



Alcohol Measures for Public Health Research Alliance (AMPHORA)

**2nd experts and counterparts meeting
translating science to policy**

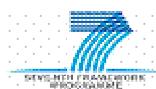
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**AMPHORA Expert meeting and WHO meeting of National Counterparts for Alcohol Policy
in the WHO European Region**

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 drink².

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 cited 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 cited 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 standardised 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 project⁶ funded by the EU, will run from January 2011 to June 2013 and builds on and expands on the work of the previous FASE⁷ (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 addictions⁸ 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.
