

CHAPTER 13

SLOVENIA

Marko Kolšek

13.1. Introduction

13.1.1. Country description

Slovenia is a wine-producing country on the sunny side of the Alps between Italy, Austria, Hungary, Croatia and the Adriatic Sea. It is approximately 20.000 km² with two million inhabitants. Of these, 15.6% are children under 15 years of age and 14.3% above 65 years. Average life expectancy is 71.3 years for men and 78.8 years for women. GDP in 2003 was 13.900 USD. Total expenditure on health is estimated at 8.2% of GDP.

13.1.2. Health services

There is a compulsory health insurance. The National Health Insurance Institute of Slovenia (NHIIS) usually covers 85% of the costs of primary health care (PHC) and 95% of the costs of secondary/tertiary care for all adults, but in addition the majority of the population is voluntarily insured (at a fee of approximately 20 Euros per month) in order to obtain all medical services free. In any case, all services for children, pregnancy, emergencies, some chronic diseases (e.g. malignant diseases, diabetes mellitus, etc.) and preventive care are free.

There are approximately 4,200 practicing physicians in Slovenia, equivalent to 476 inhabitants per doctor (i.e., much lower than most EU and central European countries). There are 860 general practitioners/family physicians (GP/FP), but pediatricians (167) and school medicine specialists (73) are also seen as »first contact« doctors. They work in health centres in public health services (approximately 75%) or as individual contractors with the NHIIS in practices that may be located in health centres or in their own premises. Nurses and other health care professionals work alongside these doctors.

Everyone is supposed to be registered with a doctor in a health centre or in a private practice, with no financial difference between patients. To see a doctor, one can make an appointment. GP/FPs diagnose conditions, provide health care advice and prescribe medication; they also do preventive care. Doctors in PHC also serve as gatekeepers for the secondary health care services but, if necessary, they can refer patients to a specialist clinician, therapist or other health care professional based in an out-patient clinic or hospital.

13.1.3. Alcohol consumption, problems and treatment

High alcohol consumption has been a problem for many years, while drinking alcohol is a part of the Slovenian culture. In the late 19th and early 20th Centuries, there were some abstainer organisations. After the 2nd World War there were political initiatives to decrease consumption but with no significant success. In the late 1970s, modern group therapy for alcoholics was introduced by Dr. Janez Rugej (based on the work of the Croatian psychiatrist, Dr. Vladimir Hudolin),

together with the introduction of more than 100 “Clubs of Treated Alcoholics” that are still run by social workers, nurses or GP/FPs¹. These clubs are the same as the “Clubs” in northern Italy that were introduced there a little later by Hudolin². During last 30 years there have also been some media campaigns to inform the population about the risks of heavy drinking.

Alcohol consumption in Slovenia is one of the highest in Europe – 12.3 litres of pure alcohol per year per person over 15 years³. Also, the exact amount of unregistered alcohol production is unknown but it is estimated to be 5–7 litres of pure alcohol per year per person over 15. While in some European wine-producing countries (e.g. France, Spain), alcohol consumption has significantly decreased in the last 10–15 years, there has been no such trend in Slovenia. Among adolescents, consumption is increasing, according to data from the international ESPAD study⁴. Even school-children of 10 are already drinking alcohol; only 40% are teetotallers and 14% have already been drunk⁵. More than one third of adult men and approximately 10% of adult women are risky drinkers and approximately 10%-15% of adults are alcoholics⁶. The result is a very high standardised death rate/100,000 inhabitants over 15 years for liver cirrhosis (52.3 males; 18.9 females; 38.9 both sexes) and for suicides over 15 years (52.1 males; 14.5 women; 33.0 both sexes)⁷.

There has been no previous research on brief alcohol interventions in Slovenia and brief interventions (as they are currently defined) have not been used or taught in Slovenia until now.

3.2. Customisation

The main aims of the customisation part of the project were to develop a screening instrument that would be valid and accepted by the PHC team and patients, and to find an acceptable way to use such an instrument and carry out brief intervention. Partly for these purposes, we used the results of another project in which we have participated.

In 1998 Slovenia became one of the participating countries (with Belgium, Bulgaria, Hungary, Italy, Latvia, Russia and Slovenia) in a 2-year project funded by the EU to develop a common method to carry out qualitative research: the ECAToD Project (European Community Actions supporting primary health care action against Tobacco consumption and hazardous Drinking) (see Chapter 1). 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.

One of the specific aims of the ECAToD project was to prepare for the customisation of different materials for early identification and brief intervention (EIBI) against drinking problems. The following were carried out: 1) Focus groups; 2) Delphi survey; 3) survey to validate the AUDIT questionnaire.

Some aims of customisation according to the ECAToD specific objectives on alcohol were:

- ◆ to analyse and compare each participating country’s PHC service situation/projects in respect of the prevention and early recognition of alcohol health-related problems;
- ◆ to define the essentials of community action and support for PHC as a way of creating 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.

3.2.1. Focus groups

Focus groups were run according to guidance document prepared by Pas, Struzzo and Heather⁸ for use by investigators in the WHO Phase IV study. We ran 4 focus groups on alcohol issues (GP/FPs and low-risk drinkers). The overall results demonstrated some barriers for the implementation of EIBI and some suggestions for how they might be overcome:

- neither doctors nor patients were familiar with low-risk alcohol drinking limits and the terms »hazardous« and »harmful« drinking;
- the GP/FP's role should be redefined and clear goals should be set so that the topic of alcohol becomes a normal and routine part of their everyday work. (At present, it seems that EIBI is nobody's role, so it is not the GP/FP's problem and there is a lack of awareness that only the PHC team can implement EIBI widely);
- there is a lack of guidelines for GP/FPs' everyday work on EIBI;
- there is a lack of customized materials for EIBI;
- there is a lack of knowledge about EIBI among GP/FPs and nurses;
- GP/FPs do not have »extra« time available to do EIBI;
- broader social action should be taken to change the majority beliefs that encourage heavy drinking;
- changes in alcohol policy and in society as a whole should be introduced to make the PHC team's efforts on alcohol issues more successful.

3.2.2. Delphi survey

In a Delphi survey of possible community action on the reduction of alcohol problems, 51 experts from 4 groups were recruited from: a) primary health care services; b) paramedical services for primary health care; c) politicians and governmental services; d) nongovernmental and voluntary organisations, trades unions, etc..

A final sample of 45 of experts participated. Three rounds of a set of questions were prepared over a 4-month period. First round questions were as follows:

- i) Which actions or measures could reduce alcohol drinking in your community ?
- ii) In what way could you participate in these actions?
- iii) What kind of approach could be used for certain population groups (children and adolescents, employees, marginal groups, lonely or widowed people, others)?
- iv) Describe what actions or measures you would expect from individuals, groups or organisations: general practitioners/ family physicians, pediatricians, occupational medicine specialists, other physicians, nurses, somatologists, other medical professionals, politicians, the National Health Insurance company, other insurance companies, students' organisations, primary schools, secondary and middle schools, mass media, church, others?
- v) Do you have any other suggestions?

An analysis of answers resulted in 4 groups of measures that should be implemented:

A. measures on the state level (legislation, price and tax policy, public policy);

- B. health promotion and health education;
- C. measures for specific groups (children and young people, widowed, etc.);
- D. measures by specific groups (physicians, politicians, mass media, etc.).

It was also agreed that there should be a comprehensive national program to reduce heavy drinking. One important aim of such a program should be the promotion of healthy life-styles and of drinking under the low-risk drinking limits.

To assist more effective local action, some countrywide measures should be implemented:

- stricter legislation on alcohol production, sale and availability (especially to children and youth);
- more severe penalties for the violation of laws related to alcohol;
- promotion of non-alcoholic drinks by subsidising the costs of production and sale.

The program should be directed at the population as a whole and to specific groups of the population. Special attention should be given to children and their education in the family and in school. Other groups in the population should also be considered. All these groups should be involved in the planning and conduct of different programmes. Many different organizations and professions in society (teachers, mass media, church, employers, etc.) have an important and specific role in actions to reduce alcohol-related problems. Health professionals' education should be revised to make them aware of their role, to inform them widely about alcohol problems and to teach them how to manage different aspects of the same problem at different stages.

3.2.3. Survey to validate the AUDIT questionnaire

In the late 1990s the original AUDIT questionnaire⁹ was introduced in Slovenia but was not well accepted either by doctors or patients, mainly because it seemed too long. We therefore decided to validate the original AUDIT-10 questionnaire (10 questions with cut-points 8 for men and 7 for women) and the shorter AUDIT-C¹⁰ (the first 3 questions with cut-points 5 for men and 4 for women). We disguised the 3 AUDIT-C items in a questionnaire about eating, physical activity, smoking and coffee drinking in order to reduce the emotional significance of alcohol.

Patients were randomly selected in GP practices. For patients reaching the cut-points of the AUDIT-10 or AUDIT-C, a CIDI questionnaire¹¹ was given to those patients who did not refuse to complete it. Responses are given in Tables 13.1 and 13.2.

**TABLE 13.1:
Responses to the original AUDIT-10 and CIDI questionnaire**

	Female	Male	Total
No. of patients	169 (53.0%)	150 (47.0%)	319 (100.0%)
AUDIT-10 positive	26 (15.4%)	31 (20.7%)	57 (17.9%)
CIDI positive	14 (8.3%)	16 (10.7%)	30 (9.4%)
CIDI negative	7 (4.1%)	5 (3.3%)	12 (3.8%)
CIDI not completed	5 (3.0%)	10 (6.7%)	15 (4.7%)

TABLE 13.2:
Responses to the AUDIT–C and CIDI questionnaire

	Female	Male	Total
No. of patients	158 (52.8%)	141 (47.2%)	299 (100.0%)
3 Q AUDIT positive	26 (16.5%)	74 (52.5%)	100 (33.5%)
CIDI positive	2 (1.3%)	19 (13.5%)	21 (7.0%)
CIDI negative	12 (7.6%)	25 (17.7%)	37 (12.4%)
CIDI not completed	12 (7.6%)	30 (21.3%)	42 (14.0%)

A total of 20.7% of men and 15.4% of women had positive screening results for at least hazardous drinking on AUDIT-10. The figure for men seems too low according to available data on drinking levels in the Slovenian population. The GP/FPs commented that they thought many patients' responses were invalid because they knew they were problem drinkers. Only a half of those who screened positive on the AUDIT also had positive scores on the CIDI questionnaire. This is not unexpected because the CIDI is intended more to detect harmful drinking and dependence while the AUDIT is concerned more with hazardous and harmful drinking.

A total of 52.5% of men and 16.5% of women had positive screening result for at least hazardous drinking on the AUDIT–C which is closer to indications from available national data. One quarter of men and less than one tenth of women had a positive score also on the CIDI questionnaire.

We found some problems during the validation process:

- the original AUDIT–10 and the CIDI are too long for use in everyday GP/FPs' practice;
- cut-points on the AUDIT–C may be too sensitive;
- the time period asked about is not defined in the AUDIT;
- there is a similar problem with all questionnaires and also in interviewing patients: *valid responses*. It seems as though all risky drinkers or patients who believe their doctor may assess their drinking as immoderate respond by underestimating consumption.

For everyday work with patients in primary care we found AUDIT–C usable in our country. It is convenient for incorporation in a life-style questionnaire, together with questions about eating habits, smoking and physical activity.

During the Phase IV study, we made some small changes to the items in AUDIT-C as a result of focus groups analysis, the experiences of some GP/FPs who used it in their practices and the comments of patients who completed it:

- the period of time asked about was defined for all three questions (i.e., the previous 12 months);
- response items for the second question were slightly changed and “half of a drink” was added as an option because some patients had difficulty in responding if they did not drink a whole glass.

The Slovenian version of AUDIT-C is shown in Appendix 13.1.

We subsequently carried out an analysis of a sample of 303 life-style questionnaires that were filled in by patients during preventive check-ups at their GP/FPs' practices. As a consequence of this analysis, we redefined cut-points for a positive score on the adapted screening test for Slovenia: for men = 6 points, for women = 5 points. Using these cut-points reduces the number of false positive and false negative results obtained considering the low risk limits for drinking that are set in Slovenia.

We are considering the development of “screening” questions that can be used in an interview with patients. This is because some patients, and some physicians too, dislike questionnaires. When suitable verbal questions have been prepared, we will conduct a study to compare this method with written questionnaires and validate it. We are also considering using actual amounts of wine, beer or spirits instead of units in the adapted AUDIT–C because some patients had difficulties translating drinks to units of alcohol.

13.3. Reframing

Slovenia is a well-known wine-producing country but spirits and beer are traditionally produced too. Nevertheless, a half of Slovenian families now produce some of their alcoholic beverages (wine and spirits) and this production is not under control⁵. There is a belief that drinking alcohol is normal behaviour and being drunk is not at all unusual, but it is unusual to be a teetotaler. Most people still think in terms of the “alcoholism” concept. On the other hand, a more rigorous law on alcohol availability was recently introduced. However, just before this, alcohol advertising was made possible again after many years of full restriction when any kind of alcohol advertising was forbidden. For example, it is now possible to advertise beer on TV or wine in newspapers or posters if a specific warning is added: “The Minister of Health warns that immoderate alcohol consumption can harm your health.”

In order to try to modify the “alcoholism” concept, a reframing process was started by:

- ❑ articles in several public and medical journals and publications¹²⁻²⁰
- ❑ alcohol issues included in the 6th year medical faculty curriculum
- ❑ alcohol issues included in vocational training of GP/FPs
- ❑ training of EIBI included in vocational training of GP/FPs
- ❑ EIBI information introduced in several CME courses
- ❑ a handbook on EIBI for GP/FPs published
- ❑ training of more trainers for EIBI begun

In addition, a one-and-a-half year widespread population-based information campaign called *Message in the Bottle* was started in October 2003 with collaboration between the Department of Family Medicine at the Medical Faculty, the Academy of Art, the Faculty of Social Work (all 3 at the University of Ljubljana) and a marketing professional. The campaign was supported by the Ministry of Health, the NHIIS, several communities, newspapers, TV and many different companies and organisations throughout the country. The campaign included press conferences,

articles in the mass media, art exhibitions on issues of alcohol-related harm, posters and an information leaflet for the general public.

At the beginning of the campaign a national press conference was organised, followed by reports in all the leading national mass media (journals, radio, TV), several journalists' articles on reframing understandings of alcohol issues and several interviews with different experts in alcohol field. The Art Academy students prepared several innovative designs on alcohol-related issues that were presented as posters, brochures, leaflets, TV and movie spots. Leaflets with important information on alcohol issues were sent to the readers of the most popular national daily newspapers. Exhibitions of posters were organised at the most frequented streets and squares in bigger towns and in some large companies where leaflets were distributed to passers-by. Posters and leaflets were sent to all GP/FPs in Slovenia, all centres of social work, pharmacies, universities, colleges, high schools and railway stations.

13.4. Strategic Alliance

Many different organisations participated in various ways in this project:

Department of Family Medicine at the Medical Faculty:

reframing understandings of alcohol issues was included in the 6th year curriculum;

Society of Family Physicians:

EIBI training was included in the vocational training curriculum for family medicine;

Ministry of Health

financial support was provided for a wide population-based information campaign called *Message in the Bottle* that began in October 2003 and will last till spring 2005; the adapted AUDIT-C questionnaire was included in a life-style questionnaire given to adults (between age 40-70) for preventive check-up every 5 years; training of GP/FPs in EIBI was supported;

Art Academy, Department of Design

several designs were prepared during a course for students on the concept of low-risk, hazardous and harmful drinking, and the harmful effects of alcohol;

Faculty of Social Work

students conducted a survey on drinking habits, knowledge of alcohol issues and attitudes to drinking among visitors to health centres and social work centres; also a terrain survey (interviews of passers-by at exhibitions) on the public's experience of the *Message in the Bottle* campaign was conducted;

GP/FPs and school medicine specialists, health centres

patients informed by posters and brochures about the concept of low-risk, hazardous and harmful drinking, the risks of heavy drinking, and the benefits of reduced drinking;

Centres of Social Work

clients informed by posters and brochures;

Colleges, high schools and universities

students informed by posters and brochures;

National railway company

passengers informed by posters and brochures;

Two big national journals

brochures distributed at reduced fees;

CINDI programme leaders

publication and distribution of handbook on EIBI for GP/FPs supported;

training of more trainers of EIBI for GP/FPS and nurses organized.

13.5. Demonstration Project

A Demonstration Project has not been carried out in Slovenia because we were unable to obtain the necessary funding. It had been planned to take place in a wine-producing region and a control region was selected too. A preliminary survey of drinking habits, knowledge of alcohol issues and attitudes to drinking among GP/FPs and their patients in both regions was carried out.

However, it seems that not having run a demonstration project is not such a big loss because we have succeeded in influencing some very important changes in the country as a whole. It would surely be a pity not to begin the nationwide reframing process or to omit the AUDIT-C questionnaire in the national, compulsory preventive check-up programme for adults, when these developments were possible and supported in the country as a whole, merely because the demonstration project had not been carried out. It would also be unhelpful to carry out a demonstration project in a small region, possibly followed some years later by a nationwide project, when the situation was already suitable for implementing some Phase IV objectives throughout the country.

13.6. Conclusions

The main products of the Phase IV study in Slovenia are:

- ❑ customisation of a screening instrument (adapted AUDIT-C);
- ❑ a widespread population-based information campaign called *Message in the Bottle* aimed at reframing understandings of alcohol issues;
- ❑ education on alcohol issues included in the Medical Faculty curriculum;
- ❑ education on EIBI included in vocational training of family physicians;
- ❑ many GP/FPs are now sensitised to their important role in EIBI;
- ❑ early identification is included in regular preventive check-ups among the adult population.

In the future we intend to:

- continue the project on reframing understandings of alcohol issues among the general population;
- continue to educate more trainers for EIBI;

- start step-by-step to educate all practising GP/FPs and nurses in EIBI;
- develop and validate some verbal questionnaires for the early identification of hazardous or harmful drinking;
- advocate to the Ministry of Health to institute National Health Insurance reimbursement for GP/FPs to deliver EIBI;
- prepare and publish a self-help leaflet for risky drinkers;
- encourage all clinicians to include early identification of risky drinking in their everyday work with patients in hospitals and out-patient clinics;
- encourage nursing schools and colleges to include information on EIBI in their curricula.

If all these planned activities are successful we expect that in a few years the widespread, routine and enduring implementation of EIBI in PHC will be reality in Slovenia. If we continue to educate and encourage PHC teams, we believe they will slowly accept EIBI, in the same way that they have accepted the measurement of blood pressure in their routine everyday work over last two decades.

13.7. References

1. Rugelj J. *Dolga pot*. Ljubljana: Republiški odbor Rdečega križa Slovenije, 1977.
2. Hudolin V. *Klubovi liječenih alkoholičara*. Zagreb: Jumea, 1982.
3. Šešok J. *Poraba alkohola in kazalci škodljive rabe alkohola v Sloveniji v letu 2003*. Ljubljana: Institut za varovanje zdravja, 2004.
4. Hibell B, et al. *The ESPAD report 2003. Alcohol and other drug use among students in 35 European countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN), The Pompidou Group and Council of Europe, 2004.
5. Kolšek M. *Pogostnost pitja alkohola in pivske navade osnovnošolcev v Sloveniji* (Doktorska disertacija). Ljubljana: Medicinska fakulteta, 2000.
6. Hovnik-Keršmanc M, Čebašek-Travnik Z. *Razširjenost rabe alkohola med prebivalci Republike Slovenije, starimi 18 let in več*. Ljubljana: Inštitut za varovanje zdravja RS, 1999.
7. Zaletel-Kragelj L, Čebašek-Travnik Z, Hovnik-Keršmanc M. Škodljiva raba alkohola med odraslimi prebivalci Slovenije (epidemiološki podatki). *Odvisnosti* 2004; 5: suppl 2.
8. Pas L, Struzzo P, Heather N. *Guidance Notes on Focus Group Methodology*. Unpublished manuscript. Newcastle upon Tyne: WHO Phase IV Co-ordinating Centre, Division of Psychology, Northumbria University, UK, 1999.
9. Saunders JB, Aasland OG. *AUDIT. The World Health Organization Screening Instrument for Harmful and Hazardous Alcohol Consumption*. Geneva: World Health Organization, 1990.
10. Bush K, Kivlahan DR, McDonnell MB, Fihn SD, Bradley KA The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. *Archives of Internal Medicine* 1998;158:1789-1795.
11. Wittchen H Reliability and validity studies of the WHO-Composite International Diagnosis Interview (CIDI); a critical review. *Journal of Psychiatric Research* 1994; 28: 57-84.
12. Čebašek-Travnik Z, Rus Makovec M. Miti, zmotna prepričanja in resnice o odvisnosti od psihoaktivnih snovi. *Viceversa* 2000; 30: 35-48.
13. Inštitut za varovanje zdravja.. Alkoholna politika in mladi ljudje. *Bilten slovenske mreže zdravih šol* 2001; 1: 24-5.
14. Čebašek-Travnik Z. Jasni dokazi o tem, da preventiva deluje. *Journal of the American Medical Association (Slov. izd.)* 2001; 9: 65-66.
15. Kolšek M. Oglasevanje alkohola - "Ali je pivo živilo?" *Delo*, 9 January 2001.

16. Čebašek-Travnik Z., Radovanovič M. Uporabnost systemskega modela za zmanjševanje škodljive rabe alkohola na delovnem mestu. *Kadri* 2002; 3: 64-72.
17. Kolšek M. Vloga družinskega zdravnika pri tveganem in škodljivem pitju alkohola. *Medic razgl* 2002; 41 (Suppl 1): 157-162.
18. Kolšek M. Vsak zase trdi, da pije zmerno. *Družina*: januar 2004.
19. Kolšek M. Projekt Sporočilo v steklenici. *Isis*: maj 2004.
20. Kolšek M. Vse več žensk je odvisnih od alkohola - alkoholna emancipacija. *Jana*: 29.1.2004.

APPENDIX 13.1

Slovenian version of AUDIT-C (adapted by Marko Kolšek)

1. How often did you drink alcohol during the last 12 months (beer, wine, spirits, alcoholic cider) ?
 - a) never (0 points)
 - b) once a month or less (1 point)
 - c) 2 - 4 times a month (2 points)
 - d) 2 - 3 times a week (3 points)
 - e) 4 times a week or more (4 points)

2. How many drinks containing alcohol did you have on a typical day when you were drinking during the last 12 months? (One drink – unit is: 1 dcl of wine **or** 2,5 dcl of beer or cider **or** 0,3 dcl of spirit.)
 - a) 1/2 or 1 drink (0 points)
 - b) 2 drinks (1 point)
 - c) 3 - 4 drinks (2 points)
 - d) 5 - 6 drinks (3 points)
 - e) 7 drinks or more (4 points)

3. How often during the last 12 months did you drink
 - **men:** 6 drinks or more per occasion?
 - **women:** 4 drinks or more per occasion?
 - a) never (0 points)
 - b) less than once a month (1 point)
 - c) monthly (2 points)
 - d) weekly (3 points)
 - e) daily or almost every day (4 points)

Slovenian national recommendations for low-risk drinking are:

*MEN: 14 units or less per week (2 units or less per day)
and 5 units or less per occasion*

*WOMEN: 7 units or less per week (1 unit or less per day)
and 3 units or less per occasion*

(1 unit of alcohol = approx. 10 g pure alcohol)