AMPHORA – Alcohol Public Health Research Alliance

Deliverable D2.9 – Experts and counterparts meetings – translating research to science

Final reports from the Joint WHO meeting of National Counterparts for Alcohol Policy in the WHO European Region and the AMPHORA Experts meeting (14-15 June 2010, Madrid), and the Joint AMPHORA Experts meeting and WHO meeting of National Counterparts for Alcohol Policy in the WHO European Region (3-5 May 2011, Zurich) are annexed.

WHO meeting of National Counterparts for Alcohol Policy in the WHO European Region and the AMPHORA Expert meeting

14-16 June 2010, Madrid, Spain **08 July 2010**

FINAL REPORT

15 June 2010, Tuesday

National Counterparts for Alcohol Policy and AMPHORA Expert joint meeting

Opening session

Chair: Dr Antoni Gual, Hospital Clinico y Provincial de Barcelona

Dr Lars Moller, WHO Regional Office for Europe; Mr Dag Rekve, WHO Headquarters; Dr Ildefonso Hernández Aguado Hernandez Aguado, Director General De Salud Publica Y Sanidad Exterior; Ms Marjatta Montonen, DG SANCO European Commission and Dr Peter Anderson, AMPHORA.

Participants were welcomed to the meeting by Dr Moller who said he was looking forward to this joint meeting between AMPHORA experts and WHO national counterparts which would look at how science can influence policy and provide a forum for sharing good practice.

Mr Rekve reported that the meeting was very timely as the 63rd World Health Assembly had recently endorsed the Global Strategy to Reduce the Harmful Use of Alcohol. He said that the development of the Strategy was a collaborative venture and that the Spanish Government had played a constructive role in the process. Mr Rekve said that he hoped the Global Strategy would provide the momentum needed for developments in alcohol policy at State and Regional level.

Ms Montonen acknowledged that the Global Strategy was an unprecedented consensus paper on reducing the harmful use of alcohol. However, Ms Montonen said that as the document is not binding on Member States it will be most important to continue to build expertise and capacity at European and national level.

Dr Anderson looked forward to the meeting as an excellent opportunity to promote the dialogue between scientists and policy makers.

Dr Ildefonso Hernández Aguado welcomed participants on behalf of the Spanish Government. He noted that the meeting had particular relevance as we explore the development of knowledge and use this to help governments to tackle this public health problem which has reached worrying proportions. He said that the meeting would

strengthen the bonds of collaboration, co-ordination and the exchange of knowledge and good practice.

Dr Ildefonso Hernández Aguado also said that the new Global Strategy represents a boost and a step forward in dealing with the harmful use of alcohol and reducing the inequities associated with it.

The potential impact of the economic recession on alcohol-related harm

Dr Peter Anderson

Dr Anderson presented findings from a number of studies looking at the impact of economic recessions on alcohol-related harm.

The main conclusions were as follows:

- In general, the evidence finds that economic recessions either have no impact on or reduce all-cause mortality. They do, however, increase deaths from suicide and alcohol use disorders, sometimes markedly so, but, often, with the number of increased deaths counterbalanced by decreases in deaths from motor vehicle fatalities, simply due to less driving.

- Although economic recessions seem associated with reductions in the volume of alcohol consumed, there is evidence that particularly risky episodic heavy drinking increases.

- Alcohol policy, and particularly policy that increases the price of alcohol, reduces deaths from alcohol use disorders, including deaths from episodic heavy drinking, and reduces unemployment

- Investments in social protection and active labour market programmes can completely mitigate the relationship between economic recession and suicide mortality.

Building up the AMPHORA database of infrastructures on alcohol policy

Dr Claudia Konig

Dr Konig outlined the objectives of the project:

- Mapping existing alcohol policy infrastructures in European countries.
- Collecting relevant laws and supporting documents across a range of alcohol policy areas.
- Placing this information on the AMPHORA website - building up a database on infrastructures on alcohol policy.
- Examining the relationship between infrastructures and achieving alcohol policy change or improvements.

A questionnaire is currently being developed and will be sent to WHO counterparts in September 2010 along with a request for copies of relevant policies, laws or regulations on the following:

- National policy/strategy documents.

- Definitions of an alcoholic beverage.
- Marketing and sponsorship regulations.

Some participants asked for clarification that the data collection exercise would not duplicate the work done by WHO. Dr Konig confirmed that the aim is to complement not duplicate the WHO database. Dr Moller also confirmed that there is good collaboration between WHO and AMPHORA on this project.

The following further points were made by participants:

- Requests need to be precise – there are laws in a number of areas which impact upon alcohol policy e.g. health, trade, taxation.
- Meaningful comparisons between national laws and policies will be difficult.
- The database will need to be updated frequently as laws/policies change.
- Some countries have regional laws and polices so making a request for national policies will not be relevant.

Presentations and facilitated group discussions on five selected topics
Chair: Dr Antoni Gual

Short presentations on five topics were followed by group discussions where each group considered the specific implications for policy and how science could better assist policy makers in relation to their topic:

1. Epidemiology of alcohol-related harm
Dr Peter Anderson
The importance of chronic diseases to global risk is often grossly underestimated
The value of an extra year of healthy life is often grossly underestimated
The importance of alcohol as a risk factor is often under recognized
Alcohol increases the risk of death in a dose dependent manner
The harm done by alcohol is, in principle, preventable

Group feedback
Better data is needed
Need to communicate data in a more meaningful way
Aim for one easily accessible data source
Provide forum where counterparts and scientists can suggest ways of refining and improving data
Have a high level expert consensus meeting on alcohol and harm
Work with journalists to help them to understand health messages

2. European research on alcohol policy
Dr Antoni Gual
Compared to other economies the EU gives a high priority to alcohol
But - US is far ahead of EU on availability research
EU – problem of alcohol is high but amount of research is relatively low
EU - alcohol should be placed higher on public health and research agenda

Group feedback
We now have good examples of the impact research can have on policy
Need more basic data on consumption and harm at European level

Need comparative research
Need multi-sectoral and multi-agency research
Need to make greater efforts to communicate research findings to policy makers

3. Infrastructures for alcohol policy
Ms Lidia Segura
Do different infrastructures play an important role in alcohol policy making?
What determinants influence infrastructure developments?
What infrastructures are a must for effective alcohol policy?
What infrastructures present barriers to effective alcohol policy?

Group feedback
Need effective lobbying by experts and NGOs – engaging with politicians and industry
Need good monitoring tools to assess impact of laws/regulations
Important to have alcohol action plan at national level
Important to have good coordinating structures at national level
Important for counterparts to meet to share good practice

4. Planned and unplanned determinants
Dr Allaman Allamani
Need to consider the impact of cultural, social and demographics on alcohol policy
Alcohol policy itself doesn't explain changes in alcohol consumption
Need to consider other planned and unplanned factors such as laws, market forces, general health awareness, immigration (i.e. the impact of different cultures)

Group feedback
Planned/unplanned is not helpful terminology
More needs to be done to assess the impact of alcohol policies – not just on consumption but also look at harms
Researchers need to make clear recommendations when presenting their findings

5. Illicit alcohol
Dr Dirk Lachenmeier
Hypothesis – illicit alcohol is toxic and presents higher heath risk
Research findings – 115 samples from 17 countries were analysed for alcohol quality. Generally, the ethanol concentration in illicit alcohol is higher than in recorded spirits
Alcohol policy currently has no evidence base for responses to unrecorded alcohol
Need to consider what policy responses might improve the quality of unrecorded alcohol

Group feedback
Large problem – more research is needed on unrecorded alcohol use generally
More research is needed on the interaction between consumption in the recorded and unrecorded markets
Need to know more about distribution methods

Moderated plenary session
Chair: Dr Peter Anderson
Participants (AMPHORA): Dr Avalon de Bruijn, Mr Thomas Karlsson, Professor Colin Drummond, Ms Karen Hughes.

Participants (WHO counterparts): Dr Joan Ramon Villabi (Spain), Ms Maria Renstrom (Sweden), Mrs Jean Nicol (UK), Mr Krzysztof Brzozka (Poland).

The group discussed a number of issues including brief interventions for harmful and hazardous use, transparency of scientific expert groups and the links between researchers, policy makers and the alcohol industry. The main outcomes of the discussions were:

- Research findings need to be made more accessible to policy makers
- Knowledge transfer is important
- There are differences within Europe but there is some consensus emerging about effective interventions
- Governments should not only consider research carried out in their own country
- We know enough for policy makers to take steps
- More comparative studies would be helpful
- Research needs to reach practitioners as well as policy makers
- Public attitudes are also important in the policy debate – need to get messages across to public.

Facilitated group discussions
Chair: Dr Peter Anderson

Participants divided into small groups to consider the following questions:
1. What science and research support is needed to influence the political agenda and alcohol policy in your country?
2. How can we provide incentives to get more and better alcohol policy science research in Europe, at the country and European levels?

The key themes which emerged were as follows:

Support needed

- To build adequate monitoring and surveillance systems to collect data
- Tools to facilitate translation of international evidence/results into local results
- Training on research methodology
- Develop models of good practice on research commissioning and infrastructure
- Guidance on step by step research procedures (action research)
- Greater co-operation between health/science/education ministries to improve co-ordination in field of alcohol research
- To have cost-effectiveness data in all countries

Research incentives

- Money in first place
- Opportunities to participate in collaborative research projects, international networks and European projects on alcohol
- Higher awareness and support by politicians, professionals and public opinion
- Joining forces with other related research areas (drugs, youth, etc).

What does the SMART project have to say about standardized methodologies for surveys

Dr Jacek Moskalewicz

Dr Moskalewicz gave details of the SMART (standardized measurement of alcohol related troubles) project. The main objectives of the project are to develop a standardized comparative surveys methodology. Specific outcomes include:

- A summary of existing alcohol survey methodologies
- The development of a standardized comparative survey instrument on alcohol use, patterns of drinking and related problems

The major findings of the EU survey review show that the methodologies of surveys differ very much from country to country and even within countries as regards:

- sampling
- age of the sample
- survey administration
- measuring alcohol consumption
- measuring alcohol problems

The main reasons for no standard approach are:

- different drinking patterns
- different research traditions
- different social importance of various aspects of alcohol consumption and patterns of alcohol related problems
- different research potency in terms of funding, skills, experiences

The final study protocol for standardized drinking surveys will be available late summer/early autumn 2010. A conference will be held in the autumn – most likely in Barcelona on 25-26 October – to discuss and adopt the survey instrument.

Reports from Member States on alcohol policy developments

Chair: Dr Lars Moller

Short presentations on alcohol policy developments were made by the counterparts for: Albania, Norway, Slovakia, Slovenia and Spain. The presentations are available on the WHO website.

The Global Strategy to Reduce the Harmful Use of Alcohol

Dr Vladimir Poznyak

Dr Poznyak presented some details of the Global Strategy which was adopted at the 63rd World Health Assembly in May 2010.

The **vision** for the Strategy is: improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to harmful use of alcohol and their ensuing social consequences.

The **aims** of the Strategy are: to give guidance for action at all levels; to set priority areas for global action; and to recommend a portfolio of policy options and measures that could be considered for implementation and adjusted as appropriate at the national level, taking into account national circumstances, such as religious and cultural contexts, national public health priorities, as well as resources, capacities and capabilities.

The Recommended target areas for policy measures and interventions contained in the strategy are:

1. Leadership, awareness and commitment
2. Health services' response
3. Community action
4. Drink-driving policies and countermeasures
5. Availability of alcohol
6. Marketing of alcoholic beverages
7. Pricing policies
8. Reducing the negative consequences of drinking and alcohol intoxication
9. Reducing the public health impact of illicit alcohol and informally produced alcohol
10. Monitoring and surveillance

Implementing the strategy will require:

- Concerted action by Member States
- Effective global governance
- Appropriate engagement of all relevant stakeholders

Dr Poznyak also outlined the mechanisms for reporting and monitoring progress with the Strategy, which will include:

- Appropriate mechanisms at different levels for assessment, reporting and re-programming
- Impact-focused perspective
- Global Information System on Alcohol and Health (GISAH) and WHO's Global Survey on Alcohol and Health as important parts
- Regular meetings of global and regional networks of national counterparts
- Regular reports to WHO regional committees and the Health Assembly. Information about implementation and progress should also be presented at regional or international forums and appropriate intergovernmental meetings.

An analysis of the European Commission's communication on alcohol, and the European Framework for Alcohol Policy – and the similarities with the Global Strategy

Dr Peter Anderson

Dr Anderson considered the next steps for countries in taking forward the Global Strategy. He focused on 3 elements of the Strategy:

- leadership, awareness and commitment
- community action
- pricing policies.

Dr Anderson suggested that in approaching each of these areas we should be looking to the EU Strategy to Support Member States in Reducing Alcohol Related Harm, the WHO Framework for Alcohol Policy in the European Region and the Handbook for Action to Reduce Alcohol-Related Harm for suggested approaches and policy options. These documents give advice on the infrastructures, processes and practical actions which can be put in place to address alcohol related harm and should provide the basis for action to implement the Global Strategy at national level.

Global and European Information Systems on Alcohol and Health
Mr Dag Rekve

Mr Rekve presented details of the global information system for alcohol and health (GISAH) and its links to regional information systems. GISAH was created in 2006 and it serves as the data repository for regional information systems. Since 2008 global surveys and passive surveillance have fed into GISAH which will be used for Global Status Reports and Country Profiles

GISAH can be accessed at: www.who.int/globalatlas/alcohol

- There are over 170 numeric indicators and over 50 text indicators on GISAH.
- Each indicator has information on +/- 100 countries that are continually being updated.
- Numeric data can be mapped and/or charted.
- Both numeric and text files can be downloaded as EXCEL files.
- References are provided in separate “Source” files. Information relative to specific indicators is presented in separate “About” files.
- Comparative Risk Assessment (CRA) is a special category found on GISAH that displays the indicators and results of the impact of alcohol consumption on the burden of disease.

Future development of GISAH will include:

- Work on definitions (global survey with definitions of indicators)
- Consistency of definitions and indicators across regions and EU
- Consistent definitions and indicators used by WHO Global Health Observatory, World Health Statistics, WHO-STEPS
- On-line data collection
- Improvement of coverage and data validity
- Network of national counterparts
- Monitoring progress on implementation of regional and global strategies

The European Status Report on Alcohol and Health
Dr Lars Moller

Dr Moller updated the meeting on progress with the European Alcohol Information System (EAIS) and the forthcoming Status Report on Alcohol and Health.

There have been a number of difficulties in establishing the EAIS, such as:

- Difficulties obtaining reliable data on consumption
- Not possible to collect information for trend analysis
- Does not cover all aspects mentioned in the Framework for Alcohol Policies adopted in 2005
- Data not always consistent with data from other sources
- Data not comparable with alcohol data from other regions
- Different stakeholders use different surveys and put extra work load on Member States

An EC/WHO project to update the EAIS began in 2008. This involved developing a new questionnaire which was circulated to Member States this year. The data has now been entered into the database and will be ready for use in late 2009.

The European Status Report on Alcohol and Health is currently being edited. The report will contain sections on

- Alcohol and Health - a European perspective
- Alcohol consumption in Europe
- Alcohol related harm
- Alcohol policies and responses
- Conclusions - including the current status, trends and differences in alcohol and health in the European Region

The report will be available in September 2010 for the WHO Regional Committee meeting.

Alcohol and Injuries – a new publication
Chair: Maria Renstrom

A new WHO publication – **Alcohol and Injuries: Emergency Department Studies in an International Perspective** – was launched by Dr Sofia Tomas Dols, Dr Vladimir Poyznyak and Dr Cheryl Cherpitel.

On behalf of the Valencian Government, Dr Tomas Dols congratulated Dr Cherpitel and the authors on the publication. She said that the book comes at a crucial time and will help us to increase our knowledge of the subject matter. Dr Poyznyak expressed gratitude to the Government of Valencia and all those who had worked on the book, which is a collaborative effort by researchers from around the world.

Dr Cherpitel gave some background as to the reasons for this publication:

- Limited knowledge on social consequences of alcohol use, particularly in less-resourced countries
- Growing recognition of fatal and non-fatal injuries as a public health problem
- Insufficient understanding of the role of alcohol in fatal and non-fatal injuries

Dr Cherpitel explained that the book addresses:

- Epidemiology of Alcohol and Injury
  - risk of injury and alcohol-attributable fraction
- Issues Related to Research in the Emergency Department
  - methodological and conceptual issues
- Identifying Alcohol-related Injuries
  - relationship between ICD-10 Y90 and Y91 codes
  - surveillance and monitoring
- Screening and Brief Intervention

It is hoped that the book will:

- Contribute to a common knowledge base to inform alcohol policy for prioritizing policy measures
- Inform monitoring alcohol policy effectiveness for developing enforcement strategies and strengthening control measures
- Inform the development of effective interventions in the Emergency Department for reducing alcohol-related harm.

The Way Forward
Chair: Professor Emanuele Scafato

Participants divided into small groups to discuss the way forward following the adoption of the Global Strategy. In particular, participants were asked to consider whether WHO Europe needs to draft a European Alcohol Action Plan in line with the Strategy.

Main suggestions:

- A European action plan or maybe named an implementation plan *is* needed
- A working group should be established by WHO with involvement of Member States and acknowledged experts
- Short re-visit of existing plans required – don't duplicate other documents
- Must cover all Member States but needs to reflect cultural differences
- Should take into account specific infrastructures for policy making
- The plan should be an 'implementation plan'
- Should be a focused document based on priority actions
- Should contain specific targets and concrete actions
- Plan should not be too extensive or take too long to produce
- Should be feasible and realistic

Conclusions and Next Steps
Dr Lars Moller

Dr Moller thanked participants for their suggestions and said that it was clear that people shared the desire for a practical instrument to help take forward work to implement the Global Strategy. However, he urged Member States not to delay in using the Strategy to influence policy and actions at national level.

Dr Moller reminded participants that next year's meeting will be on 3-5 May in Zurich and

proposed that this comprise one day shared with AMPHORA experts and one day as a closed working meeting for WHO national counterparts.

Dr Moller closed the meeting by thanking the Spanish hosts and all involved for a successful meeting.

2011 Meeting

It was announced by Mrs Petra Baeriswyl that next year's meeting of WHO National Counterparts and the AMPHORA expert group will be held on 3-5 May, 2011 at the Crowne Plaza Hotel, Zurich, Switzerland at the kind invitation of the Swiss government.

AMPHORA Expert meeting and WHO meeting of National Counterparts for Alcohol Policy in the WHO European Region

3-5 May 2011, Zurich, Switzerland

Venue: Hotel City Zürich Crowne Plaza **17 May 2011**

2nd Joint Alcohol Public Health Research Alliance (AMPHORA) meeting

Wednesday, 4 May 2011

FINAL REPORT

"AMPHORA aims to contribute with new evidence on scarcely explored or unexplored areas of alcohol consumption and alcohol-related harm in Europe. This knowledge will be disseminated to those engaged in policy-making for development and implementation of more effective public health measures"[1].

The main objective of the meeting was to enable the exchange of information and present the most recent research data within the group of alcohol policy scientists, experts and policymakers.

Dr Lars Møller, Programme Manager a.i., Alcohol and Illicit Drugs of the World Health Organization Regional Office for Europe opened the meeting and welcomed the 45 Member State representatives.

Ms Ursula Koch of the Swiss Federal Office of Public Health (FOPH) welcomed the participants. It is currently an eventful time in alcohol policy and as such, interactions between policy makers and scientific researchers are more important than ever. The first global ministerial conference on non-communicable diseases (NCDs) recently took place in Moscow with the recognition that the legislative base for action in many areas of NCDs is missing. One of the main opportunities now is to ensure that the scientific evidence is appropriately "translated" and understood by politicians and society at large.

Dr Gauden Galea, Director Division of Noncommunicable Diseases and Health Promotion, World Health Organization Regional Office for Europe thanked FOPH for hosting the meeting and welcomed all the participants. There is a substantial agenda to

[1] The AMPHORA project website: http://www.amphoraproject.net/index.php

address with NCDs in the WHO European Region, with high disease burden and uneven progress across the Region. Alcohol has taken its position now as a global issue, with AFRO also presenting their strategic plan to their Regional Committee this year. Of the 53 WHO European Member States, 40% still do not have a national alcohol policy or plan. There are worrying trends as alcohol prices fall. Therefore it is opportune to bring together national representatives and researchers to address this agenda jointly, culminating in a WHO European Alcohol Action Plan, which is expected to be endorsed by all Member States at the Regional Committee in September 2011 in Azerbaijan.

Finally, Dr Antoni Gual, Chair of AMPHORA added his thanks to the hosts and to WHO for continuing their support and collaboration. AMPHORA started in January 2009 and will end 2012. Mid term results of the project are very positive, with preliminary findings to be shared in the meeting.

Mr Bernt Bull of the Norwegian Ministry of Health and Care Services chaired the morning session. He introduced Professor Peter Anderson, an expert of more than 20 years in the field of alcohol and health who presented the latest data on the absolute and relative risks of dying from alcohol.

In 2009 the National Health and Medical Research Council (NHMRC) of Australia published guidelines to establish the evidence base for future policies and communication materials on reducing the health risks that arise from drinking alcohol. The guidelines are intended to communicate evidence concerning these risks to the Australian community to allow individuals to make informed decisions regarding the amount of alcohol that they choose to drink[2].

The data from the Australian NHMRC show that the higher the intake of alcohol over a lifetime, the higher the risk of dying from a non-injury alcohol-caused death. For such alcohol-related chronic diseases, the risk curves are similar for men and women, at average daily volume levels below 40 grams per day, while at higher levels of drinking, women are at higher risk than men per gram of alcohol consumed. Overall, risk increases by about 10 per cent with each 10 gram (1 drink) increase in alcohol consumption.

The data for injuries, whilst calculated slightly differently, show that the more alcohol consumed per drinking occasion and the greater the frequency of drinking occasions, the higher the risk of dying from an alcohol-caused injury death. For injuries, at higher levels of consumption, men have a greater risk of death per gram alcohol consumed than women.

When the alcohol-caused non-injury and injury deaths are combined, the risk curves are almost identical for men and women. With alcohol consumption levels of 20 grams per day, the lifetime risk of dying from alcohol is less than 1/100 for men and woman. However, with alcohol consumption of 60+ grams per day this increases to 1/10. Any protective effect of alcohol on heart disease disappears when light drinkers report at least just one heavy drinking occasion per month.

Finally, the exact slope of the epidemiological curve is country specific as it depends on

[2] Extract from the Australian National Health and Medical Research Council guidelines 2009. http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/ds10-alcohol.pdf

the prevalence and distribution of diseases and drinking patterns in a population. However, for most EU countries, it is likely they would be similar to the Australian data presented.

A number of questions were raised. Concerning risk being dependent on the length of time alcohol remains in the blood it has also been shown that injury risk is still increased during the "hangover" period, despite blood alcohol levels returning to zero. Concerning research data, it is invaluable for setting national drinking guidelines and better informing policy. However the data need to be synthesized into meaningful messages for (risk) communication purposes, not only to the policy makers, but also to the general public and media (relating to individual versus population risk). Comparing the alcohol risk to other health related concerns of the day (pesticides in food, sun damage etc), the alcohol and health message is very clear. The fact remains that alcohol is the world's leading risk factor for ill health and premature death in the 25-59 year old age group.

Professor Mark Bellis from Liverpool John Moores University (a WHO collaborating Centre) made a presentation on alcohol and its impact on violence. To contextualise the problem, the number of deaths globally in 2004 attributable to injury and violence was equivalent to those for TB, Malaria and HIV/AIDS combined. Alcohol has existed for millennia and throughout that time its use has been associated with violence including in warfare. Alcohol has clear links to all types of violent and anti-social behaviour (58% of imprisoned rapists in the UK reportedly drank alcohol prior to their offence; 32% of German offenders of fatal child abuse been drinking; alcohol is used to recruit, train and deploy child soldiers). The annual cost of violence in the UK has been estimated at £24 billion (England and Wales).

Alcohol related violence appears to be cyclical in trend, with victims of child abuse more likely to go on to perpetrate youth violence, sexual violence and also child abuse. The situation is aggravated by a general environment of neglect, behavioural problems, poor academic performance and early exposure to substance abuse. Unemployment, poor housing and unintended pregnancies are also exacerbating factors.[3]

Key primary prevention strategies have been outlined and include reducing overall alcohol availability and use, parenting programmes and early life interventions (e.g. nurse family partnerships). Deterrence-based interventions in key locations where alcohol is consumed have also produced some good results.

The participants then took part in working groups to share information and experience on a number of action points of the draft European Alcohol Action Plan 2012-2020. The aim of the working groups was to generate constructive debate between scientists and policy advisers on some of these issues. The sessions were jointly conducted by a WHO counterpart and an AMPHORA expert.

Professor Emanuele Scafato chaired the afternoon session. Discussions from the working groups were shared and are summarized below. The issues under discussion were: Leadership, awareness and commitment; Policy response in Europe; Marketing of alcoholic beverages; Health service's response; Availability of alcohol and pricing policies; Reducing the public health impact of illicit alcohol and informally produced alcohol; Monitoring and surveillance and Reducing the negative consequences of drinking and intoxication.

[3] Atkinson et al, 2011, Krug et al, 2002; McVeigh et al, 2005

Policy Response
The crucial first step is that a national programme and policy exists, however, there must be related action and intervention. Enforcement seems relatively weak across Europe and should be strengthened especially in the areas of age limits, alcohol sales (it is critical that youngsters are less able to obtain alcohol) and drink driving. Appropriate and open communication between researchers and policy makers is critical to achieve commitment to change.

Leadership
Enforcement of policy and legislation was identified as key role for leadership. Ways of affecting attitudes to alcohol were discussed and the promotion of the work of NGOs was highlighted. The availability of information and education around health and alcohol was also seen as an important area for focus as well as clear communication between the policy makers and the community at large.

Marketing
There is a large and growing array of marketing practices (direct and indirect) and this is having an impact on youngsters and drinking patterns. It was agreed that legislation in this area must be strengthened and sooner rather than later (Norway was sited as a good example). It was noted that there was a lack of data on the impact of changes in marketing regulation, this is an area of great interest and more data must be acquired to provide evidence to guide policy. However, it was felt by others that there is already enough evidence for action, but it needs to be translated into language that is understood by the general public, thus enabling better understanding and resistance to marketing attempts. Working with other sectors such as holiday companies, would also be important to reduce the impact of alcohol marketing.

Health service response
One key message is that investment into early detection and the provision of advice for drinkers, saves lives and reduces health care costs, and is therefore a priority. However, evidence suggests that harmful drinkers do not receive these interventions and a targeted approach could be undertaken, by which 1/3 of harmful drinkers are screened and 60% of those with more severe problems be referred for further treatment. Barriers to this being implemented include lack of training and awareness. Better incentives, improved education and capacity building for health care professionals would greatly improve the situation. It was also felt that more systematic assessment tools and data are needed to monitor progress in the area of primary care intervention. The ODHIN project (Optimizing Delivery of Health Care Interventions) will contribute to this evidence. The RUSH model was also sited as a useful tool for estimating required capacity for alcohol treatment services.[4]

Availability
Alcohol taxation is an evidence-based measure to decrease alcohol consumption and related harm. However, particularly in eastern European countries the threat of illicit and unregistered markets exist and is where there are great differences in prices in neighbouring countries. Different ways of recording alcohol consumption were discussed as well we ways to capture these data.

Reducing public health impact of illicit and informally produced alcohol

[4] http://www.alcohollearningcentre.org.uk/_library/Rush_article.pdf

Data in the area are limited and hard to capture, thus any interventions are hard to evaluate. However, surrogate and denatured alcohol will now be taxed as normal alcohol in Estonia. Minimum pricing for vodka has been introduced in the Russian Federation, so consumers are aware that the produce is likely to be "unrecorded" if it is cheaper (this is not always a disincentive). Home production is an area of concern and very difficult to control, due to cultural and economic issues. Awareness raising and increasing communication of the risks would help.

Monitoring and surveillance
The ongoing AMPHORA study was discussed. The question was raised whether there is enough data to do monitoring and surveillance. It was agreed that since there was no standardized survey, better coordination is needed to develop core indicators. Sweden has done some work in this area. An annual (or at least regular) collection of consumption would be useful. The SMART project has been looking into developing standardised methodologies to survey drinking behaviours as well as standarised cost-benefit analyses of alcohol policies.[5] This survey could be used for a larger number of countries than the 10 involved in the original project. It was agreed that the data generated by the new WHO/EU survey would be very useful as would an online method for data entry and retrieval.

Reducing the negative consequences of drinking and intoxication
Priority must be placed on drinking environments where most of the acute alcohol problems occur, and even beyond the normal drinking environments to include "hidden" drinking, such as in family environments and the effect of childhood exposure. Interventions to reduce this kind of drinking should focus on families and education.

Ms Silvia Matrai and Dr Antoni Gual introduced the ODHIN (Optimizing Delivery of Health Care Interventions) project and the impact of brief advice and the Internet. This EU funded project involving research institutions from 9 European countries, started in January 2011. The main goal is to optimize the delivery of health care interventions by understanding how to better translate the results of clinical research into every day practice. As a case study, the project will use the implementation of "identification and brief intervention" programmes (IBI) for hazardous and harmful alcohol consumption in the primary health care (PHC) setting. The project will last four years and has a budget of 4 million Euros. There are seven work packages and 19 partners. During the project lifecycle, four main tasks will be undertaken: (i) a systematic review of the literature on effective implementation and dissemination strategies (ii) the development of a European version of the Sheffield Alcohol Policy Model and to use the results of the modelling to consider generalisability of interventions across the EU (iii) a survey of general practitioners and an assessment of key informants to update knowledge and understanding of the barriers and facilitators of IBI programmes, and how they are developed and implemented and to map the current status of brief interventions in Europe; and (iv) a cluster randomized controlled trial to test three different incentives to implement and sustain IBI programmes.

Several comments and questions were raised, including the issues of sustaining incentives, after the project has finished. This point was readily acknowledged and the cost benefit analysis that will be done should inform on sustainability of economical incentives. The list of ODHIN countries is small compared to the WHO European

[5] http://www.alcsmart.ipin.edu.pl/

Region, and it was agreed that any non-ODHIN countries would be welcomed to get involved in any of the project tasks during the next 4 years, at their own expense, and of course the results will be available for everyone to use (and should be translated into Russian). A positive example was shared that Slovenian doctors receive payment for preventive work, including brief interventions. Moreover, a new incentive is that doctors can use brief interventions with drivers who lost points because of drink-driving practices. Thus it was acknowledged that sharing this kind of information between treating doctors would be very useful and ensure a more action oriented approach. Generally, there is political sensitivity to introducing incentives and alcohol is low on incentive threshold, thus it will be interesting to measure the impact of increasing the incentive rates.

Dr Michaela Bitarello and Ms Lidia Segura introduced the most recent evidence on workplace and the European workplace and alcohol EWA project respectively.

In 2003 the direct social costs of alcohol to Europe was estimated at €125bn, of this, €59bn was due to lost productivity. In the workplace, harmful alcohol use and heavy episodic drinking increase the risk for absenteeism, and a host of other inappropriate behaviours. However, structural factors in the workplace, including high stress and low satisfaction, can increase the risk of alcohol use disorders and alcohol dependence. Workplace interventions have been shown to contribute to a reduction in alcohol-related harm and promote health gains on an individual and community level.

The EWA project[6] funded by the EU, will run from January 2011 to June 2013 and builds on and expands on the work of the previous FASE[7] (Focus on Alcohol Safe Environment) project and the existing evidence. The main objectives are to raise awareness amongst employees of the consequences of drinking alcohol and to encourage changes in negative alcohol-related behaviors, to inform employers how they can better support their workers to make healthier options, and adopt a workplace culture, with regard to alcohol, that is supportive of healthier living. The project comprises a series of integrated activities structured around five sequential phases: preparation of two workplace case studies, preparation of a pilot workplan, implementation of 5 pilots in 12 countries, analysis of the pilot results and development of a tool-kit and policy recommendations for implementing work place based alcohol policies and programmes. Outputs of the project will include an analytical report of pilot interventions, a tool kit, policy recommendations and communication material. It was agreed, where possible, to explore ways to involve non-EU and other interested countries.

Professor Peter Anderson introduced the EU funded project: Addictions and Lifestyles in Contemporary Europe - Reframing Addictions Project (ALICE RAP). This project responds to a 2009 in the socioeconomic sciences and humanities, to study addictions and lifestyles in contemporary European societies. ALICE RAP is a Europe wide project of 43 partner research institutions involving 107 researchers from 25 European countries providing 1000 months of a plurality of scientific endeavour to analyse the place and challenges of addictions[8] and lifestyles to the cohesion, organization and functioning of

[6] https://sites.google.com/site/europeanworkplaceandalcohol

[7] http://www.faseproject.eu/wwwfaseprojecteu/about-fase/

[8] "Addiction" defined as substances (alcohol, tobacco, psychoactive and illegal drugs) and behaviours (gambling and internet gaming) whose use can lead to dependence

contemporary European society. With a total cost of €10million ALICE RAP will run for five years from 1st April 2011, with its launch meeting in Barcelona, 23-27 May 2011. The interdisciplinary scope is wide-ranging across some 28 distinct scientific disciplines, ranging from anthropology to toxicology. The work areas and work packages are structured around themes and approaches, and not around particular substances or behaviours. Results will start to become available towards the end of 2012.

The issue of language and terminology was raised, as "addiction" has different meanings and implications for the countries of the WHO European Region. It was already recognised that there was disparity even in the English language, and as such terminologies will be selected carefully to ensure the information is as meaningful as possible. It was acknowledged that the project will be very challenging due to the size and scope of the disciplines involved, but that the results will be incredibly useful to underpin future policy discussions on all levels.

Dates for the future: 18-19 October 2012. The last AMPHORA meeting ("Berzelius symposium"), will be held at the Swedish Association of Medicine in Stockholm.