Some of the evidence from ALICE RAP and AMPHORA

Peter Anderson

Tuesday, March 21 2017

CNAPA meeting, Luxembourg

The AMPHORA Project

The AMPHORA Project ended in 2012, and the website will no longer be updated, but the deliverables and final outputs of AMPHORA can all be found below and on these pages.

For further information on Alcohol policy in Europe after the end of AMPHORA, please see related projects ALICE RAP and ODHIN.

10 Main findings from AMPHORA

1. EU adults drink 27g alcohol (nearly three drinks) a day, more than twice the world's average.

2. About 138,000 EU citizens, aged 15-64 years, die prematurely from alcohol in any one year.

3. EU drinkers consume more than 600 times the exposure level set by the European Food Safety Authority for genotoxic carcinogens, of which ethanol is one.

4. Countries with stricter and more comprehensive alcohol policies generally have lower levels of alcohol consumption, and policies are tending to get stricter in recent years.

5. Alcohol policies impact on alcohol consumption, even when talking into account broader socio-demographic changes, such as increased urbanization which is associated with increased consumption and increased maternal age at all childbirths which is associated with decreases in consumption.

6. Online alcohol marketing and alcohol branded sports sponsorship increase the likelihood of 14 year olds to drink alcohol.

7. Brief interventions for risky drinking and pharmacological treatments for alcohol use disorders are effective.

8. The proportion of people who actually access treatment out of those who need it ranges from only 1 in 25 to 1 in 7.

9. Young people are often already drunk by the time they go out, fuelled by cheap alcohol from shops and supermarkets, with drinking venues exacerbating problems further.

10. Monitoring alcohol policy and its impact needs much improvement.

Please note: If you cannot see the further information or linked material below each point, please update the page using the keys

Addictions in Europe

Optimising Brief Interventions for Alcohol

Latest news

02-06-2014
From now on, all relevant news related to addictions can be found in ALICE RAP website

28-06-2013
A message to the European Sponsorship Agency: research shows that alcohol marketing is not harmless

03-06-2013
Vested interests in addiction research and policy - New publication

28-05-2013
Online Conference on Digital Alcohol Marketing (Online, 31st October 2013)

28-05-2013
European Week Against Cancer (Dublin-Ireland, 29-30th May 2013)

28-05-2013
INEBRIA Conference (Rome-Italy, 19-20th September 2013)

27-05-2013
Impact Factor Distortions

27-05-2013
Health in All Policies: Seizing opportunities, implementing policies

15-05-2013
Awareness Week on Alcohol-Related Harm

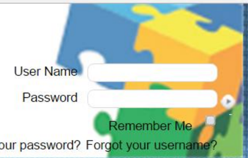
26-04-2013
Relationship between minimum alcohol prices and

Alcohol Policy in Europe: Evidence from AMPHORA

Edited by Peter Anderson, Fleur Braddick, Jillian Reynolds and Antoni Gual

ALICE RAP

Addiction and Lifestyles in Contemporary Europe
Reframing Addictions Project



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Family | A-Debate | Cannabis | Prescription opioids | Novel Psychoactive Substances

Read ALICE RAP's final Policy Paper: Addiction in the Family.

About ALICE RAP

ALICE RAP is a European research project, co-financed by the European Commission, which started in April 2011 and aims to stimulate a broad and productive debate on science-based policy approaches to addictions.

Vision Statement:
Promote well-being through a synthesis of knowledge to redesign European policy and practice to better address the challenges posed by substance use and addictive behaviours.

Mission Statement:
Advance synergy among sciences that address substance use and addictive behaviours, through a five-year programme of European trans-disciplinary

Resources - Highlights

ALICE RAP SCIENCE FINDINGS

The **ALICE RAP Science Findings** give a simple account of the main results coming out of the different lines of ALICE RAP research with links to further reading and the more detailed ALICE RAP deliverable reports.

See all ALICE RAP deliverable reports

See all ALICE RAP Policy Papers
(Family, Cannabis, Prescription opioids, NPS, Gambling and alcohol)

Latest publications 2016

3rd ALICE RAP OUP book: What

ALICE RAP News

since the beginning of the project...

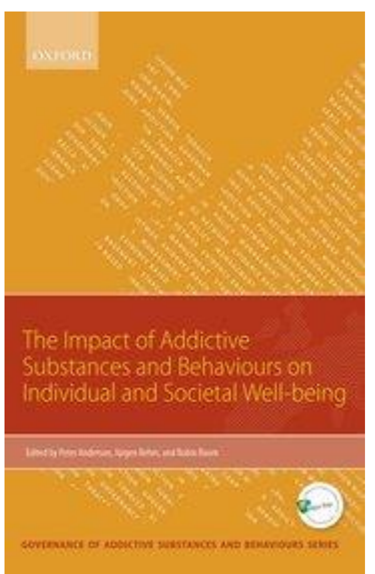
- on average, an AR dissemination activity **every 8 days**,
- a peer-reviewed paper **every 21 days**,
- we have now submitted **all of the project deliverables**
- we have achieved a **global audience** for the AR website

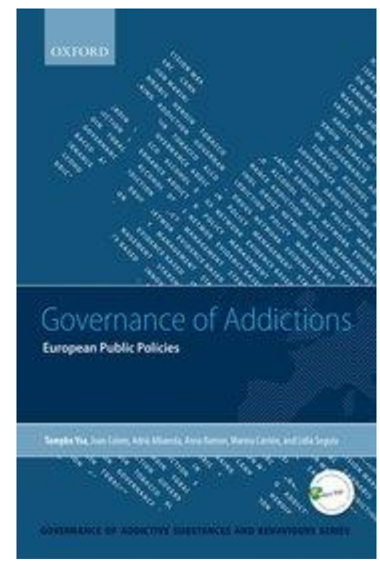
Read the ALICE RAP Impact report developed for RTD SSH projects.

Logged in users can read more details in the 4th periodic report.

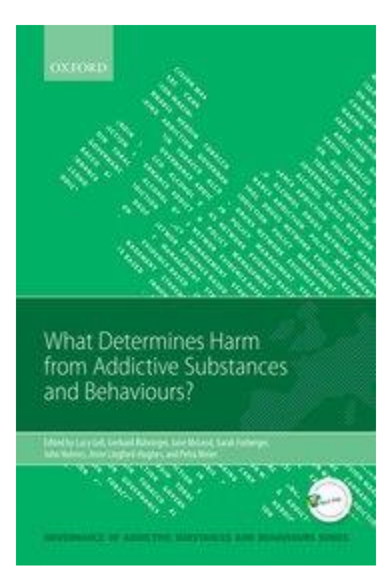
Events Calendar

OXFORD
The New Governance of Addictive Substances and Behaviours
GOVERNANCE OF ADDICTIVE SUBSTANCES AND BEHAVIOURS SERIES


OXFORD
The Impact of Addictive Substances and Behaviours on Individual and Societal Well-being
GOVERNANCE OF ADDICTIVE SUBSTANCES AND BEHAVIOURS SERIES

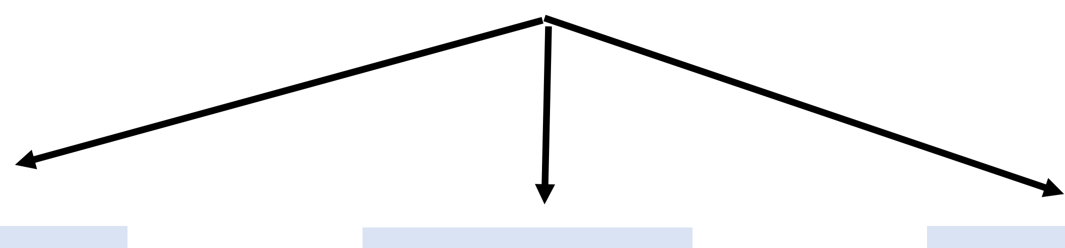

OXFORD
Governance of Addictions
European Public Policies
GOVERNANCE OF ADDICTIVE SUBSTANCES AND BEHAVIOURS SERIES

OXFORD
Concepts of Addictive Substances and Behaviours across Time and Place
GOVERNANCE OF ADDICTIVE SUBSTANCES AND BEHAVIOURS SERIES


OXFORD
What Determines Harm from Addictive Substances and Behaviours?
GOVERNANCE OF ADDICTIVE SUBSTANCES AND BEHAVIOURS SERIES

OXFORD
Impact of Market Forces on Addictive Substances and Behaviours
The web of influence of addictive industries
GOVERNANCE OF ADDICTIVE SUBSTANCES AND BEHAVIOURS SERIES

Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol



Heavy use over time	Treatment gap	Government-led prevention

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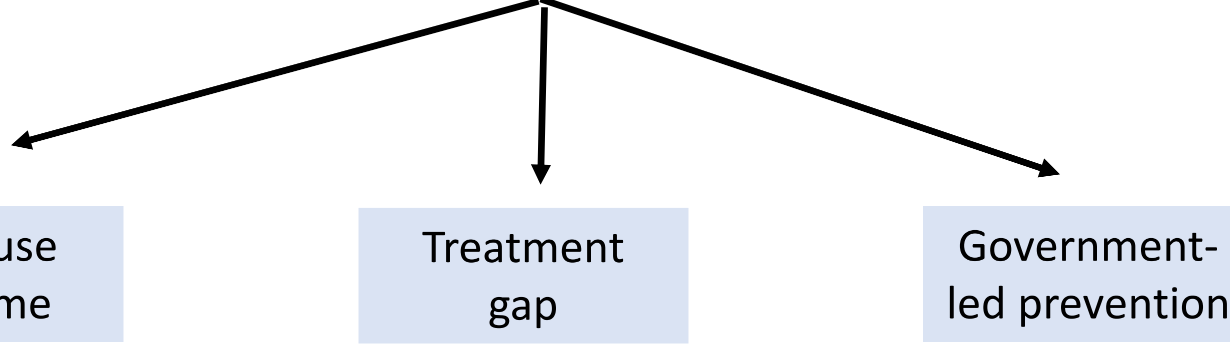
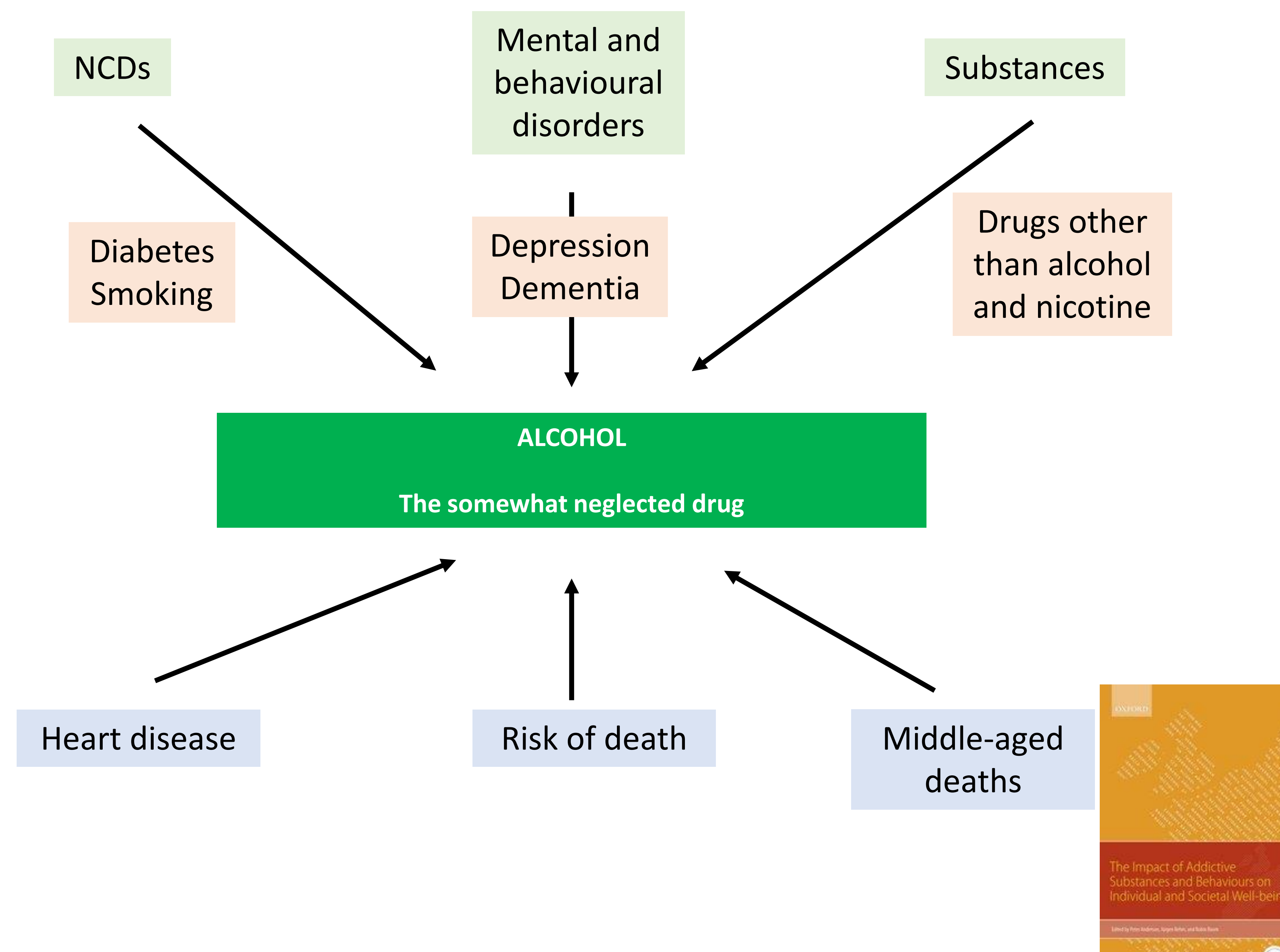
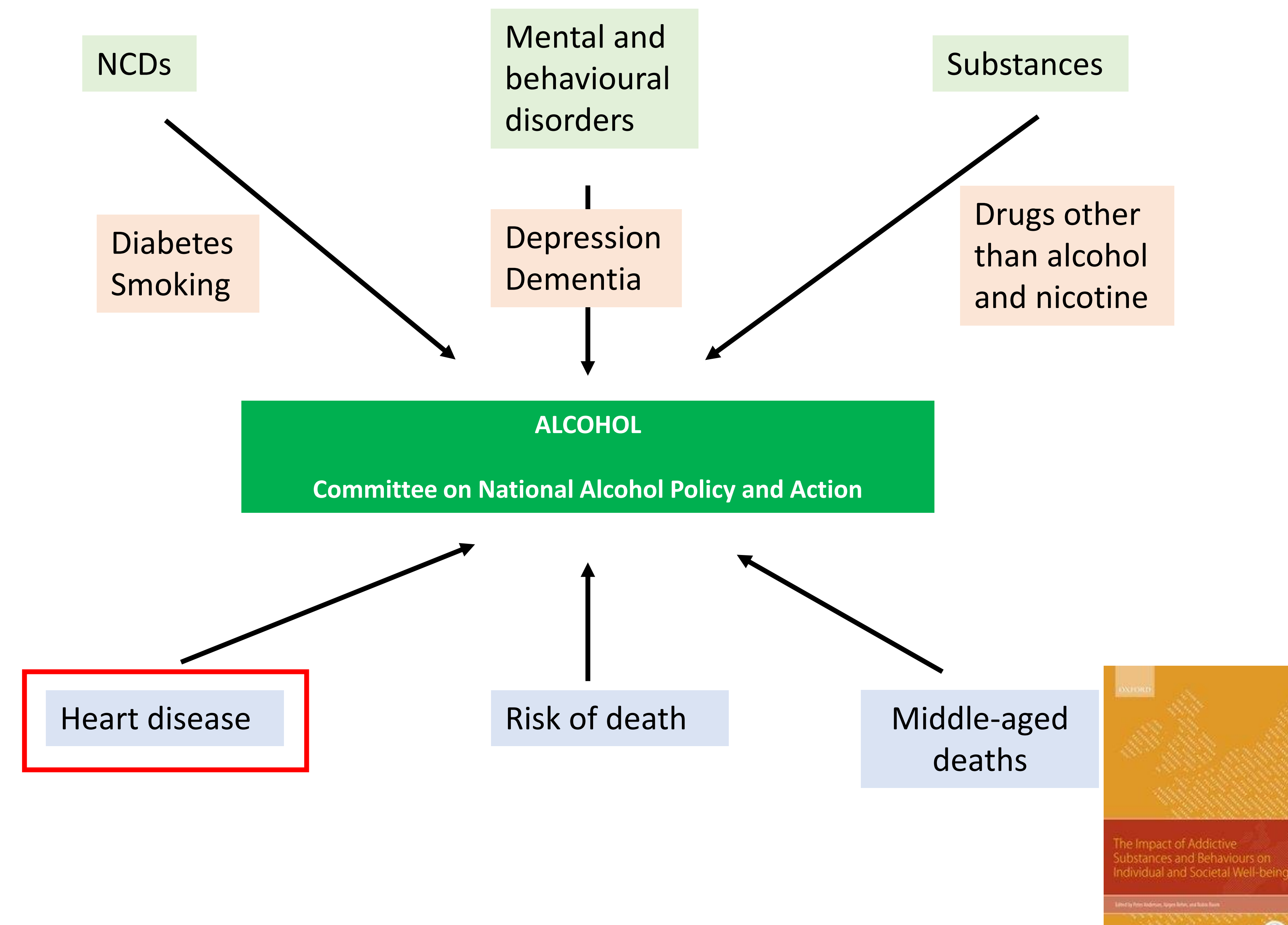




NCDs
Mental and behavioural disorders
Substances
Diabetes
Smoking
Depression
Dementia
Drugs other than alcohol and nicotine
ALCOHOL
The somewhat neglected drug
Heart disease
Risk of death
Middle-aged deaths
The Impact of Addictive Substances and Behaviours on Individual and Societal Well-being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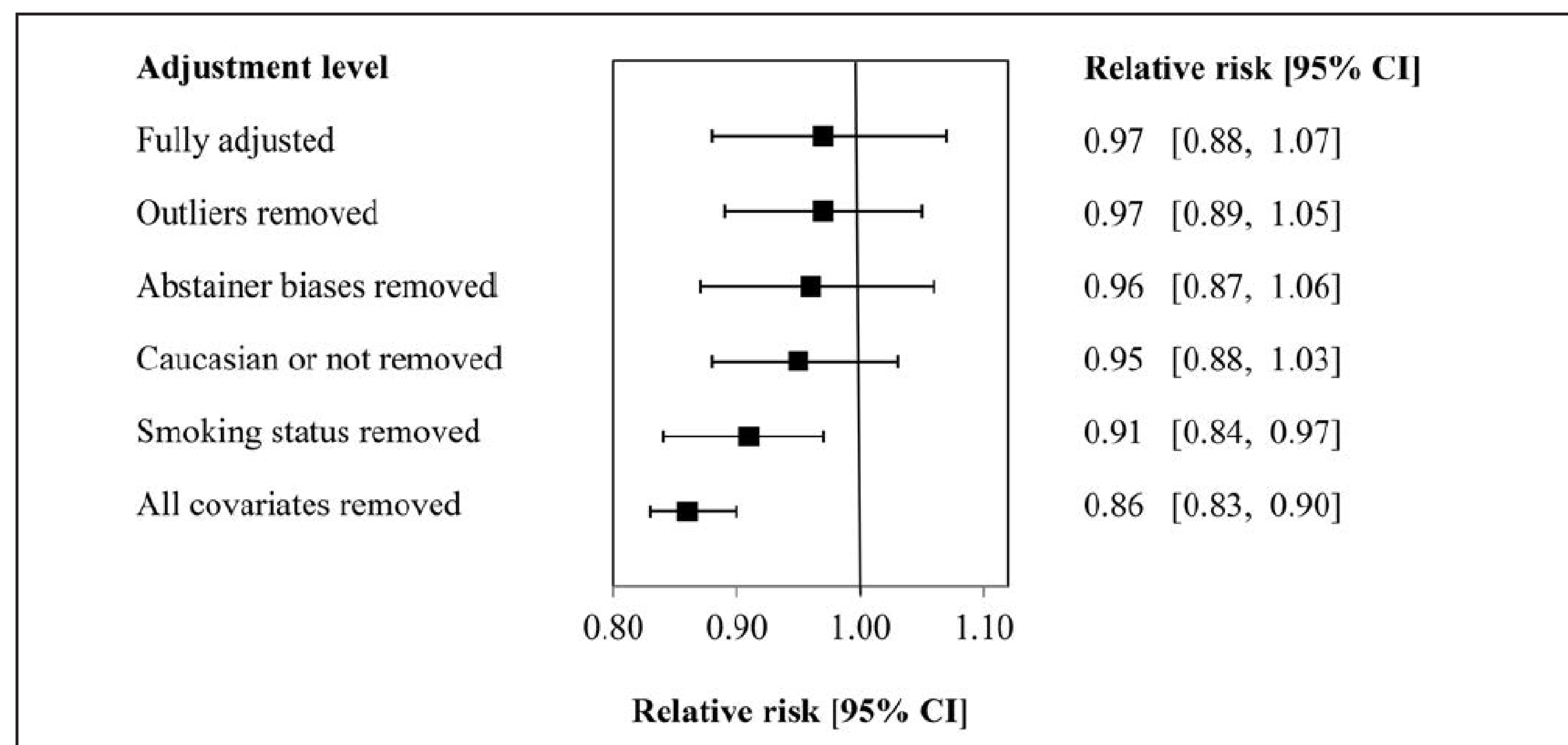
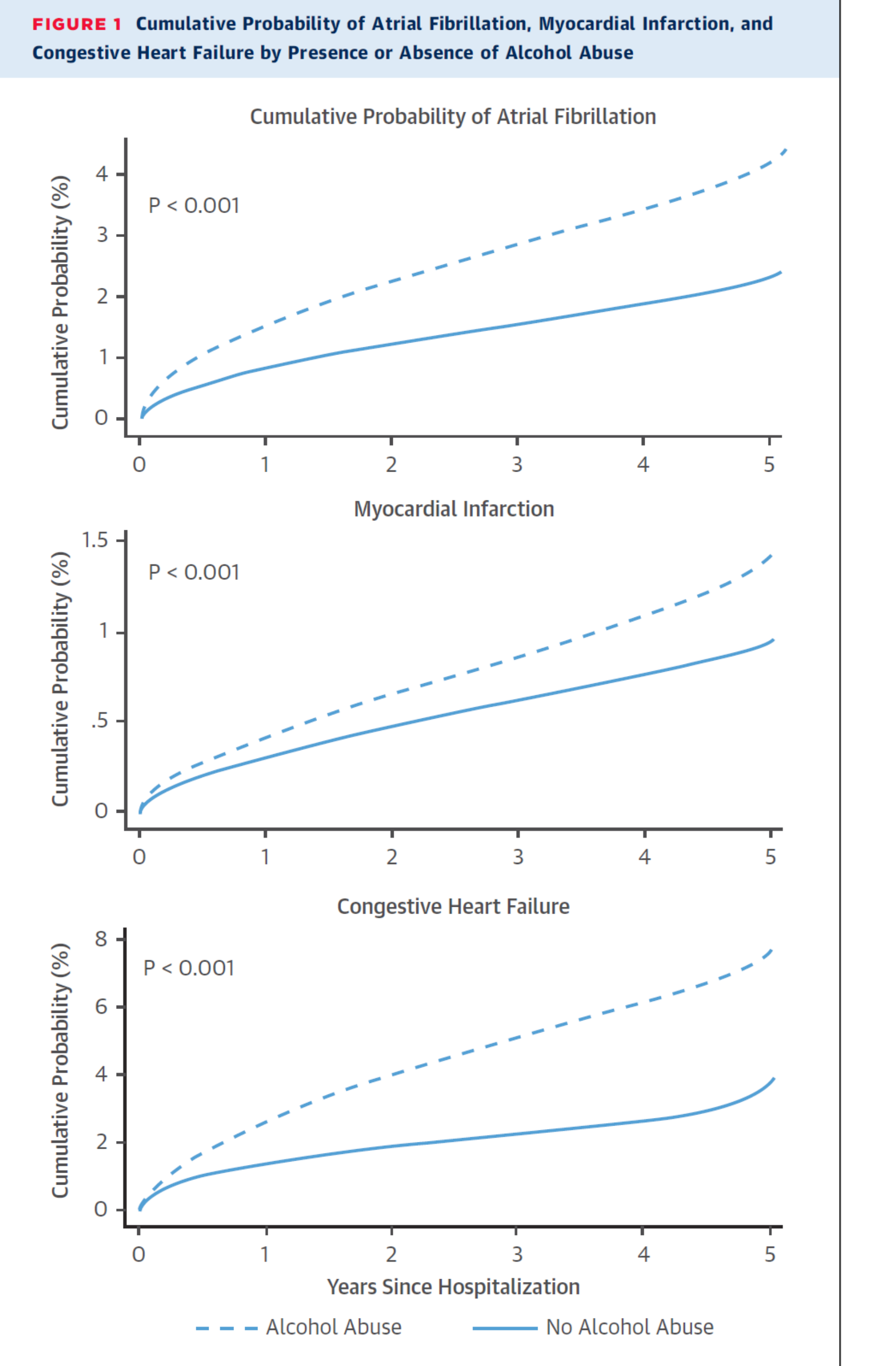


FIGURE 3. All-cause mortality relative-risk estimates for low-volume alcohol consumers versus lifetime abstainers with and without influential covariates (n = 81 studies, 229 risk estimates). CI = confidence interval.

Stockwell et al. 2016



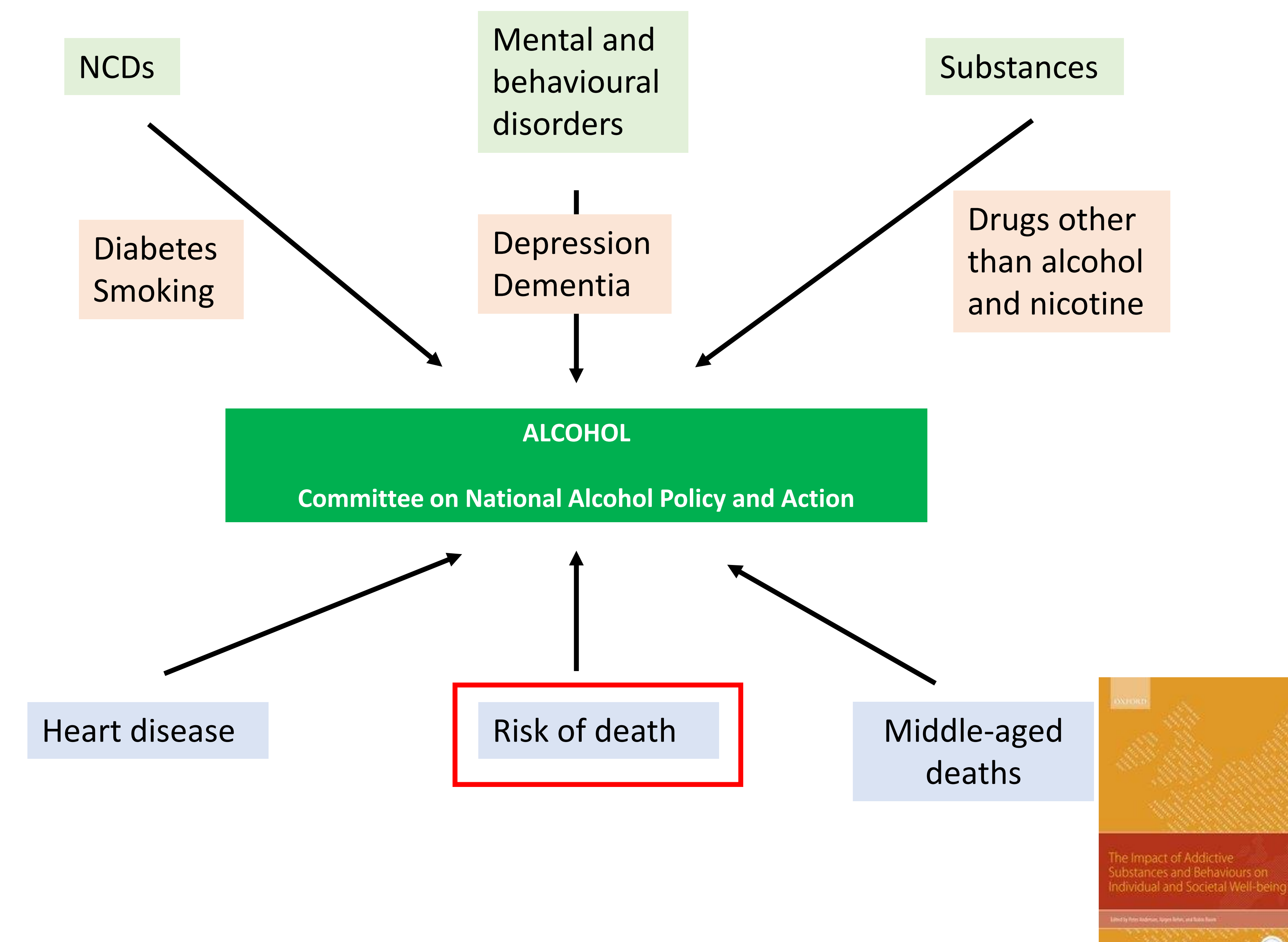
Whitman et al. 2017

So, where are we now with respect to alcohol consumption and cardiac disease:

1. Alcohol is a potentially addictive and dangerous drug, both for the cardiovascular system and multiple other organ systems;

2. The recent infatuation with the potential benefits of light-to-moderate drinking for CVD protection appears to be based on observational and subtly confounded data, rather than on RCT evidence, and perhaps on more than a little wishful thinking.

Criqui 2017



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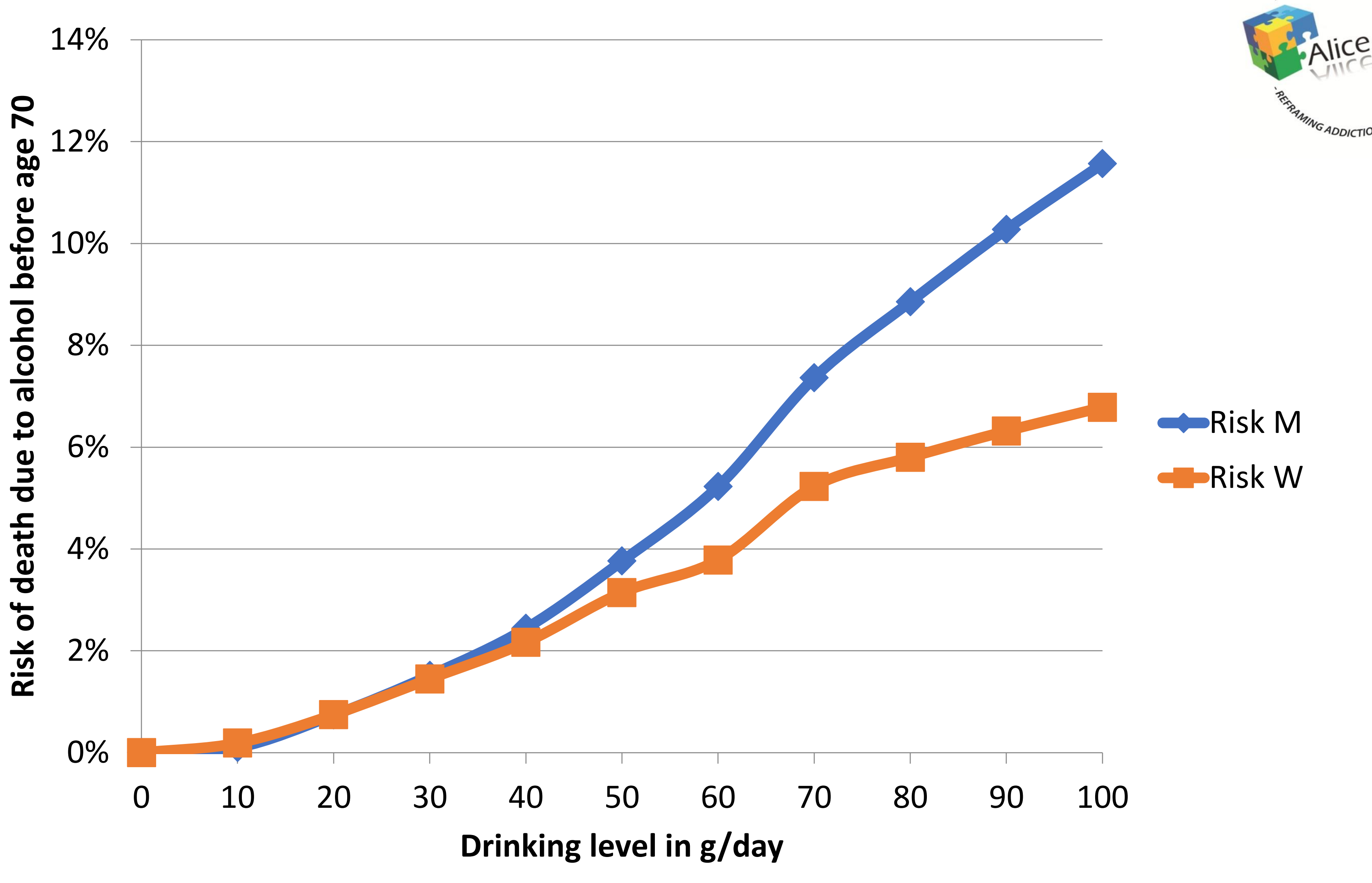
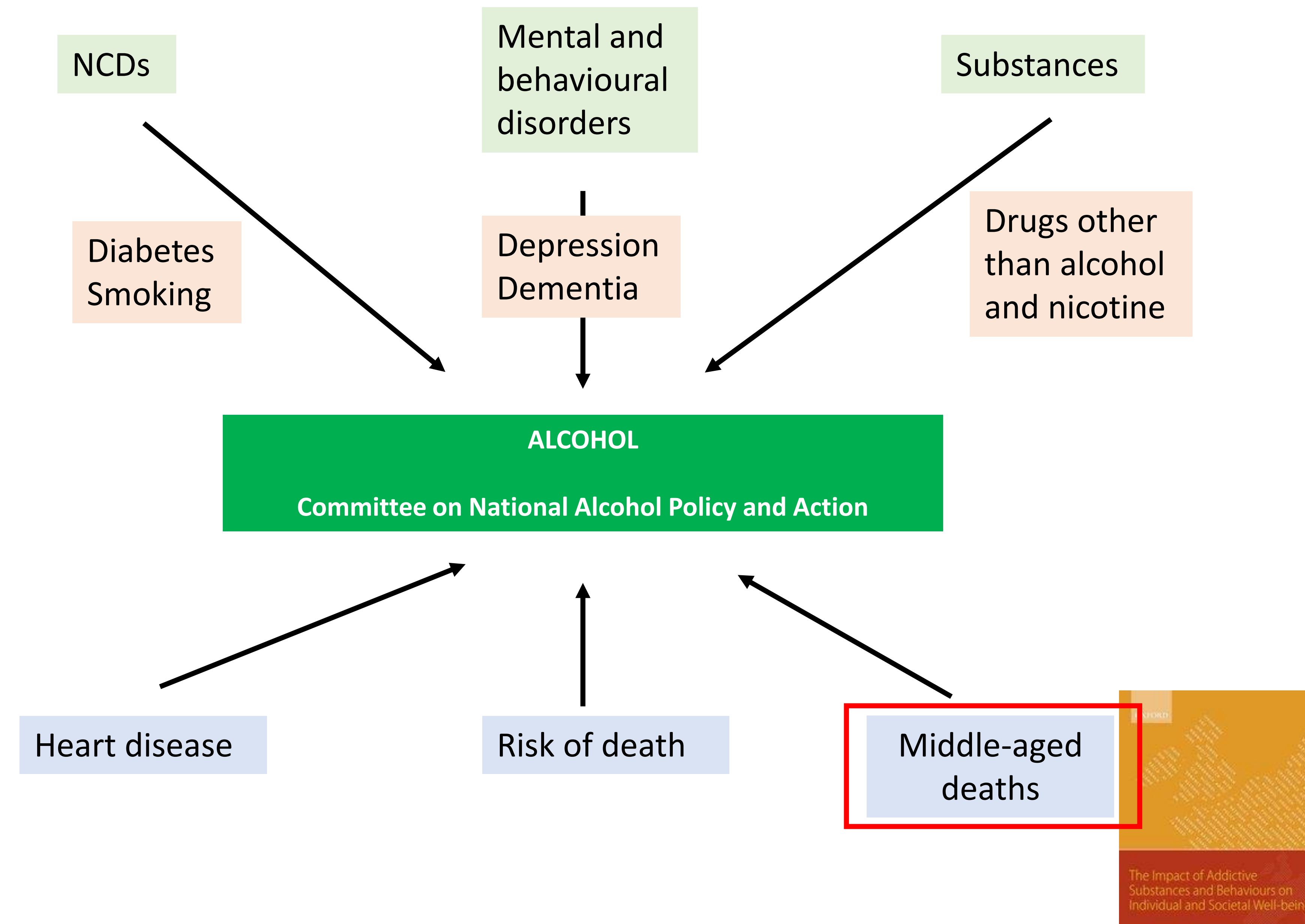
Alice Rap
ADDICTIONS AND LIFESTYLES IN CONTEMPORARY EUROPE
- REFRAMING ADDICTIONS PROJECT -



Risk of dying prematurely (up to age 70) due to alcohol consumption in European Union

Rehm et al. 2015



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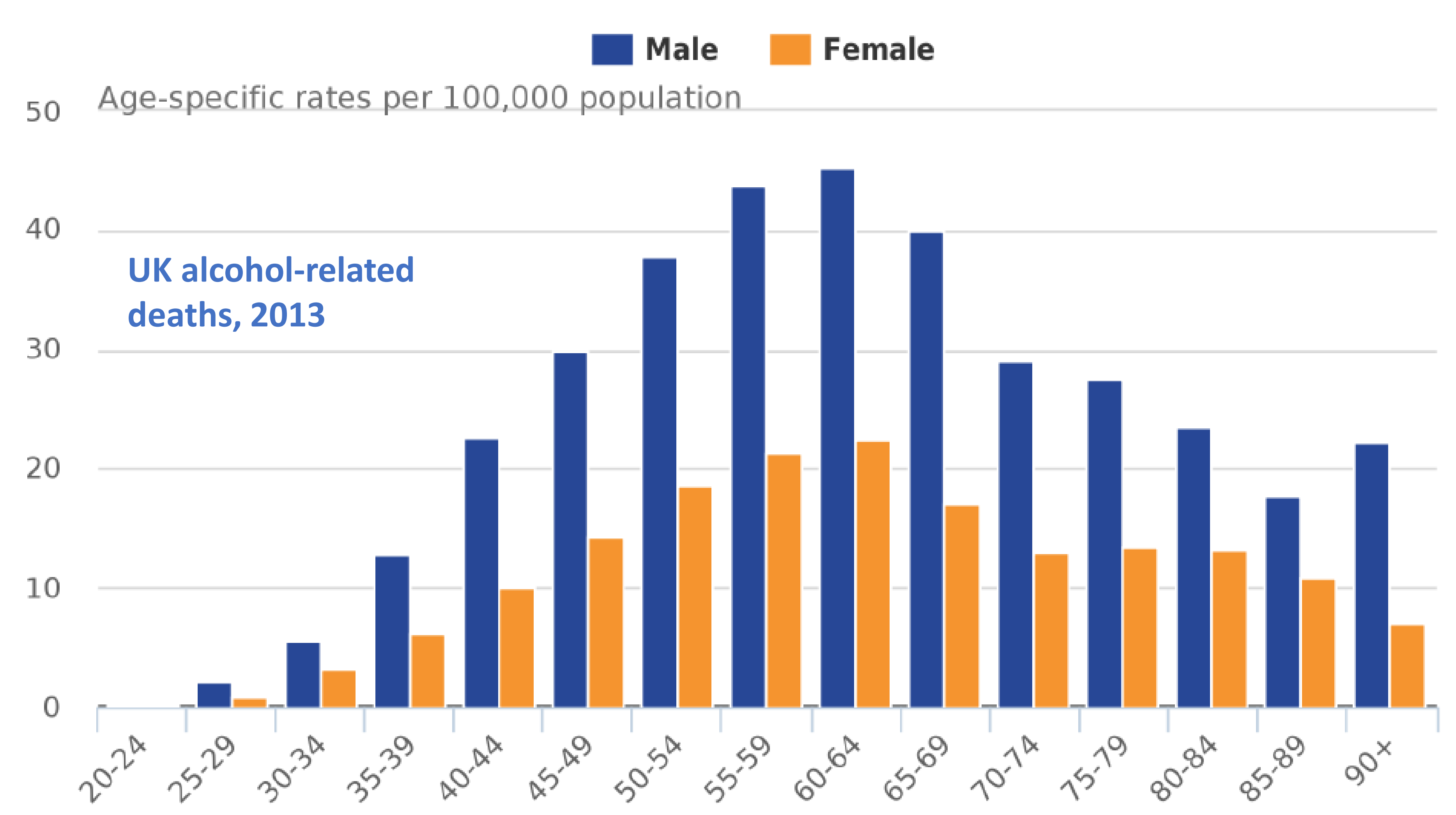
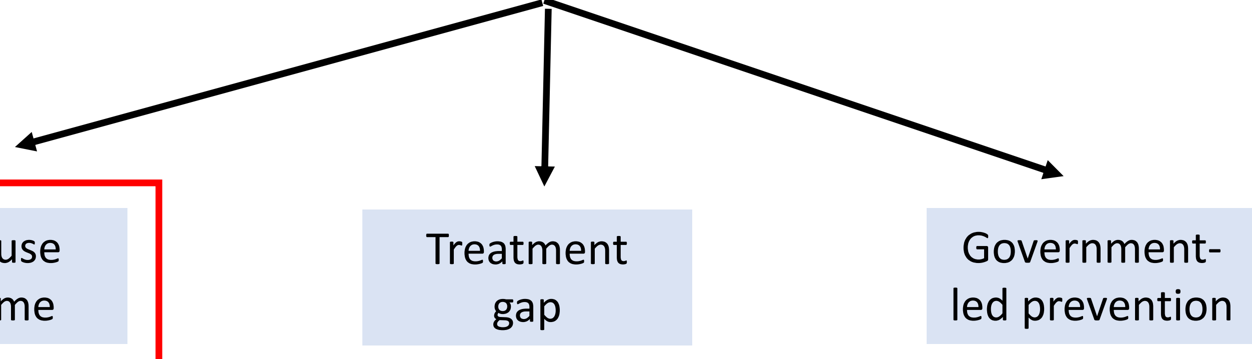
Importance of middle age



Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol



Heavy use over time

Treatment gap

Government-led prevention

Alcohol Use Disorder (AUD)

AUD GBD

AUD WHO

AUD DSM-5

AUD ICD-11

They are all different

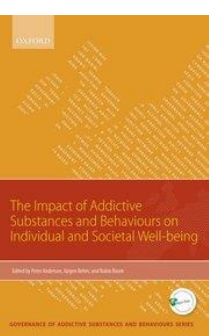
Heavy drinking over time

They are all different

Harmful use of alcohol UN SDGs

Harmful use of alcohol ICD-11

Harmful use of alcohol NCD framework



Alcohol Use Disorder (AUD)

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GBD

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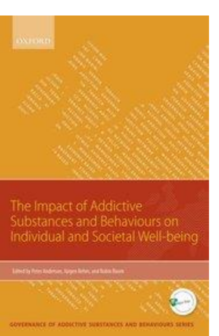


In medical settings and indeed often in academic and lay settings, heavy users of alcohol are commonly dichotomized into those with an ‘alcohol use disorder’ or not.

However, ‘alcohol use disorder’ is a clinical construct that is often used as a shorthand to identify individuals who might benefit from advice or treatment. But as a condition in itself, it is a medical artefact which occurs in all grades of severity, with no natural distinction between ‘health’ and ‘disease’.

Alcohol: Disease risk is a continuous (often exponential) relationship

Mortality Morbidity

40
35
30
25
20
15
10
5
0

Relative risk

Female liver cirrhosis

0 12 24 36 48 60 72 84 96 108 120

Alcohol consumption (grams/day)

Alcohol:

Unmanaged heavy drinking can be associated with even further heavy drinking, often culminating in a more difficult to manage state due to associated brain atrophy.

The brain atrophy, though, is a consequence of the heavy drinking.

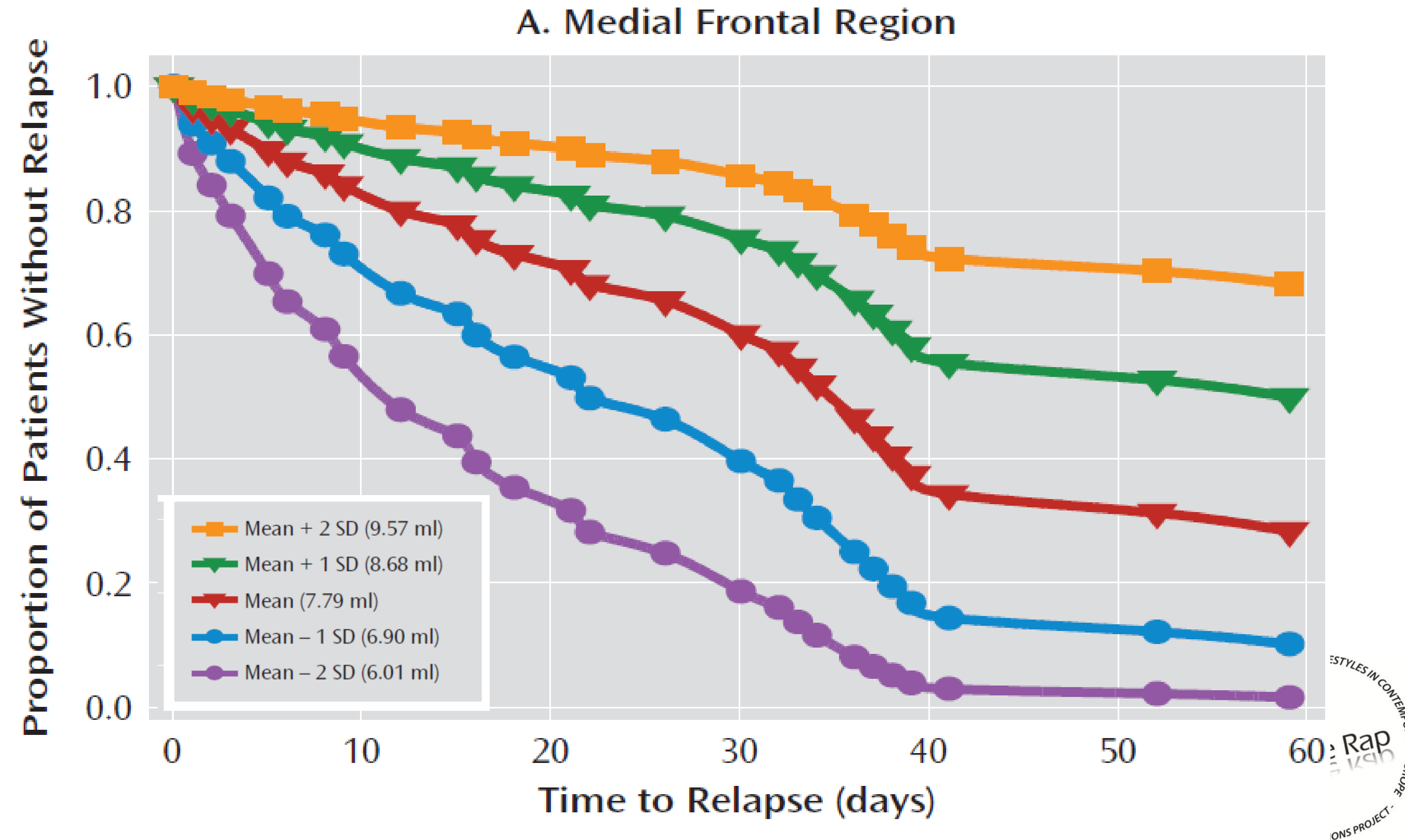
Alcohol: Relationship between drinking levels and brain volume from Framingham study

Adjusted Brain Volume, % TCV

79.0
78.8
78.6
78.4
78.2
78.0
77.8
77.6
77.4
77.2
77.0

Abstainers
Former Drinkers
Low
Moderate
High

Connecticut Mental Health Center Study: Gray matter volume deficits predict time to relapse in 'alcohol-dependent' patients



Alcohol: Alcohol consumption is close to log-normally distributed in populations, skewed towards heavy drinking. There is no natural cut-point above which "alcohol dependence" definitively exists and below which, it does not.

Alcohol distribution (grams/day), German men

Prevalence

0.00 0.01 0.02 0.03 0.04 0.05 0.06

0 50 100 150 200

Volume (g/day)

Log-Normal (red); Gamma (blue); Weibull (green)

Alcohol dependence/alcohol use disorder:

simply defined as a score on a checklist of symptoms

DSM–IV			DSM–5	
In the past year, have you:			**In the past year, have you:**	
Any 1 = ALCOHOL ABUSE	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	1	Had times when you ended up drinking more, or longer, than you intended?	The presence of at least 2 of these symptoms indicates an **Alcohol Use Disorder (AUD).** The severity of the AUD is defined as: **Mild:** The presence of 2 to 3 symptoms **Moderate:** The presence of 4 to 5 symptoms **Severe:** The presence of 6 or more symptoms
	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	2	More than once wanted to cut down or stop drinking, or tried to, but couldn't?	
	More than once gotten arrested, been held at a police station, or had other legal problems because of your drinking? ****This is not included in DSM–5****	3	Spent a lot of time drinking? Or being sick or getting over other aftereffects?	
	Continued to drink even though it was causing trouble with your family or friends?	4	Wanted a drink so badly you couldn't think of anything else? ****This is new to DSM–5****	
Any 3 = ALCOHOL DEPENDENCE	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	5	Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	
	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	6	Continued to drink even though it was causing trouble with your family or friends?	
	Had times when you ended up drinking more, or longer, than you intended?	7	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	
	More than once wanted to cut down or stop drinking, or tried to, but couldn't?	8	More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	
	Spent a lot of time drinking? Or being sick or getting over other aftereffects?	9	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	
	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	10	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	
	Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	11	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	

Alcohol: There is a smooth line relationship between levels of alcohol consumption and the score on the checklist.

By Gender

Men
Women

Mean No. of AUD Criteria

0 2 4 6

1 2 3 4 5 6 7 8 9 10 11 12

AUDIT-C Score

Thus, “alcohol use disorder” is a diagnostic artefact. No more is needed to consider what is called “alcohol use disorder” other than heavy use over time.

This approach does not imply that heavy use over time is the only cause of harm.

There are other factors involved that drive harm that are independent of, or in interaction with alcohol use, including at:

- molecular and cellular levels (e.g., alcohol dehydrogenase polymorphisms);
- individual levels (e.g., income); and,
- environmental levels (e.g., stigma).

AMPHORA
Alcohol Public Health Research Alliance
Odhin project
ADDICTIONS AND LIFESTYLES IN CONTEMPORARY EUROPE
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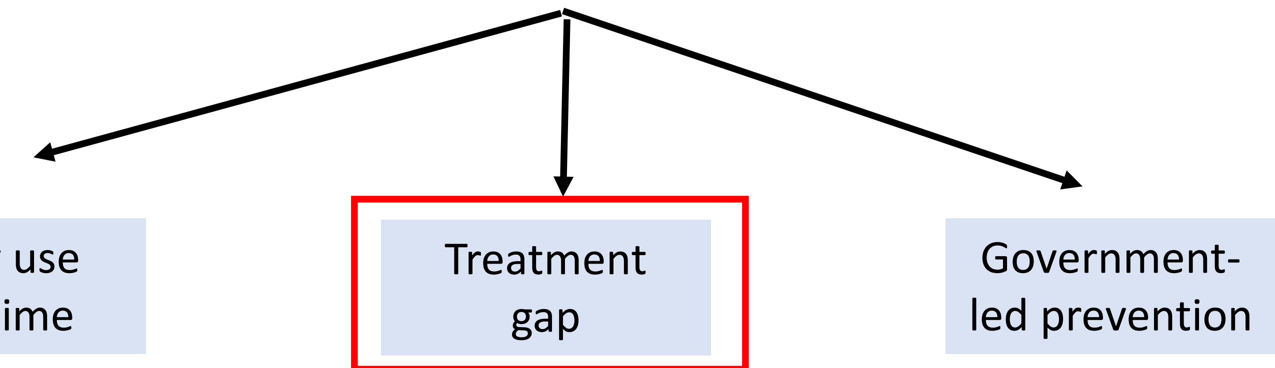
- REFRAMING ADDICTIONS PROJECT -
SUSTAINABLE DEVELOPMENT GOALS

Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol


Heavy use over time
Treatment gap
Government-led prevention

Add up the numbers:

	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%)

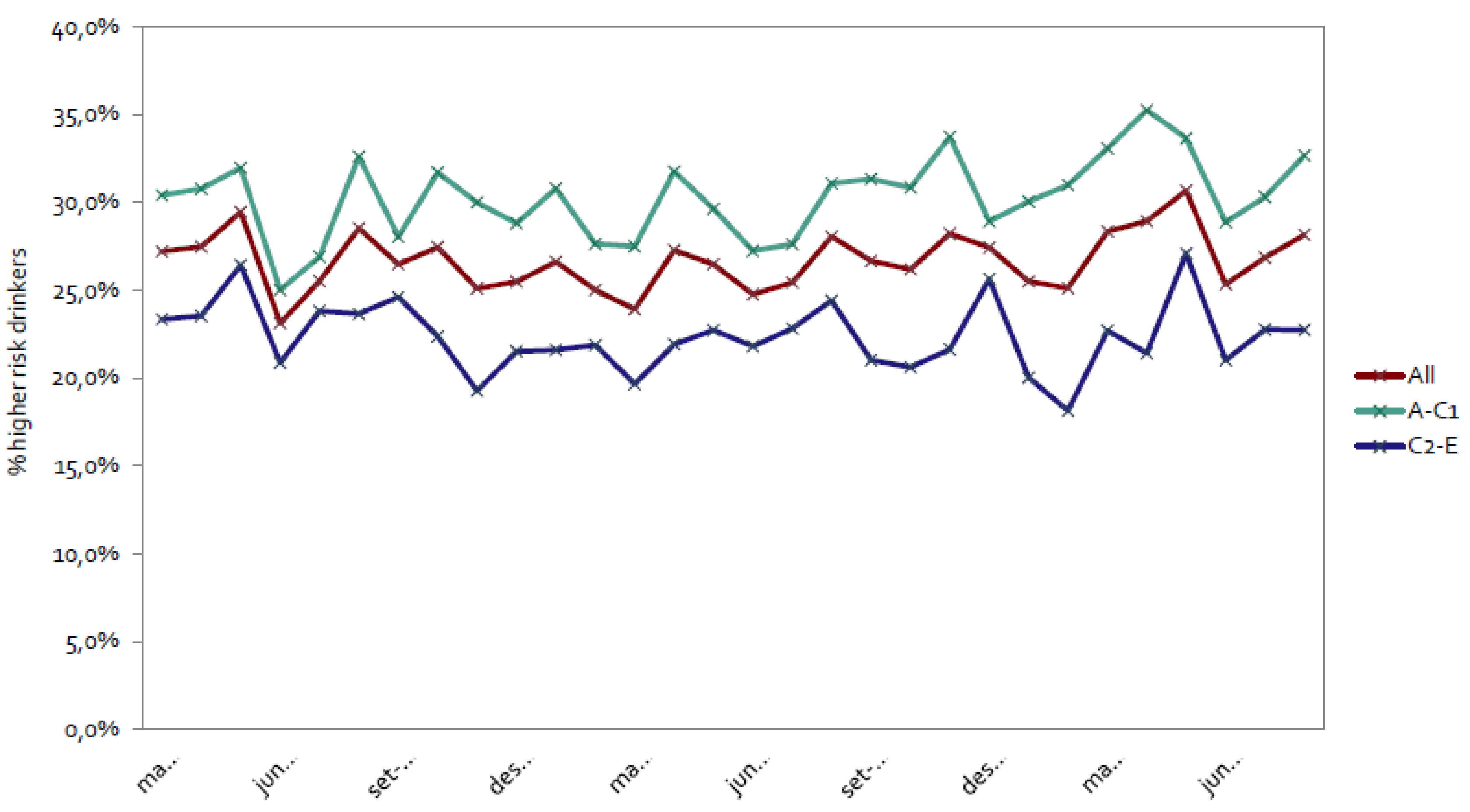
Ask the people:

Population survey in England.

Of 1110 people drinking excessively (8+ on AUDIT), 6.5% recalled receiving advice from GP in previous year

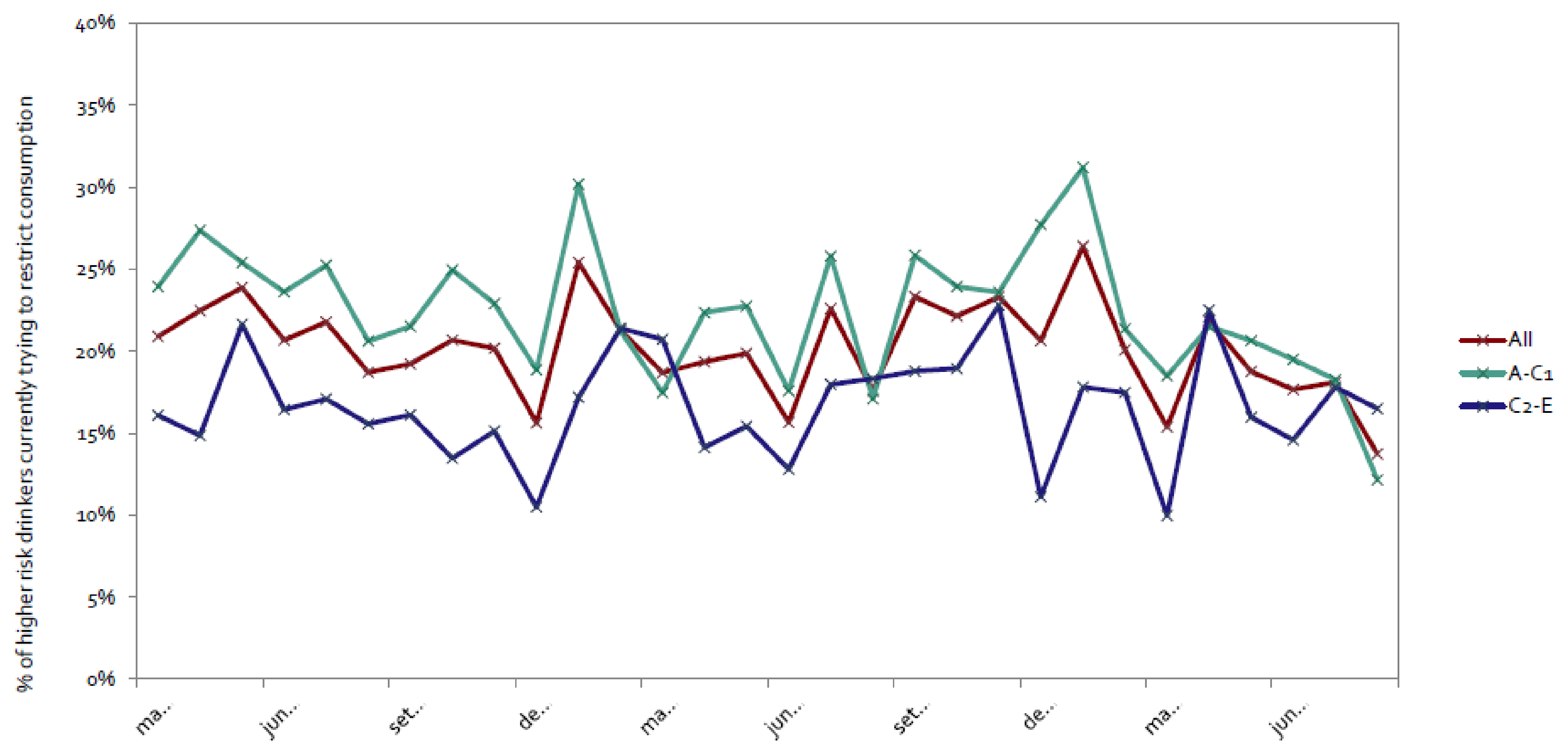
Brown et al. 2016

Prevalence of excessive drinking (AUDIT-C >4)



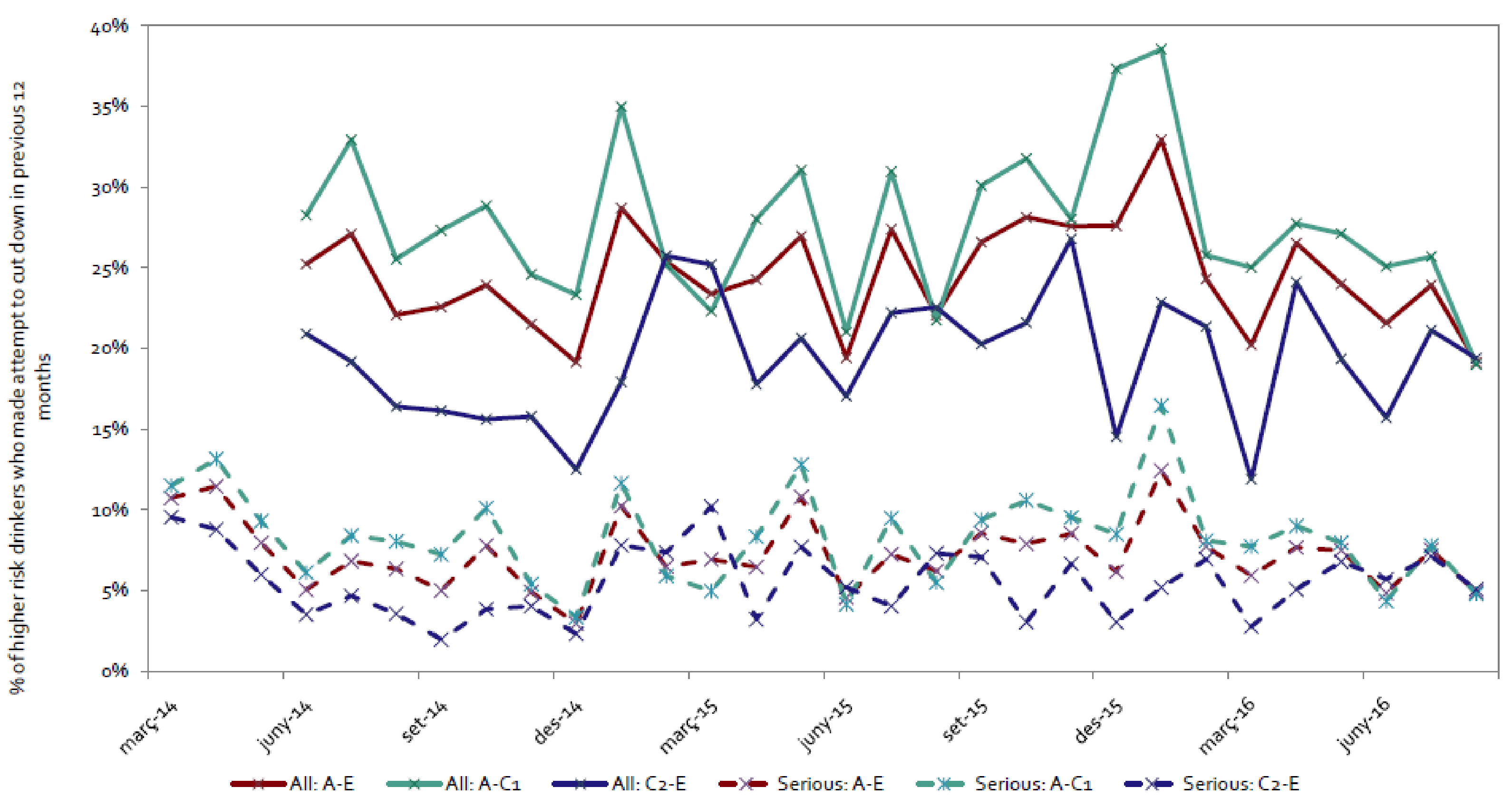
A-C1: Professional to clerical occupation C2-E: Manual occupation

Currently trying to restrict consumption



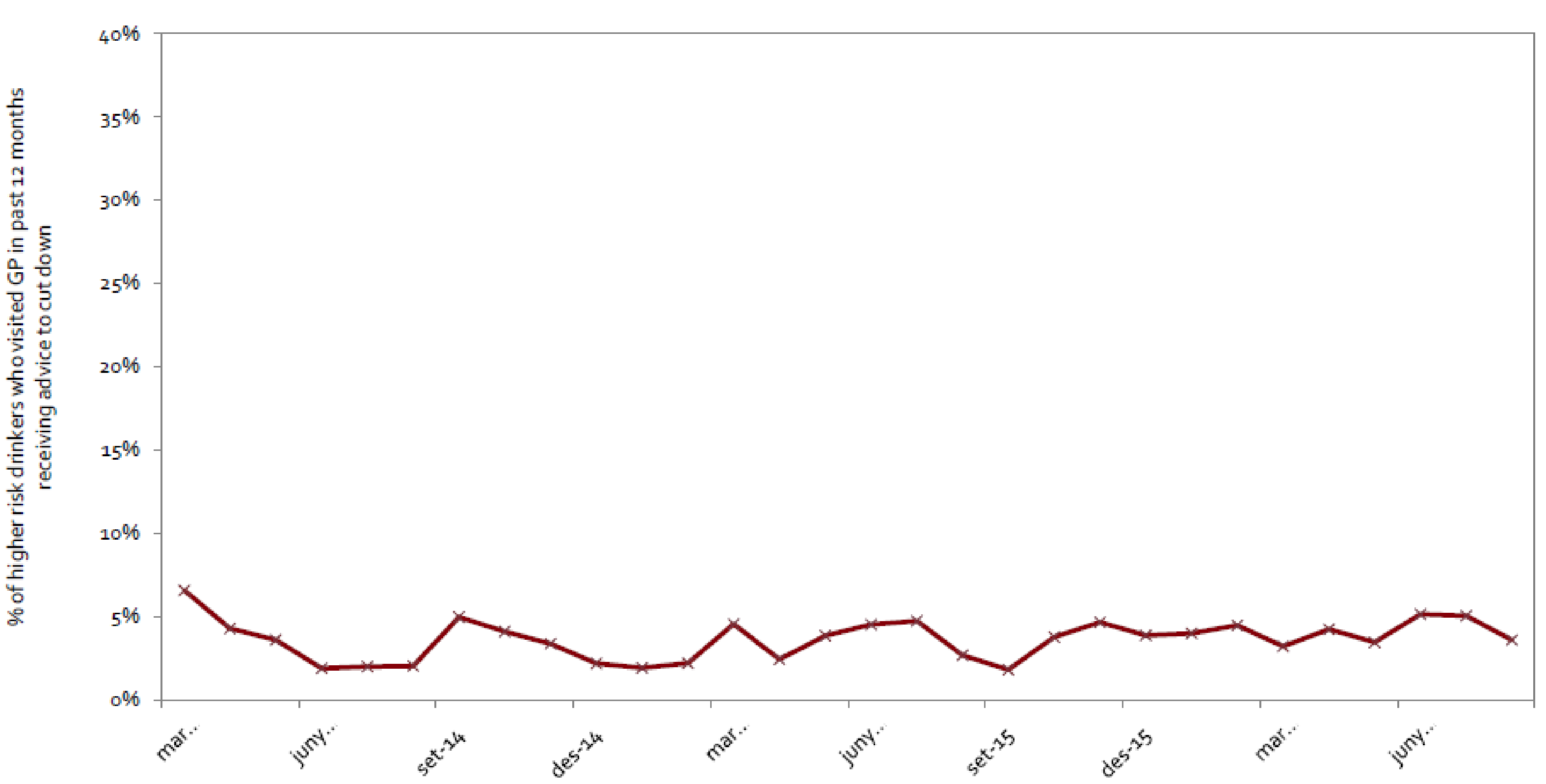
Question: Are you currently trying to restrict your alcohol consumption e.g. by drinking less, choosing lower strength alcohol or using smaller glasses?

Past-year attempts to cut down or stop



Q1: How many attempts to restrict your alcohol consumption have you made in the last 12 months (e.g. by drinking less, choosing lower strength alcohol or using smaller glasses)? Q2: During your most recent attempt to restrict your alcohol consumption, was it a serious attempt to cut down on your drinking permanently?

Reported GP/nurse advice on cutting down

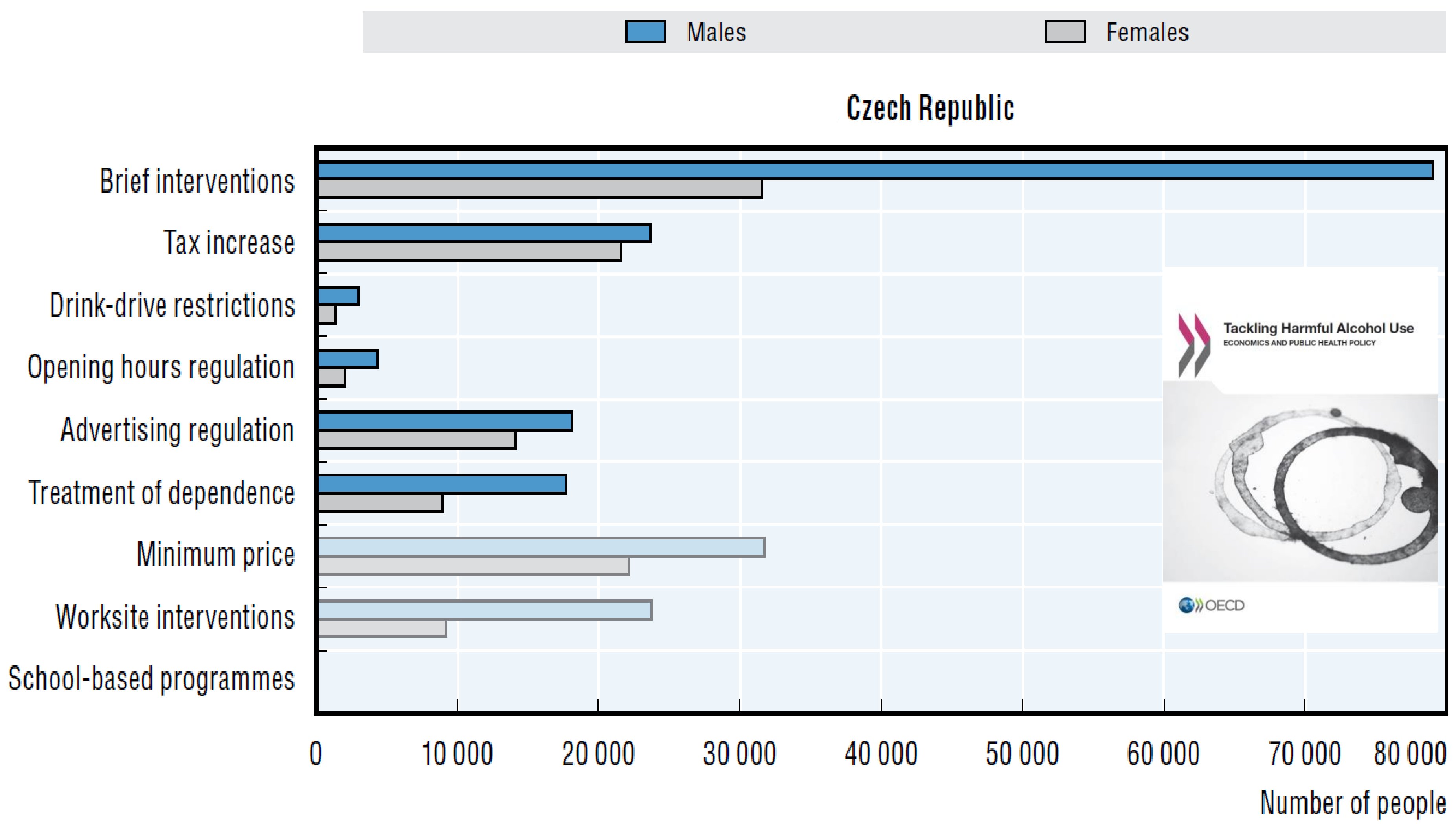


Question: In the last 12 months, has a doctor or other health worker within your GP surgery discussed your drinking?

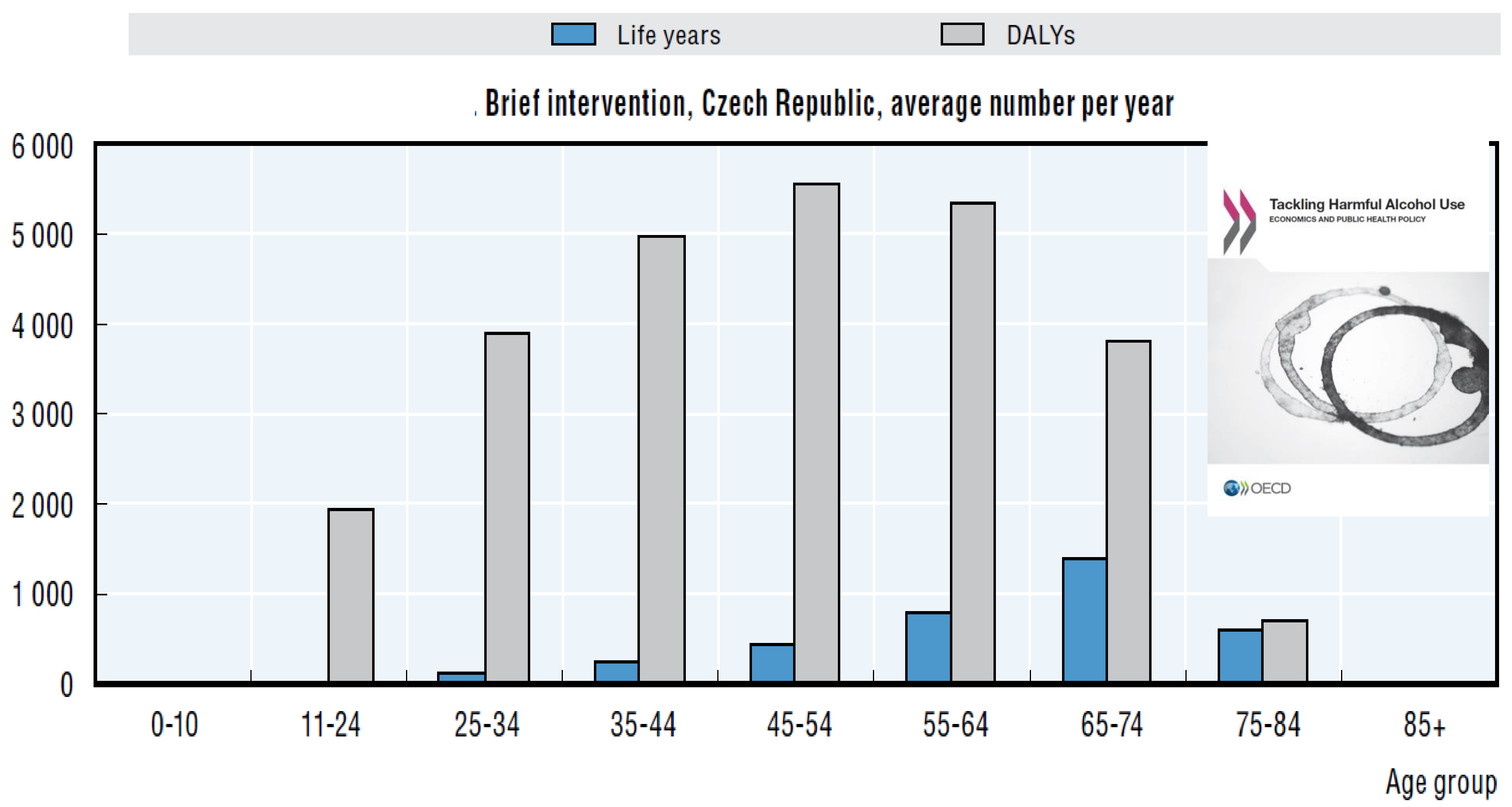
Ask the providers:

Country	Gender (% males) of respondents	Age (Mean) of respondents	Patients per week	Patients screen positive/week (%)
Austria	46.5%	55.2	285	6.54 (2.5%)
Germany	53.4%	53.8	203	7.76 (3.8%)
Italy	74.2%	56.2	117	5.18 (4.4%)
Spain (Catalonia)	23.3%	47.3	149	4.14 (2.8%)
Switzerland	61.8%	52.5	98	4.40 (4.5%)
UK (England)	52.4%	46.5	110	3.87 (3.5%)
Total (mean)	56.3%	52.7	154	5.34 (3.5%)

Number of working-age people freed of alcohol-related diseases, average effect per year



Effects of selected interventions in different age groups



Reason	N of responses	Percent of cases
Time constraints	209	70.6
Risk of upsetting patients	147	49.7
Lack of financial incentives	87	29.4
Lack of services to refer to	67	22.6
Lack of training	60	20.3

Cut-off points for screen-positives too low:

In AUDIT-C, cut-off points of 4/5 equivalent to consumption of 20g/day

At the mean of the baseline trials in the original Cochrane review, 45 grams/day, cut-off for AUDIT-C would be 8.

That lower cut-offs may be inappropriate is also illustrated by the lower effect sizes (half the size) found in an updated Cochrane review, where the average baseline consumption at enrolment had dropped to 26 grams/day.

It has also been suggested that primary health care providers might be more engaged in screening and giving brief advice, if screening were targeted to patients with comorbid conditions, such as depression or hypertension.

However, to date, there is insufficient evidence for an appropriate package that deals with comorbidity to scale-up.

Further, it has been shown that targeted screening misses out on the vast majority of patients that would be captured by universal screening.

The second reason for modest increases in primary health care-based activity could be due a focus on providers alone, whereas successful implementation of health interventions within complex health system demands addressing a range of underlying structural and support systems.

Phase IV of the WHO study on the identification and management of alcohol-related problems in primary care, outlined a range of conclusions for enhancing the widespread uptake of screening and brief advice programmes to reduce the harmful use of alcohol:

(i) training and practice-based materials need local customization that can be achieved through focus groups;

(ii) reframing views about alcohol of both professionals (through training) and the public (through mass media campaigns) is essential;

(iii) the establishment of a lead organization is essential, gathering endorsements from a range of organisations and individuals that are highly relevant to the aims of the work; and

(iv) adequately controlled community-based studies need to be undertaken to strengthen the evidence base for achieving routine implementation.

In ODHIN study, 68 providers interviewed at end of study – main conclusion:

much greater local support is needed to achieve a local screening and brief advice culture/social norm

Experience from the US-based SAMHSA SBIRT initiative stressed the importance of local champions and whole practice buy in for successful implementation.

The European five-country ODHIN study found that the proportion of patients screened and advised was higher by 50% with training and support and higher by 100% with financial reimbursement.

Anderson et al. 2016

At 9-month follow-up, the proportion of patients screened and advised was higher by 40% with training and support and higher by 26% with financial reimbursement for those providers who had increased their commitment to delivering screening and brief advice programmes.

Anderson et al. 2017

Country	Strategy	Net cost of programme (€m)	Net QALY gain vs. no SBIs (000s)	Incremental cost (€m)	Incremental QALYs (,000s)	ICER (per QALY)
England	Control	-35.4	4.6			
	TS+FR	-233.8	38.0	-198.4	33.4	Dominates
Netherlands	Control	-4.0	1.0			
	eBI	-7.9	1.3	-3.9	0.4	Dominates
	TS	-3.9	2.5	4.0	1.2	€ 3,386
Poland	Control	0.8	0.1			
	TS	3.3	2.2	2.5	2.1	€ 1,168
	TS+FR	18.5	5.5	15.2	3.3	€ 4,632

SCREENING & BRIEF INTERVENTION ON ALCOHOL PRIMARY CARE TRAINING

World Health Organization Regional Office for Europe

The WHO Phase IV study concluded that embedding primary health care-based screening and brief advice programmes within the frame of supportive community and municipal environments might lead to improved outcomes.

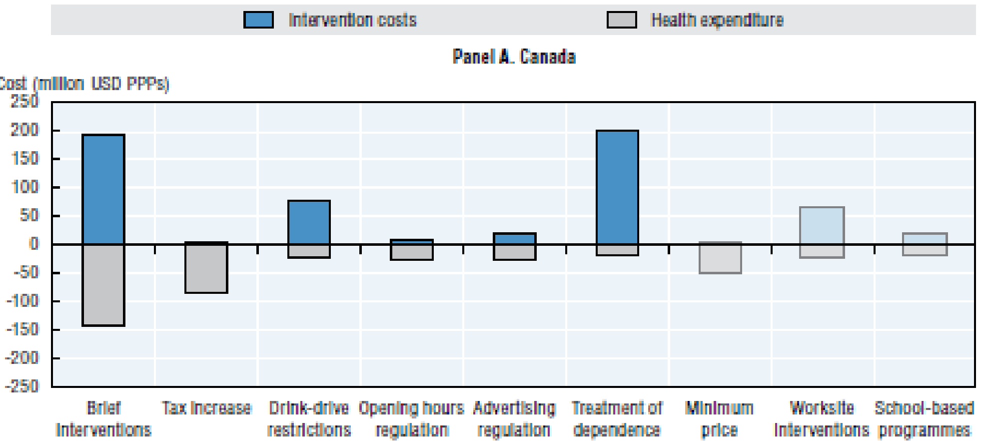
Adoption mechanisms: Superiority of package; leadership; communication; primary health care policies; health system performance

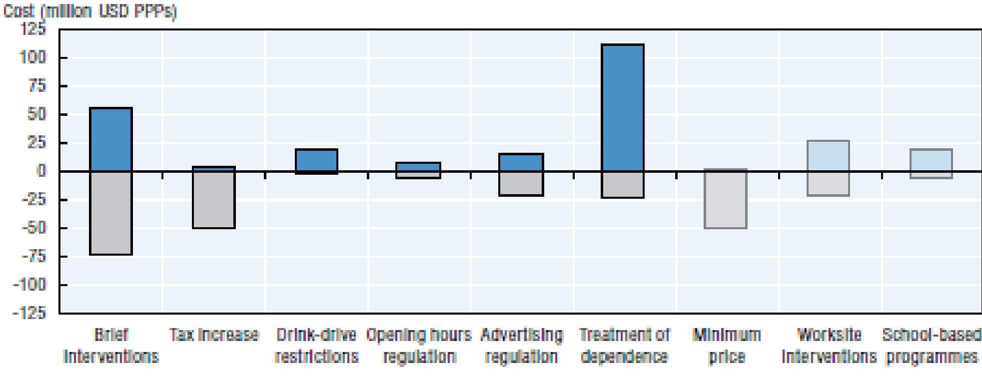
Support systems: Professional capacity; infrastructure; performance review and feedback; learning systems; sustainability

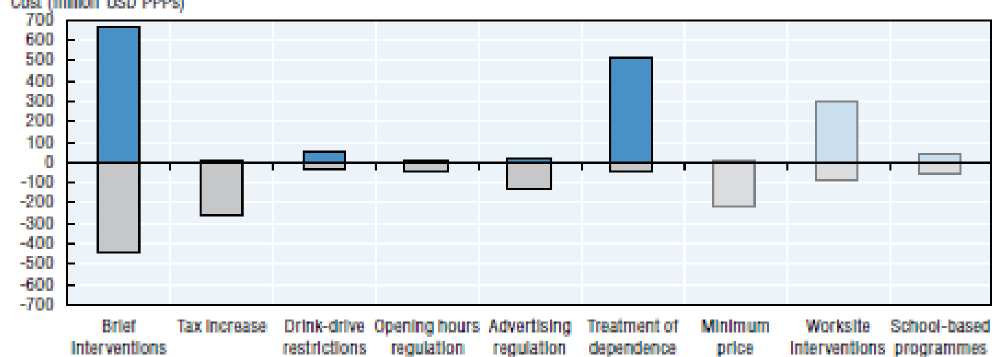
How do you fund it?

Surcharge tax on alcohol?

Figure 5.6. **Economic impact at the population level, average per year, 2010-50**





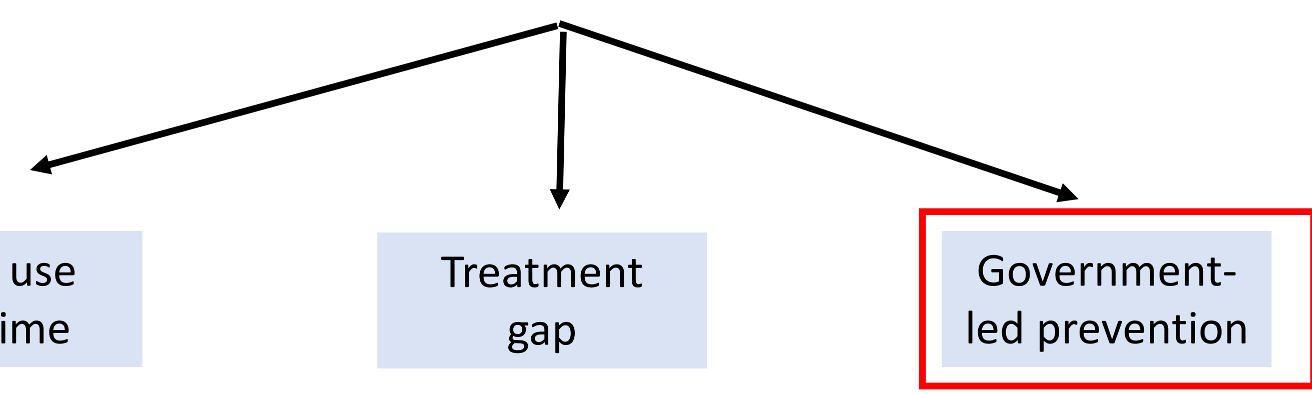


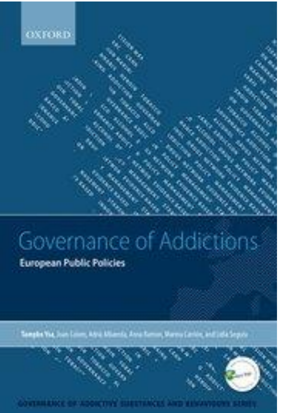
Note: Darker-shaded bars, main analysis; lighter-shaded bars, further analysis.

Source: CDP-Alcohol analysis relying on input data from multiple sources, listed in Tables A.4 to A.6 in Annex A.

StatLink http://dx.doi.org/10.1787/888933180487

Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol



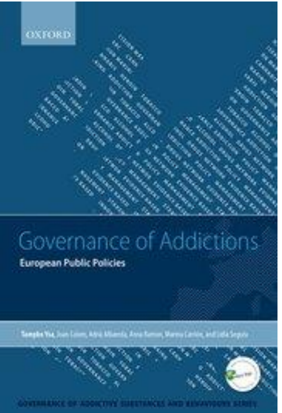


Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Government led prevention

Networked governance bolstered by local and regional public policies

Private sector:
I. Action
II. Influence
III. Producers



Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Government led prevention

Networked governance bolstered by local and regional public policies

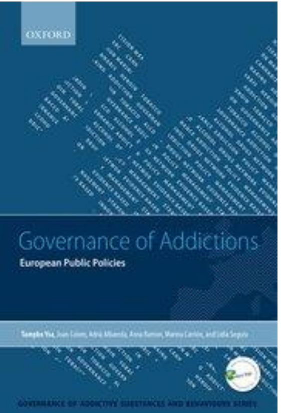
Private sector:

I. Action
II. Influence
III. Producers

Policy measure	Opportunity for city implementation
Pricing policies	
Alcohol taxes	Many cities have opportunity to set alcohol beverage sales taxes, which can bring in municipal revenues.
Access policies	
Outlet density	Licensing of alcohol sales outlets allows local governments to control where alcohol is sold to the public, with restrictions on density related to less crime.
Days and hours of sale	Licensing of alcohol sales outlets allows local governments to control when alcohol is sold to the public, with restrictions on hours of sale related to less harm.
Bar policies	
Training of bar staff, responsible serving practices, security staff in bars and safety-oriented design of the premise	Drinking environments can be foci of alcohol-related harms. Ongoing enforcement is the required ingredient to reduce harm in drinking environments.
Advertising policies	
Volume of advertising	Cities have the opportunity of restricting advertising, including billboards, in the public places that they own or through the public services, such as transportation, that they provide.

Anderson et al. Submitted

Policy measure	Opportunity for city implementation
Drink-drive restrictions	
Sobriety checkpoints and unrestrictive (random) breath testing	Cities have the opportunity to step-up sobriety checkpoints and random breath testing.
Screening, advice and treatment	
Digital interventions	Off-the-shelf applications can be deployed at city level, enhanced with context awareness and use of ecological momentary assessments.
Primary health care	Tailored screening and brief advice programmes embedded within community and municipal action are more likely to be scaled-up.
Workplace	Although business cases are made for workplace-based programmes, the evidence appears insufficient to justify a city-based investment.
Secondary health care	Treatment services can be embedded within comprehensive care pathways at the city level.
Education and information	
Public information campaigns	Media campaigns should focus on changing behaviour in relation to existing programmes, such as drink driving, rather than acting in isolation, where there is evidence of ineffectiveness.
Changing social norms	Social norms campaigns should focus on topics that are the subject of behaviour change programmes, such as drink driving.
Product reformulation	
Alcohol content and packaging	Cities could set limits on beverage container sizes.



Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Government led prevention

Networked governance bolstered by local and regional public policies

Private sector:

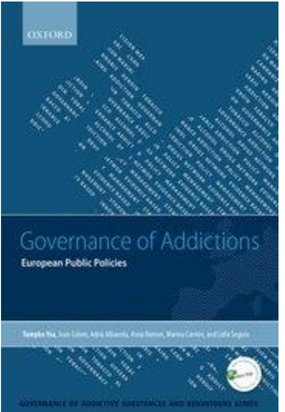
I. **Action**
II. Influence
III. Producers

Systematic review of reviews on role of alcohol industry:

- 27 relevant reviews were identified, 3 studying the industry's role in funding research and 24 exploring their role in policy.
- 24/27 reported conflicts of industry initiatives with public health principles, including:
    i. failures to adhere to scientific principles to generate or assess evidence;
    ii. advocating for policy interventions which lack evidence; and,
    iii. lobbying against evidence-based interventions.

- Most conflicts were around WHO best buys: reduction of availability, price increases, and advertising bans.

Rehm et al. Submitted



Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Government led prevention

Networked governance bolstered by local and regional public policies

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II. Influence
III. Producers

Trade Associations form sub-clusters

The European Alcohol and Health Forum constitutes strong linkage between the Associations

Impact of Market Forces on Addictive Substances and Behaviours

The web of influence of addictive industries

GOVERNANCE OF ADDICTIVE SUBSTANCES AND BEHAVIOURS SERIES

Alcohol
Food
Tobacco
Gambling
Other

There are three types of institutions linking the alcohol sector to other sectors:

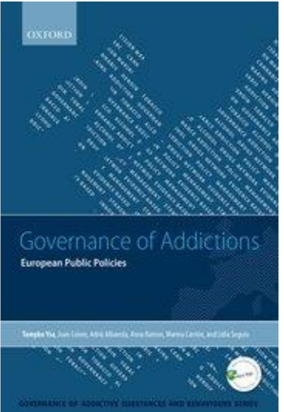
1. Think Tanks such as the European Policy Centre
2. The Advertising & Marketing industry
3. Lobby firms.

Adding another level - intermediaries and all their neighbors – finds that the most central intermediaries are mainly public relations, lobbying and consulting firms.

Alcohol
Food
Tobacco
Gambling
Other

European Alcohol and Health Forum
Spirits Europe
FoodDrinkEurope
cabinet DN consulting
FTI Consulting Belgium
FTI Consulting
The Kangaroo Group
Burson-Marsteller
Kreab Gavin Anderson
Edelman Public Relations Worldwide
Friends of Europe
European Policy Centre
EUK Consulting
FIPRA
Kellen Europe
Weber Shandwick
APCO Worldwide
EPPA
Hill & Knowlton International Belgium

ADDICTIONS AND LIFESTYLES IN CONTEMPORARY EUROPE
Alice Rap
- REFRAMING ADDICTIONS PROJECT -



Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Government led prevention

Networked governance bolstered by local and regional public policies

Private sector:

I. Action
II. Influence
III. <u>Producers</u>

In the global strategy to reduce the harmful use of alcohol of the World Health Organization (WHO), the alcohol industry was explicitly encouraged to consider effective ways to contribute within its core role as developer, producer, distributor, marketer and seller of alcoholic beverages.

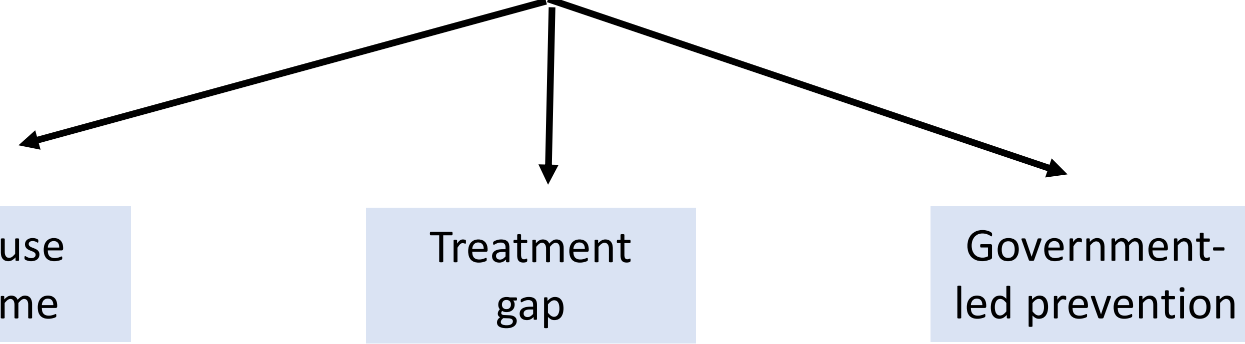
One potential way of contributing would be to reduce the level of the most harmful ingredient in alcoholic beverages, ethanol.

There are three potential mechanisms for how reduction of alcoholic strength could impact on harm by:

1. current drinkers replacing standard alcoholic beverages with similar beverages of lower alcoholic strength, without increasing the quantity of liquid consumed;
2. current drinkers switching to no alcohol alternatives for part of the time, thereby reducing their average amount of ethanol consumed; and
3. initiating alcohol use in current abstainers.

Rehm et al. 2016

Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol



Heavy use over time

1. Can be a unifying concept to reduce the harm done by alcohol
2. Is a more easily understood concept for primary health care action, and may help reduce stigma
3. As demonstrated by publications of WHO, OECD and World Economic Forum, can be readily addressed by ‘best buys’: price, advertising and availability

Treatment Gap

1. Closing the treatment gap can be led by primary health care (PHC)

2. PHC action may require higher cut-offs for brief advice

3. PHC action may be more effective when embedded within municipal action

Government-led prevention

1. Networked governance with enhanced community and municipal action

2. Manage the webs of influence that aim to take over policy

3. Is there a similar model to salt reduction initiatives?