ODHIN PROJECT FACTSHEET

- WP6 –

ODHIN ASSESSMENT TOOL REPORT.

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

Key facts

Fact 1 – The ODHIN assessment tool is an instrument to be used worldwide to assess the delivery and implementation of Early Identification and Brief Intervention programmes and it is an excellent example of networking by sharing and collaborating into the alcohol field between countries and within each country at territorial level.

- It is a feasible way to document the current situation across Europe, contributing to provide a baseline description of available services and infrastructures for managing HHAC, 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 HHAC.

Fact 2 – The ODHIN assessment tool results ask for some priorities to be integrated in the national/regional systems for HHAC management:

- The presence of a formal partnership/coalition/or a panel of experts at national/regional level supporting, and contributing to improve, the availability and management of HHAC;
- A communication and information strategy on health and social alcohol impact should be ensured, including formal, mandatory continuing training and medical education aimed at integrating EIBI in the daily practice of health professionals in the Primary Health Care settings, assuring that treatment is offered to those that need it;

  Written policies should ensure the availability of a national health plan on alcohol aimed at prevention of alcohol use disorders and alcohol dependence, including research funded strategy and/or formal research

Background

Early Identification and Brief Intervention (EIBI) for Hazardous and Harmful Alcohol Consumption in Primary Health Care (PHC) is an opportunity to communicate to patients the risks and propose ways of alcohol 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 (Kaner E, 2007). 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. Thus, the challenge is to integrate these interventions into professionals' daily clinical work. According to the World Health Organization (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 health¬care sector response to alcohol-related problems, with particular emphasis on PHC interventions. In the Framework of the ODHIN, an assessment tool to test the implementation and the extent of EIBIs for HHAC throughout PHC settings has been developed.

Methodology of work

The ODHIN assessment tool is an adaptation of a tool to assess the services for the management of HHAC in PHC, developed by P. Anderson in 2004 with the partners of the Primary Health Care European Project on Alcohol) (PHEPA, 2004). The “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 EIBI programmes for HHAC in order to provide recommendations to improve and optimize delivery of health care interventions.

Particularly, the questionnaire 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 “assessment tool” team includes 15 European 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 (AMPHORA, PHEPA II, VINTAGE, WHO national counterparts and CNAPA-Committee on National Alcohol Policy and Action experts) to involve other European countries other than the ODHIN partners, contributing to improve the results. Thus, other 14 European countries (and nearby 20 scientists) (Belgium, Cyprus, Croatia, Estonia, Germany, Latvia, Malta, Switzerland, Greece, Finland, Ireland, Iceland, Romania, and FYROM -Ex Macedonia) shared their experience with the ODHIN collaborating countries reaching a total of 23 European countries with collected data.

The tool includes 24 questions distributed across 7 key sections, covering the following topics:

1. Presence of a country coalition or partnership.

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

Results

1. 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.

2. COMMUNITY ACTION MEDICA AND EDUCATION

- Implemented media education campaigns on alcohol consumption are not widely available, or not reported. The most common available education campaigns are reported on the website followed by newspaper/magazines and radio, and they are generally fully publicly funded and implemented at country level.

3. HEALTH CARE INFRASTRUCTURES

Integrated health care system

- According to personal opinions, in most of the countries the integration of the management of HHAC in PHC 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

- Nearby half of the countries have a formal research programme for managing HHAC with specifically allocated funding (43.5%) during the last 10 years, at least in part, from governmental organizations.

- There is a lack of formal education on managing HHAC for health care professionals in all the educational levels (particularly for pharmacists and dentists), 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 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 most of the countries (82.6%) there is government funding for services for the management of HHAC, 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.

4. SUPPORT FOR TREATMENT PROVISION

Screening, quality assessment, referral and follow-up systems

- In 56.5% of the countries screening instruments to identify risky drinkers are considered available and pointed over the average of 6.4 points (in a scale from 0 to 10), while only in 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.

Reimbursement for health care providers

- The most common practice is reimbursement as a part of their normal salary as opposed to “within terms of service”.

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%).
- Training for managing HHAC within professional vocational training is available in most of the countries and for different professionals (still uncommon for obstetricians, pharmacists and dentists). 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 the majority of the professionals.

5. 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.

6. 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 PHC, there are many studies 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%).

7. HEALTH CARE USERS

Knowledge and Help seeking behaviour

- Studies on people knowledge that HHAC can be dangerous to their health are referred in 38.1% of the countries, while on people knowledge about effective methods to reduce HHAC are not available.

Conclusions for Policy and Research

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 HHAC at the country and/or regional level.

The tool has demonstrated to be useful in contributing to:

- Providing a baseline description of available services and infrastructures for managing HHAC, identifying areas where services may require development or strengthening;
- Providing a general view on the existing gaps/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 HHAC.

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; the activity was successful in involving additional scientists to voluntarily contribute to the report and participate in the consensus building around the assessment tool other than the 9 originally involved in the ODHIN project.

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 results and evaluation ask for some priorities to be integrated in the national and regional systems for HHAC management:

- The presence of a formal partnership or coalition at the national/regional level contributing to the availability and management of HHAC;
- The integration of the management of HHAC in the health care system 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, including a major effort to provide a formal, mandatory continuing training and medical education aimed at integrating EIBI in the daily practice of health professionals in the PHC settings with public allocated funding;
- Formal educational programs on managing HHAC for health care professionals, being the training levels low in most of the countries and not available for some professionals;
- The availability of a well identified national health plan on alcohol aimed at prevention of alcohol use disorders and alcohol dependence and of a research funded strategy and/or formal research programs on HHAC with targeted allocated funded activities included in a written policies;
- The availability of guidelines and protocols for health professionals for different target groups and settings;
- Studies on the adherence and implementation of the clinical guidelines for managing HHAC;
- 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 to check the quality of the advice and the cost-effectiveness of interventions for HHAC 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;
- 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, EIBI is implemented in PHC and supported by specialist services according to a real networking of the available services and competencies.

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