

Guiding questions for the discussion on "Prevention and early intervention for alcohol-related harm"

The situation in Hungary, summarized by:

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Which national data on the use of alcohol exist (consumption, costs, health damage)?

Official statistical system regularly collects data about:

- per capita alcohol consumption,
- cause specific mortality data,
- number of treated populations because of alcohol abuse, alcohol dependence and alcoholic psychosis in different treatment facilities
- prices of some typical alcoholic beverages,
- per capita household expenses for the main types of alcoholic beverages (wine, spirit, beer).

Hungary is participating in two international projects (European School Survey Project on Alcohol and other Drugs – ESPAD and Health Behavior of School-Aged Children – HBSC), which give regular information about adolescents' alcohol use.

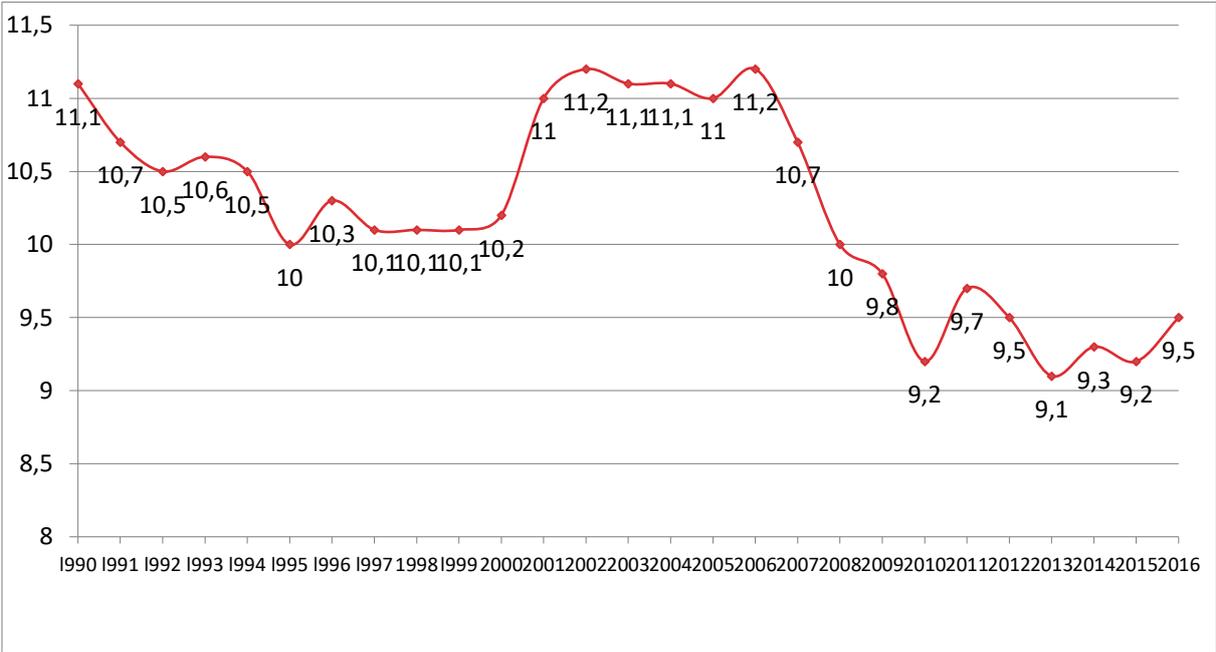
Adult population surveys are less regular in Hungary. The latest adult population survey on addictions was conducted in 2015. This year a new population survey is going on.

Hungary participated in the European Health Interview Survey (EHYS) in 2009 and 2014. These surveys also provide some information about alcohol consumption of the adult population.

Actual situation:

Hungary has belonged to the group of high alcohol consumer countries for several decades. The greatest amount of alcohol per capita was registered in the mid-80s. Other peak had been reached at the beginning of 2000's. Since 2006 the consumption has decreased and stabilized in the last few years.

Per capita alcohol consumption in pure alcohol, litre, total population



The liver cirrhosis mortality showed a steady increase up to the end of the nineties, followed by a considerable decrease after 2000. Meanwhile the mortality rate is still very high (Kovács and Bálint, 2015; Bálint and Elekes, 2016). Alcohol related mortality rate (alcoholic psychosis, dependence and abuse, alcoholic liver cirrhosis), is around 190% of the EU-15 average.

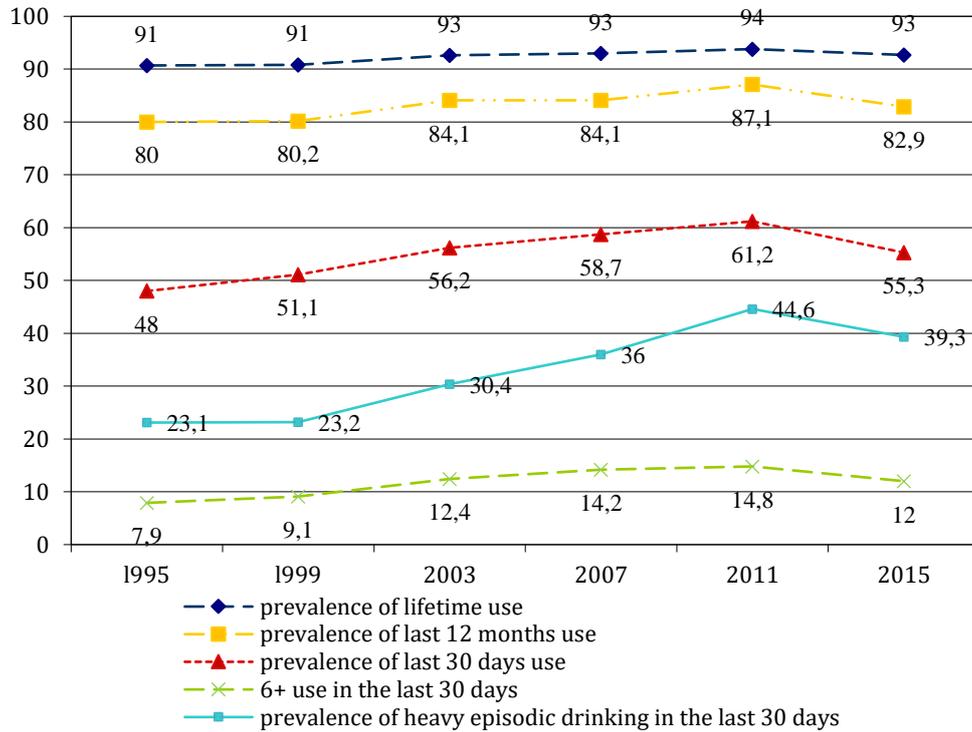
Based of the calculation of National Institute of Health Development alcohol consumption and illicit drug use together cause 10% of DAILY in Hungary, so,

these are among the most important risk factors of the health status of the population (NEFI 2015).

The few adult population surveys partly support the decrease in alcohol consumption. Based on the 2009. and 2014. Hungarian results of European Health Interview Survey (EHYS) the frequency of alcohol consumption decreased in most age groups except the oldest one. At the same time, the amount of consumed alcohol per drinkers increased. The increase was the highest among the elderly people. That is in 2014 people drink less frequently than in 2009, but when they drink, they drink a higher amount. The decrease in drinking rather characterizes younger age groups than elderly ones (Elekes, 2018).

Based on the Hungarian ESPAD results lifetime, regular and heavy episodic drinking increased between 1995 and 2011. In 2015 we registered a significant decrease of most indicators. Only proportion of ever users remained unchanged (Elekes, 2016).

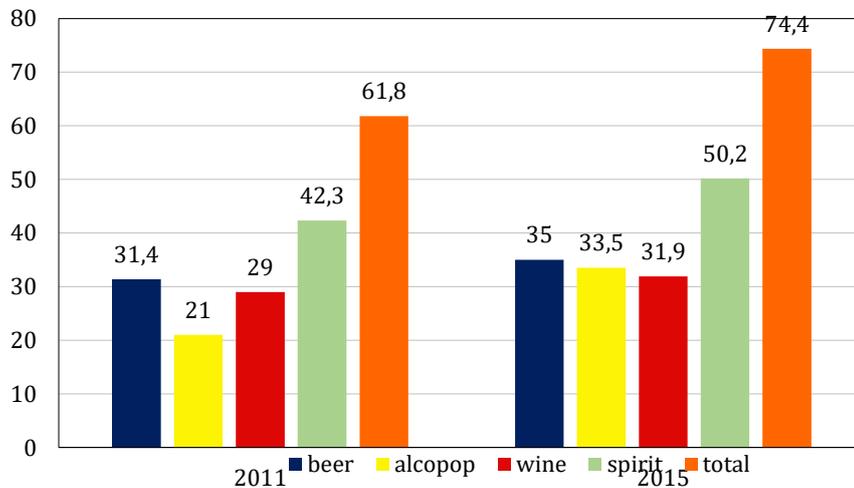
Trends in main indicators of alcohol consumption among 16 years old students in Hungary



The decrease was observed in both gender and all types of school.

Same as in case of adult population, we have found that the amount consumed by drinkers increased considerably between 2011 and 2015.

The amount of consumed alcohol on last drinking occasion per drinkers in pure alcohol (ml)



That means that adolescents drink with less regularity, but when they drink they do it in a higher quantity.

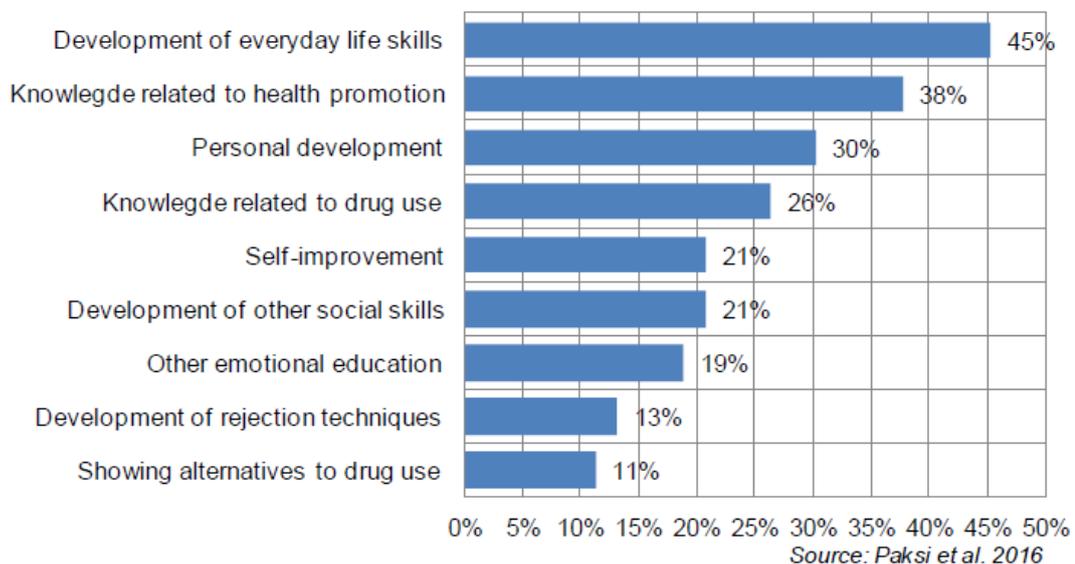
Unfortunately, there are no estimation about alcohol-attributable costs.

Are there scientific studies, for instance, on the success of preventive measures concerning alcohol consumption as well as the abuse of alcohol?

Based on the findings of a recent study (Paksi et al., 2016), the majority of the overviewed (n=96) Hungarian prevention programs (43%) are exclusively universal prevention projects or mixed universal and selective prevention programs (20%). As far as we know, there is and were no environmental prevention projects implemented in the country.

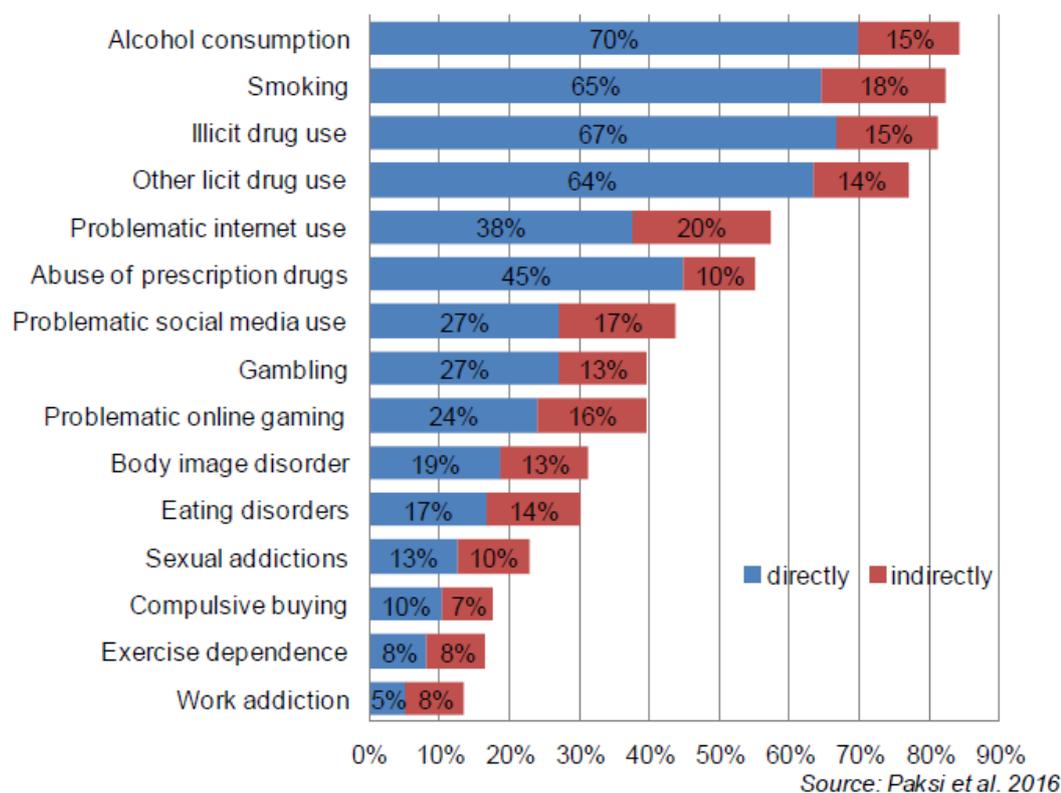
The majority (45%) of the existing prevention programs aims to improve everyday life skills instead of providing only information delivery.

Chart 21. Different objectives of interventions aimed directly at the final target group (N= 53, %)



The prevention of alcohol consumption is directly aimed in the 70% of the programs, however, they are part of programs that generally target the prevention of substance use (licit and illicit substances as well) prevention, or even are health promotion programs (Paksi and Demetrovics, 2003, 2011):

Chart 22. Addictive behaviours in prevention interventions aimed directly at the final target group (N=96)



Results of the comprehensive evaluation studies (Paksi and Demetrovics, 2003, 2011) however has not been utilized in the further development of the prevention efforts in Hungary. Additionally alcohol use has never been the focus of substance use prevention but has rather been part of the prevention of other (illicit) substance use.

A study in 2018 (Sárosi and Magi) assessed the drug prevention experiences of Hungarian high school students. Based on the respondents' answers, the majority (85%) received drug prevention lectures or watched a movie about substance use (32%). More than half of the respondents took part in prevention programs that were held by a police officer. These programs were mostly raising awareness of the dangers of illegal drugs and were not focusing on the potential harms of alcohol use, nor on the psychosocial risk factors behind excessive or problematic alcohol consumption.

Most recently, a study that assessed the potential efficacy of a gamification prevention app (Kapitány-Fövény et al., 2018), found significant correlation between the perceived utility of the application and a decreased frequency of past month alcohol consumption in a sample of high-school and vocational school students.

Summary: Substance use prevention efforts had been supported by governmental agencies systematically between 1999-2010. Though the direct efforts aimed illegal substance use, most of these programs had included alcohol use as well. As result of the governmental support, several programs had been started (most of them run by NGOs) and the evaluation of these efforts has also been initiated (Paksi and Demetrovics, 2003 and 2011). However, after the reduction of financial sources in 2010/2011, many of these NGOs gave up or dramatically reduced their prevention activity. Governmental (i.e., police) programs could receive bigger space currently.

Which legal provisions and initiatives to avoid the abuse of alcohol do exist in your country?

Unfortunately, there is no national alcohol strategy in Hungary (see: later), that might provide the basis for a well-established alcohol policy.

Hungary does not regulate physical availability of alcohol by placing any restrictions on the eligibility to sell or purchase alcoholic beverages, i.e. the government does not control alcohol distribution and sales by, for instance, restricting hours or days of sale. While tobacco is now only available in national tobacco shops (state monopoly on the sale of tobacco) as well as the taxes increased regarding tobacco sales. In case of alcohol, excise duty rules cover beer and spirits but not wine.

In the last few years some local authorities decided to control the opening hours of alcohol selling in given districts or settlements.

In order to prevent road accidents, Hungary promulgated zero tolerance regarding the permitted blood alcohol level during driving (e.g. drivers have to pay a fee at a 0.2% blood alcohol level).

Legal drinking age is 18 years old.

The law on economic advertising regulates the advertising of alcoholic beverages: advertising is prohibited in the media dedicated for adolescents, prohibited between 6.30-9.30 in the radio and 18.30-21.30 in the TV, except low alcohol contain beverages. The law also prohibits to advertise the positive effects of heavy alcohol consumption.

The lack of a national alcohol strategy, the lack of legal provisions or initiatives to avoid harmful alcohol consumption, the cultural acceptance of alcohol use has an impact on the national figures regarding alcohol-related problems. Hungary is characterized by one of the highest rates of heavy episodic drinking and the highest rates of liver cirrhosis in Europe.

Are there special protective regulations for children and youths?

A new national guideline regarding the psychiatric and addiction treatment of children and adolescents is currently being accepted. The guideline emphasizes the need for new treatment units specialized in the care of youngsters with addiction problems (including alcohol use disorder). Currently there are only three adolescent therapeutic community treatment facilities in Hungary and only few adolescent outpatient clinics.

By using the European Union's financing and supporting prevention capacity, health development offices were established in 2014. These offices were involved in the implementation of universal prevention, including the prevention of excessive alcohol consumption.

The Act on Public Education obliges schools to fulfill the protection of the youth, with the head of the educational institution being responsible for both the organization and provision of this task and with the option to employ an external expert who might help in any required youth protection tasks.

How is the care of alcoholics organised, what do you see as positive and what is problematic?

The Hungarian national guideline regarding the care of alcohol use disorder (AUD) patients is partly based on the Nice Clinical Guidance 115 (published in

2011) and – concerning its theoretical framework – places special emphasis on the recovery model of addictions, the Minnesota Model and the role of AA self-support groups as a complementary “intervention” that may prevent relapse in the population of long-term abstinent patients. An effort to integrate biomedical and psychosocial interventions is clearly manifested in the guideline. The treatment itself is therefore provided by public institutions (operated by e.g. local governments, including inpatient and outpatient centres) and by non-profit organizations (e.g. operated by churches or NGOs).

Clinical care of AUD patients starts with an assessment phase, followed by outpatient treatment. For those patients who are unable to stay abstinent, inpatient treatment or rehabilitation is suggested. In these cases, the main goal of preliminary outpatient treatment is to increase the inner motivation to change the drinking behavior, and also to maintain short-term abstinence (approx. 1-2 weeks) before inpatient treatment. Inpatient wards apply a mixed therapeutic method of pharmacological interventions (long-acting benzodiazepins, antipsychotics [e.g. tiapride]), individual and group psychotherapy, art-therapies (e.g. painting, bibliotherapy) or even fairy tale therapy in some cases.

The non-clinical setting of the management of AUD mainly consists of therapeutic communities and self-help groups. Therapeutic communities can be either religious or non-religious according to their background, and may show high variability in their applied intervention methods.

The positive aspects of the Hungarian care of AUD individuals include the 1) integration of biomedical/pharmacological, psychosocial and even spiritual paradigm in some wards (but unfortunately not at a system level); 2) the effort to adopt effective international guidelines.

Nevertheless, these efforts are often not realized, and in the majority of the addiction units biomedical approach still dominates the viewpoint of health care professionals. There are many untreated AUD patients: currently less than 10% of AUD individuals seek professional help and the capacity of the addiction care is also very limited.

The greatest and most obvious problem is that Hungary still lacks a national alcohol strategy, as it was also mentioned in the 2016 European Report on

Alcohol Policy. This might be explained by the existing powerful economical and political lobby that protects or even promotes the distribution and consumption of alcohol. Alcoholism has deep cultural roots in Hungary (an over-permissive culture). Furthermore, the LXVIII. Act from 2016, regarding the excise duty on alcohol purchase, provide tax exemption for those citizens who are able to produce 1000 liters/year of wine or beer for their family members or guests.

Of which significance are psychotherapeutic interventions within the framework of prevention and early intervention and which role do psychotherapists have in the treatment of alcoholics, both as inpatients and outpatients?

In Hungary (as well), there is still an unresolved professional debate on whether some forms of psychotherapy can or cannot be applied in case of active alcohol consumers who are able to maintain only short-term abstinence. In case of both prevention and intervention/treatment, psychotherapists should be focusing on the risk factors behind harmful alcohol use and AUD, as it is presented by, for instance, Khantzian's self-medication theory. Accordingly, prevention programs should address the problems of e.g. anger management, suppression of emotion expression (especially negative affects), falsely perceived gender roles (especially in over-permissive cultures), peer (and generally cultural) pressure, impulse control difficulties, etc. And psychotherapy, of course, should focus on similar issues.

The severity of AUD and the duration of abstinence might influence the setting of psychotherapy (e.g. inpatient vs. outpatient) but not necessarily the applied psychotherapeutic method. There are several psychotherapeutic interventions that were proven to be effective in case of AUD patients. However, in a person-centered approach, or a tailored therapy, the choice of specific interventions should be impacted by the patient's anamnestic history (e.g. traumatized vs. non-traumatized) as well.

Among the major flaws of Hungary's current situation regarding the psychotherapeutic interventions in addiction care we might mention the facts that 1) psychotherapy is unfortunately not covered by the national health

insurance; 2) majority of the health care professionals prioritize biomedical treatment approaches over psychotherapy; 3) it is often problematic to integrate different methods and approaches that are applied as part of the addiction care process.

What would in your opinion be a good environment for a moderate consumption of alcohol?

Health promotion and prevention should be given more weight in order to 1) change risk perception about the harms of excessive alcohol consumption, 2) change misbeliefs about the potential benefits of alcohol use *per se*, 3) provide alternatives for coping and stress management, 4) raise awareness about the over-permissive cultural background of our alcohol consumption, 5) demystify psychotherapy or psychosocial interventions in general.

In our understanding, the excessiveness of alcohol consumption or the addictive patterns of alcohol use highly depends on the motivational background of drinking, and especially coping motivation (e.g. see the model of Cox and Klinger). Therefore, a good environment for a moderate consumption of alcohol should emphasize the relevance of drinking motivation as well. In this process, every participants of the micro-, meso-, exo-, macro-, and chronosystems should take part in changing the attitudes toward alcohol and alcohol use (e.g. see Bronfenbrenner's Ecological systems theory), i.e. family members, teachers, peers, colleagues, etc.

It would be of high importance if we could practice open, transparent communication about alcohol-related problems in order to prevent the hidden misuse of alcohol. Probably destigmatization of AUD would be the first step to do so.

A novel treatment option is also available with the application of the opioid antagonist Nalmefene. The goals of Nalmefene-supported treatment might include controlled drinking (e.g. a special form of harm-reduction) instead of abstinence-oriented treatment aims.

How should existing services for the treatment of alcoholics be developed further?

It would be important to enhance the cooperation between the health and social care sectors.

We would need to establish transparent patient journeys between primary and secondary care services, in order to keep the patients engaged throughout the care continuum.

GPs should be trained to recognize the severity of alcohol-related problems much more effectively.

The national addiction treatment infrastructure needs to be improved with the establishment of new units, regarding the care of both adolescent and adult AUD patients.

What needs to change in your country in order to warrant this development?

The greatest challenge would be to induce a broad change in the cultural attitudes toward alcohol consumption. A potential solution would be the intensive promotion of environmental prevention, emphasizing the broader psychosocial, cultural and institutional factors that might contribute to the emergence of harmful alcohol use and later on AUD.

Promising changes might occur as a novel action plan regarding the prevention and treatment of mental disorders (including AUD) is being considered by the Ministry of Human Capacities. This new approach places greater emphasis on preventive medicine/health care, and e.g. emphasizing the importance of Health Development Offices and Mental Health Promotion Centres in the early recognition and prevention of alcohol-related problems.

Summary: The positive attitude toward drinking and the acceptance of heavy drinking and drunkenness are among the most important causes of alcohol problem in Hungary. The lack of political intention, the lack of problem's perception in the media and public opinion also contribute to the problem.

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