Chapter 5

Guidelines to support early identification and brief intervention for alcohol use disorders in Europe

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Nearly 74% of Europeans aged ≥15 years drink alcoholic beverages. It has been estimated that 58 million Europeans (15%) are hazardous drinkers, and 23 million are alcohol dependent (5% of men, 1% of women) [1]. Hazardous drinkers in particular are often unaware of being at risk of health and social harm. They are the prime target group for an intervention termed "brief", defined by the World Health Organization (WHO) as a practice aimed at early identification of hazardous alcohol consumption habits and alcohol-related problems and at motivating the individual towards change [2].

> ***Brief interventions*** *are short educational sessions and counselling (varying from 5 to 30/40 minutes and from a single session to multiple sessions). While inspired by the principles of motivational interviewing, "brief intervention" is actually a general term for a wide range of interventions, which have basically two common characteristics: they are interventions at the community level, 1. provided by non-specialist professionals (general practitioners and other primary health care professionals such as hospital doctors, nurses, social workers, criminal justice officers and others); and 2. targeted to persons with hazardous or harmful alcohol consumption, who nevertheless do not seek treatment for alcohol use disorders. Brief intervention aims to motivate the person to change their behavior, exploring with the health professional the underlying reasons for alcohol consumption and identifying concrete reasons for change. The intervention is a way to make the patient aware of possible conflicts and ambiguity, and to facilitate a clearer view, enabling them to decide autonomously that it is time to solve the dilemma.*

There is substantial evidence that Early Identification and Brief Interventions (EIBI) for Hazardous and Harmful Alcohol Consumption (HHAC) by health professionals in Primary Health Care (PHC) are effective in preventing future alcohol related diseases. The WHO encourages in the global alcohol strategy the widespread implementation of EIBI for HHAC and their integration in the routine practice of primary health care professionals [3].

It is extremely important that the individuals who have not yet developed an alcohol dependence can reduce or stop drinking receive adequate care and suitable support to prevent the onset of serious alcohol use disorders. Once the addiction has been established, change in alcohol consumption habits is more difficult and may require specialist treatment [2].

> *The term* ***Alcohol Use Disorders (AUDs)*** *refers to the varying consequences and complications caused by and related to episodic or prolonged alcohol consumption, being a broader concept than alcohol dependence. The conceptual model of AUDs has evolved over the years, passing from the dichotomy normality-alcoholism to a spectrum of alcohol-related problems ranging from low-risk consumption, to hazardous and harmful consumption and finally to alcohol dependence. The three main categories relevant for response in health services are hazardous drinking, harmful drinking and alcohol dependence. Hazardous drinking is an important concept for EIBI, although not included in WHO's International Classification of Diseases (ICD-10). [4]*

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Hazardous drinking
Level of consumption or pattern of drinking that, in the case of persistence of these habits, can cause damage to health, physical or mental.

Harmful drinking
Pattern of consumption that causes damage to health, either physical (e.g. liver cirrhosis) or mental (e.g. depression) and may be a factor in other health problems.

Alcohol dependence
A set of physiological, behavioral and cognitive phenomena, in which the consumption of alcohol has for the individual a growing priority over habits that previously had a greater value and that are progressively abandoned. Central features include a strong desire to drink, difficulty to control the level of alcohol intake despite awareness of harmful consequences, increased tolerance and physical withdrawal symptoms after stopping or reducing drinking.

Various tools are available to help identify patients who might benefit from brief intervention.

Standardized screening tests for the identification of hazardous or harmful alcohol consumption and alcohol dependence include AUDIT, AUDIT-C, CAGE and FAST. These can be used for patient interview or as self-completion questionnaires, in print or electronically, with a limited number of questions that can be answered in a few minutes.

The Alcohol Use Disorders Identification Test (AUDIT), developed by the WHO, is the most widely used screening instrument. It includes, in its integral form, 10 questions on alcohol consumption and various indications of harm, linked with a scoring which ranges from low risk from alcohol consumption, through hazardous high risk consumption to harmful consumption and, at highest points, to likely presence of alcohol dependence.

AUDIT-C is a quick test made up of the first three questions of the Alcohol Use Disorders Identification Test (AUDIT) which takes into account both the quantity of alcohol consumption and the frequency of drinking episodes.

1. *How often do you have a drink containing alcohol?*
   - *Never (0 points)*
   - *Monthly or less than monthly (1 point)*
   - *2 - 4 times/month (2 points)*
   - *2 - 3 times/week (3 points)*
   - *4 or more times a week (4 points)*

2. *How many (standard) drinks containing alcohol do you have on a typical day drinking?*
   - *1 o 2 (0 points)*
   - *3 o 4 (1 point)*
   - *5 o 6 (2 points)*
   - *7 o 9 (3 points)*
   - *10 or more (4 points)*

3. *How often do you have six or more (standard) drinks on one occasion?*
   - *Never (0 points)*
   - *Less than monthly (1 point)*
   - *Monthly (2 points)*
   - *Weekly (3 points)*
   - *Daily or almost daily (4 points)*

Score <=5 for men and <= 4 for women: alcohol consumption at lower risk level.
Score ≥ 5 for men and ≥ 4 for women: high risk alcohol consumption.

There is convincing evidence across various PHC settings [5,6,7] that EIBI significantly reduces the consumption of alcohol, even taking into account the variability of efficacy depending on variables such as the following:

- Study population (gender, age, the amount of alcohol consumed, the inclusion or not of subjects with heavy episodic drinking (binge drinking) and alcohol dependence, the characteristics of the controls, etc.);
- Settings (general medicine, inpatient care, first aid and emergency services, occupational medicine);
- Duration and type of intervention;
- Profession and training of health operators carrying out EIBI (doctors, other professionals);
- Outcome indicators (the amount of alcohol consumed, frequency, intensity, blood chemistry markers, quality of life, economic measures such as the use of health services, etc.);
- Theoretical basis of the brief intervention, the use (or not) of brochure or other printed information on alcohol and alcohol-related problems.

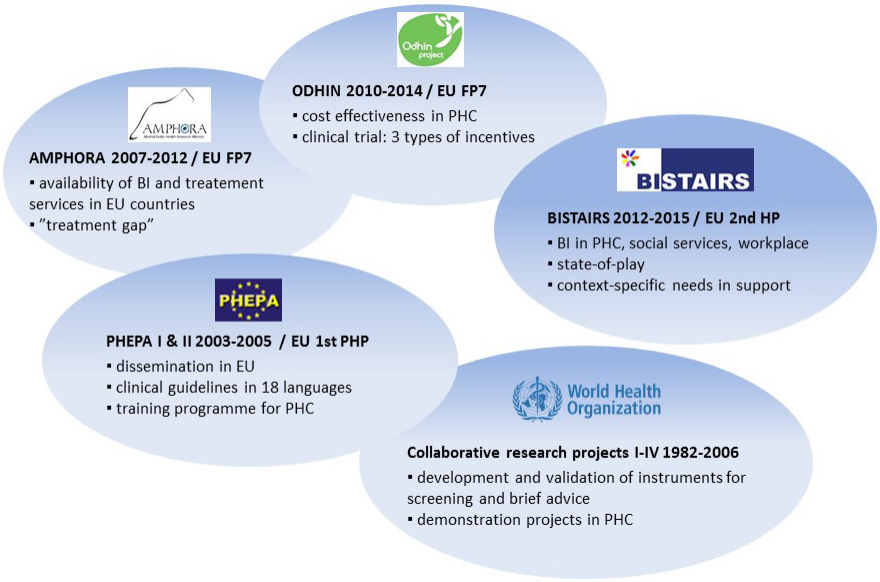
Despite the proven effectiveness of EIBI on HHAC in PHC, it has not yet been adopted as part of routine practice across services. Further efforts are needed to reduce the gap between patients at risk who need advice and motivation to reduce drinking and those who receive brief interventions.

WHO and EU projects to develop methodology and enhance implementation

EIBI for HHAC was introduced in PHC by the WHO Collaborative research project on identification and management of alcohol-related problems in 1982, focussed on developing a scientific basis and methods for screening and brief intervention in primary care settings. This initiative concluded with a Phase IV international project focussed on implementation and involving several European countries. Work to support implementation continued in the early 2000s under the EU Health programme in the Primary Health Care European Project on Alcohol (PHEPA).[8,9].

Further EU projects have taken forward the development of EIBI methodology and implementation, such as AMPHORA (Alcohol Ppublic Health Research Alliance), ODHIN (Optimizing Delivery of Health Care Interventions) and BISTAIRS (Brief Interventions in the Treatment of Alcohol use disorders In Relevant Settings) (Graph 1).[10,11,12].

Graph 1. WHO and EU projects to develop EIBI methodology and implementation



Identification of barriers and facilitators is the first step towards developing optimal methods for implementation. Project AMPHORA explored knowledge, attitudes and perceptions of general practitioners on EIBI and AUDs, and identified time constraints and lack of training as the main barriers for screening and brief alcohol interventions in PHC. Project ODHIN provided an assessment tool (adapted from a tool developed in 2004 in the PHEPA project) as an instrument for mapping the services and infrastructure available for the management of HHAC and for identifying areas that need further development and strengthening [13].

Based on work done in ODHIN, the following components are among priorities for national and regional systems for the management of HHAC:

- A coalition/partnership to reach a shared vision and to support activities for the prevention, diagnosis, treatment and rehabilitation of AUDs.
- A communication/information strategy on the health and social impact of alcohol, including continuous mandatory training of professionals in health and social settings aimed at integrating EIBI into routine daily practice, ensuring that treatment is offered to all those in need.
- The existence (or strengthening) of a National Health Plan on alcohol and of written policies for the prevention of alcohol-related disorders and of alcohol dependence.
- A mechanism for monitoring and evaluation of the provision of EIBI, including research projects (cost-effectiveness, fidelity, quality of advice, evaluation surveys, performance records, etc.), availability of guidelines and protocols.
- Specific activities to disseminate available sources of knowledge, research results and information to health care providers, along with the provision of materials and tools and the use of incentive measures aimed at ensuring that prevention and EIBI are implemented in PHC and supported by specialist services, capitalizing on the networking of available servicers and competencies.

Project BISTAIRS aimed to enhance the implementation of EIBI and promote it in medical and non-medical settings beyond PHC. The BISTAIRS guidelines summarized below are based on scientific literature reviews and on the opinions of a wide range of European experts on the implementation of EIBI in different settings [6-7, 14].

Primary health care

The scientific literature reviewed by BISTAIRS project suggests that EIBI should be made available to all adults at the time of a new patient registration in PHC, as well as to adults with high blood pressure, and to males aged between 45 and 64 years. PHC providers, in particular general practitioners should be involved in all EIBI components (screening, brief intervention, support, referral) as well as other health care professionals, especially nurses and alcohol specialists.

Emergency services

In the emergency services and first aid, the scientific literature suggests (albeit the evidence is not always consistent or conclusive) to provide EIBI to all adults (> 18 years) attending emergency services due to injury at least a leaflet/brochure informing on hazardous and harmful alcohol consumption according to national guidelines. Emergency physicians and health care providers of specialist alcohol services should be involved in all components of EIBI (screening, brief intervention, support, referral), while nurses may be involved in screening and brief advice/intervention provided in the emergency setting.

Workplace settings

For workplaces, the scientific literature suggests (although the evidence is not always consistent or conclusive) that occupational physicians should provide EIBI to all adult workers as part of voluntary health checks using the AUDIT-C and brief intervention materials based on national guidelines. Specific attention should be given to adults with high blood pressure and to males aged 45-64 years. To avoid stigma, it is recommended to integrate EIBI into a wider health promotion and wellness programme in the workplace which includes other lifestyle factors, and to include screening of alcohol consumption in

standard routine health assessments. Further components for successful implementation include fostering a climate of trust which is non-judgmental and supportive, ensuring anonymity and confidentiality (providing anonymous service or referring employees to third parties), minimizing negative impact of treatment on career and promoting workplace policies that deal with alcohol-related problems like any other medical condition.

Social services

As regards social services, the evidence is too scarce for drawing a conclusion on whether EIBI programs are effective in people with hazardous and harmful alcohol consumption in these settings. For some, the EIBI approach could serve as a "door opener" leading to referral to specialized services. Adults (> 18 years) in contact with social services because of criminal offense, because of injuries and crimes linked with drink driving, or because of domestic violence should receive at least an information leaflet on HHAC based on national guidelines. Recommendations for implementation include: using a non-judgmental and emphatic attitude with the customer; ensuring confidentiality of the collected information; carrying out routine assessments so that customers know that everybody are asked about their alcohol consumption; assessing alcohol consumption as part of a broader risk evaluation, for example, talking about lifestyles in general; assuring customers their primary role in deciding about any future actions based on screening results; ensuring that social services staff are aware of the available service network; ensuring that for high-risk situations (e.g. alcohol consumption by parents or vulnerability of relatives involved) EIBI implementation does not compromise the professional/client relationship (possibly resulting in further damage).

There is evidence that success in the implementation of EIBI is related to practitioners' attitudes, and that these attitudes can be influenced by appropriate training and support [[5], [10-12]]. Needs for training and support in various settings, as identified in the BISTAIRS project, are summarized below.

Primary health care and emergency services

- Improving training and knowledge.
- Availability of screening tools and brief intervention techniques.
- A national strategy on alcohol sending clear, consistent and relevant messages about alcohol-related risks and about the need to reformulate alcohol issues closer to the concept of "hazardous consumption" than to "alcoholism" only.
- The development of different messages for different groups at risk, identifying and communicating the risks of alcohol consumption at various levels.
- Stressing the importance of EIBI and ensuring that specialized services and resources are sufficient to enable direct links between them and primary care facilities.

Workplace settings

- Training for employees, managers and supervisors on the prevention of AUDs including EIBI.
- Highlighting the benefits of alcohol consumption at lower risk for employees and employers.
- Providing evidence of effectiveness and cost-effectiveness of EIBI in this setting focusing on a positive return of investment for EIBI implementation.
- Structured and validated screening tools and brief intervention techniques adapted to the specific needs of the various working contexts and guidelines.
- Occupational and safety policies at work that include alcohol.
- Specific challenges arise from variation across Europe in the training of occupational physicians and from the lack of a clear definition of the role of the occupational physician in some countries both regarding health surveillance and regarding prevention. There is a need to promote continuing medical education programmes for occupational physicians.

Social services

- Appropriate training to improve the skills, experience and sense of role appropriateness on AUDs, and how to identify situations in which actions can be taken.

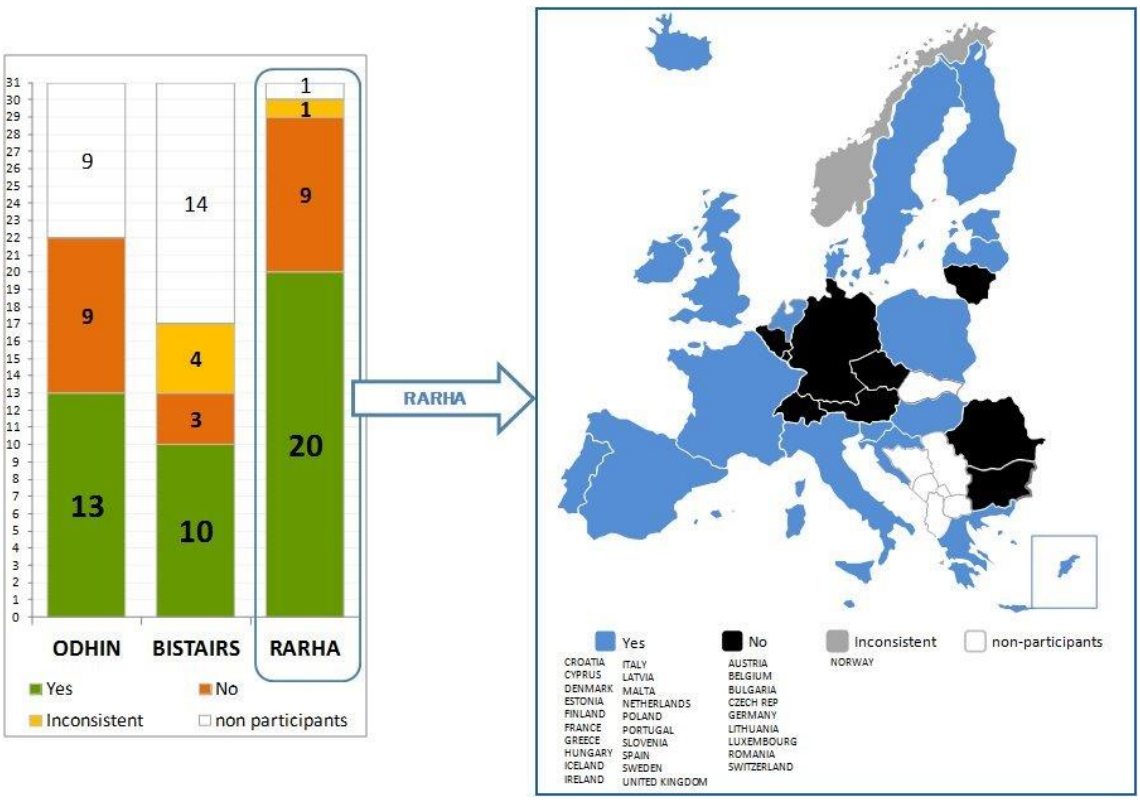
- Availability of EIBI tools and materials in these contexts, with flexible implementation in order to adapt to the needs of professionals and of the job.
- Official recognition of the role and responsibilities of social services operators for EIBI by the relevant ministries, agencies and professional organizations.
- Implementation of a national strategy on alcohol prevention activities in this setting.

RARHA survey on national guidance and support for Early Identification and Brief Intervention in health services in Europe

As part of Joint Action RARHA, information has been collected on the state of play regarding national guidance and support for the implementation of EIBI for HHAC in health services in EU Member States and RARHA partner countries. The information has been gathered by the Istituto Superiore di Sanità (ISS) in 2014 through an email questionnaire submitted to the members of the Committee on National Alcohol Policy and Action – CNAPA, as official representatives of 31 European countries [13]. The replies received from 30 countries[b] were compared with information previously gathered by the WHO and by various EIBI projects [14, 15, 16, 17].

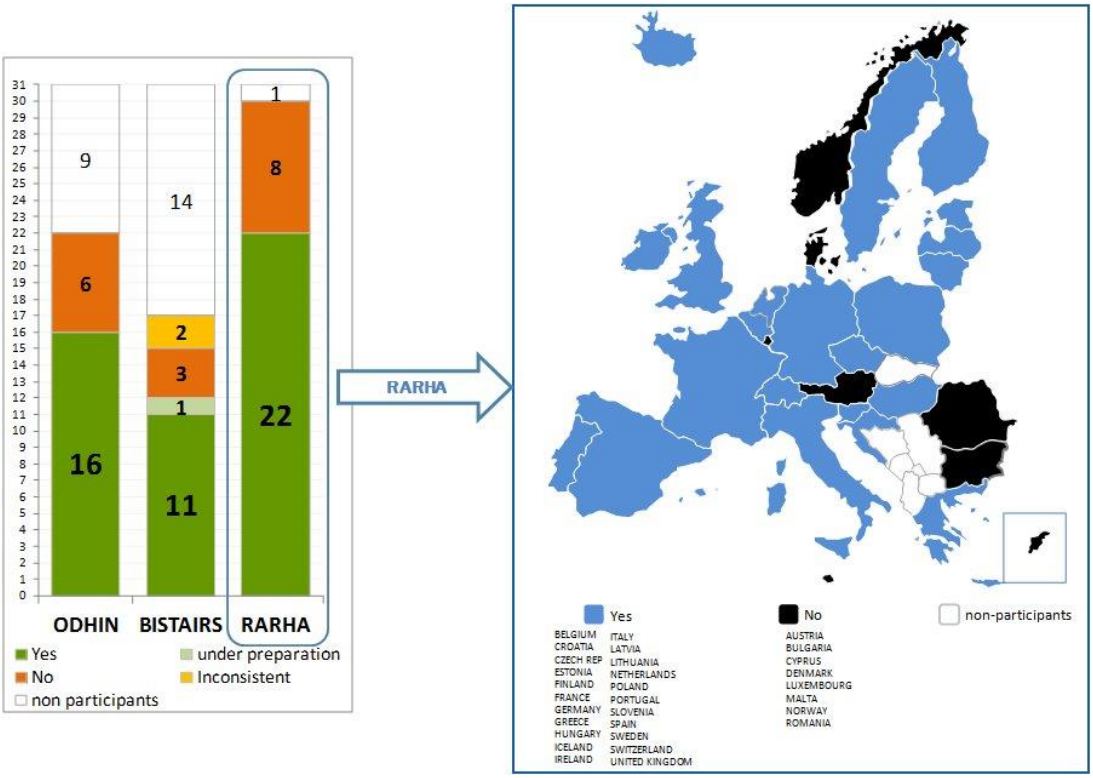
The results show widening availability of centralised support for the implementation of EIBI, with increase in recent years and in particular in comparison with the PHEPA survey in 2008. [17] (Figures 2-4). In 2014, an organization formally responsible for the development of clinical guidelines for managing HHAC existed in 20 of the 30 countries from which information was obtained. A large majority, 22, of the surveyed countries had multidisciplinary guidelines for managing HHAC. In 2008, such guidelines were in place in only 9 of the 14 countries surveyed in the PHEPA project. Guidelines or recommendations specific for brief intervention/ treatment were available in 22 countries in 2014, compared with 10 countries in 2008.

Graph 2. Presence of formal governmental organization (or similar) responsible for clinical guidelines for managing HHAC in Europe by country in 2014

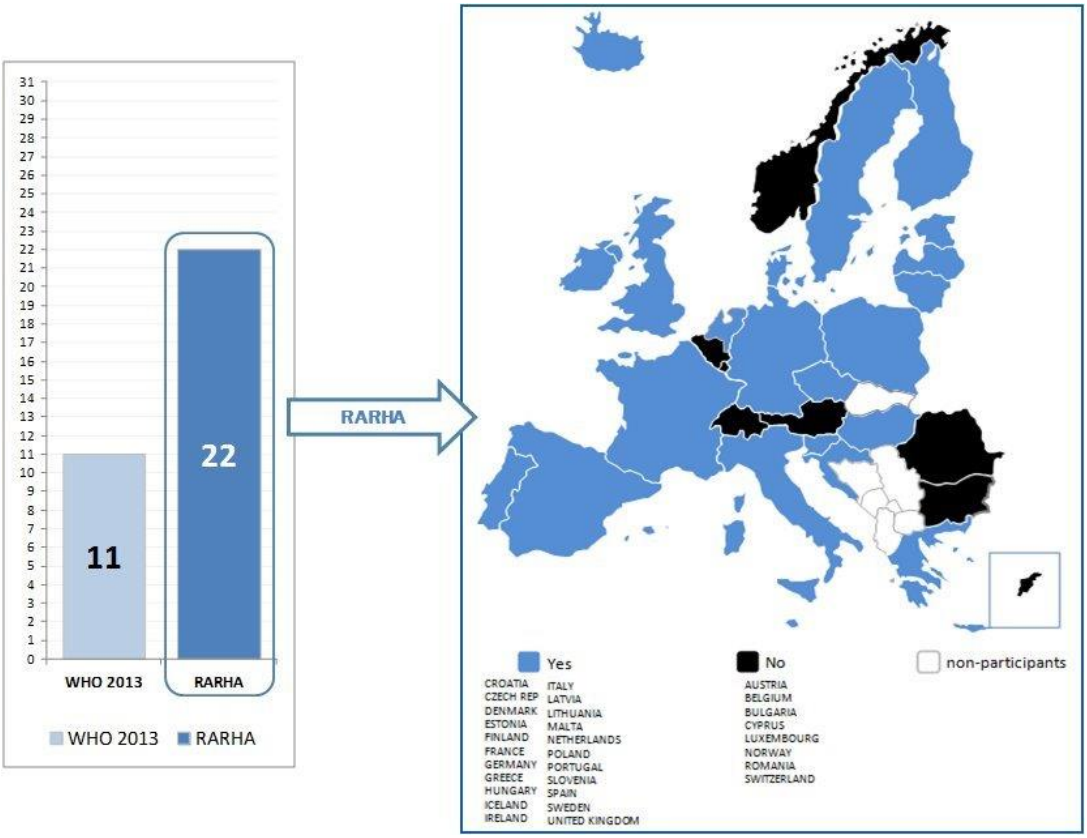


[b] Slovakia being the only country on which no information was obtained.

Graph 3. Presence of multidisciplinary guidelines for managing HHAC in Europe by country in 2014



Graph 4. Presence of guidelines or recommendations for brief intervention/treatment in Europe by country in 2014



Conclusions

Based on work already implemented by different European projects (particularly ODHIN and BISTAIRS) a RARHA survey was carried out on the availability of national guidance and support for early identification and brief intervention in EU countries [13]. This survey shows that in Europe the number of organizations formally appointed to develop clinical guidelines for managing HHAC has increased over time as well as the number of countries with multidisciplinary guidelines for managing HHAC. Thus, it is clear that the activities of the last 30 years supported by the WHO and European projects to enhance the implementation of EIBI have started to give positive results. Nevertheless, the integration of EIBI into routine clinical practice still needs to be actively supported. The present chapter summarizes background knowledge and instruments that can be used to activate national policies as well as national and international funding programmes for this purpose. Concrete examples of initiatives to implement and support EIBI are also provided by a tool kit of evidence-based good practices compiled in Joint Action RARHA [19].

An expected outcome in the action plan to reduce HHAC in the WHO's European Region in the years 2012–2020 is a progressive reduction in the gap between the number of people who would benefit from alcohol consumption advice to reduce or prevent harm and from engagement in social rehabilitation programs or treatment for AUDs, and the number who actually receive such advice or treatment [18].

The health sector and, through its support, the social welfare, education and workplace sectors have real opportunities to reap both health gains and financial savings through the widespread implementation of EIBI programmes, which have been shown to reduce ill health and premature death due to HHAC, and through the implementation of evidence-based treatment programmes for AUDs.

To achieve the goals of the WHO's global alcohol strategy and of the European action plan it will be crucial to shift the emphasis from the treatment of severe alcohol-related problems including alcohol dependence to the prevention, early identification and brief intervention for hazardous alcohol consumption [3,18]. Currently, work supported by the European Commission and others is ongoing under the leadership of the WHO to develop a training-for-trainers and brief interventions tool kit. The aim is to equip EIBI trainers and practitioners with key tools to develop training and delivery systems within PHC networks and to support European countries to develop and expand their capacity to deliver EIBI in PHC settings.[c]

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