European Union Member States initiative to assess and share good practices for reducing alcohol related harm

POBUDA DRŽAV ČLANIC EVROPSKE UNIJE ZA OCENO IN IZMENJAVO DOBRIH PRAKS ZA ZMANJŠANJE ŠKODE ZARADI ALKOHOLA

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Kaj je znanega?

Z dokazi podprte dobre prakse predstavljajo pomembno osnovo za politične odločitve in ukrepe v državah članicah na področju preventive, zmanjševanja škode in zdravljenja v povezavi s pitjem alkohola. Pri izbiri in prenosu dobrih praks v drugo okolje ali državo je potrebno upoštevati vrednote, etiko in kontekst, ki so za preventivo na področju alkohola enako pomembni, kot je učinkovitost izbranega pristopa.

Kaj je novega?

Naša raziskava je pokazala, da nekatere osnovne zahteve, ki jih morajo intervencije izpolnjevati, da bi jih prepoznali kot primere dobre praksa, pogosto niso bile izpolnjene. Zato oblikovalci in izvajalci intervencij potrebujejo jasne smernice za načrtovanje z dokazi podprtih intervencij na področju alkohola, relativno enostavna merila za ocenjevanje intervencij in stalno izmenjavo izkušenj med posameznimi inštitucijami in državami.

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Povzetek

Uvod: Z dokazi podprte dobre prakse predstavljajo pomembno osnovo za politične odločitve in ukrepe v državah članicah na področju preventive, zmanjševanja škode in zdravljenja v povezavi z alkoholom. Zato je bil eden od glavnih ciljev projekta Zmanjševanje z alkoholom povezane škode (RARHA – ang. Reducing Alcohol Related Harm) zbiranje in ocenjevanje zgodnjih intervencij, intervencij ozaveščanja javnosti in intervencij v šolskem okolju. **Metode:** Vprašalnik za zbiranje dobrih praks je bil pripravljen na podlagi obstoječih vprašalnikov za potrebe zbiranja dobrih praks znotraj različnih evropskih projektov s področja preventivnih aktivnosti na področju alkohola. Za ocenjevanje prejetih intervencij smo razvili merila za ocenjevanje, ki temeljijo na obstoječem nizozemskem sistemu za evalvacijo intervencij na področju zdravja. Intervencije smo ocenili na podlagi naslednjih meril: podan je zelo dober opis intervencije, Intervencija se izvaja v resničnem okolju/je izvedljiva/je prenosljiva, intervencija ima teoretično osnovo in intervencija je bila evalvirana. **Rezultati:** Iz 19 držav smo prejeli 48 primerov dobrih praks, od katerih jih je 43 izpolnjevalo vključitvena merila zahtevana za postopek ocenjevanja. Po oceni primerov je bilo pozitivno ocenjenih 26 (60%) dobrih praks. Vsi sprejeti primeri dobrih praks so bili razdeljeni v štiri različne ravni dokazov, odvisno od kakovosti študij, ki so preučevale učinke in uspešnost posamezne intervencije. **Zaključek:** Ta vseevropska ocena intervencij za zmanjševanje z alkoholom povezane škode je bila edinstvena skupna pobuda za izboljšanje kakovosti teh intervencij v državah članicah. Ugotovili smo, da obstaja potreba po nenehni izmenjavi izkušenj, da bi tako spodbudili izvajanje z dokazi podprtih dobrih praks na področju alkohola, in da bi strokovnjaki imeli koristi od obstoječih teoretičnih in praktičnih znanj in izkušenj.

Ključne besede: alkohol, dobre prakse, zgodnje intervencije, intervencije ozaveščanja javnosti, intervencije v šolskem okolju, preventiva, zmanjševanje škode zaradi alkohola.

Abstract

Background: Evidence-based good practices present an important base for Member States policy decisions and actions in the field of alcohol prevention, harm reduction and treatment. Therefore, one of the main objectives of the Joint Action on Reducing Alcohol Related Harm was to collect and assess early interventions, public awareness and school-based interventions. **Methods:** The questionnaire for collecting good practices was prepared on the basis of similar project questionnaires

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on collecting good practice examples of alcohol prevention. In order to assess the collected examples we have developed the Assessment criteria based on an existing Dutch system for evaluating health-based interventions. We assessed the interventions based on the following criteria: Intervention is well described, intervention is implemented in the real world and is feasible/transferable, intervention has a theoretical base and intervention has been evaluated. **Results:** We have received 48 examples from 19 countries, 43 of them met inclusion criteria requested for the assessment procedure. After assessing the examples, 26 were assessed positively (60 %). All accepted interventions were assorted into four different levels of evidence depending on the design of the studies that were looking into the effects of the specific intervention. **Conclusion:** This Europe-wide assessment of alcohol prevention interventions was a unique joint initiative to improve the quality of alcohol prevention interventions in the Member States. We have learned that there is a need for a continuing exchange of experience in order to promote implementation of evidence-based alcohol related interventions and for professionals to profit from existing theoretical and practical knowledge and experience.
Key words: Alcohol, good practice, early interventions, public awareness interventions, school-based interventions, prevention, alcohol-related harm.

1 Introduction

"What should we do about alcohol?" Michael Marmot asked in 2004. (1) In his frequently cited editorial in the British Medical Journal, "Evidence based policy or policy based evidence?", he was referring to the situation in the United Kingdom, characterised by a rate of alcohol consumption that had risen by about 50 % in the previous 30 years. Conversely, average consumption in Europe reached its lowest point in 2012 since 1961. (2) Such averages may, however, disguise the underlying heterogeneity. (3) Indeed, while the highest consumption countries have seen a drop, like France and Italy, some of the countries with lower alcohol consumption rates have actually seen a rise in the same 50-year period. Despite this diversity of epidemiologic developments in Europe, there is a shared concern, which has brought together partners in the Joint Action on Reducing Alcohol Related Harm (RARHA). Europe remains the world region with the highest alcohol consumption rate. (4) The significant harm associated with consumption of alcohol at this level creates a need for identifying the most effective measures to counter the harm. (5, 6, 7, 8)

The Joint Action RARHA was a three-year action co-funded by the European Union (EU), under the second EU Health Programme, with contribution from Member States (MS). One of the core work packages (WP) was a WP 6 "A toolkit for evidence-based good practices" with the aim to contribute to the implementation of the EU strategy to support MS in reducing alcohol related harm by focusing on concrete examples of good practice approaches that are implemented in MS.[1] The Health Programme's objective to "identify, disseminate and promote the uptake of evidence-based good practices for cost-effective health promotion and disease prevention" is identified as one criterion on how actions can achieve EU added value. They present an important evidence base for MS's policy decisions and actions in the field of alcohol prevention, harm reduction and treatment. Our objective was to collect and to assess the group of practices that were disseminating different type of information related to alcohol. WP6 work was built on the information gathered by the WHO report Alcohol in the European Union, which indicates that information activities related to alcohol consumption are widespread. (8) Good practice approaches exist but are not collectively evaluated and available for use by other MS, while in some settings they seem to be missing. WP6 work was also built on the results of related projects funded under the EU Health Programme and under the EU Research Framework Programme. (10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21) There are several good practice compilations – publications and databases – many of which have been produced with EU funding. The challenge within the WP6 was to make them more accessible and more useful for the intended beneficiaries, in this case for relevant ministries, policy makers, decision makers, public health professionals, NGOs or other stakeholders and professionals responsible for designing and implementing alcohol policy interventions.

2 Methods

The first step towards collecting and assessing the examples was to decide which group of interventions to focus on. For that reason, we asked the MS representatives in the Committee on National Alcohol Policy and Action (CNAPA) to select groups of interventions, having in mind

what would be most useful for national public health organizations. A short survey was conducted to select three groups of interventions which will be assessed: 1. Early interventions (Early identification and brief intervention for hazardous and harmful drinking); 2. Public awareness interventions (including new media, social networks and online tools for behaviour change); and 3. School-based interventions (information and education).

A review of good practice definitions in prevention was carried out, aimed at the preparation of a most suitable and exact definition of good practice. (22, 23, 24, 25, 26, 27, 28, 29, 30, 31) Together with WP6 partners we came to a final version of the good practice definition: "Good practice refers to a preventive intervention (action / activity / working method / project / programme / service) that was found to be effective in accomplishing the set objectives and thus in reducing alcohol related harm. The intervention in question has been evaluated either through a systematic review of available evidence and/or expert opinion and/or at least one outcome evaluation. Furthermore, it has been implemented in a real world setting so that the practicality of the intervention and possibly the cost-effectiveness has also been examined."

The questionnaire for collecting good practices was prepared on the basis of similar other project questionnaires on collecting good practice examples on alcohol prevention. (11, 12, 13, 14, 15, 16, 17, 18, 19, 29, 21) It consisted of six sections: Evidence base (quick scan), Basic facts, Development (including preparation, planning and core processes), Implementation, Evaluation and Additional information. After piloting the questionnaire, we sent it to previously identified national public health professionals from all MS. The collection phase ended in April 2015. For some countries, we did not manage to collect any data, mainly because the contact persons reported that their existing interventions did not met the basic inclusion criteria defined in the questionnaire (Objectives, Target group, Approach, Prerequisites for implementation and Participants' satisfaction should be described in such detail that the methodology is comprehensible and transferable).

3 Results

In order to assess the collected interventions, we have developed the criteria based on an existing Dutch system for evaluating health-based interventions from the National Institute for Public Health and the Environment. (32, 33) This institute supports the delivery of efficient and effective local health promotion in the Netherlands. It promotes the use of the most appropriate lifestyle interventions (health promotion and primary and secondary prevention) by clearly presenting available interventions, planning instruments, communication materials and links to relevant Dutch knowledge and support organizations on the portal Loketgezondleven.nl. This portal also presents information on the quality, effectiveness and feasibility of health promotion interventions. The selected Dutch system for evaluating examples of health based interventions, rates interventions along a continuous scale of evidence levels, ensuring that a number of minimum requirements are met (Table 1). Other internationally well-established systems for evaluation of health-based interventions were also considered, including "SAMHSA Evidence-Based Practices", "Grüne Liste Prävention" register, EMCDDA portal and others, however the Dutch system was selected since the National Institute for Public Health and the Environment was one of the partners in the project and they were able to provide necessary support.

There are four levels of evidence-based interventions depending on the design of the studies that were looking into the effects of the intervention (Table 2). A good practice must accomplish all listed criteria in the specific section to be recognized as theoretically sound at the basic level, or at the level of first indications of effectiveness or at the level of good indications of effectiveness, etc.

From 19 countries we have received 48 examples, 43 of them met the inclusion criteria requested for the assessment procedure. After assessing the examples, 26 were positively assessed (Table 3).

The accepted interventions are presented by type in tables 4, 5 and 6 as Early interventions, Public Awareness Interventions and School Based Interventions, respectively. (34, 35, 36) All accepted interventions were divided into four different levels of evidence. Table 7 shows the distribution of accepted interventions into different levels of evidence.

4 Discussion

Most accepted interventions in the same categories were somewhat similar, in the sense that school-based interventions often included

programmes 'targeting' both students as well as their parents to prevent or reduce alcohol use among adolescents. Regarding early interventions, many programmes focused on providing training for healthcare professionals to recognize alcohol-related problems within their field.

It was a different story concerning the public awareness campaigns. There were interventions aimed at football supporters ("do not drink too much"), but also campaigns aimed at drivers of boats and employees ("do not drink at all"). It was difficult to assess public awareness campaigns with the criteria that were set up there because in some cases these were not entirely applicable (for example, during the evaluation there was not always information available on participants' dropout because intervention-related activities were sometimes directly evaluated by spontaneously recruited participants/visitors of certain events). Therefore, in addition to meeting the criteria, a more general impression of the public awareness campaign was taken into account if doubts arose.

All positively assessed interventions are presented in the WP6 publication "A tool kit for evidence based good practices: Public awareness, school-based and early interventions to reduce alcohol related harm", on the RARHA project web page and on the European Commission Best practice portal. (34, 35, 36)

Interventions, which were not positively assessed, did not meet the following common requirements:

1. The intervention is well-described: A problem that would often arise during assessment was that the goal of the intervention wasn't clearly described. Furthermore, the description of the intervention was often not complete or clear. For example, an intervention would be described in general terms, but no specifics would be given on frequency, intensity or duration.
2. The intervention is implemented in the real world, and is feasible/transferable: Specifics on financial costs or time that needed to be invested were often missing or unclear; also, there was no manual or concrete description of activities for the intervention available.
3. The intervention has a theoretical base: It was often the case that there were no effective elements (or techniques or principles) in the approach stated or specified, in the framework of a change model or an intervention theory, or based on results of previously conducted research.
4. The intervention has been evaluated: The outcomes found were not always the most relevant given the objective that was stated in the intervention description. This often occurred simultaneously with an unclear description of the intervention goal. In these cases, it was impossible to assess the effectiveness of the intervention properly.

We have noticed that none of the Public awareness interventions ranked in the group of interventions with a strong indication of effectiveness and only one ranked in the group with a good indication of effectiveness. Considering the fact that for the intervention to be ranked in the group with a strong indication of effectiveness, it has to be evaluated using a pre and post experimental or quasi experimental study with control group and follow up, it is to be expected that a very limited number of public awareness interventions are designed in such a way that it is possible to conduct such evaluations. This is at the same time the limiting factor of our research and/or criteria.

5 Conclusions

Working as a multi-national team we have learned that values, ethics and context all matter and that there is no "one-size-fits-all" approach to effective alcohol prevention. Furthermore, epidemiological developments differ between and within countries and so do value systems and cultures, which should also be taken into account. Additionally we have realised that sometimes it is difficult to get enough information about the interventions from countries that have no information available in English. Translations take much time and sometimes there is a lack of capacity for this task.

This European-wide assessment of alcohol prevention interventions was a unique attempt to improve the quality of alcohol prevention interventions in the MS. It was a first step towards a continuing exchange of field experience in order to promote evidence-based implementation of alcohol-related interventions, and for professionals to profit from existing theoretical and practical knowledge and experience.

From the perspective of countries that have a lack of capacities to build their own comprehensive system for assessing prevention interventions, and that have a language barrier for using the tools that already exist (due to the limitations of these tools that mainly accept only interventions

that are translated into English), our straightforward Assessment Criteria can be easily used at national level to recognize good practices that can be recommended for broader use. At the very least, this work will help choose a highly evaluated and effective intervention in the field of dissemination of information to reduce alcohol-related harm, over a poorly evaluated and ineffective one.

By the end of the Joint action RARHA it became clear that the European Commission recognized the need of MS to identify and share evidence-based interventions, not only the alcohol related interventions, but more broadly interventions to prevent and manage chronic diseases. The DG SANTE is aiming to provide MS with a resource centre which, as well as providing other information, will pool together a wealth of best practices in the fields of health promotion and chronic disease prevention and management. The best practices to be selected may serve for a group of similar MS or for all of them. This will support MS in reaching the WHO/UN targets on non-communicable diseases as they can study these best practices and consider testing and implementing them in their own countries. This is especially important for smaller countries as many of them lack the capacity to go through lengthy "trial and error" phases. (37)

Recently DG SANTE invited us to prepare the examples of best practices from RARHA to be included in the best practice portal on noncommunicable diseases (NCDs) and at the same time decided to support MS in reducing alcohol-related harm through the procurement contract defined in the Annual work plan for 2018. (38)

The main expected results are implementation of best practices for early screening and brief interventions, activities in schools and public communication and awareness campaigns as identified by the Joint Action RARHA and supported by evidence. (39)

Table 1: assessment criteria

1. The intervention is well described
Problem
Risk or theme is comprehensively and clearly described (e.g. description of nature, severity and possible consequences of the problem).
Objectives
Clearly described and if relevant differentiated in the main objectives and sub-objectives.
Target group
Clearly described based on relevant characteristics.
Approach
The design of the intervention is described (frequency, intensity, duration, timing of activities, recruitment method and location where it will be implemented).
2. The intervention is implemented in the real world, and is feasible/transferable
Participants' satisfaction
The intervention is accepted by the target group.
Prerequisites for implementation
• The necessary costs of and/or hours needed for the intervention are specified and transparent.
• The specific skills and vocational training of the professionals who will implement the intervention are described as well as which people are needed to support the intervention. There is also a description of how this support can be created.
• There is an implementation plan or action plan.
• A manual is available with a concrete description of activities (if relevant).
• The methods and instruments used are didactically sound and comprehensibly described.
3. The intervention has a theoretical base
Theoretical Base
• The intervention is built on a well-founded programme theory or is based on generally accepted and evidence-based theories (e.g. meta-analyses, literature reviews, studies on implicit knowledge).
• The effective elements (or techniques or principles) in the approach are stated and justified, in the framework of a change model or an intervention theory, or based on results of previously conducted research.

4. The intervention has been evaluated

Evaluation

- The method of the evaluation is described.
- The outcomes found are the most relevant given the objective, programme theory and the target group for the intervention.
- Possible negative effects have been identified and stated.
- Information on attrition (dropout rate) is available.

Table 2: levels of evidence

Basic level: theoretically sound

- Theoretically sound and with positive results (observational or qualitative studies).

First indications of effectiveness

- The above basic level criteria and
- Pre-post study without control group.

Good indications of effectiveness

- All of the above criteria for the first indications of effectiveness.
- A reliable and valid measurement of the intervention's effect was conducted with:
  - An experimental or quasi experimental design or
  - A repeated N = 1 study (at least 6 cases) with a baseline or a time series design with a single or multiple baseline or alternating treatments or a study into the correlation between the extent to which an intervention has been used and the extent to which the intended outcomes were achieved or
  - The effects of the study are compared with other research into the effects of the usual situation or another form of care for a similar target group.

Strong indications of effectiveness

- All of the above criteria for the good indications of effectiveness.
- There is a follow-up of at least 6 months.

Table 3: the received and accepted interventions by intervention type

	Early interventions	Public Awareness Interventions	School Based Interventions	Total
Rejected Interventions	10	3	5	18
Accepted interventions	11	7	8	26
Total interventions assessed	21	9	13	43
% Accepted	52%	78%	62%	60%

Table 4: accepted early interventions according to level of effectiveness

Indication of effectiveness	Name	Country
Basic	MOVE – Motivational Brief Intervention for Young People at Risk	Croatia
	IPIB – Identificazione Precoce Intervento Breve	Italy
	Online Course on Brief Alcohol Intervention (Ota puheeksi alkoholi; Puheeksioton perusteet – verkkokurssi)	Finland
	Towards a Framework for Implementing Evidence-Based Alcohol Interventions	Ireland
First	School-Based Intervention for Drug Using Students	Poland
Good	The National Risk Drinking Project	Sweden
Strong	Web-ICAIP – Web-Based Individual Coping and Alcohol-Intervention Programme	Sweden
	Nine Months Zero (Negen Maanden Niet)	Netherlands
	The Swedish National Alcohol Helpline (Alkohollinjen) Sweden "Drink Less" Programme	Catalonia/Spain
	Trampoline (Trampolin)	Germany

Table 5: accepted public awareness interventions according to level of effectiveness

Indication of effectiveness	Name	Country
Basic	Don't Drink and Drive a Boat (Klar for sjoen, in Norwegian)	Norway
	Message in a Bottle (Sporočilo v steklenici)	Slovenia
	APD – Alcohol Prevention Day	Italy
	VOLLFAN statt voll fett	Austria
First	Raising Awareness Among Employers at the Workplace	Croatia
	No Alcohol Under 16 Years – We Stick to It! (Keen Alkohol ënner 16 Joer. Mir halen eis drun!)	Luxemburg
Good	The Local Alcohol, Tobacco and Gambling Policy Model (PAKKA – Paikallinen alkoholi-, tupakka- ja rahapelipolitiikka -malli)	Finland
Strong	/	

Table 6: accepted school-based interventions according to level of effectiveness

Indication of effectiveness	Name	Country
Basic	/	
First	Me and the Others Programme (Programa Eu e os Outros)	Portugal
	I'm also Involved in Prevention (Ειμαι Και Εγω Στην Προληψη)	Greece
Good	Unplugged (Gyvai)	Lithuania
	Unplugged (Izštekani)	Slovenia
	Stop to Think: Prevention Programme of Use/Abuse of Alcohol in School Aged Adolescents	Portugal
Strong	Slick Tracy Home Team Programme and Amazing Alternatives programme (PDD – Program Domowych Detektywów + FM – Fantastyczne Możliwości)	Poland
	PAS – Preventing Heavy Alcohol Use in Adolescents	Netherlands
	Love & Limits (Kjarlighet og Grenser)*	Norway

*The intervention Strengthening Families Programme (Kjarlighet & Grenser) reaches families through schools, but is implemented outside school. Schools are used as a channel.

Table 7: accepted interventions by level of evidence

Level of Evidence	Early interventions	Public Awareness Interventions	School Based Interventions	Total
Basic Level	4	4	0	8 (31 %)
First indications for effectiveness	1	2	2	5 (19 %)
Good indications for effectiveness	1	1	3	5 (19 %)
Strong indications for effectiveness	5	0	3	8 (31 %)
Total	11	7	8	26

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