Optimizing Delivery of Health Care Interventions (ODHIN)

ODHIN ASSESSMENT TOOL –REPORT
A description of the available services for the management of hazardous and harmful alcohol consumption
Deliverable D6.1, Work Package 6

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ABSTRACT

ODHIN - Optimizing Delivery of Health care INterventions is an European project (EC, FP7) involving research institutions from 9 European countries using the implementation of Early Identification and Brief Intervention programmes for Hazardous and Harmful Alcohol Consumption in Primary Health Care as a case study to better understand how to translate the results of clinical research into every day practice.

The Istituto Superiore di Sanità - ISS, Rome, Italy was the project leader of the Work Package 6 "Assessment tool". The aim of the assessment tool was to develop and test a comprehensive standard format to be used for the evaluation of the availability of services devoted to the management of hazardous and harmful alcohol consumption throughout Primay Health Care settings at the country and/or regional level. This report will present the main results and promote the ODHIN assessment tool as an instrument to be used worldwide to assess the delivery and implementation of EIBI programmes.

The ODHIN assessment tool was an excellent example of networking by sharing and collaborating into the alcohol field between countries and within each country at territorial level. Data have been collected from 23 European countries (Belgium, Catalonia-Spain, Croatia, Cyprus, Czech Republic, England-UK, Estonia, Finland, FYROM - ex Yugoslav Republic of Macedonia, Germany, Greece, Iceland, Ireland, Italy, Latvia, Malta, Poland, Portugal, Romania, Slovenia, Sweden, Switzerland and The Netherlands). The experience of the ODHIN project gave the opportunity to look at the assessment tool as a feasable way to document the current situation across Europe, contributing to identify existing gaps or areas that need further work and strengthening at the country/regional level. The tool has demonstrated to be useful in contributing to provide a baseline description of available services and infrastructures for managing hazardous and harmful alcohol consumption, identifying areas where services may require development or strengthening; providing a general view on the existing gaps or areas that need further work and strengthening; providing a mechanism for future monitoring services provision over time; solicit sharing of information and examples of practice; solicit partnerships and/or national/regional coalition to reach a consensus on a shared view on services for managing hazardous and harmful alcohol consumption. The ODHIN assessment tool shows that, in 2012, early identification and brief intervention is still not the norm in daily consultation in Primary Health Care and that more resources are needed to overcome the main obstacles.

Particularly, the ODHIN assessment tool results and evaluation ask for some priorities to be integrated in the national and regional systems for hazardous and harmful alcohol consumption management:

- there is the need for a formal partnership or coalition involved into an infrastructure or a panel of experts supporting this analysis at the national/regional level and contributing to improve the availability and management of hazardous and harmful alcohol consumption;
- the integration of the management of hazardous and harmful alcohol consumption in the health care system should be supported assuring that treatment is offered to those that need it, hopefully widening the availability of existing treatments;
- the implementation of a communication and information strategy about health and social alcohol impact should be ensured, including a major effort to provide a formal, mandatory continuing training and medical education aimed at integrating early detection and brief intervention in the daily practice of health professionals in the Primary Health Care settings. Public funding should be allocated for that purpose;
- formal educational programs on managing hazardous and harmful alcohol consumption for all health care professionals should be provided, being the level of training low in most of the EU countries and mostly not available for some professionals such as dentists, obstetricians and pharmacists;
- written policies should ensure the availability of a well identified national health plan on

alcohol aimed at prevention of alcohol use disorders and alcohol dependence involving health professionals and scientific societies and advisors for the specific guidelines to be provided for the general population and the high risk population targets;

- there is a need to include in the written policies a research funded strategy and/or formal research programs on hazardous and harmful alcohol consumption with targeted allocated funded activities that are currently lacking or missed in nearby half of the countries;
- guidelines and protocols should be made widely available for health professionals taking into consideration different target groups, gender and age approaches and focusing on clinical settings and general population settings as well;
- there is a need mainly to carry out studies on the adherence and implementation of the clinical guidelines for the managing of hazardous and harmful alcohol consumption as well as to develop tools and structures for reviewing the cost effectiveness of interventions for managing focused in monitoring health care users needs and on what health care providers are delivering;
- specific studies should be developed and periodically performed mainly aimed at the check of the quality of the advice and on the cost-effectiveness of interventions for hazardous and harmful alcohol consumption. These studies should be integrated by yearly evaluation surveys and reports on the activities by health care providers aimed at collecting information about the management of hazardous and harmful alcohol consumption and on the evaluation of the health professionals who receive specific training on hazardous and harmful alcohol consumption management;
- specific activities should be devoted to the dissemination of available sources of knowledge, research results and information to health care providers together with the provision of materials and incentive measures aimed at ensuring that prevention, early detection and brief intervention, is implemented in primay health care and supported by specialist services according to a real networking of the available services and competencies.

1. INTRODUCTION

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

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

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

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

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

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

This report will present the main results and promote the ODHIN assessment tool as an instrument to be used worldwide to assess the delivery and implementation of EIBI programmes.

2. METHODOLOGY

2.1. Development of the questionnaire

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

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

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

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

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

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

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

The revision of the PHEPA "assessment tool" by the ODHIN WP6 research team started during the ODHIN kick off meeting held in Barcelona on February 2011. After that, each partner was provided, by email, with a copy of the draft tool discussed in Barcelona and they were asked to read the new draft, to consider each item in terms of its apparent relevance and comprehensibility, and to provide their views and feedback on the overall content and organisation of the assessment tool. A fruitful and interesting discussion concerning the assessment tool was followed up by various email contacts between the ODHIN WP6 partners and the WP6 leaders. The core version of the PHEPA questionnaire has been supplemented with questions specific for the culture or system of each country or of interest to the participating partners. Questions considered useful or relevant for the participating partners have been added maintaining the original frame and the progressive number of questions. The final version of the questionnaire has been approved by all partners (Annex 1). In some cases (Czech Republic, Slovenia and Portugal) it has been judged appropriate to translate into the native language of the partner (Annexes 2,3,4).

2.2. Description of the questionnaire

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

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

2.3. Data collection

The ODHIN participating countries were requested to complete the questionnaire and to indicate the source of some data provided, if available, by the end of March 2012.

Since, within the same country the knowledge of the available services was expected to be different according to the respondents completing the questionnaire, it was suggested to select at each country level up to 10 key informants for the specific task activities recommending the answers from different professionals, mainly for the questions for which the validity of the answers rely on personal opinions. Key informants were selected based on their expertise in the alcohol field, covering a large range of perspective such as general practitioners, scientists working in the field of epidemiology and public health, clinicians from alcohology units, experts from the national society on alcohology and policy makers. It was also suggested that the tool had to be completed by country or regional coalitions or partnerships, playing a central role in supporting the development, the dissemination and the implementation of services for managing HHAC. If no such coalition or partnership existed, the ODHIN research team used the opportunity to solicit the creation of a collaborating group with its first task to complete the tool.

The research team agreed:

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

As mentioned before, during this period, a contact was also activated with the project leaders of selected EU Projects and Networks on alcohol such as AMPHORA, PHEPA II, VINTAGE and with WHO in order to involve other European countries other than the ODHIN partners and contribute to improve the results. At this regard, we have invited 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) and 14 out of 36 send us back the fulfilled questionnaire. Thus, the following 23 European countries participated into the ODHIN

assessment tool analysis:

- 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).

A preliminary analysis and overview of the collected data was carried out and presented in the ODHIN meeting on the 1stth and 2nd of October 2013. Two drafts of the report circulated among all the participants requesting for their feedback.

2.4. Data analysis

The data were introduced in SPSS. Descriptive statistics and graphs were calculated. All percentages are calculated based on cases with a valid answer "valid percentages" (excluding missing and not applicable cases) unless otherwise indicated in the text.

The information was also reported qualitatively with comments from the partners, which are also reported.

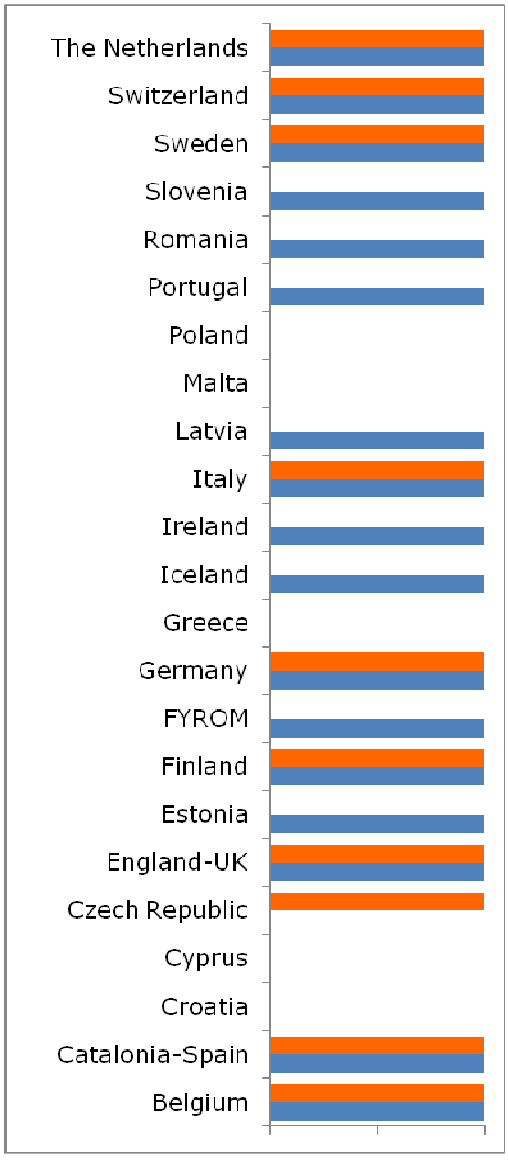
3. RESULTS

3.1. European overview across 23 countries in 2012

In this section, both a general overview across all the countries, but also the specific situation reported by the partners on their national/regional assessment tool questionnaires (in italics), are given. Caution is recommended in the use of this information for official purposes, since, as written in the methodology, it reflects a consensus opinion given the difficulty to measure some questions with objective data, but it can be helpful as an orientation towards the issue.

3.1.1. Presence of a country coalition or partnership

In 2012, most of the countries have a country and/or regional coalition for the management of HHAC. Particularly, 17 (73.9%) have a country-wide coalition, and 10 (43.5%) a region-wide formal or informal coalition or partnership that deals with the management of hazardous and harmful alcohol consumption (Figure 1).



Country coalition (73.9%)

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

Regional coalition (43.5%)

Yes: Belgium, Czech Republic, England (UK), Finland, Germany, Italy, Catalonia (Spain), Switzerland, Sweden, The Netherlands.
No: Croatia, Cyprus, Estonia, FYROM, Greece, Ireland, Iceland, Latvia, Malta, Poland, Portugal, Romania, Slovenia.

Figure 1. Is there a country-wide and a regional-wide formal or informal coalition or partnership that deals with the management of hazardous and harmful alcohol consumption?

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

COUNTRY	NAME	YEAR OF CREATION	AIM OF THE COUNTRY-WIDE COALITION
Belgium	1. On policy level: General Drug Policy Level-GDPC 2. On practitioners level: Informatie over Drugs en Alcohol-IDA	1. 2009	1. GDPC: establishing a global and integrated alcohol and drug policy (www.drugpolicy.be); 2. IDA: dissemination of information on research, good practices, overview of available specialised treatment and prevention (www.ida-web.be)
Catalonia (Spain)	Programa de Actividades Preventiva y de Promoción de la Salud-PAPPS (Health Promotion and Prevention Activities Programme)	1991	-Working group of the Spanish Society of GPs that deals with preventive activities and developed SBI in PHC setting; -Working group of the Spanish Society of GPs that promotes preventive activities in PHC; -Prevention and education.
England (UK)	Department of Health – Substance Misuse Policy Unit		The Department of Health – Substance Misuse Policy unit – is tasked with developing and implementing policies to reduce alcohol consumption including the dissemination and implementation of strategies to reduce hazardous and harmful drinking.
Estonia	Task Force 1 for the Green Book of Alcohol Policy	2011	To design the system of treatment, rehabilitation and counseling.
Finland		2004	The National Institute for Health and Welfare-THL coordinates the National Alcohol Programme activities. The Alcohol Programme was launched by the Government in 2004. A new programme period runs from 2012.
FYROM	Expert group for alcohol related problems, Ministry of Health	2010	The aim of the coalition is preparing the strategy and action plan for HHAC.
Germany	Die Deutsche Hauptstelle für Suchtfragen - DHS (German Centre for Addiction Issues)	1947	The DHS has the aim of informing people about addiction-related problems, advising them and drawing their attention to support provision. A priority of the work is the development of effective strategies to reduce the harmful consequences of alcohol and illicit drugs. In addition, the DHS member organisations offer dependent people and their families concrete support and help towards self-help. This enables sufferers to find ways out of their dependency. The DHS promotes the constant qualitative development of counselling and treatment for people with addiction problems and is committed to ensuring the availability of such provision.
Iceland	Directorate of Health	2007	The directorate of Health published in the year 2007 clinical guidelines on how to screen and treat alcohol problems in the PHC.
Italy	1. Istituto Superiore di Sanità- ISS-CNESPS 2. Società Italiana di Alcologia-Italian Society on Alcohology-SIA 3. Italian Association of Territorial Club alcoholism-AICAT	1. 2000 2. 1979 3. 1989	The coalition has no name but ISS, SIA and AICAT network has been established since 2001 as a steering group mainly orienting the Alcohol Prevention Month, the Alcohol Prevention Day. ISS is the advisory board of the NHS dealing with the National Alcohol and Health Plan and strategic issues providing formal advise. ALIA is the recent National Alliance on Alcohol gathering several realities and representatives belonging to the different areas of citizenship, families, scientific societies. 1.ISS – CNESPS: Since year 2000 Population Health Unit (PHU) at the CNESPS has received the governmental mandate to deal with the identification and implementation of strategies aimed at curbing under-age drinking, HHAC preventive programmes providing scientific evidence for the policy decision-makers and for the implementation of the National Alcohol and Health Plan. PHU is the National Focal point, the scientific and technical expert and advisor appointed by the MoH and the Government representative on policy, research, prevention and health promotion on alcohol and alcoholism. On 2007 PHU adapted and implemented the PHEPA programme in Italy; 2.S.I.A.:It promotes scientific activities, preventive programmes, treatment, rehabilitation and alcohol epidemiology; 3.AICAT:a non-profit social organization to promote & coordinate the activities of the Regional Club alcoholism according to the principles of V.Hudolin; CONTINUED

Italy	4. ALIA 5. Italian Collaborating network on Alcohol-ICON	4. 2008 5. 2012	4.ALIA:the alliance devotes attention to the increasing levels of alcohol related harm; propose evidence based solutions to reduce it; influence decision makers to take positive actions, to address the damage caused by alcohol misuse. It brings together research, social and medical bodies, patient representatives and stakeholders; 5.ICON:The Italian Collaborating network on Alcohol, a formal network created between the ONA-CNESPS, WHO CC for Research on Alcohol and the CARs of Tuscany and Liguria at the ISS deserving attention to the specific workplan of activities agreed between WHO and ISS in the field of epidemiology, prevention, training and treatment.
Ireland	Health Service Executive-HSE	2005	HSE is the National Organization responsible for providing Health and Personal Social Services for everyone living in the Republic of Ireland.
Latvia	1.National Board for the Restriction of Alcohol 2.Latvian National Coalition on Tobacco and Alcohol Control	1. 2003 2. 2009	1.National Board for the Restriction of Alcohol. Aim: co-ordination of the work of central and local governments in restricting and combating alcohol addiction. 2.Latvian National Coalition on Tobacco and Alcohol Control. Aim: the Coalition's mission is to support the WHO and EU health policies on tobacco and alcohol harm prevention and mitigation of Latvian and Baltic States.
Malta		In progress of definition	There is not coalition. However, virtually all the functions are performed by the National Agency against Drug and Alcohol abuse and Compulsive Gambling-SEDQA.
Portugal	1. On policy level: IDT–SICAD establishing a global and integrated alcohol and drug policy (www.idt.pt),(www.sicad.pt) 2. On practitioner level: Portuguese Association of Family Phisicians(APMGF)	2009	It promotes scientific activities, preventive programmes, treatment, rehabilitation and epidemiology in additive behaviors and dependence.
Romania	Informal technical group	2013	In 2013 a technical group was set in place at the initiative of the Alliance for the Fight against Alcoholism and Toxicomanies (ALIAT), in order to work at the future National Alcohol Strategy and the following Action Plan. At the moment the group has generated a document which aims at creating a common framework, of approaching this topic both in policy and in actions. The technical group is an informal one, its constituents being specialists from NGOs, public and also private sector.
Slovenia	Council for alcohol politics, Ministry of Health	2004	It aims at planning and approval of effective politics and interventions at alcohol field. Members are from different political, professional and economic fields-stakeholders including alcohol industry, so compromises are needed.
Sweden	Alcohol, Narcotics, Doping and Tobacco-ANDT, Swedish Association of Local Authorities and Regions (SALAR-SKL), National Board of Health and Wellfare (Socialstyrelsen)	2010	During 2004-2010 there was a formal organization promoting the work called *Riskbruksprojektet* "Risk Drinking Project". It has since been replaced by several bodies with prime coordination from *Socialstyrelsen* (National board of Health and Social Welfare). Otherwise the regions are each responsible for treatment provision.
Switzerland	The coalition has no name	2008	Dissemination and implementation of the management of HHAC is coordinated by the National Programme Alcohol (NPA). The implementation of the programme is controlled by the NPA Strategic Directorate. This group comprises representatives of the Federal Office of Public Health, the Swiss Alcohol Board, the Federal Commission for Problems linked to Alcohol and the Swiss Conference of the Cantonal Ministers of Public Health. The implementation partners (organizations which implement activities/projects within the scope of the NPA) meet approx. twice annually to exchange information and make use of synergies.
The Netherlands	Partnership Vroegsignalering Alcoh (Partnership Early Identification Alcohol)	2005	PVA aims at early detection and intervention of hazardous or harmful alcohol consumption. (www.vroegsignaleringalcohol.nl).

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

COUNTRY	NAME	YEAR OF CREATION	AIM OF THE REGIONAL-WIDE COALITION
Belgium	1. Vereniging voor Alcohol en andere Drugproblemen 2. Fedito Wallonne and Fedito Bruxelles		Federations for institutions for alcohol and drug treatment and prevention. 1. www.vad.be 2. www.feditobruxelles.be
Catalonia (Spain)	Drink Less Coordinating Committee Working Group	1996	Drink Less Coordinating Committee – created in 1996 but reformed in 2009 – Working group lead by the Program on Substance abuse combining representatives of the Spanish Societies of GP and Nurses (CAMFIC and AIFICC), alcohol specialists and policy makers. Design and lead the implementation of the Drink Less program in Catalonia in the PHC.
Czech Republic	National network of health promotion	2004	To promote health of the Czech population in an evidence-based way. Operates in several regions of the CR.
England (UK)	Balance	2009	"BALANCE" is a regional office in the North East of England whose remit is to implement alcohol policies in this area. There is a similar structure in the North West called "OUR LIFE". Whilst there are coordinators in other regional areas but they do not have the same level of organization or infrastructure. There are a number of these organizations and forums across the country and across specialties (the Eastern Alcohol Leads Forum, the Hospital Alcohol Liaison Forum to cite just two examples).
Finland	Regional State Administrative Agencies		Agencies coordinate the activities in social and health services
Germany	Centers for addiction issues		Centers for addiction issues are in the 16 Federal Länder (aim s.o.)
Italy	1. Regional public alcohology services within the NHS 2. CAT-Country association of territorial Club in every regions and autonomous province of Italy 3-4 CAR- Centro Alcologico Regionale Toscano e Ligure 5. CRARL – Centro di Riferimento Alcologico Regione Lazio	1. 1999 (State-Region agreement on drug & dependency) 2. 1989 3. 2000 4. 2012 5. 2006	1.Prevention, treatment, rehabilitation, monitoring on HHAC and alcohol dependency; 2. CAT are communities made up of no more than 12 families and a servant, teacher, that promote the change of lifestyle that tends to sobriety, through growth and maturation of the multidimensional person (emotional, cultural, spiritual, relational); 3-4. CAR is the formal Regional Coordination Centre in Tuscany and in Liguria with a mandate to harmonize the prevention and treatment activities in alcohol field in the Region. It deals with the National Health System Units; 5 CRARL is the formal Regional Coordination Centre in Latium with a mandate to harmonize the prevention and treatment activities in alcohol field in the Region. It deals with the National Health System Units.
Portugal	Department of intervention in addictive behaviours and dependencies at all five Regional Heath Administrations	2012	A multidisciplinary team for the area of coordination of intervention in addictive behaviours and dependencies, in conjunction with national guidelines issued by the Service for Intervention on Addictive Behaviours and Dependencies.
Sweden	Country offices with area name, eg. Skane Scania (Region Skane)		To 90% generic treatment provision. Health promotion is mandatory as part of the services.
Switzerland			Most of the 26 Swiss cantons have their own strategy (formally published as a programme or as part of their daily work) for the management of HHAC.
The Netherlands	1. PVA Limburg project 2. Projectgroep alcoholmatiging jeugd 3. A coalition between Maastricht University and the Mondriaan zorggroep. 4. Regional or municipal alcohol prevention networks. 5. SRE (coalition region Eindhoven), www.sre.nl 6. Collaboration of municipalities in the region West-Friesland.	1. 2007	1. To improve the practice of early detection of GPs in the Province of Limburg. 2. *Project group alcohol moderation youth.* To reduce alcohol consumption and its impact among youngsters. (in Achterhoek, 2006 and Stedendriehoek, 2008). 3.To initiate research contributing to prevention of addiction or treatment of addiction and to implement evidence based interventions in the practice of prevention and treatment. 4. Networks are coordinated by addiction services

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

3.2. COMMUNITY ACTION AND MEDIA EDUCATION

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

Figure 4 shows that implemented media education campaigns on alcohol consumption, in general are not widely available or not reported especially in some countries. The results show that the most common education campaigns are reported on the website (15 out of 23 countries, 65.2%) followed by newspaper / magazines (47.8%) and radio (39.1%). Between the media, billboards and TV are the least used for community action and education campaigns about HHAC. When available, they are generally fully publicly funded (F) from those campaigns where the type of funded was reported, with a minor proportion of those being partially funded (P) and no funded (N).

3.3. HEALTH CARE INFRASTRUCTURES

3.3.1. Integrated Health Care System

This section explores to what extent the management of HHAC is integrated in the health care system, including co-operation or relationships between primary health care and secondary health care, similar to that for other chronic diseases such as hypertension or diabetes. Partners were asked to give their opinion to this issue, in a scale from 0 to 10. Caution is recommended in the use of this information for official purposes, since it reflects a consensus opinion given the difficulty to measure the question with objective data, but it can be helpful as an orientation towards the issue.

According to personal opinions, the integration of the management of HHAC in the primary and secondary health care is considered quite low in most of the participating countries, with great differences between countries (See Figure 5 and 5a). Only 11 out of 23 countries in a scale from 0, no integrated, to 10, fully integrated, pointed the integration of the management of HHAC in the PHC system over the average of 5.4 points (Figure 5a).

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

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

Integration of the management of HHAC in the primary and secondary health care system (scale 0-10)	Primary	Secondary
Belgium	6	6
Croatia	10	10
Cyprus	8	8
Czech Republic	2	3
England (UK)	5	6
Estonia	1	1
Finland	5	5
FYROM	8	8
Germany	8	9
Greece	4	7
Iceland	5	4
Ireland	3	3
Italy	5	4
Latvia	3	3
Malta	5	7
Poland	1	0
Portugal	6	7
Romania	3	3
Slovenia	6	5
Catalonia (Spain)	8	8
Sweden	10	4
Switzerland	6	9
The Netherlands	7	4
Mean±SD	**5.4±2.5**	**5.3±2.7**

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

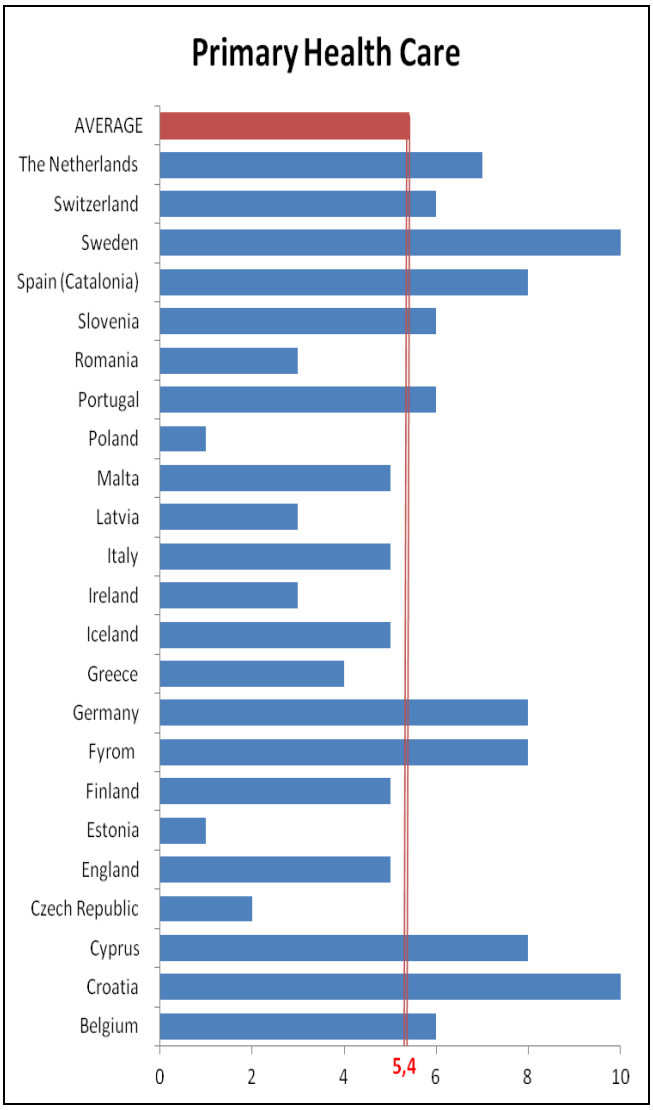


Figure 5a. Integration of the management of HHAC in the primary health care system. The question is pointed in a scale from 0 (no integrated) to 10 (fully integrated)

Further details on the integration of the management of HHAC in the primary health system of Figures 5 and 5a can be found in the following paragraph:

Belgium	*The ASSIST (Alcohol Smoking and Substance Involvement Screening Test) of the WHO was translated and adapted for use in PHC practice; a training program for GP's and welfare workers was set up to use the screening instrument and implement a brief intervention/advice or referral.*
Catalonia (Spain)	*Introduced in the contractual incentives with the PHC provider and the Direction for Objectives of the Professional; Services of drug dependency is not near of the PHC; Huge efforts invested in coordination.*
Croatia	*The treatment and rehabilitation of persons with HHAC is fully integrated in the health care system and financed by the basic national health insurance. The PHC practitioners follow these patients during hospital and out-patient treatment. The rehabilitation is very well developed, consisting of more than 250 "clubs for treated alcoholics", lead by professionals and involving the family members as well.*
Czech Republic	*Based on time-limited projects/grants.*
England (UK)	*The links between alcohol and areas of chronic disease management in PHC remain relatively weak. There is some work on trying to persuade GPs to put alcohol SBI into the Quality and Outcomes Framework and the national screening committee to include alcohol as a must-screen condition, without success so far. Implementation largely voluntary.*

Estonia	*The process of integrating EIBI to PHC has started in 2009, the concept and guidelines are developed and published, the piloting of the service is going on. The present project's funding is secured until the end of 2013, the funding will be revised and probably reorganized (to the more permanent basis) after the end of the pilot project.*
FYROM	*During 2012, we organised 4 educative seminars and 1 regional conference under Macedonian doctors's chambers and macedonian doctor's organization for doctors in primary and secondary health care.*
Germany	*Specialised outpatient care for dependence is very well developed in Germany with the outpatient counseling addictions services. They exist as a parallel system to PHC, but they operate with very low threshold and refer patients to specialized care.*
Iceland	*There is a lack of implementation and follow-up on the implementation of the clinical guidelines. However we have established a webpage and short seminars for healthcare professionals on how to use Motivational Interview and Brief intervention. The infant and maternity service is doing well in monitoring alcohol consumption of the mother.*
Ireland	*A steering group report on a National Substance Misuse Policy was published in February 2012 and will be implemented shortly.*
Italy	*- In the last years an increased interest arose in Italy in relationship with the need to develop, validate and implement instruments and methodologies for the EIBI of HHAC in the PHC settings. The ONA-CNESPS and the WHO CC on Alcohol at the ISS played a pivotal role in carrying out a formal activity in preparing a country strategy aimed at the implementation and dissemination of a common standard of training and at the coherent application of the EIBI (according to the PHEPA standard) starting from 2006. The IPIB training programme (Identificazione Precoce e Intervento Breve) is actually the formal institutional standard of training in Italy funded by the MoH and the Presidency of the Council of the Ministries-DPA. At the moment, this activity is waiting to receive fundings for its implementation. GPs only provide non organized counselling for HHAC, but not for alcohol dependents. -"Progressi delle Aziende Sanitarie per la Salute in Italia" – PASSI, 2009.*
Poland	*There is no formal integration of management of HHAC to the health care system in Poland. No national guidelines as to management HHAC. However, some GPs (only a few really trained) include HHAC management in practice.*
Portugal	*- We have a National Alcohol Plan and a treatment referral network with oriented procedures to clinical referral. A new Plan is being prepared National Additive Behavior and dependences 2013-2020 with an Action Plan and a referral network concerning Additive Behavior and dependences integrated in Regional Health Administration. and Primary Health Care National Plan on Additive Behavior and Dependences http://www.idt.pt/PT/Noticias/Paginas/PlanoNacionalparaaRedu%C3%A7%C3%A3odosComportamentosAditivosedasDepend%C3%AAncias(PNRCAD)2013%E2%80%932020.aspx - National network on additive behavior and dependences: http://www.idt.pt/PT/Noticias/Paginas/RededeReferencia%C3%A7%C3%A3oArticula%C3%A7%C3%A3ono%C3%A2mbitodosComportamentosAditivosedasDepend%C3%AAncias.aspx*
Sweden	*It is integrated in the health care system, but not always implemented*

Further details on the integration of the management of HHAC in the secondary health system of Figure 5 can be found in the following paragraph:

Belgium	*IDA-web (www.ida-web.be) offers a referral system for GPs and PHC towards the more specialized treatment center.*
Catalonia (Spain)	*Some improvements are still possible.*
Czech Republic	*Limited extent, rather locally. Mainly referral to specialized clinics.*
England (UK)	*There is increasing integration of alcohol management in the hospital system via the development of the alcohol liaison nurse role – which bridges emergency care to inpatient hospital care. This effort to integrated alcohol treatment systems across the whole country have been partially successful. But evidence from the Alcohol Needs Assessment Research Project (ANARP) and National Audit Office (NAO) show it is very patchy.*
Estonia	*The Task Force for the Green Book of Alcohol Policy is about to design the system of service provision; currently there is no systematic approach.*
Germany	*Specialised medical services for alcohol dependence is integrated part of the health care system.*
Iceland	*This is especially for psychiatry departments, but also other departments.*
Ireland	*A steering group report on a National Substance Misuse Policy was published in February 2012 and will be implemented shortly.*

Italy	*The public referral procedures are the followings:* *-There is not referral for subjects with HHAC.* *-Referrals to therapeutic communities for alcohol dependents are made by the Ser.T.S. (the public treatment units for drug and alcohol dependency) which in most cases authorize the Local NHS unit to pay the fees for the treatment.* *-Residential treatment for patients with alcohol use disorders is offered by specialist alcohol services, by departments of general hospitals and/or by dependences departments according to the different regulation existing in the different regions that devote a part of the yearly budget to the rehabilitation of alcohol dependences ensured by the national law (125/2001 frame law on alcohol) in term of access for prevention on alcohol and care. The number of beds available for alcohol dependence treatment is not formalized but always submitted to change according to funding availability and epidemiological trend evaluations.* *-GPs only provide non organized counselling for HHAC, but not for alcohol dependents.* *-Furthermore, independent outpatient facilities are given by NGOs service providers and self help or mutual help organizations, such as Clubs of alcoholics in treatment (AICAT) and Anonymous Alcoholists (AA).*
Portugal	*At present there is an integration of services for treatment of alcohol related problems in the National Health Care System to guarantee a better intervention from PHC to other levels of care. We have an Alcohol Directory where we provide information at: http://directorioalcool.com.pt/Paginas/HomePage.aspx.* *Organic law of the Service for Intervention on Addictive Behaviours and Dependencies (Decree-Law no. 17/2012, 26 January)* *MISSION: To promote the reduction of psychoactive substances consumption, the prevention of addictive behaviours and the decrease of dependencies.* *Organic law of Regional Health Administrations (Decree-Law no. 22/2012, 30 January)* *MISSION: To ensure the population of the respective geographical area of intervention access to health care, suiting available resources to the needs, and to comply with and enforce policies and health programs in their area of intervention* *ATTRIBUTIONS:* *To ensure implementation of local intervention programs aimed at reducing the consumption of psychoactive substances, prevention of addictive behaviours and the decrease of dependencies including excessive alcohol consumption (hazardous and harmful).*
Sweden	*Not at all carried to the same extent as in PHC.*

3.3.2. Structures for quality care

In Figure 6, the results to the question: "is there a formal governmental organization, or organization appointed or contracted by the government with responsibility of managing HHAC?" are provided. In most of the countries, there are structures in charge for monitoring health outcomes at the population level from HHAC (18 out of 23, in 78.3% of the countries), and to a lesser extent for reviewing the safety of pharmacological treatments for managing alcohol dependence (15 out of 22, 68.2%) and for providing information on managing HHAC to health care providers (14 out of 22, 63.6%). In nearby half of the countries there are structures in charge for the monitoring of the quality of care provided for managing HHAC (12 out of 21, 57.1%) and for preparing clinical guidelines (13 out of 23, 56.5%). The structures for reviewing the cost-effectiveness of interventions for managing HHAC are available in England, Finland, Portugal, Sweden and The Netherlands (21.7%) (Figure 6).

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

COUNTRY	*Preparing clinical guidelines*	*Monitoring health outcomes*	*Monitoring the quality of care*	*Cost-effectiveness review of interventions*	*Reviews the safety of pharmacological treatments*	*Provides information to health care providers*
Catalonia (Spain)	*Spanish Drug Agency (http://www.agemed.es)*	*Health Plan Unit of the Department of Health*	*Institute of Health Studies (http://www.ieasalut.es/)*	-	*Spanish Drug Agency (http://www.agemed.es)*	*Health Department of the Government of Catalonia*
Croatia	*Croatian society for alcoholism and other dependencies*	*Croatian National Institute of Public Health (http://www.hzjz.hr/epocetna.htm)*	*NO*	*NO*	*Refent centre for alcoholism of Ministry of Health*	*NO*
Cyprus	*Cyprus Antidrug Council (www.ask.org.cy)*	*Cyprus Antidrug Council (www.ask.org.cy)*	*Cyprus Antidrug Council (www.ask.org.cy)*	*NO*	*NO*	*NO*
Czech Republic	*NO*	*NIPH-Coordination, monitoring and*	*NO*	*NO*	*NO*	*NO*

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

Portugal	*Institute on Drugs and drug Addiction (IDT); SICAD General Directorate of Health*	*Institute on Drugs and drug Addiction (IDT); SICAD Ministry of Health*	*Institute on Drugs and drug Addiction (IDT); SICAD Regional Health Administration*	*Institute on Drugs and drug Addiction (IDT) SICAD*	*Infarmed (Autoridade Nacional do Medicamento e Produtos de Saude)*	*SICAD* *General Directorate of Health*
Sweden	*National Board of Health and Wellfare as well as the regions*	*It has recently started*	*But not in all counties*	*To at least a minimal extent*	-	-
Switzerland	*NO*	*Swiss Addiction Monitoring (Federal Office of Public Health)*	-	*NO*	*Swissmedic*	-
The Netherlands	*Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling in de GGZ (National Steering Committee Development Guidelines in mental health care);* *Scoring Results;* *Trimbos Institute*	*-Municipal health organizations;* *-National Drug Monitor (including tabacco and alcohol);* *-RIVM (National Institute for Public Health and the Environment);* *-Nemesis onderzoek (Netherlands Mental Health Survey and Incidence Study);* *-Univ. projects* *-Trimbos Institute*	*Scoring Results; Trimbos Institute; Inspection Ministry of Health; Health Care Inspectorate (IGZ)*	*Universities;* *Netherlands Economic Institute*	*Surgeon General Health;* *Inspection Ministry of Health*	*Trimbos Institute: drug education by department of addiction care;* *PVA*

EXISTENCE OF FORMAL GOVERNMENTAL ORGANIZATION WITH RESPONSIBILITIES FOR MANAGING HHAC IN:	**Preparing clinical guidelines**	**Monitoring health outcomes**	**Monitoring the quality of care**	**Cost effectiveness review of interventions**	**Reviews the safety of pharmacological treatments**	**Provides information to health care providers**
Belgium						
Catalonia (Spain)						
Croatia						
Cyprus						
Czech Republic						
England (UK)						
Estonia						
Finland						
FYROM						
Germany						
Greece						
Iceland						
Ireland						
Italy						
Latvia						
Malta						
Poland						
Portugal						
Romania						
Slovenia						
Sweden						
Switzerland						
The Netherlands						
VALID PERCENTAGES (%)	**13/23 (56.5)**	**18/23 (78.3)**	**12/21 (57.1)**	**5/23 (21.7)**	**15/22 (68.2)**	**14/22 (63.6)**

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

:YES; **:Not available ;** **:NO.**

Further details can be found in the following paragraphs:

Catalonia (Spain)	*There are agencies but mainly for other topics. Not yet on alcohol.*
Estonia	*National Institute for Health Development provides information on early identification and brief intervention.*
England (UK)	*Regarding "monitors the quality of care provided for managing HHAC", the national Audit Office has had one go – but it is being disbanded. NICE has developed quality standards but yet to be implemented. For "reviewing the safety of pharmacological treatments for managing alcohol dependence", it is possibly done by the Medicines and Health Regulatory Authority (MHRA).*
Germany	*With reference of "preparing clinical guidelines for managing HHAC", by definition of clinical guidelines they are done by Scientific Medical Societies, which define their self as independent from governments.*
Italy	*At national level, the monitoring and reporting on the activities of the structures devoted to care and rehabilitation of alcohol dependents is set by a law decree that establish a common standard of data collection. Different sources of information are taken into account to monitor and report the impact of alcohol on the population and to assess the performance of the treatment systems in reply to the changing trends observed by the monitoring system. Together with the specific treatment system evaluation (structures) the MoH evaluates and reports on alcohol consumption patterns, alcohol mortality, alcohol attributable hospital discharges and other quantitative as well as qualitative data coming from the regional monitoring and reporting activities set by law. Data are elaborated and reported by a yearly formal report of the MoH to the Parliament on the implementation of the 125/2001 frame law on alcohol, the national frame law on alcohol. All the reports are public and fully disseminated on the institutional web site. The ISS-CNESPS contributes to the elaboration of the yearly report to the Parliament.*
Portugal	*Organic law of the Ministry of Health (Decree-Law no. 124/2011, 29 December)* *Option of reinforcement of the component of planning and monitoring of programs on reduction of psychoactive substances consumption, in the prevention of addictive behaviours and in the decrease of dependencies* - *Creation of the Service for Intervention on Addictive Behaviours and Dependencies (SICAD)* - *Attribution to Regional Health Administrations (RHA) of the component of operationalizing of health policies* *Organic law of the Service for Intervention on Addictive Behaviours and Dependencies (Decree-Law no. 17/2012, 26 January)* *ATTRIBUTIONS:* • *To develop, promote and foster scientific research in the field of psychoactive substances, addictive behaviours and dependencies* • *To develop mechanisms for effective planning and coordination leading to the definition of policies for interventions in the context of addictive behaviours and dependencies* • *To make diagnoses of intervention needs nationwide and set the priorities and the kind of intervention to develop including alcohol related problems* • *To set technical and regulatory guidelines for the intervention in the areas of addictive behaviours and dependencies including excessive alcohol consumption* • *To promote training in the field of psychoactive substances, addictive behaviours and dependencies including excessive alcohol consumption* *Organic law of Regional Health Administrations (Decree-Law no. 22/2012, 30 January)* *MISSION: To ensure the population of the respective geographical area of intervention access to health care, suiting available resources to the needs, and to comply with and enforce policies and health programs in their area of intervention* *ATTRIBUTIONS:* • *To ensure implementation of local intervention programs aimed at reducing the consumption of psychoactive substances, prevention of addictive behaviours and the decrease of dependencies including excessive alcohol consumption.* *We have an Alcohol Directory where we provide the important information related to Alcohol (http://www.diretorioalcool.pt/Paginas/HomePage.aspx*
Switzerland	*Regarding "monitors the quality of care provided for managing HHAC", there is not a comprehensive national monitoring, but partial/voluntary initiatives with a high coverage:* *(1) the quality norm „QuaTheDA" has been developed for the area of expert addiction support (including alcohol) and ensures the quality of structures and processes. (www.quatheda.ch);* *(2) Infodrog maintains a database where all addiction support services in Switzerland can be found: www.suchtindex.ch* *Regarding "provides information on HHAC to health care providers", there are some further organisations that provide information (partly funded by the Federal Office of Public Health): Addiction Switzerland, Infodrog, www.praxis-suchtmedizin.ch, SSAM, www.infoset.ch*
The Netherlands	*For each topic there is an organization and they receive partly money from the government*

3.3.3. Research and knowledge for health

3.3.3.1. Formal research programme

This section explored whether there has been a research call during the last 10 years managing HHAC with specifically allocated funding from governmental, government appointed or non-governmental organizations (excluding the pharmaceutical companies and the alcohol industry). Nearby half of the countries have a formal research programmes (10 out of 23 countries, 43.5%). Those who have formal research programme are always, at least in part, from governmental organizations (Figure 7).

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

Yes, from governmental appointed organizations (Czech Republic, England-UK, Italy, Poland, Switzerland, The Netherlands)

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

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

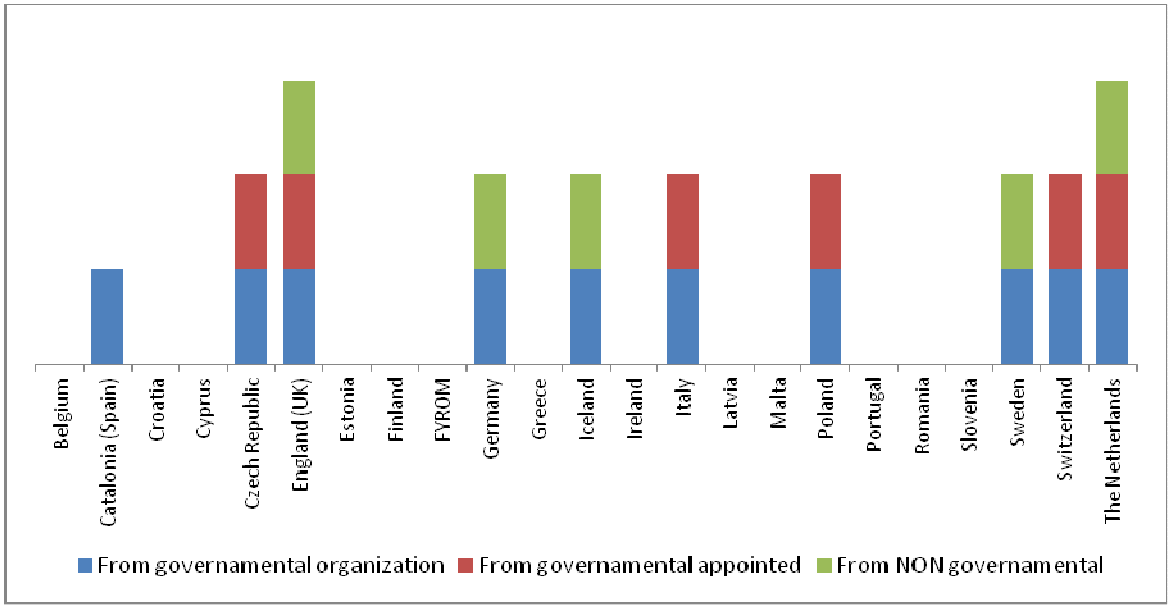


Figure 7. Characteristics of formal research programmes in the participating countries

3.3.3.2. Education in the curriculum of professional training

The estimation of the formal inclusion of education on managing HHAC in the curriculum (Undergraduate, Postgraduate and Continuing professional Education) of several health care providers is considered in this section (Figure 8 and 8a).

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

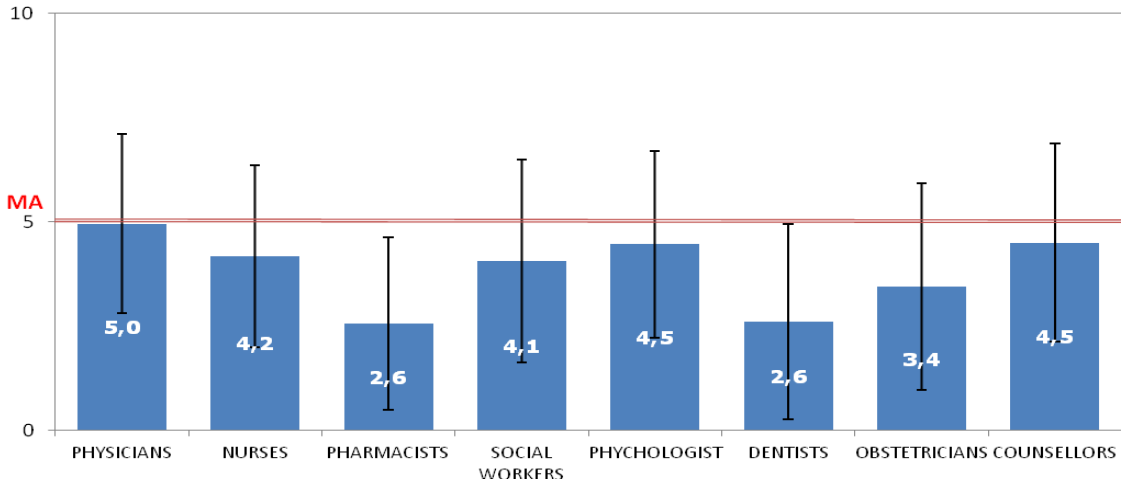


Figure 8. Education on managing HHAC in the curriculum of professional training as mean values of undergraduate (U), postgraduate (P) and continuing professional education (CE) pointed in a scale from 0 (no included) to 10 (fully included)

Further details can be found in the following paragraphs:

Belgium	*Postgraduate and continuing education is available, but it depends on the individual whether he or she is attending these trainings. As a result, it is difficult to score.*
Catalonia	*Doctors and nurses who specialize in Family and Community Medicine are getting more training on alcohol.*
England	*No national strategy as yet apart from undergraduate medical curriculum: Department of Health had a project which is coming to an end shortly. Medical Council on Alcohol has been promoting this for about 25 years and has a network of regional coordinators who coordinate training in medical schools. Almost full national coverage and a medical students' handbook provided free to all medical students nationally.*
Estonia	*"Counsellors" is not applicable. We do not have this specialty.*
Finland	*It is possible to perform a two-year training program for Addiction Medicine Special Competence authorized by the Finnish Medical Association. The program has attracted only about 100 doctors.* *"Counsellors" is not applicable because it is not a professional title in Finland.*
Germany	*Curricula for the education varies depending on "Bundesland" and depending on University. Therefore general answers to these questions are often not possible. Postgraduate professional training for specialization in addiction is offered by the German Medical Association.*
Greece	*Substance addiction/use (where alcohol addiction / use is part of the lessons of the course) is included in the undergraduate / postgraduate curriculums of medical school, school of nursing, social work, psychology and dental school. Continuing medical education is mainly related to seminars, conferences on alcohol use/abuse.*
Iceland	*There is a special diploma education with focus on alcohol and drug use – counseling at the social workers unit, but all students can apply.*
Italy	*1.At the University of Florence, Toscana Region, there is a post graduated course (from the second half of 90s) on "alcohology and life style". About 170 operators have been attended it (country wide level). In the latest years physicians are a minority.* *2.In Perugia, Umbria Region, training courses have been carried out for physicians, psychologists, nurses and social workers.*
Romania	*In 2011 ALIAT has initiated the first national study that evaluates the specialized medical services for people with problematic alcohol consumption shows the need of dedicated medical and social services for this risk group. One of the main conclusion of the study was the lack of training programs, compulsory and continuous within the university and post university curricula. Overall, physicians that are part of the target groups follow none, or very few training programs in the area of prevention/treatment of alcohol abuse/addiction.*
Portugal	*There are training programs to stop smoking, reducing alcohol consumption, doing exercise regularly and avoiding excess calories that are covered at undergraduate level. On public health system there are also post graduate training programs on alcohol consumption and at al Regional Health Administration we have a specific department responsible to ensure implementation of local intervention programs aimed at reducing the consumption of psychoactive substances, prevention of addictive behaviours and the decrease of dependencies including excessive alcohol consumption (hazardous and harmful)*
Slovenia	*Counsellors" is not applicable, because we do not have health counsellors.*
Sweden	*Improvement is underways at least among nurses and physicians in general, and among GPs in particular.*
Switzerland	*In most of the curriculums education on managing HHAC is formally part for the mentioned professional groups. However there is no systematic overview, and curriculums differ from university to university /school to school. Currently, a project aims at the concerted integration of relevant content on the topic of addiction into basis modules of the education of relevant professional groups.*

	PHYSICIANS				NURSES				PHARMACISTS				SOCIAL WORKERS				PHYCHOLOGIST				DENTISTS				OBSTETRICIANS				COUNSELLORS			
	U	P	CE	Mean	U	P	CE	Mean	U	P	CE	Mean	U	P	CE	Mean	U	P	CE	Mean	U	P	CE	Mean	U	P	CE	Mean	U	P	CE	Mean
Belgium	3	4	4	3,7	1			1,0	1			1,0	3			3,0	5			5,0	0			0,0	2			2,0				
Catalonia-Spain	3	5	8	5,3	5	5	8	6,0	2	1	1	1,3	5	7	7	6,3	5	8	6	6,3	3	2	2	2,3	3	2	2	2,3	5	7	7	6,3
Croatia	6	9	9	8,0	6	8	8	7,3	6	6	6	6,0	8	8	8	8,0	6	6	6	6,0	5	5	5	5,0	6	7	8	7,0	8	8	8	8,0
Cyprus	8	8	8	8,0	8	8	8	8,0	7	7	7	7,0	8	8	8	8,0	8	8	8	8,0	7	7	7	7,0	8	8	8	8,0	8	8	8	8,0
Czech Republic	2	2	2	2,0	1	2	2	1,7	1	1	0	0,7	1	2	0	1,0	0	1	0	0,3	2	2	1	1,7	2	2	1	1,7	3	3	2	2,7
England-UK	3	3	3	3,0	4	4	4	4,0	2	2	2	2,0	4	4	4	4,0	2	2	2	2,0	2	2	2	2,0	1	1	1	1,0	4	4	4	4,0
Estonia	5	7	6	6,0	3	5	6	4,7	1	1	1	1,0	1	2	3	2,0	5	7	7	6,3	3	0	0	1,0	3	2	2	2,3	n.a	n.a	n.a	
Finland	8	8	2	6,0	7	6		6,5	4	0		2,0	5	5		5,0	6	6		6,0	6	6		6,0	8	6		7,0	n.a	n.a	n.a	
Fyrom	7	8	7	7,3	7	7	7	7,0	5	5	5	5,0	7	8	7	7,3	7	8	7	7,3	5	5	5	5,0	5	5	5	5,0	3	3	3	3,0
Germany	6			6,0	4			4,0	3			3,0	6	8		7,0					1			1,0	4			4,0				
Greece	5	6	5	5,3	3	5	5	4,3	0	0	0	0,0	3	4	4	3,7	4	6	5	5,0	0	0	0	0,0	0	0	0	0,0	4	6	5	5,0
Iceland	3	3	4	3,3	4	4	4	4,0					4	5	6	5,0	3	5	5	4,3	1	1	1	1,0	4	4	4	4,0				
Ireland	5	5	7	5,7	5	5	7	5,7	4	4	4	4,0	4	4	4	4,0	5	5	5	5,0	4	4	4	4,0	6	6	6	6,0	7	7	7	7,0
Italy	4	5	5	4,7	2	3	3	2,7	1	2	1	1,3	1	2	2	1,7	2	3	4	3,0	1	2	1	1,3	1	2	2	1,7	2	3	3	2,7
Latvia	3	3	4	3,3	3	4	4	3,7	2	2	2	2,0	5	5	5	5,0	5	5	5	5,0	3	3	3	3,0	4	4	4	4,0	3	3	3	3,0
Malta	8	8	8	8,0	5	5	5	5,0	5	5	5	5,0	2	2	2	2,0	6	6	6	6,0	7	7	7	7,0	7	7	7	7,0	5	7	7	6,3
Poland	1	1	1	1,0	0	0	0	0,0	0	0	0	0,0	0	0	0	0,0	1	2	2	1,7	0	0	0	0,0	0	0	0	0,0	2	2	2	2,0
Portugal	5	7	6	6,0	4	6	4	4,7	4	4	4	4,0	5	6	6	5,7		7	7	7,0	4	4	4	4,0	4	4	4	4,0				
Romania	2	0	0	0,7	0	0	0	0,0	0	0	0	0,0	0	0	0	0,0	1	0	0	0,3	0	0	0	0,0	1	0	0	0,3	1	0	0	0,3
Slovenia	5	10	5	6,7	3	3	4	3,3	1	1	1	1,0	3	3	3	3,0	2	3	4	3,0	1	0	0	0,3	1	1	1	1,0	n.a	n.a	n.a	
Sweden	5	4	6	5,0	2	4	6	4,0	4			4,0	1	1	5	2,3	1	1	5	2,3					5	4	6	5,0				
Switzerland																																
The Netherlands	3	5	4	4,0	3	5	5	4,3	3	3	4	3,3	5	6	5	5,3	3	4	4	3,7	3	3	3	3,0	3	2	2	2,3	4	5	5	4,7
MEAN	4,5	5,3	5,0	5,0	3,6	4,5	4,7	4,2	2,7	2,4	2,5	2,6	3,7	4,3	4,2	4,1	3,9	4,7	4,6	4,5	2,8	2,8	2,5	2,6	3,5	3,4	3,3	3,4	4,2	4,7	4,6	4,5
S.D.	2,0	2,7	2,5	2,1	2,2	2,2	2,4	2,2	2,1	2,2	2,3	2,1	2,4	2,6	2,6	2,4	2,3	2,5	2,3	2,2	2,3	2,4	2,4	2,3	2,4	2,5	2,7	2,5	2,2	2,5	2,5	2,4

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

3.3.4. Health care policies and strategies

In 2012, an official written policy on managing HHAC from the Government or Ministry of Health is reported in 19 out of 23 (82.6%) of the countries, mostly as a part of a more general alcohol policy strategy (Figure 9).
When the policy is available (n=19), 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% of the countries (14 out of 19), and a strategy to support interventions in primary care in 68.4% (13 out of 19). A national funded research strategy is included in nearby half of the countries where an official written policy is available (47.4%) (Figure 10).

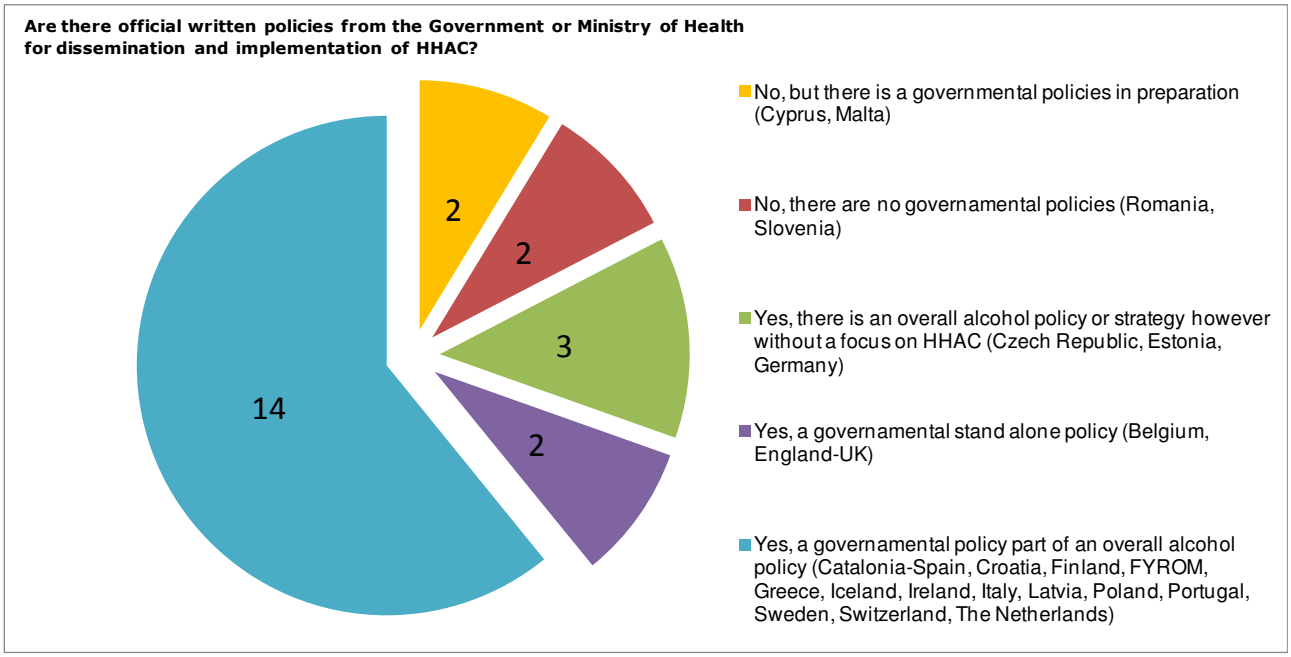


Figure 9. Number of countries according to the presence (or not) and the type of written policies on managing HHAC from the Government or Ministry of Health

Further details can be found in the following paragraphs:

Belgium	*Common Declaration of the Interministerial Conference on Health on the future alcohol policy.*
Catalonia (Spain)	*White paper on Drug Prevention*
Croatia	*Croatian Strategy on prevention of harmful use of alcohol and alcohol-related harm 2011-2016 at www.vlada.hr*
Czech Republic	*1. Long-term program of improving the health status of the population - Health 21 (12, 12.1) (www.mzcr.cz)* *2. National strategy of anti-drug policy (www.drogy-info.cz)*
England (UK)	*1. Models of Care for Alcohol Misusers 2006/7 produced by the Department of Health;* *2. Public Health Outcomes Framework (Jan 2012);* *3. HM Government, The Government's Alcohol Strategy. 2012: UK.* *4. NHS England (2013) 2013/14 guidance and audit requirements for new and amended enhanced services Version 1. NHS Employers 2013.* *Alcohol is included in the remit for all funding panels of the National Institute for Health Research (NIHR) which is directly funded by government but there is no ring-fenced programme of work or funding.*
Estonia	*There is a concept of integrating EIBI of HHAC prepared by National Institute of Health Development, acknowledged by Ministry of Social Affairs.* *The Green Book of Alcohol Policy, under development, will include a chapter envisaging the future system of treatment, rehabilitation and counseling for harmful use of alcohol.*
Finland	*http://www.thl.fi/fi_Fl/web/fi/tutkimus/ohjelmat/alkoholiohjelma*
FYROM	*Strategy, intended for reduction of the alcohol misuse consequences on the health of the population in R. of Macedonia (2008-2012).*
Greece	*National Action Plan on Alcohol Harm Reduction 2008-2012 (www.ygeianet.gov.gr)*

Iceland	*A comprehensive policy on alcohol and other substances was written for the Ministry of Welfare and the government late in the year 2012. Is not formally approved yet by the government. There is a plan to write the policy as a parliament bill. The strategy and implementation is to be written in 2013.*
Italy	*1.Italy. Frame law 125, 30 march 2001 on alcohol and alcohol related problems (http://www.salute.gov.it/imgs/C_17_normativa_452_allegato.pdf);* *2.Ministry of Health, National Alcohol and Health Plan 2007-2010 (PNAS) (http://www.salute.gov.it/imgs/C_17_pubblicazioni_623_allegato.pdf);* *3.Ministry of Health, Gain Health 2007-2010 (http://www.salute.gov.it/stiliVita/paginaMenuStiliVita.jsp?menu=programma&lingua=italiano)* *4.Ministry of Health, National Prevention Plan 2010-12 (PNP) (http://www.ccm-network.it/Pnp_2010-2012);* *5.Ministry of Health, National Health Plan 2011-2013 (PSN) (www.salute.gov.it/imgs/C_17_pubblicazioni_1454_allegato.pdf)*
Latvia	*1.From 2005-2008 "Program for Reduction of Alcohol Consumption and Restriction of Alcohol Addiction for 2005-2008".* *2. Action plan for reduction of alcohol consumption and alcoholism 2012-2014.*
Malta	*The draft document is not available to the general public.*
Ireland	*A steering group report on a National Substance Misuse Strategy 2012 (http://healthupdate.gov.ie/wp-content/uploads/2012/02/Steering-Group-Report-on-a-National-Substance-Misuse-Strategy-7-Feb-11.pdf)*
Poland	*National Program for Prevention of Alcohol-Related Problems 2011-2015 (http://fas.nazwa.pl/parpa_en/images/stories/NPPiRPA 2011 2015 eng.pdf)*
Portugal	*1.Ministry of Health, PLANO NACIONAL PARA A REDUÇÃO DOS PROBLEMAS LIGADOS AO ÁLCOOL 2009-2012 (http://www.min-saude.pt/NR/rdonlyres/DFF7BEF4-9F5F-4470-B058-8376F8644B16/0/PlanoNacionalPLA202009II.pdf)* *2.Organic law of the Ministry of Health (Decree-Law no. 124/2011, 29 December)* *3.Organic law of the Service for Intervention on Addictive Behaviours and Dependencies (Decree-Law no. 17/2012, 26 January)* *4.Organic law of Regional Health Administrations (Decree-Law no. 22/2012, 30 January)* *5.National Plan on Additive Behavior and Dependences http://www.idt.pt/PT/Noticias/Paginas/PlanoNacionalparaaRedu%C3%A7%C3%A3odosComportamentosAditivosedasDepend%C3%AAncias(PNRCAD)2013%E2%80%932020.aspx* *6.National network on additive behavior and dependences http://www.idt.pt/PT/Noticias/Paginas/RededeReferencia%C3%A7%C3%A3oArticula%C3%A7%C3%A3ono%C3%A2mbitodosComportamentosAditivosedasDepend%C3%AAncias.aspx*
Sweden	*National board of health and wellfare has published guidelines for risk drinking (2011) and another guideline for misuse of alcohol and drugs (2007), www.socialstyrelsen.se)*
Switzerland	*1.English, short version available at: http://www.bag.admin.ch/themen/drogen/00039/00596/index.html?lang=en* *2.Italian, long version (Programma nazionale Alcol 2008-12) available at: http://www.bag.admin.ch/themen/drogen/00039/00596/index.html?lang=it*
The Netherlands	*http://www.rijksoverheid.nl/ministeries/vws/documenten-en-publicaties/notas/2011/05/25/landelijke-nota-gezondheidsbeleid.html*

THE WRITTEN POLICIES ON MANAGING HHAC INCLUDE THE FOLLOWING AREAS:	A strategy on training health professionals	A national funded research strategy	Strategy to support interventions by primary care professionals	Intensive support for managing SDA in specialised treatment facilities
Belgium	■			■
Catalonia (Spain)	■	■	■	■
Croatia	■		■	■
Czech Rep				■
England (UK)		■	■	■
Estonia	■	■	■	■
Finland	■	■	■	■
FYROM	■		■	■
Germany			■	■
Greece	■	■		■
Iceland				■
Ireland	■		■	■
Italy	■	■	■	■
Latvia	■		■	■
Poland	■	■		■
Portugal	■		■	■
Sweden	■	■	■	■
Switzerland				■
The Netherlands	■	■	■	■
PERCENTAGES (%)	14 out of 19 (73.7)	9 out of 19 (47.4)	13 out of 19 (68.4)	19 out of 19 (100.0)

Figure 10. Areas included in the policies on managing HHAC from the Government or Ministry of Health. The figure shows only the countries where written policies are available (n=19)

■ **:YES;** □ **:NO.**

3.3.5. Structures to manage the implementation of treatment within Health Services

In 43.5% of the countries (Cyprus, Czech Republic, England-UK, Italy, Latvia, Portugal, Romania, Catalonia-Spain, Sweden and the Netherlands) there is an identified person within the Department of Health or Government or who is contracted by the Department of Health or Government, who oversees or manages services for HHAC.

Further details can be found in the following paragraphs:

Cyprus	*The Mental Health Services of the MoH are responsible for managing services for HHAC. The Cyprus Antidrug Council is responsible for the provision of treatment guidelines, approval and monitoring.*
England (UK)	*The new alcohol strategy is: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98121/alcohol-strategy.pdf*
Germany	*In Germany it is not the responsibility of the government to oversee any health care services directly. Health-care in Germany is self-administered by physicians and statutory health insurance.*
Ireland	*Under the strategy, a new clinical directorate that includes alcohol is to be established.*
Italy	*The monitoring (and reporting) on the activities of the structures devoted to treatment of drug and alcohol dependents is set by two different law decrees with a common standard of data collection. The last surveys on alcohol and drugs services activities have been in 2011 and 2012 respectively. Different sources of information are taken into account to monitor and report the impact of alcohol on the population and to assess the performance of the treatment systems in reply to the changing trends observed by mean the monitoring system. Together with the specific treatment system evaluation (structures) the MoH evaluates and reports on alcohol consumption patterns, alcohol mortality, alcohol attributable hospital discharges and other quantitative as well as qualitative data coming from the regional monitoring and reporting activities set by law. Data are elaborated and reported by mean two reports submitted formally to the Parliament: 1. the report on the implementation of the 125/2001 frame law on alcohol by the MoH and 2. the report on drug dependency by the Presidency of the Council of the Ministries.*

Romania *The only governmental specialists that tackle the issue of alcohol misuse and the needed policy the coordinate the field are the experts from the National Institute for Public Health. Within the MoH there is one expert who deals, but in a broader manner, with this issue, but without a specific portofolio of activities.*

Portugal *Now each Regional Health Administration is responsible for implementation according to New Organic Law (http://www.sg.min-saude.pt/NR/rdonlyres/065B7F96-F9E1-4E18-AD3C-9E9425DF78FC/28477/DecLei_17_2002depe.pdf , Decreto-Lei n.º 17/2012, de 26 de janeiro)*

Switzerland *"Infodrog" maintains a database where all addiction support services in Switzerland can be found and they provide a minimal standard of quality control (www.suchtindex.ch). In Switzerland, the 26 Cantons are in charge for the controlling of addiction facilities.*

The Netherlands *There are several identified persons within the Department of Health. (www.loketgezondleven.nl)*

3.3.6. Funding health service and allocating resources

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

GOVERNMENTAL FUNDING FOR HHAC	GOVERNMENTAL FUNDING	REVISION OF FUNDING	PROPORTION OF TAXES FOR HHAC SERVICES
Belgium			
Catalonia (Spain)		Annually	
Croatia			
Cyprus		Annually	
Czech Republic			
England (UK)			
Estonia		Project based	
Finland		Annually	
FYROM		Annually	
Germany		Annually	
Greece			
Iceland		Annually	
Ireland			
Italy		Annually or more	
Latvia		Annually	
Malta		Annually	
Poland			
Portugal		Annually	
Romania			
Slovenia			
Sweden			
Switzerland		Annually	
The Netherlands		Annually or more	
VALID PERCENTAGES (%)	**19 out of 23 (82.6%)**	**15 out of 17 (88.2%)**	**1 out of 23 (4.3%)**

Figure 11. Governmental funding health service and allocating resources

:YES; **:Not available;** **:NO.**

Further details can be found in the following paragraphs:

England (UK) *No specific ring-fenced funding–this work is supposed to occur via generally allocated funding.*

Estonia *Currently funding is project-based, more permanent funding is envisaged.*

Finland *Equalization payment made by the government to municipalities to compensate basic social and health services.*

FYROM *By financing project applications.*

Germany *The answer is: 1.Yes: Local communities fund the outpatient addiction counseling services; 2.No: Medical treatment is fully paid by the statutory health insurances and the statutory pension insurance (not by government directly). Therefore the services receive - as any other medical service - funding per patient.*

Greece *According to the Action Plan on Alcohol Harm Reduction (2008-2012), government funding for the development of such services has been provided. However, in all probability the funding of the services has been slashed.*

Italy *Funding are reviewed annually or every 2-5 years, depending on what is funded. Funding for the implementation of the 125/2001 frame law on alcohol are allocated on annual basis, but resources are limited. Other funding could be allocated every 3 years by the MoH under the frame of the National Prevention Plan.*

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

3.4. SUPPORT FOR TREATMENT PROVISION

3.4.1. Screening and quality assessment systems

In this section, partners were again asked their opinion on a scale from 0 to 10, about to what extent they consider that the following screening and support systems are available for PHC providers in managing HHAC. Results are reported in Figure 12.
The results show a great difference between countries.
In general, they considered more available the screening instruments to identify at risk drinkers, case notes or computer record to record alcohol risk status, facilitators or advisors for HHAC consumption, follow up system for monitoring and advice patients and finally, with the lowest level of agreement, protocol charts or diagrams for HHAC consumption.
In 56.5% of the countries (13 out of 23) participants considered available and pointed the presence of screening instruments to identify at risk drinkers over the average of 6.4 points (in a scale from 0- no integrated, to 10-fully integrated), while only 7 out of 23 (30.4%) considered available and pointed follow up systems for monitoring and advice patients over the average of 4.1 points (Figure 12).

SUPPORT FOR TREATMENT PROVISION	Screening instruments to identify at risk drinkers	Case notes or computer records to record alcohol risk status	Protocol charts or diagrams for HHAC consumption	Facilitators or advisors for HHAC consumption	Follow up systems for monitoring and advice patients
Belgium	2	1	3	3	4
Catalonia (Spain)	9	9	9	8	8
Croatia	5	5	1	8	8
Cyprus	1	8	1	9	9
Czech Republic	5	1	0	2	1
England (UK)	5	5	5	2	2
Estonia	10	10	5	4	3
Finland	10	10	10	5	5
FYROM	8	8	3	4	8
Germany	9	9	5	9	5
Greece	0	0	0	0	4
Iceland	9	6	7	5	3
Ireland	8	8	7	6	4
Italy	5	2	5	3	3
Latvia	7	6	1	5	3
Malta	1	1	1	8	2
Poland	8	1	0	3	0
Portugal	6	5	5	4	4
Romania	2	0	0	1	0
Slovenia	10	10	5	3	2
Sweden	10	7	4	4	10
Switzerland	10	3	3	4	3
The Netherlands	8	7	8	6	4
MEAN +/-SD	6.4+/-3.3	5.3+/-3.5	3.8+/-3.0	4.6+/-2.5	4.1+/-2.8

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

Further details can be found in the following paragraphs:

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

3.4.2. Protocols and guidelines

Most of the countries (69.6%) have already developed multidisciplinary guidelines, while one more is developing them (Greece). The majority are stand alone guidelines as opposed to a part of other clinical guidelines. However, there is still a great lack of studies about their adherence and implementation (just in 25% of the countries who reported having clinical guidelines) (Figure 13).

PROTOCOLS AND GUIDELINES	MULTIDISCIPLINARY CLINICAL GUIDELINES FOR MANAGING HHAC	STUDIES ON ITS IMPLEMENTATION OR ADHERENCE
Belgium		
Catalonia (Spain)	Stand alone guidelines	
Croatia	As a part of other clinical care guidelines	
Cyprus		
Czech Republic	Stand alone guidelines	
England (UK)	Stand alone guidelines	
Estonia		
Finland	As part of other clinical care guidelines	
FYROM		
Germany	As part of other clinical care guidelines	
Greece	No, but under development	
Iceland	Stand alone guidelines	
Ireland	Stand alone guidelines	
Italy	Stand alone guidelines	
Latvia	As part of other clinical care guidelines	
Malta		
Poland		
Portugal	Stand alone guidelines	
Romania		
Slovenia	Stand alone guidelines	
Sweden		
Switzerland	Stand alone guidelines	
The Netherlands	Stand alone guidelines	
PERCENTAGES (%)	**16 out of 23 (69.6%)**	**4 out of 16 (25.0%)**

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

:YES; **:NO;**

Further details can be found in the following paragraphs:

Catalonia (Spain)	*PHEPA guidelines, Socidrogallcohol guideline, Pla director.*
Belgium	*www.domusmedica.be/.../709-problematisch-alcoholgebruik-aanpak-door-de -huisarts.html https://www.ebmpracticenet.be/nl/paginas/welkom.aspx*
Czech Republic	*Guidelines - based on PHEPA II project –Czech version by NIPH at:http://www.gencat.cat/salut/phepa/units/phepa/pdf/czechguidelines.pdf*
England (UK)	*Three sets of NICE guidance were published in 2010: 1.NICE. Alcohol-use disorders: preventing harmful drinking at http://guidance.nice.org.uk/PH24/Guidance/pdf/English; 2.NICE. Alcohol dependence and harmful alcohol use at http://guidance.nice.org.uk/CG115/NICEGuidance/pdf/English; 3.NICE. Alcohol-use disorders: physical complications at http://guidance.nice.org.uk/CG100/NICEGuidance/pdf/English*

Estonia	*The health care providers develop and apply their own guidelines.*
Finland	*http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/tunnus/hoi50028* *Treatment of Alcohol Abuse, Current Care Summary:* *http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/tunnus/ccs00005*
Germany	*Clinical guidelines are under preparation.*
Greece	*Guidelines for treatment of alcoholism have been recently developed (i.e. guidelines for clinical evaluation, for withdrawal syndrome treatment, for alcoholic intoxication, for relapse prevention and so on).* *http://www.eof.gr/c/document_library/get_file?p_l_id=34765&folderId=236302&name=DLFE-1701.pdf*
Italy	*Guidelines - based on PHEPA II project – Italian version by Scafato E., Gandin C., Patussi E. Alcol ed assistenza sanitaria primaria. Linee guida cliniche per l'identificazione precoce e l'intervento breve 2010, PHEPA-ISS at: http://www.epicentro.iss.it/temi/alcol/linee/linee_guida_cliniche.pdf*
Latvia	*Narcologic patient treatment guidelines.*
Portugal	*1.*Guidelines - based on PHEPA II project – Portuguese version by The Portuguese Association of Family Medicine and the Institute on Drugs and Drug Addiction at: http://www.apmgf.pt/index.php?section=publications&f=cdi ; 2.Stand alone guidelines for managing HHAC and as a part of other clinical care guidelines at: http://www.apmgf.pt/index.php?section=publications&f=cdi ; 3. Health General Directorate (DGS) National guidelines on adult EIBI and young people alcohol consumption and intoxication ; 4. Norma nº 036/2012 de 30/12/2012 - *Diagnóstico de Policonsumos em Adolescentes e Jovens* ; 5. Norma nº 035/2012 de 30/12/2012 - *Abordagem da Intoxicação Alcoólica Aguda em Adolescentes e Jovens* ; 6. Norma nº 030/2012 de 28/12/2012 - *Deteção precoce e Intervenção Breve no consumo excessivo do álcool no adulto*
Slovenia	*Guidelines - based on PHEPA II project – Slovenian version by Kolšek Marko (ed.&adapt.). Klinične smernice za zgodnje odkrivanje tveganega in škodljivega pitja in kratki ukrepi : alkohol in osnovno zdravstvo : evropski projekt za obravnavo alkoholne problematike v osnovnem zdravstvu (PHEPA). Ljubljana: Medicinska fakulteta, Katedra za družinsko medicino, 2006. (str. 159) ISBN 961-6264-77-X.*
Switzerland	*www.praxis-suchtmedizin.ch offers guidelines, information, instruments, tools, advice and support for the PHC settings (especially physicians); the available information has been reviewed by experts and is regularly updated.*
The Netherlands	*1.Stand alone: CBO (Dutch Institute for Healthcare Improvement) richtlijn stoornissen in het gebruik van alcohol (guideline disorders in the use of alcohol), see: http://www.cbo.nl/Downloads/206/rl_alcohol_09.pdf, or http://www.trimbos.nl/webwinkel/productoverzicht-webwinkel/behandeling-en-re-integratie/af/af0857-multidisciplinaire-richtlijn-alcohol.* *2.Part of: Scoring Results, see: www.resultatenscoren.nl.*

3.4.3. Reimbursement for health care providers

A small proportion of addition specialists (41.2%), general practitioners (33.3%) and psychiatrists (29.4%) are reimbursed for managing HHAC (Figure 14) but the most common practice is reimbursement as a part of their normal salary (Figure 15).

Further details can be found in the following paragraphs:

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

REIMBURSEMENT OF HEALTH CARE PROVIDERS FOR MANAGING HHAC WITHIN TERMS OF SERVICE (CONTRACT)	General practitioners	Doctor in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospitals	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Catalonia (Spain)												
Croatia												
Cyprus												
Czech Republic												
England (UK)												
Estonia												n.a.
Finland												n.a.
FYROM												
Germany												
Greece												
Iceland												
Ireland												
Italy												
Latvia												
Malta												
Poland												
Portugal												
Romania												
Slovenia												n.a.
Sweden												n.a.
Switzerland												
The Netherlands												
VALID PERCENTAGES	33.3	16.7	41.2	29.4	18.8	11.8	0.0	12.5	23.5	0.0	6.3	25.0

Figure 14. Reimbursement of health care providers for managing HHAC

:YES; **:Not available;** **:NO;** **n.a.** **:Not applicable**

REIMBURSEMENT OF HEALTH CARE PROVIDERS FOR MANAGING HHAC AS A PART OF NORMAL SALARY	General practitioners	Doctor in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospitals	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Catalonia (Spain)												
Croatia												
Cyprus												
Czech Republic												
England (UK)												
Estonia												n.a.
Finland												n.a.
FYROM												
Germany												
Greece												
Iceland												
Ireland												
Italy												
Latvia												
Malta												
Poland												
Portugal												
Romania												
Slovenia												n.a.
Sweden												n.a.
Switzerland												
The Netherlands												
VALID PERCENTAGES	85.7	85.7	81.0	90.5	70.0	71.4	40.0	81.8	81.8	40.0	70.0	57.9

Figure 15. Reimbursement as a part of normal salary of health care providers for managing HHAC

:YES; **:Not available;** **:NO;** **n.a.** **:Not applicable**

Protocols, policies and training for professionals

In most of the countries (Figure 16), there are specialized guidelines or protocols for managing HHAC mainly for addiction specialists (81.8%), general practitioners (65.2%), psychiatrists (59.1%), doctors in hospital (55.0%), for psychologists (50.0%). Guidelines are uncommon for pharmacists and dentists (respectively 10.5 and 5.6%).

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

In most of the countries (Figure 18), there is training for managing HHAC within professional vocational training for addiction specialists (84.2%), general practitioners (78.9%), psychiatrists (73.7%), psychologists (72.2%), and to a lesser extent for social workers (68.4%) and doctors in hospital (64.7%); training is particularly uncommon for obstetricians (25.0%) pharmacists (23.5%) and for dentists (18.8%).

SPECIALIZED GUIDELINES OR PROTOCOLS	General ractitioners	Doctors in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospital	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Catalonia (Spain)												
Croatia												
Cyprus												
Czech Republic												
England (UK)												
Estonia												n.a.
Finland												n.a.
FYROM												
Germany												
Greece												
Iceland												
Ireland												
Italy												
Latvia												
Malta												
Poland												
Portugal												
Romania												
Slovenia												n.a.
Sweden												n.a.
Switzerland												
The Netherlands												
VALID PERCENTAGES	**65.2**	**55.0**	**81.8**	**59.1**	**35.0**	**30.0**	**10.5**	**47.4**	**50.0**	**5.6**	**16.7**	**35.3**

Figure 16. Specialized guidelines or protocols for managing HHAC

:YES; **:Not available;** **:NO;** **n.a.** **:Not applicable**

WRITTEN POLICY BY PROFESSIONAL ASSOCIATION	General ractitioners	Doctors in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospital	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Catalonia (Spain)												
Croatia												
Cyprus												
Czech Republic												
England (UK)												
Estonia												n.a.
Finland												n.a.
FYROM												
Germany												
Greece												
Iceland												
Ireland												
Italy												
Latvia												
Malta												
Poland												
Portugal												
Romania												
Slovenia												n.a.
Sweden												n.a.
Switzerland												
The Netherlands												
VALID PERCENTAGES	38.9	27.8	38.9	38.9	21.1	21.1	6.3	27.8	23.5	0.0	6.7	13.3

Figure 17. Written policies for managing HHAC

:YES; **:Not available;** **:NO;** **n.a.** **:Not applicable**

TRAINING WITHIN PROFESSIONAL VOCATIONAL TRAINING	General practitioners	Doctors in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospital	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Catalonia (Spain)												
Croatia												
Cyprus												
Czech Republic												
England (UK)												
Estonia												n.a.
Finland												n.a.
FYROM												
Germany												
Greece												
Iceland												
Ireland												
Italy												
Latvia												
Malta												
Poland												
Portugal												
Romania												
Slovenia												n.a.
Sweden												n.a.
Switzerland												
The Netherlands												
VALID PERCENTAGES	78.9	64.7	84.2	73.7	38.9	44.4	23.5	68.4	72.2	18.8	25.0	41.2

Figure 18. Training for managing HHAC within professional vocational training

:YES; **:Not available;** **:NO;** **n.a.** **:Not applicable**

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 and psychiatrists (Figure 19).

TRAINING WITHIN ACCREDITED CME	General practitioners	Doctors in hospital	Addiction specialists	Psychiatrists	Nurses in general practice	Nurses in hospital	Pharmacists	Social workers	Psychologists	Dentists	Obstetricians	Counsellors
Belgium												
Catalonia (Spain)												
Croatia												
Cyprus												
Czech Republic												
England (UK)												
Estonia												n.a.
Finland												n.a.
FYROM												
Germany												
Greece												
Iceland												
Ireland												
Italy												
Latvia												
Malta												
Poland												
Portugal												
Romania												
Slovenia												n.a.
Sweden												n.a.
Switzerland												
The Netherlands												
VALID PERCENTAGES	**68.4**	**61.1**	**66.7**	**73.7**	**41.2**	**41.2**	**20.0**	**43.8**	**46.7**	**6.7**	**13.3**	**25.0**

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

:YES; **:Not available;** **:NO;** **n.a.** **:Not applicable**

Further details can be found in the following paragraphs:

Belgium *The training protocols are available but are not made compulsory.*

England (UK) *Three sets of NICE guidance covers all these groups of professionals*
NICE (2010) Alcohol-use disorders: physical complications (CG100), London http://www.nice.org.uk/guidance/CG/Wave17/1;
NICE (2011) Alcohol use disorders: management of alcohol dependence, London http://www.nice.org.uk/guidance/CG/Wave17/1;
NICE (2010) Alcohol-use disorders - preventing the development of hazardous and harmful drinking. London http://www.nice.org.uk/guidance/CG/Wave17/1
1. http://www.sips.iop.kcl.ac.uk/documents/factsheets/SIPS_factsheet_ED.pdf;
2. Kaner, E., et al., Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial. BMJ, 2013. 346: p. 1-14.
3. http://www.sips.iop.kcl.ac.uk/documents/factsheets/SIPS_factsheet_CJS.pdf.
Some local training programmes provide training, but no national strategy for postgraduate training apart from GPS through Royal College of General Practitioners and alcohol treatment part of core curriculum for psychiatrists in training. All professional (caring) groups are encouraged to access continuing medical education and stay up to date.

Greece *Training is related to seminars, conferences on alcohol use/abuse and so on.*

Germany *It all depends on regions, professions, and institutions. The options not crossed do not mean that do not exist.*

Iceland *For addiction specialists and counselors working at the main treatment hospital, private owned but partially publically funded, they have their own guidelines.*

Italy *The implementation of EIBI PHEPA II programme started at the CNESPS-ISS, on 2007 with the first formal training course; from that time many courses have been carried by the ISS funded by the MoH and by the Presidency of the Council of the Ministries, Dept of anti drugs policies. The national EIBI working team at the ISS- "Gruppo IPIB-Identificazione Precoce Intervento Breve" started its activities in April 2006 to deliver a communication strategy and to organise conferences to announce, promote and disseminate the training programme. IPIB is actually the formal institutional standard of training in Italy according to the PHEPA standard approved by the National Committee on Alcohol (set by the frame law on alcohol 125/2001). The ISS has been indicated as the national provider of the training activities in tight connection with the SIA (Italian Society of Alcohology) and the Regions. The training course has received a good evaluation in terms of credits to be earned through the Continuous National Training Programme (ECM), compulsory for the professionals of the National Health System. In Perugia, Umbria Region, training for managing HHAC has been carried out also for nurses, pharmacists and obstetricians.*

Sweden *1. We still lack a system for accreditation in Sweden. 2.The national guidelines are generic, and not directed towards any particular professional group. At least for nurses one is underways. Please observe that concerning nurses and physicians must is done in Occupational health care, which may be the group that presently does most work with HHAC among it's clients. Increasing efforts on all levels.*

Switzerland *1.Information on www.praxis-suchtmedizin.ch ; 2.Guidelines for midwives (see below). 3.QuaTheDA – quality norm in expert addiction support.*

3.5. INTERVENTION AND TREATMENT

3.5.1. Availability and accessibility

In this section, partners were again asked about their opinion on a scale from 0 to 10, about how much they consider that patient help for HHAC is accessible in different settings. Results are reported in Figure 20. Patients help for HHAC is considered accessible mainly in addition services (7.6%), in specialists clinics (6.3%), in general/family practice (6.0%), in hospital clinics (5.7%) and to a lesser extent, with the lowest percentage, in pharmacies.

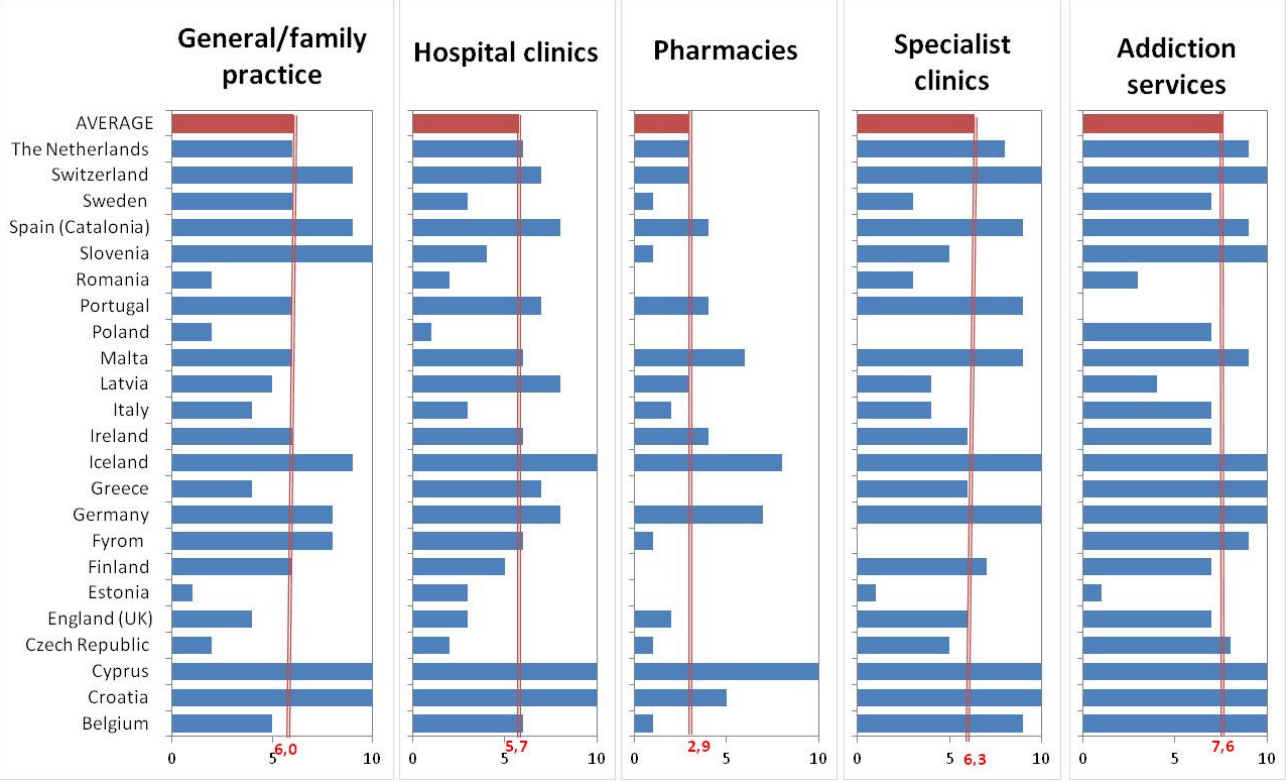


Figure 20. Patients help for HHAC obtainable in different settings.

Further details can be found in the following paragraphs:

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

Italy *It is important to take into account that not all addiction public services are engaged on EIBI of HHAC: this task is mainly carried out in specialist alcohol services only.*

Poland *Rehabilitation clinics don't exist in Poland.*

Portugal *There is a specific training program in hospitals, in addiction units and also in undergraduate medical settings. See at: http://www.acss.min-saude.pt/Projectos/ProjectoQRENPOPH/tabid/223/language/pt-PT/Default.aspx?PageContentMode=1 , http://www.acss.min-saude.pt/Portals/0/ANEXO%20IX%20-%20FormacaoProblAlcDepend.pdf , http://www.fm.ul.pt/#3278*

Romania *In the same study mentioned earlier another problematic issue was the health services in the area of problematic/hazardous alcohol consumption. The services fail to reach the younger sections of the population with less severe issues. Women are strongly sub-represented among the beneficiaries of health services. Over 80% of the people with problematic alcohol consumption from within the general population and that have never resorted to specialized services know of no institutions/specialized services in treating problems of abuse and addictions in their county. People resorting to these services tend to be over 50 years of age (over 50%), when presumably they have reached a greater stage of alcohol addiction. Family physicians fail to discern, in the early stages, disorders regarding alcohol consumption; they rather asses them in advanced stages. Thus, 55% of people that have had treatment for a problem related to alcohol consumption have received information from their family physician, and 44% were directed to a specialized service, compared to just 2%, respectively 3% of people that never received any treatment. In conclusion, in the lack of training, physicians rarely recognize minimal cases of alcohol abuse, with people reaching hospital treatment being rather older patients where we can suppose a greater stage of alcohol addiction. The study shows that another aspect important to the specialists interviewed is that of the absence of guidebooks and work protocols agreed at a national level in the area of specialized interventions for the treatment of alcohol consumption disorders. The sole official document developed at a national level regarding specialized services in this area is framed within the National Antidrug Strategy. Currently, in Romania, the main specialization addressing interventions related to alcohol consumption is psychiatry, with interventions in this field being very appreciated by those struggling with problematic alcohol consumption, over 50% of them considering them very useful. The same positive note is being said about self-help groups such as Alcoholics Anonymous or socio-medical intervention centers developed in this field.*
This will change starting from 2014 when, through the healthcare reform in Romania, screening and brief interventions will be made available within primary care units(as part of the minimal healthcare service package).

Sweden *These fairly low figures are explained by practical reason, not by formal accessibility. The shortcomings are both due to lack of attention to this issue, and inconvenience in working with alcohol issues. Increasing activities on all levels, not in the least in somatic and psychiatric hospital care. More done in cities than elsewhere.*

3.6. HEALTH CARE PROVIDERS

3.6.1. Clinical accountability

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

Further details can be found in the following paragraphs:

Czech Republic *Training in brief intervention - PILOT PROJECT NIPH - launched in 2010 - slower implementation into clinical practice - lack of motivation of health professionals.*

England (UK) *SIPS "Screening and Intervention Programme for Sensible drinkers" reports cover General Practitioners and Emergency Departments.*

- *Kaner E et al (2013). Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial. BMJ, 346: p. 1-14.*
- *Criminal Justice Service Protocol: http://www.biomedcentral.com/1471-2458/9/418/;*
- *Accidents and Emergency Departments Protocol: http://www.biomedcentral.com/1472-6963/9/114*

FYROM *Alcohol related problems in Republic of Macedonia;*
Why young people should not drink alcohol;
Alcoholism and deviated behaviour;
Alcoholism, recovery and sober life

Germany *For social worker and counselors, it varies a lot where they work. If they work in specialized addiction services the score is certainly 10*

Ireland

Health Service Executive 2011. A guiding framework for education and training in screening and brief intervention for problem alcohol use. Dublin: HSE at http://www.hse.ie/eng/services/Publications/topics/alcohol/interventionforproblemalcoholabuse.pdf

Switzerland

- *General practitioners and others: www.praxis-suchtmedizin.ch; http://www.fosumos.ch/images/stories/pdf/risikotrinken_dt_web_verschlsselt.pdf;*
- *Midwives: http://www.hebamme.ch/x_data/lit_pdf/Guideline%20zu%20Screening%20und%20Beratung%20bei%20Zigaretten-%20und%20Alkoholkonsum.pdf*

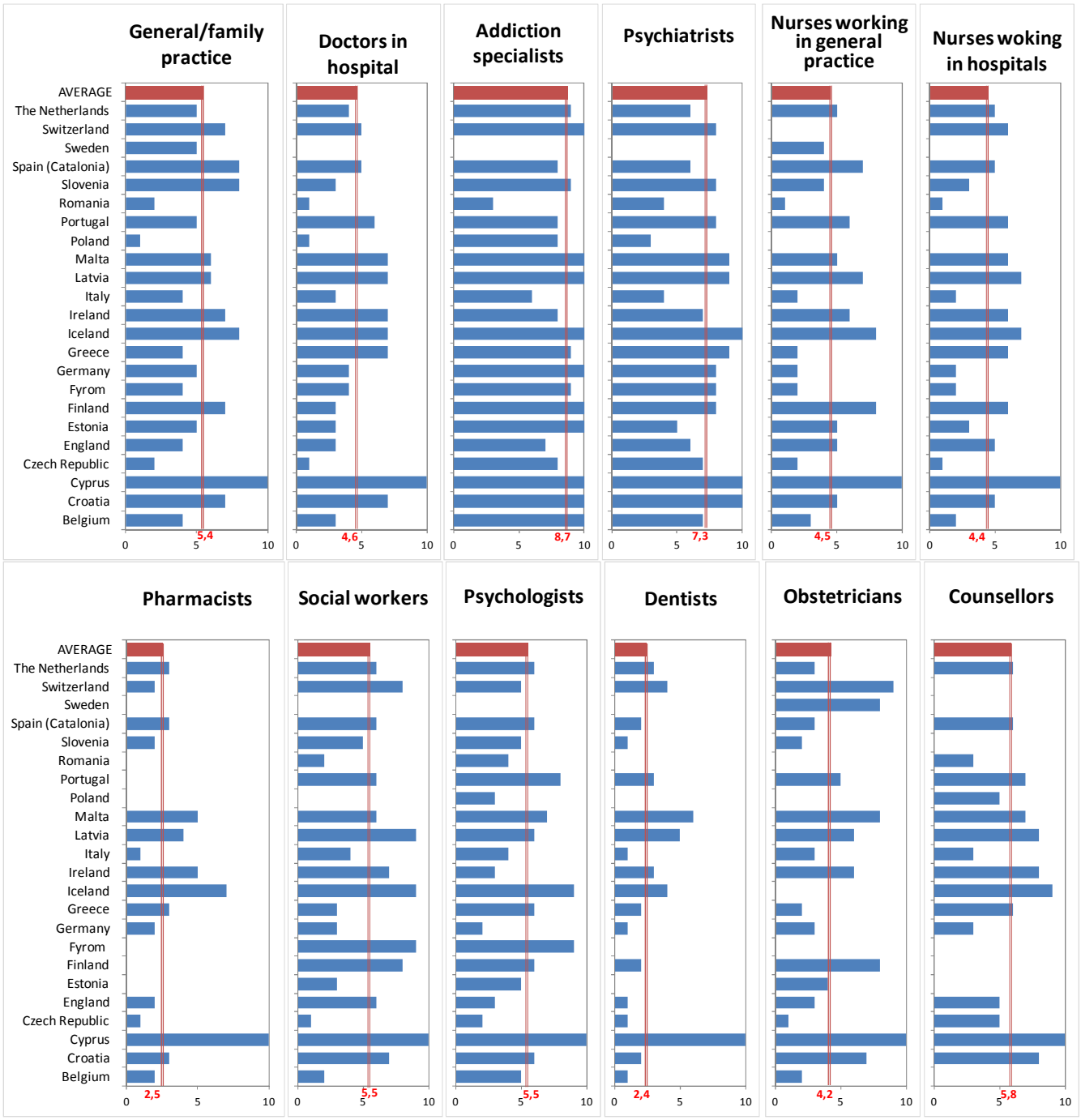


Figure 21. Estimation of advices for HHAC as part of the routine clinical practice

Addiction specialists followed by psychiatrists consider advices for HHAC as part of their routine clinical practice, but not pharmacists and dentists.

3.6.2. Treatment provision

In this section a summary of the main findings reported on different areas is provided in the tables, taking into consideration that many other studies, surveys and publications available, even if not reported by key informants.

STUDIES, SURVEYS OR PUBLICATIONS IN PHC	PATIENTS ARE ASKED OR SCREENED ABOUT THEIR ALCOHOL CONSUMPTION		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	Y	2008	Health interview survey, Belgium
Catalonia (Spain)	Y	2010	45% of patients are asked about alcohol consumption. Not published
Croatia	N		
Cyprus	N		
Czech Republic	Y	2011	Almost 30% of young men drink in an hazardous way. Sovinová H et al. The Czech Audit: Internal consistency, latent structure and identification of risky alcohol consumption. Cent Eur J Public Health 2010; 18 (3): 127 – 131
England (UK)	Y	2011	-Occurs sporadically. AMPHORA in the latest. -Wilson G, Lock C, Heather N, Cassidy P, Christie M, Kaner E. (2011). Intervention against excessive alcohol consumption in primary health care: a survey of GPs attitudes and practices in England ten years on. Alcohol and Alcoholism 2011: doi: 10.1093/alcalc/agr067; -Drummond C, Gual A, Goos C, Godfrey C, Deluca P, et al (2011). Addiction;106:31-36
Estonia	Y		Adult health behavior survey available at: http://www.tai.ee/et/terviseandmed/uuringud?limit=10&filter_catid=17&filter_year=0&filter_pubid=0&filter_languageid=0&filter_order=p.publish_year&filter_order_Dir=DESC&start=10
Finland	Y	2008	Makela et al_2011_addiction_brief intervention.docx
FYROM	N		
Germany	Y	2011	Pilot project on Screening and Brief Intervention in the general practice in Northeast Germany (Frühintervention bei Patienten mit Alkoholproblem in Arztpraxen FrühA)
Greece	Y	2006	1.Aim: The detection of alcohol addiction/abuse among patients with psychiatric problems visiting the Emergency Psychiatric Department (EPD) of a General Public Hospital. Method: For a period of 3 months all adult patients were asked to answer the CAGE TEST. Sample: 220 patients with mean age 41 years (± 14.4). Results: Men showed statistically higher values in CAGE TEST compared to women (t-test p <0.05) as well as the divorced patients compared to unmarried and married patients (ANOVA Test p <0.05). Conclusions: Alcohol abuse appears to be increasing among individuals with psychiatric problems compared to those of general population. Alcohol abuse as a comorbid factor should be further investigated. Moussas G et al. Alcoholism in the Emergency Department of the Psychiatric clinic of the Public General Hospital: An epidemiological study of comorbidity (In: 19th National Congress of Psychiatry, 4-8 May 2006, Athens, Greek Psychiatric Association), Psychiatry, v.17 (1), p.200; 2. Method: Method: Data on sex, age, city, substance use, psychiatric comorbidity, medication, number of admissions, number of relapses and number of visits derived from the data collected by the Outpatient's Substance Department of the hospital. Sample: 183 new patients who participated in 800 scheduled sessions. Results: The patients who were alcohol and poly-drug users outnumbered. The majority of them were men. The low rate of relapses and hospital admissions is attributed to the regular attendance of the scheduled sessions. Conclusions: The Outpatient's Substance Department seems to meet the need for evaluation and health care of substance dependent patients visiting the hospital. It is also stressed the need of such interventions being further developed in public hospitals. Diakogiannis I et al. Clinical – epidemiological study of the Patients of the Outpatient's Substance Department of the Psychiatric Clinic of AXEPA University General Hospital: Three-year operation (In: 19th National Congress of Psychiatry, 4-8 May 2006, Athens, Greek Psychiatric Association.

Iceland	Y	2009	15% of doctors ask, if patient have no symptoms. 84% ask if patient have symptoms. Prevention in the PHC. The findings we have on SBI are mainly from a master thesis from the year 2009. In that thesis a comparison was done on changes in doctors attitude on smoking prevention in the PHC. Data from the year 2000 was compared with data from 2009. In addition, questions regarding alcohol were added in 2009 data collection.
Ireland	Y	2006	4,584 patients were screened. The results show that 61% of these patients were in the 'low/no risk' categories, while 22% were in the 'hazardous' zone and 17% were 'harmful/dependent'. Irish College of General Practitioners. (2006) Alcohol Aware Practice Pilot Study 2005-2006. Dublin: ICGP Publications.
Italy	Y	2006	No difficulties for about 60% of GPs http://www.who.int/substance_abuse/publications/identification_management_alcoholproblems_phaseiv.pdf
Latvia	Y		The most frequent issues caused by alcohol consumption was the inability to stop drinking, higher than planned amount of consumption, hangovers, and attempts to fight them by continuing drinking of the following day. 28% of the population (15-64 yrs) faced various alcohol related problem during last year period, but CIDI test criteria confirm this for 12.5% of the population. These indicators point out that drinking habits in Latvia exhibit major similarities to those in Finland and United Kingdom, thus it might be important to give thorough consideration to evidences found in similar to Latvia countries. Snikere.S. et al. "Addiction inducing substance use among general population". Survey results.
Malta	N		
Poland	N		
Portugal	Y	2009	Rev Port Clin Geral 2009;25:281-304 "Hábitos alcoólicos e protecção cardiovascular no Centro de Saúde de Barão do Corvo" at http://www.rpmgf.pt/ojs/index.php?journal=rpmgf&page=article&op=view&path%5B%5D=4610
Romania	N		
Slovenia	Y	2006	1. Only 50% of patients have ever been asked about their alcohol drinking (2006). SIMONIČ R. Osveščenost odrasle populacije o učinkih uživanja alkohola na telesno zdravje ter poznavanje sodobnih meril za tvegano pitje; specialistična naloga. Ljubljana: Medicinska fakulteta, 2010. 2. 95% of patients aged: men 35 – 65, women 45 – 70 has been asked about their alcohol drinking (2006). FRAS, Z. et al. Prevalence of arterial hypertension, its awareness and control in the adult population of the Ljubljana area of Slovenia. Results of WHO's countrywide integrated non communicable diseases intervention (CINDI) program survey 2002/2003 = Prevalenca arterijske hipertenzije, njenega zavedanja in urejenosti pri odraslih prebivalcih ljubljanske regije. Rezultati raziskave CINDI (WHO countrywide integrated non communicable diseases intervention) program survev 2002/2003. Slov. Kardiol, 2006;3(2):106-14.
Sweden	Y	2008 2011	Staff in PHC recorded strong increase in asking patients between 2006 and 2009, not confirmed in studies with patients, these report being asked 12-15%. 1. Holmqvist M et al. Alcohol Prevention Activity in Swedish PHC and Occupational Health Services. Asking patients about their drinking. Nordic Studies on alcohol and drugs. 2008;25:489-504. 2. Geirsson M et al. The impact of the Swedish Risk Drinking Project on clinical practice in primary Care. In dissertation Geirsson M 2011 Alcohol prevention in Sweden primary health care at http://hdl.handle.net/2077/26274
Switzerland	Y	2010	-Group brief interventions proved significant for participants in the risk group (3-4 binge drinking events in the previous month). However no such effect for the high risk group (more than 4 binge drinking events) (Gmel, 2010, S. 49); -Interventions for the group with the higher drink amount led to a greater reduction of the drink amount and the number of excessive drinking events compared to the control group (no intervention). -G.Gmel et al (2010) in: http://www.sucht-info.ch/fileadmin/user_upload/Images/Abschlussbericht_Z%C3%BCrich_Kurzinterventionen.pdf; -Daeppen JB., Bertholet N., Gaume J., Fortini C., Faouzi M., Gmel G.

			(2010). Efficacy of brief motivational intervention in reducing binge drinking in young men: A randomized controlled trial. Drug and Alcohol Dependence 113, 69-75
The Netherlands	Y	1995 2009	- GP-standard for recognizing alcoholics is not adequate; - NEMESIS (Netherlands Mental Health Survey and Incidence Study) - Cornel et al. Alcohol and Alcoholism 1995; 30: 651-659; - www.trimbos.nl
PERCENTAGE	73.9%		

Figure 22. Studies, surveys or publications in PHC about patients screened for their alcohol consumption

STUDIES, SURVEYS OR PUBLICATIONS IN PHC	**PATIENTS WITH HHAC ARE GIVEN ADVICE**		
	Y/N	**YEAR**	**MAIN FINDINGS - REFERENCE**
Belgium	N		
Catalonia (Spain)	Y	2010	Not published
Croatia	N		
Cyprus	N		
Czech Republic	N		
England (UK)	Y	2013	Kaner E et al (2013). Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial. BMJ, 346: p. 1-14.
Estonia	Y		Adult health behavior survey at http://www.tai.ee/et/terviseandmed/uuringud?limit=10&filter_catid=17&filter_year=0&filter_pubid=0&filter_languageid=0&filter_order=p.publish_year&filter_order_Dir=DESC&start=10
Finland	Y		makela et al_2011_addiction_brief intervention.docx
FYROM	N		
Germany	Y	2011 2009	-Frühintervention bei Patienten mit Alkoholproblem in Arztpraxen FrühA; -Reis O, Pape M, Häßler F (2009): Ergebnisse eines Projektes zur kombinierten Prävention jugendlichen Rauschtrinkens. Sucht 2009; 55: 347-356.
Greece	Not available		
Iceland	Y		81% give advice to change lifestyle, master theises: http://skemman.is/stream/get/1946/4457/13019/1/kristin_olafsdottir_fixed.pdf
Ireland	N		
Italy	Y		http://www.who.int/substance_abuse/publications/identification_management_alcoholproblems_phaseiv.pdf
Latvia	N		
Malta	N		
Poland	N		
Portugal	Y	2012	Patients accept screening of alcohol consumption by their physician and are open to advice regarding their alcohol intake. RASTREIO DO CONSUMO DE ÁLCOOL NOS CUIDADOS DE SAÚDE PRIMÁRIOS - ATITUDES DOS UTENTES–Campos–Master degree at: http://repositorio.ul.pt/handle/10451/6768
Romania	N		
Slovenia	N		
Sweden	Y		See above
Switzerland	Y	2010	-Gmel G et al (2010) in: http://www.sucht-info.ch/fileadmin/user_upload/Images/Abschlussbericht_Z%C3%BCrich_Kurzinterventionen.pdf; -Daeppen JB, Bertholet N, Gaume J, Fortini C, Faouzi M, Gmel G (2010). Efficacy of brief motivational intervention in reducing binge drinking in young men: A randomized controlled trial. Drug and Alcohol Dependence 113, 69-75.
The Netherlands	Y		Pilots and research
PERCENTAGE	50.0%		

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

STUDIES, SURVEYS OR PUBLICATIONS IN PHC	THE USE OF AUDIT QUESTIONNAIRE		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	Y	2008	Occupational health:13% *van de werknemers gebruikt alcohol op een onveilige manier (categorieën samengeteld: risicogebruik + schadelijk gebruik + risico op afhankelijkheid). Er zijn significant meer mannen (18%) met een onveilig alcoholgebruik dan vrouwen (6%). Daarbij kan ruim 1 op 100 werknemers.* Securex (2008). White paper *'Het alcoholgebruik van de Belgische werknemer'*
Catalonia (Spain)	Y	2002 2010 2011	18.3% of prevalence . Detección y abordaje los problemas de alcohol en la atención primaria de Cataluña. Lidia Segura Garcia, Antoni Gual Solé,Olga Montserrat Mestre, Ángela Bueno Belmonte y Joan Colom Farran. Aten Primaria. 2006;37(9).
Croatia	N		
Cyprus	N		
Czech Republic	Y	2010	Experience with Czech AUDIT is promising. Csémy L., Sovinová H., Procházka B.: Risky and harmful alcohol consumption in young adults: social and demographic context. Prakticky lekar 2011, 91, (10): 655 - 660
England (UK)	Y	2013	Kaner E et al (2013). *Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial.* BMJ, 346: p. 1-14
Estonia	N		
Finland	Y	2008	http://www.thl.fi/thl-client/pdfs/185cd443-0aa9-4bb7-8755-7a98bcfaaed7 Table (taulukko) 20a. Kaikki=all, Miehet=men, Naiset=women
FYROM	N		
Germany	Not available		
Greece	Not available		
Iceland	N		
Ireland	Y	2006	4,584 patients were screened. The results show that 61% of these patients were in the 'low/no risk' categories, while 22% were in the 'hazardous' zone and 17% were 'harmful/dependent'. Irish College of General Practitioners. (2006) Alcohol Aware Practice Pilot Study 2005-2006. Dublin: ICGP Publications.
Italy	Y	1997 2006	-1. The AUDIT has been validated in Italy in 1997 (Piccinelli M. et al, 1997. BMJ, 314:420-424) -2. A study aimed to evaluate the feasibility of adapting a shorter version of the WHO AUDIT (AUDIT-C) in the national PHC context. It examined 232 questionnaires previously administered to an opportunistic sample of GPs patients to verify the internal validity of the first three items of the AUDIT questionnaire in comparison to the full set of ten questions. It revealed that the short-AUDIT is predictive of the same results obtained by the ten questions-AUDIT (Struzzo P et al, 2006 in http://www.unicri.it/wwk/publications/dacp/journal/2006_12/j%20xxix%202006_12%206_Struzzo.pdf)
Latvia	N		
Malta	N		
Poland	N		
Portugal	Y	2011	-A Medicina Geral e Familiar e a Abordagem do Consumo de Álcool Detecção e Intervenções Breves no âmbito dos Cuidados de Saúde Primários Cristina Ribeiro at: http://repositorio.ul.pt/handle/10451/2733 -Acta médica portuguesa http://repositorio.ul.pt/bitstream/10451/6822/1/MGF_alcool.pdf
Romania	N		
Slovenia	N		
Sweden	Y	2011 2013	Nilsen P, McCambridge J, Karlsson N, Bendtsen P (2011). Brief interventions in routine health care: a population-based study of conversations about alcohol in Sweden (Addiction, Oct;106(10):1748-56. doi: 10.1111/j.1360-0443.2011.03476.x. Epub 2011 Jun 1. Reinholdz H, Fornazar R, Bendtsen P, Spak F (2013). Comparison of systematic versus targeted screening for detection of risky drinking in primary care. (Alcohol Alcohol, Mar-Apr;48(2):172-9. doi: 10.1093/alcalc/ags137. Epub 2013 Jan 7

Switzerland	Y	2010	Based on the AUDIT: -G.Gmel et al at http://www.sucht-info.ch/fileadmin/user_upload/Images/Abschlussbericht_Z%C3%BCrich_Kurzinterventionen.pdf; -Daeppen JB., Bertholet N., Gaume J., Fortini C., Faouzi M., Gmel G. (2010). Efficacy of brief motivational intervention in reducing binge drinking in young men: A randomized controlled trial. Drug and Alcohol Dependence 113,69-75
The Netherlands	Y		Pilots and research
PERCENTAGE	52.4%		

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

STUDIES, SURVEYS OR PUBLICATIONS IN PHC	ADVICE MEETS QUALITY CRITERIA		
	Y/N	**YEAR**	**MAIN FINDINGS - REFERENCE**
Belgium	N		
Catalonia (Spain)	Y	2010	
Croatia	N		
Cyprus	N		
Czech Republic	N		
England (UK)	Y	2013	-O'Donnell, A. Haighton K, Chappel D, Shevills C, Kaner E. (2013). Can routine data help evaluate the implementation of brief alcohol intervention in primary health care? RSA Conference Abstract. Alcoholism Clinical and Experimental Research. -O'Donnell, A. Haighton K, Chappel D, Shevills C, Kaner E. (2013) Can routine data help evaluate the implementation of a brief alcohol intervention in primary health care? A mixed-methods study to evaluate the delivery of ' Screening and Brief Interventions (SBI) for alcohol European Journal of General Practice, 2013; 19: 165
Estonia	N		
Finland	Not available		
FYROM	N		
Germany	Not available		
Greece	Not available		
Iceland	N		
Ireland	N		
Italy	N		
Latvia	N		
Malta	N		
Poland	N		
Portugal	N		
Romania	N		
Slovenia	N		
Sweden	N		
Switzerland	Not available		
The Netherlands	Y		Only pilot, regional application
PERCENTAGE	15.8%		

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

STUDIES, SURVEYS OR PUBLICATIONS IN PHC	PRACTICE PROTOCOLS AND GUIDELINES ARE FOLLOWED		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Catalonia (Spain)	Y		Studies show low fidelity to guidelines. Not published.
Croatia	N		
Cyprus	N		
Czech Republic	N		
England (UK)	Y	2001 2004 2006	Kaner E et al (2001). Patient and practitioner characteristics predict brief alcohol intervention in primary care. British Journal of General Practice, 51: p. 822-827. Lock C and Kaner E (2004). Implementation of brief alcohol interventions by nurses in primary care: do non-clinical factors influence practice? Family Practice, 21(3): p. 270-275. Rapley T, May C, and Kaner E (2006). Still a difficult business? Negotiating alcohol-related problems in general practice consultations. Social Science and Medicine, 63: p. 2418-2428. May C, Rapley T, and Kaner E (2006). Clinical Reasoning, clinical trials and risky drinkers in everyday primary care: a qualitative study of British general practitioners. Addiction Research & Theory, 14(4): p. 387 397.
Estonia	N		
Finland	Not available		
FYROM	Not available		
Germany	Not available		
Greece	Not available		
Iceland	N		
Ireland	N		
Italy	Y	2007	EIBI PHEPA programme implemented by ISS from 2007. 1. Scafato E. et al (Eds), (2008). Programma di formazione IPIB-PHEPA Identificazione Precoce e Intervento Breve dell'abuso alcolico in Primary Health Care. Alcol e Prevenzione nei contesti di Assistenza Sanitaria Primaria, at: http://www.gencat.cat/salut/phepa/units/phepa/pdf/italian_training_programme.pdf ; 2. Scafato E. et al (Eds), (2010). L'alcol e l'assistenza sanitaria primaria. Linee guida cliniche per l'identificazione e l'intervento breve, at: http://www.epicentro.iss.it/temi/alcol/linee/linee_guida_cliniche.pdf
Latvia	N		
Malta	N		
Poland	N		
Portugal	Y	2009	Do not recommend alcohol consumption for cardiovascular benefits and recommend less alcohol consumption. Rev Port Clin Geral 2009;25:281-304 "Hábitos alcoólicos e protecção cardiovascular no Centro de Saúde de Barão do Corvo" at http://www.rpmgf.pt/ojs/index.php?journal=rpmgf&page=article&op=view&path%5B%5D=4610
Romania	N		
Slovenia	N		
Sweden	N		
Switzerland	Not available		
The Netherlands	Y		There are, but application is uncertain. www.nhg.artsennet.nl
PERCENTAGE	27.8%		

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

STUDIES, SURVEYS OR PUBLICATIONS IN PHC	EFFECTIVENESS OF INTERVENTIONS FOR HHAC		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Catalonia (Spain)	Y	2003	IB reduced significantly alcohol consumption (d=-0.46; IC95%, -0.29 to -0,63; p<0,0005) and prevalence of risky drinkers (OR=1,55; IC 95%, 1.06-2.26; p=0.02). Gaceta sanitaria 2003.
Croatia	N		
Cyprus	N		
Czech Republic	N		
England (UK)	Y	2007 2012	-Kaner E et al (2013). Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial. BMJ, 346: p. 1-14 -Kaner E et al (2007). Brief interventions for excessive drinkers in PHC settings (Full Review). Cochrane Database of Systematic Reviews, Issue 2. Art No.:CD04148
Estonia	N		
Finland	Not available		
FYROM	N		
Germany	Not available		
Greece	Y		Aim: the Outpatients' Alcohol Department (Gastroenterology Clinic, University General Hospital of Crete) has been operating since 2004. It provides health care (medical and psychiatric care, counseling and motivation interviewing) to patients with alcoholic liver damage. It cooperates with family clubs for the support of the family members of the patients. Outcome of the patients attending the programme of the Outpatients' Alcohol Department for 1 month to 5 years: 104 of 227 patients abstained from alcohol use and 20 of 227 reported occasional use of alcohol without loss of control (54.6%). Of those (104 individuals), 54% abstained from alcohol use for less than 3 months, 23.4% for 3-6 months, 7.2% for 6-12 months and 15.3% for more than 1 year. Conclusion: The disciplinary approach of a sensitized health professional group in cooperation with family club volunteers is related to the fact that a significant proportion of patients (over 50%) abstained from alcohol use for a short/long period of time. Koulentaki M et al (2010). Outpatients' Alcohol Department: Five-year Experience from Crete. 30th Panhellenic Congress of Gastroenterology, Athens, 11-14 November 2010
Iceland	N		
Ireland	N		
Italy	Y		1. The aims, methodology and preliminary results of a national pilot study are described. Mezzani et al, 2007 2. A randomized controlled non-inferiority trial is ongoing in PHC in the Friuli Venezia Giulia Region aimed at evaluating whether facilitated access to an alcohol reduction website for at-risk drinkers is not inferior to the face-to-face brief intervention in primary care. Wallace et al, 2013
Latvia	N		
Malta	N		
Poland	Y	2009 2010	At 3 and 12 month follow ups, intervention and assessment groups compared to screened only group showed significant decreases in alcohol consumption. -Cherpitel CJ, Moskalewicz J, Świątkiewicz G, Ye Y. (2009). Screening, brief intervention, and referral to treatment (SBIRT) in a Polish Emergency Department: three-month outcomes of a randomized, controlled clinical trial. J. Stud. Alcohol. Drugs, Vol.70, No.6, pp.982-990; -Cherpitel CJ, Korcha RA, Moskalewicz J, Światkiewicz G, Bond J (2010). Screening, brief intervention, and referral to treatment (SBIRT): 12-month outcomes of a randomized controlled clinical trial in a polish emergency department. Alcohol. Clin. Exp. Res., Vol.34, No.11, pp.1922-1928
Portugal	Y	2011	Decrease in consumption was observed patients followed by physicians of the experimental group. Results concerning the relationship demonstrates that a better attitude of physicians in can influence the decrease alcohol. Ribeiro C. *A Medicina Geral e Familiar e a Abordagem do Consumo de Álcool Detecção e Intervenções Breves no âmbito dos Cuidados de Saúde Primários.*

Romania	N		
Slovenia	N		
Sweden	Y	1989	Romelsjo A, Andersson L, Barrner H, Borg S, Granstrand C, Hultman O, et al (1989). A randomized study of secondary prevention of early stage problem drinkers in primary health care. Br J Addict,84:1319-27. At the one-year follow-up there were greater, however not significant, reduction in GGT-level, in self-reported alcohol consumption and in a 'problem index' in the minimal intervention group than in the comparison group.
Switzerland	Not available		
The Netherlands	Not available		
PERCENTAGE	36.8%		

Figure 27. Studies, surveys or publications in PHC about effectiveness of interventions for HHAC

STUDIES, SURVEYS OR PUBLICATIONS IN PHC	**COST-EFFECTIVENESS OF INTERVENTIONS FOR HHAC**		
	Y/N	**YEAR**	**MAIN FINDINGS - REFERENCE**
Belgium	N		
Catalonia (Spain)	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England (UK)	Y	2013	Kaner E et al (2013). Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial. BMJ, 346: p. 1-14
Estonia	N		
Finland	Not available		
FYROM	N		
Germany	Not available		
Greece	Not available		
Iceland	N		
Ireland	N		
Italy	Y	2013	Colin et al. Modelling the Cost-Effectiveness of Screening and Brief Interventions in Italy. An Adaptation of the Sheffield Alcohol Policy Model (In press)
Latvia	N		
Malta	N		
Poland	N		
Portugal	N		
Romania	N		
Slovenia	N		
Sweden	N		
Switzerland	Not available		
The Netherlands	N		
PERCENTAGE	10.5%		

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

STUDIES, SURVEYS OR PUBLICATIONS IN PHC	THE ATTITUDES OF HEALTH CARE PROVIDERS TO MANAGING HHAC		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	Y	2013	Results will be available soon.
Catalonia (Spain)	Y		2003, improvement. In preparation.
Croatia	N		
Cyprus	N		
Czech Republic	N		
England (UK)	Y	2004 2011 2013	-Drummond C et al. Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122341 -Wilson G et al (2011). Intervention against excessive alcohol consumption in primary health care: a survey of GPs' attitudes and practices in England ten years on. . Alcohol & Alcoholism, 46(5): p. 570-577 -Kaner E et al (2013). Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial. BMJ, 346: p. 1-14
Estonia	Y		A technical document, only in Estonian, not published yet
Finland	Not available		
FYROM	N		
Germany	Y	2011	*Frühintervention bei Patienten mit Alkoholproblem in Arztpraxen FrühA* at: http://tannenhof.de/fileadmin/user_upload/download/pdf/THBB%20Projekt%20Fr%C3%BCh%20-%20A%20%20Abschlussbericht%2030.06.2011.pdf
Greece	Not available		
Iceland	Y	2009	To refer patient to other professionals; to gain more training in BI; Prevention in PHC, master theises: http://skemman.is/stream/get/1946/4457/13019/1/kristin_olafsdottir_fixed.pdf
Ireland	N		
Italy	Y	2000 2003 2006 2003 2007	1. Within proposed disincentives to a sample of 800 GPs, availability of structures, health policies, lack of training programmes were the main barriers, while incentives, the access to a national network of specialised services, NGOs- self help groups, availability of screening tools and training programmes. Polvani S et al, 2000, http://www.unicri.it/min.san.bollettino/bulletin/2000-1e/art3.html 2. Focus groups with GPs on barriers to implement EIBI, how to involve GPs into preventive approach on alcohol, the need of a package suitable to clinical practice, the formalization of GPs role on primary prevention, incentives, training on communication techniques, instruments.Patussi V. et al 2003, http://www.unicri.it/wwk/publications/dacp/journal/2003_4/j%20xxvi%202003%204%20prevenzione%20alcol%20medicina%20generale%20progetto%20who.pdf 3. GPs suggested 3 types of interventions into their general daily's practice: information to the general population, diagnosis and BI for HHAC, motivational interview for alcohol dependence and referral to specialized centres. Some more problems have been underlined by GPs: young people rarely meet GPs, women tend to hide problems related to alcohol consumption, the tendency to minimize alcohol consumption by patients, GPs themselves have difficulties in asking their patients questions on alcohol consumption. Scafato E et al (2006) at: http://www.who.int/substance_abuse/publications/identification_management_alcoholproblems_phaseiv.pdf 4. A survey to assess GPs basic knowledge of risky drinking and their attitudes towards performing routine BI. 60%, have no difficulties in talking about these issues with patients (only 23% have some difficulties). To increase the success of SBI they suggested specific information, more practical and personal training. Struzzo P et al, 2003, at http://www.priory.com/fam/italgp.htm 5. The protocol of a national pilot study. Mezzani L et al. (2007). Establishing an Italian GP BI pilot project for problem drinkers. Substance Use and Misuse,42:12-13.
Latvia	N		
Malta	N		
Poland	N		

Portugal	Y	2011	Acta médica portuguesa http://repositorio.ul.pt/bitstream/10451/6822/1/MGF_alcool.pdf Not yet published. Working with HHAC: derivation and validation of a model for predicting distinct general practitioners groups.
Romania	N		
Slovenia	N		
Sweden	Y	2008 2011	1. Holmqvist M et al (2008). Alcohol Prevention Activity in Swedish Primary Health Care and Occupational Health Services. Asking patients about their drinking. Nordic Studies on alcohol and drugs. 2008;25:489-504;. 2. Geirsson M et al (2011). The impact of the Swedish Risk Drinking Project on clinical practice in primary Care. In dissertation Geirsson M. Alcohol prevention in Swedish primary health care (http://hdl.handle.net/2077/26274)
Switzerland	Y	2006	-Factors: Addressing the topic of alcohol (the necessary skills and competencies are a prerequisite, otherwise the topic is avoided by many health care providers). Generally, patients accept questions regarding their alcohol consumption in the interest of their health. (vgl. Daeppen & Gaume, 2006, S. 5-9); Daeppen Daeppen J.-B. & Gaume J. (2006). Implémentation et dissémination de l'intervention brève pour la consommation d'alcool à risque en médicine de premiers recours: évaluation du projet partiel „médecins" du programme national alcool „Ca débouche sur quoi". Travail réalisé sous mandat de l'Office Fédéral de la Santé Publique. Centre de traitement en Alcoologie, Lausanne.
The Netherlands			
PERCENTAGE	50.0%		

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

STUDIES, SURVEYS OR PUBLICATIONS IN PHC	INCREASING THE INVOLVEMENT OF HEALTH CARE PROVIDERS IN MANAGING HHAC		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	Y	2013	Results will be available soon.
Catalonia (Spain)	Y	2003	Improvement. Not published.
Croatia	N		
Cyprus	N		
Czech Republic	N		
England (UK)	Y	2013	Kaner E et al (2013). Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial. BMJ, 346: p. 1-14
Estonia	Y		
Finland			
FYROM	N		
Germany	Not available		
Greece	Y	2011	Mouzas I. (2011). Care devices for alcoholic patients in Southern Europe» Alcoholism: Clin and Experimental Res 2011,35:22A
Iceland	N		
Ireland	N		
Italy	Y	2000 2003 2006 2007 2013	Focus groups to collect information on their experience, knowledge and needs; distribution of brochure and other information materials; providing support staff; providing specific training and incentives. Polvani et al 2000; Patussi et al 2003; Scafato et al 2006; Struzzo et al 2003; Mezzani et al 2007; Struzzo et al 2013
Latvia	N		
Malta	N		
Poland	N		
Portugal	Y	2013	http://www.euro.who.int/en/what-we-publish/abstracts/status-report-on-alcohol-and-health-in-35-european-countries-2013, Pages 104-107-Portugal (national and epidemiologic studies concerning alcohol and also the developing of political strategies that facilitates EIBI in PHC)
Romania	N		
Slovenia	N		
Sweden	Y	2011	Geirsson M et al 2011. The impact of the Swedish Risk Drinking Project on clinical practice in primary care. http://hdl.handle.net/2077/26274
Switzerland	Not available		There are a variety of projects and programmes with the aim of increasing the involvement of PHC providers in managing HHAC however there's no or only partial evaluation intended.
The Netherlands	Y		Pilot and research
PERCENTAGE	45.0%		

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

3.7. HEALTH CARE USERS

3.7.1. Knowledge

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

STUDIES, SURVEYS OR PUBLICATIONS	PEOPLE KNOW THAT HHAC CAN BE DANGEROUS TO THEIR HEALTH		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Catalonia (Spain)	Y	2003	People does not know the limits. Not published.
Croatia	N		
Cyprus	N		
Czech Republic	Y	2010	Respondents underestimate harmful effects. Eurobarometer 2010.
England (UK)	Y	2003	Low knowledge. This was referred to in recent House of Commons Science Technology committee. A published review of sensible drinking guidelines in Feb 2012. The recommendations was to send out to an Expert Committee. Minister's Strategy Unit, Cabinet Office Alcohol Project (2003): Interim Analytical Report.Cabinet Office, London, UK
Estonia	Y		Not published.
Finland	N		
FYROM	N		
Germany	Not available		
Greece	N		
Iceland	N		
Ireland	Y	2012	In general, there is good knowledge about the common diseases associated with alcohol consumption such as its effects on the liver, pancreas and blood pressure. Knowledge about the association with breast cancer and bowel cancer is less well understood. There are mistaken beliefs about its association with stomach ulcers and to a lesser extent, skin cancer. Health Research Board (2012) Alcohol: Public Knowledge, Attitudes and Behaviours available at: http://www.hrb.ie/uploads/tx_hrbpublications/Alcohol_-_Public_Knowledge_Attitudes_and_Behaviours_Report.pdf
Italy	Y	2010	High level of risk awareness for liver diseases, lower for heart disease, depression, risk of birth defects and cancer. Eurobarometer 2010
Latvia	N		
Malta	N		
Poland	N		
Portugal	N		
Romania	N		
Slovenia	Y	2006	96% of patients are aware that HHAC is risky for their health. SIMONIČ R. Osveščenost odrasle populacije o učinkih uživanja alkohola na telesno zdravje ter poznavanje sodobnih meril za tvegano pitje; specialistična naloga (Awareness of adult population of the effects of alcohol drinking on health and knowledge on low risk drinking limits). Ljubljana: Medicinska fakulteta, 2010
Sweden	Y	2006 2009	High awareness of social consequences, low on cancer association. Eurobarometer 2006, 2009.
Switzerland	Not available		
The Netherlands	N		
PERCENTAGE	38.1%		

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

3.7.2. Help seeking behavior

In this section a summary of the main findings reported on studies about people knowledge on help seeking methods to reduce HHAC is provided in the tables.

STUDIES, SURVEYS OR PUBLICATIONS	PEOPLE KNOW ABOUT EFFECTIVE METHODS TO REDUCE HHAC		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Catalonia (Spain)	N		
Croatia	N		
Cyprus	N		
Czech Republic	N		
England	Y	2004	Little awareness. Prime Minister's Strategy Unit, Cabinet Office Alcohol Harm Reduction Strategy for England (2004). Cabinet Office, London, UK
Estonia	N		
Finland	N		
FYROM	N		
Germany	Not available		
Greece	N		
Iceland	N		
Ireland	Not available		
Italy	N		
Latvia	N		
Malta	N		
Poland	N		
Portugal	N		
Romania	N		
Slovenia	N		
Sweden	N		
Switzerland	Not available		
The Netherlands	N		
PERCENTAGE	5.0%		

Figure 32. Studies, surveys or publications in PHC about effective methods to reduce HHAC

STUDIES, SURVEYS OR PUBLICATIONS	PROVIDE INFORMATION ON THE PROPORTION OF HHAC USERS WHO HAVE EVER USED ONE METHODS* TO REDUCE ALCOHOL CONSUMPTION		
	Y/N	YEAR	MAIN FINDINGS - REFERENCE
Belgium	N		
Catalonia (Spain)	N		
Croatia	Not available		
Cyprus	N		
Czech Republic	N		
England (UK)	N		
Estonia	N		
Finland	N		
FYROM	N		
Germany	Not available		
Greece	N		
Iceland	N		
Ireland	N		
Italy	Y	2012	Help from self help groups: Carlesso L et al (Ed.). La banca dati dei Club Alcologici Territoriali in Italia, Anno 2010. Associazione Italiana dei Club Alcologici territoriali (AICAT); 2012.
Latvia	N		
Malta	N		
Poland	N		
Portugal	Y		Help from a doctor are effective. See the Alcohol Directory collecting studies related to those aspects at: http://directorioalcool.pt/Paginas/HomePage.aspx
Romania	N		
Slovenia	Y		Help from the internet: not published yet.
Sweden	N		Forthcomning not yet published manuscript on The SPIRA Study. Silfversparre, Bendtsen, Fornazar, Spak.
Switzerland	Y		-From a specialist clinic: Siehe Alkoholismus Therapieforschung Schweiz atf Schweiz – Forschungsverbund der Forel Klinik und Klinik Südhang. Laufende Projekte:http://www.atf-schweiz.ch/forschung/aktuelle_projekte.htm abgeschlossenen Projekte:http://www.atf-schweiz.ch/forschung/abgeschlossene_projekte.htm Publikationen:http://www.atf-schweiz.ch/forschung/forschungs_publikationen.htm -Help from willpower alone: Selbstheilung von der Sucht von Harald Klingemann und Linda Sobell von VS Verlag für Sozialwissenschaften (Taschenbuch - 13. Juni 2006).
The Netherlands	Y		-Help from the internet: www.brijder.nl -Help from specialist clinics: www.brijder.nl
PERCENTAGE	23.8%		

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

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

4. CONCLUSIONS

Baseline measurement of services for managing hazardous and harmful alcohol consumption

PRESENCE OF A COUNTRY/REGIONAL COALITION OR PARTNERSHIP

- In 2012, most of the countries (78.3%) have a country and/or regional coalition for the management of HHAC.

COMMUNITY ACTION MEDICA AND EDUCATION

- 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.

HEALTH CARE INFRASTRUCTURES

Integrated health care system

- 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. Only 47.8% of the countries (11 out of 23) 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).

Structures for quality of care

- 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%).

Research and knowledge for health

- In 2012, nearby 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, (particularly for pharmacists and dentists) in all the educational levels, with great differences among countries. There is a tendency for most of the professionals (but not for dentists, obstetricians and pharmacists) to have more formal education on the managing of HHAC in the curriculum of postgraduate and continuing professional training compared to the undergraduate curriculum.

Health care policies and strategies for dissemination and implementation of the management of HHAC

- In 2012, 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%, a strategy to support interventions in primary care in 68.4%, while a national funded research strategy is included only in nearby 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).

Funding health services and allocating resources

- 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.

SUPPORT FOR TREATMENT PROVISION

Screening, quality assessment, referral and follow-up systems

- In 56.5% of the countries (13 out of 23) screening instruments to identify at risk drinkers 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%) a follow up system for monitoring and advice patients is considered available and pointed over the average of 4.1 points.

Protocols and guidelines

- Nearby three out of four of the countries have already developed, or are developing, multidisciplinary guidelines for managing HHAC (73.9%). 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.

Reinbursement for health care providers

- About 40% of addition 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.

Protocol, policies and training for professionals

- In most of the countries there are specialized guidelines or protocols for managing HHAC for addiction specialists (81.8%), general practitioners (65.2%), psychiatrists (59.1%), doctors in hospital (55.0%) and psychologists (50.0%). 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 and psychiatrists.

INTERVENTION AND TREATMENT

Availability and accessibility

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

HEALTH CARE PROVIDERS

Clinical accountability

- Participants considered that addiction specialists and psychiatrists consider advices for HHAC part of their routine clinical practice, but not pharmacists and dentists.

Treatment provision

- Regarding treatment provision in primary care, there are many studies, surveys or

publications on patients screened about alcohol consumption (in 73.9% of the countries) followed by studies on the use of AUDIT questionnaire, on the attitudes of health care providers to managing HHAC, and on patients with HHAC are given advice and on (52.4%, 50.0% and 50% respectively), on increasing the involvement of health care providers in managing HHAC (45%), on the effectiveness of interventions for HHAC (36.8%) and on practice protocols and guidelines followed (27.8%). Few studies, survey or publications have been carried out on advice meets quality criteria (15.8%) and on cost-effectiveness of interventions for HHAC (10.5%).

HEALTH CARE USERS

Knowledge

- Studies, surveys or publications on people knowledge that HHAC can be dangerous to their health are referred in 38.1% of the countries.

Help seeking behavior

- Studies on people knowledge about effective methods to reduce HHAC are not available.

5. DISCUSSION and RECOMMENDATIONS

The aim of the assesment tool was to develop and test a comprehensive standard format to be used for the evaluation of the availability of services devoted to the management of hazardous and harmful alcohol consumption at the country and/or regional level.

The experience of the ODHIN project gave the opportunity to look at the assessment tool as a feasable way to document the current situation across Europe, contributing to identify existing gaps or areas that need further work and strengthening at the country/regional level.

The tool has demonstrated to be useful in contributing to:

- providing a baseline description of available services and infrastructures for managing hazardous and harmful alcohol consumption, identifying areas where services may require development or strengthening;
- providing a general view on the existing gaps or areas that need further work and strengthening.
- providing a mechanism for future monitoring services provision over time;
- solicit sharing of information and examples of practice;
- solicit partnerships and/or national/regional coalition to reach a consensus on a shared view on services for managing hazardous and harmful alcohol consumption.

The ODHIN assessment tool was an excellent example of networking by sharing and collaborating into the alcohol field between countries and within each country at territorial level: This activity was very successful in involving scientists to voluntarily contribute to the report and participate in the consensus building around the assessment tool: a contact with the project leaders of selected EU Projects and Networks on alcohol such as AMPHORA, PHEPA II, VINTAGE and with WHO national counterparts and/or the contact details of national experts of the CNAPA meetings (Committee on National Alcohol Policy and Action) has been activated in order to involve more European countries other than the ODHIN partners and contribute to improve the results. This activity allowed us to add and share information from other 14 countries in addition to the 9 originally involved in the ODHIN project.

Nonetheless, some points need further development to increase the validity and the comparability of the results taking into consideration that some answers relying on personal opinions and professional experiences. Since, within countries the knowledge of the available services can vary according to the respondents completing the questionnaire, the setting of a core panel of representatives from the different professional areas that should contribute in a much more comprehensive way to the assessment tool fulfillment could be recommended. The creation of a formal and stable panel of experts within countries would ease the reach of a best fitting and grounded consensus on those questions that can't been supported by an objective indicator. In any case, it is important to say that for some questions, objective information could be added to the original form also according to some local needs to obtain the monitoring of specific situations related with the management of HHAC.

The ODHIN assessment tool shows that, in 2012, EIBI is still not the norm in daily consultation in PHC and that more resources are needed to overcome the main obstacles.

Particularly, the ODHIN assessment tool results and evaluation ask for some priorities to be integrated in the national and regional systems for HHAC management:

- there is the need for a formal partnership or coalition involved into an infrastructure or a panel of experts supporting the analysis of the ongoing situation at the national/regional level and contributing to possible improvement of availability and management of HHAC
- the integration of the management of HHAC in the health care system should be supported assuring that treatment is offered to those that need it, hopefully widening the availability of existing treatments;

- the implementation of a communication and information strategy about health and social alcohol impact should be ensured, including a major effort to provide a formal, mandatory continuing training and medical education aimed at integrating early detection and brief intervention in the daily practice of health professionals in the Primary Health Care settings . Public funding should be allocated for that purpose;
- formal educational programs on managing HHAC for all health care professionals should be provided, taking into consideration that training levels are low in most of the EU countries and mostly not available for some professionals such as dentists, obstetricians and pharmacists;
- the written policies should ensure the availability of a well identified national health plan on alcohol aimed at prevention of alcohol use disorders and alcohol dependence involving health professionals and scientific societies and advisors for the specific guidelines to be provided for the general population and the high risk population targets
- there is a need to include in the written policies a research funded strategy and/or formal research programs on HHAC with targeted allocated funded activities that are currently lacking or missed in nearby half of the countries;
- guidelines and protocols should be made widely available for health professionals taking into consideration different target groups, gender and age approaches and focusing on clinical settings and general population settings as well;
- studies about the adherence and implementation of the clinical guidelines for the managing of HHAC should be carried out.
- there is a need to develop tools and structures for reviewing the cost effectiveness of interventions for managing HHAC mainly focused in monitoring health care users needs and what health care providers are delivering
- specific studies should be developed and periodically performed mainly aimed at the check of the quality of the advice and on the cost-effectiveness of interventions for HHAC. These studies should be integrated by yearly evaluation surveys and reports on the activities by health care providers aimed at collecting information about the management of HHAC and on the evaluation of the health professionals who receive specific training on HHAC management
- specific activities should be devoted to the dissemination of available sources of knowledge, research results and information to health care providers togeteher with the provision of materials and incentive measures aimed at ensuring that prevention, early detection and brief intervention, is implemented in PHC and supported by specialist services according to a real networking of the available services and competencies.

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