

CHAPTER 11

ITALY

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11.1. General Introduction

11.1.1. Country description

Italy has been a Democratic Republic since 1948. In 2002 the residential population was nearly 57 million, slightly more than 190 people per square kilometre. Life expectancies for men and women were approximately 76 and 82 years respectively. In 2000 Italy was the “oldest” country in Europe, having an elderly index (116.54) among the highest in the world. The north and the south of the country represent different social, cultural and economic realities, with the northern region being much richer and more industrialized than the southern region which is predominantly agrarian.

11.1.2. Health services

The National Health Service (*Servizio Sanitario Nazionale*: SSN) was introduced in 1980 under legislation enacted in 1978. A series of reforms took place in 1992 and are still in progress. The SSN offers universal coverage financed by social insurance contributions and taxation, and the majority of hospitals and primary health care centres currently remain in public ownership. However, public health services are undergoing a basic reorganization according to the principle of devolution of health issues and related matters to the 20 Italian Regions. Due to this change, the role of the Minister of Health, who oversaw regional health activities until a few years ago, has been limited to the formulation of broad guidelines and regulations, with a minor influence on the budget allocations of health care services provision of the regional authorities. The State allocates financial resources to each region for the health care needs of the population on the basis of *per capita* criteria (using as the main variables the proportions of young, adult and elderly and the prevalence rates of the main diseases). The regional health authorities (*Assessorati alla Salute*) provide the framework for the provision of local health services (*Aziende Sanitarie Locali*: AUSL).

Hospital care and curative treatment are provided free of charge in hospitals, clinics and other bodies falling under the SSN. Almost 7% of GDP is currently spent on health, equivalent to approximately US\$1500 (parity purchasing power) per inhabitant. Total expenditure on health services is determined yearly at the central government level through the national budget. These funds are regularly allocated to the regions and are obtained from contributions from all workers, both employed and self-employed, additional levies on employers for each of their employees, health taxes paid by self-employed workers and national government funding to cover the remaining costs.

11.1.3. Alcohol policy

Over the last few years the majority of National Health Plans (NHPs) produced by the EU Member States, including Italy¹, have followed a general population approach, based on epidemiological findings in their different contexts and social realities, and setting “evidence-based” targets, objectives or goals. Starting from 2000, this kind of approach received renewed impetus from the

* The full composition of the Working Group is given in Appendix 11.1.

suggestions of WHO *Health 21*, as well as from the documents, recommendations and programmes of the European Commission, Council and Parliament²⁻¹¹.

The promotion of primary and secondary prevention, as well as programmes linked to alcohol abuse and related problems, found a formal implementation in Italy for the first time in the 1998-2000 NHP by means of two main targets to be reached within the year 2000:

- *To reduce by 20% the prevalence of male and female drinkers consuming respectively more than 40 gr. and 20 gr. alcohol a day;*
- *To reduce by 30% the prevalence of drinkers consuming alcohol between meals.*

As a consequence of the reduction in prevalence of people drinking alcohol at levels associated with an increased risk to health, a consistent decrease in the level of alcohol-related problems and diseases at the population level was expected. In order to reach these targets by the year 2000, a number of strategies and actions were identified in several areas (Information, Drink Driving, Legislation, Advertising, etc.). The most recent NHP in 2000-2003, while not setting new targets for alcohol, confirmed the previous approach by leaving it to regional autonomy to implement alternative strategies and programs, explicitly including early detection and brief intervention in the primary health care services of the SSN.

With different degrees of regional magnitude, alcohol represents, together with tobacco, one of the most important risk factors for the Italian population. In line with the *European Charter on Alcohol* (December 1995), the Ministry of Health set up a national committee to promote and develop an action programme based on the WHO European Alcohol Action Plan (EAAP). This committee includes representatives of several ministries, i.e., Social Affairs, Foreign Affairs, Agriculture, Justice, Labour, Finance, Industry, Education, and Transport, as well as experts and officers from the Ministry of Health¹².

The promotion of primary and secondary prevention, as well as of programmes linked to alcohol abuse and related problems, has found full implementation in the 1998-2000 NHP and its two main targets mentioned above. In order to reach these targets, a number of strategies and measures have been identified, including:

- regulating the advertising of alcoholic products and disseminating explicit warnings as to their alcohol contents and potential harm to health;
- initiatives to reduce the alcoholic contents of drinks and to increase quality control;
- preventive information and education campaigns (at national and regional levels) aimed at reducing alcohol consumption among specific population groups, such as pregnant women and young people, and/or in specific social contexts, such as schools and barracks;
- initiatives to promote alcohol rehabilitation with the participation of general practitioners and to help heavy drinkers withdraw from drinking;
- measures to monitor and regulate the distribution and sale of alcoholic beverages in community settings, particularly at sporting and cultural events and in motorways rest areas;
- tax incentives to reduce alcohol consumption;
- more effective enforcement of regulations on limits to blood alcohol concentrations when driving;
- initiatives to promote a ban on the sale of alcoholic beverages to minors;
- reorganization of health services devoted to diagnosis, care and rehabilitation of alcohol problems;
- setting up of an epidemiological network for monitoring alcohol consumption and alcohol-

- related diseases (development of adequate indicators);
- reduction of the limits of blood alcohol concentration for safe driving;
- recognition and support for the work carried out by NGOs and self-help groups;
- possible introduction of alcoholology in the teaching curricula of several faculties (medical, social).

Measures and regulations are being discussed in Italy to promote the prevention of alcohol misuse for under-age drinkers, and to delay the age of onset of use as well as preventing alcohol abuse¹³⁻²³. A debate is also in progress concerning issues like the need for a code of practice on labelling, packaging and merchandising of alcoholic beverages. Moreover, a number of key barriers to progress in the specific implementation of evidence-based management of alcohol use disorders in general practice in Italy have to be taken into account²⁴. The most important are:

- lack of financial incentives for GPs
- lack of a specific National/Regional programme for general practice and PHC
- co-operation among addiction services and formal links with GPs are still to be promoted
- lack of "evaluated" results to prove the efficacy of the chosen pilot strategy
- the idea of submitting to evaluation the effectiveness of HP strategies by health authorities and administrators is still missing

Italy is the first country in the European Region to achieve the target set by the *WHO Health for All* strategy of a 25% reduction in per capita alcohol consumption during the period 1980-2000¹³. Italy reduced per capita consumption by 36% during this period (see Table 11.1). The decrease in average alcohol consumption was due mainly to wine, as well as to a decrease in spirits consumption. Beer consumption increased steadily throughout the period.

TABLE 11.1 ABOUT HERE

Some useful indicators available from ISTAT (National Institute of Statistics), which carries out annually a nationwide health survey of lifestyles, are the prevalence by sex, age (14+) and geographical distribution of wine consumers, beer consumers, consumers of alcoholic beverages between meals, consumers of more than a 1/2 litre of wine, consumers of more than 1/2 litre of beer. According to these indicators, during the period 1998-2000, together with a decrease in *per capita* consumption, there were increases in the above-mentioned ISTAT indicators:

- a) an increase in the prevalence of drinkers, indicating that the number of people exposed to alcohol-related harm and risk has widened, particularly among adolescents and females. (From the 1998 baseline, the 2000 year overall prevalence of abstainers dropped from 13.9 to 12.8% for males and from 38.6 to 36.4% for females. Accordingly the number of drinkers increased from 86.1 to 87.2% and from 61.4 to 64.6% for males and females respectively. More detailed statistics from OSSFAD can be found at the link <http://www.ossfad.iss.it/alco/imgs/Tabe.gif>, <http://www.ossfad.iss.it/publ/ppdf/0009.pdf> and <http://www.epicentro.iss.it/focus/alcol/alcol.htm>);
- b) a constant and progressive increase in beer drinkers (particularly among teenagers);
- c) an increase in the number of women drinking more than ½ litre of wine daily (and beer for young people)
- d) an unexpected upward trend reflecting a change in the traditional modalities of consumption towards drinking between meals and progressively away from the "Mediterranean" habit of

consuming moderate quantities of wine at meals (see Tables 11.2 and 11.3). For young people, this means that alcohol (mainly beer and spirits) is mainly drunk, not as a “food” as it was previously culturally and traditionally regarded, but increasingly as a substance to be consumed outside family or formal control and according to well-established modality of binge-drinking observed in northern European countries.

This last trend sheds a new light on the dynamic of alcohol consumption within the Italian population, calling for a major effort to respond to an emerging culture, apparently widespread among the younger population, linked to new modes of consumption that appear much more unhealthy than before²⁵⁻³². Furthermore, an in-depth analysis of the prevalence of drinkers according to the different variables investigated in 1998 in the ISTAT survey confirms a worrying change in youth’s attitudes towards alcohol consumption, resulting in a better understanding and the need for a renewed effort to set and monitor targets specifically aimed at reducing risk among the younger generation.

The number of alcohol abusers in Italy is estimated at 3½ million, with one million alcoholics; only a small proportion of them (less than 30,000) is currently under treatment in the public health services. A consistent proportion of alcoholics is currently under treatment within private health or self-help organizations.

TABLES 11.2 AND 11.3 ABOUT HERE

The level of attention of the Ministry of Health and of the Italian Government has been recently increased as witnessed by the first Annual Report of the Minister of Health to the Parliament (<http://www.ministerosalute.it/dettaglio/phPrimoPiano.jsp?id=204>) and by the specific web pages published by the Italian Government

(http://www.governo.it/GovernoInforma/Dossier/alcop_relazione/presentazione.html), also on the occasion of the Alcohol Prevention Day in year 2004

(http://www.governo.it/GovernoInforma/Dossier/alcop_prevenzione/index.html) and 2004.

The emerging trends and the epidemiological findings³³⁻³⁸ strongly contributed to a demand for the National Health Plan 2003-2005 to renew the effort to implement actions and strategies that can help in the following areas:

- promoting healthier lifestyles and habits (life skills);
- tackling misleading risk-taking cultures
- improving settings (family, schools, communities)
- strengthening health protection of vulnerable groups
- decreasing “gradients” within and between groups (inequalities in health) and reducing harm
- ensuring a wider range of initiatives devoted to the early detection of alcohol abuse.

This last policy has been the common ground of specific activities³⁹⁻⁴⁸ carried out at the local level and of four different projects carried out in Italy in four different areas over the last few years and these have produced findings that are being evaluated in drafting a forthcoming National Strategy aimed at including early detection and brief intervention activities in the daily work of the Italian NHS General Practitioner. (Two of these projects subsequently combined to share methods and collect data – see Section 11.4. below.) All these projects were carried out in the framework of the WHO Phase IV Project under the national coordination of the *Istituto Superiore di Sanità* and represent a valuable scientific programme to produce the evidence-base for shared utilisation at the international level of common instruments and methodologies to contribute to the reduction of alcohol-related risk and harm in individuals and society.

The following sections of this chapter will examine the results of these projects. Full membership of the Italian Phase IV working group may be found in Appendix 11.1.

11.2. Florence 1 Unit: Northern Chianti & Scandicci Project

11.2.1. Introduction

In the city of Florence (about 400,000 inhabitants) and its metropolitan area (about 900,000 inhabitants in all), there has been a focus on alcohol consumption and related problems by both researchers and clinicians since the second half of the 1970s. At that time, one of the first Italian surveys was carried out⁴⁹, followed by another four-part survey on the topic of alcohol and the workplace^{50,51}, and the creation of both in- and out-patient programs and school educational programs, as well as the planning and implementation of a community alcohol action project in the district of Rifredi within the city itself (1992-1997)^{52,53}. Health professionals from the Careggi Hospital in Florence also took part in the WHO Phase III study.

With regard to the WHO Phase IV Project, the contiguous areas of Scandicci and Northern Chianti, situated along the belt surrounding Florence southwards and westwards, were identified following an interest in prevention of alcohol problems shown at the same time (1998) by both Scandicci Municipality and Leonardo, an association of local general practitioners. Therefore the *Scandicci* and *Northern Chianti* Project (Florence 1 Project) is made up of two components:

- (A) the first component is the WHO Early Identification and Brief Intervention (EIBI) program implemented in the five Chianti municipalities of Impruneta, Tavarnelle, Barberino, Greve, and Bagno a Ripoli through a number of GPs applying the WHO study among their clients; minimal communication strategies with the Municipality authorities were added;
- (B) the second component consists of both an EIBI program engaging other GPs in the same association and a full Community Alcohol Action Project (CAAP) in the town of Scandicci. The latter was been implemented between 2000 and 2004, while the EIBI part, that had begun in 2002 with alcohol training for all health professionals involved in the study, started in 2004 and will end by 2006.

Implementation of EIBI in (A) and (B) is contemporary.

This project has contacts with the other Italian projects that are part of WHO Phase IV. It is coordinated with the EIBI project in Friuli Venezia Giulia (see Section 11.3. below) and also with the other project in the north-west surroundings of Florence (Florence 2, see Section 11.4. below).

11.2.2. Customisation

In Italy it is unusual for primary health care professionals to ask their patients straightforward questions about their drinking habits, since the context would be interpreted by both parties as investigating the issue of alcoholism. In practice, the doctor might become judgemental and the patient might feel offended.

Therefore the chief investigators, including the GP representative involved in the project planning, decided that proposing to use all direct questions from AUDIT would risk making the project unsuccessful. Instead, a simplified *Alcohol Card* drawn from AUDIT, that had already been tested in general population surveys in Tuscany, was agreed on; it asks how many glasses of each type of alcoholic beverage and how frequently were drunk per day, whether the patient drinks outside meals (indicating a drinking behaviour which tends to deviate from cultural norms in Italy), how frequently he or she had six or more drinks per occasion, and if somebody had ever suggested to

him/her cutting down or stopping. Also blood tests of high-risk drinkers (SGPT, gamma-GT, MCV, triglycerides) are recorded .

A 4-page leaflet, *Check Your Alcohol Intake*, developed from educational material used in the Rifredi alcohol community project, was also prepared by the investigators and accepted with minor changes by GPs during the training day. It is to be handed out to risky drinkers. It reminds one of the alcohol content of the different types of beverages and the high-risk levels, and suggests recording alcohol intake daily.

A *Communications Skills Training Program* for the helping professions, developed in Florence during the 1980s by a team appointed by Regione Toscana Health Authority⁵⁴ and successfully used among a range of health professions, was simplified for incorporation in the Brief Intervention guidelines.

The aim of a focus group with GPs attending one-day training was how the *Alcohol Card*, the *Check Your Alcohol Intake* leaflet and the *Communication Skills Brief Intervention* pack could work in the GP's office during the WHO study period. On a whole, GPs accepted the Brief Intervention pack and recommended minor changes both to the card and the leaflet.

11.2.3. Reframing

Among Italian GPs both knowledge and practice in the alcohol field are lower than in other medical disciplines and may be lower than among other PHC professionals⁵². Therefore, any alcohol program whose aim is to involve physicians must focus primarily on education. Also, drawing on the observation of the failure of expert-lead educational programs addressed to doctors when the subject is not specifically biological, the investigators assumed that the best way of motivating GPs to participate in alcohol training would be if they were actively part of the training organisation and perhaps of the teaching team, rather than just the target of an educational program. Luckily enough, at the end of the 1990s, there occurred the birth of *Leonardo*, one of the few GP co-operatives or associations of family doctors in Italy; this has gathered together dozens of physicians in the greater Florence area and sets both practical and educational goals for its members. An innovative project such as this one, promoted by WHO, was sufficiently attractive *per se* to the *Leonardo* whose president was invited to join the team of investigators and who accepted.

In 2001 the *Leonardo* GPs in the project areas who were part of the co-operative numbered 32 and their clients amounted to 41,600 in total, as shown in Table 11.4 below:

TABLE 11.4
***Leonardo* GPs and their clients**

<i>Municipality</i>	<i>Number of GPs (2001)</i>	<i>Number of Clients (2001)</i>
Scandicci	15	19,500
<i>North Chianti:</i>		
Impruneta	7	9,100
Tavarnelle	3	3,900
Barberino	2	2,600
Greve	2	2,600
B.a Ripoli	3	3,900
<i>Total</i>	32	41,600

11.2.4. Strategic Alliance

Building alliances has been a long process, due both to the bureaucracy of the local alcohol institutions and to the relatively low concern among health administrators regarding the issue of alcohol problems.

Initiated by the Florence Health Agency Alcohol Centre in 1998-1999 with the agreement of *Leonardo* GPs co-operative, the process involved the Florence Health Agency Education Unit, both the Addiction Department and the Florence Health Agency Management, and the Scandicci Municipality. WHO Europe contributed to moving the process forward by making the project official via the Italian Ministry of Health in 2001.

Community action in Scandicci started in 2000, while the EIBI program began in June 2002 with alcohol training for GPs. After the project began in 2000, the following agencies entered the alliance:

- the Municipality Police
- the community network of pharmacies
- the local branches of nation- or region-wide associations: a) *COOP* Consumers; b) *Slow Food*, gourmets aiming to educate people how to eat and drink; c) *Humanitas*, a volunteer association
- the town shopkeepers' association, two associations for youngsters, one catholic parish
- the Florence College of Physicians (*Ordine dei Medici*) and the Family Medicine Scientific College (SIMG)
- the local Health Care Addiction Unit. (Due to overlapping of alcohol prevention activities between the unit and the Alcohol Center, this alliance transpired to be ambiguous on some occasions.)

11.2.5. Demonstration Project

The two components of the Project, that is (A) only EIBI in the 5 northern Chianti towns, and (B) EIBI plus the Community Action Alcohol Project in Scandicci, provided the context to evaluate whether the EIBI program needs to be supported by other community actions to make its impact on the population successful.

11.2.5.1. Early identification and brief intervention (EIBI) in Northern Chianti and Scandicci

Training for GPs

A 2-session alcohol training program for GPs was planned in 2000 by the Florence Health Agency Alcohol Centre and the *Leonardo* GPs co-operative. It was agreed that, even though a greater number of sessions could be more profitable, the very busy doctors would not be able to attend more than 8 hours of education on this topic. The aim was to inform doctors about the extent of risky drinking so that they could take action for their patients' health, and to involve them in the WHO Phase IV project. A few subsequent meetings with two local Addiction Units, the Florence Health Education Unit and the leader of WHO Phase IV Florence 2 project resulted in a common document endorsed by the Florence Agency Health Manager in 2001.

Training for GPs in the Scandicci and Northern Chianti municipalities was organised by the Florence Family Medicine Scientific College (SIMG) and took place on Saturday, 29 June 2002 in the premises of the Florence College of Physicians. Attending physicians obtained credits from the Italian Health Ministry. Teachers came from the Alcohol Centre and the tutor was from SIMG. The methods included lectures, role-plays, group and plenary discussions, and focus groups. The following were the aims, objectives and contents of the two sessions:

Session one

- Aim:* to inform GPs about alcohol-related problems among their patients
- Objectives:* identify risky drinkers and alcohol-related problems
use communication skills to educate patients how to reduce or stop drinking if necessary
- Contents:* early identification of hazardous alcohol drinkers vs alcoholics
biological markers
Communication Skills & Brief Intervention

Session two

- Aim:* to inform GPs about Phase IV and consequently take action
- Objectives:* understand the meaning of a local alcohol prevention approach
adapt and share the EIBI principle
- Contents:* the WHO Phase IV Project
the local prevention project and its planning
focus groups: tailoring diagnostic and educational tools.

Forty-three GPs, including a few from districts other than the study areas who had not taken part in earlier phases of the WHO Collaborative Project, attended, demonstrating a high level of interest. The conventional daily limit of 40g alcohol for men and 20g for women to divide moderate from high-risk drinking caused some surprise among the participants. The comparison between pre-test and post-test showed that participants improved their knowledge about alcohol, the average score per person increasing from 64% at the beginning to 76% at the end of the day (maximum score=100%). According to the results of a questionnaire completed by participants, 49% considered the training as relevant or very relevant, while 30% said it was rather relevant; 59% rated it as good or excellent; and 57% as effective or very effective. Depending on the particular question, between 4 and 9 physicians (11-21% of respondents) were critical of the training. Participants were also invited to take part in one of three parallel one-hour focus groups led by three experts and aimed at customising the EIBI package (see above). At the end of the day trainees agreed to incorporate a customized version of the WHO Phase IV package into their practice at the start of the Project. A further meeting focused on implementing the package was planned just before the EIBI program was scheduled to start in 2004.

GP intervention

A protocol on how to implement EIBI was agreed among the project chief investigators, including the chief of the *Leonardo* co-operative:

- a) All GPs involved in the EIBI must have been trained in the Alcohol Training for General Practitioners;
- b) A short seminar with GPs should take place just before the start of the EIBI programme. On that occasion GPs would fill in a questionnaire to express their views on alcohol-related problems among their patients;
- c) A random sample of clients (18-75 years) at GPs' offices would be enrolled in the study; they shall be given the *alcohol card*. After a patient has turned out to be a risky drinker, he/she should enter a 12-month EIBI *brief intervention*, i.e. receiving:
 - a baseline and 6- and 12-month educational intervention by the GP aimed at modifying the client's drinking behaviour
 - baseline and 6- and 12-month blood test and a 4-page leaflet informing about the risk of alcohol
 - a 3-month clinical follow up.
- d) The interaction between physicians and their patients should be randomly evaluated by means of both a self-report questionnaire and a videotape focusing on communication;

- e) The quantitative evaluation should rely on intervention rates and community diagnoses of alcohol-related disease. The qualitative evaluation should rely on interviews with key people in the community.

Training for PHC professionals other than GPs

A 6-day alcohol training program on prevention for PHC health professionals and employees was successfully implemented in Scandicci during one semester between 2002 and 2003. It was a component of a longer program started at the beginning of 2002 as part of the Scandicci Alcohol Community Project that also included training on the topic of treatment of alcohol dependence. Its methods included lectures, role-play and group discussion. Aims, objectives and contents were the following:

- Aim:* to increase concern among PHC professionals about alcohol-related problems among their clients and get them involved in early identification of risky drinkers and related brief intervention
- Objectives:* improve communication skills with clients
identify risky drinkers and alcohol-related problems and motivate them to change their drinking habits
co-operate with GPs and existing alcohol services
- Contents:* communicational skills
risky alcohol drinkers and alcoholics local prevention projects
customising diagnostic and educational tools

About 20 professionals (midwives, nurses, community nurses, employees) attended, showing high interest. A noteworthy change observed was a shift from the attitude of identifying drinking alcohol with alcoholism to the idea of risky drinking. Some participants decided to add a few simple Q/F questions to their routine health records and agreed to co-operate with GPs.

11.2.5.2. Community Action Alcohol Project in Scandicci

In 1997 the Alcohol Centre and the Education Unit of the Florence Health Agency developed and proposed to the municipality of Scandicci an intersectoral, multi-component community alcohol prevention project. The project was endorsed in 1998 and fully formalised in 1999. Since the town was too large for the project, only 3 out of 6 districts were chosen by the town council, totalling 21,851 residents (June 1999).

A *Project Promotion Group*, intended to support the development of the project, was appointed in 1999 and included representatives of the three local Municipality Districts, the Municipality of Scandicci and the Greater Florence School System. In this context, the task of the Alcohol Centre professionals was to: (a) facilitate community interactions; (b) evaluate the baseline, process and outcome phases; (c) be available as experts on issues of alcohol and food.

The aim was to promote “responsible drinking” and prevent alcohol-related problems in the sectors of health, education and road traffic. The objectives were: (a) people in the community to acknowledge both the benefits and the risks of alcohol; (b) school teachers to produce educational tools together with their students; (c) PHC professionals to be able to reduce or stop their patients’ risky drinking; (d) community personnel to be mobilised. The method was the following: (a) facilitating interactions in the community and activating local resources to carry out preventive initiatives; (b) planning local training courses; (c) spreading messages produced within the community itself; (d) ensuring that all messages from each sector of the project were circulated in appropriate ways and informing the local media about all phases of the project.

A needs analysis on 154 community key persons from 33 institutions or groups interviewed through 19 focus groups and 13 individual interviews indicated that there was concern about alcohol abuse, especially regarding young people, alcohol-related violence within the family, drinking and driving, and problems of public order. The traditional drinking pattern (i.e., having wine at meal-times) was sometimes seen to be changing. The results were fed back to the community together with an information booklet.

A 19-member Co-ordinating Committee was established to support initiatives, including local institutional and volunteer organisations and groups. Among the initiatives successfully completed during the years 2000-2003 were:

- i) three school projects (2001-2002) carried out by 18 elementary and middle school teachers who had attended a 2-year communication skills training programme: (a) watercolor community workshop; (b) collection of local stories about eating and drinking; (c) drawings on food and drinking. A limited number of the drawings by 320 pupils were displayed in 2001-3 in Scandicci at a Spring exhibition and at the Scandicci October fair;
- ii) six thousand Alcohol Carousels, card disks giving information about the limits and risks of alcohol, were distributed in shops, markets, schools, chemist shops and GP offices during Spring 2002. People who used them showed great interest in the issue;
- iii) a one-day alcohol training for policemen in 2000;
- iv) two movies on alcoholism, risky drinking and eating, shown in one parish theatre at the end of 2002;
- v) newspaper or TV coverage of the local events in the project on a few occasions.

Epidemiological baseline evaluation

In February 2001 a convenience sample of 299 persons in the community area of Scandicci as well as in the Northern Chianti area were interviewed by telephone in a collaboration with the Tuscany Regional Health Agency. The average alcohol consumption *per capita* per day in Scandicci was 13.4g and in Northern Chianti 12.5; this is somewhat less than indicated by national statistics (15.8g in 2000 according to World Drink Trends). As expected, wine was the most popular beverage, being about 82% of all the alcohol consumed. In Scandicci 11.7% of people and in Northern Chianti 9.7% were to be considered *at risk* since they drank more than 40g per day if men or 20g if women. These percentages parallel those in other contemporary Tuscan surveys. Abstainers in Scandicci were 13.6% (men) and 25.7% (women); and in Northern Chianti, 18% and 30% respectively.

11.3. Martignacco Unit: Municipality of Martignacco Project (Region Friuli Venezia Giulia)

11.3.1. Introduction

This section of the chapter will mainly underline the importance of the role that municipalities can play, not only in promoting healthy lifestyles but also in proposing innovative projects leading to useful changes in primary health care services.

After the newly elected administration of the Municipality of Udine resigned from the WHO Collaborative Study in 1999, the smaller Municipality of Martignacco decided to continue this work in PHC and to propose the integration of risky alcohol consumption activities with smoking cessation strategies. This political decision was taken because of previous experience in preventive community projects and the conviction that mayors have a leading role in public health. General

practice can be the ideal setting to make connections between the scientific and policy-making worlds.

As will be more clearly explained below, the study area is still represented by the primary care work located in the city of Udine but enlarged by the surrounding small municipalities to form a total of about 120,000 inhabitants. The control group is the city of Gorizia and its surrounding towns. This section summarizes the work carried out by both administrations.

11.3.2. Customisation

In 1998 the Municipality of Udine, in partnership with the *Vlaams Instituut* in Brussels, successfully applied for EU funding to enable six other participating countries (Belgium, Slovenia, Bulgaria, Hungary, Russia and Latvia) to create a common method for carrying out qualitative research - the ECAToD Project (an exchange of methodology between EU countries, newly-independent states and CCE to define essentials of European Community Actions supporting primary health care action against Tobacco consumption and hazardous Drinking). This project created the basis for a common approach to Delphi and Focus Group methodologies and stimulated links between the PHC setting and the local community in its wider meaning (see also Chapter 1).

The specific aims of the customization phase were set by a group of experts, mainly taking into consideration the public administration's point of view (see Table 11.5). The following activities were carried out:

- i) Focus groups
- ii) Delphi study
- iii) A survey to validate the AUDIT questionnaire

11.3.2.1. Focus groups

Guidance Notes on Focus Group Methodology were prepared by Dr. Leo Pas, Dr. Pierluigi Struzzo and Professor Nick Heather and were adapted for use by investigators in the WHO Phase IV study. (See Phase IV Study Protocol, especially sub-section 4.1.1 of the Protocol on "Focus Groups", [pp.6-7] for a full understanding of the context of these notes. Focus groups are also mentioned in sub-section 4.4 of the protocol on "Customization of EIBI Training" [p.20] and in Section 5 on "Reframing Understanding of Alcohol Issues" [p.23].) A total of 8 focus groups were carried out (GPs, young people, smokers and ex-smokers).

TABLE 11.5
Aims of customisation according to the ECAToD objectives

To analyze and compare each participant's primary health care service situation/projects in respect to the prevention and early diagnosis of alcohol health-related problems
To assess availability of epidemiological data of participants' health services
To define adequate measures for evaluating future community action programmes
To define the essentials of community action and support for primary health care as a tool to create more efficient health care systems in the proposed field
To define the essential elements of success for such community action programmes
To develop proposals for implementation programmes in all participating countries

GPs: The recruitment phase was difficult; out of 20 invitations only 8 participated. There was general agreement on the difficulty in dealing with alcohol-related problems within the office.

Risky or hazardous drinking is neither completely understood nor correctly addressed. Patients are referred to the Alcoholics Centres and no specific procedure is previewed for risky drinkers. The GP's role is mainly focused on medical actions such as blood testing, assessment of liver function, improving drugs and/or time limitation of driving permissions. Brief intervention (not really clearly understood) is considered as a further intrusion into the patient's life. Packages to help GPs and their patients should not be used because of the increase in workload. Barriers to implementation were identified (lack of a sense of role, lack of time, not their problem) and possible incentives were suggested (training, communication skills, counselling techniques, positive approach, etc.).

Young people: Teenagers participated actively and the recruitment was easy. Sixteen youngsters agreed on the fact that any authoritarian approach has a contradictory effect. They do not think risky drinking among young people is a real problem in their area; it could possibly refer to the adult population. The distinction between alcohol use and abuse is more difficult to explain. There was agreement with the definition that loss of control is the result of alcohol abuse. The activity suggested that, to increase awareness of drinking problems, a campaign of information is needed targeted towards young people. Alcohol should not be sold to drivers, public places should have special devices to check blood alcohol level, and special promotions of alcohol should be abolished. Risks involved in alcohol consumption should be written on the product and the price should be increased. For young people, direct experience is important. Therefore it is useful to involve other young people in talking about the damage caused by alcohol.

Delphi study

Aim: To identify ingredients of a community action plan on alcohol from the views of specific groups of experts.

Method: in an area of about 2-300,000 inhabitants, at least 10 respondents in each group were identified to answer a set of questions in 3 rounds over a period of 3-4 months.

Specific groups of respondents were selected:

- NHS or other experts from official organizations
- people working in socio-cultural or non-profit associations
- at least 20 GPs
- nurses working in health services and occupational or school settings.

Recruitment: an invitation letter was sent followed by a 'phone call after 5 days

Questions in Round 1:

1. In your opinion, what are the strategic issues in reducing alcohol consumption?
2. How could you contribute to this initiative?
3. List what actions you would expect from the following experts (list of experts follows).

Delphi results

- It is necessary to train the trainers and to increase awareness of these problems in the population. Activities proposed up to now are not enough to awaken the community or, at least, it seems necessary to consider a new strategic approach for the general population. The demand for collaboration between corporate bodies indicates limited co-operation at present between existing structures and the relevant professionals and experts. Counselling from general physicians was another priority expressed by the group interviewed.
- Performing EIBI is not characteristic of our health-care culture but it seems to be a useful tool for primary health care.

Survey

In addition to the identification of alcoholics, there is a need to find an instrument to measure risky alcohol consumption. The aim of the questionnaire was to validate items about alcohol use so that

each participating country could identify alcoholics and risky drinkers in the same way and with the same measures of alcohol consumption.

Nearly 300 individuals, recruited in different primary care centres in each participant's area, were given the AUDIT questionnaire. Those with high scores were double-checked with CIDI (Composite International Diagnostic Interview) which is a diagnostic tool for alcohol dependence. At the end of the survey, investigators had identified and double-checked a group people with a score of 8 or above (equivalent to risky drinker or more).

Inclusion criteria : Each 3rd female patient attending GP office
Each 3rd male patient attending GP office

Exclusion criteria : Those unable to read or understand the AUDIT
< 16 years of age,
> 70 years of age.

Interviewers : Psychologists or GPs involved in the project interviewed the same patient according to standard CIDI WHO protocol.

Survey results: The CIDI is not applicable in practice. AUDIT questionnaire should be limited to the first 3 questions. 54 subjects were identified as risky drinkers (9.4% of the total) and, of these, 13 (2.2% of the total) showed signs of dependence. The prevalence of risky drinkers was low because the entire region is already sensitized to alcohol issues and there is much denial of the problem.

For more detail on these issues the reader is referred to the specific reports⁵⁵⁻⁵⁷. One important general finding that emerged was that is not realistic to use long questionnaires in PHC and general practice in particular. Even a 10-question instrument may be too long for routine, everyday work.

11.3.3. Reframing

Friuli Venezia Giulia is a wine-producing region and alcohol continues to place a heavy burden on the general population's health. No data on moderate or risky drinking exist. Since 1980, when the first "training the trainers" meeting on the Hudolin methodology (a psychosocial treatment method for alcohol dependent people based on group therapy and family/community involvement) was held, the only known "safe" drinking pattern was abstinence; no risky or moderate drinking was accepted and no official drinking limits were set by the Alcohol Units, formally part of the National Health Service. Any level of drinking was considered dangerous and possibly leading to alcoholism. A couple of hundred Clubs in the region are now dealing with thousands of alcohol dependent people and their families. Information and preventive work with GPs, primary care workers and the general public were, and still are, carried out by experts and other trained people who disseminate ideas strictly linked to the concept of "alcoholism". GPs and primary care workers were involved in the work of the Alcohol Units only as part of wider projects and did not initiate "unorthodox" activities. In this setting, the proposal for an innovative project, like Phase IV, was cautiously accepted only because it was supported by the prestige of WHO.

The first step was to ask the main representatives of the alcohol services and GPs to discuss the project at a two-day meeting. An expert from the Phase IV Coordinating Centre in Newcastle (Dr. Eileen Kaner) was invited to present the rationale for the study in June 1998. A *consensus document* was produced from the input of 20 alcohol experts (8 general practitioners, 2 directors, 2 sociologists and 8 community workers of the Alcohol Services of the Local Health Units of the two cities, Udine and Pordenone). (Even if not directly participating, the NHS experts in Pordenone have followed the project with close attention and are now, in fact, implementing what we were trying to demonstrate.) The consensus reached was as follows:

Alcohol: 1 standard drink = 10 grams of alcohol = 1 glass of wine. GPs should be able to estimate their patients' consumption levels. The safe drinking threshold is 3 standard drinks for men and 2 for women, preferably with 1-2 days/per week of abstinence. A list of specific situations was composed in which any drinking is allowed.

In the identification process, GPs should allocate their clients to the following groups: Abstainers, Moderate drinkers, Risky drinkers, Alcohol dependents.

GPs and other PHC workers are encouraged to adopt a 5-minute brief intervention to counsel risky drinkers. Alcohol dependents should be referred to specialist alcohol services and smokers should be invited to join cessation clinics.

11.3.4. Strategic Alliance

A major strength of working with politicians is the credibility it brings and the possibility of creating partnerships. Formal agreements were made between the Municipality of Martignacco and the following organizations:

- University of Udine, Faculty of Economics, Faculty of Languages, course in Public Relations (Prof. L Brusati, Prof. R. Kodilija)
- University of Siena, Faculty of Medicine, Public Hygiene (Prof. M. Giacchi)
- Florence Health Unit, Alcohol Centre (Dr A. Allamani)
- Regional School for the Continuing Training of General Practitioners (Dr. R. Paduano)
- Local Health Unit of Udine, District of Udine City (Dr. M. Casini)
- Local Health Unit of Pordenone (Dr. G. Di Gregorio, Dr. A. Beacco)
- The Provincial Association of Industries
- The Provincial Association of Medium and Small Industries
- The Association of Commerce and Public Places
- Another 32 small municipalities in the Region

The Local Health Unit of Pordenone is presently following up a group of more than 100 GPs working on EIBI. Discussions are active and the entire Local Unit is highly motivated to follow this methodology. The results achieved by the city of Pordenone will be included in the final national report on the project.

The municipalities will support the project by involving the local community, their GPs, bars and restaurants, and by supporting the proposed surveys among the general population. The strength of this project results from the partnerships that have been created.

11.3.5. Demonstration Project

At the end of the demonstration project it should be clear whether the knowledge and behavior of GPs in the control area (Gorizia) (no specific training nor a specific communication strategy for the GPs) will be the same as GPs in the intervention area (Udine) where specific training, support and a communication strategy will be provided.

In more general terms, the expectation is that a well-implemented community action in both areas (with the involvement of mayors, bars, restaurants, industries and the general population) will persuade GPs in Gorizia (without any other support) to obtain more information about EIBI and carry it out in their own offices.

The city of Gorizia was chosen as the control group because the University of Udine (Public Relations) is located there. A sub-sample of this control group of GPs recently received vocational training on EIBI by a local association. From one point of view this is causing confusion, since the sample is no longer strictly a control group. From another point of view, however, it demonstrates

that the Local Health Units are attempting to update their knowledge and practices according to what is promoted internationally.

In the Udine intervention group GPs will receive training and a specific communication strategy according to the WHO Phase IV Study Protocol and to what will be jointly agreed in Rome. Community actions will be carried out in both areas in order to obtain maximum diffusion in Udine and to persuade the Gorizia community to ensure that GPs utilize EIBI without specific support. In order to take baseline measures from the 76 GPs in Udine and a comparable sample in Gorizia, a survey was run in 2002. Topics such as the attitude towards alcohol issues, self-efficacy, knowledge of prevention tools and the need for training were explored.

No significant differences were observed between the two areas in sample characteristics such as gender, age, experience and reasons for non-response. Even if deriving from two distinct cities, with the same background but with different involvement, they showed the same attitudes towards BI. The vast majority had a positive or very positive attitude (97%) to asking their patients about alcohol and tobacco. 94% of GPs think it is useful to enquire about alcohol; 98% consider it relevant to their practice. No difference between the two groups was observed when addressing self-efficacy (success at motivating patients to modify their lifestyle or influencing patients' drinking patterns). As regards their opinion of possible drinking limits, they gave (62% -71%) the first choices either to one occasion and for weekly doses (for men and women), demonstrating a preference for the lowest possibility. The results of this study also show that the implementation of a short period of early identification and brief intervention in general practice has no significant negative effect on the attitudes, self-efficacy and commitment of GPs in Italy.

The results have been published in *General Practice On-Line*⁵⁷ and can be found there <http://www.priory.com/fam/italgp.htm>

A questionnaire to evaluate the baseline knowledge of EIBI in the general population is now ready to be administered to a significant sample of the general public. This will be carried out by the end of 2004. At the moment the dissemination of the project to the local community (bar, industries) is ongoing. Mayors are actively involved in this work.

11.3.5.1. Training

In accordance with the Faculty of Medicine of the University of Udine, a postgraduate course on early identification and brief intervention was launched on September 2004. The aim of the course (88 hours) is to provide knowledge and expertise in the early identification of risky situations mainly linked to lifestyles and will include medicine and social science issues such as Counselling, Laboratory techniques, Nutrition, Pediatrics, Psychology, Respiratory diseases, Occupational medicine, Sexual behaviors. Elements of demography, epidemiology, statistics, community medicine, health policies, economics etc. will also be provided.

The University of Udine is currently providing trainees to run the Martignacco Office and to administer the questionnaires reviewed above. Their role is mainly to maintain contacts with the other municipalities included in the project. (The 22 small municipalities are now involving their local communities in disseminating activities to reduce smoking and drinking in bars, restaurants, and occupational settings). Trainees are also preparing a website (in both Italian and English) and trialling a Press Centre for the investigators and all regional participants in the project. Their input will be very useful when the communication strategy is implemented and an economic evaluation will also be carried out with their assistance.

The Regional School for the Continuing Training of GPs will conduct GP training, first within Udine city. Then, after the Demonstration Project has been completed, the training methodology will be disseminated to the entire Friuli Venezia Giulia region. The School has also decided to offer occasional sessions when more interested GPs can be trained in depth in motivational interviewing. Through the Alcohol Unit, the local Health Unit organized a 6-day training session on motivational interviewing (Prof G. Guelfi) for a limited number of GPs (30), but only 13 individuals attended (including only 6 GPs). Incentives were promised for the participating GPs but, until now, no contacts have been made and relationships remain only formal.

11.3.6. Future plans

Thanks to the partnership between the University of Udine and the University Bocconi of Milano, the specific expertise of an economist has been requested to perform the economic evaluation of the local project.

More focus groups need to be done, with GPs and hopefully other PHC workers, to customise materials. An agreement with the Regional School of GPs on a training module will need to be reached. The baseline general population survey will be carried out in the near future. All aspects of the demonstration project, the communication strategy and the data collected will need to be planned, performed and analysed. Indicators for the reduction of the burden of alcohol within the general population will have to be defined and investigated. All the local community actions will have to be completed and the results analysed.

All results of the project will eventually have to be disseminated to the general population and to official organizations. No major objections to this from GPs are expected. An additional objective is to obtain financial support for this work from the regional government.

11.4. Padua and Florence 2 Units: Padua and North-West area of Florence projects

11.4.1. Introduction

Since the development of Phase III of the WHO Collaborative Study, both *Centro di Alcolologia* in Florence and *Associazione Eurocare Italia* in Padua have contributed to the evaluation of the results of questionnaires targeting GPs. In regard to Phase IV, partners in the Florence 2 and Padua areas have worked together to share the results of the project as far as customisation and reframing are concerned.

11.4.2. General description

In recent years health policies have moved towards a population approach for the prevention of health-related problems, including alcohol use. In particular, WHO guidelines and European health plans have been translated at the national level to focus on health determinants rather than risk factors. This means a different perspective to coping with behaviours related to general population health and life-styles.

Regarding alcohol use, the approach adopted by the Florence 2 and Padua areas focuses on awareness of the risk related to alcohol consumption as an incentive to the reducing alcohol use and identifying life-styles that can counterbalance the rewards produced by alcohol, thus promoting community health. In these respects, the community alcohol programmes of the *Clubs of Alcoholics in Treatment* promote sobriety which includes both abstinence and risk awareness related to alcohol consumption, together with the management of relapse and the search for lifestyles which are positive and rewarding at the emotional, spiritual and cultural level. In these geographical areas the concepts of primary prevention, screening, care and rehabilitation are superseded as separate categories by including them in a global approach to health promotion.

11.4.3.1. Customisation

A Steering Committee was established to implement the research project. Members of this steering committee included researchers, medical doctors, GPs and experts in the alcohol field. A qualitative study was carried out to better understand GPs' experiences and needs. Focus groups and training were used in this study. The aim was to build an EIBI package that could be effective and meet the GPs' needs.

Objectives of the focus groups were:

- To analyze GPs' perceptions and understand their experiences in the field of alcohol-related problems;
- To assess the GP's role in primary health care related to alcohol problems;
- To self-evaluate GPs' knowledge and competencies on alcohol-related problems
- To discuss among participants the most feasible way to involve GPs in interventions on alcohol.

In 2000, 3 focus groups were organized with the participation of about 5-7 GPs each. GPs involved in the focus groups belonged to MEDICOOP, an organization of GPs working in the North-west area of Florence. The main results concerned the following 3 topics:

- i) Problems and difficulties in working on alcohol:
 - Lack of sufficient knowledge;
 - Need to be supported by the local community and local policy-makers in their work;
 - Need to have available instruments and tools.
- ii) GPs' involvement
 - Provision of an adapted EIBI package;
 - Recognition of GPs' role in prevention work related to alcohol
 - Provision of economic support.
- iii) Training for GPs:
 - Receiving more training on alcohol in general and on EIBI instruments;
 - Feeling more competent in preventive work in the alcohol field.

These results were discussed in the training sessions included in the customisation process. The following conclusions on the GPs' role have been drawn by the Steering Committee:

- A. *Information – education* for the general population;
- B. *Diagnosis and brief intervention* for risky drinkers;
- C. *Motivation and referral* for people with alcohol dependence.

Some problems linked to their work setting were underlined by GPs:

- a) they work primarily with adults/elderly people, who have strong cultural beliefs on alcohol;
- b) young people rarely go to see their GPs
- c) women tend to hide problems related to their alcohol consumption
- d) a tendency to minimize alcohol consumption by patients
- e) GPs themselves have difficulties asking their patients questions on alcohol consumption

A specific request from GPs was to be supported by the local community in their work for alcohol-related problems, in terms of implementation programmes aiming at reframing the understanding of alcohol issues.

As far as customised training is concerned, the Steering Committee designed a two half-days course or a one day intensive course in agreement with SIMG, a national organization for GPs. The first part of the course is focused on information and training on alcohol problems; the second part on the use of the EIBI package. The provisional training programme was designed to devote 20% to information, 20% to early identification, 40% to brief intervention and 20% to alcohol dependence. The training course was based on the results of GP focus groups and responses to their needs in relation to alcohol interventions.

11.4.4. Reframing

A Working Group dealing with the identification of an effective communication strategy was established. The members of this group are representatives of the local partners in the project. They have collected and analyzed the existing information/educational materials on alcohol, dividing them by target groups (young people, women) and by subject (mainly driving and work). Starting from these materials, some have been reprinted and new tools have been produced:

- European Charter on Alcohol;
- *Alcol Informa*: complete directory of national public services, non-governmental organisations and groups dealing with alcohol-related problems;
- Women and Alcohol;
- GUIDA: Guidelines on EIBI and diagnosis of alcohol-related problems for health professionals;
- *Alcol: sai cosa bevi? Più sai, meno rischi!*: an information leaflet on alcohol to be used for brief intervention by GPs.

These materials and tools were used both for GP training and for actions targeting the general population in the Demonstration Project.

11.4.5. Strategic Alliance

At the national level, partners participating in the WHO Collaborative study are co-ordinated by Dr Emanuele Scafato, *Istituto Superiore di Sanità*, Rome as National Supervisor, Chief Investigator and Country Co-ordinator. Strategic alliances with national partners have been built:

- *Istituto Superiore di Sanità* (ISS), Rome;
- EUROCARE Italia, Padua;
- *Società Italiana di Medicina Generale* (SIMG);
- *Azienda Sanitaria di Padua*
- *Società Italiana di Alcologia*
- *Centro di Alcologia dell'Università degli Studi di Firenze, Azienda Ospedaliera di Careggi*;
- *Società Italiana di Alcologia*

The lead organizations (i.e., *Centro di Alcologia* in Florence and *Associazione Eurocare Italia* in Padua) activated existing community programmes and networks in order to implement the project.

At the local level in Florence, strategic alliances have been built with the following partners:

- *Università di Firenze, Centro di Alcologia*,
- Municipalities of the North-west area of Florence,
- *Associazione dei Club degli Alcolisti in Trattamento* (ACAT) di Scandicci, Sesto Fiorentino e Campi Bisenzio;

- Azienda Ospedaliera Careggi, Florence;
- Istituto Fondazione Andrea Devoto, Florence;
- Dipartimento delle Dipendenze, Azienda Sanitaria 10, Florence;
- Servizio Tossicodipendenze, zona Nord Ovest, Florence;
- Osservatorio Socio-Epidemiologico, Dipartimento delle Dipendenze, Azienda Sanitaria 10, Firenze;
- MEDICOOP, Cooperativa di MMG operante nell'Area Nord Ovest di Firenze.

At the local level in Padua, strategic alliances have been built with the following partners:

- Local Municipalities
- Municipal Healthy City Office Padua
- Drugs and Alcohol Addiction Service
- GPs' associations and networks
- Volunteer associations (particularly with the Association of the Club of Alcoholics in Treatment (ACAT) in Padua
- Regional Association of City Government (ANCI - Veneto)

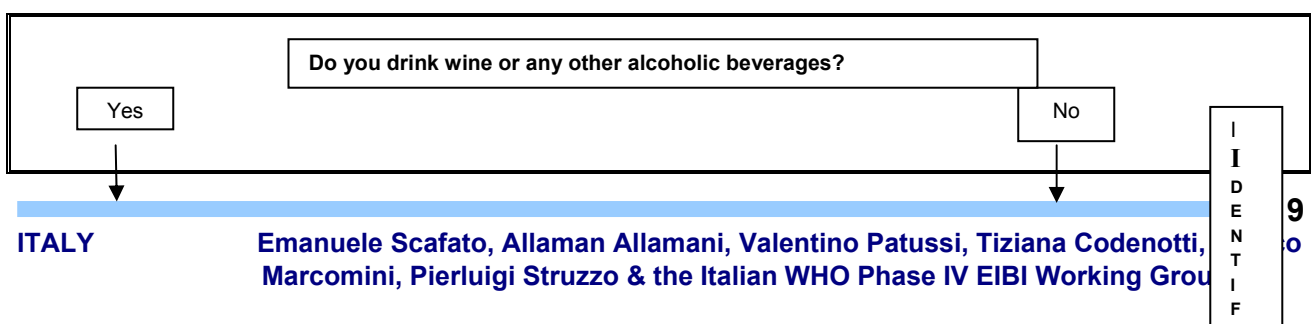
11.4.6. Demonstration Project

The Demonstration Project will include the implementation of EIBI by GPs supported at the same time by community action. GPs' activity is shown in Figure 11.1 below.

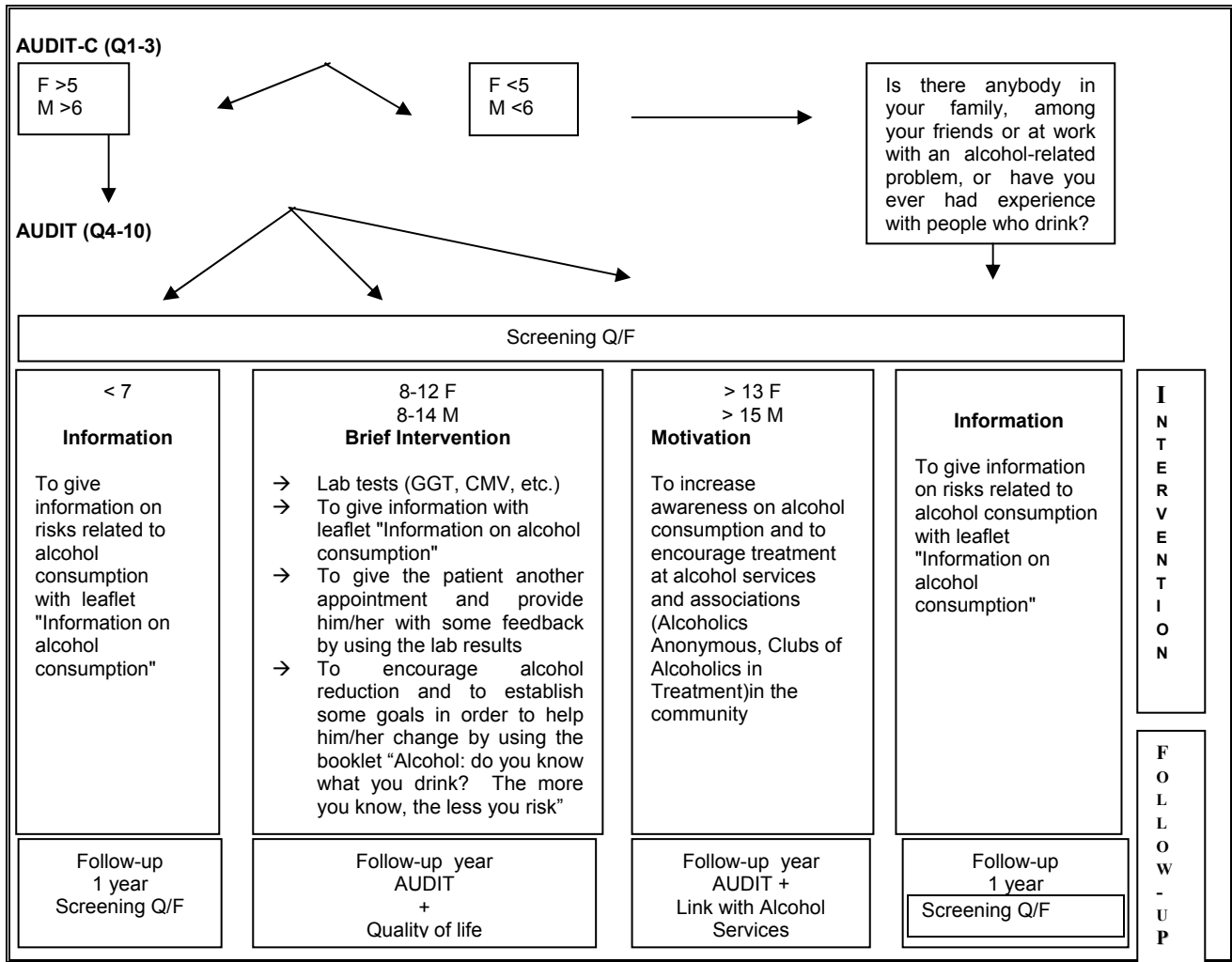
1. Identification: assessment of alcohol use of their patients by GPs using AUDIT and other questions on quantity-frequency. This assessment consists of two phases: (i) information on alcohol consumption (yes/no), quantity/frequency and binge drinking, based on the first three AUDIT items (AUDIT-C); (ii) information on alcohol consumption patterns, based on the remaining AUDIT items. Subsequently the choice of one of 3 different kind of intervention is made according to the total AUDIT score.
2. Intervention: three different interventions according to the AUDIT score:
 - *Information* on alcohol consumption and related risks (cut-off point <7);
 - *Brief Intervention* to encourage a reduction in alcohol consumption (cut-off points 8-12 female, 8-14 male);
 - *Motivation* to enter an alcohol program in public services or alcohol community programmes (cut-off point >13 female, > 15 male);
3. Follow-up after one year based on the different AUDIT scores in order to evaluate changes in alcohol consumption and quality of life.

In general terms, GPs carry out some kind of minimal intervention with everybody, including those patients with no reported alcohol consumption. This minimal intervention consists of one question on alcohol problems in the family, relatives or friends (see Figure 11.1) and in informative intervention.

FIGURE 11.1
GP screening and brief intervention package



WHO COLLABORATIVE PROJECT PHASE IV



The effectiveness of GP interventions will be closely related to reaching the following objectives:

- ◆ GP training on alcohol-related problems in order to carry out an effective prevention strategy
- ◆ Education and information activity, both on the available local resources and on alcohol-related issues in general terms. These community actions should be performed on the one hand by involving community key-figures working in hospitals, addiction services and self-help groups, and, on the other hand, by targeting the general population with specific information and communication strategies.

11.4.7. Future Plans

The next step in the project is a Demonstration Project in two different areas, one in the north-west area of Florence and another one in the Padua area. The evaluation will be designed and an economic evaluation is needed.

11.5. Conclusions

The possibility of improving the capacity to deal with alcohol problems seems to have received new strength from the experiences reported above. This Italian experience was extremely important for focusing attention on the need for standardised instruments and methodology and on the development of the local capacity to involve all the possible stakeholders into a community strategy that should be limited to the primary health care settings.

The need for a much more formalised approach to alcohol-related problems and diseases and the possibility of implementing early detection of alcohol abuse into the daily work of general practitioners by means of validated instruments has started to become a priority of public health strategy, even if many obstacles and prejudices have to be overcome and much effort made to convince that the common practice will not be affected by difficult screening procedures and that the cost-benefit ratio will be higher than today. The currently reported feelings and perceptions of GPs in considering early detection and brief intervention for alcohol abuse, clearly influenced by the burden of the pilot testing procedures, should not be underestimated but taken into account and accurately evaluated together with the other countries' experiences to try to find a common (and easier) way to tailor a new and effective strategy that could help reduce alcohol risk and harm. According to this, the need for a good model of training for the professionals involved in the preventive strategy seems to be a priority, together with a major effort to introduce a common standard of brief intervention and subsequent evaluation.

The country adaptation of EIBI and the creation of a specific country strategy will be a challenge for the forthcoming years, together with the need to implement methodologies and specific approaches to early detection and interventions aimed at preventing people becoming alcohol dependent. A general point should be made on the opportunity for developing and implementing at the general population level, and for all individuals negative on the AUDIT questionnaire, a preventive communication strategy oriented not only to reducing alcohol-related harm but at increasing awareness of the risks (particularly among youngsters) of an unhealthy lifestyle where alcohol, combined with smoking, inappropriate dietary habits and low levels of physical activity, are becoming common throughout the population.

In terms of implementing the EIBI strategy, the *Istituto Superiore di Sanità*, the *Osservatorio Nazionale Alcol*, *OssFAD*, *Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute Osservatorio*, the *WHO Collaborating Centre for Research and Health Promotion on Alcohol and Alcohol-related Health Problems* are now collaborating with the SIMG (Italian Society of General Practitioners) in a national project funded by the *Fondo Nazionale Droga* (Dependences National Funding) of the *Ministero del Lavoro e delle Politiche Sociali – Welfare, Presidenza del Consiglio*, to verify the feasibility of the early detection (AUDIT) and brief intervention in primary health care settings. Furthermore, the implementation of Phase IV of the WHO Project is linked to the activities of the national PRISMA project (Italian Project on Prevention, Identification and Strategies Management for Alcohol-related Problems), already acknowledged on the international Phase IV website (<http://www.gencat.net/salut/phaseiv/>) and currently funded for 3 years by the *Presidenza del Consiglio*. The demonstration projects will be realised in the 4 local areas where the EIBI project was carried out over the last few years involving all the partners that contributed to this report. Original documentation and methodologies have been printed and distributed in by specific web pages (*Osservatorio su Fumo, Alcol e Droga-ISS*: <http://www.iss.it/sitp/ofad/alco/down.html>, *Società Italiana di Alcolologia*: <http://www.dfc.unifi.it/sia/mese-prevenzione/aprile2004.htm> and *Alcolonline*: <http://www.alcolonline.org/alcoday/2004.html>), supporting the national setting of the network of strategic alliances including public health, research, scientific and third sector bodies and institutions together with the strong commitment of the Italian Society of General Practitioners (SIMG) which is fully involved in the ongoing funded projects.

Far from being completed, the WHO Phase IV Project will proceed through the implementation of national as well as European ongoing research and activity, particularly by means of the creation of a national strategy in the EU PHEPA project (<http://www.phepa.net/>). This will help to achieve both health and social outcomes giving people more opportunity to play an active role in the individual as well as the collective process of establishing healthier contexts and a much safer environment.

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APPENDIX 11.1

Composition of Italian WHO Phase IV EIBI Working Group**Coordinating body: Istituto Superiore di Sanità, Rome**

Project supervisor and national coordinator (appointed by WHO in agreement with the Italian Ministry of Health):

ISS: Emanuele SCAFATO, *Istituto Superiore di Sanità (ISS), WHO CC for Research and Health Promotion on Alcohol and Alcohol-related Health Problems, Osservatorio Nazionale Alcol dell'Osservatorio Fumo Alcol e Droga – OssFAD, Centro Nazionale di Epidemiologia, Sorveglianza e Promozione della Salute, Rome, Italy*

Principal Investigators:

Florence 1: Allaman Allamani *Centro Alcolologico, Florence Health Agency, NHS.*

Martignacco: Pierluigi Struzzo, N.H.S., *Regional Network of the Healthy Cities, Udine*

Padua: Franco Marcomini, *Addiction Department, Alcohol Unit, Padua* and Tiziana Codenotti, *EUROCARE Italia Association, Padua*

Florence 2: Valentino Patussi, *Research Centre for Alcohol Studies, Florence*

Units composition**Istituto Superiore di Sanità Unit**

Chief investigators: E. Scafato (ISS), R. Russo (ISS), G. Farchi (ISS), C. Gandin (ISS), P.G. Zuccaro (ISS), F. Cicogna (Ministry of Health), Alessandro Rossi (SIMG)

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TABLE 11.1

Trends in *per capita* alcohol consumption during the period 1981-2000

Litres/person/year by main alcoholic beverages and pure alcohol consumption

	1981	1991	2000	1981-2000 Changes (%)
Wine	86.2	62.1	51	- 40.8
Beer	17.9	24.9	28.1	+ 57
Spirits	3.5	2.5	1.2	- 65.7
Pure alcohol	11.7	9.1	7.5	- 35.9

Source: ISS-OSSFAD from PVGD – World Drink Trends data

Alcohol, Health and Policy: the Italian perspective. Emanuele Scafato, Piergiorgio Zuccaro, Rosaria Russo and Gloriana Bartoli. ALCOLOGIA, 13 (1), 21-25, 2001

TABLE 11.2

Consumers of alcoholic beverages between meals among males.

Prevalence (%) in years 1993-2000 and changes (%) during the period 1995-2000

Age group	1993	1994	1995	1996	1997	1998	1999	2000	Var.% 95-00
14-17	9,8	13,4	12,9		18,4	15,2	18,0	16,8	30,7
18-24	30,9	36,5	35,2		40,6	39,9	39,3	42,5	20,6
25-44	37,6	39,5	39,8		42,1	46,2	40,3	39,4	-1,0
45-64	36,8	39,2	39,5		38,7	42,3	36,7	37,3	-5,5
65-74	27,0	29,3	28,5		29,8	30,0	26,9	28,2	-1,0
75+	22,0	18,8	21,6		20,0	21,2	19,1	16,4	-24,4

TABLE 11.3

Consumers of alcoholic beverages between meals among females.

Prevalence(%) in years 1993-2000 and changes (%) during the period 1995-2000

Age group	1993	1994	1995	1996	1997	1998	1999	2000	Var.% 95-00
14-17	7,1	8,0	6,0		10,8	9,7	12,8	12,2	103,7
18-24	13,2	15,0	16,5		22,4	20,8	25,2	24,8	50,2
25-44	12,3	13,2	12,8		15,1	15,4	15,4	15,4	20,7
45-64	9,1	9,9	9,5		11,6	12,4	11,4	10,9	15,1
65-74	5,8	5,7	5,1		6,4	6,4	6,2	5,6	9,9
75+	4,6	3,6	3,9		4,0	3,7	4,0	4,1	3,7