviews to assess the impact of different behavioural, organisational and financial strategies in changing healthcare provider behaviour across a range of clinical lifestyle interventions.

Methods: Three reviews were done as described in study the protocol. Firstly, the (cost-) effectiveness of professional educational and reimbursement strategies on lifestyle and prevention targeted at health professionals were reviewed (review of reviews) as well as the (cost-) effectiveness of e-health strategies on lifestyle and prevention targeted at patients/citizens. Secondly, a review and meta-regression of trials on implementing screening and brief interventions for hazardous and harmful alcohol consumption in primary healthcare was completed. Thirdly, results of the review of trials were compared with other reviews on lifestyle issues such as smoking, non-exercise and unhealthy diet.

Results: The review of reviews showed that none of the categories of educational, financial, e-health or multifaceted oriented interventions was consistently effective on changing behaviour of professionals or patients. Nevertheless, overall trends were identified. Reviews of multi-component implementation strategies suggested that synergy was created in implementation effectiveness by combining different types of implementation strategies, especially when strategies were finetuned to implementation barriers. Furthermore, the evidence base with regard to professional educational and e-health interventions



regarding lifestyle interventions showed positive results on provider and patient level. The effect of financial oriented interventions remains inconclusive and needs further investigation.

The results from the review of trials confirmed our presumption that implementation strategies significantly increased the uptake of screening and brief interventions by healthcare providers. In patients' alcohol consumption level we saw a positive trend which was not statistically significant. Meta-regression analysis suggested that application of implementation strategies from multiple implementation domains or levels (e.g. professional education compared with patient oriented strategy like patient feedback) was more effective than using strategies from a single domain on improving screening and brief interventions at the provider level. On the patient level, combining patient oriented with professional and/or organisational oriented strategies showed strongest effect.

The comparative narrative review revealed findings on some implementation strategies of the whole spectrum that could be compared to the trials included in the 2nd review (review of trials): 1) The use of electronic medical records showed positive trends, but were not statistically significant in either of the studies from the review of trials as well as from this comparative review; 2) Both reviews showed a strong effectiveness of multi-component implementation strategies; 3) Both reviews showed that professional educational strategies are likely to be effective amongst a range of lifestyles; 4) Evidence about organisational oriented strategies to enhance implementation of lifestyle interventions was hardly found.

Discussion, conclusion and recommendations: The results presented in these reviews highly agree overall literature about implementation science. Implementation strategies have statistically significant effect on the provision of prevention and health promotion activities of care providers. On the patient level, only some implementation strategies have proven effects regarding lifestyle interventions. Multi-component implementation strategies tailored at identified implementation barriers seem to have positive effect on the healthcare provider as well as on patients. In addition, there were strong indications that professional education is effective, but the effect size varies per lifestyle topic. Besides, optimal education intensity was not identifiable. However, it seemed important that professional education was delivered in the practice setting and applied a stepwise problem solving approach, and that involving professionals with various backgrounds is likely to give synergy in effects (e.g. in general practice). Evidence about optimal education intensity was inconclusive. Evidence from especially the review of trials indicated that combining patient oriented as well as professional and/or organisational oriented implementation strategies was of significant added value, compared to only professional oriented strategies, on the patient alcohol consumption.

Recommendations for practice:

- Successfully changing professional behaviour with regard to SBI does not automatically result in a reduction of patients' alcohol consumption. Therefore we recommend the use of multi-component oriented implementation strategies including the patient level as well as the professional and/or organisation level.
- Involving professionals with various backgrounds in the professional oriented implementation strategy is likely to be more effective on screening behaviour than involvement of just one professional discipline.

Recommendations for further research:

- Evaluate effects on both the levels of provider screening and brief interventions as well as patients' alcohol consumption.
- It needs some time to firstly change healthcare provider behaviour and subsequently influencing patient behaviour. This requires long-term trials, measuring the effects on the short term, after 3 and 6 months and long-term after 12, 18 and even 24 months.
- Investigate effectiveness of financial oriented implementation strategies, as there is a clear knowledge gap in that field.



- Investigate to what extent other providers in primary healthcare besides GP's can be involved in, since many trials involve solely GPs.
- Cost-effectiveness of different implementation strategies should be further investigated.
- Determinants of effective implementation strategies should be further investigated. For example: what is the optimal intensity of an educational intervention aimed at nurses and GPs to stimulate screening and brief interventions for hazardous and harmful alcohol use; what is the optimal intensity of financially incentivising general practices in stimulating them to do screening and brief interventions; what factors of e-health strategies determine the effectiveness at patient level. In addition, applied implementation strategies in studies should be described in more detail.

**Milestones and working documents** of WP2 are as follows:

This Work Package's Milestone (MS1: Core group workshop on the search strategy for the series of scientific papers review) has been achieved. This was done at the ODHIN kick-off meeting during 21-23 February 2011 in Barcelona. Supporting documents of this milestone are:

- Workshop 2011 presentation (attached to the 1st periodic report).
- WP2 protocol (attached to the 1st periodic report).
  - This includes WP2 objectives, description of three-stepped approach, ODHIN WP2 participants, checklist for inclusion, search methods, selection of relevant papers, data extraction, methodological quality, data analyses, proposed search strategy, WP2 milestones, and WP2 deliverables.
- WP2 protocol amendment (attached to the 1st periodic report). This includes revised in-/exclusion criteria and revised time schedule.

Other Working documents and tools produced the first 18 months and which were used and fine-tuned throughout months 19-36 are:

- Logs of step 1 and step 2 (see "OD\_WP2\_AP9\_WP2 Log step 1" and "OD\_WP2\_AP10\_WP2 Log step 2"): of both approaches we kept a log of all in-/ and excluded (with reason of exclusion) papers. In both documents, 1 final table was managed as a current final overview of included papers.
- Tools: Data extraction forms both from step 1 and step 2 (attached to 1st periodic report, not changed after delivering 1st periodic report).
- All data extracted from step 1 and step 2 were entered in an electronic database (excel), see "OD\_WP2\_AP5\_WP2 data-extracted step 1" and "OD\_WP2\_AP6\_WP2 data-extracted step 2"
- All data quantitatively analysed from step 2 was applied with MetaEasy and with SPSS. These datasets are available upon request.

During months 19-36 two dissemination activities have been organised:

- Presenting preliminary results from step 1 and step 2 in a plenary session at the INEBRIA conference in Rome September 20, 2013 (see "OD\_WP2\_AP7\_WP2 presentation INEBRIA").

Presenting results from step 1 and results from narrative analysis of step 2 data, and planned quantitative step 2 analyses and step 3 approach (see "OD\_WP2\_AP8\_WP2 presentation ODHIN meeting Oct 2013").

## **6. REASONS FOR DEVIATIONS FROM THE DESCRIPTION OF WORK AND THEIR IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING**

- In the original Description of Work it was proposed to write a protocol for the Cochrane Effective Practice and Organisation of Care Group. The protocol (approach 2; review of trials) was not written for the EPOC group, although it was written following the EPOC criteria. We decided to aim at publications in peer-reviewed journals instead of focusing on the Cochrane Library, as described in the 1st periodic report.



- In the original Description of Work it was planned to also search Psychinfo, Alcohol Problems Science Database (ETOH), Special Register of EPOC and Cochrane Drug and Alcohol Group, and DARE. At the kick-off meeting, it was decided to focus on the main literature databases, as described in the 1st periodic report.
- Hand-searching relevant specialised journals was not done, as these journals all are included in the Medline, EMBASE, Cinahl and/or CCTR databases. Hand-searching is therefore redundant as described in the 1st periodic report.
- Identified references were not entered into Reference Manager, but were entered into Endnote X3, as described in the 1st periodic report.
- In the original Description of Work we described that it was expected to produce at least 6 scientific papers. We adjusted our expectation to 2 to 6 papers, as described in the 1st periodic report
- In the original Description of Work we described to use SPSS and/or Review Manager to quantitatively analyse step 2 data. SPSS was applied, but instead of Review Manager we used MetaEasy version 1.0.4. programme, as this programme provided more facilities for statistical tests. Still, as described in the original Description of Work, standardized effect sizes were calculated and a formal meta-analysis of the research findings was undertaken. In addition, SPSS was applied for the meta-regression analysis. Sub-group analyses were undertaken to explore the effect of differences in interventions (1. use of a single type of EPOC implementation strategy versus the use of multiple EPOC implementation strategies; 2. the type of EPOC implementation strategy; 3. whether or not the programme included multiple components within their implementation strategy; and 4. Study duration  $\leq$  12 months versus study duration  $>$ 12 months). Specificity of the programme (e.g. alcohol specific or behaviour specific) and country were not taken into account as these were of less relevance, as described in the deliverable report.
- Available resources: we increased the number of man-months invested in this WP as described in the 1st periodic report. During the 1st reporting period there were 10.63 man-months invested in this work package. During the 2nd reporting period there were more hours invested compared to the 1st reporting period (14.32 man-months). The total amount of man-months is approximately consistent with the original scheduled 27 man-months for this WP, but a bit lower than the latest estimation of 31 man-months. These man-months were instead invested in WP5, due to difficulties in recruitment practices (See report WP5).
- Planning: The completion of the reviews was expanded 12 months as explained in the 1st periodic report.

## **7. REASONS FOR FAILING TO ACHIEVE CRITICAL OBJECTIVES AND/OR NOT BEING ON SCHEDULE, EXPLAINING IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING**

- The delivery date of WP2 Knowledge Base was expanded 12 months as explained in the 1st periodic report.
- WP2 was expanded with an additional step, which comprised a review of reviews, as described in the 1st periodic report.

## **8. PROPOSAL OF CORRECTIVE ACTION**

Not applicable.





## 9. WP MEETINGS AND CALLS

The following table lists face to face meetings and conference calls between work package partners occurred throughout Months 19-36. Notes of all face-to-face WP2 discussions are included in “OD\_WP2\_AP11\_WP2 minutes”. These notes are in Dutch. Besides face-to-face discussions, many discussions took place via e-mail. However, these are not described in this document (unfeasible).

| DATE (DD/MM/YYYY) | TYPE (FACE TO FACE MEETING OR CONFERENCE CALL) | LOCATION (ONLY IF FACE TO FACE MEETING) (VENUE/CITY/COUNTRY) | AIM OF THE MEETING  | ATTENDEES   |
|-------------------|--|--|---|---|
| 12/03/2013        | Conference call                                | -  | WP2 update on progress call   | Peter Anderson, Toni Gual, Miranda Laurant, Jillian Reynolds  |
| 24/04/2013        | Skype meeting                                  | -  | Reaching consensus about data-extraction details  | Eileen Kaner, Myrna Keurhorst   |
| 20/09/2013        | Conference meeting                             | INEBRIA conference, Rome, Italy                              | Presenting preliminary results from step 1 and step 2 in a plenary session  | INEBRIA members   |
| 01/10/2013        | Face to face meeting                           | Barcelona, Spain   | Presenting results from step 1 and results from narrative analysis of step 2 data, and planned quantitative step 2 analyses and step 3 approach | P. Anderson, C. Angus, P. Bendtsen, F. Braddick, K. Brzozka, N. Charles-Harris, J. Colom, L. Csémy, P. Deluca, C. Gandin, T. Gual, M. Keurhorst, M. Laurant, J. Li, H. López, S. Matrai, D. Newbury-Birch, K. Okulicz, J. Palacio, K. Parkinson, C. Ribeiro, F. Rosario, L. Segura, E. Scafato, L. Slodownik, H. Sovinova, F. Spak, P. Struzzo, M. Wojnar |

## 10. LIST OF DISSEMINATION ACTIVITIES

### Activity 1

- Type of activity: Oral Conference presentation
- Main Leader: RUMC
- Title: International collaboration in Primary Health Care Research
- Date: 05/10/2012
- Place: Utrecht, Netherlands
- Type of audience: Scientific community (higher education, or Research)
- Size of audience: 90
- Countries addressed: Netherlands

### Activity 2

- Type of activity: Oral Conference presentation
- Main Leader: RUMC
- Title: Effective Implementation of EIBI/SBI
- Date: 20/09/2013
- Place: INEBRIA conference, Rome



- Type of audience: Scientific community (higher education, or Research); Industry; Policy makers
- Size of audience: 200
- Countries addressed: All countries participating in the INEBRIA Meeting, mostly Europe + USA

### Activity 3

- Type of activity: Oral presentation to a scientific community
- Main Leader: RUMC
- Title: Changing providers' behavior – what works? WP 2 – Knowledge base
- Date: 01/10/2013
- Place: Barcelona
- Type of audience: Scientific community
- Size of audience: 25
- Countries addressed: Spain, United Kingdom, Italy, Sweden, Poland, Slovenia, Portugal, Czech Republic, Netherlands

## 11. PROJECT PUBLICATIONS

The WP2 partners are currently working on various scientific papers, which are expected to be submitted to scientific journals throughout 2014.

## 12. APPENDICES

| NAME FILE ATTACHED                                       | TYPE OF DOCUMENT:<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | CORRESPONDING<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | COMMENTS   |
|--|--|--|--|
| OD_WP2_AP1_D2.1_<br>Knowledge base                       | Deliverable  | D2.1   | Deliverable completed December 2013 and submitted early January 2014   |
| OD_WP2_AP2_EPOC<br>post-2008 search<br>template          | Other: working document  | ..   | EPOC revised their search templates, therefore we updated our search with this template  |
| OD_WP2_AP3_WP2<br>search strategy step 3                 | Other: working document  | ..   |  |
| OD_WP2_AP4_WP2<br>data-extraction form<br>step 3         | Other: working document  | ..   |  |
| OD_WP2_AP5_WP2<br>data-extracted step 1                  | Other: working document  | ..   |  |
| OD_WP2_AP6_WP2<br>data-extracted step 2                  | Other: working document  | ..   |  |
| OD_WP2_AP7_WP2<br>presentation INEBRIA                   | Other: dissemination activity  | ..   | Document to share preliminary results from step 1 and step 2 at INEBRIA conference 2013, Rome  |
| OD_WP2_AP8_WP2<br>presentation ODHIN<br>meeting Oct 2013 | Other: dissemination activity  | ..   | Document to present results from step 1 and results from narrative analysis of step 2 data, and planned quantitative step 2 analyses and step 3 approach |
| OD_WP2_AP9_WP2 Log<br>step 1                             | Other: working document  | ..   | We kept a log of all in-/and excluded papers. 1 final table was managed as   |



|                               |                         |    |   |
|-------------------------------|-------------------------|----|---|
|                               |                         |    | current final overview of included papers.  |
| OD_WP2_AP10_WP2<br>Log step 2 | Other: working document | .. | We kept a log of all in-/ and excluded papers. 1 final table was managed as current final overview of included papers.  |
| OD_WP2_AP11_WP2<br>minutes    | Other: working document | .. | In this document notes of all face-to-face minutes were documented. Notes are in Dutch. Besides face-to-face discussions, a lot of discussions were done by e-mail. However, these are not described in this document (unfeasible). |

### 13. STATEMENT ON THE USE OF RESOURCES – WP2

See 4.7. *Summary on the use of resources per work package and per beneficiary* (below).



## WP3 – COST EFFECTIVENESS

### **1. WP LEADER:**

USFD (THE UNIVERSITY OF SHEFFIELD, UNITED KINGDOM)

### **2. OTHER PARTNER INSTITUTIONS INVOLVED:**

RUNMC (RADBOD UNIVERSITY NIJMEGEN MEDICAL CENTRE, NETHERLANDS)

UOY (UNIVERSITY OF YORK, UNITED KINGDOM)

CEFORMED (CENTRO REGIONALE DI FORMAZIONE PER L'AREA DELLE CURE PRIMARIE, ITALY)

PARPA (PANSTWOWA AGENCJA ROZWIĄZYWANIA PROBLEMÓW ALKOHOLOWYCH, POLAND)

### **3. DESCRIPTION OF WP OBJECTIVES (OVERALL AND FOR MONTHS 19-36)**

The objectives of WP3 are threefold:

1. To adapt the Sheffield Alcohol Policy Model (SAPM) and its appraisal of the cost-effectiveness of screening and brief interventions (SBI) from its current context of England, to model the effectiveness of SBI in the Netherlands, Poland and Italy
2. To use the results of the modelling to consider generalizability of interventions across the EU
3. To investigate modelling long-term cost-effectiveness of dissemination approaches studied in RCTs in other WPs.

In months 19-36 we have completed our work on objectives 1 and 2. We are awaiting the results of the WP5 trial in order to address objective 3.

### **4. DESCRIPTION OF THE PROGRESS TOWARDS OBJECTIVES, INCLUDING DETAILS FOR EACH OF THE WP'S TASKS**

The DoW lists 9 tasks for WP3 (with months in brackets):

1. Work with country collaborator teams to define SBI strategies to be analysed (1-2)
2. Explore data availability in each country compared with ideal data required for model adaptation. Agree proposed data collection/evidence synthesis specific to each country (2-6)
3. Agree outline of model adaptation required in each country given available data (7-9)
4. Adapt model to context in the Netherlands (10-15)
5. Adapt model to context in Italy (16-21)
6. Adapt model to context in Poland (22-27)
7. Analyse results within and across countries (15-33)
8. Make generalisations on EU transferability (15-33)
9. Reporting (9-36)

Tasks 1-3 were completed by month 10, with the production of a report outlining the protocol for tasks 4-6.

Task 5, the Italian model adaptation, was begun in month 10 and completed in month 15. A scientific paper describing the model adaptation process and presenting the results and their implications for Italian decision makers has been published by BMC Family Practice (see publications).

Work on task 4, the Dutch model adaptation, began in month 16. A preliminary version of the model was produced in month 28, with a revised and refined final adaptation completed in advance of the project



meeting in month 34. A draft journal article has been produced, although we are awaiting some of the results from the Dutch arm of the WP5 trial, before submitting this for publication.

Work on task 6 was carried out concurrently with sections of task 4, with work commencing in month 22. As with the Dutch model, a preliminary version was produced in month 28, with the final adaptation completed in month 33. A draft journal article has been produced and we are presently revising this in collaboration with colleagues at PARPA in Poland, with a view to submitting this for publication before month 39.

An analysis of the results both within and between the 3 countries (task 7) was presented at the project meeting in month 34. This has subsequently been expanded and forms a significant part of the final WP3 model report (see "OD\_WP3\_AP1\_D3.1-Cost Effectiveness Model Report").

Work began in month 25 on a novel 'meta-modelling' methodology which allows the results from tasks 4-6 to be generalised to other EU countries. This work was presented at the 39<sup>th</sup> annual alcohol epidemiology symposium of the Kettil Bruun Society from 3<sup>rd</sup>-7<sup>th</sup> June 2013 (see dissemination activities for more details). Further improvements to the methodology were undertaken in months 32 and 33 and are presented in the final WP3 model report (see "OD\_WP3\_AP1\_D3.1-Cost Effectiveness Model Report"). We hope to submit a paper detailing the methods and results of this work for publication before month 42.

Overall the progress of this WP has been highly successful, with all tasks completed and the deliverable submitted on schedule (December 2013). However, work on objective 3 has not been able to start until the results of the WP5 trial are available. This will be discussed further in section 6.

## **5. SIGNIFICANT RESULTS ACHIEVED SO FAR**

The principal scientific results achieved so far within the WP are the adaptation of the Sheffield Alcohol Policy Model to Italy, the Netherlands and Poland. These adaptations show that national programmes of Screening and Brief Interventions are estimated to be highly cost-effective in all three countries. We have also devised a framework to allow these results to be generalised to estimate the costs and health benefits of such programmes in other EU countries. For full details please see the final WP3 model report (see "OD\_WP3\_AP1\_D3.1-Cost Effectiveness Model Report").

## **6. REASONS FOR DEVIATIONS FROM THE DESCRIPTION OF WORK AND THEIR IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING**

The original description for task 8 proposed a 2 day joint workshop involving invited participants from all of the countries in the ODHIN consortium. Following discussions between Alan Brennan and Colin Angus as USFD with Peter Anderson it was decided that the logistical difficulty of arranging such a workshop, whilst ensuring attendance of key stakeholders from all ODHIN partner countries, meant that it was unclear that such a workshop was the best way to achieve objective2 of the WP. We believe that the creation of the meta-model framework described in the final model report (see "OD\_WP3\_AP1\_D3.1-Cost Effectiveness Model Report") presents a clearer benefit to policy makers across Europe and we plan to disseminate the results of this work via a series of briefing notes and/or fact sheets. In addition to these plans, the collaborating teams in each country have sought to communicate the WP3 results directly with stakeholders. For example we have shared the results of the Dutch model and discussed their practical implications with the Dutch College of General Practitioners (NHG) who are in the process of revising their guidelines on the treatment of alcohol disorders.



## 7. REASONS FOR FAILING TO ACHIEVE CRITICAL OBJECTIVES AND /OR NOT BEING ON SCHEDULE, EXPLAINING IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING

Analysis of the cost-effectiveness of the strategies being trialled in WP5 is the 3<sup>rd</sup> key objective of WP3. Work on this objective has not yet begun as the results from the trial are not yet available to analyse. It is anticipated that the results from WP5 will be available by month 40 (April 2014) and an addendum to the final WP3 model report (see “OD\_WP3\_AP1\_D3.1-Cost Effectiveness Model Report”) will be produced by month 46 (October 2014) detailing the methods and results of this analysis to fulfil objective 3.

This delay has had no impact on any other tasks or objectives, nor any resource or planning issues.

## 8. PROPOSAL OF CORRECTIVE ACTION

No corrective action required.

## 9. WP MEETINGS AND CALLS

| DATE (DD/MM/YYYY) | TYPE (FACE TO FACE MEETING OR CONFERENCE CALL) | LOCATION (ONLY IF FACE TO FACE MEETING) (VENUE/CITY/COUNTRY) | AIM OF THE MEETING          | ATTENDEES  |
|-------------------|--|--|-----------------------------|--|
| 12/03/2013        | Conference call                                | -  | WP3 update on progress call | Peter Anderson, Colin Angus, Alan Brennan, Toni Gual, Jillian Reynolds |

## 10. LIST OF DISSEMINATION ACTIVITIES

### Activity 1

- Type of activity: Conference
- Main Leader: USFD
- Title: Towards a generalised cost-effectiveness model for screening and brief interventions - Results from the ODHIN project
- Date: 04/06/2013
- Place: Kampala, Uganda: Kettil Bruun Society annual conference
- Type of audience: Scientific community
- Size of audience: 200
- Countries addressed: International audience
- Link to online information about this activity: Not available

## 11. PROJECT PUBLICATIONS

In addition to the publication below, 3 other publications are in various stages of submission and preparation. It is anticipated that these will all be published in open access scientific journals by month 42.

### Publication 1

- D.O.I: 10.1186/1471-2296-15-26
- Title\*:Cost-effectiveness of a programme of screening and brief interventions for alcohol in primary care in Italy
- Main Author\*:Colin Angus



- Other authors\*: Emanuele Scafato, Silvia Ghirini, Aleksandra Torbica, Francesca Ferre, Pierluigi Struzzo, Robin Purshouse, Alan Brennan
- Title of the periodical or the series\*: BMC Family Practice
- Number, date or frequency\*: 2014, 15:26
- Publisher: BioMed Central
- Date of publication\*: 06/02/14
- Open access is/will be provided to this publication: yes
- Link to online abstract/text: <http://www.biomedcentral.com/1471-2296/15/26/>

## 12. APPENDICES

| NAME FILE ATTACHED                                 | TYPE OF DOCUMENT:<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | CORRESPONDING<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | COMMENTS                                |
|--|--|--|---|
| OD_WP3_AP1_D3.1-Cost<br>Effectiveness Model Report | Deliverable  | D3.1   | Listed as Deliverable 3.1 in<br>the DoW |

## 13. STATEMENT ON THE USE OF RESOURCES – WP3

See 4.7. *Summary on the use of resources per work package and per beneficiary* (below).



## WP4 – SURVEYS

### **1. WP LEADER:**

MUW (MEDICAL UNIVERSITY OF WARSAW)

### **2. OTHER PARTNER INSTITUTIONS INVOLVED:**

FCRB (FUNDACIO PRIVADA CLINIC PER A LA RECERCA BIOMEDICA /HOSPITAL CLINICO PROVINCIAL DE BARCELONA – HCPB, SPAIN)

RUNMC (RADBODU UNIVERSITY NIJMEGEN MEDICAL CENTRE, NETHERLANDS)

CEFORMED (CENTRO REGIONALE DI FORMAZIONE PER L'AREA DELLE CURE PRIMARIE, ITALY)

NU (NEWCASTLE UNIVERSITY, INSTITUTE OF HEALTH AND SOCIETY, NEWCASTLE, UNITED KINGDOM)

KCL (KING'S COLLEGE LONDON, LONDON, UNITED KINGDOM)

UGOT (UNIVERSITY OF GOTHENBURG, SWEDEN)

LIU (LINKOPING UNIVERSITY, SWEDEN)

GENCAT (DEPARTAMENT DE SALUT – GENERALITAT DE CATALUNYA, SPAIN)

UL (UNIVERZA V LJUBLJANI, SLOVENIA)

IDT (ISTITUTO DA DROGA E DA TOXICODIPENDENCIA, PORTUGAL)

ISS (ISTITUTO SUPERIORE DI SANITA, ITALY)

UM (UNIVERSITEIT MAASTRICHT, NETHERLANDS)

SZU (STATNI ZDRAVOTNI USTAV, CZECH REPUBLIC)

### **3. DESCRIPTION OF WP OBJECTIVES (OVERALL AND FOR MONTHS 19-36)**

The **Overall objectives** of Work Package 4 Surveys were:

1. To consolidate and update knowledge of potential barriers and facilitators for general practitioners to implement 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;
4. To learn how information about health care interventions is created, packaged, transmitted, and interpreted among a variety of important stakeholder groups.

In the course of the project (1-36 months) objectives 1 – 3 have been addressed. The survey performed did not allow meeting objective 4 (see section 6).

### **4. DESCRIPTION OF THE PROGRESS TOWARDS OBJECTIVES, INCLUDING DETAILS FOR EACH OF THE WP'S TASKS**

**Work Package 4** included several consecutive tasks undertaken mostly in the months 1-18: construction of the survey instrument, adaptation of the instrument, writing the protocol of the survey, implementation of the survey in 9 European countries, and collection of data.

#### **Task 1. Construction of the survey instrument**

The survey questionnaire (attached to the 1<sup>st</sup> periodic report) consisted of 28 questions with the possibility for each of the participating countries to add up to three further country-specific additional questions.

The questionnaire included 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. Moreover, the Shortened Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ) was included to assess GPs' inclination towards intervening for alcohol problems; the instrument measures adequacy, task-specific self-esteem, motivation, legitimacy and satisfaction of physicians. The SAAPPQ items were used separately in respect of hazardous or harmful drinkers and dependent drinkers.

In the subsequent section, respondents indicate their agreement 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. At the end, an open-ended question was included 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 was later approved by all the partners after a series of email exchange.

#### **Task 2.1 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 in close consultation with the ODHIN project leaders. The final version of the protocol (attached to the 1<sup>st</sup> periodic report) was presented, discussed, and approved by all partners across a series of email communication and at the ODHIN Partner Meeting in Barcelona (14-15.02.2012).

#### **Task 2.2 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 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 were attached to the 1<sup>st</sup> periodic report (and are also annexed to the end of the WP's deliverable 4.1).

#### **Task 2.3 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.

#### **Task 2.4 Sampling**

In each country, an accessible database of general practitioners was sought and used to draw a sample. 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 the 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.



Following this common sampling procedure, there were some variations between countries in the survey fieldwork:

- In Catalonia, the survey was done online, and email invitations were sent to all members of the Catalan Association of Family Physicians. In this case, measures were taken to ensure the representativeness by sex, age group and geographic location of the final 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. One GP randomly was sampled from each of 419 selected PC practices.
- In Italy, a database of Italian GPs with available telephone numbers and email addresses was used. From those physicians, 500 GPs were selected by regions.
- 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 randomly select 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.

The details of the sampling method and survey implementation are described in the Table 1 of the Final Report of the Survey (OD\_WP4\_AP1\_D4.1\_Survey Report).

### **Task 3. 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 of the Final Report of the Survey 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 a login name and password. 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 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.

In the UK, 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.

In the first reporting period, 4 countries (UK, Slovenia, Catalonia, and Czech Republic) completed the survey fieldwork, whereas the rest of the countries completed the fieldwork and data collection within the second reporting period. The detailed data collection periods per country are available in Table 2 of the Final Report of the Survey (OD\_WP4\_AP1\_D4.1\_Survey Report).

#### **Task 4.1 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; attached to the 1<sup>st</sup> periodic period) was designed and prepared in the leader centre (Medical University of Warsaw, Poland). Final statistical analysis and comparisons of combined data from all countries were conducted as the collection process was completed in the months 19-36.

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 the survey questionnaire). Following the method adopted by Anderson, 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.

***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 the survey questionnaire). Following the method adopted by Anderson, 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'.

***A supportive working environment*** was measured by four items that resulted from a factor analysis of 18 statements measuring views as to why general practitioners might spend very little or no time at all on early intervention for alcohol problems (Question 24 of the survey questionnaire). The factor analysis was undertaken with SPSS version 10, varimax rotation, and eigen value > 1.0. The four items measured the availability of suitable screening materials; the availability of suitable counselling materials; training in counselling; and the availability of help with handling difficult family and social problems (Cronbach's standardized item alpha 0.76). Individual missing values for any of the items of the factor were assigned the mean value of the remaining items of the factor before being summed. Responses to the four statements comprising the factor were summed. General practitioners were grouped as those with a supportive working environment (the top half of the total possible score) and those with a non-supportive working environment (the bottom half of the total possible score).

***Role security and therapeutic commitment*** were measured by responses to the short form of the Alcohol and Alcohol Problems Perception Questionnaire (see Question 20 of the survey instrument). The SAAPPQ 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).

The whole dataset was combined and analysed at the level of the individual general practitioner. The basic statistical analyses included comparisons across countries. Mantel-Haenszel common odds ratio estimates were calculated.

**Achieved Deliverable:** D4.1 Survey Report - a report describing the findings of the surveys and giving guidance on the dissemination and implementation of screening and brief interventions based on the findings – was submitted to the European Commission in March 2013. However, after submission the authors have produced an updated version of the document which has been submitted replacing the previous version and is attached to this report (see OD\_WP4\_AP1\_D4.1\_Survey Report).

**Achieved Milestone:** MS3: 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), resulting in the final version of the survey protocol (Appendix file attached to the 1<sup>st</sup> periodic report).

**Publications and dissemination:** No publications have been prepared so far; however, two paper presentations (1<sup>st</sup> - attached to the previous report, and 2<sup>nd</sup> - “OD\_WP4\_AP2\_Abstract INEBRIA 2013” attached to this report) were presented at the 9<sup>th</sup> Conference of INEBRIA, (27-28.09.2012, Barcelona, Spain) and the 10<sup>th</sup> Conference of INEBRIA, (18-20.09.2013, Rome, Italy) respectively.

## 5. SIGNIFICANT RESULTS ACHIEVED SO FAR

With respect to the WP4 planned results:

1. **Survey Questionnaire** (Appendix 1 to the 1<sup>st</sup> periodic report) for family physicians was designed, translated and validated in 9 European countries (corresponding questionnaires may be found annexed to the WP deliverable).
2. **Survey Methodology** for the study was elaborated (Appendix 2 to the 1<sup>st</sup> periodic report).
3. The master **Data Set** was prepared (Appendix 13 to the 1<sup>st</sup> periodic report).
4. The survey was completed in all 9 countries (Catalonia, Czech Republic, Italy, Netherlands, Poland, Portugal, Slovenia, Sweden and UK) reaching 2435 GPs who completed the questionnaire.
5. The detailed results of primary analyses are included in the “**Survey of attitudes and managing alcohol problems in general practice in Europe – Final Report**” (see OD\_WP4\_AP1\_D4.1\_Survey Report).

As explained in the Deliverable report, 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.

## 6. REASONS FOR DEVIATIONS FROM THE DESCRIPTION OF WORK AND THEIR IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING

1. We decided not to address **Objective 4** in the surveys. After construction and final approval of the survey questionnaire, since the survey covers only general practitioners, there was no way to gather and analyse information from different stakeholders groups. This decision will not impact the flow and the procedures in the other ODHIN work packages.
2. We decided not to include the question about **alcohol consumption of doctors** because some GPs might feel uncomfortable or insulted, potentially having a negative effect on the response rate and risking the completion of the survey.
3. Also, the **working environment** of GPs was covered only in some countries, as in some cases this issue appeared not to be relevant at all.
4. In some countries, where the survey was sent to all GPs in the country (Slovenia) or to all GPs from one organisation (Catalonia, Poland), it was not possible to select only one GP per practice or to stratify the sample by age, sex, etc. So, in these few countries the sample was designed and the survey was performed **without stratification**. (In Catalonia the representativeness of the responses was checked throughout and after the completion of the survey, and the final distribution by age, sex and location did not differ substantially from the real distribution).
5. **Ethical issues**: There was no need to obtain informed consent from the subjects participating in an anonymous survey, according to the ethical regulations in some countries. Only in a few countries (UK, Poland, Slovenia) ethical approval from the Bioethics Committees was sought and received, according to the regional tradition and regulations. See the Sampling and survey implementation by country (Table 1. in the Final Report; OD\_WP4\_AP1\_D4.1\_Survey Report).
6. All these changes are minor and will not impact the flow and the procedures in the other ODHIN work packages.

## 7. REASONS FOR FAILING TO ACHIEVE CRITICAL OBJECTIVES AND /OR NOT BEING ON SCHEDULE, EXPLAINING IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING

1. In most of the participating countries there were problems in getting General Practitioners involved and recruited to participate in the survey. In some countries these problems were substantial, which led to low recruitment or response rates and to significant delays. Due to these difficulties in reaching the expected number of the GPs surveyed and questionnaires completed in some countries, the **timeline** had to be adjusted. Implementation of the survey was not completed by Month 12 as anticipated in ODHIN's Description of Work. The completion of the survey was delayed until **Month 21**. Data analyses were conducted afterwards, between **Months 21 and 24**.
2. Due to significant delays in some countries (as described above), the timeline was adjusted, and the main **DELIVERABLE** including the data analysis of all countries (**D4.1 Survey Report: see OD\_WP4\_AP1\_D4.1\_Survey Report**) was delayed until **March 2013**. This impacted the writing of scientific papers that started after **Month 30**, and has not been completed yet.

The delay in the survey implementation and preparing the survey report will not impact the flow and the procedures in the other ODHIN work packages.



## 8. PROPOSAL OF CORRECTIVE ACTION

More intensive work on writing the papers is planned for **Months 37-40** of the project.

## 9. WP MEETINGS AND CALLS

| DATE (DD/MM/YYYY) | TYPE (FACE TO FACE MEETING OR CONFERENCE CALL) | LOCATION (ONLY IF FACE TO FACE MEETING) (VENUE/CITY/COUNTRY) | AIM OF THE MEETING          | ATTENDEES  |
|-------------------|--|--|-----------------------------|--|
| 21/02/2013        | Conference call                                | -  | WP4 update on progress call | Peter Anderson, Toni Gual, Jillian Reynolds, Marcin Wojnar |

## 10. LIST OF DISSEMINATION ACTIVITIES

As mentioned above, results from the ODHIN WP4 survey were presented at the 10<sup>th</sup> INEBRIA conference in Rome.

### Activity 1

- Type of activity: Oral presentation to a scientific event
- Main Leader: MUW
- Title: Attitudes and managing alcohol problems in general practice in Europe. Results from the European ODHIN study
- Date: 20/09/2013
- Place: INEBRIA conference, Rome
- Type of audience: Scientific community
- Size of audience: 200
- Countries addressed: Europe
- Link to online information about this activity (if available): N/A

## 11. PROJECT PUBLICATIONS

No publications based on the results of WP4 have been submitted so far, although they are expected to be in the upcoming project months.

## 12. APPENDICES

| NAME FILE ATTACHED               | TYPE OF DOCUMENT: DELIVERABLE/MILESTONE/OTHER ACTIVITY OR TASK | CORRESPONDING DELIVERABLE/MILESTONE/OTHER ACTIVITY OR TASK | COMMENTS   |
|----------------------------------|--|--|--|
| OD_WP4_AP1_D4.1_Survey Report    | Deliverable  | D4.1   | Survey of attitudes and managing alcohol problems in general practice in Europe – Final Report |
| OD_WP4_AP2_Abstract INEBRIA 2013 | Other activity   | ..   | Abstract of the paper presented at the 2013 INEBRIA Meeting                                    |



### 13. STATEMENT ON THE USE OF RESOURCES – WP4

See 4.7. *Summary on the use of resources per work package and per beneficiary* (below).



## WP5 – STEPPED CLUSTER RCT

### **1. WP LEADER:**

UGOT (UNIVERSITY OF GOTHENBURG, SWEDEN)

and

LIU (LINKÖPING UNIVERSITY, SWEDEN)

### **2. OTHER PARTNER INSTITUTIONS INVOLVED:**

FCRB (FUNDACIO PRIVADA CLINIC PER A LA RECERCA BIOMEDICA /HOSPITAL CLINICO PROVINCIAL DE BARCELONA – HCPB, SPAIN)

RUNMC (RADBOUD UNIVERSITY NIJMEGEN MEDICAL CENTRE, NETHERLANDS)

NU (NEWCASTLE UNIVERSITY, INSTITUTE OF HEALTH AND SOCIETY, NEWCASTLE, UNITED KINGDOM)

KCL (KING’S COLLEGE LONDON, LONDON, UNITED KINGDOM)

GENCAT (DEPARTAMENT DE SALUT – GENERALITAT DE CATALUNYA, SPAIN)

PARPA (PANSTWOWA AGENCJA ROZWIĄZYWANIA PROBLEMÓW ALKOHOLOWYCH, POLAND)

UCL (UNIVERSITY COLLEGE LONDON)

UM (UNIVERSITEIT MAASTRICHT, NETHERLANDS)

PAM (POMERANIAN MEDICAL UNIVERSITY IN SZCZECIN, POLAND)

### **3. DESCRIPTION OF WP OBJECTIVES (OVERALL AND FOR MONTHS 19-36)**

The overall objective is to study a number of factors that might increase implementation of evidence based methods of identification and brief intervention for excessive alcohol consumption in routine primary health care. The study will be a cluster RCT in 5 countries and the endpoint of the study is the number of interventions delivered during a certain time period.

More specifically, the WP will examine:

1. The effect of training and support to PHC providers
1. The effect of financial reimbursement to PHC providers as a pay-for-performance of brief alcohol interventions
2. Whether an alternative internet based method of delivering brief intervention can increase the proportion of patients reached
3. If one implementation strategy will give an added value to one already enforced.

During the first 18 months of the ODHIN project time a number of planning meetings have been held both as plenary face-to-face meetings with all partners together, and as conference calls with all partners and with individual partners as seen in section 9.

In addition, a large number of planning meetings have been held locally in all the five participating countries, also seen in section 9. The objectives with these meetings were to formulate and agree on a study protocol for the study and to go ahead with the local planning and implementation.

### **4. CONCISE DESCRIPTION OF THE PROGRESS TOWARDS OBJECTIVES, INCLUDING DETAILS FOR EACH OF THE WP’S TASKS**

The WP formally started working in the first year of the project with all necessary preparatory work leading to the randomized controlled trial (RCT). As a result, the final protocol describing all aspects of the study procedure was agreed upon in June 2012 and submitted to the EC as **Deliverable 5.1 RCT protocol**.





Well into the preparatory phase of the WP, the research partners decided to start the RCT flexibly in the five participating countries between September and November 2012, which would thus run to the end of 2013, with the final follow-up measurement. Once the trial is formally over in all five countries, data collection and integration, data analysis and writing of the final reports and scientific papers will be carried out throughout 2014.

The specific tasks envisaged in the Description of work for WP5 are:

Task 1: To summarize the best evidence concerning continuous medical education (CME) and operationalize the findings in a structuralized manner in order to build a basic education package and CME to all participants in the RCT.

This task was completed within the 1<sup>st</sup> reporting period and the knowledge was incorporated in the study protocol, where a detailed outline of a training programme was agreed upon. All participants checked that the country education package and CME was fully compatible with the detailed common training programme agreed upon, and have made slight adaptations when required. Pilot-testing of these education packages was not performed, as explained in the 1<sup>st</sup> technical report.

Task 2: Developing an interactive website to be used in the RCT, developed by the Catalan team in cooperation with all participants.

This website was not created, since, as explained in the 1<sup>st</sup> technical report, it was decided that each country should use an appropriate existing website already implemented in their country, provided that it fulfilled certain criteria to be used in the study. Therefore, the project agreed upon a number of criteria for a local website to be used in the study. Within the 1<sup>st</sup> reporting period each country identified such a website, and revised its functionalities and contents, making adaptations and improvements if necessary to ensure it fulfils the project's criteria.

Task 3: Designing the various elements of the RCT.

The RCT design was discussed and developed over the first months of the project, and in the frame of the ODHIN 2012 plenary meeting a workshop was held to finalize the WP5 protocol, which was agreed upon by all partners and submitted within the 1<sup>st</sup> reporting period. After this workshop, a round of country calls took place between the WP coordinators and the partners in each country, to further discuss and agree on the country specific RCT implementation issues. Therefore, the common RCT protocol was translated and adapted to country particularities where necessary, meeting Milestone 4 in the summer of 2013, with country adapted protocols for Catalonia, Poland, Sweden and England (in the Netherlands an English version was used), attached to this report as appendix files (see "OD\_WP5\_AP1\_Catalonia country protocol", "OD\_WP5\_AP2\_Poland country protocol", "OD\_WP5\_AP3\_Sweden country protocol" and "OD\_WP5\_AP4\_England country protocol").

Task 4: Identifying PHC providers in each of the 5 countries for inclusion in the RCT.

Recruitment of the 120 (24 per country) Primary Health Care Units started in spring 2012 and continued through the fall of 2012. For enrolment, different strategies have been used in the participating countries, ranging from random selection to snow-ball enrolment.

In general the recruitment was successfully completed, but some delay occurred (please see section 7). This delay will not jeopardize the results and final outcome.

However, the sampling procedure may have introduced some bias in the sense that the enrolled primary health care centres in some countries are more positive to carry out secondary prevention of alcohol problems than the average primary health care unit is.



Task 5: Randomization of PHC providers to the different arms in order to make a time table for each participant's inclusion into the RCT.

This task was started in September 2012 by the coordination centre in Barcelona.

Randomization procedure

The PHCU is the unit of randomization, and therefore each primary care unit included in the study constitutes a cluster and participating health care providers in the unit are allocated to the same condition. Each of the 5 countries recruited 24 PHCUs, with 3 PHCUs allocated randomly to one of the 8 arms of the study.

Between July 2012 and May 2013 the 5 country teams recruited the 24 PHCUs, holding a *first introduction meeting* at the PHCU premises inviting all eligible providers to attend. The RCT's aim and design was presented, and specific instructions were given concerning the use of the ODHIN tally sheet. At this same meeting, those providers who voluntarily agreed to participate in the study signed an informed consent form. The baseline measurement was then taken within 1-2 months of this first visit

In this frame, the randomization process went as follows:

- 1) Once the *first introduction meeting* was scheduled with each PHCU, they were then numbered 1 to 24 by the country research team. Numbers were appointed based on enrolment, in subsequent order.
- 2) Next, the country research team randomly gave each PHCU-number (1-24), an alphabetical letter from A up to and including X. Each letter represents the PHCU.
- 3) In parallel, the Coordinating team, on 10<sup>th</sup> November 2013, carried out the computerized randomization for all countries, randomly assigning each countries' A-X letters to one of the 8 conditions, but with equal numbers across the 8 conditions in each country. This was done once for each country, so the randomization would not be the same for all countries (unless by chance that randomly happened).
- 4) Throughout the baseline measurement, the country research teams contacted the Coordinating team after the baseline had started in each PHCU (one email per PHCU) informing the Coordination team which PHCU had started baseline measurement, giving the PHCU-letter and name of the PHCU. Within 1-2 days, the Coordinating team replied informing the country research team about the group allocation of these specific PHCU and not revealing the allocation of the other PHCU-letters (as they had not yet been visited and started the baseline).
- 5) Once the country research teams received the randomization of PHCUs and the baseline measurement was complete, they could contact PHCUs that were in the T&S conditions so as to plan the T&S sessions. However, the T&S sessions were planned just with the PHCU contact person, and the PHCU contact person was told not to comment the allocation with any other active participants until the day of the Introduction to conditions session.

Therefore, although the PHCUs were randomly allocated by the Coordinating team before the baseline measurement, the research team in each of the countries was only informed of the allocation after the collection of the baseline measurement had started<sup>1</sup>, whereas the PHCU providers were not informed until formal agreement to participate in the study had been collected and the baseline measurement was completed, to avoid bias as a result of group allocation. Once the baseline measurement was completed, an *Introduction to conditions session* was held at the PHCU premises, and from then onwards the PHCU providers were no longer blind to the group allocation.

---

<sup>1</sup> It was not necessary to wait until the end of the baseline measurement to reveal the allocation to the country research team members, since there was to be no contact between the country teams and the PHCU until the completion of the baseline measurement, and therefore there was no way of biasing the baseline measurement.



Task 6: Organizing and delivering the initial training of participants in one of the arms of the RCT.

Initially all units were given a general overview of the ODHIN RCT in a *first introduction meeting*. Subsequent training sessions were given to the units randomly allocated to an arm with Training and Support (T&S), according to the research protocol. In the T&S groups there has been some cross-country differences concerning the number of face to face training sessions given (one or two); in case only one face-to-face meeting was held, the same information was given as with two sessions. Units also received a follow-up telephone call. There are also cross-country differences regarding who has delivered the training, e.g. researchers or hired free-lancers. We are not aware of this procedure causing any problems or any deviations from the protocol.

The training sessions started in September 2012 and were completed generally in January 2013. As a few units were recruited with a delay, the very last training session was held in June 2013 (see section 7).

Task 7: Data collection

For data collection no major problems have been reported. Data for the baseline measurement was submitted to the WP coordinators by early autumn 2013, and for the interventions period in early 2014. Due to the study delay described in section 7, the last follow-up measurement will be finished in May 2014 (England) and June 2014 (The Netherlands).

Task 8: Database management.

Once the RCT Protocol was completed, the Coordinating team, in consultation with the country partners, designed a common template database to be used by the country research teams to collect and incorporate all necessary variables for the RCT analysis. The database was split into two parts: a template “Providers file”, containing variables as to describe the providers’ profile, allocation, PHCU environment, SAAPPQ results, performance rates, etc. (see “OD\_WP5\_AP5\_Template Providers file”); and a template “Patients file”, containing the data collected by the (electronic) tally sheets concerning which patients were visited, screened and received BI in each of the measurement periods (see “OD\_WP5\_AP6\_Template Patients file”). In addition to a complete definition of each variable, the template included specific instructions on data coding and also a guide as to when and how the information should be collected. This ensured a common procedure and criteria for all participating countries.

Throughout the trial the country research teams progressively incorporated the data from the different measurement periods into the “Providers file” and the “Patients file”. The final versions of these files (with the accumulated data from all 5 measurement periods) are expected to be delivered to the Coordinating team between January and June 2014, once the follow-up measurement has been completed in each country. Once received, the 5 separate datasets will be merged into 1 by the Coordinating team. Data quality and coherence will be checked both by the national teams and the coordinators, then the complete analyses will be performed.

Task 9: Writing a series of papers during the final stages of the project timeframe.

A study protocol was published January 2013 in Implementation Science (see publications and OD\_WP5\_AP7\_Study protocol paper). Concerning future papers, these are expected to be produced throughout 2014 as the RCT results become available. An analysis plan and a publication plan have been discussed and agreed amongst the partners.

## 5. SIGNIFICANT RESULTS ACHIEVED SO FAR

Deliverable 5.1 Study protocol was delivered within the 1<sup>st</sup> reporting period, and a paper based on the protocol has been published in Implementation science (see see publications and OD\_WP5\_AP7\_Study



protocol paper). The protocol has been translated and adapted in the different countries, fulfilling Milestone 4.

Concerning the results of the RCT, since the data collection is not fully completed, these aren't available yet. However, a preliminary analysis of the baseline measurement carried out in the 5 participating countries shows that 723 providers across the five countries gave 182,000 consultations in the corresponding 4-week period. They undertook alcohol screening in 13,000 of these consultations, 1 in 14. This indicates that the data collection in the baseline period was successful.

## **6. REASONS FOR DEVIATIONS FROM THE DESCRIPTION OF WORK AND THEIR IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING**

Concerning task 2, the project agreed upon a number of criteria for a local website to be used in the study. Each country identified an appropriate existing website already implemented in each country, and revised its functionalities and contents, making adaptations and improvements if necessary to ensure that the programs fulfilled the project's criteria. E.g. has Poland used the WHO database (adjusted for Polish conditions) and in the Netherlands [www.minderdrinken.nl](http://www.minderdrinken.nl) was used. These adjustments follow the basic principles we have agreed upon.

## **7. REASONS FOR FAILING TO ACHIEVE CRITICAL OBJECTIVES AND /OR NOT BEING ON SCHEDULE, EXPLAINING IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING**

The RCT was originally intended to start spring 2012 but was postponed to the autumn of 2012 since we calculated that this would affect the data collection less than if we had started the study in the spring, due to problem with data collection during the summer months. These adjustments are not estimated to cause any changes on the total study performance since we still would have finished all data-collection except the follow-up measurement by end of 2013.

The recruitment of practices caused some troubles, particularly in The Netherlands and in UK. This meant that some practices had to start a couple of months later than planned. However, each country has recruited all intended 24 units, and started T&S, reimbursement and E-MI interventions according to the original plan. The last follow-up measurement in the project will be completed by June 2014.

Concerning task 6, in each country the trainers have met with all participating units, been in contact with the locally appointed contact person, held training meetings, supplied the units with necessary materials for providing information to patients and staff, distributed tally sheets to the providers for them to assess the alcohol consumption of patients, and collected the produced tally sheets (except in Catalonia in the last two cases, since the alcohol consumption is assessed using an electronic tally sheet, and data is retrieved through the central IT service of the Catalan Health Institute, with prior informed consent of the providers). Only minor problems have been reported for these undertakings.

Concerning task 7, the data collection has been delayed due to the above mentioned problems with recruiting PHC units.

As the data collection proceeds over a time span that is about 11 months, some providers change in the units, with the result that some providers do not participate over the whole period. This was expected to happen as a usual event of RCTs. However, one primary health care unit in Sweden unexpectedly, and with only one week's notice, closed 6 months into the trial. The Swedish research team has attempted to retrieve



data concerning the activity of the providers of that unit after that point, but in some cases this was not possible. This unexpected event will be accounted for in the final dataset and analysis.

Concerning task 8 – database management. Data quality checks are being carried out on the data delivered by the country teams to the coordinating team. Data delivery for the follow up period has not been done, as the data collection is yet not completed in some units.

This means that all the tasks for WP5 have been met, although with a slight delay for some PHCs, but we can still in large deliver analysis, deliverables and scientific articles as planned throughout the remaining months of the ODHIN project.

All critical objectives have been met, but there is a delay in the data collection for a few units. The most difficult task has been to recruit all units, particularly in the Netherlands and the UK. Primary health care is heavily burdened and it has become increasingly difficult to involve the primary health care units in research projects.

Since the data obtained from the RCT in WP5 was a key input for fulfilling Objective 3 of WP3 Cost effectiveness, the WP3 colleagues have submitted D3.1 within the original deadline of December 2013 (see chapter for WP3) and plan to submit an addendum to D3.1 covering Objective 3 in October 2014.

#### **Resources**

These became short in several countries due to problems encountered in the enrolment of many units: more difficult procedures in the recruitment, as well as delaying the RCT, meant a higher need of person-months to meet the aim of 24 PHCUs per country.

### **8. PROPOSAL OF CORRECTIVE ACTION**

As to meet the delivery deadlines of D5.2 and D5.3, once the final RCT dataset is available, work on the analysis and writing will be intensified in the remaining months of the project.

As mentioned above, to not delay the submission of Deliverable 3.1 (submitted December 2013), an addendum will be produced by the WP3 colleagues based on the WP5 RCT data and delivered to the EC in October 2014.

### **9. WP MEETINGS AND CALLS**

During the second 18-month period of the ODHIN project a number of planning meetings have been held both as plenary face-to-face meetings with all partners together (see “OD\_WP5\_AP8\_Agenda\_WP5meeting\_26-9-12” and “OD\_WP5\_AP9\_Agenda\_WP5meeting\_7.8-5-13”), and as conference calls with all partners and with individual partners. In addition, a large number of planning meetings have been held locally in all five participating countries. The objectives of these meetings were to share experiences of recruiting and training, to supervise the implementation period, to discuss and coordinate necessary minor adjustments, and to coordinate data collection. In the latter part of the period more of the discussions were devoted to scrutinizing the baseline data and formulating data analysis plans.

The following table includes a (non-exhaustive) list of meetings that have taken place throughout the second reporting period:



| DATE (DD/MM/YYYY)            | TYPE (FACE TO FACE MEETING OR CONFERENCE CALL) | LOCATION (ONLY IF FACE TO FACE MEETING) (VENUE/CITY/COUNTRY) | AIM OF THE MEETING   | ATTENDEES  |
|------------------------------|--|--|--|--|
| <b>Meetings in Sweden</b>    |  |  |  |  |
| 11/10/2012                   | Conference call                                | ..   | Collaboration in WP5   | C. Lindeskog, P. Bendtsen, C. Andersson, A. Ronstad, B-M. Finnbom, V. Tegleström, F. Spak.   |
| 06/12/2012                   | Conference call                                | ..   | Collaboration in WP5   | C. Lindeskog, P. Bendtsen, C. Andersson, A. Ronstad, B-M. Finnbom, V. Tegleström, F. Spak.   |
| 14/02/2013                   | Conference call                                | ..   | Collaboration in WP5   | C. Lindeskog, P. Bendtsen, C. Andersson, A. Ronstad, B-M. Finnbom, V. Tegleström, F. Spak.   |
| 08-09/01/2013                | Face to face                                   | Mullsjö, Sweden  | Collaboration planning   | C. Lindeskog, P. Bendtsen, C. Andersson, A. Ronstad, B-M. Finnbom, V. Tegleström, F. Spak.   |
| 17/05/2013                   | Conference call                                | ..   | Collaboration in WP5   | C. Lindeskog, P. Bendtsen, C. Andersson, A. Ronstad, B-M. Finnbom, V. Tegleström, F. Spak.   |
| 29/08/2013                   | Conference call                                | ..   | Collaboration in WP5   | C. Lindeskog, P. Bendtsen, C. Andersson, A. Ronstad, B-M. Finnbom, V. Tegleström, F. Spak.   |
| <b>Meetings in Catalonia</b> |  |  |  |  |
| 09/07/2012                   | Face to face                                   | Departament de Salut, Generalitat de Catalunya, Barcelona    | Meeting with members of the Catalan Association of General Practitioners, inviting them to become ODHIN T&S trainers | R. Alcolea, A. Altaba, J. Auba, B.Baena, N. Bastida, C. Cabaco, J. Colom, E. Diaz, A. Duran, T. Gual, C. Marquilles, J.Palacio, B. Perez, J. Reynolds, L. Segura, C.Urgeles, N. Villanueva               |
| 19/09/2012                   | Face to Face                                   | Institut Català de la Salut, Barcelona                       | Preparation of the ODHIN RCT   | S. Calero, T. Gual, M. Medina, L. Mendez, C. Olmos, J. Palacio, J.Reynolds, L.Segura   |
| 29/10/2012                   | Face to Face                                   | Departament de Salut, Generalitat de Catalunya, Barcelona    | Final preparation of pending trial materials and discussion of data exploitation                                     | B.Baena, E. Diaz, E. Moreno, J. Palacio, J. Reynolds, L.Segura   |
| 28/11/2012                   | Face to face                                   | Institut Català de la Salut, Barcelona                       | Meeting to fine tune the research electronic tally sheet   | C. Olmos, J. Palacio, J. Reynolds  |
| 10/12/2012                   | Face to face                                   | Departament de Salut, Generalitat de Catalunya, Barcelona    | Meeting with the ODHIN T&S trainers, explaining schedule and dynamics of the training sessions                       | R. Alcolea, A. Altaba, J. Auba, B.Baena, N. Bastida, C. Cabaco, B. Catarineu, J. Colom, E. Diaz, A. Duran, T. Gual, C. Marquilles, J.Palacio, B. Perez, J. Reynolds, L. Segura, C.Urgeles, N. Villanueva |
| 21/01/2013                   | Face to face                                   | Departament de Salut, Generalitat de Catalunya, Barcelona    | Coordination meeting revising progress of trial and next steps   | B.Baena, J. Colom, E. Diaz, T. Gual, E. Moreno, J. Palacio, J. Reynolds, L.Segura  |
| 25/02/2013                   | Face to face                                   | Departament de Salut, Generalitat de Catalunya, Barcelona    | Meeting with the ODHIN T&S trainers, as to fine tune the training and support materials                              | R. Alcolea, A. Altaba, J. Auba, B.Baena, N. Bastida, C. Cabaco, B. Catarineu, J. Colom, E. Diaz, A. Duran, T. Gual, C. Marquilles, J.Palacio, B. Perez, J. Reynolds, L. Segura, C.Urgeles, N. Villanueva |



| DATE (DD/MM/YYYY)              | TYPE (FACE TO FACE MEETING OR CONFERENCE CALL) | LOCATION (ONLY IF FACE TO FACE MEETING) (VENUE/CITY/COUNTRY) | AIM OF THE MEETING   | ATTENDEES  |
|--------------------------------|--|--|--|--|
| 20/03/2013                     | Face to face                                   | Institut Català de la Salut, Barcelona                       | Meeting to finetune the ODHIN RCT data extraction procedure    | S. Calero, F. Fina, M. Medina, L. Mendez, J. Palacio, J.Reynolds   |
| 26/04/2013                     | Face to face                                   | Departament de Salut, Generalitat de Catalunya, Barcelona    | Coordination meeting revising progress of trial and next steps | B.Baena, E. Diaz, L. Segura, J. Reynolds, J. Palacio   |
| 03/06/2013                     | Face to face                                   | Departament de Salut, Generalitat de Catalunya, Barcelona    | Coordination meeting revising progress of trial and next steps | L. Segura, J. Reynolds   |
| 28/06/2013                     | Face to face                                   | Departament de Salut, Generalitat de Catalunya, Barcelona    | Coordination meeting revising progress of trial and next steps | L. Segura, B. Baena and J. Palacio   |
| 29/11/2013                     | Face to face                                   | Departament de Salut, Generalitat de Catalunya, Barcelona    | Coordination meeting revising progress of trial and next steps | L. Segura, B. Baena and J. Palacio   |
| <b>Meetings in Netherlands</b> |  |  |  |  |
| 13/09/2012                     | Conference call                                | -  | WP5 Update of planned use of e-BI website MinderDrinken        | Iris Rosier (I.com; Trimbo), Miranda Laurant, Myrna Keurhorst  |
| 07/11/2012                     | Conference call                                | -  | WP5 discussing log-in codes                                    | Iris Rosier (I.com; Trimbo), Myrna Keurhorst   |
| 13/11/2012                     | Conference call                                | -  | WP5 update and proceedings of the trial                        | Gaby Ronda, Ben van Steenkiste, Miranda Laurant, Myrna Keurhorst   |
| 03/12/2012                     | Face to face meeting                           | IQ healthcare, Nijmegen                                      | WP5 update and proceedings of the trial                        | Gaby Ronda, Ben van Steenkiste, Miranda Laurant, Myrna Keurhorst   |
| 26/03/2013                     | Face to face meeting                           | CAPHRI, Maastricht   | WP5 update and proceedings of the trial                        | Gaby Ronda, Ben van Steenkiste, Miranda Laurant, Myrna Keurhorst   |
| 30/05/2013                     | Conference call                                | -  | WP5 scheduled reporting of e-BI use/ log-in codes              | Iris Rosier (I.com; Trimbo), Myrna Keurhorst   |
| 15/10/2013                     | Face to face meeting                           | IQ healthcare, Nijmegen                                      | WP5 update and proceedings of the trial                        | Gaby Ronda, Ben van Steenkiste, Miranda Laurant, Myrna Keurhorst   |
| <b>Meetings in UK</b>          |  |  |  |  |
| 24th July 2012                 | Conference call                                |  | Study progress and planning                                    | Dorothy Newbury-Birch (NCL), Eileen Kaner (NCL), Kathryn Parkinson (NCL),  |
| 19th Sept 2012                 | Conference call                                |  | Study progress and planning                                    | Kathryn Parkinson (NCL), Paolo Deluca (KCL), Colin Drummond (KCL)  |
| 24th Oct 2012                  | Conference call                                |  | Study progress and planning                                    | Eileen Kaner (NCL), Kathryn Parkinson (NCL), Paolo Deluca (KCL), Paul Wallace (UCL), Natalie Billington (PCRN) joined for short period to discuss Excess Treatment Costs |
| 5th Dec 2012                   | Conference call                                |  | Study progress and planning                                    | Paul Wallace (UCL), Kathryn Parkinson (NCL), Dorothy Newbury-Birch (NCL), Colin Drummond (KCL), Paolo Deluca (KCL), Eileen Kaner (NCL)                                   |
| 9th Jan 2013                   | Conference call                                |  | Study progress and planning                                    | Chair Eileen Kaner (NCL), Dorothy Newbury-Birch (NCL), Kathryn Parkinson (NCL), Julie Dickinson (NCL), Paolo Deluca (KCL),   |



| DATE (DD/MM/YYYY)                      | TYPE (FACE TO FACE MEETING OR CONFERENCE CALL) | LOCATION (ONLY IF FACE TO FACE MEETING) (VENUE/CITY/COUNTRY) | AIM OF THE MEETING                               | ATTENDEES  |
|--|--|--|--|--|
|  |  |  |  | Amy Wolstenholme (KCL)<br>Catherine Elzerbi (KCL)  |
| 19th Feb 2013                          | Conference call                                |  | Study progress and planning                      | Chair Colin Drummond (KCL), Dorothy Newbury-Birch (NCL), Kathryn Parkinson (NCL), Julie Dickinson (NCL), Paolo Deluca (KCL), Amy Wolstenholme (KCL), Catherine Elzerbi (KCL), Paul Wallace (UCL)   |
| 26th Mar 2013                          | Conference call                                |  | Study progress and planning                      | Chair Kathryn Parkinson (NCL), Eileen Kaner (NCL), Dorothy Newbury-Birch (NCL), Julie Dickinson (NCL), Paolo Deluca (KCL), Amy Wolstenholme (KCL), Paul Wallace (UCL), Catherine Elzerbi (KCL), Lidia Segura (Catalonia)   |
| 10th July 2013                         | Conference call                                |  | Study progress and planning                      | Eileen Kaner(NCL), Colin Drummond(KCL), Kathryn Parkinson(NCL), Paul Wallace (UCL)   |
| 4th Sept 2013                          | Conference call                                |  | Study progress and planning                      | Eileen Kaner (Chair, NCL), Paolo Deluca(KCL), Colin Drummond(KCL), Catherine Elzerbi(KCL), Dorothy Newbury-Birch(NCL), Kathryn Parkinson (NCL)   |
| 6th Nov 2013                           | Conference call                                |  | Study progress and planning                      | Paul Wallace (Chair, UCL), Paolo Deluca(KCL), Colin Drummond(KCL), Catherine Elzerbi (KCL), Dorothy Newbury-Birch (NCL), Kathryn Parkinson (NCL), Amy Wolstenholme (UCL).  |
| <b>Coordination calls and meetings</b> |  |  |  |  |
| 26/09/2012                             | Face to face                                   | Caixa Forum, Barcelona                                       | WP5 coordination meeting                         | Peter Anderson, Begoña Baena, Preben Bendtsen, Krzysztof Brzozka, Paolo Deluca, Colin Drummond, Toni Gual, Myrna Keurhorst, Miranda Laurant, Dorothy Newbury-Birch, Katarzyna Okulicz-Kozaryn, Jorge Palacio-Vieira, Kathryn Parkinson, Jillian Reynolds, Lidia Segura, Luiza Slodownik, Fredrik Spak, Paul Wallace, Marcin Wojnar, Amy Wolstenholme |
| 16/04/2013                             | Conference call                                | -  | WP5 Overview of trial status country per country | P. Anderson, P. Bendtsen, P. Deluca, T. Gual, M. Keurhorst, M. Laurant, A. Mierzecki, K. Parkinson, J. Reynolds, L. Segura, F.   |





| DATE (DD/MM/YYYY) | TYPE (FACE TO FACE MEETING OR CONFERENCE CALL) | LOCATION (ONLY IF FACE TO FACE MEETING) (VENUE/CITY/COUNTRY) | AIM OF THE MEETING   | ATTENDEES   |
|-------------------|--|--|----------------------|---|
| 7&8/5/13          | Face to face                                   | Catalan Health Department premises, Barcelona                | WP5 planning meeting | Spak, M.Wojnar<br>Peter Anderson, Begoña Baena, Fleur Braddick, Preben Bendtsen, Joan Colom, Paolo Deluca, Estela Díaz, Colin Drummond, Aleksandra Dubanowicz, Toni Gual, Myrna Keurhorst, Artur Mierzecki, Kasia Okulicz, Jorge Palacio, Kathryn Parkinson, Jillian Reynolds, Lidia Segura, Luiza Slodownik, Fredrik Spak, Ben van Steenkiste, Marcin Wojnar |

## 10. LIST OF DISSEMINATION ACTIVITIES

### Activity 1

- Type of activity: Oral presentation to a scientific event
- Main Leader: UGOT and UL
- Title: Design of the ODHIN Study
- Date: 20/09/2013
- Place: INEBRIA 11<sup>th</sup> Conference, Rome, Italy
- Type of audience: researchers and health professionals
- Size of audience (approx. number): 200
- Countries addressed: International

### Activity 2

- Type of activity: Flyer
- Main Leader: GENCAT and FCRB
- Title: El projecte ODHIN i el Beveu Menys
- Date: September 2012
- Place: Beveu Menys Bulletin, Barcelona
- Type of audience: Scientific community and PHC providers
- Size of audience (approx. number): 1500
- Countries addressed: Spain
- Link to online information about this activity (if available): <http://146.219.25.61/butlletins/public/view-not.php?ID=115&idnot=1424&SKIN=0>

### Activity 3

- Type of activity: Flyer
- Main Leader: GENCAT and FCRB
- Title\*: Proyecto ODHIN (optimización de la implementación del cribado y la intervención breve en el consumo de riesgo y perjudicial en Cataluña)
- Date: November 2012.
- Place: Odhin project website
- Type of audience: health professionals and policy makers
- Countries addressed: Catalonia



- Link to online information about this activity (if available): [http://www.odhinproject.eu/images/Country\\_own-language\\_material/Catalonia/Flyer\\_ODHIN\\_-\\_Catalunya.pdf](http://www.odhinproject.eu/images/Country_own-language_material/Catalonia/Flyer_ODHIN_-_Catalunya.pdf)

#### Activity 4

- Type of activity: Oral presentation to a wider public
- Main Leader: GENCAT and FCRB
- Title: Proyecto ODHIN (optimización de la implementación del cribado y la intervención breve en el consumo de riesgo y perjudicial en Cataluña)
- Date: 6-8 June 2013
- Place: Annual Conference of the Spanish Society of Family Physicians (SEMFYC), Granada, Spain
- Type of audience: Scientific community and PHC providers
- Size of audience: 1500
- Countries addressed: Spain
- Link to online information about this activity (if available): [http://www.semfy2013.com/contents/scientific/pro\\_cientifico.pdf](http://www.semfy2013.com/contents/scientific/pro_cientifico.pdf)

#### Activity 5

- Type of activity: Brief presentation at the 4<sup>th</sup> Workshop of Alcohol referents in Catalonia
- Main Leader: GENCAT and FCRB
- Title: Projecte ODHIN
- Date: 2<sup>nd</sup> October 2013
- Place: Barcelona
- Type of audience: Primary health care professionals who are members of the network of Alcohol referents in Catalonia (XaROH)
- Size of audience: 50
- Countries addressed: Catalonia
- Link to online information about this activity (if available): <http://beveumenys.cat/Adm/upload/docs/BeveuMenysDoc519.pdf>

#### Activity 6

- Type of activity: Poster presented at the 3<sup>rd</sup> Workshop of Research in Public Health
- Main Leader: GENCAT and FCRB
- Title: Seguretat i compromís terapèutic dels professionals d'atenció primària pel cribratge del consum d'alcohol. Projecte ODHIN
- Date: 14th November 2013
- Place: Barcelona and Health Department website
- Type of audience: Public health professionals and policy makers
- Size of audience: 100
- Countries addressed: Catalonia

#### Activity 7

- Type of activity: Poster presented at the 3<sup>a</sup> Workshop of the Health Plan of Catalonia
- Main Leader: GENCAT and FCRB
- Title: Seguretat i compromís terapèutic dels professionals d'atenció primària pel cribratge del consum d'alcohol. Projecte ODHIN
- Date: 13th December 2013.
- Place: Sitges, and Health Department website
- Type of audience: Health professionals and policy makers



- Size of audience: 1000
- Countries addressed: Catalonia
- Link to online information about this activity (if available):  
<http://www20.gencat.cat/portal/site/salut/menuitem.08bf9901ea011adbe23ffed3b0c0e1a0/?vgnextoid=9782366ff11e2410VgnVCM1000008d0c1e0aRCRD&vgnextchannel=9782366ff11e2410VgnVCM1000008d0c1e0aRCRD&vgnextfmt=default>

#### Activity 8

- Type of activity: Conference presentation
- Main Leader: Karolina Kłoda -Pomeranian Medical University
- Title: ODHIN Project – first aid for the hazardous and harmful alcohol drinkers. (Projekt ODHIN - pierwsza pomoc dla pijących ryzykownie i szkodliwie.)
- Date: 21.06.2013
- Place: XIII Family Medicine Congress, Pozna
- Type of audience: Scientific community
- Size of audience: 1200
- Countries addressed: Poland
- Link to online information about this activity (if available):  
[http://www.kongresmedycynyrodzinnej.pl/kongres2013/files/PROGRAM%20NAUKOWY\\_XIII%20Kongres%20Medycyny%20Rodzinnej.pdf](http://www.kongresmedycynyrodzinnej.pl/kongres2013/files/PROGRAM%20NAUKOWY_XIII%20Kongres%20Medycyny%20Rodzinnej.pdf) (page 7)

#### Activity 9

- Type of activity: Conference presentation
- Main Leader: Newcastle University
- Title: Scientific Challenges of European Implementation Research
- Date: 20<sup>th</sup> September 2013
- Place: Inebria Symposium, Rome
- Type of audience: Scientific community
- Countries addressed: All European countries

#### Activity 10

- Type of activity: Oral presentation
- Main Leader: Newcastle University
- Title: Scientific challenges of European implementation research
- Date: 29/08/13
- Place: Newcastle, UK
- Type of audience: Scientific community (research)
- Size of audience: 50
- Countries addressed: Attendees mainly from Europe

#### Activity 11

- Type of activity: Poster
- Main Leader: Newcastle University
- Title: Design of the ODHIN five country study - Implementing brief interventions for heavy drinking in primary health care
- Date: 08/09/2013
- Place: 14th Congress of European Society for Biomedical Research on Alcoholism (ESBRA), Warsaw, Poland
- Type of audience: Scientific community



- Size of audience: n/a
- Countries addressed: Europe

#### Activity 12

- Type of activity: Poster
- Main Leader: Newcastle University
- Title: Implementing brief interventions for heavy drinking in primary health care - ODHIN baseline and preliminary outcome results.
- Date: 08/09/2013
- Place: 14th Congress of European Society for Biomedical Research on Alcoholism (ESBRA), Warsaw, Poland
- Type of audience: Scientific community
- Size of audience: n/a
- Countries addressed: Europe

#### Activity 13

- Type of activity: Poster
- Main Leader: Newcastle University
- Title: Scientific challenges of European implementation research – experiences from the ODHIN five country study on implementing brief interventions for heavy drinking in primary health care
- Date: 08/09/2013
- Place: 14th Congress of European Society for Biomedical Research on Alcoholism (ESBRA), Warsaw, Poland
- Type of audience: Scientific community
- Size of audience: n/a
- Countries addressed: Europe

## **11. PROJECT PUBLICATIONS**

### Publication 1 (see OD\_WP5\_AP7\_Study protocol paper)

- D.O.I: 10.1186/1748-5908-8-11
- Title: [Implementing training and support, financial reimbursement, and referral to an internet-based brief advice program to improve the early identification of hazardous and harmful alcohol consumption in primary care \(ODHIN\): study protocol for a cluster randomized factorial trial.](#)
- Main Author: Keurhorst MN
- Other authors: Anderson P, Spak F, Bendtsen P, Segura L, Colom J, Reynolds J, Drummond C, Deluca P, van Steenkiste B, Mierzecki A, Kłoda K, Wallace P, Newbury-Birch D, Kaner E, Gual T, Laurant MG
- Title of the periodical or the series: Implementation Science
- Number, date or frequency: 2013 Jan 24;8:11
- Publisher: BioMed Central Ltd
- Date of publication: 24 January 2013
- Relevant pages: 1-7
- Open access is/will be provided to this publication: yes
- Link to online abstract/text (if available):  
<http://www.implementationscience.com/content/8/1/11>

### Publication 2 (not included in ECAS portal as impossible to edit "Journal" field)

- D.O.I: 10.1093/alcalc/agt118



- Title: Design of the ODHIN five country study - Implementing brief interventions for heavy drinking in primary health care
- Main Author: P. Anderson
- Other authors: A. Gual, F. Spak, P. Bendtsen, M. Keurhorst, L. Segura, J. Colom, J. Reynolds, C. Drummond, P. Deluca, B. van Steenkiste, A. Mierzecki, K. Kłoda, P. Wallace, D. Newbury-Birch, E. Kaner, M. Laurant, M. Wojnar
- Title of the periodical or the series: Alcohol and Alcoholism
- Number, date or frequency: 2013 48 (suppl. 1)
- Date of publication: 8 September 2013
- Relevant pages: i58
- Open access is/will be provided to this publication: no

Publication 3 (not included in ECAS portal as impossible to edit "Journal" field)

- D.O.I: 10.1093/alcalc/agt118
- Title: Implementing brief interventions for heavy drinking in primary health care - ODHIN baseline and preliminary outcome results
- Main Author: P. Anderson
- Other authors: A. Gual, F. Spak, P. Bendtsen, M. Keurhorst, L. Segura, J. Colom, J. Reynolds, C. Drummond, P. Deluca, B. van Steenkiste, A. Mierzecki, K. Kłoda, P. Wallace, D. Newbury-Birch, E. Kaner, M. Laurant, M. Wojnar
- Title of the periodical or the series: Alcohol and Alcoholism
- Number, date or frequency: 2013 48 (suppl. 1)
- Date of publication: 8 September 2013
- Relevant pages: i58
- Open access is/will be provided to this publication: no

Publication 4 (not included in ECAS portal as impossible to edit "Journal" field)

- D.O.I: 10.1093/alcalc/agt118
- Title: Scientific challenges of European implementation research – experiences from the ODHIN five country study on implementing brief interventions for heavy drinking in primary health care
- Main Author: P. Anderson
- Other authors: A. Gual, F. Spak, P. Bendtsen, M. Keurhorst, L. Segura, J. Colom, J. Reynolds, C. Drummond, P. Deluca, B. van Steenkiste, A. Mierzecki, K. Kłoda, P. Wallace, D. Newbury-Birch, E. Kaner, M. Laurant, M. Wojnar
- Title of the periodical or the series: Alcohol and Alcoholism
- Number, date or frequency: 2013 48 (suppl. 1)
- Date of publication: 8 September 2013
- Relevant pages: i59
- Open access is/will be provided to this publication: no

## 12. APPENDICES

| NAME FILE ATTACHED                    | TYPE OF DOCUMENT:<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | CORRESPONDING<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | COMMENTS |
|---------------------------------------|--|--|----------|
| OD_WP5_AP1_Catalonia country protocol | Milestone  | MS4  | ..       |
| OD_WP5_AP2_Poland country protocol    | Milestone  | MS4  | ..       |
| OD_WP5_AP3_Sweden country protocol    | Milestone  | MS4  | ..       |
| OD_WP5_AP4_England country protocol   | Milestone  | MS4  | ..       |
| OD_WP5_AP5_Template Providers file    | Other  | ..   | ..       |



| NAME FILE ATTACHED                    | TYPE OF DOCUMENT:<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | CORRESPONDING<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | COMMENTS |
|---------------------------------------|--|--|----------|
| OD_WP5_AP6_Template Patients file     | Other  | ..   | ..       |
| OD_WP5_AP7_Study protocol paper       | Other  | ..   | ..       |
| OD_WP5_AP8_Agenda_WP5meeting_26-9-12  | Other  | ..   | ..       |
| OD_WP5_AP9_Agenda WP5meeting 7.8-5-13 | Other  | ..   | ..       |

### 13. STATEMENT ON THE USE OF RESOURCES – WP5

See 4.7. *Summary on the use of resources per work package and per beneficiary* (below).



## WP6 – ASSESSMENT TOOL

### **1. WP LEADER**

ISS (ISTITUTO SUPERIORE DI SANITA', ITALY)

### **2. OTHER PARTNER INSTITUTIONS INVOLVED:**

FCRB (FUNDACIO PRIVADA CLINIC PER A LA RECERCA BIOMEDICA /HOSPITAL CLINICO PROVINCIAL DE BARCELONA – HCPB, SPAIN)

RUNMC (RADBOD UNIVERSITY NIJMEGEN MEDICAL CENTRE, NETHERLANDS)

CEFORMED (CENTRO REGIONALE DI FORMAZIONE PER L'AREA DELLE CURE PRIMARIE, ITALY)

NU (NEWCASTLE UNIVERSITY, INSTITUTE OF HEALTH AND SOCIETY, NEWCASTLE, UNITED KINGDOM)

KCL (KING'S COLLEGE LONDON, LONDON, UNITED KINGDOM)

UGOT (UNIVERSITY OF GOTHENBURG, SWEDEN)

LIU (LINKOPING UNIVERSITY, SWEDEN)

GENCAT (DEPARTAMENT DE SALUT – GENERALITAT DE CATALUNYA, SPAIN)

PARPA (POLISH STATE AGENCY FOR PREVENTION OF ALCOHOL-RELATED PROBLEMS, POLAND)

UL (UNIVERZA V LJUBLJANI, SLOVENIA)

IDT (ISTITUTO DA DROGA E DA TOXICODIPENDENCIA, PORTUGAL)

UM (UNIVERSITEIT MAASTRICHT, NETHERLANDS)

SZU (STATNI ZDRAVOTNI USTAV, CZECH REPUBLIC)

PAM (POMERANIAN MEDICAL UNIVERSITY IN SZCZECIN, POLAND)

### **3. DESCRIPTION OF WP OBJECTIVES (OVERALL AND FOR MONTHS 19-36)**

The objectives of the ODHIN WP6 were to formalize, to operationalize and to adapt the assessment tool originally developed by the PHEPA project (Primary Health Care European Project on Alcohol, European Commission) in order to produce an instrument to be used by countries to test the implementation and the extent of early identification and brief interventions (EIBI) for hazardous and harmful alcohol consumption (HHAC) throughout Primary Health Care (PHC) settings.

The ODHIN WP6 “assessment tool” is an instrument for the identification of the state of the art, gaps and areas in the country that need further work and strengthening; to monitor the adequacy of brief intervention programmes for HHAC in order to provide recommendations to improve and optimize delivery of health care interventions.

Particularly, the ODHIN WP6 “assessment tool” collects elements that enable to:

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

**A.** The main tasks of ODHIN WP6 research group for the first period (months 1-18, *January 2011-June 2012*) have been the following:



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

**B.** During the second period (months 19-36, *July 2012-December 2013*), the main tasks of ODHIN WP6 have been the following:

- workshop to identify the variables providing an estimate of the implementation and extent of EIBI's (Milestones MS5);
  - data collection;
  - data analysis;
- ODHIN Assessment tool final report (Deliverable D6.1, see "OD\_WP6\_AP1\_D6.1 Assessment tool").

#### **4. DESCRIPTION OF THE PROGRESS TOWARDS OBJECTIVES, INCLUDING DETAILS FOR EACH OF THE WP'S TASKS**

**A.** During the first period of the ODHIN project (months 1-18, *January 2011-June 2012*), the following activities have been carried out for WP6 (as stated in the Description of work):

- Revision of the Assessment Tool PHEPA questionnaire (M6)
- Description of the final tool (M12)
- Milestone (MS5) "Workshop to identify the variables providing an estimate of the implementation and extent of IBI's " (M12)
- Translation of the questionnaire (M15)
- Identification of key informants and stakeholders (M15)

All the planned activities have been carried out as stated in the DoW, except the Milestone (MS5) "*Workshop to identify the variables providing an estimate of the implementation and extent of IBI's -M12*", postponed to M21 (being the workshop aimed at identifying the variables providing an estimate of the implementation and extent of IBI's) to optimize and increase the value of the preliminary data collection activities.

The revision of the PHEPA Assessment Tool questionnaire by the ODHIN WP6 research team started during the ODHIN kick off meeting held in Barcelona from 21 - 23 February 2011.

The main efforts of the ODHIN WP6 research group during this period have been concentrated on the identification of the best fitting format for an effective description of the variables that allow to provide a good estimate of the implementation and the extent of EIBI for HHAC throughout PHC settings. The final version of the questionnaire has been approved by all partners (see "OD\_WP6\_AP2\_Questionnaire assessment tool"). The assessment tool has been translated into the native language of the partners, where judged appropriate: it has been translated by Czech Republic, Slovenia and Portugal (see "OD\_WP6\_AP3\_CZ\_Questionnaire assessment tool", "OD\_WP6\_AP4\_SI\_Questionnaire assessment tool" and (see "OD\_WP6\_AP5\_PT\_Questionnaire assessment tool", respectively). The ODHIN WP6 Assessment Tool is a semi-structured questionnaire. The collection of information in the ODHIN WP6 "assessment tool" includes all the elements that are required for effective dissemination of brief interventions within a health care systems' perspective, including the domains of organization of health care, support for providing brief interventions, availability of brief interventions, provision of effective brief interventions by health care





providers and uptake of effective brief interventions by the general population. It analyses 24 questions distributed across 7 key sections, covering the following topics:

- A. Presence of a country coalition or partnership.
- B. Community action and media education.
- C. Health care services and infrastructure for harmful / hazardous alcohol use management.
- D. Support for treatment provision (screening and quality assessment systems, protocols and guidelines, reimbursement for health care providers).
- E. Intervention and treatment (availability and accessibility).
- F. Health care providers (clinical accountability and treatment provision).
- G. Health care users (knowledge and help seeking behavior).

For further details and the complete list of questions included in the ODHIN Assessment Tool, see “OD\_WP6\_AP2\_Questionnaire assessment tool”.

Within the participating ODHIN partners, up to 10 key informants have been selected for the activities of this task (the collection of data at national level and the fulfillment of the questionnaire), based on their expertise in the alcohol field, covering a large range of perspective such as general practitioners, scientists working in the field of epidemiology and public health, clinicians from alcoholology units, experts from the national society on alcoholology and policy makers (see “OD\_WP6\_AP6\_List of key informants”). The tool has been completed by country or regional coalitions or partnerships, giving the countries, where such coalition or partnership was not available, the opportunity to use the ODHIN project to request its creation with its first task to complete the tool. A country coalition or partnership (informal or formal) has been defined as a panel of experts, professionals, relevant stakeholders or key persons that are usually involved in the dissemination and implementation of management of hazardous and harmful alcohol disorders, diseases or problems. The specific experience of key informants has been defined as related to activities performed by law, elaborating proposals to Ministries involved in the alcohol issues, cooperating with international bodies and institutions working in the alcohol fields, and/or providing opinions to different stakeholders on any alcohol related issues.

As to ensure a maximum feedback from key informants, different options have been given to partners to fulfill the questionnaire:

- sending the tool by post (or email) to the selected key informants
- completing it through the organization of *ad hoc* meetings with individual key informants
- dividing the tool into separate sections to be completed by different key informants according to each different expertise
- achieving a consensus through meetings of coalitions or partnerships for certain questions which require opinion or expert judgment and then sending one completed questionnaire to the WP6 leaders.

During the first 18 months of ODHIN project, the revision of PHEPA questionnaire, the description of the final tool and the translation of the questionnaire took less time than expected, also thanks to the ongoing complementary activities of the AMPHORA (Alcohol Public Health Research Alliance) project, and also since the completion of the list of key informants was facilitated by already available lists of European projects, such as AMPHORA and VINTAGE-Good Health into older age. This enabled anticipating the data collection, whereas Milestone MS5, a workshop aimed at identifying the variables providing an estimate of the implementation and extent of IBI's, was postponed to optimize and increase the value of the data collection activities from M12 to M21.



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

**B.** During the second period (months 19-36, *July 2012-December 2013*), the following activities have been carried out for ODHIN WP6:

- Milestone (MS5): Workshop to identify the variables providing an estimate of the implementation and extent of IBI's (M21)
- Data collection (M27)
- Data analysis (M30)
- Deliverable (D6.1): Assessment tool final report (M38)

The Workshop to identify the variables providing an estimate of the implementation and extent of IBI's (Milestone MS5) was held in Barcelona on September 26<sup>th</sup>, 2012. During the workshop an overview of the completed activities was presented, including the activities added to the original tasks of the project: the data collection of additional countries. The outcome of the WP and pending activities concentrating on data collection (at that time it was still ongoing for ODHIN partners and for additional countries) and on data analysis, were discussed by means of a brain storming consensus. Partners agreed to make an integrated analysis (including ODHIN partners and additional countries other than those covered by the formal ODHIN partners), instead of dividing the analysis between ODHIN partner-countries and additional countries. Another issue discussed was the modality for reporting specific questions including qualitative data with comments from the partners. Finally, a preliminary view of the collected data, even if not complete, was presented and discussed. For further details on the workshop, see appendices 7 and 8 (the MS5 agenda "OD\_WP6\_AP7\_Agenda MS5workshop" and the powerpoint presentation of the MS5 workshop "OD\_WP6\_AP8\_PPT workshop MS5").

Regarding data collection, the ODHIN "assessment tool" team is composed of 15 European scientific partners from 9 countries (Catalonia-Spain, Czech Republic, Italy, Portugal, Slovenia, England-UK, Poland, Sweden and the Netherlands) and nearby 25 scientists. Furthermore, we invited another 36 European countries to share their national qualified experience with the ODHIN collaborating countries sending them the ODHIN assessment tool by email using in part the mailing list of WHO national counterparts and/or the contact details of national experts of the CNAPA meetings (Committee on National Alcohol Policy and Action). By the deadline for completing data collection, March 2013 (M27), 14 out of 36 countries had completed the questionnaire, involving some other 20 scientists. Therefore, the 23 European countries included in the ODHIN assessment tool analysis are the following:

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

After the data collection, all obtained information were introduced into SPSS at the ISS. At the same time the preparation of the final WP6 assessment tool report (D6.1) started. The ODHIN members agreed to write the report following the structure of the previous PHEPA report, as much as possible. An extensive correspondence via email between the WP6 leaders and the participants has been carried out as to review and check the collected conflicting data, and also to recover, whenever possible, missing data. The information was also reported qualitatively with comments from the partners, included in the final report. A preliminary complete analysis of the collected data was presented in the ODHIN plenary meeting on the 1st and 2nd of October 2013 (see WP1 section of this report). Two drafts of the WP6 final report (deliverable D6.1) circulated among all the participants requesting their feedback, the first in September 2013 and the second in December 2013.



## 5. SIGNIFICANT RESULTS ACHIEVED

**A.** The main result duly achieved during the first 18 months of ODHIN project (months 1-18, *January 2011-June 2012*) was the final version of the **questionnaire ODHIN WP6 Assessment Tool**. The availability of this questionnaire was instrumental to the scientific results now available, collected and analysed during the second period. The final version of the ODHIN assessment tool questionnaire has been attached (see "OD\_WP6\_AP2\_Questionnaire assessment tool").

**B.** During the second reporting period (months 19-36, *July 2012-December 2013*), many results have been achieved and included in the **Deliverable D6.1** -ODHIN assessment tool report: a description of the available services for the management of hazardous and harmful alcohol consumption- (see "OD\_WP6\_AP1\_D6.1 Assessment tool"). The final report consists of 60 pages plus annexes and the results are explained in detail in the report. Following is a brief summary of the results on the baseline measurement of services for managing HHAC in PHC, referring to the appendix file for further reading.

- In 2012, most of the countries (78.3%) have a country and/or regional coalition for the management of HHAC.
- Implemented media education campaigns on alcohol consumption in general are not widely available or not reported especially in some countries. The most common education campaigns are reported on the website followed by newspaper/magazines and radio. When available, they are generally fully publicly funded and implemented at country level.
- According to personal opinions, in most of the countries the integration of the management of HHAC in the health care system is quite low with great differences between countries. Nearly half of the countries pointed the integration of the management of HHAC in the PHC system over the average of 5.4 points (in a scale from 0- no integrated, to 10- fully integrated).
- Most of the countries have formal governmental organizations in charge for monitoring health outcomes at the population level from HHAC (78.3%), for reviewing the safety of pharmacological treatments for managing alcohol dependence (68.2%) and for providing information on managing HHAC to health care providers (63.6%). About half of the countries have structures in charge for the monitoring of the quality of care provided for managing HHAC (57.1%) and for preparing clinical guidelines (56.5%). The structures for reviewing the cost effectiveness of interventions for managing HHAC are available in England, Finland, Portugal, Sweden and The Netherlands (22.7%).
- Nearly half of the countries have a formal research programme for managing HHAC with specifically allocated funding (43.5%) during the last 10 years. Those who have a formal research programme are always, at least in part, from governmental organizations.
- There is a lack of formal education on managing HHAC for health care professionals in all the educational levels, with great differences among countries. There is a tendency for most of the professionals (but not for dentists, obstetricians and pharmacists) to have more formal education on the managing of HHAC in the curriculum of postgraduate and continuing professional training compared to the undergraduate curriculum.
- An official written policy on managing HHAC from the Government or Ministry of Health is reported in 82.6% of the countries, mostly as a part of a more general alcohol policy strategy. In the countries where such a policy exists, an intensive support for managing alcohol dependence in specialised treatment facilities is included in all countries, a strategy on training for health professionals in 73.7% and a strategy to support interventions in primary care in 68.4%, while a national funded research strategy is included in nearly half of the policies.
- In about half of the countries there is an identified person within the Department of Health or Government who oversees or manages services for HHAC (43.5%: Cyprus, Czech Republic, England-UK, Italy, Latvia, Portugal, Romania, Catalonia-Spain, Sweden and The Netherlands).
- In most of the countries (82.6%) there is government funding for services for the management of HHAC. In the countries where governmental funding for services is available, the amount of funding is usually



reviewed from time to time. In almost none of the countries (but not for Switzerland) a proportion of alcohol taxes is specifically earmarked or allocated to fund the costs of services for managing HHAC.

- Only in about half of the countries screening instruments to identify subjects with HHAC are considered available and pointed over the average of 6.4 points (in a scale from 0 to 10), while only in 7 out of 23 (30.4%) follow up systems for monitoring and advice patients is considered available and pointed over the average of 4.1 points.
- Nearby three out of four of the countries (73.9%) have already developed, or are developing, multidisciplinary guidelines for managing HHAC. The majority are stand alone guidelines as opposed to a part of other clinical guidelines. However, there is a great lack of studies about their adherence and implementation.
- About 40% of addiction specialists and more than 30% of general practitioners are reimbursed for managing HHAC; the most common practice, however, is reimbursement as a part of their normal salary.
- In most of the countries there are specialized guidelines or protocols for managing HHAC mainly for addiction specialists, general practitioners, psychiatrists, doctors in hospital and psychologists. On the contrary, guidelines or protocols are uncommon for pharmacists and dentists.
- The training for managing HHAC within professional vocational training is available in most of the countries and for different professionals, but still uncommon for obstetricians, pharmacists and dentists in most of the countries. The availability of training for managing HHAC within accredited continuing medical education is inferior to the training for managing HHAC within professional vocational training for all professionals but not for nurses in general practice, doctors in hospitals and psychiatrists.
- Patients help for HHAC is considered accessible mainly in addiction services, followed by specialist clinics, in general/family practice, in hospital clinics and to a lesser extent in pharmacies.
- Participants considered that mainly addiction specialists and psychiatrists consider advices for HHAC part of their routine clinical practice, but not pharmacists and dentists.
- Regarding treatment provision in primary care, there are studies, surveys or publications on patients screened about alcohol consumption, followed by studies on patients with HHAC are given advice, on the use of AUDIT questionnaire, on the attitudes of health care providers to managing HHAC, on increasing the involvement of health care providers in managing HHAC and on the effectiveness of interventions for HHAC, while few studies, survey or publications have been carried out on advice meets quality criteria and on cost-effectiveness of interventions for HHAC.
- Studies, surveys or publications on people knowledge that HHAC can be dangerous to their health are referred in 38.1% of the countries, while studies on people knowledge about effective methods to reduce HHAC are not available.

## **6. REASONS FOR DEVIATIONS FROM THE DESCRIPTION OF WORK AND THEIR IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING**

It was agreed to optimize timing postponing the workshop Milestone (MS5) “*Workshop to identify the variables providing an estimate of the implementation and extent of IBI’s*” from M12 to M21. The WP partners considered an added value to gain preliminary results from the collection to better finalize the workshop outcomes. The workshop was held in Barcelona on the 26<sup>th</sup> of September 2012, one day before the 9th conference of the International NEtwork on BRIef Interventions for Alcohol problems (INEBRIA, 27-28/09/2012).

This adaptation of the timescale did not represent an obstacle to the development of planned activities but rather it improved the performance of the WP6 team. The adaptation of the timetable gave also the possibility to contact and collect information from additional countries, as mentioned before.



## 7. REASONS FOR FAILING TO ACHIEVE CRITICAL OBJECTIVES AND /OR NOT BEING ON SCHEDULE, EXPLAINING IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING

All planned objectives have been achieved. However, there was a slight delay in the final submission of D6.1 (delivered M38 instead of M36) due to the revision process incorporating all relevant feedback and comments received by the WP6 partners.

## 8. PROPOSAL OF CORRECTIVE ACTION

No corrective actions.

## 9. WP MEETINGS AND CALLS

| DATE (DD/MM/YYYY) | TYPE (FACE TO FACE MEETING OR CONFERENCE CALL)  | LOCATION (ONLY IF FACE TO FACE MEETING) (VENUE/CITY/COUNTRY) | AIM OF THE MEETING   | ATTENDEES   |
|-------------------|---|--|--|---|
| 26/09/2012 (M21)  | Milestones MS5 "Workshop to identify the variables providing an estimate of the implementation and extent of IBI's" | Barcelona, Catalonia, Barcelona, Spain                       | To identify the variables providing an estimate of the implementation and extent of IBI's  | Peter Anderson, Begoña Baena, Paolo Deluca, Colin Drummond, Claudia Gandin, Antoni Gual, Marko Kolsek, Jillian Reynolds, Gaby Ronda, Emanuele Scafato, Lidia Segura, Hana Sovinova, Fredrik Spak, Pierluigi Struzzo, Cristina Ribeiro, Amy Wolstenholme, Krzysztof Brzozka, Luiza Slodownik, Kasia Okulicz  |
| 22/02/2013        | ODHIN WP6 teleconference call   |  | Teleconference with the WP6 ODHIN team and the coordination team to revise the work status and plan ahead for 2013 including discussion on the final report to be produced | Gandin, Scafato, Gual, Anderson, Reynolds   |
| 01/10/2013        | ODHIN plenary meeting   | Barcelona, Catalonia, Barcelona, Spain                       | A preliminary analysis and overview of the collected WP6 data was carried out and presented in the ODHIN meeting.  | P. Anderson, C. Angus, P. Bendtsen, F. Braddick, K. Brzozka, N. Charles-Harris, J. Colom, L. Csémy, P. Deluca, C. Gandin, T. Gual, M. Keurhorst, M. Laurant, J. Li, H. López, S. Matrai, D. Newbury-Birch, K. Okulicz, J. Palacio, K. Parkinson, C. Ribeiro, F. Rosario, L. Segura, E. Scafato, L. Slodownik, H. Sovinova, F. Spak, P. Struzzo, M. Wojnar |

## 10. LIST OF DISSEMINATION ACTIVITIES

### Activity 1

- Type of activity: workshop



- Main Leader : ISS
- Title: Alcol 2012: la nuova addiction
- Date: 10/10/2012
- Place of publication: Genova, Italy
- Type of audience: Scientific Community
- Countries addressed: Italy

#### Activity 2

- Type of activity: conference
- Main Leader: ISS
- Title: Le regioni e le province autonome si interrogano sui problemi alcolcorrelati: politiche, strategie, organizzazione dei servizi
- Date: 25-27/10/2012
- Place of publication: Trieste, Italy
- Type of audience: Scientific Community, Policy Makers, Medias
- Countries addressed: Italy

#### Activity 3

- Type of activity: Oral presentation for a wider public
- Main Leader: ISS
- Title: Global Health Forum
- Date: 15/11/2012
- Place of publication: Washington, USA
- Type of audience: Scientific Community, Policy Makers, Medias
- Countries addressed: USA

#### Activity 4

- Type of activity: Oral presentation to a scientific community
- Main Leader: ISS
- Title: Training course on diagnosis and treatment on alcoholology
- Date: 14/12/2012
- Place of publication: Bologna, Italy
- Type of audience: Scientific Community
- Countries addressed: Italy

#### Activity 5

- Type of activity: workshop
- Main Leader: ISS
- Title: National Information Day 2013 European Health Programme
- Date: 17/01/2013
- Place of publication: Rome, Italy
- Type of audience: Scientific Community
- Countries addressed: Italy

#### Activity 6

- Type of activity: training course
- Main Leader: ISS
- Title: Training course on early identification and brief interventions on hazardous and harmful alcohol



- Date: 16.03.2013
- Place of publication: Rome, Italy
- Type of audience: Scientific Community
- Countries addressed: Italy

#### Activity 7

- Type of activity: workshop
- Main Leader: ISS
- Title: Alcohol Prevention Day
- Date: 18/04/2013
- Place of publication: Rome, Italy
- Type of audience: Scientific Community, Policy makers, Medias
- Countries addressed: Italy
- Link to online information about this activity: <http://www.epicentro.iss.it/alcol/apd13.asp>

#### Activity 8

- Type of activity: Oral presentation to a wider public
- Main Leader: ISS
- Title: WHO meeting of national focal points for alcohol policy and Global Symposium on Alcohol Control
- Date: 25-27/04/2013
- Place of publication: Istanbul, Turkey
- Type of audience: Scientific Community, Policy makers
- Countries addressed: European Countries

#### Activity 9

- Type of activity: workshop
- Main Leader: ISS
- Title: V Convegno Nazionale Alcol e Medicine complementari SIA
- Date: 17/05/2013
- Place of publication: Pitigliano (GR), Italy
- Type of audience: Scientific Community
- Countries addressed: Italy

#### Activity 10

- Type of activity: Oral presentation to a scientific community
- Main Leader: ISS
- Title: XXIII National Scientific Meeting SIA Società Italiana di Alcolologia
- Date: 18.09.2013
- Place of publication: Rome, Italy
- Type of audience: Scientific Community
- Countries addressed: Italy

#### Activity 11

- Type of activity: Oral presentation to a scientific community
- Main Leader: ISS
- Title: 10th Annual Conference of INEBRIA - The ODHIN assessment tool: a tool to describe the available services for the management of hazardous and harmful alcohol consumption at the country and regional level (Emanuele Scafato, Claudia Gandin, et al)



- Date: 19-20.09.2013
- Place of publication: Rome, Italy
- Type of audience: Scientific Community, Policy Makers, Medias
- Countries addressed: Italy

## 11. PROJECT PUBLICATIONS

### Publication 1

- D.O.I: doi:10.1186/1940-0640-8-S1-A67
- Title: The ODHIN assessment tool: a tool to describe the available services for the management of hazardous and harmful alcohol consumption at the country and regional level
- Main Author: Emanuele Scafato
- Other authors: Claudia Gandin, Miranda Laurant, Myrna Keurhorst, Marko Kolsek, Antoni Gual, Silvia Matrai, Jillian Reynolds, Joan Colom, Lidia Segura, Eileen Kaner, Dorothy Newbury Birch, Peter Anderson, Fredrik Spak, Preben Bendtsen, Hana Sovinova, Pierluigi Struzzo, Brzozka Krzysztof, Cristina Ribeiro, Van Schayck Onno, Gaby Ronda, Colin Drummond and Artur Mierzecki
- Title of the periodical or the series: Addiction Science & Clinical Practice
- Number, date or frequency: 8 (Supplement 1)
- Date of publication: 2013

## 12. APPENDICES

| NAME FILE ATTACHED                             | TYPE OF DOCUMENT:<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | CORRESPONDING<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | COMMENTS  |
|--|--|--|---|
| OD_WP6_AP1_D6.1 Assessment tool                | Deliverable  | D6.1   | ..  |
| OD_WP6_AP2_Questionnaire<br>assessment tool    | Other  | Other  | ..  |
| OD_WP6_AP3_CZ_Questionnaire<br>assessment tool | Other  | Other  | Assessment<br>tool<br>translated<br>Czech<br>Republic |
| OD_WP6_AP4_SI_Questionnaire<br>assessment tool | Other  | Other  | Assessment<br>tool<br>translated<br>Slovenia          |
| OD_WP6_AP5_PO_Questionnaire<br>assessment tool | Other  | Other  | Assessment<br>tool<br>translated<br>Portugal          |
| OD_WP6_AP6_List of key informants              | Other  | Other  |   |
| OD_WP6_AP7_Agenda MS5workshop                  | Milestone  | MS5  | Workshop<br>agenda                                    |
| OD_WP6_AP8_PPT workshop MS5                    | Milestone  | MS5  | Workshop<br>presentation                              |

## 13. STATEMENT ON THE USE OF RESOURCES – WP6

See 4.7. *Summary on the use of resources per work package and per beneficiary (below).*





## WP7 – FROM SCIENCE TO POLICY

### **1. WP LEADER:**

GENCAT (DEPARTAMENT DE SALUT – GENERALITAT DE CATALUNYA, SPAIN)

### **2. OTHER PARTNER INSTITUTIONS INVOLVED:**

FCRB (FUNDACIO PRIVADA CLINIC PER A LA RECERCA BIOMEDICA /HOSPITAL CLINICO PROVINCIAL DE BARCELONA – HCPB, SPAIN)

NU (NEWCASTLE UNIVERSITY, INSTITUTE OF HEALTH AND SOCIETY, NEWCASTLE, UNITED KINGDOM)

### **3. DESCRIPTION OF WP OBJECTIVES (OVERALL AND FOR MONTHS 19-36)**

The aim of ODHIN as a whole is to contribute to the body of knowledge of how to optimize the delivery of identification and brief interventions (IBI) for hazardous and harmful alcohol consumption in Primary Health Care (PHC). In this framework, the overall objective of WP7 is to bring about a better understanding of how to translate the results of clinical research in everyday practice in PHC settings supported by evidence-based policy, using two tools: a publication, ‘future challenges guidance’, and decision maker dialogues, leading to the development of a strategy and tool kit on effective approaches to adopting IBI into daily practice and making them available to the general population.

To achieve this, the following objectives were defined:

1. To disseminate the findings amongst the scientific community
2. To form a critical mass of IBI implementation researchers (network)
3. To update and expand the clinical evidence-based database on effective and cost-effective IBI measures for use in PHC
4. To translate science into easily understandable conclusions and recommendations for PHC professionals, policy makers and the public

Throughout the 2<sup>nd</sup> reporting period, WP7 has focused on the following activities:

- The continued development of a project website for dissemination of findings (contributing to objectives 1 and 2 above)
- Ongoing communication throughout the network of IBI implementation researchers
- The initiation of a review of the clinical evidence-based database on effective and cost-effective IBI measures for use in PHC (objective 3)
- Creation of a fact sheet template for the dissemination of findings and initial developments of fact sheets (contributing to objective 4 above).

### **4. CONCISE DESCRIPTION OF THE PROGRESS TOWARDS OBJECTIVES, INCLUDING DETAILS FOR EACH OF THE WP’S TASKS**

**The ODHIN website** (continued development):

The ODHIN permanent website ([www.odhinproject.eu](http://www.odhinproject.eu)) (DoW Task 1) was launched in December 2011, and developments and updates have continued throughout the 2<sup>nd</sup> period of the project, with the features and materials added to both the public and private-access only parts of the website, including:

- Events calendar
- Highlights section incorporated into the homepage
- Media and press tab
- WP pages: outputs (including deliverables) and own-language sections



Screen shots of the updated sections of the ODHIN website can be seen in appendix 1 (OD\_WP7\_ AP1 Website screenshots).

### **Ongoing communication of relevant findings and events throughout a network of IBI implementation researchers**

The ODHIN researchers are in close touch with relevant researchers in the field of identification and brief interventions for harmful and hazardous alcohol consumption, being involved in the activities of [PHEPA](#), [INEBRIA](#), [ESBRA](#), the [Kettyl Bruun society for social and epidemiological research on alcohol](#), [APN](#) and [WONCA](#), amongst others. This enables the dissemination of the project's findings and other relevant news throughout a regular network of researchers and other stakeholders in the area of alcohol policy and treatment (DoW Task 2).

ODHIN members were invited to give oral presentations based on ODHIN's aim and findings in the frame of the following events, thus strengthening bonds with other experts in the area:

- WHO meeting of national focal points for alcohol policy and Global Symposium on Alcohol Control, Istanbul (April 2013)
- Annual Conference of the Spanish Society of Family Physicians (SEMFYC), Granada (June 2013)
- Kettel Bruun Society 39<sup>th</sup> annual conference, Kampala (June 2013)
- 13<sup>th</sup> Family Medicine Congress, Poznan, Poland (June 2013)
- 14th Congress of the European Society for Biomedical Research on Alcoholism. 8-11.09. 2013, Warsaw, Poland
- 11<sup>th</sup> INEBRIA Conference in Italy, Rome (September 2013)
- 23<sup>rd</sup> National Scientific Meeting of the Società Italiana di Alcolologia, Rome (September 2013)

### **Review of the clinical evidence-based database on effective and cost-effective IBI measures for use in PHC**

As specified in the DoW, ODHIN members have taken over the existing evidence-based database of effective practice (DoW task 3) generated by the PHEPA project, which has now been incorporated into the ODHIN website.

Throughout the 2<sup>nd</sup> reporting period, work to update the contents of this database has started and will continue throughout the remaining months of the project, as to ensure that by the end of the project all new relevant evidence is included and ready to be made available to scientists and policy makers.



Screenshot of the ODHIN website's section including the Brief interventions database



### Creation of a factsheet template and production calendar for the dissemination of findings

A series of 6 concise and clearly written factsheets (DoW Task 4) are being prepared as the ODHIN research findings arise, following a common template already agreed upon. The planned factsheets, and the expected schedule for their dissemination, is as follows:

1. Process and policy implications in changing provider behaviour to deliver screening and brief interventions for hazardous and harmful alcohol consumption (WP2). Spring 2014
2. Cost-effectiveness of screening and brief interventions for hazardous and harmful alcohol consumption (WP3). Spring 2014
3. Available services for the management of hazardous and harmful alcohol consumption in Europe (WP6). Summer 2014
4. Attitudes and managing alcohol problems in general practice in Europe (WP4). Summer 2014
5. Factors to increase implementation of evidence-based methods of identification and brief intervention for excessive alcohol consumption in routine primary health care (WP5). Autumn 2014
6. ODHIN highlights (WP7). Winter 2014

These factsheets will be e-published and give information for policy advisors, programme managers and financiers of health services on the implementation of IBI for HHAC in everyday clinical practice. They will also be used as input for the elaboration of WP7's final deliverable "D7.1 Future challenges guidance": a report of the overall findings of the project giving comprehensive guidance on the future governance of delivering screening and brief intervention programmes for hazardous and harmful alcohol consumption. This will include 2 **guidance e-manuals**: one for providers and one for commissioners of services (DoW Task 5). The manuals will be developed in a very friendly and interactive manner and will be available in December 2014 (Project Month 48).

### Policy makers' dialogues:

A first round of policy makers' dialogues (task 6) took place on a national basis in all participating countries. This resulted in the establishment of a forum for on-going discussion around policy to support effective and evidence-based IBIs in PHC settings for hazardous and harmful alcohol consumption.

A second policy dialogue is planned for the last year of the project. Initial conversations as to plan this meeting have already taken place, with the preferred option being celebrating the dialogue in the frame of 6<sup>th</sup> European Alcohol Policy Conference (November 2014), organised by [EUROCARE](#).



## 5. SIGNIFICANT RESULTS ACHIEVED SO FAR

### Press launch of ODHIN:

Within the 1<sup>st</sup> reporting period the ODHIN project was launched to the local and national press in Spain, resulting in 21 articles (print and online, see screenshots below), release by 3 news agencies, 3 radio interviews and 1 television interview. The press release was also included in the international press release portal 'Eureka' and the blog spots of IDIBAPS and Hospital Clinic, which have international readership.

Miércoles, 15 de febrero 2012  
L'AVANGUARDIA.com | Salud

Portada Internacional Política Economía Sucesos Opinión Deportes Vida  
EO Magazine Barcelona Metrópolis Ciencia Salud Solidaridad Medi

### El 15% de las visitas al médico de cabecera presentan consumos de alcohol de riesgo

En España se producen al año unas 20.000 muertes relacionadas con el consumo de alcohol. El 15 por ciento de las personas que acuden al médico de cabecera presentan consumos de alcohol considerados de riesgo, cifra que es de dimensiones de una problemática sobre la que los expertos defienden la necesidad de actuar. Así se ha puesto de manifiesto este martes en el **CaixaForum** de Barcelona, motivo de la segunda reunión internacional del proyecto europeo Odhin, una iniciativa financiada por el VII programa marco de investigación de la Comisión Europea y liderada por el Hospital Clínic de Barcelona y el departamento de Drogodependencias de la Generalitat de Catalunya.

En España se producen al año unas 20.000 muertes relacionadas con el consumo de alcohol, la segunda práctica de riesgo con más incidencia sobre la salud por detrás de fumar. Así se ha puesto de manifiesto este martes en el **CaixaForum** de Barcelona, motivo de la segunda reunión internacional del proyecto europeo Odhin, una iniciativa financiada por el VII programa marco de investigación de la Comisión Europea y liderada por el Hospital Clínic de Barcelona y el departamento de Drogodependencias de la Generalitat de Catalunya.

Los expertos, que han recordado que por consumo de riesgo se entiende la ingesta continuada de unas 20 unidades de bebida estándar (UBE) para los hombres y 17 mujeres a lo largo de una semana, han señalado que al menos 60 enfermedades relacionadas con el alcoholismo. Las muertes están producidas especialmente por cirrosis hepática, aunque el alcohol también puede causar muertes en accidentes de tráfico. En España, se producen al año unas 20.000 muertes relacionadas con el consumo de alcohol, la segunda práctica de riesgo con más incidencia sobre la salud por detrás de fumar. Así se ha puesto de manifiesto este martes en el **CaixaForum** de Barcelona, motivo de la segunda reunión internacional del proyecto europeo Odhin, una iniciativa financiada por el VII programa marco de investigación de la Comisión Europea y liderada por el Hospital Clínic de Barcelona y el departamento de Drogodependencias de la Generalitat de Catalunya.

El proyecto Odhin, que se lleva a cabo en una veintena de instituciones académicas de nueve países europeos, pretende identificar en qué medida la formación médica continuada, la retribución económica al sanitario y la derivación a un programa de apoyo puede contribuir a reducir los consumos de riesgo. La Fundación Clínic para la Investigación Biomédica y la Generalitat colaboran desde 1995 en el ámbito de la atención primaria, y Colom ha señalado que en un breve plazo de tiempo se pondrá en marcha un programa piloto en Catalunya que permitirá a la población calcular su consumo de riesgo a través de una aplicación on line.

EL PAÍS CATALUÑA

### Los ambulatorios reducen en un 20% los consumos de riesgo de alcohol

El 15% de los pacientes que acuden a atención primaria consumen alcohol de riesgo. Los ambulatorios reducen en un 20% los consumos de riesgo de alcohol, según se ha informado en el programa pionero de prevención que aplican centros catalanes desde 2002.

La atención primaria frena el alcoholismo. Los médicos de familia reducen en un 20% los consumos de riesgo de alcohol, según se ha informado en el programa pionero de prevención que aplican centros catalanes desde 2002.

El consumidor de riesgo ingiere grandes cantidades de alcohol. El 15% de las personas que visitan la atención primaria consumen alcohol de riesgo. Los ambulatorios reducen en un 20% los consumos de riesgo de alcohol, según se ha informado en el programa pionero de prevención que aplican centros catalanes desde 2002.

El alcohol en España supone un 3.800 millones de euros en consumo. El alcohol en España supone un 3.800 millones de euros en consumo. El alcohol en España supone un 3.800 millones de euros en consumo.

El alcohol en España supone un 3.800 millones de euros en consumo. El alcohol en España supone un 3.800 millones de euros en consumo. El alcohol en España supone un 3.800 millones de euros en consumo.

ABC.es CATALUÑA

### La intervención precoz reduce en un 20% el consumo de riesgo de alcohol

El consumo excesivo de esta sustancia cuesta a España 3.800 millones de euros anuales. La intervención precoz reduce en un 20% el consumo de riesgo de alcohol. El consumo excesivo de esta sustancia cuesta a España 3.800 millones de euros anuales.

El alcohol en España supone un 3.800 millones de euros en consumo. El alcohol en España supone un 3.800 millones de euros en consumo. El alcohol en España supone un 3.800 millones de euros en consumo.

El alcohol en España supone un 3.800 millones de euros en consumo. El alcohol en España supone un 3.800 millones de euros en consumo. El alcohol en España supone un 3.800 millones de euros en consumo.

The project website has been fully functional since November 2011 and has been used as an internal communication tool between project partners since then, using the private-access parts for document exchange and storage. Conceived also as a communication tool with the general public, it has been regularly updated with news, events, project outputs, etc. All submitted project deliverables are also available in the relevant WP pages and are highlighted when published.

As mentioned in the previous section, ODHIN partners form part of a strong network of IBI implementation researchers, and also have access to relevant forums for debate and knowledge exchange, and have been able to present the preliminary findings of the ODHIN project in outstanding events for this research area. This will continue throughout the remaining months of the project, with an ODHIN workshop already planned for the 11<sup>th</sup> INEBRIA Conference in September 2014.

In total, ODHIN partners have carried out over 50 dissemination activities in the first 3 years of the project, including workshops, posters, oral presentations at conferences, press releases leading to articles in the popular press.



Work to complete DoW tasks 3 (evidence-based database), 4 (factsheets) and 5 (guidance e-manuals) is progressing and is expected to be completed by the end of the project (see section above).

## **6. REASONS FOR DEVIATIONS FROM THE DESCRIPTION OF WORK AND THEIR IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING**

As explained in the 1<sup>st</sup> periodic report, given the difficulty of convening a large EU-level policy decision makers' dialogue meeting in a short time (within the 1<sup>st</sup> year of the project), and the importance of ensuring the attendance of key decision makers with the appropriate expertise and authority to comment on the work plan and research, it was decided that a more effective approach would be to ask ODHIN partners to arrange small meetings with regional or national policy makers to raise awareness of the project aims and the field of research, gather feedback on the methodology proposed and prime them in preparation for participating in a single larger meeting at a later date where results could be presented. These meetings took place within the first reporting period.

The Description of Work planned for the series of 6 factsheets to be e-published from the second year of the project onwards. However, since the ODHIN project was able to achieve a high level of visibility through parallel ongoing dissemination activities, the ODHIN partners decided to concentrate the production of the factsheets in the last year of the ODHIN project, as this was considered the most cost-effective dissemination strategy: the factsheets would then include the most relevant and up-to-date findings across all work packages, instead of preliminary or partial results.

## **7. REASONS FOR FAILING TO ACHIEVE CRITICAL OBJECTIVES AND /OR NOT BEING ON SCHEDULE, EXPLAINING IMPACT ON OTHER TASKS AS WELL AS ON AVAILABLE RESOURCES AND PLANNING**

See section 6, above. No major impact on other tasks or available resources is foreseen.

## **8. PROPOSAL OF CORRECTIVE ACTION**

Not applicable.

## **9. WP MEETINGS AND CALLS**

No specific WP7 meetings took place, as dissemination issues are dealt with transversally throughout the project, i.e. through email exchange with WP leaders as relevant findings arise, using general communication tools to all ODHIN partners to inform of relevant news or events in the IBI area, publishing relevant information on the project's website, and also dedicating space for the discussion of dissemination strategies in the ODHIN plenary meetings.

## **10. LIST OF DISSEMINATION ACTIVITIES**

All dissemination activities are included in the respective WP sections of this report, as to avoid duplication.

## **11. PROJECT PUBLICATIONS**

No specific WP7 publications have been produced.



## 12. APPENDICES

| NAME FILE ATTACHED             | TYPE OF DOCUMENT:<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | CORRESPONDING<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | COMMENTS |
|--------------------------------|--|--|----------|
| OD_WP7_AP1_Website screenshots | Other  | ODHIN Website  | ..       |

## 13. STATEMENT ON THE USE OF RESOURCES – WP7

See 4.7. *Summary on the use of resources per work package and per beneficiary* (below).



## 4. PROJECT MANAGEMENT DURING THE PERIOD

### WP1 – COORDINATION

#### 4.1. WP LEADER:

FCRB (FUNDACIO PRIVADA CLINIC PER A LA RECERCA BIOMEDICA /HOSPITAL CLINICO PROVINCIAL DE BARCELONA – HCPB, SPAIN)

#### 4.2. OTHER PARTNER INSTITUTIONS INVOLVED

None

#### 4.3. CONSORTIUM MANAGEMENT TASKS AND ACHIEVEMENTS

WP1 is in charge of the coordination and management of ODHIN both at administrative, financial and scientific level. During the first 18 months of the project, efficient communication channels between the project participants were created, enabling both collaboration and exchange of ideas between the different scientists involved in the project's seven work packages, and also continuous support and follow-up of the different tasks foreseen in each work package. The project participants have continued using these communication channels throughout the 2<sup>nd</sup> reporting period:

- **Regular e-mail exchange** with the participants in each work package has taken place to discuss both technical and organisational matters.
- A **database** with all participants valid e-mail addresses<sup>2</sup>, and mailing lists, enabling e-mail thread discussions both on general and work package specific issues. This has proved to be a most helpful tool both in preparatory and completion phases of the project's events and outputs, enabling transparency and equal opportunities to all scientists to contribute to the discussions, and ensuring regular communication between the project's participants.
- **Rounds of conference calls** between the coordination team and the work package leaders took place at two key moments of the first reporting period: calls per work packages at the midpoint of the reporting period (Autumn 2011), and calls per country in Spring 2012. During the second reporting period a third round of conference calls took place (between February and April 2013), organised by work packages as to go through the status of all expected tasks, tackle any difficulties and plan out future actions, in particular taking into account the writing of WP deliverables.
- **Plenary meetings:** During the first reporting period two plenary meetings took place: the ODHIN Kick Off meeting was held on 21-23<sup>rd</sup> February 2011, whereas the second plenary meeting took place on 14-15<sup>th</sup> February 2012. In the second reporting period a third plenary meeting was held in Barcelona on 1-2<sup>nd</sup> October 2013, presenting and discussing the main scientific findings of the different work packages.
- By early 2012 the **password-protected members' area of the ODHIN website** ([www.odhinproject.eu](http://www.odhinproject.eu); see section 3-WP7 *From Science to Policy* for a full description of the development of the website) was fully functional, and has been updated incorporated all relevant project-related documents and used regularly by the partners since.
- The ODHIN partners continue to use an **ODHIN Publications Register**, by means of which publication ideas are proposed, discussed and agreed upon. Concerning publications, the Coordinating team has also established **Publication Guidelines** for the ODHIN project, which has been sent to all

---

<sup>2</sup> This password-protected Microsoft Access database contains relevant contact and institutional details of the scientific contact persons, scientific collaborators and administrative and financial contact persons of each partner institution.



participants and is available on the project website. Amongst others, authors are enhanced to seek open access, agreed acknowledgement, and reminded to inform the ODHIN coordinating team when papers are submitted or published, also sending a copy to all participants.

## Changes in the consortium

### Termination of beneficiary 12-UCL – University College of London

Prof. Paul Wallace, principal investigator, stated as *Person in charge of scientific and technical/ technological aspects* for 12-UCL in the original Grant Agreement Preparation Forms, retired from UCL in March 2012. UCL informed the Coordinator that they wish to terminate their participation in the project. As UCL's work on the project is located in the United Kingdom, the optimal solution was to transfer their activities and, consequently, their remaining EU contribution to another existing beneficiary in the same country. Beneficiary 6-NU – University of Newcastle worked in close collaboration with 12-UCL on the project; their researchers are familiar with the remaining UCL activities to carry out, and are able to deliver the work at the same high standards as UCL. In addition, Prof. Paul Wallace will continue to give support and advice to 6-NU on a non-remunerated basis.

The termination and transfer of activities entered took effect on 01/07/2012, and were duly requested in Amendment Nr1. approved on 06/12/2013.

### Universal transfer of rights and obligations beneficiary 14-IDT Instituto da Droga e da Toxicodependencia

Beneficiary 14-IDT underwent a universal transfer of rights and obligations on 01/02/2012, and currently operates as SICAD (PIC: 951070451) under FP7. To the Coordinator's knowledge, the approval of this change was a long administrative process that concluded in November 2013.

Based on Article 6.2 of the amendment guidelines, the Coordinator confirmed with EC legal officer in charge of the project that, in case of a UTRO of a partner, there is no need for amendment and an information letter will be issued.

## Project funding management

The **pre-financing** of the financial contribution of the European Commission to the ODHIN project was received at the Coordinator's bank account on 17th January 2011, and was distributed to most partners by 18th March 2011, except for beneficiaries 4-UoY, 11-PARPA, and 18-PAM who received the payment by 10<sup>th</sup> June 2011, and 14-IDT by 1<sup>st</sup> August 2011. The delay in transferring the pre-financing to the aforementioned four beneficiaries was due to their late providing of bank details to the Coordinator.

The pre-financing generated an **interest** of 1,946.94 euro at the Coordinator's bank account, which has duly been declared in the financial statement (Form C) of beneficiary 1-FCRB.

The **payment of the EU contribution for period 1** was received at the Coordinator's bank account on 05/04/2013; the payment letter was dated 09/04/2013. The payment was distributed to all beneficiaries through bank transfer dated 07/05/2013. In accordance with the Commission's policy to retain 10% plus a guarantee fund of 5% of the maximum EU contribution, and applying the usual practice of the Coordinator in its coordinated EU-funded research projects, the Coordinator transfers funds to beneficiaries according to the costs approved in the payment letters up to the 85% of the total maximum EU contribution of each beneficiary before the final payment.





### Amendment request Nr. 1

According to the amendment request Nr. 1 submitted in 23/10/2013 and approved as detailed in the EC's amendment letter dated 06/12/2013, the revised Part A and B of Annex I dated 01/07/2012 replaces any former version.

## 4.4. PROJECT MEETINGS, PLANNING AND STATUS

### Project meetings

In the period 01/01/2011 to 31/12/2013, the following **overall project meetings** were held:

- Kick-off meeting: 21-23 February 2011, Barcelona
- Annual plenary meeting: 14-15 February 2012, Barcelona
- 1<sup>st</sup> round call meetings: 13 December 2011 (WP2), 3 October 2011 (WP4), 14 October 2011 (WP5), 17 October 2011 (WP6)
- 2<sup>nd</sup> round country specific call meetings: 2 May 2012 (Sweden), 7 May 2012 (Catalonia), 8 May 2012 (UK), 24 May 2012 (Netherlands), 4 June 2012 (Poland)
- 3<sup>rd</sup> round call meetings: 21 February 2013 (WP4), 22 February 2013 (WP6), 12 March 2013 (WP2 & WP3), 16 April 2013 (WP5)
- Annual plenary meeting: 1-2 October 2013, Barcelona (see OD\_WP1\_AP1\_Agenda\_Plenary Oct2013).

In the same period, the following **work package-specific meetings** were held<sup>3</sup>:

#### WP2

- 21-23 February 2011, Barcelona
- 15 June 2011, Barcelona
- 13 December 2011, call meeting
- 14-15 February 2012, Barcelona
- 8 May 2012, call meeting
- 24 April 2013, call meeting
- 20 September 2013, call meeting

#### WP3

- 21-23 February 2011, Barcelona
- 29 September 2011, call meeting
- 15 October 2011, call meeting
- 20 October 2011, call meeting
- 14-15 February 2012, Barcelona

#### WP4

- 21-23 February 2011, Barcelona
- 3 October 2011, call meeting
- 1 December 2011, Warsaw
- 17 January 2012, Barcelona

---

<sup>3</sup> See section 3. *Project objectives, work progress and achievements during the period* for further details on work package meetings



- 14-15 February 2012, Barcelona
- 22 March 2012, Barcelona

#### WP5

- 18 January 2011, call meeting
- 21-23 February 2011, Barcelona
- 2 March 2011, call meeting
- 4 April 2011, call meeting
- 14 April 2011, call meeting
- 27 April 2011, Göteborg
- 18 May 2011, call meeting
- 15-16 June 2011, Barcelona
- 6-7 July 2011, Warsaw
- 28 July 2011, Barcelona
- 24 August 2011, call meeting
- 29 September 2011, Barcelona
- 2 October 2011, call meeting
- 6 October 2011, Göteborg
- 14 October 2011, call meeting
- 4 November 2011, call meeting
- 10 November 2011, call meeting
- 16 November 2011, call meeting
- 24 November 2011, Barcelona
- 20 December 2011, Barcelona
- 17 January 2012, Barcelona
- 7 February 2012, Newcastle
- 9 February 2012, Barcelona
- 14-15 February 2012, Barcelona
- 22 February 2012, Barcelona
- 23 February 2012, call meeting
- 28 February 2012, Newcastle
- 7 March 2012, Göteborg
- 9 March 2012, Barcelona
- 14 March 2012, call meeting
- 20 March 2012, Utrecht
- 20 March 2012, Poznan
- 27 March 2012, call meeting
- 2 April 2012, Newcastle
- 3 April 2012, Barcelona
- 18 April 2012, Newcastle
- 24 April 2012, Barcelona
- 2 May 2012, call meeting
- 7 May 2012, call meeting
- 8 May 2012, call meeting
- 25 May 2012, call meeting
- 4 June 2012, call meeting
- 8 June 2012, Barcelona
- 14 June 2012, call meeting



- 27 June 2012, call meeting
- 9 July 2012, Barcelona
- 24 July 2012, call meeting
- 13 September 2012, call meeting
- 19 September 2012, Barcelona
- 19 September 2012, call meeting
- 26 September 2012, WP5 coordination meeting, Barcelona
- 11 October 2012, call meeting
- 24 October 2012, call meeting
- 29 October 2012, Barcelona
- 7 November 2012, call meeting
- 13 November 2012, call meeting
- 28 November 2012, Barcelona
- 3 December 2012, Nijmegen
- 5 December 2012, call meeting
- 6 December 2012, call meeting
- 10 December 2012, Barcelona
- 8-9 January 2013, Mullsjö, Sweden
- 9 January 2013, call meeting
- 21 January 2013, Barcelona
- 14 February 2013, call meeting
- 19 February 2013, call meeting
- 25 February 2013, Barcelona
- 20 March 2013, Barcelona
- 26 March 2013, Maastricht
- 26 March 2013, call meeting
- 26 April 2013, Barcelona
- 7 & 8 May 2013, WP5 coordination meeting, Barcelona
- 17 May 2013, call meeting
- 30 May 2013, call meeting
- 3 June 2013, Barcelona
- 28 June 2013, Barcelona
- 10 July 2013, call meeting
- 29 August 2013, call meeting
- 4 September 2013, call meeting
- 15 October 2013, Nijmegen
- 6 November 2013, call meeting
- 29 November 2013, Barcelona

#### WP6

- 22 February 2011, Barcelona
- 17 October 2011, call meeting
- 14-15 February 2011, Barcelona
- 26 September 2012, WP6 workshop, Barcelona

#### WP7

- 22 February 2011, Barcelona
- 7 October 2011, Barcelona



- 20 October 2011, Lisbon
- 23 November 2011, Lisbon
- 24 November 2011, Barcelona
- 29 November 2011, Stockholm
- 9 January 2012, Barcelona
- 7 February 2012, Prague
- 14-15 March 2012, Barcelona
- 22 February 2012, Barcelona
- 9 March 2012, Utrecht
- 20 March 2012, Lisbon
- 25 June 2012, Warsaw

**Project planning and status**

Deliverables:

Within the first 18 months of the project, 2 deliverables were due to be achieved:

- D4.1 Survey Report, expected in month 18, was rescheduled to month 24, after finding difficulties in some countries to complete the survey fieldwork reaching the expected number of GP replies.
- D5.1 Protocol was achieved in June 2012.

In the second reporting period all due deliverables have been achieved and submitted:

- Submission of D4.1 Survey report (March 2013)
- Submission of D2.1 Knowledge base science (January 2014)
- Submission of D3.1 Model report (December 2013)
- Submission of D6.1 Assessment tool report (February 2014)

All remaining deliverables (D5.2, D5.3 and D7.1) are progressing as planned and are expected to be on time. An addendum to D3.1 will also be delivered in October 2014.

Milestones:

Concerning the milestones, of the five due in the first reporting period (MS1, MS2, MS3, MS5, MS6), all were achieved except MS5, as the workshop for WP6 was adjourned until September 2012. In the second reporting period the remaining two milestones (MS5 and MS4) have been achieved.

In the last year of the project, work will continue as planned, with a strong focus on WP5's RCT analysis and translating science to policy through the outputs of WP7, plus the writing of scientific papers. A WP5 specific meeting will be held in March 2014 as to discuss the trial's preliminary results, whereas the final project meeting is scheduled for September 2014.

**4.5. APPENDICES**

| NAME FILE ATTACHED                | TYPE OF DOCUMENT:<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | CORRESPONDING<br>DELIVERABLE/MILESTONE/OTHER<br>ACTIVITY OR TASK | COMMENTS |
|-----------------------------------|--|--|----------|
| OD_WP1_AP1_Agenda_Plenary Oct2013 | Other activity   | ..   |          |

**4.6. STATEMENT ON THE USE OF RESOURCES – WP1**

See section 4.7. *Summary on the use of resources per work package and per beneficiary of (below).*



#### 4.7. SUMMARY ON THE USE OF RESOURCES PER WORK PACKAGE AND PER BENEFICIARY

| Beneficiary  | WP1       |              |              |              | WP2       |              |              |              | WP3       |              |              |              | WP4       |              |              |              | WP5        |               |              |               | WP6       |               |              |              | WP7       |             |             |              | Total per Beneficiary |               |
|--------------|-----------|--------------|--------------|--------------|-----------|--------------|--------------|--------------|-----------|--------------|--------------|--------------|-----------|--------------|--------------|--------------|------------|---------------|--------------|---------------|-----------|---------------|--------------|--------------|-----------|-------------|-------------|--------------|-----------------------|---------------|
|              | Amend     | P1           | P2           | Total        | Amend     | P1           | P2           | Total        | Amend     | P1           | P2           | Total        | Amend     | P1           | P2           | Total        | Amend      | P1            | P2           | Total         | Amend     | P1            | P2           | Total        | Amend     | P1          | P2          | Total        | Amend                 | Reported      |
| 1 FCRB       | 36        | 11,76        | 19,65        | 31,41        |           |              |              |              |           |              |              |              | 5         | 1,02         | 4,12         | 5,14         | 25         | 5,16          | 4,98         | 10,14         | 3         | 0,34          | 2,53         | 2,87         | 11        | 1,35        | 8,30        | 9,65         | 80                    | 59,21         |
| 2 RUNMC      |           |              |              |              | 28        | 10,24        | 14,08        | 24,32        | 3         | 3,11         | 0,18         | 3,29         | 2         | 1,77         | 0,18         | 1,95         | 39         | 7,98          | 15,53        | 23,51         | 1         | 0,97          | 0,18         | 1,15         |           |             |             |              | 73                    | 54,22         |
| 3 USFD       |           |              |              |              |           |              |              |              | 44        | 7,03         | 50,3         | 57,34        |           |              |              |              |            |               |              |               |           |               |              |              |           |             |             |              | 44                    | 57,34         |
| 4 UoY        |           |              |              |              |           |              |              |              | 3         | 0,50         | 1,04         | 1,54         |           |              |              |              |            |               |              |               |           |               |              |              |           |             |             |              | 3                     | 1,54          |
| 5 Ceformed   |           |              |              |              |           |              |              |              | 6         | 4,80         | 0,50         | 5,30         | 2         | 1,50         | 0,50         | 2,00         |            |               |              |               | 2         | 1,50          | 0,50         | 2,00         |           |             |             |              | 10                    | 9,30          |
| 6 NU         |           |              |              |              | 3         | 0,39         | 0,24         | 0,63         |           |              |              |              | 5         | 2,78         | 0,50         | 3,28         | 18         | 5,68          | 7,05         | 12,73         | 5         | 2,33          | 0,50         | 2,83         | 18        | 1,00        | 0,00        | 1,00         | 49                    | 20,47         |
| 7 KCL        |           |              |              |              |           |              |              |              |           |              |              |              | 2         | 0,00         | 0,00         | 0,00         | 6          | 0,73          | 13,01        | 13,74         | 2         | 0,00          | 0,00         | 0,00         |           |             |             |              | 10                    | 13,74         |
| 8 UGOT       |           |              |              |              |           |              |              |              |           |              |              |              | 2         | 0,00         | 2,00         | 2,00         | 15         | 0,00          | 8,83         | 8,83          | 2         | 0,00          | 2,00         | 2,00         |           |             |             |              | 19                    | 12,83         |
| 9 LIU        |           |              |              |              |           |              |              |              |           |              |              |              | 2         | 0,00         | 0,00         | 0,00         | 15         | 0,00          | 13,29        | 13,29         | 2         | 0,00          | 0,00         | 0,00         |           |             |             |              | 19                    | 13,29         |
| 10 GENCAT    |           |              |              |              |           |              |              |              |           |              |              |              | 2         | 1,90         | 0,11         | 2,01         | 15         | 5,84          | 7,39         | 13,23         | 2         | 1,07          | 0,72         | 1,79         | 6         | 1,76        | 1,55        | 3,31         | 25                    | 20,34         |
| 11 PARPA     |           |              |              |              |           |              |              |              | 2         | 0,44         | 0,60         | 1,04         |           |              |              |              | 18         | 0,76          | 11,97        | 12,73         | 2         | 0,06          | 0,20         | 0,26         |           |             |             |              | 22                    | 14,03         |
| 12 UCL       |           |              |              |              |           |              |              |              |           |              |              |              |           |              |              | 2            | 1,916      | N/A           | 1,92         |               |           |               |              |              |           |             |             | 2            | 1,92                  |               |
| 13 UL        |           |              |              |              |           |              |              |              |           |              |              |              | 4         | 2,20         | 1,20         | 3,40         |            |               |              |               | 4         | 2,20          | 1,90         | 4,10         |           |             |             |              | 8                     | 7,50          |
| 14 IDT       |           |              |              |              |           |              |              |              |           |              |              |              | 4         | 2,00         |              | 2,00         |            |               |              |               | 4         | 2,00          |              | 2,00         |           |             |             |              | 8                     | 4,00          |
| 15 ISS       |           |              |              |              |           |              |              |              |           |              |              |              | 5         | 3,50         | 0,10         | 3,60         |            |               |              |               | 8         | 7,69          | 0,21         | 7,90         |           |             |             |              | 13                    | 11,50         |
| 16 UM        |           |              |              |              |           |              |              |              |           |              |              |              | 2         | 2,36         | 2,39         | 4,75         | 18         | 0,368         | 5,12         | 5,49          | 2         | 0,832         | 1,17         | 2,00         |           |             |             |              | 22                    | 12,24         |
| 17 SZU       |           |              |              |              |           |              |              |              |           |              |              |              | 4         | 4,47         | 0,08         | 4,55         |            |               |              |               | 4         | 2,63          | 0,07         | 2,70         |           |             |             |              | 8                     | 7,24          |
| 18 PAM       |           |              |              |              |           |              |              |              |           |              |              |              |           |              |              | 18           | 3,00       | 4,50          | 7,50         | 2             | 0,50      | 1,00          | 1,50         |              |           |             |             | 20           | 9,00                  |               |
| 19 MUW       |           |              |              |              |           |              |              |              |           |              |              |              | 6         | 3,80         | 1,00         | 4,80         |            |               |              |               |           |               |              |              |           |             |             |              | 6                     | 4,80          |
| <b>TOTAL</b> | <b>36</b> | <b>11,76</b> | <b>19,65</b> | <b>31,41</b> | <b>31</b> | <b>10,63</b> | <b>14,32</b> | <b>24,95</b> | <b>58</b> | <b>15,88</b> | <b>52,63</b> | <b>68,51</b> | <b>47</b> | <b>27,30</b> | <b>12,18</b> | <b>39,48</b> | <b>189</b> | <b>31,434</b> | <b>91,67</b> | <b>123,10</b> | <b>45</b> | <b>22,122</b> | <b>10,98</b> | <b>33,10</b> | <b>35</b> | <b>4,11</b> | <b>9,85</b> | <b>13,96</b> | <b>441</b>            | <b>334,51</b> |

1st period adjusted in 2nd period

Period 2 PM numbers not provided by the beneficiary by the date of submission of the periodic report

## 5. DELIVERABLES AND MILESTONES TABLES

### 1. TABLE OF DELIVERABLES

| DELIVERABLE NO. | DELIVERABLE NAME         | VERSION | NAME FILE ATTACHED                              | WP | LEAD BENEFICIARY | NATURE* | DISSEMINATION LEVEL** | DELIVERY DATE FROM ANNEX 1 (PROJECT MONTH) | ACTUAL / FORECAST DELIVERY DATE | STATUS (NOT SUBMITTED/ SUBMITTED) | CONTRACTUAL (YES/NO) | COMMENTS   |
|-----------------|--------------------------|---------|---|----|------------------|---------|-----------------------|--|---------------------------------|-----------------------------------|----------------------|--|
| D2.1            | Knowledge base science   | 1       | OD_WP2_AP1_D2.1 Knowledge base                  | 2  | RUNMC            | R       | PU                    | 24→Revised to 36                           | 13/01/2014                      | Submitted                         | Yes                  | ..   |
| D3.1            | Model report             | 1       | OD_WP3_AP1_D3.1-Cost Effectiveness Model Report | 3  | USFD             | R       | PU                    | 36   | 20/12/2013                      | Submitted                         | Yes                  | ..   |
| D3.2            | Addendum to model report | ..      | ..  | 3  | USFD             | R       | PU                    | 46   | 31/10/2014                      | Not submitted                     | Yes                  | Addendum to D3.1 including analysis of the results from the WP5 trial representing the fulfilment of objective 3.    |
| D4.1            | Survey report            | 1       | ..  | 4  | MUW              | R       | PU                    | 18   | 05/03/2013                      | REJECTED: REPLACED BY VERSION 2   | Yes                  | Due to difficulties in completing the survey fieldwork and data collection the delivery was delayed until March 2013 |
| D4.1            | Survey report            | 2       | OD_WP4_AP1_D4.1_Survey Report                   | 4  | MUW              | R       | PU                    | 18   | 27/03/2014                      | SUBMITTED                         | Yes                  | Updated version replacing previous one   |

| DELIVERABLE NO. | DELIVERABLE NAME                       | VERSION | NAME FILE ATTACHED                      | WP | LEAD BENEFICIARY | NATURE* | DISSEMINATION LEVEL** | DELIVERY DATE FROM ANNEX 1 (PROJECT MONTH) | ACTUAL / FORECAST DELIVERY DATE | STATUS (NOT SUBMITTED/ SUBMITTED) | CONTRACTUAL (YES/NO) | COMMENTS  |
|-----------------|--|---------|---|----|------------------|---------|-----------------------|--|---------------------------------|-----------------------------------|----------------------|---|
| D5.1            | RCT protocol                           | ..      | Submitted in the first reporting period | 5  | UGOT, LIU        | R       | PU                    | 12   | 15/06/2012                      | SUBMITTED                         | Yes                  | ..  |
| D5.2            | Implementation science                 | ..      | ..                                      | 5  | UGOT, LIU        | R       | PU                    | 48   | 31/12/2014                      | NOT SUBMITTED                     | Yes                  | ..  |
| D5.3            | Implementation guide for policy makers | ..      | ..                                      | 5  | UGOT, LIU        | R       | PU                    | 48   | 31/12/2014                      | NOT SUBMITTED                     | Yes                  | ..  |
| D6.1            | Assessment tool report                 | Final   | OD_WP6_AP1_D6.1 Assessment tool         | 6  | ISS              | R       | PU                    | 36   | 24.02.2014 (M38)                | SUBMITTED                         | Yes                  | Final revisions of the document explain a slight delay in the submission. |
| D7.1            | Future challenges guidance             | ..      | ..                                      | 7  | GENCAT           | O       | PU                    | 48   | 31/12/2014                      | NOT SUBMITTED                     | Yes                  | ..  |

## 2. TABLE OF MILESTONES

| MILESTONE NO. | MILESTONE NAME   | WP | LEAD BENEFICIARY | DELIVERY DATE FROM ANNEX 1 (PROJECT MONTH) | ACHIEVED YES/NO | ACTUAL FORECAST ACHIEVEMENT DATE (DD/MM/YYYY) | DOCUMENTATION PROVING ACHIEVEMENT  | NAME FILE ATTACHED   | COMMENTS   |
|---------------|--|----|------------------|--|-----------------|---|--|--|--|
| MS1           | Core group workshop on the search strategy for the series of scientific papers review                | 2  | RUNMC            | 2  | Yes             | 22/02/2011                                    | Provided together with the 1 <sup>st</sup> Periodic report                 | Provided together with the 1 <sup>st</sup> Periodic report   | ..   |
| MS2           | Core group workshop on the country-specific adaptation of the policy model                           | 3  | USFD             | 7  | Yes             | 20/10/2011                                    | DATA AVAILABILITY DOCUMENT attached to the 1 <sup>st</sup> Periodic Report | Provided together with the 1 <sup>st</sup> Periodic report   | Achieved in the 1 <sup>st</sup> reporting period |
| MS3           | Core group workshop on the design of the implementation methodology of the developed assessment tool | 4  | MUW              | 10   | Yes             | 21-23/02/2011 and 14-15/02/2012               | 1. Survey Questionnaire<br>2. Survey Protocol                              | Both attached to the 1 <sup>st</sup> periodic report   | ..   |
| MS4           | Pilot testing of the evidence-based education package proposal and suggested CME in each country     | 5  | UGOT, LIU        | 19   | Yes             | 15/07/2013                                    | Translated and adapted country protocols                                   | OD_WP5_AP1_Catalonia country protocol<br>OD_WP5_AP2_Poland country protocol<br>OD_WP5_AP3_Sweden country protocol<br>OD_WP5_AP4_England country protocol | The Netherlands used the protocol in English     |



| MILESTONE NO. | MILESTONE NAME   | WP | LEAD BENEFICIARY | DELIVERY DATE FROM ANNEX 1 (PROJECT MONTH) | ACHIEVED YES/NO | ACTUAL FORECAST ACHIEVEMENT DATE (DD/MM/YYYY) | DOCUMENTATION PROVING ACHIEVEMENT     | NAME FILE ATTACHED   | COMMENTS  |
|---------------|--|----|------------------|--|-----------------|---|---------------------------------------|--|---|
| MS5           | Workshop to identify the variables providing an estimate of the implementation and extent of IBI's | 6  | ISS              | 12   | YES             | 26/09/2012                                    | PPT presentation and agenda           | OD_WP6_AP7_Agenda MS5workshop<br><br>OD_WP6_AP8_PPT workshop MS5 | The workshop was originally planned at M12; it was postponed at M21 because the ODHIN team felt that having the preliminary results from data collection would be an added value to the workshop, allowing participants to better finalize the workshop outcomes. The workshop was held in Barcelona during the 9th INEBRIA Conference 27-28.09.2012. |
| MS6           | Decision makers dialogues to discuss research direction of project                                 | 7  | GENCAT           | 12   | Yes             | 30/8/12                                       | Achieved in previous reporting period | Achieved in previous reporting period                            | Achieved in previous reporting period   |