Counselling

This is a snapshot of alcohol policies in twenty five member states[1] of the European Union as at 31 December 2007. The data were collected as a joint initiative between the World Health Organization and the European Union as part of the World Health Organization's global alcohol database. Further information was taken from and is available in two publications of the World Health Organization: Evidence for effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm [http://www.euro.who.int/document/E92823.pdf], and handbook for action to reduce alcohol-related harm [http://www.euro.who.int/Document/E92820.pdf].

The Alcohol Policy Series includes the following ten fact sheets documenting the state of the European Union's member state alcohol policy:

1. Infrastructures for alcohol policy
2. Price and tax measures
3. Awareness raising activities
4. Counselling and treatment
5. Availability regulations
6. Drink driving legislation
7. Health warning labels
8. Alcohol advertising
9. Alcohol sponsorship
10. Monitoring and evaluation.

The present fact sheet deals with counselling and considers three issues:

1. The evidence for the impact of counselling programmes
2. The current situation
3. Considerations and next steps

[1] Austria; Belgium; Bulgaria; Cyprus; Czech Republic; Denmark; Estonia; Finland; France; Germany; Hungary; Ireland; Italy; Latvia; Lithuania; Malta; Netherlands; Poland; Portugal; Romania; Slovakia; Slovenia; Spain; Sweden; and United Kingdom

1. EVIDENCE BASE

Alcohol use disorders, including harmful alcohol use and alcohol dependence, are officially recognized in the list of mental and behavioural disorders in the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) (WHO, 2006). Data from national or representative surveys can indicate the number of people at risk for hazardous or harmful alcohol consumption, or the number whose drinking exceeds the consumption level that a health ministry, public health organization or guideline organization proposes as a level for which advice should be offered. These numbers can be quite high. For example, in the EU it is estimated that one in six adults drinks at hazardous or harmful levels, defined here as at least 40 g alcohol per day for a man and 30 g for a woman. Survey or specialized study data can also provide information on the proportion of the adult population with alcohol dependence. Again, these figures can be quite high, with as much as an estimated 6% of the EU's adult population suffering from alcohol dependence in any given year. In almost every country studied, there is a considerable gap between the number of people who need alcohol consumption advice or treatment and the number of them who actually receive such advice or treatment. It has been estimated that only 1 in 20 of those with hazardous or harmful alcohol use are actually identified and offered brief advice by a primary care provider. Similarly, less than 5% of those with a diagnosis of alcohol dependence have actually seen a specialist for treatment.

Evidence strongly supports the widespread implementation of early identification and brief advice programmes in primary care settings for individuals with hazardous and harmful alcohol consumption. There is also some evidence that similar programmes implemented in accident and emergency departments can be effective. However, there is not yet enough evidence to determine the effectiveness of such programmes outside primary care settings.

There exist a wide variety of identification and screening instruments for hazardous and harmful alcohol use. Of them, the most studied, best known and most effective is the Alcohol Use Disorders Identification Test (AUDIT) developed by WHO (Babor et al., 2001). While the AUDIT consists of 10 questions that can be time-consuming to respond to, the first 3 questions (known as the AUDIT-C) are quick to use and almost as effective in identifying hazardous and harmful alcohol use as the full AUDIT.

Brief advice programmes should be based around the behavioural counselling framework known as "the five As":

1. *assess* alcohol consumption with a brief screening tool, followed by clinical assessment as needed;
2. *advise* patients to reduce alcohol consumption to lower levels;
3. *agree* on individual goals for reducing alcohol use or abstinence (if indicated);
4. *assist* patients in acquiring the motivations, self-help skills or support needed for behaviour change; and
5. *arrange* follow-up support and repeated counselling, including the referral of dependent drinkers to specialty treatment.

A brief advice programme can be quite brief (5–10 minutes) and should include an offer of one or two follow-up sessions.

Governments can support identification and brief advice programmes by ensuring that clinical guidelines for these interventions are widely available; that primary care providers receive the training, the clinical materials and the advice they need to set up such programmes; and that they are adequately reimbursed for the interventions, either as part of quality improvement initiatives or with fee-for-service payments.

It is necessary to decide whether to implement this screening programme universally, so that primary care providers offer the identification and brief advice programme to every adult, or incrementally, so that they offer it e.g. every time a patient registers with a new doctor, comes in for a health check or comes in for another condition such as hypertension or tuberculosis.

Primary care providers find it easier to undertake this intervention when they are supported by specialist services to which they can refer difficult-to-manage drinkers. In the management of alcohol use disorders, the transition from primary to specialist care should ideally be seamless. Specialist services for managing alcohol withdrawal and treating alcohol use disorders should be offered to those who need them. While the clinical management of these disorders is beyond the scope of this handbook, it is essential to know that there is an evidence base of behavioural and pharmacological treatments for them, as well as a good deal of experience. The trend has been to move away from lengthy inpatient treatment to outpatient and community-based treatment. Compulsory treatment is no longer recommended, except in the case of court-mandated treatment for recidivist drink–drivers, which some evidence has shown can be effective.

In the workplace, harmful alcohol use and heavy episodic drinking increase the risk for problems such as absenteeism, “presenteeism” (reduced performance at work), arriving to work late, leaving work early, turnover due to premature death, low productivity, inappropriate behaviour, theft and other crimes, other problems that require disciplinary action, poor coworker relations and low company morale. Conversely, structural factors at the workplace, including high stress and low satisfaction, can increase the risk of alcohol use disorders and alcohol dependence.

2. CURRENT SITUATION

Respondents were asked about the availability of a range of counselling programmes, with no questions about the extent or quality of implementation. The answers are reported in table 1.

Table 1. Availability of a range of counselling programmes

Counselling programme	Number (%) of countries with such programme
Family counselling in health systems	20 (80%)
Counselling to pregnant women in health systems	18 (72%)
Brief interventions availably in health systems	19 (76%)
Train health professionals in brief interventions	14 (56%)
Prevention and counselling at workplaces	16 (64%)

3. CONSIDERATIONS AND NEXT STEPS

Although there is reasonable availability of counselling programmes in the countries, this could be improved upon, and little is known about population coverage or the quality of delivered programmes.

Questions to consider

1. ***Are there clinical guidelines for early identification and brief advice programmes?*** The guidelines should lay the foundation of the scientific evidence for early identification and brief advice programmes, outlining what can be done, when and by whom. They should be issued by appropriate bodies, such as the guideline development bodies or institutes of clinical excellence that are responsible in some countries for preparing and disseminating such guidelines. Development should involve appropriate professional organizations to ensure that the guidelines reflect the needs of primary care providers and to ensure their support. The Primary Health Care European Project on Alcohol (PHEPA) has prepared clinical guidelines on identification and brief advice interventions for the EU, and these guidelines can be adapted for local use (Anderson, Gual & Colom, 2005). National guidelines can also be supplemented with models of the effectiveness and cost–effectiveness of different scenarios for implementing identification and brief advice programmes.
2. ***Are there training programmes for primary care providers on early identification and brief advice interventions?*** Few primary care providers are trained to deliver these interventions during their clinical training or postgraduate education. Training programmes for them can be developed based on the clinical guidelines. They should be systematically offered to all primary care providers. Accredited versions of these courses can be included as part of mandatory continuing medical education. PHEPA has also prepared a training programme that can be adapted for local use (Gual et al., 2005).
3. ***Are their systems for monitoring the quantity and quality of early identification and brief advice programmes, so that their effectiveness can be analysed and improved?*** It is important to measure the extent and quality of these programmes. Such monitoring can be carried out through a regular audit of medical records and implementation of a quality assurance programme. PHEPA has prepared an assessment tool for monitoring the delivery of these interventions (2009).
4. ***Is there any financial support for delivering early identification and brief advice programmes?*** Such support can be provided by either quality improvement programmes or fee-for-service payments. Financial incentives can play an important motivating role for primary care providers, especially given their relatively poor uptake of these programmes, and the reluctance that some of them exhibit about incorporating preventive interventions into their practices.

Options for action

- ***Preserve the status quo*** on the assumption that hazardous and harmful drinkers already receive advice from primary care providers as a matter of course, and that people with alcohol use disorders are currently receiving appropriate treatment, primarily from specialist services. However, all the evidence suggests that this assumption is highly unlikely to be true. And in the absence of surveys or reliable estimates of the provision-to-need ratio, it is impossible to know what the present situation is with any accuracy. Preserving the status quo might be viewed as costing nothing, but that is a false assumption. Investments in early identification and brief advice programmes not only improve health and save lives, but also save health systems money. Moreover, it can be argued that people

who suffer from alcohol use disorders, including harmful use and dependence, have a moral if not a legal right to appropriate treatment.

- ***Set a target of offering early identification and brief advice programmes to 30% of the population at risk for hazardous or harmful alcohol consumption.*** This target could be achieved by putting into place appropriate systems, including provider training, so that every patient who registers with a new primary care provider, receives a health check, consults a provider about particular disease categories (such as hypertension or tuberculosis) or goes to particular types of clinics is offered these interventions.
- ***Set a target of offering early identification and brief advice programmes to 60% of the population at risk.*** This more ambitious target would require that every patient who receives primary care services would be offered these interventions, irrespective of the reason for the consultation. It would also necessitate a greater investment in training and supporting primary care providers.

Stakeholders for action

- One key stakeholder is the clinical body or institute for clinical excellence that is responsible for developing clinical guidelines, and which can therefore be asked to prepare guidelines for early identification and brief advice.
- Another major stakeholding group consists of the professional bodies that represent primary care providers. Their involvement will help ensure that the guidelines reflect their professional perspective, as well as secure their endorsement and support for early identification and brief advice programmes.
- A third stakeholder category covers the public bodies and private organizations that fund and provide primary care services. This category includes the national health service, local trusts and commissioning services, insurance companies and local communities and municipalities. These stakeholders need to be persuaded of the case for funding and managing early identification and brief advice programmes. To make this case effectively, it may be helpful to model the impact and cost–effectiveness of different scenarios for implementing these programmes.

Bibliography

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This report, a companion document to the present handbook, details the available evidence for the impact of early identification and brief advice programmes on alcohol consumption and related harm.

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Babor TF, Higgins-Biddle JC (2001). *Brief intervention for hazardous and harmful drinking: a manual for use in primary care.* Geneva, WHO (http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf, accessed 19 August 2009).

This manual is written to help primary care workers – physicians, nurses, community health workers and others – deal with people whose alcohol consumption has become hazardous or harmful to their health.

Babor TF et al. (2001). AUDIT: the Alcohol Use Disorders Identification Test: guidelines for use in primary care, second edition. Geneva, WHO (http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf, accessed 16 August 2009).

This manual introduces the AUDIT and describes how to use it to identify people with hazardous or harmful patterns of alcohol consumption.

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This tool assesses among other things the provision of identification and brief advice programmes in primary care settings and provides results for selected European countries. The individual country assessments can be found at gencat.cat/salut/phepa/units/phepa/html/en/dir532.

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FACT SHEET

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