IMPLEMENTING BRIEF ALCOHOL INTERVENTION IN PRIMARY AND OCCUPATIONAL HEALTH CARE.
EVALUATION OF THE FINNISH CASE

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ABSTRACT

We describe here the Finnish case of implementing brief alcohol interventions in primary and occupational health care in the light of the two latest nationwide projects. These projects build on earlier national and international research results and practical knowledge and they are tailored according to the Finnish political and medical culture. In this paper we report how actively the regions participated in the primary health care nationwide implementation project and what was the quality of the primary and occupational health care projects in light of the recently published quality instructions.

Our conclusion is that these two projects, with a relatively high quality, have shown that widespread implementation of brief alcohol intervention in health care is possible. The attitudes especially among leaders have changed positive, and education and training are actively asked as well by primary as occupational health centres.
**INTRODUCTION**

Brief intervention on hazardous drinking, based on several randomized studies, systematic reviews and meta-analyses (1-3), is effective. Compared to other tools available for alcohol misuse in health and social care it is the most effective one (4). The latest Cochrane review shows that the number needed to treat in primary health care setting is 7-10 (5). In spite of these facts the widespread implementation has been difficult (6).

**1. BI history in Finland**

Finland has a long history of interest in brief intervention, both in research and in everyday work. Three dissertations on the topic, based on randomized studies, have been published, one from trauma centre, one from health screenings and the latest from primary health care setting. The Finnish research activity also includes one study on macrocytic patients in primary health care. There are and have been several research groups working to develop biochemical markers for early detection of hazardous drinking.

For years, there have been sporadic activities in primary, occupational and specialized health care to promote brief intervention in real life work. However, in spite of written guidelines (7), the activity has concentrated on only few professionals, mainly in leading positions. At the practical professional level the activity has been scarce and short-lasting.

In the middle of the first decade of this century a wide regional implementation project started in Pirkanmaa region (8). This project was based on the detected low activity in alcohol-related matters in health care (9) and it was funded by the Ministry of Social Affairs and Health. The target groups included both primary and occupational care as well as hospital settings. The project used modern and multi-faceted implementation tools, e.g. only short lectures, but group-works and role-plays. Additionally, it built local strategic alliances and also used population approach. The researchers traveled around the region to make the learning sessions more easily reachable for all. With limited resources, however, the results remained small (10). Also, based on our evaluations, there were other reasons for the low activity; government health policies did not support, professionals were too busy, they still felt themselves insufficiently trained, they had too few resources, they were confused about the target group of BI, they lacked self-efficacy, expressed need for simple guidelines, had difficulties in identification of the target group and uncertainty about the justification of BI. These obstacles are much the same as can be found internationally (6).
Finland has also been a collaborator in the WHO Phase-IV brief intervention implementation project and a partner in the EU PHEPA-project (11,12). These two collaborations have contributed a lot of ideas and knowledge to national efforts in implementation.

After February 2004, alcohol taxation in Finland was reduced by 33% (spirits 44%; strong wines 40%; wines 10%; beer 32%). The aim was to reduce alcohol imports from other EU countries, especially from the new EU member state Estonia. A disintegration of preventive measures led to an increase in consumption and in alcohol-related harm. In 2007 alcohol was the leading death cause among working-aged population, both in men and women (13).

In its decision on alcohol policy of 9th October 2003, the Government defined the main objectives and the priorities for action to be followed in public administration to diminish the adverse effects of alcohol. Brief alcohol intervention was emphasized in the Government’s Resolution on Strategies in Alcohol Policy and in the Finnish Alcohol Programme 2004-2007. This is why the Government funded two big (nationwide) brief intervention implementation projects (VAMP, VAltakunnallinen Mini-interventioProjekti [National Brief Intervention Project] and Occupational Health Care Project) (14). In these two projects, aiming at nationwide implementation of brief intervention in primary and occupational health care as part of every-day work, the academic, practical and political interests have come together nicely.

2. Challenges of measuring the results in implementation projects

Implementation of a new activity is timely (15). The history of health care shows that decades pass before non-medicine based new practices in particular are accepted. There is some evidence what kind of implementation activities are most effective. The evidence implies that an array of different activities should be done, not only lectures and education (16). It is also known that activities which are effective in some cultures and organizations may not work in others. This means that implementation projects must, at least at country level, be tailored to local needs (11).

Another problem is that measuring the change in implementing new actions is difficult. If the change is measured by comparing the outcome measures to the corresponding measures in the beginning of the study, the design is not rigorous enough; many confounding factors may have contributed to the change. If a controlled design is used, it is impossible in practice to protect the control area from contamination. This is especially true as the implementation projects are usually funded by organizations, which are not interested in strictly scientific evaluation. Also, the projects are time-limited so, that there may not be a possibility to detect any change in activity during the
funding period of about 2-3 years. Here, the measure should be some other variable preceding the final goal.

In this paper we aim at measuring the outcome of decades-long Finnish implementation efforts by asking how actively the regions joined the nationwide implementation project and what was the quality of these implementation projects.
**MATERIAL AND METHODS**

1. **The content of the two projects**

The VAMP-project had a national coordinator and 14 regional coordinators working in all the five Finnish provinces. In the end of the project there were 46 municipalities with about 1000 general practitioners and 5000 nurses working in these municipal health centres. The population in the municipalities involved was about 25% of the total Finnish population (12, 17).

The regional coordinators were a physician – nurse or social worker pair. Working with a pair was designed to make the coordinators give each other support. Also, they met with the national coordinators four times a year during one-two-day seminars where the experiences were changed and future planned. Their salary came from the funding body, but facilities were guaranteed by the communities involved. The health care authorities of the communities had made a formal agreement to support the activity in the region. Regional coordinators mainly came from the local centres knowing the regional professionals and practices. They did not do brief intervention, but used several ways in activating the professionals to do it; education and training, reminders and support, campaigns and communication. They used modern education methods e.g. other than lectures, met small groups and heard what the groups needed. They traveled to the centres and provided the professionals with material needed in brief intervention work. This material was specifically designed for the needs of this project. Specific campaigns were also organized, which lasted from one to several days. The main type was delivering of AUDIT to all patients coming to the centre. Feedback from these campaigns was considered important to the centres.

The Occupational Health Care Project had two coordinators working in whole Finland. In the end of the project 2000 occupational health workers had had education or other contact with the project. It was about 40% of occupational nurses and physicians in Finland.

The co-ordinators – one medical doctor and one occupational nurse – were working as in VAMP-project, but target groups were all occupational health clinics in Finland and specially their physicians and nurses. Their salary came from the funding body, but facilities were at Finnish Institute of Occupational Health. They used several ways in activating the professionals to do brief intervention; education, free material, support, campaigns and communication. They travelled to all parts of Finland giving lectures and demonstrations for professionals and with material needed in brief intervention for them. This material was partly specifically designed for occupational health care practice.
2. Evaluation

The two projects are to be evaluated both quantitatively and qualitatively. The quantitative evaluation will be reported separately. Here we present the qualitative results of the Finnish implementation case:

1) how actively the regions participated in the project by years e.g. was nationwide activity gained

2) what was the quality of the projects

We can find the answers to the first question by analyzing the number of municipalities willing to participate in the VAMP during the years, collecting the feedback from the field e.g. how much training was asked and how many professionals participated in the training sessions.

The second part of the evaluation is based on the ‘Quality criteria on alcohol and drug – related preventive projects’ (18)
RESULTS

1. Participation activity

To start with, in spite of wide advertising of the VAMP-project, only 16 communities from four municipalities wanted to join the project. Much work was done to activate the biggest cities and contact was made several times with the leaders. The project was open to new participants once a year. In time, interest in joining increased significantly. In the end, all the municipalities were involved. For example from Lapland municipality all but two communities had joined the project (Figure 1). Nationwide, an open one-day seminar was given in all municipalities. These seminars collected multi-professional audience up to 100 participants per session. Several municipalities not involved in the project wanted to have half-day education on brief intervention; this trend also was clearly increasing by the project years. The national coordinators also educated trainers to municipalities which had not joined the project; these needs arose during the last year of the project.

In summary it can be said that at the end of the VAMP-project there remained no doubts of the importance of brief intervention among leaders. However, the project did not reach all professionals in the field; even in the VAMP communities 10-20% of the professionals never came to the sessions.

The Occupational Health Care Project had only two coordinators, but could reach 40% of all occupational health care professionals. The result of the National survey of occupational health services was that over 50% of occupational health care units do brief interventions but the volume was low (near 10 000 brief interventions in an year, at least 100 000 occupational brief interventions is needed)(21). After the project the Finnish Institute of Occupational Health will continue the implementation.

2. Quality evaluation

Based on the quality criteria (18) the quality of a project can be evaluated based on the so called Quality Star (Figure 2), where the quality elements are 1) quality of the content (knowledge, values, ethics and targeted collaboration), 2) quality of the activity (goal, resources, processes), 3) follow-up and evaluation. In the figure, the points of the triangle represent the quality of the content and activity; the central area represents follow-up and evaluation.
Content

As mentioned earlier, there is a thorough knowledge of brief-intervention and early detection-related topics. Concerning values and ethics we have evaluated both patients’ and professionals’ attitudes and values in relation to alcohol-related discussions and treatment in health care (10, 19, 20). The values and ethics have been permanently discussed in the coordinators’ meetings and in sessions in the participating communities. The project-workers of the both projects have participated in these meetings.

Activity

The final goal of the two projects was to decrease alcohol consumption among hazardous drinkers. The short-term goal was to activate health-care professionals to do brief intervention. This increase in activity can be supposed to lead to the final goal which, however, will not be measured in these projects.

In order to end up with a permanent change in brief intervention activity the coordinators themselves have not done the brief intervention work. They have made every effort to activate the professionals in the centres to do this. The problem today is that professionals move from one centre to another. This is why the projects have aimed at having a contact person in the communities, who could in future refresh the activity and give reminders of it.

Follow-up and evaluation

Both projects have been action-projects, where the coordinators have lived with the feedback from the field. The content of the sessions has been tailored according to the needs of the professionals.

In each community there is a separate evaluation of the project. The increase in the activity to do brief interventions is measured by two different quantitative methods. These surveys will involve both patients and professionals, as well nurses as physicians in VAMP and non-VAMP regions. In occupational health care, surveys to the professionals have been done before and after the project.
DISCUSSION

The long development of the Finnish preventive alcohol work in primary health care setting has in the present case-report been evaluated in the frame of the two latest brief intervention studies. The positive trend seen here is a consequence of the long history of activities nationally and internationally. Actually, the two projects themselves are a consequence of earlier efforts and in a way they represent a result in themselves.

When the progress first comes to certain point the results can be clearly seen. This has happened during the two projects presented here. Earlier efforts have affected attitudes and increased knowledge in health care, the political situation in Finland has forced politicians to fund preventive alcohol work, increase in alcohol consumption has changed attitudes of citizens and development in the academic general practice and occupational health care has highlighted prevention.

The importance of the present projects in implementation of brief alcohol intervention is smaller that what could be interpreted by the progress. Based on the criteria by STAKES their quality can be judged to be relatively good. They used all the expertise gathered from collaboration in the WHO study group and PHEPA. The main explanation, however, to their success is, that they started at right time and used the updated knowledge on the topic; brief intervention and implementation. Future surveys will show how big the progress, if any, in light of quantitative measures will be found. It may be that the final goal, decreasing alcohol consumption of the citizens, may never be seen if the primary preventive measures in Finland remain un-effectively used. Even in that case it can be speculated that without these activities the hazards would have been decidedly greater.
REFERENCES


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Figure 1. Number of communities joining the national brief intervention project (VAMP) in 2004-2006.

Figure 2. Quality elements of the two brief intervention projects according to the quality criteria by STAKES (Ref. 18).

**FIGURE 1.**

**FIGURE 2.**

**LEGENDS**

**GOAL**
- decrease in symptoms
- decrease in alcohol-related diseases
- work capacity
- length of life
- treatment satisfaction
- decrease in health care visits

**RESOURCES**
- co-ordinators
- all the physicians and nurses in the centre
- consultations
- occupational health care
- maternity and child care
- health check-ups

**VALUES AND ETHICS**
- patients have right to knowledge of their health-related topics
- health care professionals need to inform patients of health risks
- patients have right to do decisions based on the given information

**PROCESS**
- feedback from the professionals
- discussions to change attitudes
- knowledge-based education
- support
- information to the population
- written material for patients

**TARGETED COLLABORATION**
- specialised health care, addiction clinics
- information to the citizens/patients

**KNOWLEDGE**
- alcohol-related health consequences
- differential diagnostics of these consequences
- diagnosis and treatment
- methods to recognise hazardous drinking
- content of brief intervention

The goal is measured, other measures will be followed.