Fact sheet:
Brief interventions and treatments for alcohol use disorders across Europe

December 2012

Health systems and treatment for alcohol use disorders (AUD)

The provision of screening and brief interventions for risky drinking and treatment for alcohol use disorders (AUD) was studied in six European countries (Austria, England, Germany, Italy, Spain and Switzerland) over the years 2009-2012.

Table 1 shows that there are considerable variations in the organisation and provision of alcohol interventions between the six countries. Countries that have more developed national alcohol strategies in relation to individually directed alcohol interventions appeared to achieve higher levels of implementation of both brief interventions and specialist treatment than countries without such strategies. The devolution of health care management and funding to a local level appears to hamper implementation of effective public health strategies, although they may be more effective for other types of health care delivery for other disease conditions.

Table 1. Health systems and treatment for AUD

	Provision of screening and brief interventions, for hazardous/ harmful drinking	**Provision of specialist treatment for alcohol dependence**	**Health system funding sources**	**Treatment monitoring systems in place**	**Availability of a national alcohol strategy (including aspects of service provision)**	**Existence of decentralisa-tion in the health system**
Austria	No	Yes: mainly residential setting (units/ hospitals), though moving towards outpatient	Social insurance, Government / tax (local, regional, national), private insurance and co-payments	Not specifically mentioned, but hospital discharge data available	No: moves afoot to develop but still some way off	Yes: 9 Länder and very decentralised. Plus multi-layered health systems.
England	Yes: primary Health Care, A&E and out of hours	Yes: community based or residential - psychosocial, detoxification and stepped care - some also treat physical and mental comorbidity	Government / tax: and out-of-pocket/ copayments	Yes NATMS	Yes: little if any service provision	Yes: strategic Health Authorities, and potentially more so with new structures due in the present reorganisation of National Health Service

Germany	SBI programmes do exist but are rarely implemented	Yes: outpatient, inpatient and rehabilitation. Past decade has changed to shorter and more intensive package of care	Social insurance	Yes	No	Yes: 16 Bundesländer
Italy	Yes: primary health care – GPs only, but rarely implemented	Yes: mainly outpatient: Specialist addictions clinics, departments or hospital - medically assisted and psychosocial. Inpatient by not for profit orgs recognised by NHS	National and regional taxes, and co-payments. Private insurance does not play a significant role due to the universal coverage of the NHS	Yes	Yes: including aspects of service provision	Yes: 21 Regions and 145 Local Health Authorities (ASLs)
Spain	Yes: primary Health Care and increasingly in other medical settings, and outpatient and inpatient units in mental health units	Yes: outpatient and inpatient . Therapeutic communities. Mutual aid and self help connect with health care institutions	Tax	Yes	Yes: but contains nothing on service provision	Yes: 17 autonomous communities
Switzer-land	Yes: widespread, undertaken by most disciplines, but not officially driven	Yes: range of inpatient, outpatient, medical and psychosocial. Demand for large scale treatment has reduced and system of care has updated over past 10yrs	Tax, health insurance, and a mixture of other funding sources (depends on the particular service and setting) Access at almost no cost to patient	In some single Cantons only	Yes (in the form of a national program, which is the forerunner to a strategy. But not much by way of service provision)	Yes: 26 Cantons This is a big factor in the variation and fragmentation of the treatment on offer

Number of patients identified as positive for alcohol use disorders

Table 2 shows that across the six countries, out of the 154 patients seen per week, only five patients were screened positive for an alcohol use disorder (AUD) over a four-week period, representing only 0.8% of the patients seen. This is considerably lower than the actual prevalence of AUD in primary care.

Table 2. Sample demographics and patients seen and screened positive for AUD per week.

Country	Gender of respondents(% males)	Mean age of respondents	Patients per week	Patients screen +ive/4 weeks (%)
Austria	46.5%	55.2	285	6.54 (0.5%)
Germany	53.4%	53.8	203	7.76 (0.9%)
Italy	74.2%	56.2	117	5.18 (1.1%)
Catalonia	23.3%	47.3	149	4.14 (0.7%)
Switzerland	61.8%	52.5	98	4.40 (1.1%)
England	52.4%	46.5	110	3.87 (0.8%)
Mean across countries	56.3%	52.7	154	5.34 (0.8%)

Screening practice and barriers to screening in primary health care

Figure 1 shows that GPs had a fairly high level of knowledge and understanding of screening tools, but the actual use of screening tools was lower across the six countries. GPs reported time constraints and the risk of upsetting the patient as the two main barriers to alcohol screening, Table 3.

Figure 1. Are GPs familiar with and use standardized alcohol screening tools?

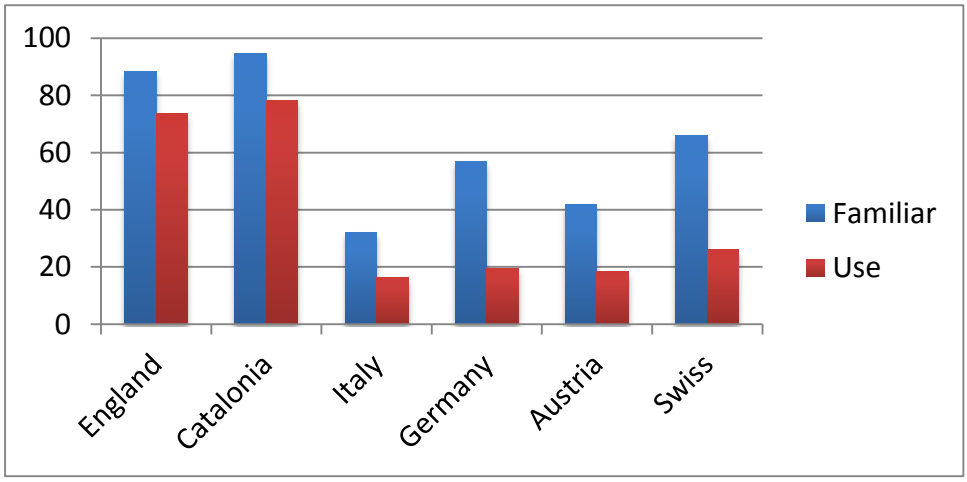

Table 3. Main barriers to alcohol screening in primary care

Reason	N of responses	Percent of cases
Time constraints	209	70.6
Lack of financial incentives	87	29.4
Risk of upsetting the patient	147	49.7
Lack of training	60	20.3
Lack of services to refer patient to	67	22.6
Other reasons	81	27.4

Brief intervention practice and barriers in primary health care

Figure 2 shows that GPs had a fairly high level of knowledge and practice of brief interventions across the six countries. GPs reported time constraints and lack of training as the two main barriers to delivering brief alcohol interventions, Table 4.

Figure 2. Are GPs familiar with and use brief interventions?

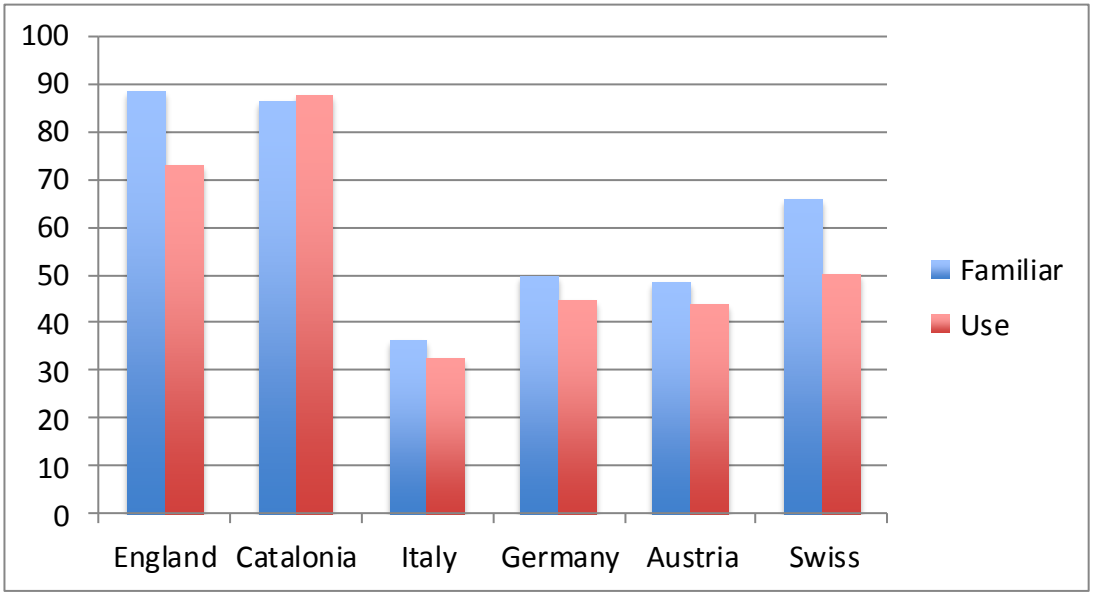

Table 4. Main barriers to alcohol brief interventions in primary care

Reason	N of responses	Percent of cases
Time constraints	224	72.0
Lack of financial incentives	97	31.2
Risk of upsetting the patient	87	28.0
Lack of training	125	40.2
Lack of services to refer patient to	68	21.9
Other reasons	33	10.6
Total	634	

The gap between need and treatment for alcohol use disorders

By comparing the number of people with alcohol dependence to the number of people accessing treatment, it is possible to calculate the prevalence-service utilisation ratio (PSUR), which measures the proportion of people in need who actually access treatment. Table 5 shows that the gap varied across the six countries with only some 4% of people in need of treatment in Germany actually accessing it to some 15% of people in need of treatment in Spain accessing it. Overall, there is a large gap between the need for treatment and actually accessing treatment.

Table 5. Gap analysis of specialist treatment for alcohol dependence

	General population **(full & aged 15yrs+)** T-Total M- Male F- Female	**Prevalence rate (% of population aged 15yrs+):** M=male, F=female, T=Total population, if figure provided	**Number of adults with AD (n)** **(aged 15yrs+, England 16yrs+)**	**Access to treatment (n)** **(aged 15yrs+, England 18yrs+)**	**PSUR** **(% of in need population accessing treatment)**
Austria [1] 2010	7,148,204	M: 7.5% F: 2.5% T: 5%	357,410	39,814	9.0 (11.1%)
England [2] 2007 (& '11)	T: 53,013,000 43,682,712 (15yrs+)	M: 6% F: 2% T: 4%	1,572,577	111,381	14.1 (7.1%)
Germany [3] 2007 (& '11)	T: 81,902,000 70,845,230 (15yrs+)	Approx: 2.3%	1,600,000 (no age group specified)	57,259	28.0 (3.6%)
Italy [4] 2009	T: 60,045,068 M: 24,818,220 F: 26,798,140 = 51,616,360 (15yrs+)	M: 0.7% F: 0.4%	280,921	65,360	4.3 (23.3%)
Spain [5] 2008	M: 22,978,661 F: 23,264,850 T: 46,063,511 (14.7% under 15yrs 39,2892,174 (15yrs+)	M: 1.2% F: 0.2%	M: 273,583 F: 46,529 T: 320,112	49,036	6.5 (15.3%)
Switzerland[6] 2007	T: 7,551,000 6,373,044 (15yrs+)	M: 7.2% F: 1.4%	M: 206,800 F: 42,300 T: 249,100	39,000 - 23,589	6.4 - 10.6 (15.7% - 9.5%)

Take home messages

1. There is wide variation in the organization and provision of alcohol interventions across the six countries studied, implying that the free movement of citizens throughout Europe is not matched by equal standards of care for risky drinking and alcohol problems.

2. There is a mismatch between general practitioners knowledge and use of screening instruments. This is reflected in the very low level of screen positives identified (5% in a four week period). GPs express lack of time and fear of upsetting patients as the main obstacles to screening.

3. Despite poor screening, GPs seem quite familiar with and use brief interventions. Time constraints and lack of training are impediments to greater use.

4. Across the six countries studied, the best case scenario was that 1 in 7 of people in need of treatment for alcohol dependence accessed treatment; the worst case scenario was 1 in 25.

5. There is an urgent need to improve the standards and availability of brief interventions for risky drinking, and, in particular, treatments for alcohol dependence across the six countries studied, and most likely the whole of the European Union.

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