Northern Dimension Partnership
in Public Health and Social Well-being

Early Identification and Brief Intervention on hazardous and harmful alcohol consumption in the Baltic Sea Region

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Background

Early identification and brief intervention (EIBI) of hazardous and harmful alcohol use is a method designed for the health care sector, for example primary care. It is not intended for treating addictions but for preventing them.

The "alcohol EIBI" usually includes an Alcohol Use Disorders Identification Test (AUDIT) questionnaire developed by the WHO to screen and identify people with risky drinking patterns. In cases where such consumption is detected, the doctor/nurse gives the patient brief counselling on the health gains of cutting down alcohol consumption.

EIBI is an evidence based and effective preventive method directed towards the adult population. The "number needed to treat" (NNT) is the number of patients that has to receive treatment in order to save one patient from ill-health. It has been shown that for treatment of moderately elevated blood pressure, 167 patients must be treated for five years in order to prevent one stroke. After advice on tobacco use by health care personnel, one in 20 quit smoking. In the case of brief advice on alcohol, one in eight risk consumers decrease their consumption to safe levels. Accordingly, the cost to the health sector to prevent one year of disease or one premature death from alcohol has been estimated to 1/16th of the average medical treatment. Moreover, research shows that patients feel positively towards being asked about their alcohol habits by their doctor, especially in connection to health disorders.

This fact sheet stems from a short questionnaire, which was prepared and disseminated to contact persons in SIHLWA during the summer of 2009. Responses came from Finland, Latvia, Lithuania, Norway, Northwest Russia, Poland, and Sweden. The questionnaires were studied and a summary prepared.

Image: photos.com

The method and its present use

The extent of EIBI implementation varies greatly in the studied countries and seems to shorten eastwards; from multi-decade experiences in Norway, Sweden and Finland to the first probing steps in the Baltic States and Northwest Russia. The context in which EIBI was piloted also varies, from regional and national programmes and projects with support from national and local governments to international projects with special project funding.

Some elements of the training content may vary from country to country, or even from area to area within one country, depending on local contexts and conditions. Motivational Interviewing (MI) is becoming central in the training, particularly in Sweden. Some countries have prepared nationwide EIBI training programmes to educate all Primary Health Care workers.

Comprehensive evaluations of the method have so far only been conducted in Sweden and Finland. Both evaluations underline that attitudes of healthcare staff, the key implementers of alcohol EIBI, change slowly with time and is often initially associated with scepticism and preconceived opinions. It is evident that the fear of talking about alcohol is dependent on the cultural context in which the implementation is to take place. Common challenges are:

- Opposition towards systematic screening, with preference given to opportunistic screening and advice (although even in cases where drinking pattern was an apparent factor behind the patient's disorder, 30% of Swedish doctors/nurses admitted not having asked about it).
- Believed lack of time to perform EIBI.
- Believed lack of competence to do EIBI.
- Disbelief towards EIBI effectiveness.

As EIBI implementation often faces difficulties in Primary Health Care, wider approaches are being looked at. The experiences of the seven countries in this study show that EIBI is targeted at: family doctors and nurses, general practitioners, by doctors or nurses in occupational health care, maternity care, and child health care. Some countries report experimenting with EIBI in inpatient settings, primarily where hospitalization could result from alcohol misuse. An option expressed by some countries was to explore the use of alcohol EIBI in the social services. However, no country in the study has yet implemented EIBI in social services.

Experience from some countries has shown that using doctors as trainers is essential to overcome the reluctance to the method that is expressed by many doctors. The "training of trainers" within the medical profession is a particular success factor. Availability of materials, both for patients and healthcare professionals, is a must. Lastly, support to EIBI from administrators increases chances for successful EIBI implementation in the health care institutions.

The future

As health professionals sometimes/often feel reluctant to carry out EIBI as part of their practise, alternate ways to encourage healthcare workers to incorporate the procedure in everyday work should be explored. Analysis of the studied countries' approaches reveals a broad set of incentives, from extra-pays for preventive sessions to training and provision of materials. However, the conventional approach is that alcohol screening and brief advice are part of salaries, an approach which may also improve chances of long term results after external funding has been withdrawn.

A model of EIBI implementation

From the experiences expressed by the seven participating countries, particularly those with long-running experiences of alcohol EIBI implementation, we identified eight prerequisites for a successful EIBI implementation:

1. Official alcohol programmes and alcohol-related harm reduction plans, stating firm support from national and local governments.
2. National implementation, as opposed to regional or local, and large resources until the method is fully established.
3. Training of healthcare workers, free of charge, accessible and flexible to meet time constraints, and availability of printed material for both health care staff and patients.
4. Establishment of alliances (governmental-municipal-research-professional-mass media-NGOs). The Finnish arm of the PHEPA project serves as a good example, where the established alliance included the national government (represented by the Ministry of Social Affairs and Health), the National Research and Development Centre for Welfare and Health (as a research institute and administrator of the activity), National Medical Societies of Addiction Medicine and Alcohol Researchers (as training facilitators), municipality of Tampere City (Tampere health care centre as a site for a demonstration project), and the Tampere Temperance Movement (third sector and communications with local mass media).
5. Research on the EIBI concept in order to provide more evidence of medical effectiveness and cost-effectiveness in different settings and cultures.
6. Media campaigns can be helpful to improve problem awareness and possible solutions.
7. Patience and persistence - results do not come tomorrow.
8. As is true for all prevention work, EIBI is part of a holistic alcohol policy where other elements such as regulations and restrictions should be present.

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The responsibility for the content of this fact sheet lies with the Swedish National Institute of Public Health. More fact sheets about the work by NDPHS and SIHLWA can be downloaded from the NDPHS web site (www.ndphs.org), "Info corner" section.