Annual report of Bridging the Gap Project: 2004

1. INTRODUCTION

The Eurocare project, Alcohol Policy Network in the Context of a Larger Europe: Bridging the Gap (BtG) is co-financed by the European Commission for the years 2004-2006. The project includes partners in 29 European countries as well as the World Health Organization (European Office), the European Youth Forum, the European Public Health Alliance and the European Cultural Foundation.

The main aim of the project is to create a vibrant alcohol policy network to further the development of an integrated Community strategy to reduce alcohol related-harm in the context of a larger Europe as embodied in the Council's conclusions of 5 June 2001, and to support and encourage European countries to implement the Council Recommendation on the drinking of alcohol by young people.

The planned deliverables of the Bridging the Gap 2004-2006 Project are:

- European Alcohol Policy Network, together with collaboration and coordination with other multi-annual projects in the field of alcohol;
- Report of current alcohol policy, identifying barriers and facilitators in all Member States and applicant countries;
- Launch of the Network at a European conference in Poland in 2004, accompanied by the publication of an alcohol policy document;
- Series of theatre sketches contrasting stakeholder views on alcohol policy to convey complex policy issues in an innovative way to and by young people;
- An alcohol policy questionnaire to be produced and distributed for young people by young people.
- An alcohol advocacy policy manual to meet the needs of up and coming policy makers and programme implementers;
- Two advocacy training schools for up and coming policy makers and programme implementers; and
- Alcohol policy technical visits to new Members States of EU.

2. ACTIVITIES ACHIEVED DURING 2004

2.1 Creation of European Alcohol Policy Network

The European Alcohol Policy Network (APN) has been set up with representation in the Member States, Applicant countries, Norway, Switzerland, the European Cultural Foundation, the European Youth Forum, the European Public Health Alliance and the World Health Organization (Annex 1). Representatives are drawn from governmental and non-governmental organizations and professional and scientific bodies. Representatives remain to be confirmed from Cyprus and Greece. Members of the APN are regularly briefed on European Union, European Commission and alcohol policy matters.

The APN held its first meeting in Warsaw, 15-16th June 2004. During the meeting, the APN was briefed about the project, the results of the European Comparative Alcohol Study and the work of the European Office of the World Health Organization (Annex 2). APN members were divided into three task forces to oversee the work of the project: country reports and profiles; advocacy training manual and course; and young people and alcohol policy. The presentations and the outline of the work of the task forces will be available on the APN website (www.eurocare.org) from March 2005.

2.2 Review of alcohol policy in all partner countries

APN members are reviewing alcohol and alcohol policy at the country level and preparing country reports by:

i. Revising the 2004 WHO alcohol policy summary (for an example, see Annex 3) and the 2005 WHO alcohol profile (for an example, see Annex 4), where these are currently available, and completing them, where they are not currently available, by the end of January 2005;
ii. In collaboration with the National Research and Development Centre for Welfare and Health (STAKES) of Finland revising the 2002 country report of the European Comparative Alcohol Study (for an example, see Annex 5), where these are currently available, and completing them to an greed template, where they are not currently available, by the end of March 2005;
iii. In collaboration with the HP-source project (www.HP-source.net) and the International Union for Health Promotion and Education completing a questionnaire documenting alcohol policy infrastructures (Annex 6) by the end of March 2005.

Once available, the country reports and profiles will be placed on the project's website, and summary papers will be prepared for publication in scientific journals.

2.3 European Alcohol Policy Conference: Alcohol Policymaking in the Context of a Larger Europe - "Bridging the Gap", 16-19 June 2004

With the support of the Ministry of Health of Poland and the Polish State Agency for Prevention of Alcohol Problems, a European alcohol policy conference was convened in Warsaw, Poland, 16-19 June 2004.

The conference was preceded by a workshop of speakers and moderators in Leiden in the Netherlands, 1-2 April 2004. During the workshop, the speakers and moderators were introduced to each other, and fully briefed about the Bridging the Gap Project and conference. They were briefed about the theatre and puppet performances that supported the conference. They discussed the draft papers and presentations and received supportive peer review comments. They also gave advice on the conference workshops and on the draft Alcohol Policy for Europe.

The conference, which was the first of its kind, was attended by nearly 400 participants from 32 countries, one of the largest European conferences on alcohol policy. The conference opened with speeches of welcome by the then European Commissioner Designate Pavel Telicka, the Irish Health Minister, Michael Martin, and the European Office of the World Health Organization delivered by Lars Møller. The conference was the first in a series of initiatives designed to bridge the gaps between scientists, policy makers and program implementers. The conference comprised a series of plenary presentations and parallel workshops covering all aspects of alcohol policy (Annex 7). All the conference presentations will be available on the project website. Prior to each plenary session, a puppet group had been hired to convey the theme of the plenary topic from the point of view of the beverage alcohol industry. The script will be available on the project website.

Feedback from participants confirmed that the conference was a very successful event. Experts, scientists, policy makers and programs implementers had a chance to meet each other in one place and discuss all the needs, challenges and successes in the field of alcohol policy. It is planned to publish a book with a commercial publisher, based on the conference papers, presentations and workshops. The document, A Policy on Alcohol for Europe was launched after the conference in lieu of the planned conference charter.

2.4 A Policy on Alcohol for Europe and its countries

During its first meeting, the APN agreed the text of a Policy on Alcohol for Europe and its countries (Annex 8). The Bridging the Gap principles, as the document is sub-titled, summarizes a set of alcohol policy issues that should be considered by European countries and Europe as a whole. The document has been widely disseminated to national and international governmental and non-governmental organizations throughout Europe.

2.5 Theatre sketches to contrast stakeholder views on alcohol policy to convey complex policy issues in an innovative way to young people

The aims of the theatre sketches were: to improve young people's participation and information as priority themes of the Commission’s 2001 White Paper on youth policy (as suggested by the Commission’s proposed set of objectives to Member States on 14 April 2003); and to promote the horizontal role of culture within the framework of other Treaty provisions as discussed in the Education, Youth and Culture Council on 5 and 6 May 2003.

The theatre sketches, “Alcoholiens” were prepared by the Polish Association Wybrzezak, in partnership with the European Cultural Foundation. The sketches were developed in order to give young people a voice and a chance to think about alcohol advertising, one of the central themes of the Council Recommendation on the drinking of alcohol by young people. This process helped to provide young people not only with a basic understanding of the policy issues, but also gave them the possibility to listen to others, to work co-

operatively and to communicate their ideas as well as understand their own and others' cultures. As "Alcoholiens" is an interactive performance, it facilitated young people to be involved in producing and distributing information for their peers.

"Alcoholiens" was first performed in English at the June 2004 Warsaw conference. Since then, it has been performed in Polish to a total audience of 1100 young people aged 14 to 18 years, funded by the City of Gdynia. The project has been presented at national conferences and at international conferences in Croatia and Estonia.

2.6 Alcohol policy advocacy training manual and course

It is planned to prepare a training manual and offer two advocacy training courses for those new in the alcohol policy field during 2005 and 2006. The main contents of the course, which were confirmed by the advocacy task force during the June 2004 meeting of the APN, will include:

- Understanding the evidence base for effective alcohol policy;
- Understanding the alcohol policymaking process at the local, regional, national, supranational and global levels;
- How to influence opinion framers and decision makers;
- How to undertake media advocacy;
- How to form appropriate alliances and coalitions;
- How to monitor the alcohol industry, and its social aspects and trade organizations; and
- How to access and use information sources.

2.7 Liaising with other alcohol-related projects

The Bridging the Gap project is liaising with two other European Commission funded alcohol-related projects: Integrating health promotion interventions for hazardous and harmful alcohol consumption into primary health care professionals' daily work managed by the Ministry of Health of Catalonia, and Enforcement of National Laws and Self-Regulation on Advertising and Marketing of Alcohol, which will be managed by the National Foundation for Alcohol Prevention of the Netherlands (STAP), once the contract with the Commission is signed.

2.8 Country visits to new Member States

During the first year of the Bridging the Gap Project it was planned to undertake visits to three or four new Member States. Due to time involvement in preparing the Warsaw conference, a technical visit only took place to Poland. Technical visits to other countries have been deferred to years two and three of the project.

2.9 Set up project website:

The project website (www.eurocare.org) has been structured during the end of 2004 and will be fully accessible from the beginning of March 2005.

3 ACTIVITIES FOR YEAR TWO OF THE PROJECT (2005)

The first year of the project has been highly successful, and all the planned deliverables were achieved, with the exception of the technical visits to three new Member States, which have been deferred to years two and three of the project. In addition, year two will focus on strengthening the role of the APN in advising on and supporting the development and implementation of alcohol policy throughout Europe, completing the country reports, completing the advocacy training manual and delivering one advocacy training school, and, with the help of the European Youth Forum, strengthening the work with young people.

3.1 Consolidating and supporting Alcohol Policy Network in Europe

The Alcohol Policy Network will be extended by confirming and inviting participation to representatives from Cyprus and Greece. Members of the APN will receive regular e-mail briefings on European alcohol policy activities and initiatives. The second meeting of the APN will take place in Slovenia, 19th-21st May. The Director General of DG SANCO has agreed to address the APN. The meeting will discuss the progress of the completion of the country profiles, will be presented with some of the main findings of the report being prepared for the Commission on Alcohol in Europe by the Institute of Alcohol Studies, and will consider the latest available draft of the proposal for a European Commission strategy on alcohol. The APN will be informed about other ongoing European projects in the field of alcohol and will discuss the evidence for the effectiveness of educational based strategies and the harm that can be done by alcohol to people other than the drinker.

3.2 Building up the web-site

The Bridging the Gap website will be launched early in 2005 and consolidated throughout the year.

3.3 Follow-up to the conference

A commercial publisher is being approached to publish a scientific publication of the main presentations of the June 2004 Warsaw conference.

3.4 Country reports and profiles

Country reports based on the alcohol policy reviews will be completed and placed on the project website. The country reports will be analyzed and publications prepared for submission to scientific journals.

3.5 Advocacy manual and training

The Advocacy manual will be completed and piloted as a training course with members of the APN immediately after the APN meeting in Slovenia. Following the pilot, the course will be revised and delivered to its intended target audience to support the professional development of younger people new to the alcohol policy field.

3.6 Liaising with other alcohol-related projects

The Bridging the Gap project will continue to liaise and coordinate with other existing and new European and Commission funded projects in the alcohol field to ensure an efficient use of resources, synergy of action and briefing of all members of complimentary projects.

3.7 Young people's work

The European Youth Forum has been invited to support the work of the Bridging the Gap project, and, if agreed by its Board, to lead on the young people's related activities of the project, and in particular, the alcohol policy questionnaire that is to be produced and distributed for young people by young people. It is planned that work will start on this activity towards the end of 2005 to be completed during 2006.

3.8 Country visits

Five technical visits are planned to new member States during 2005: Slovenia, Czech Republic, Estonia, Latvia and Lithuania. The purpose of the technical policy visits is to assist in the understanding of alcohol policy development in the European Union and the role of the European Commission, to provide technical advice on alcohol policy development issues and to strengthen the role of non-governmental organizations in alcohol policy.

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FIRST MEETING OF THE ALCOHOL POLICY NETWORK

WARSAW, JUNE 15-16 2004

Notes of meeting

1. *Partners:* Following an introduction of all the partners, the Alcohol Policy Network (APN) was informed that the representatives of Bulgaria and Turkey had unfortunately been unable to attend, while no suitable partner organisation had been found in Cyprus. It was also noted that there was no representative from Lithuania as they have not signed the Commission's public health agreement, but that the Eurocare staff are attempting to work around this restriction. Finally, the APN were made aware that the country partner for Greece had withdrawn from the project, but it was hoped that a new partner would be found in the near future.

2. *European Parliament:* The role of the APN in engaging with new Members of the European Parliament (MEPs) was discussed. It was noted that Eurocare are intending to organise a conference with these MEPs later this year in conjunction with the European Public Health Alliance – APN members will be invited to this conference and it was hoped that a number of APN organisations will be able to attend.

3. *Country Reports:* 26 of the total of 28 preliminary country reports had been completed. Of the two outstanding reports, one country representative was expected to submit their completed preliminary report in the near future, while the other report was awaiting the agreement of a new partner in Greece.

4. *Country Groups Discussion:* The following points emerged as themes in the discussion:

    a. Lack of enforcement of policy was felt to be a problem where such policy exists.

    b. The difficulties of implementing effective alcohol control policies with a background of illegal supply of alcohol were noted.

    c. Evidence of effective policies from other countries would be very useful for national campaigning in different APN countries. It was also noted that this could play a vital role in helping to overcome prejudices and misunderstandings about alcohol policy between APN members.

    d. The importance of tracking the activities of the alcohol industry across Europe was stressed.

    e. A need to involve a broader range of people in alcohol policy activities was noted, including greater engagement with the general public and politicians as well as greater intersectoral cooperation. It was noted that

the completion of the country reports could play a role in facilitating the creation of country coalitions.

f. It was agreed that there was a need to assert that alcohol was no ordinary commodity in the context of international trade agreements.

g. The need for adequate funding for research was also raised.

h. The effect of alcohol on non-drinkers could be used more in advocacy. A need for effective terminology for this point was identified (e.g. “passive drinking”), and APN members were invited to submit any suggestions they had in this regard.

Alcohol Policy for Europe

5. *Overall Need:* The need for the Alcohol Policy for Europe (“the document”) was agreed. It was also noted that partners were expected to agree with the final document in spirit, but that they were not being asked to put their name to each detail by formally or legally signing the document.

6. *Title:* The following variants on the title of the policy were suggested:

   a. “Alcohol Policy for Europe and the challenge of reducing the harm done by Alcohol”

   b. “A proposal for an Alcohol Policy for Europe”

   c. “A vision for an Alcohol Policy for Europe”

   d. “A strategy for an Alcohol Policy for Europe”

   e. “Tackling alcohol related harm in Europe: a challenge to the European Community”

7. *Structure of preamble:* it was agreed to include subheadings to make the preamble clearer. It was also agreed to add the phrase “often leading to intoxication and harm” to the end of point 8.

8. *Structure (main):* The order of paragraphs in the document was agreed. However, it was further noted that any version of the document for public audiences should pay attention to the impact of ordering these sections differently.

9. *Section I:*

   a. The issue of suggesting policies that are less stringent than currently practiced in certain countries was raised. It was noted that this problem was considered in the drafting of the policy, and any outstanding concerns in this regard should be communicated to the drafting group.

   b. The BAC level specified in the alcohol policy was also discussed. It was agreed that those with concerns should meet with the drafting group to consider revising the relevant elements of the policy.

10. *Section II:*

    a. It was agreed to rephrase the statement on peer group education in light of the limited evidence as to its effectiveness.

    b. The potential for both family member education and alternative education institutions/cultural education was noted, and it was agreed that the drafting group should consider statements on both of these issues.

11. *Section III.1*: The role in relapse of drinks that are classed as non-alcoholic but have low levels of alcoholic content was discussed, but it was agreed that a statement on this matter would not be fully relevant for the document.

12. *Section III.6:* It was agreed to amend II.5.1 to include the type of shop (e.g. supermarkets) and the closure of premises for selling alcohol to minors (both temporarily for initial offences and indefinitely for repeat offences).

13. *Section III.7:*

    a. It was agreed that bans on sports sponsorship and advertising to minors should be included in the document, but that there was insufficient support for a complete ban on alcohol advertising. It was further agreed that the drafting group should consider a number of other proposals, including the possibility of identifying advertising that appeals to minors through research and a ban on alcohol advertising in public spaces.

    b. The proposal to earmark a proportion of the total expenditure by the alcohol industry on advertising, promotion and sponsorship was discussed at length. It was agreed that there was insufficient agreement to include this proposal, but that the drafting group should consider other opportunities in the document to secure funding for alcohol control and prevention programmes.

14. All other sections were agreed without amendment.

15. *Additional sections:* It was noted that the new Director General of DG SANCO had asked the APN to consider benchmarking of the alcohol industry. Following this, it was agreed that Peter Anderson should write a draft document on this to be presented to the APN meeting for consideration the following day. However, a statement on the role of the alcohol industry in alcohol policy was agreed to be unadvisable at this stage.

Wed 16/6/2004

16. Task Forces:

    a. Country Reports: It was noted that the WHO and the EC are both collecting their own data, and that the APN should seek to add value to rather than duplicate this work. To this end, it was proposed that the template and BtG questionnaire would have a common structure together with space for additional information. It was agreed that the BtG questionnaire would be distributed in August 2004 to be completed by

December 2004, while the Country Report Template would be ready in December 2004 to be completed in draft form before the 2nd APN meeting in May/June 2005. It was further agreed that Eurocare would provide other data from existing databases.

b. Advocacy: It was suggested that the format of the training courses should be a four day training course with two tutors running two parallel groups of roughly 15 people, and that a pilot course should be run before the Slovenia training course. It was proposed that although these courses should be targeted at those new in the field, it was sensible to also train the trainers initially. WHO-EURO agreed that it could provide a short demonstration of the WHO online databases to the training courses.

   For the manual, it was agreed that the task force should advise on the content and that a draft version should be ready by the end of 2004 to enable it to be reviewed in Jan 2005.

c. Young People: It was noted that there was a need to define young people initially, as well as to recognise in this definition that 'young people' are not a homogeneous group despite facing a common situation in the transition from childhood to adulthood. It was agreed that this group should focus on adolescents and young adults rather than children, including a rough age range of 15-30 years old. It was decided that the task force should aim to involve young people and give them a voice in the media.

   The European Youth Forum (EYF) agreed to create a working group on the questionnaire to go alongside the theatre sketch which could be considered for performing at the EYF general assembly in November. It was further agreed that the European Cultural Foundation (ECF) should document the process of the sketch to see if it could be further used as a model, and also consider performing the sketch at other events dependent on funding. Given that none of the members of the task force had seen the sketch at this time, it was also agreed that the members would comment on the sketch by email and also invite wider APN comment.

   Eurocare agreed to identify and contact other structures with a shared interest to both build coalitions and avoid duplication of research with young people. The EYF agreed to circulate a list of National Youth Councils so that coalitions can be built in this area on a national as well as European level, and the ECF agreed to circulate the details of its 10 resource centres around Europe to interested parties.

   Finally, WHO-EURO invited suggestions as to how to assess the implementation of the Stockholm Declaration.

Policy Paper

17. *Title:* It was agreed that the document's title should be "A Policy for Europe and Member States: Principles to Reduce the Harm Done by Alcohol" with a note saying this comes from BtG and who BtG are.

18. *Preamble:* The Network's attention was drawn to the preamble in order to clarify the status of the document. The wording of the preamble and the status of the document was agreed.

19. *Annex on the Alcohol Industry:* It was noted that this section of the document needed some deliberation but that it was highly desirable that the full document would be completed in time to present to the new Commissioner on his or her arrival at DG SANCO in November. It was proposed to convene a working group to draft this annex which would then be circulated to other APN members by email for approval. It was hoped that the complete document would therefore be ready by the intended deadline in November 2004. Those APN members who wished to be involved in the drafting of this section of the document were invited to notify Peter Anderson or Florence Berteletti-Kemp of their interest in the period immediately following the meeting.

Meeting Ending

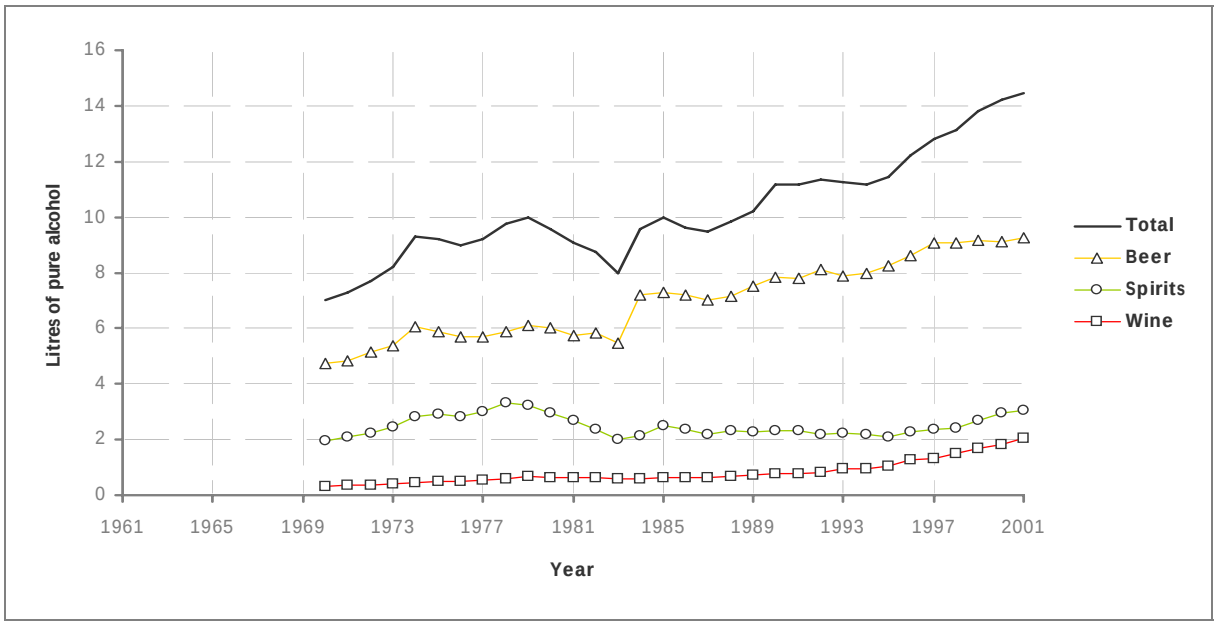
20. *Next meeting:* It was agreed that the next meeting of the APN will be the second of half of May 2005 in Slovenia, and that the length of the meeting should be maintained at 1 and $^{2}/_{3}$ days.

Ireland		Beverage categories		
		Beer	Wine	Spirits
Control of retail sale and production	Monopoly on production of	NO	NO	NO
	Monopoly on sales of	NO	NO	NO
	Licence for production of	YES	YES	YES
	Licence for sale of	YES	YES	YES
Off-premise sales restrictions and level of enforcement	Hours of sale	YES	YES	YES
	Days of sale	NO	NO	NO
	Places of sale	YES	YES	YES
	Density of outlets	NO	NO	NO
	Level of enforcement	PARTIALLY		
Age limit for purchasing alcoholic beverages	On-premise:	18	18	18
	Off-premise:	18	18	18
Taxation of alcoholic beverages	Sales TAX/VAT exists?	YES		
	% sales TAX/VAT	21		
	Tax as % of retail price [95]	20.4	22.5	41.3
	Excise stamps exist?	NO		
Restrictions on advertising [96]	National television	VOLUNT	VOLUNT	VOLUNT
	National radio	VOLUNT	VOLUNT	VOLUNT
	Print media	VOLUNT	VOLUNT	VOLUNT
	Billboards	VOLUNT	VOLUNT	VOLUNT
	Health warning on advertisements	NO		
	Enforcement of advertising and sponsorship restrictions	N.A.		
Restrictions on sponsorship of	Sports events	NO	NO	NO
	Youth events	NO	NO	NO
Restrictions on alcoholic beverage consumption in public domains	Health care establishments	VOLUNTARY		
	Educational buildings	VOLUNTARY		
	Government offices	VOLUNTARY		
	Public transport [97]	PARTIALLY		
	Parks, streets, etc. [98]	VOLUNTARY		
	Sporting events [99]	PARTIALLY		
	Leisure events (concerts, etc.) [100]	PARTIALLY		
	Workplaces	VOLUNTARY		
Definition of alcohol, BAC level and RBT	Definition of alcohol (vol. %)	0.5		
	Maximum Blood Alcohol Concentration (BAC) level	0.8		
	Use of Random Breath Testing (RBT)	NO		

[95] In off-premise sale and without the VAT (including the VAT raises the percentages to 37.8%, 39.9% and 58.7% respectively).
[96] There is a voluntary agreement that spirits are not advertised on TV, radio and cinema. Only other restriction is that alcohol ads should not be shown around children's programmes.
[97] Alcohol can be consumed and sold on trains but not buses.
[98] Up to local authorities.
[99] Licence can be obtained to sell and consume alcohol.
[100] Licence can be obtained to sell and consume alcohol.

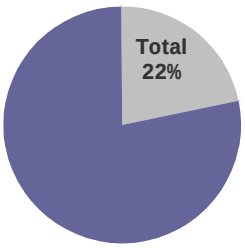
IRELAND

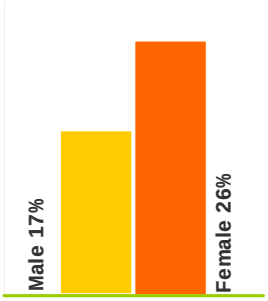
Recorded adult per capita consumption (age 15+)



Sources: FAO (Food and Agriculture Organization of the United Nations), World Drink Trends 2003

Last month abstainers





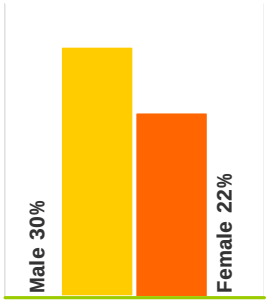
2002 national survey of adults aged 18 years and above. Total sample size *n* = 5992; males *n* = 2448 and females *n* = 3526.[1]

In a 2002 survey among a nationally representative sample of adults aged 18 years and older (total sample size *n* = 1069), it was found that 23% (20% of males and 25% of females aged between 18 and 64 years) had not consumed any alcohol during the past 12 months. The average volume of alcohol consumption reported, expressed in pure alcohol per respondent aged 18 years and over, amounts to 9.3 litres. Further, the combination of high drinking level and high abstention rates suggest that in Ireland reported consumption per drinker is 12.1 litres of alcohol.[2]

Estimates from key alcohol experts show that the proportion of adult males and females who had been abstaining (last year before the survey) was 9% (males) and 16% (females). Data is for after year 1995.[3]

According to a national survey conducted in 2003 (total sample size *n* = 1007; aged 15 years and over), the average number of drinks consumed per drinking day was 4.03.[4]

Heavy drinkers

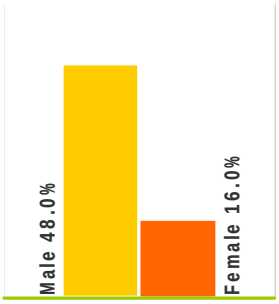


2002 national survey of adults aged 18 years and above. Subsample size *n* = 2966. Heavy drinking was defined as consuming more than 21 units of alcohol a week for men and more than 14 units of alcohol a week for women.[1]

Fourteen percent of respondents had an alcoholic drink on five or more days of the week; 15% men and 13% women. Those reporting that they drank more than six drinks on an average drinking day were 41.4% of men and 16.2% of women. The survey also found that of those who regularly drink alcohol, on a typical drinking occasion, male respondents consumed on average 6.6 alcoholic drinks and females on average 3.7 alcoholic drinks.[1]

In a 2002 survey among a nationally representative sample of adults aged 18 years and older (subsample for age group 18–64 years old; males *n* = 421 and females *n* = 459), it was found that 28.6% of males and 13.3% of females reported weekly risky drinking. Risky drinking was defined as weekly consumption of greater than 21 standard drinks for men and 14 standard drinks for women (one standard drink is equivalent to ½ pint beer or 10 g of pure alcohol).[2]

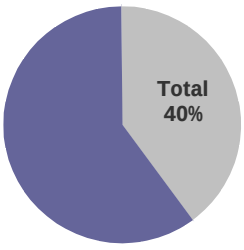
Heavy episodic drinkers (at least weekly)

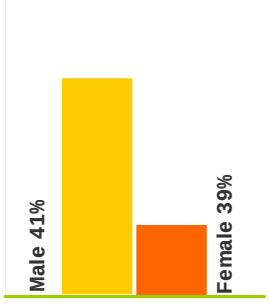


2002 national survey of adults aged 18–64 years. Subsample size males *n* = 421 and females *n* = 459.[2]

According to a national survey conducted in 2003 (total sample size *n* = 1022; aged 15 years and over), the average number of times that respondents had consumed the equivalent of one bottle of wine, five pints/bottles of beer or five measures of spirits on one drinking occasion was 0.86.[4]

Youth drinking (alcohol consumers)

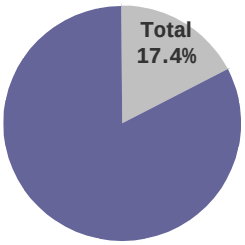


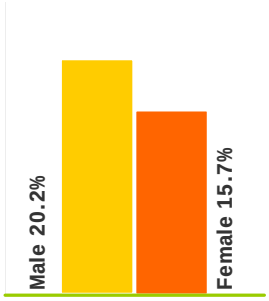


Data from the 1999 ESPAD survey. Total sample size *n* = 2277; males *n* = 1108 and females *n* = 1169; age group 15 to 16 years. Alcohol consumer was defined as lifetime use of 40 times or more.[5]

In a study of 125 school-going children aged 15–17 years in the Cork city area, it was found that alcohol consumption among females was higher than among males.[6]

Youth drinking (drink at least weekly)

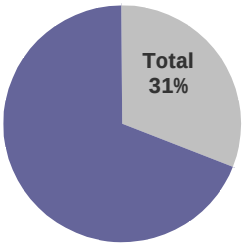


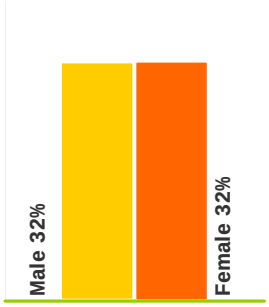


HBSC survey 2001/2002. Data shows proportion of 15-year-olds who report drinking beer, wine or spirits at least weekly. Total sample size *n* = 919.[7]

According to the 1997/1998 HBSC survey (total sample size *n* = 1457), 27% of 15-year-old boys and 12% of 15-year-old girls reported drinking beer, wine or spirits at least weekly.[8]

Youth drinking (binge drinkers)





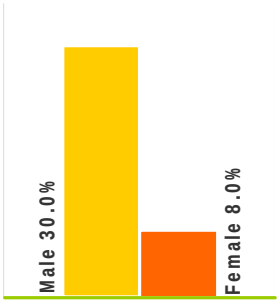
Data from the 1999 ESPAD survey. Total sample size *n* = 2277, males *n* = 1108 and females *n* = 1169; age group 15 to 16 years. Binge drinking was defined as consuming five or more drinks in a row three times or more in the last 30 days.[5]

Youth drinking (drunkenness)

According to the 2001/2002 HBSC survey (total sample size *n* = 919), the proportion of 15-year-olds who reported ever having been drunk two or more times was 32.6% for boys and 31.7% for girls.[7]

In the 1999 ESPAD study of subjects 15 to 16 years old (total sample size *n* = 2277; males *n* = 1108 and females *n* = 1169) the proportion of subjects who reported being drunk three times or more in the last 30 days was 24% (total), 27% (males) and 23% (females).[5]

Alcohol abuse or dependence in a general hospital



A study randomly selected 1133 adult patients from all hospital admissions in a university teaching hospital in Dublin (759 were interviewed; 378 men and 381 women). Data shows proportion who met DSM-IV criteria for alcohol abuse or dependence.[9]

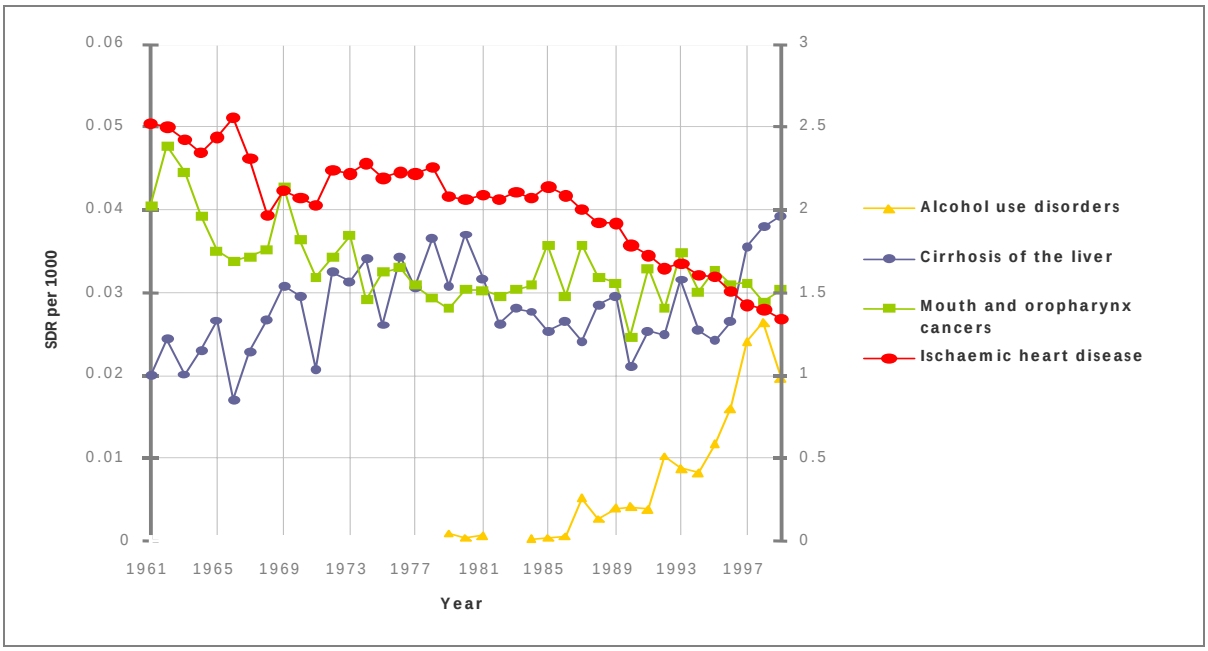
Unrecorded alcohol consumption

The unrecorded alcohol consumption in Ireland is estimated to be 1.0 litre pure alcohol per capita for population older than 15 for the years after 1995 (estimated by a group of key alcohol experts).[3]

Mortality rates from selected death causes where alcohol is one of the underlying risk factors

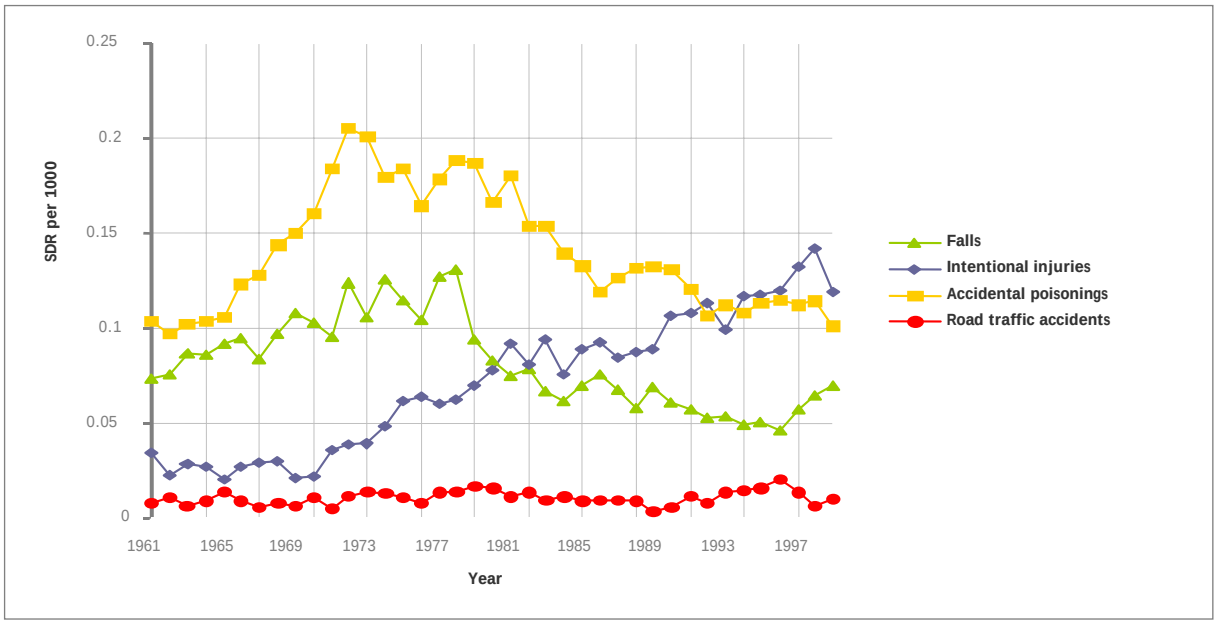
The data represent all the deaths occurring in a country irrespective of whether alcohol was a direct or indirect contributor.

Chronic mortality



Note: Chronic mortality time-series measured on two axes, ischaemic heart disease on right axis and the other causes on the left.

Acute mortality



Source: WHO Mortality Database

Morbidity, health and social problems from alcohol use

In Ireland, alcohol is estimated to be associated with at least 30% of all road accidents and 40% of all fatal accidents. In 2000 approximately 10 500 detections for drink driving were made. The majority

(93%) of detections were over the blood alcohol concentration legal limit and 62% of those were over twice the limit.[10]

A pilot study of alcohol-related attendance in the emergency room showed that alcohol was a factor in 25% of those in attendance at the hospital Accident and Emergency Department and 13% were clinically intoxicated. The vast majority of patients where alcohol was involved were in attendance between 18:00 and 08:00.[10]

In a 1997 study of 111 patients admitted to one hospital following drug overdose, it was found that alcohol was consumed synchronously by 51% and 17% fulfilled criteria for alcohol dependency. Six patients who required ventilation had consumed a combination of tricyclic antidepressants and alcohol.[11]

A 2002 national study found that 39% of male drinkers and 24% of female drinkers have experienced at least 1 of 8 adverse consequences during the last 12 months as a result of their drinking. Furthermore, men who binge at least once a month have an almost three times higher risk (271%) of experiencing adverse effects compared with those who binge less often. The corresponding figure for women is almost twice as likely (180%). Thus, both a high level of drinking and regular binge drinking is associated with a higher risk of problems in Ireland.[2]

Problem drinking is an important contributory factor to martial difficulties in Ireland. Marriage counseling services reported that alcohol abuse was the primary presenting problem in up to 25% of cases. Services dealing with the legal aspect of marital breakdown reported that up to 34% of clients cited alcohol abuse as the main cause of their martial problems.[10]

A study among 2754 pupils (15–18 years) in Galway City and County reported that 35% of the sexually active respondents said that alcohol was an influencing factor for them engaging in sex.[12] Alcohol use has also been identified as one of the main risk factors in relation to teenage pregnancy. Among a group of 32 teenage girls attending a sexually transmitted disease clinic, nearly half reported that they had unprotected intercourse on at least one occasion when drunk.[10]

In 2000 there were 62 000 incidents of public order offences of which 38 000 people were charged and the remaining 24 000 were cautioned. The vast majority of public order cases are alcohol-related. Between 1996 and 2000, there has been a 370% increase in ‘intoxication in public places’ among teenagers.[10]

Alcohol-related disorders continue to be a main cause of admissions to psychiatric hospitals, especially for males. In 1999, out of all psychiatric hospital admissions, alcohol-related disorders accounted for 26% of male admissions and 11% of female admissions.[10]

A comparison of alcohol-related mortality and alcohol consumption in Ireland over the last thirty years show increases in cancers related to alcohol consumption, cirrhosis and other conditions specifically related to alcohol – alcohol poisoning, alcohol psychosis, alcohol dependence, toxic effect of alcohol and alcohol abuse. During the last decade, the increase in consumption mirrors the increases in cancers relating to alcohol and in particular alcohol poisoning and alcohol dependence.[10]

The SDR per 100 000 population for chronic liver disease and cirrhosis was 4.37 in 2000 and 5.78 in 2001.[13]

Economic and social costs

A paper commissioned as part of the European Comparative Alcohol Study (ECAS) estimated that alcohol-related problems cost Irish society approximately €2.4 billion (£1.9 billion) per year. These include healthcare costs (€279 million), costs of road accidents (€315 million), costs of alcohol-related crime (€100 million), loss of output due to alcohol-related work absences (€1034 million), alcohol-related transfer payments (€404 million) and taxes not received on lost output (€234 million).[10]

Country background information

Total population 2003	3 956 000	**Life expectancy at birth (2002)**	Male	74.4
Adult (15+)	3 125 240		Female	79.8
% under 15	21	**Probability of dying under age 5 per 1000 (2002)**	Male	8
Population distribution 2001 (%)			Female	6

Urban	59	**Gross National Income per capita 2002**	US$	23 870
Rural	41			

Sources: Population and Statistics Division of the United Nations Secretariat, World Bank World Development Indicators database, The World Health Report 2004

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Chapter 10

Ireland

Ann Hope, Sean Byrne, Thomas Karlsson and Esa Österberg

The country

Ireland, known in the Irish language as Eire, is a republic comprising about five sixths of the island of Ireland, which is situated at the western edge of Europe. The country consists of the provinces of Leinster, Munster and Connacht, and part of the province of Ulster. For administrative purposes, the Irish Republic is divided into 26 counties and five county boroughs. Six of the counties of Ulster in the north-eastern part of the island belong to the United Kingdom.

The republic of Ireland has an area of 70,273 km^2. With a population of 3.6 million inhabitants the average population density is 51 inhabitants per km^2. Population density is highest in the east and south. The population is young, with 41 per cent being under the age of 25 years. Emigration, which for more than a century caused the population of Ireland to decrease or stagnate, has virtually ceased and, as a result of recent strong economic growth, there is now substantial immigration. The capital and the largest city is Dublin with over 1 million inhabitants. Some 60 per cent of the Irish population nowadays live in urban areas.

The Irish population is predominantly of Celtic origin but since the ninth century Ireland has been subject of successive invasion by Norse, Normans and English. About 93 per cent of the Irish population are Roman Catholics, and 4 per cent are Protestants. Religion is of importance in many people's lives, but the dominance of the Roman Catholic Church has declined significantly in recent decades. Originally the Irish language was predominant, but nowadays almost all Irish people speak English. About a quarter can still speak some Irish. According to the constitution both Irish and English are official languages.

Ireland achieved independence from the United Kingdom in 1922 and became a republic in 1949 when Commonwealth ties with the United Kingdom were ended. The prime minister serves as the head of the government, and is appointed by the president after nomination by the lower house. The president of Ireland is the official head of the state and is elected by direct popular vote for a seven-year term. Ireland has a bicameral parliament known as the Oireachtas. The lower house (Dáil Éireann) is directly elected by the Irish population and has 166 members. The upper house (Seanad Éireann) is elected by a combination of vocational panels, university representatives and nominees from the prime minister (Taoiseach) and has 60 members. The upper house is limited in

authority, while the lower house has the power to support or bring down the government in the parliamentary tradition.

Until the middle of the twentieth century, the Irish economy was predominantly agricultural and trade was predominantly with the United Kingdom. Since the mid-1950s, however, the country's industrial base has been transformed. Manufacturing accounts for approximately 36 per cent of the gross domestic product, while agriculture accounts for about 10 per cent. In recent years the highest growth rates in Irish industry have been achieved in the high technology sectors of manufacturing. In the mid-1990s, about 28 per cent of the population worked in the industrial sector, approximately 12 per cent in the agriculture and about 60 per cent in the service sector.

The Irish economy is very open to international trade with exports accounting for 73 per cent of the Gross Domestic Product (GDP) and imports for 54 per cent of the GDP. Tourism is also a significant source of foreign exchange and has increased rapidly over the past 20 years. In 1997, some 5.5 million tourists visited Ireland. Ireland has experienced a considerable social and cultural change over the past decades due to increasing economic prosperity, membership of the European Union (EU) and the influence of the mass media of the United Kingdom and the United States. While becoming more open to outside influences, some aspects of indigenous culture, particularly music, literature and sport, remain strong.

Alcohol production and trade

Ireland has a long tradition of brewing and distilling, and until the middle of the twentieth century these industries were among the few large manufacturing industries. The Irish distilling industry is dominated by the Irish Distillers, which in 1994 produced 95 per cent of the country's total output of distilled spirits. In the same year, imports accounted for 37 per cent of the Irish consumption of distilled spirits. Irish whiskey dominates the spirits market, followed by vodka and gin. In 1994 whiskey covered 46 per cent of the spirits market. Over the past 20 years, whiskey has been losing ground to vodka and miscellaneous other distilled beverages (Hurst, Gregory and Gussman, 1997).

The Irish beer market is served by three independent brewing companies with seven breweries. The largest brewer, Guinness Ireland, dominates the market and its stout accounts for half of total beer sales. The consumption of lagers has risen to 40 per cent of total beer consumption over the past 20 years, largely at the expense of ales, whose share of the beer market has declined sharply since the early 1980s. In the mid-1990s the market share of domestic beer was 90 per cent, but imports of beer have gained ground in the last two decades. In 1975 imported beer covered only 0.4 per cent of the Irish beer consumption, but it increased to 9.7 per cent by 1996. In 1994 total production of beer reached 7.2 million hectolitres, of which 3.3 million hectolitres were exported, the United Kingdom being clearly the most important export market for Irish beer (Hurst, Gregory & Gussman,1997).

With the exception of made wine, wine produced from imported concentrate, all of the wine consumed in Ireland is imported. Wine consumption has increased considerably in

Ireland over the past twenty years. French, Italian and Spanish wines have the largest shares of the wine market. In 1976 table wine had a market share of about 50 per cent. The share of fortified wine was 32 per cent, that of made wine 16 per cent and that of sparkling wine 3 per cent. In 1994 table wine accounted for about 90 per cent of all wine consumed. The rates of fortified wine, made wine and sparkling wine had declined to 5 per cent, 4 per cent and 2 per cent, respectively (Hurst, Gregory & Gussman,1997).

Cider and perry, cider made from pears, are also popular in Ireland. This market has grown significantly during the past twenty years (Hurst, Gregory & Gussman, 1997). In the mid-1970s the consumption of cider and perry was some 50,000 hectolitres a year. At the beginning of the 1990s the total consumption of cider and perry in litres of the product exceeded that of wine, and in 1998 the yearly consumption of cider and perry reached 550,000 hectolitres. Within this market, perry accounts for about one fifth of the sales. Domestic producers supply 85 per cent of the cider and perry market.

Ireland is a net exporter of alcoholic beverages. In 1996, the value of exports was one and a half times the value of imports of alcoholic beverages. While exports of alcoholic beverages have increased dramatically in volume and value terms over the past 30 years, alcohol exports have declined as a share of total exports due to the growth of other manufacturing industry (Foley, 1999). Also the value of alcohol exports to alcohol imports has declined because of a strong growth in alcohol imports.

Employment in the drinks industry and trade

Total employment in the drinks industry has declined over the past two decades from 8,299 persons, constituting 3.1 per cent of total manufacturing employment in 1981, to 4,874 persons in 1995 (Byrne, 1999). Direct employment in the manufacturing of alcoholic beverages generates indirect employment through the purchase of services, raw materials or other inputs in other industries. Every manufacturing job generates approximately 2.3 additional jobs in services and the supply of inputs. This means that the 4,900 manufacturing jobs in 1995 generated 11,000 additional jobs, excluding jobs in the retailing of alcoholic beverages (Byrne, 1999).

Because of high levels of part-time work and the variety of outlets in which alcoholic beverages are sold, it is difficult to estimate accurately the total employment in the retail distribution of alcoholic beverages. Figures in different surveys and censuses diverge widely. A conservative estimate of the total full-time equivalent employment in the retailing and wholesaling of alcoholic beverages in 1997 is 39,000 (Byrne, 1999).

Workers in retailing alcoholic beverages are distributed over a very large number of retail outlets. According to the most recent Drinks Industry Group's survey there were over 10,000 licensed on-premises in Ireland in 1994. Of these, 80 per cent were public houses and the rest were other types of licensed retail outlets, including hotels, sports clubs, nightclubs, restaurants etc. Of the 10,000 retail outlets, most are small. Because of the historical evolution of the licensing system, there are many more pubs per 1,000 inhabitants in rural areas than in Dublin and other major towns. Dublin, with almost one third of the population, only contains 10 per cent of licensed premises.

Alcohol consumption

There are some differences between the figures for alcohol consumption in Ireland prepared by different organisations. These differences are largely explained by differences in units of measurement. Traditionally Ireland used the imperial barrels and gallons to measure alcohol consumption. These were changed to litres in the mid-1970s for distilled spirits and wines and to hectolitres for beer in 1993. The most reliable sales data are those supplied by the Irish tax authorities based on their receipts of excise duties on alcoholic beverages, and those figures are used here unless otherwise indicated. These figures capture most alcohol consumption apart from small amounts of alcohol purchased in other EU member states by the Irish people and consumed in Ireland. Illegal distilling today accounts for negligible consumption.

Total alcohol consumption per capita has increased in Ireland threefold between 1950 and 1998, from 3.2 litres per capita to 10.2 litres. Alcohol consumption was quite stable in the 1950s and even decreased in some years. The 1950s were a period of economic stagnation in Ireland. Between 1960 and 1980 the total alcohol consumption grew from about 3 litres per capita to almost 7 litres per capita in 1980. This period was a time of economic growth, though growth slowed in the 1980s. After a decrease in the early 1980s, the total alcohol consumption increased again during the rest of the 1980s and in the 1990s (Table 10.1). In 1998 it reached a figure of 10.2 litres per capita. The period since 1990 has been one of unprecedented growth in the Irish economy, accompanied by a strong growth in consumer incomes.

Table 10.1. Consumption of alcoholic beverages by beverage categories in Ireland in litres of pure alcohol per capita and as percentages of total recorded alcohol consumption in the years 1955, 1965, 1975, 1985 and 1995, five years' averages

Sources: Central Statistical Office (CSO) Statistical Abstract, various years; Revenue Commissioners' Annual Report, various years.

The consumption of beer remained stable in the 1950s and began to increase in the 1960s. The increase continued to the mid-1970s, when it reached a figure of 4.1 litres of pure alcohol per capita in 1974. The consumption of beer stayed on about the same level until 1989. The figures in consumption statistics, however, do show a sudden increase to 4.9 litres per capita in 1984, but this reflects the change in calculation methods from standard barrels to hectolitres rather than a real increase in beer consumption. In fact, the change in measurement practice happened in 1993 but because of the correction of consumption figures backwards for a ten years period this change is showed in statistics in 1984. During the 1990s beer consumption continued to increase, with the most rapid growth taking place after 1994. In 1998 beer consumption was up to 6 litres of pure alcohol per capita.

The consumption of distilled spirits remained stable in the 1950s at a level of about 0.8 litres pure alcohol per capita a year. It began to increase in the early 1960s. The consumption of distilled spirits peaked in 1978 at a level of 2.3 litres of alcohol per

capita. After a sharp decrease during the 1980s, the consumption of distilled spirits has grown from 1.4 litres in 1983 to 1.9 litres of pure alcohol per capita in 1998. The apparent decrease in recorded consumption of distilled spirits in the 1980s may have resulted from a significant smuggling of distilled spirits from Northern Ireland due to a higher excise duty in the Republic of Ireland compared to Northern Ireland, as well as to the economic recession experienced in Ireland at that time.

Also the consumption of wine was quite stable in the 1950s, and began to increase in the early 1960s. With a slight decrease in the early 1980s, the consumption of wine has shown a constant increase since the early 1960s. In the 1990s the growth in wine consumption was very strong, and it reached a figure of 1.2 litres of pure alcohol per capita in 1998.

In Irish statistics the consumption of cider and perry is presented separately. In broad terms the consumption of cider and perry did not change much during the 1950s, 1960s and 1970s. During the 1980s the consumption of cider and perry doubled from 0.1 litres to 0.2 litres of pure alcohol per capita a year, and by the year 1998 it had further grown to 0.9 litres of alcohol per capita.

At the beginning of the 1950s, beer dominated the Irish alcohol market with a share of little over 70 per cent. By the end of the 1990s the market share of beer had decreased but in 1998 it was still 62 per cent of the total alcohol consumption. At the beginning of the 1950s, distilled spirits accounted for one quarter of the total alcohol consumption. This proportion had grown by the late 1970s to over 30 per cent. By the late 1990s the proportion of distilled spirits of the total alcohol consumption had decreased to just below one fifth (Table 10.1). The market share of wine has increased from a low 3 per cent in 1950 to over 11 per cent in 1998. The proportion of cider and perry of the total alcohol consumption was 2 per cent at the beginning of the 1950s, and it decreased to just under 1 per cent in the mid-1970s. During the late 1980s and in the 1990s the proportion of cider and perry increased, and in 1998 it accounted for almost one tenth of the total alcohol consumption.

The number of abstainers decreased from 47 per cent of the Irish population in 1968 to 30 per cent in 1981. Today only 13 per cent of the adult Irish population do not drink alcohol. Abstainers are nowadays largely found in the over 55 age group and they are predominantly women (SLÁN, 1999).

Traditionally, drinking in Ireland was considered a male privilege, and it was not socially acceptable for women to be seen drinking in public or to be seen in drinking establishments. Since the end of the Second World War, there has been a gradual acceptance of women in public houses. Distilled spirits are considered the most favoured drink of women. Traditionally alcoholic beverages have not been integrated with meals except on festive occasions such as weddings. Prior to the 1970s, food was rarely served in pubs, but today food is available in over 35 per cent of on-premise establishments (Hurst, Gregory & Gussman, 1997).

A 1988 study found that 84 per cent of Dublin drinkers did most of their drinking in public bars or lounges. It was estimated that 90 per cent of beer, 70 per cent of distilled spirits and 68 per cent of cider and perry were consumed in on-premise establishments.

During the last decade drinking at home has increased, due to changing social habits and decreased public tolerance of drunk driving. Between 1990 and 1994, distilled spirits sold for off-premise consumption increased from 28 per cent to 45 per cent, and in 1994, about 50 per cent of the cider and perry were sold for off-premise consumption (Hurst, Gregory & Gussman, 1997).

In 2000 about 193 litres of alcoholic beverages in their beverage form were consumed in Ireland, consisting of 7 litres of distilled spirits, 33 litres of wine and 153 litres of beer. In 1980 the corresponding figure was about 131 litres. In 2000 the consumption of commercial non-alcoholic beverages was about 658 litres per capita, consisting of 270 litres of tea, 155 litres of milk, 120 litres of soft drinks, 48 litres of juices, 40 litres of coffee and 24 litres of waters. In the 1985-2000 period the annual per capita consumption of soft drinks increased by 72 litres, that of juices by 43 litres, that of tea by 19 litres, that of bottled waters by 22 litres, that of coffee by 7 litres and that of milk by 8 litres (World Drink Trends, 2002).

Administrative structure of preventive alcohol policies

On behalf of the government, the department of health and children prepared in 1996 the first National Alcohol Policy - Ireland and as such provided the main structure for preventive alcohol policies from a public health perspective. However, many other government departments and agencies also have an important part to play in alcohol policy (Table 10.2). The eight regional health boards, through their regional drug coordinators and health promotion officers, provide the regional structure for addressing the prevention of alcohol-related problems and for promoting the health and well-being of local communities.

Table 10.2. Role of government departments and agencies in alcohol policy in Ireland

The document National Alcohol Policy - Ireland aims to promote moderation in alcohol consumption among those who wish to drink and to reduce the prevalence of alcohol-related problems, thereby promoting the health of the community. The policy outlined in this document covers environmental and public health strategies in relation to the availability, pricing and promotion of alcoholic beverages, and to drunk driving regulations, as well as strategies oriented to individual prevention and treatment. These preventive strategies include awareness and education, working in settings such as schools, colleges, families, communities and workplace, the training of those who serve alcohol, high-risk groups, especially young people and a broad community-based treatment service. National Alcohol Policy - Ireland stresses the importance of a multisectoral approach and a commitment at national, regional and local levels. The plan of action sets out the actions required of the different partners, such as government departments, health boards and the drinks industry, in implementing national alcohol policy (National Alcohol Policy - Ireland, 1996). The health promotion unit established the national alcohol surveillance project in 1997 with a brief to monitor the implementation of the alcohol action plan.

In the 1950s there were no specific national coordinating mechanisms for preventing and dealing with alcohol-related problems. However, the Irish national council on alcoholism (INCA), a voluntary organisation mainly of interested psychiatrists, was formed in 1966 with its primary aim to prevent alcoholism, to encourage its early diagnosis and to provide treatment for alcoholism. Its ideology was grounded on the disease concept of alcoholism with a strong curative emphasis. In response to a request from the Minister of Health, INCA published in 1973 a report Alcoholism - Report to the Minister of Health setting out an extensive list of recommendations in relation to preventive alcohol policy issues around information, education, availability, advertising, and treatment (INCA, 1973). During 1973 it was also given statutory funding and formal recognition by the Minister of Health (Butler, 1999). INCA had a high profile for many years and produced publications and provided information and advice on alcoholism and training to social workers in the alcohol arena. During the early 1980s INCA began to recognise the public health perspective and the role of alcohol control policy as an essential feature of preventive measures (Butler, 1999). However, INCA's demise was inevitable when its funding ceased, and it was closed in 1988.

The public health perspective on alcohol was also reflected in the activities of the Health Education Bureau, established in 1975 by the Minister for Health, with a broad remit to develop health education. It was the lead organisation in promoting the World Health Organisation (WHO) vision of health promotion. The Health Promotion Unit, a policy and executive section of the department of health, replaced in 1987 the health education bureau as part of a new core structure for health promotion. The intersectoral national consultative committee on health promotion chaired by the Minister of State was also established to advise the Minister for Health and to submit periodic reports on health promotion to a cabinet subcommittee. In 1991, the government announced its intention to formulate a national alcohol policy. The Minister for Health requested the advisory council on health promotion to undertake this task. As part of the consultative process, interested parties were invited to make written submissions. In addition, a number of reports were commissioned from the economic and social research institute (Butler, 1999). The National Alcohol Policy - Ireland was eventually published in 1996.

Licensing policy

Alcohol producers need a licence to operate. The licence is granted by the department of enterprise and employment and issued by the revenue commissioners. Alcohol wholesalers and importers must have a beer licence, which is granted on the production of a certificate by a judge of the district court. For distilled spirits, wine and liqueurs a licence is obtained from the Revenue Commissioners without the requirement of a court certificate. The cost of the licence is 200 Irish punts per year and it is paid to the revenue commissioners.

In the retail sector, a licence is also required of anyone who wishes to sell alcoholic beverages. The licence is granted by a judge on the district court and it is renewed each year. The annual licence fee ranges from 200 to 3,000 Irish punts, depending on turnover, and it is collected by the revenue commissioners. There are four main types of outlets for which licences are issued: off-licence, on-licence, restaurants and clubs. The

licence permitting the sale of alcoholic beverages on the premises is the most common licence, attached mainly to pubs and hotels.

In 1998 a parliament committee proposed radical changes in the liquor licensing laws (A Review of Liquor Licensing Laws, 1998). In the same year the competition authority examined the economic effects of the liquor licensing laws and their impact on competition in the retail drinks market. The report recommended total deregulation to allow the market to function efficiently and in the best interests of the consumer (Competition Authority, 1998). During the year 2000 the Minister for Justice, Equality and Law Reform introduced a new liquor licensing bill which proposed a broad set of measures to allow for greater availability of alcohol.

Under the Intoxicating Liquor Act 2000, a new licence may be issued in substitution for one existing licence anywhere in the country, provided the court is satisfied that the person meets a number of conditions. This is a fundamental change to the general restrictions existing since the early part of the twentieth century against granting of any new licences. The 1902 Licensing Act and subsequent Licensing Acts restricted the granting of a new licence except where an existing licence, or two licences, depending on geographical location, had been revoked. This in effect prevented any overall increase in licences. For example, the number of publicans' licences was 13,427 in 1925, 11,962 in 1955 and 9,970 in 1996 (Competition Authority, 1998).

Under the Intoxicating Liquor Act 2000 restaurants can obtain a full licence in the same way as pubs, and those with on-licence for only wine can now also serve beer with a meal. Registered clubs may supply alcoholic beverages to their members and guests on the basis of having a certificate to do so from the courts. A club must satisfy the court that its rules qualify it for registration. In recent years entry to the alcohol retail sector has occurred mainly through an increase in the number of clubs and hotels applying for a licence. In 1986 there were 658 registered clubs. Ten years later the corresponding figure was 919, an increase of almost 40 per cent. The number of hotels registered with Bord Failte showed an increase of 10 per cent in the same ten-year period (Competition Authority, 1998). A growth in the off-licence trade has also occurred due to an increase in the number of outlets attached to licensed facilities and in the food retail sector, where supermarkets or grocery shops can either obtain a full off-premises licence or a licence for selling only wine, which is easier to obtain.

Special restrictions of alcohol availability

Alcoholic beverages cannot be sold to persons under 18 years of age and they cannot be consumed in public by persons under 18 years old. There is no legal age restriction on alcohol consumption in private. The licence-holder who serves alcoholic beverages to those aged under 18 years can be convicted and fined (National Alcohol Policy - Ireland, 1996). The Intoxicating Liquor Act 2000 provides for mandatory closure of licensed premises for selling alcoholic beverages to underage customers.

The 1988 Intoxicating Liquor Act tried to address the problem of underage drinking in a number of ways. It removed existing loopholes in the sale of alcoholic beverages to those aged under 18 years of age by easing the burden of proof in removing the word

knowingly from the Intoxicating Liquor Act, thus making it easier to obtain convictions. It legislated that a person under 15 years of age cannot be in a licensed bar unless accompanied by his or her parent or guardian. It also stated that a person under 18 years of age cannot be in licensed premises during the time an exemption is in force, i.e. outside normal opening hours, and that a person under 18 years of age cannot be at any time in an off-licence outlet unless accompanied by his or her parent or guardian.

The 1988 Intoxicating Liquor Act also contained a provision that the Minister for Justice could introduce by regulation a national age card for a person of or over 18 years of age. However, this regulation was not introduced until 1999. These regulations provide for a voluntary national age card scheme. The cards can be purchased by persons who have reached 18 years of age in order to confirm that they have attained the legal age for the purchase of alcoholic beverages. Despite the 1988 changes, the age limit was not strictly followed and enforced, partly due to the legal anomaly of the reasonable grounds defence which continued to make convictions very difficult. However, under the new 2000 Liquor Licensing Act this defence is no longer acceptable.

Major expansion of the opening hours began with the 1960 Intoxicating Liquor Act, by which the opening of licensed premises was extended by one hour in the winter from 10 to 11 p.m. and to 11.30 p.m. in the summer. Further changes occurred in 1962, by which restaurants were allowed to stay open until half an hour past midnight provided that a substantial meal was served. The concept of drinking-up time was also introduced, where customers were allowed 10 minutes to finish their drinks. In 1988 the drinking-up time was extended to 30 minutes.

The 2000 Liquor Licensing Act has further increased the permitted hours of trading with alcoholic beverages. The main changes are an additional hour of drinking on three nights a week, the abolition of winter time regulations and the abolition of the Sunday holy hour regulation, and longer opening hours for nightclubs, which can serve alcohol until 2.30 a.m. plus 30 minutes of drinking-up time. On Monday, Tuesday and Wednesday licensed premises are now open from 10.30 a.m. to 11.30 p.m. plus 30 minutes drinking-up time all year round. On Thursday, Friday and Saturday the opening time is one hour longer (12.30 a.m.) plus 30 minutes drinking-up time all year round. Opening hours on a Sunday are from 12.30 a.m. to 11 p.m. Off-licensed premises may now open for sales at 8 a.m. on weekdays. Earlier they could open at 10.30 a.m. Alcohol is not for sale in pubs on Christmas Day or Good Friday.

The licensing laws over the years have permitted application to the courts for exemptions, which means an extension of opening hours outside that of the normal business hours for licensed on-premise outlets. The 1962 Liquor Licensing Act saw the introduction of four new categories of exemptions, giving a total of six categories, as well as an increase in the number of exemptions permitted each year. The number of exemptions granted were further extended in 1977, which meant that many on-premise outlets were able to open more often and for longer hours. There was a tenfold increase in the number of special exemptions granted between the years 1967 and 1997, from 6,342 in 1967 to 68,204 in 1997.

Nowadays there are six main exemption categories, each of them has a different application in terms of availability, and allows alcoholic beverages to be sold at discos or nightclubs, at special events such as dinner dances and at local or general festivals. The special exemption order, under which nightclubs obtain extensions, is by far the biggest category. Under the 2000 Liquor Licensing Act, there are substantial increases in the number of special exemptions and area exemption orders which can be granted by the courts. In addition, special exemptions are no longer restricted to hotels and restaurants and extended opening hours are permitted until 2.30 a.m. plus 30 minutes drinking-up time.

Generally, drinking in public places is not allowed, as alcohol can only be consumed in licensed premises or in private houses. However, there are some exceptions under the licensing laws. At sporting events, many sport clubs or sporting venues have a licence to sell alcoholic beverages. Therefore, alcohol can be consumed generally before or after a sporting event and in some cases also during the event. Many cultural events and concerts, including open-air events, can obtain a licence to sell alcoholic beverages. Alcoholic beverages are also allowed to be sold and consumed during train journeys. Urban by-laws have recently been passed in many cities and towns to restrict drinking in public places.

Alcohol prices and taxes

There are a number of economic measures which governments could take in relation to the price and availability of alcohol that can influence alcohol consumption or change the pattern of alcohol consumption. A government can make alcoholic drinks more expensive both in absolute and relative terms through increasing taxes on alcoholic beverages. In Ireland the price elasticity of demand for alcohol, which measures the responsiveness of the demand for alcohol to a change in its own price, is less than - 1. Conniffe and McCoy (1993) estimated the price elasticity for total alcohol consumption to be at -0.4. This means that increasing the price of all alcoholic beverages by 1 per cent would result in a drop of 0.4 per cent in total alcohol consumption. The demand for distilled spirits and wine is more responsive to price changes than beer, and there is a high degree of substitutability between the different alcoholic beverages.

A major issue which has not been addressed is the high cost of non-alcoholic beverages in Irish pubs. As the prices of non-alcoholic beverages are not controlled, publicans can often make a greater profit on these than on alcoholic beverages, the price of which has been subject to brief periods of price control. For moderate drinkers who might alternate between alcoholic and non-alcoholic beverages, there is little incentive to switch to non-alcoholic beverages if they are almost as expensive as beer, as is frequently the case in Ireland.

Conniffe and McCoy (1993) estimated the income elasticity of total alcohol consumption to be at 1.15 in 1987. This would mean that an increase of 1 per cent in consumers' incomes would result in a slightly greater increase in total alcohol consumption. The income elasticity of wine was particularly high at 1.63, and this partly explains the dramatic increase in wine consumption over the past decade. The fact that the income elasticity of alcoholic beverages is higher than one makes a

reduction in total alcohol consumption difficult to achieve in a period with growing consumer incomes.

In Ireland the difference between on- and off-premise prices of alcoholic beverages is not as large as in other EU countries. One explanation for this presumably is that many on-premise outlets also sell alcoholic beverages for home consumption.

In Ireland the excise duty on beer is nowadays calculated per hectolitre per degree of alcohol in the finished product (Table 10.3). The excise duty on wine is based on hectolitre of the product in three different categories expressed in per cent alcohol by volume and whether the beverage is still or sparkling. For fermented beverages other than wine and beer, including cider and perry, the excise duty is set per hectolitre of the product in four different categories expressed in per cent alcohol by volume and whether the beverage is still or sparkling. For intermediate products the excise duty is calculated per hectolitre of the product in two categories on the basis of the alcohol content by volume. For distilled spirits the excise duty is set per hectolitre of pure alcohol in the finished product.

Table 10.3. Excise duty rates for alcoholic beverages in Ireland in 2000 in Irish punts and in euro

* For details of the lower limits of alcoholic beverages and other EU rules concerning alcohol taxation, see Chapter 2.

Source: European Commission, DG XXI, Excise duty tables, November 2000.

Alcohol excise duty rates prevailing in 2000 were introduced in January 1994. Before 1994 there had been numerous changes in excise duty rates since the 1950s. The history of excise duty rates since 1975 is documented in Hurst, Gregory & Gussman (1997). According to that data, excise duty rate for beer increased from 42 Irish punts per standard barrel of a specific gravity of 1055 in 1975 to 68 punts in 1979 and further to 90 punts in 1980 and to 154 punts in January 1983. Since then it decreased somewhat but rose again in January 1989 to 153 punts per standard barrel. Since 1993 beer has been taxed on the basis of the amount of pure alcohol in the finished product.

In 1975 the excise duty rate for distilled spirits was 838 punts per hectolitre of pure alcohol in the finished product. By 1979 it had increased to 1,195 punts, in 1980 to 1,708 punts and in January 1981 to 2,156 punts, which is about the same rate as in 2000. The excise duty rate for distilled spirits peaked in 1983 at 2,578 punts per hectolitre of pure alcohol in the finished product, but was significantly reduced a year later due to a suspected increase in illegal cross-border trade with Northern Ireland.

The excise duty rate for table wine was 38 punts per hectolitre of the product in 1975. By 1979 it had increased to 63 punts, by 1980 to 110 punts and by January 1983 to 208 punts. In 2000 it was 215 punts per hectolitre of the product. Excise duty rates for fortified and sparkling wines have increased in similar manner (Hurst, Gregory & Gussman, 1997).

Excise duty rates for all alcoholic beverages have increased greatly in absolute and relative terms since 1950. Between 1950 and 1994 the excise duty rate for distilled spirits increased by 660 per cent while the excise duty rate for beer increased by 2,570 per cent. The excise duty rates increased sharply in the 1960s and 1970s but the rate of increase slowed since 1980. While excise duty rate for beer increased by 1,350 per cent between 1960 and 1994, it only increased by 120 per cent between 1980 and 1994. The increase in the excise duty rate for distilled spirits has been much smaller than the increase in that for beer, which has narrowed the differential between the price of beer and the price of distilled spirits. The excise duty rate for distilled spirits has actually fallen since 1983 partly to counteract smuggling from Northern Ireland. The excise duty rate for distilled spirits in Ireland was so much above the United Kingdom rate at the beginning of the 1980s that there was significant smuggling from Northern Ireland to Ireland, resulting in a loss of state revenue, which led to a reduction in the Irish excise duty rate for distilled spirits. While the overall excise alcohol duty rate for alcoholic beverages is high in Ireland, alcohol excise duties have not been increased significantly over the past five years. Therefore, the real burden of alcohol taxation has fallen slightly as prices of other consumer goods have risen.

The VAT of 21 per cent is nowadays applied to all alcoholic beverages. In 1975 the VAT was only 10 per cent. In 1981 it was raised to 15 per cent, in 1982 to 18 per cent, in 1983 to 23 per cent and in 1986 to 25 per cent. In 1990 the VAT was lowered to 23 per cent and in 1991 to its present level. The reduction to 21 per cent was in response to the pressure to harmonise indirect taxes in the single European market.

Changes in the excise duty levels on alcoholic beverages referred to above are given in nominal values. During the 1950-2000 period the value of the Irish currency has decreased because of inflation. The increase in the general price level in Ireland in the 1960-2000 period as described by the consumer price index (CPI) is given in table 10.4.

Table 10.4. Consumer price index in Ireland, 1960-2000, 1995 is 100

Source: OECD, Main Economic Indicators, March 2000 CD-ROM.

The real price of all alcoholic beverages increased in Ireland during the 1960s by about 20 per cent, mainly at the beginning and at the end of the decade (Walsh & Walsh, 1981; see also Sulkunen, 1978). In the 1970s the real price of alcoholic beverages first declined, reaching its lowest level in 1974, and then increased again. At the end of the 1970s the real price of alcoholic beverages was some 10 per cent lower than at the beginning of the decade. The increases in the real price of beer have been stronger and decreases weaker than the corresponding changes in the real price of distilled spirits. In 1979 the real price of beer was about 20 per cent higher than in 1961, whereas the real price of distilled spirits was about 10 per cent lower in 1979 than in 1961 (Walsh & Walsh, 1981, 110). According to the data collected in the ECAS project the real price of alcoholic beverages increased in Ireland in the 1979-1995 period by a third (Leppänen, 1999).

Calculated per litre of pure alcohol, the excise duty is lowest for cider and perry. It is only half of the excise duty set on beer. The excise duty on wine is about 15 per cent and that for distilled spirits about 40 per cent higher than that of beer. If the VAT is also taken into account, the tax burden on distilled spirits is some 15 per cent higher than that of beer. Calculated as a percentage of the price, the total tax burden is 44 per cent for beer, 50 per cent for table wine and 65 per cent for distilled spirits.

The taxation of alcoholic beverages is a major source of revenue to the Irish government. In 1997 the VAT and excise duties on alcoholic beverages raised over 1 billion Irish punts in taxation. Excise duties were 579 million Irish punts and the VAT receipts were about 432 million Irish punts. Indirect taxes collected from the drinks industry were about a quarter of all excise receipts and about 13 per cent of VAT receipts. A further 240 million Irish punts are collected in profits tax, income tax and social insurance contributions from those directly employed in the industry. Together with the VAT and the excise receipts from alcoholic beverages, this produced a total annual tax revenue of 1.2 billion Irish punts in 1997 (Byrne, 1999).

Heavy dependence on alcohol tax incomes is a long-standing phenomenon in Irish state revenues. In the early 1950s about 18 per cent of all state revenue came from alcohol taxes. Since then this rate has decreased to 16 per cent in 1960, to 10 per cent in the late 1970s and to 5 per cent in 1994 (Walsh & Walsh, 1981; Hurst, Gregory & Gussman, 1997). As a result of the high excise duties on alcoholic beverages, spending on alcohol has taken a large part of total consumer expenditure in Ireland. It was 7.6 per cent in 1960, 10 per cent in 1970 and 11.5 per cent in 1996 (Foley, 1999; Walsh & Walsh, 1981).

Alcohol advertising

Advertising of alcoholic beverages is allowed in Ireland, with the exception of the broadcast media, television, radio and cinema, where advertising of distilled spirits is not permitted. The voluntary code of standards for the broadcasting media, provided in the 1990 Broadcasting Act, was updated in 1995 to be in keeping with EU directive 89/552/EEC. No alcoholic beverage advertisements are allowed in or around programmes primarily intended for young viewers or listeners. The provision of the 1995 updated code also applies to sponsorship. It ensures editorial independence, and does not allow the drinks industry to sponsor youth programmes.

The advertising standards authority for Ireland (ASAI) is a self-regulatory body which has drawn up a code of standards as a means of self-regulating the advertising industry. The new revised 1995 code applies to all media, i.e. to press, radio, television, cinema and outdoor advertising, and where appropriate to direct marketing and sales promotions. The code, in relation to alcohol, notes that advertisements for alcoholic beverages should be socially responsible and should not exploit the young or the immature. They should neither encourage excessive drinking nor present abstinence or moderation in a negative way. The rules regarding the advertising of alcoholic beverages now require that anyone depicted in such an advertisement should appear to be over 25 years of age. The code of sales promotion practice also administered by ASAI aims to regulate marketing techniques. There is no specific section on alcohol in

the code of sales promotion and practice, but it does state that promotional products and samples should be distributed in such a way as to avoid the risk of harm to consumers. The code of the poster advertising association of Ireland indicates that the advertising of alcoholic beverages should not appear within 100 yards of schools, youth centres, hospitals, churches or other places of worship. The code of the cinema advertising association provides that alcohol commercials cannot be shown to an overtly young cinema audience.

Overall, the advertising of alcoholic beverages is mainly self-regulated through a number of voluntary codes across various media. There is no effective independent monitoring mechanism to ensure that alcohol advertisements comply with the various codes.

The code of ethics and good practice for children's sport in Ireland was developed by the government and has been in effect since 1996. It actively discourages the use of alcohol as being incompatible with a health approach to sporting activity. It calls on organisers of underage sports clubs to ensure that celebrations are in a non-alcohol environment. It indicates that sports leaders in children's sports should refrain from seeking sponsorship from the alcohol and tobacco industries. To date, the drinks industry group has not endorsed this code.

The drinks industry group published a voluntary code of practice in 1997 in relation to the naming, packaging and merchandising of single-serve alcoholic drinks. This was in response to the public outcry with the launch of alcopops, alcoholic fruit drinks that resemble fruit drinks in terms of packaging and flavour, and were attracting underage drinkers, especially girls. In Ireland the market value of alcopops was 30 million Irish punts in 1996. A weakness in the code is that the complain procedure is not independent of the drinks industry.

In earlier years alcohol advertising, especially in the broadcast media, was more clearly defined than at present. Since 1967 the national television station (RTE) has had a special code of standards governing the advertising of alcoholic beverages as part of the broader RTE code of standards for broadcasting advertising, which is revised from time to time. The 1985 code included a stipulation that when a group scene featured drinking alcohol not more than six people could be depicted and that the sound effects should be kept to a minimum. There were specific criteria of what was and was not acceptable regarding sequencing, tag lines, music scores and optical effects. On television the same alcoholic beverage commercial could not be shown more than twice per night, and alcohol commercials were excluded from afternoon television sports outside broadcasts. All of the above mentioned criteria have been omitted from the present 1995 code.

Education and information

In the post-primary schools, alcohol education is part of a wider substance abuse prevention programme called on my own two feet, with a strong life-skills approach. This programme and supporting resource materials, available to teachers after 50 hours of training, is supported by the department of education and science, the health promotion unit (HPU) in the department of health and children and the regional health

boards. It is part of the social, personal and health education curriculum in schools. At primary level, a similar programme was developed and initially directed at schools in disadvantaged areas but it has been expanded to other schools. To youth leaders, the youth work support pack for dealing with the drug issue, including alcohol, is available through a training process. Alcohol and drug school policies are also promoted through the health promoting school framework.

At community level a resource package, drug questions local answers (DQLA) and family communication and self-esteem, are provided through training to professionals, parents and other interested local groups with the purpose of helping long-term prevention of alcohol and drug misuse. Both the youth leader pack and the DQLA were developed and supported by the HPU. The appointment of regional drug coordinators in each of the health boards, as part of the national drugs strategy, has provided a focus and resource to address illegal drugs and alcohol problems, recognising that alcohol is the major drug of abuse among young people in Ireland. Health promotion officers within some of the health boards facilitate parenting courses and are involved in other health education initiatives.

Information leaflets for problem drinkers, their children and family members, designed for use with addiction counsellors, were produced and distributed in the health board areas in 1997. A national alcohol awareness campaign using posters was developed by the HPU in 1998. It was targeted at young adults, and focussed in particular on the practice of high-risk drinking. The overall message was: control your drinking before it controls you. An evaluation showed that overall there was a very low recall of the campaign; however, among binge drinkers 41 per cent indicated that the message made them think a little more about the amount they drank, and 33 per cent said they were determined to cut down (HPU, 1998). The most recent alcohol awareness campaign has expanded previous efforts and includes an advocacy focus on public support for public health alcohol policy. The national safety council has for many years implemented a high profile TV campaign against drinking and driving. The clear message is: don’t drink and drive, and the campaign depicts strong images of crashes and its aftermath.

There was a major shift from the 1960s to the 1990s in the approach to alcohol issues, both in scope and method, which was reflected in the development of the awareness and educational initiatives. In the 1960s the main focus was information on alcoholism and treatment services. This was developed and delivered by the voluntary organisation INCA. The health education bureau set up in 1975 extended health education beyond just a knowledge base and had at its core the empowerment model advocated in the health promoting Ottawa Charter. Therefore, health education programmes developed since the 1970's were based on a strong empowerment and life-skills framework.

Drunk driving

The Road Traffic Act of 1994 set the blood alcohol concentration (BAC) level at its present level of 0.08 per cent. The 1994 Act also allowed the Minister for Environment to vary the levels of alcohol permissible in a person's blood, urine or breath and to set different limits for different classes of drivers. This possibility has not, however, been used to date. Breath testing is carried out by the police after they have formed an

opinion that a person in charge of a mechanically propelled vehicle has consumed alcohol. This can occur at a road checkpoint or at any other place. If positive, the driver must provide a blood or urine specimen taken by a qualified doctor, and this is then analysed by the medical bureau. Evidential breath testing is currently being introduced and will allow for a more effective system. Random breath testing is still being considered.

The reduction of fatal road traffic accidents linked to drinking was set as a priority in the strategy for road safety by the government for the years 1998-2002, in which alcohol was reported as an important factor in up to 40 per cent of road accidents. Enforcement of the drunk driving laws is evident from the first progress report, which indicated that in 1998 there was an increase of 19 per cent on the previous year in the number of blood and urine samples submitted for analysis (High level group on road safety, 1999).

The Road Traffic Acts of 1994 and 1995 introduced penalties for drunk driving offences. Automatic licence disqualification for three months is applied to all drunk driving convictions for the first offence. For the second offence, the period of disqualification is doubled to six months. Disqualification can be for up to four years, depending on the BAC level in individual cases and the reoccurrence of offences. Other penalties such as fines, the retaking of the driving test and possible terms of imprisonment are at the discretion of the court. In some cases the judge may impose attendance at an alcohol education programme.

Historically, the BAC was set much higher. Under the 1968 Road Traffic Act the permitted level was 0.125 per cent. However, the analytical procedures prescribed by this Act, although brought into force in 1969, did not come into general application until 1971 (Hickey, Hayden & Layden, 1975). The 1978 Road Traffic Act further reduced the BAC limit to 0.1 per cent, and in 1994 the BAC was lowered to its present level of 0.08 per cent.

Administrative structure of treatment for alcoholism

Treatment services currently provided by the statutory sector by eight regional health boards are based on the community outpatient model, unless specific psychiatric needs are identified. Public health treatment services are available firstly through the outpatient service provided by alcohol addiction counsellors, or through inpatient treatment services in psychiatric hospitals, or in some acute cases in general hospitals, and are then provided by a team of health professionals including psychiatrists, counsellors, psychologists and psychiatric nurses.

Since the introduction of the community outpatient model, inpatient admissions for alcohol-related disorders have only shown a slight reduction. Consequently, treatment services are also provided on an inpatient basis. Therefore, it could be concluded that the new community outpatient service provides treatment for a new treatment population, i.e. those who are at an earlier stage of alcohol dependence. Nearly all of the nonstatutory treatment centres are inpatient-based (Butler, 1999).

In the most recent Irish psychiatric services report (1998) the length of a stay in an inpatient treatment in the public health service varied from less than a week to several weeks or months. The vast majority, however, were discharged from hospital after two weeks. Treatment could then be continued on an outpatient basis through the addiction counselling services. In the private treatment services, length of treatment may be several weeks, with many of the patients availing themselves of health insurance cover. Treatment services, be they community-based addiction counselling services or inpatient treatment in psychiatric services, are free to all who wish to use them. The patients with health insurance are covered for up to 91 days of hospital treatment during any five-year period.

Historically, treatment services were predominately available in the public psychiatric sector, and were inadequate due to funding problems. However, in 1957 the voluntary health insurance scheme was established which, for the first time, covered the cost of alcohol treatment services in private hospitals. This ensured a funding mechanism and the expansion of treatment services in private psychiatric hospitals. During the 1970s, INRA reported that treatment was predominately inpatient treatment services and that private psychiatric hospitals provided for 52 per cent of the admissions to the treatment of alcoholism in Ireland (INCA, 1973).

In 1984 the report on the development of psychiatric services, planning for the future, recommended a policy shift towards community-based outpatient treatment services. The rationale for this shift was that alcohol-related problems occur in local and family settings and a local service can, therefore, provide for an earlier response, and that the drinkers' immediate environment must also be part of the solution. A community-based approach is also more likely to be cost-effective. Guidelines for developing of local alcoholism services recommended that one consultant psychiatrist take special responsibility for the development of the services in each hospital catchment area, and that alcohol counsellors and general practitioners be part of this service. The report also recommended that services provided by voluntary agencies should be integrated with the local health board service.

The green paper on mental health, published by the Government in June 1992, noted that some health boards had developed local alcohol services under the community care programme and others provided services through the psychiatric services. The report concluded that either administrative structure can work, provided that responsibility for the development of services for alcohol dependence in the catchment or community is clearly identified.

Summary

The trend in alcohol policies in Ireland has been to treat alcoholic beverages more and more like normal commodities with relatively fewer restraints on where, to whom and when they can be sold and when, by whom and where they can be consumed. This reflects the declining influence of the temperance movement as well as the more recent general developments in western societies towards allowing people to take responsibility for their own life and health. Like the temperance movement from the first half of the twentieth century with its emphasis on the moral evils of heavy

drinking, the elaborate system of control of places and time of alcohol availability inherited from the British rule in the early years of the twentieth century seems to be fading away.

Ireland is a country where alcoholic beverages have traditionally been consumed in public houses, usually at weekends and without any connection to eating. The drinks preferred by the Irish people have been traditional and national. Beer has accounted for the biggest part of alcohol consumption. In the Irish context beer has meant stouts and ales. Only quite recently have lagers increased their proportion of the beer consumed by the Irish people. Distilled spirits have had the second largest rate, and the most popular distilled spirits have been national in origin, namely Irish whiskey. Even today the traditional alcoholic beverages play an important part in alcohol consumption, and although wine consumption has increased, it accounted for only just over 10 per cent of the total alcohol consumption in the late 1990s.

Does Ireland have an official preventive alcohol policy? The answer must be affirmative. There are clearly government-funded efforts to increase awareness of the dangers of high risk and heavy drinking. The retail sale of alcoholic beverages has been and still is regulated and both off- and on-premise retail outlets need a licence to operate. There are regulations concerning opening hours, and there are very specific rules on exemptions to these general regulations. Ireland has age limits for buying alcoholic beverages, and in the 1990s there have been legal changes to increase the effectiveness of the enforcement of these rules. Alcohol excise duties are well over the EU minimum levels. Alcohol advertising is self-regulated. There are numerous educational and information programmes. There is a BAC limit for drunk driving, and this limit has been lowered during the last decades, and its enforcement has become stricter.

Despite these preventive alcohol policy measures the per capita alcohol consumption has increased almost steadily during the last decades, and there is a very worrying increase in alcohol consumption by young people. These developments are undoubtedly related to the increased availability of alcoholic beverages, particularly in clubs, nightclubs and off-licences outlets. The total alcohol consumption has also increased due to the increased affluence of Irish people. Many young people who are in full-time education have part-time jobs and often their earnings are spent on alcohol, which is consumed in large quantities on one or two weekend nights. In addition to being damaging to health, the Irish drinking habits often lead to violence and road traffic accidents. The recent extension of opening hours of pubs on Thursday, Friday and Saturday nights has been linked to increased levels of late-night violence in Ireland. The controls of alcohol advertising have been relaxed, and while there is some education on the dangers of excessive drinking, these are largely confined to schools and are not forcefully aimed at adult drinkers. Legal controls of the sale of alcohol are not rigorously enforced, particularly the controls on sale of alcohol to people under 18 years of age.

The Irish system of regulating alcohol availability has mainly been concerned with on-premise consumption as most alcohol consumed in Ireland has been and still is consumed in pubs or other on-premise outlets. Alcohol prices have been high and they are still reasonably high compared to other European countries. This, combined with the

habit of drinking in public houses rather than at home, has led to the situation where the amount of disposable income spent on alcohol has been very high in Ireland, despite the fact that alcohol prices in on-premises outlets are quite similar to those of off-premise outlets. High alcohol taxes have also meant high state revenues from alcohol.

Although Ireland's only border is with Northern Ireland, which is part of the United Kingdom and which also has alcohol taxes that are higher than the average taxes in EU member states, smuggling and cross-border trade have already had their effect on the decisions concerning the Irish alcohol taxation. Excise duties on distilled spirits have been considered to be too high, and they have been lowered. Therefore, it is unlikely that the Irish government will be willing or able to increase excise duties significantly in the future, whether for health and social policy reasons or to raise state tax revenues. Rather it is to be expected that excise duties will in the future be brought closer to the average EU levels.

The fact that excise duties on alcoholic beverages are unlikely to be raised means that other methods of promoting more moderate drinking habits are all the more important. Since the decline in the influence of the temperance movement, there has been no effective non-governmental organisation whose role is to lobby for an effective preventive alcohol policy. By contrast, the licensees who retail alcohol are a powerful political lobby, and are well represented in the parliament. They resisted the lowering of the BAC level and they succeeded in extending the opening hours of pubs. Alcohol policy, like all government policy, is the outcome of compromise, and governments must balance the welfare of the population as a whole against sectional interests. Excessive consumption of alcohol in Ireland creates considerable costs which were estimated to 1.9 billion Irish punts in 1999, many of which were paid for from public expenditure. Effective policies to moderate alcohol consumption and decrease alcohol-related problems are therefore urgently needed, and must be carefully formulated and vigorously implemented if they are to be effective.

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BtG ALCOHOL QUESTIONNAIRE

Instructions for questionnaire completion

Introduction

The BtG questionnaire aims to capture information on the infrastructures and strategies on alcohol policy and the prevention of the harm done by alcohol that are available in European countries. In this questionnaire, alcohol policy and the prevention of the harm done by alcohol are considered as separate but overlapping strategies and therefore information on both is distinctively required across the items of the questionnaire.

There are no standardized definitions of alcohol policy or of the prevention of the harm done by alcohol. In this questionnaire, for alcohol policy, we are using the terms outlined by the book Alcohol Policy and the Public Good published in 1994[1], in which alcohol policy included alcohol taxation, legislative controls of alcohol availability, alcohol education and information, measures affecting drinking within particular contexts and measures affecting directly certain alcohol-related problems like drinking driving. This definition is similar to that used in the European Comparative Alcohol Study project[2], and is within the definition of regulatory policies described by the book Alcohol: No Ordinary Commodity published in 2003[3].

The prevention of the harm done by alcohol includes, for example, programmes that support alcohol education in schools, the training of waiters and waitresses in responsible beverage service, or the provision of brief interventions in primary health care for hazardous and harmful alcohol consumption, that come within the definition of allocative policies described by the book Alcohol: No Ordinary Commodity.

The BtG database includes complete reference to original documents (documents that provide a proof of statements), permitting independent assessment and verification of the basis for inclusion of policies, programmes and actions in the database. The database does not contain information on strategies that cannot be documented as described above. The BtG Data Entry Form is an adaptation of the *HP-Source.net*[4] standard for documenting health promotion infrastructure, policies and programmes, with modifications required to suit the objectives of the BtG project.

Certain questions of the tool ask respondents to provide document and organizational references. When asked to do so please complete the attached document and organization reference templates, a separate template for each document and organization.

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[1] Edwards et al. Alcohol Policy and the Public Good. Oxford: Oxford University Press, 1994.
[2] Österberg & Karlsson. Alcohol policies in EU Member States and Norway. Helsinki: Stakes, 2002.
[3] Babor et al. Alcohol: No Ordinary Commodity. Oxford: Oxford University Press, 2003
[4] www.hp-source.net

BtG Data Entry Form

A Database of Infrastructures for Alcohol Control Policy and Prevention Programmes

To be completed at the Country and/or Regional Levels

PART I

Personal details of contact person for completion of tool

Name:

Organization and position:

Address (name and number of street, postal code, town):

Telephone:

Fax:

Email:

Website:

Country:

If you are answering for a jurisdictional[5] region rather than a country as a whole, which jurisdictional region is it?

Please note: unless you state otherwise in the tool, it will be assumed, if you are completing the questionnaire for a jurisdictional region other than a country, that all your answers are for this jurisdictional region.

Population size of the country/region:

Date of completing the tool (dd-mm-yy):

[5] Such a jurisdictional region could be a region within a country or a municipality

1.1 Self-rating of expertise level in the area of alcohol control policy in your country (tick one):

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

↑ ↑

Fully conversant Slightly conversant

1.2 Self-rating of expertise level in the area of the prevention of the harm done by alcohol in your country (tick one):

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

↑ ↑

Fully conversant Slightly conversant

Is there a country-wide or region-wide formal or informal smoking cessation coalition or partnership?

☐ Yes
☐ No
☐ Do not know

If yes:

What is the name of the coalition?

When was it established?

Please describe the aim of the coalition in one sentence:

Please provide a document listing the members of the coalition or partnership, including the following information:

Name of member organization or individual:

One sentence description of organization or individual: (e.g. “national scientific body representing general practitioners”, or “recognized expert”)

Was this data entry form completed with the collaboration of other people?

- [ ] Yes
- [ ] No

If yes, please provide a document listing the names of the other individuals and organizations, including the following information:

Name of member organization or individual:

One sentence description of organization or individual: (e.g. “national scientific body representing general practitioners”, or “recognized expert”)

2. Politics, Policies and Priorities

2.1 Do relevant politicians/policy makers refer to alcohol control policy in a manner that suggests it is a priority area?

☐ Yes, in speeches, talks, press conferences, etc.
☐ Yes, in documents **[Document Reference(s)]**
☐ No

2.2 Do relevant politicians/policy makers refer to the prevention of the harm done by alcohol in a manner that suggests it is a priority area?

☐ Yes, in speeches, talks, press conferences, etc.
☐ Yes, in documents **[Document Reference(s)]**
☐ No

2.3 In your opinion, taking into account everything you know, what level of real priority does the present government place on alcohol control policy? Real priority means translations of words into at least some action.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

↑ ↑

Low priority, Mostly rhetoric — High priority, much action

2.4 In your opinion, taking into account everything you know, what level of real priority does the present government place on the prevention of the harm done by alcohol? Real priority means translations of words into at least some action.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

↑ ↑

Low priority, Mostly rhetoric — High priority, much action

2.5 What is the recent trend (past several years) in resource allocation to alcohol control policy and programmes to prevent the harm done by alcohol?

☐ Large increase in resources
☐ Small increase in resources
☐ No or little change in resources
☐ Small decrease in resources
☐ Large decrease in resources

2.6. Have governmental policy documents on alcohol policy and on preventing the harm done by alcohol been published in the following areas (tick all that apply)?

- ☐ Drinking and driving **[Document Reference]**
- ☐ Education and public awareness **[Document Reference]**
- ☐ Packaging and labelling of alcohol products **[Document Reference]**
- ☐ Taxation of alcohol products **[Document Reference]**
- ☐ Illicit trade in alcohol products **[Document Reference]**
- ☐ Travellers' allowances within the EU **[Document Reference]**
- ☐ Availability of alcohol, including licensing **[Document Reference]**
- ☐ Sales to minors **[Document Reference]**
- ☐ Alcohol advertising, promotion and sponsorship **[Document Reference]**
- ☐ Reducing harm in drinking environments **[Document Reference]**
- ☐ Help and treatment for alcohol problems **[Document Reference]**
- ☐ Help and treatment for family members **[Document Reference]**

2.7 Have non-governmental (private enterprise, research institute, NGO, etc) policy documents on alcohol policy and on preventing the harm done by alcohol been published (tick all that apply)?

- ☐ Drinking and driving **[Document Reference]**
- ☐ Education and public awareness **[Document Reference]**
- ☐ Packaging and labelling of alcohol products **[Document Reference]**
- ☐ Taxation of alcohol products **[Document Reference]**
- ☐ Illicit trade in alcohol products **[Document Reference]**
- ☐ Travellers' allowances within the EU **[Document Reference]**
- ☐ Availability of alcohol, including licensing **[Document Reference]**
- ☐ Sales to minors **[Document Reference]**
- ☐ Alcohol advertising, promotion and sponsorship **[Document Reference]**
- ☐ Reducing harm in drinking environments **[Document Reference]**
- ☐ Help and treatment for alcohol problems **[Document Reference]**
- ☐ Help and treatment for family members **[Document Reference]**

2.8 Name up to five of the most senior government officials with responsibility to oversee/manage alcohol control policy and the prevention of the harm done by alcohol **[Organisation References]**

3. Evaluation

3.1 Are national alcohol control and prevention policies evaluated and reported (tick one)?

☐ Yes – provide **[Document References]** for the most recent reports
☐ No

4. Monitoring and/or surveillance

4.1 Are national alcohol policy monitoring and/or surveillance activities reported (tick one)?

☐ Yes – provide **[Document References]** for the most recent reports
☐ No

5. Knowledge development

5.1 List up to ten principal bodies (e.g. academic bodies, public health laboratories, agencies, government units) that are involved in developing the knowledge base for alcohol control and prevention policies. **[Organisational Reference(s)]**

6. Implementation

6.1 List up to ten principal bodies that are involved in implementing programmes and other actions for alcohol control policy. **[Organisational Reference(s)]**

7. Information dissemination for health care professionals

7.1 Provide **[Organisational Reference(s)]** for the principal bodies that are involved in information dissemination and other actions to keep health care professionals informed about managing hazardous and harmful alcohol consumption and alcohol dependence.

8. Programmes

8.1 How available are programmes for preventing the harm done by alcohol? (circle the number that best applies).

8.2

Programmes	Not available				Widely available
8.1.1 Public education through mass media	☐	☐	☐	☐	☐
8.1.2. Comprehensive community based	☐	☐	☐	☐	☐
8.1.3 Home/family	☐	☐	☐	☐	☐
8.1.4 School	☐	☐	☐	☐	☐
8.1.5. College	☐	☐	☐	☐	☐
8.1.6 University	☐	☐	☐	☐	☐
8.1.7 Work place	☐	☐	☐	☐	☐
8.1.8 Primary health care	☐	☐	☐	☐	☐
8.1.9 Hospital/clinic	☐	☐	☐	☐	☐
8.1.10 Internet	☐	☐	☐	☐	☐
8.1.11 Social welfare and youth services	☐	☐	☐	☐	☐
8.1.12 Custodial settings (prisons, probation etc)	☐	☐	☐	☐	☐
Other (write in):	☐	☐	☐	☐	☐
8.1.13	☐	☐	☐	☐	☐
8.1.14	☐	☐	☐	☐	☐
8.1.15	☐	☐	☐	☐	☐
8.1.16	☐	☐	☐	☐	☐
8.1.17	☐	☐	☐	☐	☐

8.3 Please Provide **[Organisational Reference(s)]** for key programmes that exemplify high quality

9. Professional Workforce

9.1 Is higher education in alcohol control policy and/or the prevention of the harm done by alcohol available from at least one institution of higher education (tick one)?

☐ Yes – provide **[Organisational Reference(s)]** for each institution
☐ No

10. Funding

10.1. Are funds dedicated to alcohol control policy and/or programmes to prevent the harm done by alcohol clearly identifiable in the most recent national budget?

☐ Yes
☐ Funds are available for alcohol, but mixed in with other funding and hard or impossible to link explicitly with alcohol (skip to 10.2).
☐ No (skip to item 10.2).

Indicate the arena/activities for which funds are provided, and provide **[Document Reference]** for each relevant activity (tick all that apply):

☐ 10.1.1 Governmental Centre(s) and/or institutes
☐ 10.1.2 Non-governmental Centres (s) and/or institutes
☐ 10.1.3 Research
☐ 10.1.4 Monitoring and reporting
☐ 10.1.5 Masters/doctoral training
☐ 10.1.6 Community prevention programmes
☐ 10.1.7. School, college, university-based educational programmes
☐ 10.1.8. Public education programmes
☐ 10.1.9 Health care based programmes
☐ 10.1.10 Health professional education
☐ 10.1.11 Conference(s), workshops, seminars, symposia, etc.
☐ 10.1.12 Other
☐ 10.1.13 Other
☐ 10.1.14 Other
☐ 10.1.15 Other

10.2. Are funds dedicated to alcohol control policy and/or programmes to prevent the harm done by alcohol clearly identifiable in the budgets of non-governmental institutions (foundations, private institutes, welfare societies, professional groups, etc, associations)?

☐ Yes
☐ No (skip to item 12).

Indicate the arena/activities for which funds are provided, and provide **[Document Reference]** for each relevant activity (tick all that apply):

☐ 10.2.1 Governmental Centre(s) and/or institutes
☐ 10.2.2 Non-governmental Centres (s) and/or institutes
☐ 10.2.3 Research
☐ 10.2.4 Monitoring and reporting
☐ 10.2.5 Masters/doctoral training
☐ 10.2.6 Community prevention programmes
☐ 10.2.7. School, college, university-based educational programmes
☐ 10.2.8. Public education programmes
☐ 10.2.9 Health care based programmes
☐ 10.2.10 Health professional education
☐ 10.2.11 Conference(s), workshops, seminars, symposia, etc.
☐ 10.2.12 Other
☐ 10.2.13 Other
☐ 10.2.14 Other
☐ 10.2.15 Other

11.1 Is a proportion of alcohol taxes specifically earmarked (hypothecated) to fund the development and/or implementation of alcohol policies and programmes?

☐ Yes
☐ No
☐ Do not know

11. 2 If yes, please state the proportion:

11.3 If yes, is the money raised from the tax actually spent on the development and/or implementation of alcohol policies and programmes?

- [ ] Yes
- [ ] No
- [ ] Do not know

11.4 Is the hypothecated tax reviewed?

☐ Yes
☐ No
☐ Do not know

If yes,

☐ Annually reviewed
☐ Reviewed every 2 to 5 years
☐ Reviewed every 5 years or longer
☐ Other (please specify):

12. Public opinion

12.1 Have there been surveys of public opinion on alcohol policies or prevention programmes?

☐ Yes – provide **[Document References]** for the most recent reports
☐ No

13 ***Personal evaluation of the state of the field***

13.1 List up to five key recent advances in your country related to alcohol control policy, with their date:

13.2 List up to five key recent advances in your country related to the prevention of the harm done by alcohol, with their date:

13.3 List up to five key barriers/obstacles/issues that stand in the way of achieving, in your country, action on alcohol control policy:

13.4 List up to five key barriers/obstacles/issues that stand in the way of achieving, in your country, action on the prevention of the harm done by alcohol:

13.5 List, in descending order of importance, up to five key advances that are needed to support implementation of evidence-based alcohol control policy in your country:

13.6 List, in descending order of importance, up to five key changes that are needed in your country, to achieve the advances in (13.5), above:

13.7 List, in descending order of importance, up to five key advances that are needed to support implementation of evidence-based prevention of the harm done by alcohol in your country:

13.8 List, in descending order of importance, up to five key changes that are needed in your country, to achieve the advances in (13.7), above:

13.9 List up to ten persons who you believe are important for action on alcohol control policy and the prevention of the harm done by alcohol in your country **[Organisational Reference(s)]**

14 ***Comments about this BtG Data Entry Form:***

15 Inclusive dates of data entry (dd/mm/yy through dd/mm/yy):

BtG DOCUMENT REFERENCE TEMPLATE

Where you see **[Document Reference]** in the Assessment Tool, please provide the information listed below using this HP Document Reference Template, one for each document.

Please copy the closed blank form and then save the completed form with a file name in the format: ATHPquestionnumbercountry.doc (no spaces)

Example: 2.1-btg-ireland-hope-11.10.03.doc

At the point where you see the relevant **[Document Reference]** in the tool, please insert the file name of this document.

Please provide the following information for the document:

Document title in original language:

Document title translation to English (if needed):

Author(s):

Date of issue:

Place of issue:

Issue authority/publisher:

Publisher's suggested reference/journal reference:

URL (web-site address) where document, or summary, is available:

Notes/remarks:

BtG ORGANISATION REFERENCE TEMPLATE

Where you see **[Organization Reference]** in the Assessment Tool, please provide the information listed below using this HP Organization Reference Template, one for each organization.

Please copy the closed blank form and save this completed form with a file name in the format: ATHPquestionnumbercountry.doc (no spaces)

Example: 2.1-btg-ireland-hope-11.10.03.doc

At the point in the tool where you see the relevant **[Organization Reference]** in the questionnaire, please insert the file name of this document.

Please complete the following information for the organization:

Organization title:

Telephone:

Contact e-mail address:

Website - URL:

Notes/remarks:

Thursday 17 June Programme Details

09.30 -10.30
Opening Session
Grand Ballroom

Moderator: Michel Craplet, Chairman, Eurocare

Opening remarks
Government of Poland
World Health organization
European Commission

10.30 -11.00
Coffee Break

11.00 -12.30
Plenary Session 1
Grand Ballroom

Introduction to the Conference
Peter Anderson, Policy Advisor, Eurocare
Florence Berteletti Kemp, Project Leader, Bridging the Gap

Alcohol in Europe: Science and the enlarged Europe

Moderator: Alicia Rodriguez-Martos Dauer
Public Health Agency, Barcelona; Socidrogalcohol, Spain.

Bringing Science to the people of Europe
Sally Casswell, Centre for Social and Health Outcomes Research and Evaluation, New Zealand

Poland at the European crossroads
Jerzy Mellibruda, Director, The State Agency for Prevention of Alcohol-Related Problems, Poland

12.30 -14.00
Lunch Break

14.00-15.30
Plenary Session 2
Grand Ballroom

Alcohol in Europe: Health, Economics and Harm

Moderator: Rolf Hüllinghorst, Director, Deutsche Hauptstelle für Suchtfragen (DHS), Germany

The risk of alcohol in Europe
Peter Anderson, International Consultant in Public Health

The financial costs and benefits of alcohol
Christine Godfrey, Centre of Health Economics, University of York, England

Alcohol and World Health
Leanne Riley, World Health Organization

15.30 -16.00
Coffee Break

16.00-17.30

CONCURRENT SESSION 1

Bridging the gap between different levels of supplying help for addicted people - the German/Swiss approach

Room: Grand Ballroom (with interpretation into Polish)

Objective of the session: Different levels of intervention for addicted people will be presented. Discussion will highlight the different ways of organizing the helping system in the countries of the participants, discussing advantages and disadvantages and facilitating an exchange about specific national experiences.

Joachim Koehler: **The German system of rehabilitation of alcohol addiction: A successful way of treatment or late and expensive intervention?**

Helmut Urbaniak: **Bridging the gap between out patient alcohol counseling services and the general practitioners to establish a system for early identification and treatment of addiction problems**

Matthias Meyer: **E-Health: How can the Internet be used for the treatment of addicted people and to help of people looking for information**

CONCURRENT SESSION 2

The harm and cost related to 'alcohol problems in the workplace' - latest evidence and current trends.

Room: Krakowska

Moderator: Anders Ulstein, Actis.
Dr Sverre Nesvåg, research director at the department of Work Environment at Rogaland Research, Norway. **Alcohol related problems in the workplace; the level of harm and cost – latest evidence and current trends.**
Mr Paddy Creedon, private consultant specialising in alcohol problems in the workplace. **Ireland's experience from a booming economy and a pervasive drinking culture; what is the cost of alcohol in Ireland for workers and business?**
Joannah Caborn, SafeWork, International Labour Office ***Comments from the ILO***
Christine Godfrey, Professor of Health Economics at the University of York **Comments from an economist**

Panel discussion and questions.

- Do we know what we need to know in this area?
- Where do we find comprehensive reviews of the research area for policy advocates?
- How does research in this area correspond with and relate to three major policy processes and paradigms in health: Public health strategy of the EU, the WHO Global burden of disease and the Macroeconomics and health, and the EU Lisbon strategy?
- As the nature of work changes: more individuality, larger service sector, less blue collar etc – how does this affect the nature of alcohol related problems in the "workplace", and how is this apprehended by the research community?

CONCURRENT SESSION 3

Methods of Monitoring Alcohol Marketing

Room: Mazurska

Objective: This workshop presents the results of some experiences of monitoring practices of alcohol marketing in the Netherlands and in Norway. The nature and amount of alcohol marketing is not easy to detect and in many cases political debates about alcohol marketing

are held without sufficient and actual information about the practice of alcohol marketing. In general we underestimate not only the impact but also the amount and the reach of the different marketing strategies of alcohol producers and sellers. Marketing via internet, sponsoring, events, magazines is, as a matter of course, targeted towards specific targets groups and in many cases this information does not reach policy makers or prevention workers who are lobbying for an effective alcohol policy. In this workshop we present some first concrete experiences with the practices of monitoring of alcohol marketing via discotheques, restaurants, supermarkets, internet, TV and marketing by means of sponsorship. Experiences concerning the confrontation with Advertising Code Committees are presented. In this workshop all participants are invited to present their own experiences with monitoring alcohol marketing and with Advertising Code Committees.

Ms. Trine Stensen Lunde (AlkoKutt, Norway): **Monitoring alcohol marketing in Norway**
Ms. Monique Kuunders: (National Foundation for Alcohol Prevention, STAP, the Netherlands): M**onitoring in discotheques by means of mystery guests**
Mr. Wim van Dalen: (National Foundation for Alcohol Prevention, STAP, the Netherlands): **Results of different monitoring studies and complaining practices and their value for the political debate. A scientific study of the effects of alcoholmarketing via internet as a result of monitoring**

CONCURRENT SESSION 4

Against the Odds: development of a national alcohol policy in England

Room: Ujazdów

Objective: To set out a case history of the development of alcohol policy in one country over a 20 year period, factors that have facilitated or inhibited development of effective policy and lessons that may of use to those seeking to influence policy in other countries.

Eric Appleby: **Series of brief thematic presentations, each leading to an opportunity to identify, assess and discuss similar (or different) scenarios in participants' own countries.**

CONCURRENT SESSION 5

Feasibility & effectiveness of Eurocare recommendations on drinking & driving (I)

Room: Królewski

Objective: to review the feasibility and experience of the EUROCARE recommendations on drinking & driving (session 1).

Design: Eurocare Recommendations will be circulated before the start of the workshop and presented in a schematic way. A discussion will follow each recommendation or group of recommendations with the participation of experts who have experience in the feasibility and effectiveness of them.

Francisco Cermerón **Drinking & driving: simulation of a real case**

Alicia Rodríguez-Martos **Presentation of the recommendations**

Recommendation 1/2: What does experience tell us about BAC limits? Hans Laurell
Recommendation 3/4: Enforcement of Drinking & Driving laws. The British and French experience. Andrew McNeill and Claude Rivière. Alcolock- the ultimate solution of the drink driving problem? Hans Laurell

CONCURRENT SESSION 6

European Union, alcohol and young people

Room: Saski

Objective: To give an overview of youthful drinking habits in Europe on the basis of the ESPAD study; to discuss how the EU is dealing with youthful drinking; and how the alcohol industry is targeting youngsters as potential consumers.

Salme Ahlström, STAKES, Finland: **Youthful drinking in Europe**
Thomas Karlsson & Esa Österberg, STAKES, Finland: **Alcohol policy and young people in EU**
Dag Rekve, Ministry of Social Affairs, Norway: **Youth as a target group in marketing alcoholic beverages**

Friday 18 June Programme Details

09.00 -10.30
Plenary Session 3
Grand Ballroom

Marketing, communication and alcohol free roads

Moderator: Tamsin Rose
European Public Health Alliance

The Loi Evin – a French Exception
Alain Rigaud, Président Association Nationale de Prévention en Alcoologie et Addictologie(ANPA) and Michel Craplet, Medical advisor of ANPAA, chairman of Eurocare

Communicating About Alcohol: Educational and Regulatory Policies
Thomas Babor, University of Connecticut, USA

Towards alcohol free roads in Europe
Hans Laurell, Swedish National Road Administration

10.30 -11.00
Coffee Break

11.00-12.30

CONCURRENT SESSION 1

Dealing with Alcohol in Primary Health Care. What the European PHEPA Project has to say.

Room: Grand Ballroom (with interpretation into Polish)

Objective: This workshop is aimed to present, through the developments of the Phepa Project, an integrated way to deal with the detection and management of alcohol-related problems in primary health care and to discuss the best way to encourage the uptake and utilization of health promotion interventions into physicians' daily clinical work.

Dr. Joan Colom **Introduction**
Dr Leo Pas **Clinical Guidelines**
Dr. Antoni Gual **Training Manual**

Ms Lídia Segura **Website**
Dr. Kaija Seppä **Translation into practice**
Dr. Joan Colom **Conclusions and discussion**

CONCURRENT SESSION 2

The role of the courts in alcohol policy

Room: Krakowska

Objective: The workshop will discuss the role of international courts in shaping national and international alcohol policy, particularly with regard to the European Union.

Moderator: Dag Rekve (Ministry of Social Affairs, Norway)

Angela Öst (Ministry of Social Affairs, Sweden) **The juridification of public health - the abdication of politics?** Presentations of three public health related cases that recently have been before the courts
Anders Ulstein (Actis) **The Gambelli case on gambling**
Tamsin Rose (European Public Health Alliance) **The EU Tobacco directive**
Haakan Kjellsson, (IOGT-NTO) **The Gourmet-case on alcohol advertising**

CONCURRENT SESSION 3

The role of public campaigns in alcohol policy

Room: Mazurska

Objective: The workshop will discuss public information campaigns in light of existing evidence on effectiveness, and explore what purpose (if any) such campaigns may serve.

Moderator: Norman Giesbrecht

Linda Hill **Existing evidence regarding the results of public information campaigns; are popular measures and effective policies irreconcilable?"**
Sally Casswell **What should be the role of public information campaigns?"**
Therese Reitan **Public information campaigns and alcohol policy in Eastern Europe**

CONCURRENT SESSION 4

World Trade Organization and alcohol policy

Room: Ujazdów

Questions: What are the World Trade organization (WTO) and its trade negotiations potential impact on alcohol policy and legislation? Is there a risk that alcohol advertising, distribution, hospitality sector, licensing, treatment and more, will be subject to the General Agreement on Trade in Services (GATS) either directly or indirectly?

Moderator: Mr Robert Reynolds, Director, Center for Policy Analysis and Training, Pacific Institute for Research and Evaluation (PIRE), USA.

Dr. Jim Grieshaber-Otto: Independent Trade Policy Consultant at Cedar Isle Research, BC, Canada. Grieshaber-Otto has written extensively on international trade agreements and on the aspects of public health and alcohol. **Alcohol policy instruments are currently on the negotiating table in the GATS. What is the aim of the GATS; what alcohol policies might be affected; how do the negotiations proceed; and what are the public health safeguards?**

Panel discussion and questions:
Mr. Matthias Meyer, Swiss Institute for the Prevention of Alcohol and Drug Problems
Mr. Anders Ulstein, Actis.
Dr. Jim Grieshaber-Otto
Mr. Robert Reynolds, Pire (moderator)
Mr. Derek Rutherford, Eurocare

- What is the precise nature of the challenge posed by GATS?
- To what extent are the WTO negotiations relevant for *European* alcohol policy?
- What appears to be the EU's dilemmas in relation to the WTO negotiations?
- Is there a role for civil society in influencing the negotiations?

CONCURRENT SESSION 5

You can choose – win or loose

Room: Królewski

Objective: Presentation of successful prevention campaign of NGO "Z glavno na zabavo" ***(You can choose – win or loose)***, with the unique simultaneous combination of preventive work, leisure activities, road safety and research study – three years of experience.

Zdenka Cebasek-Travnik, Bojan Zlender and Sas Kravos **Video film, results of surveys and discussion.**

CONCURRENT SESSION 6

The lessons from the European comparative alcohol study

Room: Saski

Objective: To give an overview of alcohol consumption and drinking habits as well as alcohol policies and alcohol related harms on the bases of the ECAS study conducted in the years 1998-2002 in the EU member states and Norway.

Thomas Karlsson, STAKES, Finland: **Alcohol consumption and drinking habits in the EU Member States**
Mats Ramstedt, SoRAD, Sweden: **Alcohol-related mortality in the EU Member States.**
Esa Österberg, STAKES, Finland: **Alcohol policy in the EU Member States and at the EU level**

12.30 -14.00
Lunch Break

14.00-15.30
Plenary Session 4
Grand Ballroom

Helping people Change

Moderator: Jan Walburg, President/CEO Trimbos-instituut, Netherlands Institute of Mental Health and Addiction

Promoting "natural recovery" from addiction and social support: Towards a self-change friendly society
Harald Klingemann, Research Director, Institute for Social Planning and Social Management (ISS), University of Applied Sciences Berne - School of Social Work, Switzerland

Strategies to help people change. The role of primary health care (general practice)
Kaija Seppä, Professor of General Practice, University of Tampere, Finland

From Primary Health Care to Specialized Treatment Centres: a gap difficult to bridge
Antoni Gual, Head of the Alcohol Unit, Hospital Clinic, Barcelona. Alcohol Consultant, Program on Substance Abuse, Health Department, Catalonia

Specialist Services and helping people change
Gerhard Bühringer, Director, IFT Institute for Therapy Research, Munich, Germany

15.30 -16.00
Coffee Break

16.00-17.30

CONCURRENT SESSION 1
Implementing Brief Interventions in Primary Health Care: First Report from the WHO Phase IV Project.
Room: Grand Ballroom (with interpretation into Polish)

Objective: to make the first public presentation of findings from Phase IV of the WHO Collaborative Project on Identification and Management of Alcohol-related Problems in Primary Health Care (Development of Country-wide Strategies for Implementing Early Identification and Brief Interventions in Primary Health Care).

Professor Nick Heather **Introduction: aims and methods**
Dr. Bart Garmyn **Belgium**
Dr. Philippe Michaud **France**
Dr. Marko Kolsek **Slovenia**
Professor Nick Heather **Summing up**
Questions and general discussion

CONCURRENT SESSION 2
The harm done by alcohol
Room: Krakowska

Objective: To improve the understanding of the changing patterns of drinking in Europe, the balance between benefit and harm, the physical consequences of hazardous and harmful alcohol use and the interventions that might reduce harm.

Professor Ian T Gilmore, Royal College of Physicians, London and Dr. Peter Anderson.

CONCURRENT SESSION 3

Alcohol marketing and problem drinking. 'The effects on binge-drinking and the starting age of consumption'

Room: Mazurska

Objective: The workshop will focus on the effects of alcohol advertising on binge-drinking and the starting age of consumption and their implications for regulation of alcohol marketing as an element of alcohol prevention policy. The limitations and possibilities regarding the regulation of alcohol marketing will be discussed in a European context.

Matthias Meyer, Swiss Institute for the Prevention of Alcohol and other Drug Problems (SIPA), Switzerland **Will regulation of alcohol marketing prevent young people from starting to drink?'**
Monique Kuunders, STAP (National Foundation of Alcohol Prevention), the Netherlands **Effects of alcohol marketing on starting age and on binge drinking according to recent literature**
Dag Rekve, Ministry of Social Affairs, Norway **Regulation of alcohol marketing in a European context - closing statement and discussion.**

CONCURRENT SESSION 4

Partnership between the government, NGOs and the industry: a new National Alcohol Programme in Finland

Room: Ujazdów

Objectives:

- To give information about the aims of the National Alcohol programme
- To share experiences of the process of partnership mobilisation
- To invite feedback and suggestions on good practices

Ismo Tuominen, Ministerial Adviser: **The need for a fresh approach and the partnership mobilisation process**
Marjatta Montonen, Co-ordinator: **The structure and the aims of the National Alcohol Programme.**

CONCURRENT SESSION 5

Feasibility & effectiveness of Eurocare recommendations on drinking & driving (2)

Room: Królewski

Objective: to review the feasibility and experience of the EUROCARE recommendations on drinking & driving (session 2).

Design: Eurocare Recommendations will be circulated before the start of the workshop and presented in a schematic way. A discussion will follow each recommendation or group of recommendations with the participation of experts who have experience in the feasibility and effectiveness of them.

Recommendation 5: Treatment schemes (brief intervention in traffic casualties). Alicia Rodríguez-Martos
Recommendation 6: Responsible Serving of Alcoholic Beverages: how RSA can contribute to prevent Drinking & Driving: Alicia Rodríguez-Martos. Designated driver campaigns: prevention or promotion? Wim van Dalen
Recommendation 7: Is independence from industry feasible? Wim van Dalen
Recommendation 8-9: Feasibility of awareness campaigns and challenges for a monitoring system. Andrew McNeill

Alicia Rodríguez-Martos **Proposal of conclusions**

CONCURRENT SESSION 6

Alcohol taxes and public health in EU perspective

Room: Saski

Objective: The objective of this workshop is to give an insight in EU activities in harmonising traveller's alcohol import allowances and alcohol excise duties and the attempts to construct public health programmes for alleviating the problems of alcohol use.

Jenny Cisneros, SoRAD, Sweden: **Sweden and the negotiations concerning increasing traveller's alcohol import allowances**
Esa Österberg & Thomas Karlsson, STAKES, Finland: **Harmonising alcohol excise duties in EU**
Kari Paaso, Sanco, EU: **EU's public health programme**

Saturday 19 June Programme Details

0900-10.30
Plenary Session 5
Grand Ballroom

Alcohol and families, communities and countries

Moderator: Katy Orr, European Youth Forumr

Alcohol and the family in Europe
Andrew McNeill, Institute of Alcohol Studies, London, England

Mobilizing local communities in Europe
Vesna-Kerstin Petric, Ministry of Health, Slovenia

Alcohol Policy and young people
Ann Hope, National Alcohol Policy Advisor, Department of Health and Children, Ireland

10.30 -11.00
Coffee Break

11.00-12.30

CONCURRENT SESSION 1

Self-help groups and community programmes

Volunteer mutual help groups in a community based setting - bridging a gap in prevention and treatment on grassroots level.

Room: Grand Ballroom (with interpretation into Polish)

Moderator: Mr Bernt Bull, international advisor, Actis, Norwegian Policy Network on Alcohol and Drugs.

Mr Rolf Hüllinghorst, director of DHS ('German Head Office for Dependency Matters') **Volunteerism and self-help hand in hand, a simple model covering a huge demand; looking back at important achievements, looking ahead towards new challenges.**

Mr Ennio Palmesino, president AICAT ("Clubs of Alcoholics in Treatment"). **Clubs of Alcoholics in Treatment: Alcoholics and their**

families meet in friendship and solidarity, choosing "sobriety" not "abstinence".

Mr Bernt Bull and Anders Ulstein **Brief presentation of an emerging European Network on Self-Help Groups and Community Programmes.**

Panel discussion and questions:

Dr Antoni Gual, Head of the Alcohol Unit, Hospital Clinic, Barcelona. Alcohol Consultant, Program on Substance Abuse, Health Department, Catalonia
Mr Ennio Palmesino, president AICAT, Italy
Dr Rolf Hüllinghorst, director DHS, Germany
Mr Stephan Broutin, General Secretary, Vie Libre, France.

- ☞ Can self-help groups play a significant and larger role in treatment and prevention?
- ☞ Are self-help groups sufficiently recognised by health professionals on one hand and the health politicians on the other?
- ☞ What are the pitfalls of self-help groups and community work?
- ☞ Do we need a great variety of groups and methods? And what are currently the unchartered territories?

CONCURRENT SESSION 2

Prevention in the Workplace

Room: Krakowska

Moderator: Lucie Paus Falck, AKAN, Norway - in cooperation with Anders Ulstein, Actis.

David Gold and Joanna Caborn, the International Labour Organisation
Why it is important and necessary to do prevention work in the workplaces: Accidents, Absenteeism, Tardiness, Hangovers, Strains on co-workers, Replacement costs etc.

Four workplace programmes in Europe
How to be a change agent, how to motivate and help companies make alcohol- and drugs policies and programmes in their own workplace, how to work within the companies, the role of the social partners, establish a network.

Euridice, Italy	**Marcella Deluca**
Experiences from Poland	**Ewa Osiatynska**
AKAN, Norway	**Annette Paul**
ANPA, France	**Claude Riviere**

Marcella Deluca represents Euridice, Italian programme which is also in use in several EU-countries
Ewa Osatynska has a long experience from working in Poland and with the ILO
Annette Paul represents AKAN, the predominant Norwegian workplace programme since 1963
Claude Riviere, European advisor, ANPA (Association Nationale de Prévention en Alcoologie et Addictiologie).
Lucie Paus Falck is the Director of AKAN - the Norwegian Tripartite Committee for the Prevention of Alcohol and Drug Problems in the Workplace

CONCURRENT SESSION 3

Youth and sports – A prevention project to keep youth in sports free from alcohol.

Room: Mazurska

Objectives: To introduce a cooperation project between the IOGT-NTO; a temperance organisation and the Swedish Sport Confederation in Sweden. The main aim of the project is to keep youth in sports below 18 from alcohol use. There have been many engagements; the Swedish Football Association has joined the project.

Moderator: Ms Sofia Modigh

Speaker: Mr Erik Hellmén, Örebro County Sport Federation. Mr Hellmén is actively working with the implementation of the project at regional local levels; his profession is information work within the sport organisations, together with the local and regional authorities; he is active in martial arts.

CONCURRENT SESSION 4

EU Surgery: Advocating for health in Brussels

Room: Ujazdów

Objectives:

Alcohol policy has a significant effect on the political and social environment and NGOs have a unique and important experience and expertise to contribute to the social and political decision-making at the European level. However, many organizations are not able to fully engage in this process due to a lack of understanding of how policy is made at European level.

This presentation will provide a basic overview of how the EU institutions work and how NGOS can effectively engage with the process of policymaking and implementation. This session will seek to be as interactive as possible.

Speaker: Florence Berteletti Kemp

CONCURRENT SESSION 5

Visegrad group cooperation for road safety

Room: Królewski

Objective: Introduction of Visegrad group states cooperation (Czech Republic, Hungary, Poland, Slovakia) between Ministries of transport in the field of road safety. Presentation of comparable statistics of road safety and alcohol. Discussion of Visegrad cooperation enhancement in other fields of alcohol policy.

Robert Šťastný MA, Ministry of transport, Czech Republic **Visegrad group states cooperation in the field of road safety**
Pavel Kubů MD, National Institute of Public Health, Czech Republic **Road safety and alcohol consumption in Visegrad Group States**

CONCURRENT SESSION 6

What information is needed for alcohol policy - the role of knowledge transfer

Room: Saski

Objective: One base for successful actions in alcohol policy is having the right information. This workshop shall define together with the participants' experiences the following aspects of knowledge transfer:
What information is needed?

- Do different actors need different information?
- Who creates the scientific information?
- How can information be given to the actors in the field of alcohol policy?

Irene Abderhalden Sommerfeld, Ministry of Health, Berne, Switzerland **What information does the government need for a progressive alcohol policy**

Matthias Meyer, Swiss Institute for the Prevention of Alcohol and Drug Problems (SIPA), Lausanne, Switzerland **The experiences of SIPA in knowledge transfer: from science to action**

Peter Anderson, Policy Advisor, Eurocare **Databases and sources of international information**

12.30 -14.00
Lunch Break

14.00-15.00
Grand Ballroom
Round table discussion with the speakers
Moderator: Jo Revill, Health Correspondent, Observer Newspaper

15.00-15.30
Grand Ballroom
Closing remarks
Derek Rutherford, Secretary, Eurocare

15.30 -16.00
Coffee Break

A POLICY ON ALCOHOL FOR EUROPE AND ITS COUNTRIES
REDUCING THE HARM DONE BY ALCOHOL –
BRIDGING THE GAP PRINCIPLES

WWW.EUROCARE.ORG

OCTOBER 2004.

A POLICY ON ALCOHOL FOR EUROPE AND ITS COUNTRIES[1]
REDUCING THE HARM DONE BY ALCOHOL[2] - BRIDGING THE GAP[3] POLICIES

PREAMBLE

The partners of the 27 countries[4] of the European Bridging the Gap project,

Determined to give priority to the right to protect European public health and social welfare,

Determined to give priority to reduce the health, social and economic burden caused by alcohol,

Recognizing that the harm done by alcohol is a European problem with serious consequences for public health and social welfare that calls for the widest possible international cooperation and the participation of all European countries in an effective, appropriate and comprehensive international response,

Recognizing that scientific evidence has unequivocally established that alcohol consumption can cause premature death, disease and disability, as well as accidents, violence and intentional and unintentional injuries to both the user and people other than the user,

Recognizing that alcohol consumption is responsible for at least 9% of the total annual burden of ill-health and premature death in Europe, the third most important risk factor, after smoking and raised blood pressure, and a net figure taking into account any potential benefits from alcohol,

Recognizing that in Europe violent deaths and deaths related to alcohol consumption and smoking dominate premature mortality amongst young men and account for more than 30% of all premature deaths,

Recognizing the compelling evidence of the strong relationship between individual and population consumption and risk of harm; and the evidence that overall

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[1] This document was prepared by Peter Anderson, policy advisor to Eurocare on behalf of the Alcohol Policy Network of the Bridging the Gap project. The document was discussed at the first meeting of the network, June 2004 in Warsaw, and subsequently revised by members of the Network and finalized during October 2004.

[2] Alcohol is responsible for a wide range of harm, which can be reduced by alcohol policies (for example, increases in alcohol taxes reduce deaths from cirrhosis of the liver and drink driving fatalities). This is what is meant by a policy to reduce the harm done by alcohol. This is not the same as harm reduction policies (for example safer drinking glass design to prevent injuries in fights), whose limited and targeted purpose is to reduce harm in specific situations, without necessarily reducing alcohol consumption.

[3] The Bridging the Gap project is co-financed by the European Commission, Norwegian Policy Network on Alcohol and Drugs (ACTIS), IOGT-NTO Sweden, and the Government of Norway, in partnership with the European Cultural Foundation, the European Public Health Alliance, the European Youth Forum and the World Health Organization.

[4] The partners represent governmental, non-governmental, health professional and research organizations from Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey and the United Kingdom.

reductions in consumption would not have adverse effects on deaths or illness from coronary heart disease,

Concerned about the increase in the use of alcohol, binge drinking[5] and the harm done by intoxication amongst young people, particularly in public settings, such as cafes, pubs and bars,

Concerned that alcohol consumption is likely to increase following economic development in new Member States and increased earning capacity of women and young adults,

Concerned about designer drinks[6] marketed to young people,

Concerned about the impact of all forms of advertising and promotion[7] and sponsorship[8] aimed at encouraging the use of alcohol products[9],

Recalling the preamble to the Constitution of the World Health Organization, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition,

Recalling Article 12 of the International Covenant on Economic, Social and Cultural Rights, adopted by the United Nations General Assembly on 16 December 1966, which states that it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,

Recalling that the Convention on the Rights of the Child, adopted by the United Nations General Assembly on 20 November 1989, provides that Parties to that Convention recognize the right of the child to the enjoyment of the highest attainable standard of health,

Recalling resolution WHA57.16 of the World Health Organization, which urges Member States to promote strategies to reduce the adverse physical, mental and social consequences of harmful use of alcohol,

Recalling the 1995 European Charter on Alcohol of the World Health Organization (see Annex), which states that all people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption,

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[5] "binge drinking" means a pattern of heavy drinking that occurs during a single occasion, commonly defined as six alcoholic drinks (60g of alcohol) consumed on a single occasion.

[6] "Designer drinks" includes flavoured alcoholic drinks and pre-mixed spirits, manufactured with an alcoholic strength commonly ranging from 1.2% to 5.5% made from any alcoholic base, which are traditionally sold in 27.5 and 33cl bottles often designed to appeal to young people. Also known as alcopops and ready-to-drinks.

[7] "advertising and promotion" means any form of commercial communication, recommendation (including product placement) or action with the aim, effect or likely effect of promoting an alcoholic product or alcohol use either directly or indirectly.

[8] "alcohol sponsorship" means any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting an alcoholic product or alcohol use either directly or indirectly.

[9] Different countries have different definitions of an alcohol product. In this document, "alcohol products" means any product that contains more than 1.2% alcohol by volume which is manufactured to be orally consumed. It is proposed that countries with a definition of a higher concentration reduce it to 1.2%, and countries with a definition of a lower concentration maintain that definition.

Recalling the 2001 Stockholm Declaration on Young People and Alcohol of the World Health Organization, which states that public health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests,

Recalling Article 3 of the European Community Treaty which states that the activities of the Community shall include a contribution to the attainment of a high level of health protection,

Recalling Article 95 of the European Community Treaty, which states that the Commission, in its proposals concerning health, safety, environmental protection and consumer protection, will take as a base a high level of protection, taking account in particular of any new development based on scientific facts,

Recalling Article 152 of the European Community Treaty, which states that a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health,

Recalling that the Constitutional Treaty of 18 June 2004 (which to enter into force requires ratification by all the Member States in accordance with their respective constitutional provisions) gives the Community the competence to establish incentive or other measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol,

Recalling the programme of European Community Action in the field of Public Health (2003-2008) which should contribute to ensuring a high level of human health protection in the definition and implementation of all Community polices and activities, through the promotion of an integrated and inter-sectoral health strategy and to encouraging co-operation between Member States in the areas covered by Article 152 of the Treaty,

Recalling the Recommendation of the Council of the European Union of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents (2001/458/EC), which, amongst other issues, stresses that (a) producers do not produce alcoholic beverages specifically targeted at children and adolescents; and (b) alcoholic beverages are not designed or promoted to appeal to children and adolescents,

Recalling the Conclusions of the Council of the European Union of 5 June 2001 on a Community strategy to reduce alcohol-related harm (2001/C 175/01), which stresses the need for a co-ordinated range of Community activities in all relevant policy areas, and a high level of health protection in the definition and implementation of Community activities, in fields such as research, consumer protection, transport, advertising, marketing, sponsoring, excise duties and other internal market issues,

Recognizing that alcohol is no ordinary commodity,

Concerned of the conflict of interest, that alcohol, whereas a threat to public health, also, as a commodity, falls under the rules for free market competition and common agricultural policy,

Determined that agreements of the World Trade Organization, the General Agreement on Trade in Services (GATS) and proposals for a Directive on Services in the Internal Market of the European Community do not undermine the implementation of effective alcohol policy,

Recognizing the need to be alert to any efforts by the commercial alcohol industry[10] to undermine or subvert alcohol policy[11] efforts and the need to be informed of activities of the alcohol industry that have a negative impact on alcohol policy efforts,

Recognizing that the alcohol industry needs to be accountable for its actions, giving accurate information about its products, warning about the consequences of its products, and supplying its products in ways that minimize harm,

Recognizing that evidence based policy that reduces the harm done by alcohol is a public good,

Recognizing that countries that have put into place evidence based alcohol policies to protect the health and welfare of their citizens have the right under the principles of proportionality to protect their existing alcohol policies, even when these are more stringent than other European countries,

Determined to promote measures of alcohol policy that are evidenced based,

Recognizing that comprehensive multisectoral measures and responses to reduce hazardous and harmful alcohol consumption at the local, regional, country and European levels are essential so as to prevent, in accordance with public health principles, the incidence of diseases, premature disability and mortality due to alcohol consumption and other people's drinking,

Recognizing the need to develop, implement and evaluate alcohol policies and programmes that are socially and culturally appropriate to the circumstances and perspectives of different communities, countries and target groups,

Emphasizing the special contribution that nongovernmental organizations[12] and other members of civil society not affiliated with the alcohol industry, including health professional bodies, women's, youth, consumer, cultural and care groups, and academic and health care institutions, can have for alcohol policy efforts locally, nationally and internationally and the vital importance of their participation in local, national and international alcohol policy efforts,

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[10] "commercial alcohol industry" means commercial alcohol manufacturers, wholesale distributors and importers of alcohol products, retailers and the hospitality and pub industry and the social aspects organizations set up and funded by the commercial alcohol industry.

[11] "alcohol policy" means a range of supply, demand and harm reduction strategies that aim, through laws, rules and regulations, to improve the health of a population by reducing the harm done by alcohol.

[12] The European Alcohol Action Plan of the World Health Organization calls on all countries of the European Region to support nongovernmental organizations and self-help movements that promote initiatives aimed at preventing or reducing the harm that can be done by alcohol, including those nongovernmental organizations and networks that have experience and competence in advocating policies at international and country levels to reduce the harm that can be done by alcohol, those non-governmental organizations and networks that have a specific advocacy function within their remit, such as associations of health care professionals, representatives of civil society and consumer organizations, and those nongovernmental organizations and networks that have a specific role to play in informing and mobilizing civil society with respect to alcohol-related problems, lobbying for policy change and effective implementation of policy at government level, as well as exposing harmful actions of the alcohol industry.

Recognizing that every person should be informed of the health consequences, addictive nature and mortal threat that can be posed by alcohol consumption and of the effective legislative, executive, administrative or other measures that should be taken at the appropriate governmental level to protect all persons from exposure to the harm done by other people's drinking,

Recognizing that strong political commitment is necessary to develop and support at the local, regional, national and international levels, comprehensive multi-sectoral measures and coordinated responses, taking into consideration:

a. the need to take measures to protect all persons from the harm done by other people's drinking, such as traffic accidents and violence;
b. the need to take measures to reduce the harm done by alcohol, and to promote and support reductions in hazardous and harmful alcohol consumption and dependence on alcoholic products;
c. the need to take measures to promote the participation of indigenous individuals and communities in the development, implementation and evaluation of alcohol policy programmes; and
d. the need to take measures to address gender-specific risks when developing alcohol policy strategies,

Recognizing that international cooperation, particularly transfer of technology, knowledge and financial assistance and provision of related expertise is needed to establish and implement effective alcohol policy programmes, taking into consideration local culture, as well as social, economic, political and legal factors,

Recognizing that cooperative action is necessary to eliminate all forms of illicit trade[13] in alcohol,

Recognizing that policies and programmes to reduce the harm done by alcohol require funding commensurate with the size of the problem,

Propose that a Policy on Alcohol for Europe and its countries[14], addresses the following issues:

I. REDUCTION IN DRINKING DRIVING

1. Recognizing the heavy burden that drinking and driving[15] places on premature mortality, harm to people other than the driver and economic costs to society;
2. Effective legislative, executive, administrative and other measures necessary to reduce drinking and driving should be implemented;
3. Drinking driving policies should take into account the following principles:
   - ☞ A maximum blood alcohol concentration limit of 0.5 g/L (and breath equivalent) should be introduced throughout Europe with immediate effect; a lower limit of 0.2 g/L should be introduced for novice drivers and drivers of

[13] "illicit trade" means any practice or conduct prohibited by law and which relates to production, shipment, receipt, possession, distribution, sale or purchase including any practice or conduct intended to facilitate such activity.

[14] The partners recognize that the policies stated in this document must be developed and implemented according to the circumstances, perspectives, legislative, executive and administrative structures, and interpretation of the evidence appropriate for each country.

[15] Notwithstanding that drinking can be an important cause of boat, plane and train accidents in some communities, attention is placed on drinking and driving in this policy since alcohol related road accidents far outweigh other alcohol related transport accidents in the Community as a whole.

public service and heavy goods vehicles, with immediate effect; countries with existing lower levels should not increase them;

- ☞ Reducing the maximum blood alcohol concentration for all drivers to 0.2g/L would significantly further reduce the harm done by drinking and driving;
- ☞ Unrestricted powers to breath test, using breathalysers of equivalent and agreed standard, should be implemented throughout Europe;
- ☞ Common penalties for drinking and driving, with clarity and swiftness of punishment, should be introduced throughout Europe; penalties should be graded depending at least on the BAC level, and should include license penalties, license suspensions, fines, prison sentences, ignition locks and vehicle impoundment; all drivers on European roads with a BAC level greater than 0.5 g/L should have an unconditional license suspension for a minimum period of 6 months; and
- ☞ Driver education, rehabilitation and treatment schemes, linked to penalties, including the return of suspended licenses, need to be strengthened and implemented throughout Europe for drinking and driving offenders, including those with evidence of dependence on alcohol, based on agreed evidence based guidelines and protocols.

II. EDUCATION, COMMUNICATION, TRAINING AND PUBLIC AWARENESS

1. Recognizing that education and information approaches can be effective in countering the marketing practices of the commercial alcohol industry and in mobilizing public support for alcohol policy measures, but that unfortunately, in general, it is difficult to show any long-lasting effects of school based education in reducing the harm done by alcohol;
2. Effective and impartial[16] education, communication, training, school, college and university-based programmes, and other alternative forms of education, including culture and the arts, and informal youth based initiatives should be implemented to empower and enable all people to make healthy choices and to raise public awareness;
3. Impartial education, communication and training, should take into account the following principles:

- ☞ Public awareness of alcohol policy issues should be strengthened and promoted using all available communication tools;
- ☞ Broad access to effective and comprehensive school, college and university-based education and on the health risks including the intoxicating and addictive characteristics of alcohol consumption should be provided, based on evidence-based health promotion principles;
- ☞ Public awareness on the health risks including the intoxicating and addictive characteristics of alcohol consumption and on the benefits of reducing hazardous and harmful alcohol consumption should be increased;
- ☞ Public access, in accordance with national law, to a wide range of information on the commercial alcohol industry as relevant to the implementation of alcohol policy should be provided;
- ☞ Effective and appropriate training or sensitization and awareness programmes on alcohol policy to persons such as health workers, community workers, social workers, media professionals, educators, decision-makers, administrators and other concerned persons should be addressed;

[16] Impartial education would preclude, for example, school based education provided by the commercial alcohol industry.

- ☞ Education on the harm done by alcohol and what can be done to reduce it should be provided to all involved in the alcohol production, sales and supply chain; and
- ☞ Awareness and participation of public and private agencies and nongovernmental organizations not affiliated with the commercial alcohol industry in developing and implementing intersectoral programmes and strategies for alcohol policy should be promoted.

III. REGULATION OF THE ALCOHOL MARKET

III.1 PACKAGING AND LABELLING OF ALCOHOL PRODUCTS

1. Recognizing the importance of appropriate packaging and labelling[17] of alcohol products;
2. Effective legislative, executive, administrative and other measures necessary to ensure appropriate packaging and labelling should be implemented;
3. Packaging and labelling policy should take into account the following principles:

- ☞ Alcohol product packaging and labelling should not promote an alcoholic product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics or health effects, including any term, descriptor, trademark, figurative or any other sign that directly or indirectly creates the impression that a particular alcoholic product is more attractive or healthier than another alcoholic product;
- ☞ Alcohol product packaging and labelling should not promote an alcoholic product by any means, including any term, descriptor, trademark, figurative or any other sign that directly or indirectly appeals to minors[18];
- ☞ Each unit package of alcoholic products should carry warnings determined by ministries of health, describing the harmful effects of alcohol when driving or operating machinery, and during pregnancy or other appropriate messages determined by ministries of health; and
- ☞ Each unit packet and package of alcoholic products and any outside packaging and labelling of such products should, in addition to health warnings, contain information on its alcohol concentration (% by volume), alcohol content (grams of alcohol), calorific value and ingredients that might lead to allergies.

III.2 PRICE AND TAX MEASURES TO REDUCE THE HARM DONE BY ALCOHOL

1. Recognizing that price and tax measures are a highly cost-effective and important means of reducing the harm done by alcohol by all segments of the population, including young people and heavier drinkers;
2. Tax policies and, where appropriate, price policies, on all alcohol products, including wine and wine based products, should be introduced by all Member States and the Community as a whole so as to contribute to the health and economic objectives aimed at reducing the harm done by alcohol;

[17] "packaging and labelling" means each unit container (bottle, can, box or other type of container), text, characters or graphics on the unit container, labels on the unit container, and any outside packaging and labelling, where a number of unit containers can be placed in wrapping or in a box.
[18] "minor" is a person under the age set by domestic law, national law or eighteen years, whichever is the higher, to whom the sale of alcoholic products is prohibited

3. Tax policies and tax levels should take into account the following principles:

- ☞ The price of alcohol should take into account the external costs of consumption, the inadequate knowledge that consumers have about the harm done by alcohol and its dependence producing properties;
- ☞ The price of alcohol should be increased in line with inflation;
- ☞ Taxes should be proportional to the alcoholic content of alcoholic beverages, including all beverage types and with no threshold. Higher alcohol concentration beverages such as liquors and spirits should be taxed at a disproportional higher level, in view of their high alcohol concentration;
- ☞ Countries should retain the flexibility to use taxes to deal with specific problems that may arise with specific alcoholic beverages, such as designer drinks aimed at young people;
- ☞ Taxes should be increased throughout Europe up to a minimum level. Countries with higher taxation should not reduce their taxation levels; and
- ☞ A proportion of alcohol taxes can be earmarked (hypothecated tax) to fund programmes to reduce the harm done by alcohol.

III.3 ILLICIT TRADE IN ALCOHOLIC PRODUCTS

1. The elimination of all forms of illicit trade in alcoholic products, including smuggling, illicit manufacturing and counterfeiting are essential components of alcohol policy;
2. Effective legislative, executive, administrative or other measures should be implemented to ensure that all unit packages of alcoholic products and any outside packaging of such products are marked to assist in determining the origin of alcoholic products and any point of diversion and to monitor, document and control the movement of alcoholic products and their legal status.

III.4 TRAVELLERS ALLOWANCES WITHIN THE EUROPEAN UNION

1. Recognizing the failure of an upward harmonization of alcohol taxes within the European Union resulting in a cross-border disparity in alcohol taxes, and recognizing that the standard guidance for individuals to carry across European Union borders without paying excise tax in the country of residence is currently 10 liters of spirits, 20 liters of intermediate products, 90 liters of wine and 110 liters of beer (overall equivalent to about 270 bottles of wine), resulting in a substantial increase in alcohol consumption in some countries that is not reflected in official statistics;

2. Effective legislative, executive, administrative and other measures should be implemented to progressively reduce the personal allowance to about one seventh of the current limit, the equivalent of 40 bottles of wine (a 40 day supply for a heavy drinker, which is equivalent to the current allowance of tobacco which represents a 40 day supply of 20 cigarettes a day).

III.5 RESTRICTIONS ON THE AVAILABILITY OF ALCOHOL

1. Recognizing that reducing the number and density of outlets, including availability in supermarkets and general retail stores, changing the location of outlets and reducing the days and hours of opening can all reduce the harm done by alcohol;

2. Countries that regulate outlets through number and density, location and hours and days of sale should not relax their regulations; countries without such regulations or with very liberal regulations should consider introducing them or strengthening them.
3. Measures to manage the availability of alcohol should take into account the following principles:

- ☞ Impact assessments on health and the social environment should be undertaken when opening new or changing existing outlets.

III.6 SALES TO MINORS

1. Recognizing that alcohol consumption, the harm done by alcohol and binge drinking amongst young people is increasing at an alarming rate;
2. Effective legislative, executive, administrative and other measures necessary to restrict sales to minors should be implemented;
3. Measures to restrict sales to minors should take into account the following principles:

- ☞ The sales of alcoholic products to persons under the age set by domestic law, national law or eighteen years, whichever is the higher, should be prohibited;
- ☞ All sellers of alcoholic products should place a clear and prominent indicator inside their point of sale about the prohibition of alcohol sales to minors and, in case of doubt, request that each alcohol purchaser provide appropriate evidence of having reached full legal age;
- ☞ Within supermarkets and other general retail stores, alcoholic products should be placed in a section clearly separated from the sale of other products that might appeal to minors, such as sweets, snacks, toys, or soft drinks;
- ☞ The distribution of free alcoholic products (including brand related paraphernalia such as t-shirts, ashtrays, glasses, caps, etc.) should be prohibited to minors; and
- ☞ Penalties against sellers and distributors, such as withdrawal of license or temporary and permanent closures, in order to ensure compliance with relevant measures should be implemented.

III.7 ALCOHOL ADVERTISING, PROMOTION AND SPONSORSHIP

1. Recognizing that a comprehensive ban on advertising, promotion and sponsorship would reduce the harm done by alcohol, and that self-regulation is an ineffective mechanism to reduce the harm done by alcohol;
2. Effective legislative, executive, administrative and other measures necessary to strictly regulate advertising, promotion and sponsorship of alcohol products through statutory controls should be introduced both within and across borders;
3. Regulation of advertising, promotion and sponsorship should take into account the following principles:

- ☞ All forms of alcohol advertising, promotion and sponsorship that promote an alcoholic product by any means that are false, misleading or deceptive or likely to create an erroneous impression about its characteristics, health effects, or hazards should be prohibited;
- ☞ All forms of alcohol advertising, promotion and sponsorship that promote an alcoholic product to minors should be prohibited;
- ☞ Appropriate health warnings or safety messages should accompany all alcohol advertising and, as appropriate, promotion and sponsorship;

- ☞ The use of direct or indirect incentives that encourage the purchase of alcohol products (sales promotion) should be prohibited;
- ☞ Expenditures by the alcohol industry on advertising, promotion and sponsorship should be disclosed to relevant governmental authorities;
- ☞ Article 15 of the Television Without Frontiers Directive should be enforced in all Member States under statutory control. Article 15 should be strengthened by adding time limits, programme limits, and limits on concentration of alcohol advertising;
- ☞ All alcohol advertising, promotion and sponsorship on radio, television, print media and, as appropriate, other media, such as the internet, where not part of a comprehensive ban, should be restricted to information about the product only, with messages and images only referring to the origin, composition, means of production, and patterns of consumption;
- ☞ Technologies and other means necessary to regulate cross-border advertising, promotion and sponsorship should be developed;
- ☞ Countries which have a ban on certain forms of alcohol advertising, promotion and sponsorship have the sovereign right to ban those forms of cross-border alcohol advertising, promotion and sponsorship entering their territory and to impose equal penalties as those applicable to domestic advertising, promotion and sponsorship originating from their territory in accordance with their national law; and
- ☞ A proportion of the total expenditure by the alcohol industry on advertising, promotion and sponsorship can be considered for earmarking to fund independent public health programmes to reduce the harm done by alcohol.

IV. REDUCING HARM IN DRINKING AND SURROUNDING ENVIRONMENTS

1. Recognizing that drinking and surrounding environments can impact on the harm done by alcohol;
2. Effective legislative, executive, administrative and other measures necessary to improve drinking and surrounding environments to reduce the harm done by alcohol should be implemented;
3. Measures to improve drinking and surrounding environments should take into account the following principles:

- ☞ Urban planning, community strategies, licensing regulations and restrictions, transport policies and management of the drinking and surrounding environments should ensure that all peoples, and in particular local residents, are free from the injurious, noxious and polluting effects, including noise pollution, that result from alcohol intoxication;
- ☞ Introduction and strengthening of alcohol sales and licensing laws which prohibit the sales of alcohol to minors and intoxicated persons;
- ☞ Adequate policing and enforcement of alcohol sales and licensing laws;
- ☞ Effective and appropriate training for the hospitality industry and servers of alcohol to reduce the harmful consequences of intoxication, harmful patterns of drinking and the risk of drinking and driving; and
- ☞ Server training programmes can be backed up by civil liability for subsequent alcohol related accidents, including drinking driving accidents to increase their effectiveness.

V. INTERVENTIONS FOR INDIVIDUALS AND FAMILIES

V.1 INTERVENTIONS FOR HAZARDOUS AND HARMFUL ALCOHOL CONSUMPTION AND ALCOHOL DEPENDENCE

1. Recognizing the heavy burden that hazardous and harmful alcohol consumption and alcohol dependence place on the health care sector, individuals, families and societies, and recognizing that brief interventions for hazardous and harmful alcohol consumption are amongst the most cost effective of all health sector interventions;
2. Effective legislative, executive, administrative and other measures necessary to promote the widespread delivery of interventions for hazardous and harmful alcohol consumption and alcohol dependence should be implemented;
3. The following principles should be taken into account:
   - ☞ Appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices to promote reductions in hazardous and harmful alcohol consumption and adequate treatment for alcohol dependence should be developed, disseminated and implemented;
   - ☞ Effective programmes aimed at promoting the reduction in hazardous and harmful alcohol consumption, in such locations as educational institutions, health care facilities and workplaces[19] should be designed and implemented;
   - ☞ The identification and management of hazardous and harmful alcohol consumption should be included in national health and education programmes, plans and strategies, with the participation of health workers, community workers and social workers as appropriate; and
   - ☞ Programmes for diagnosing, counselling, preventing and treating hazardous and harmful alcohol consumption and alcohol dependence should be established in statutory and non-statutory health care facilities, specialized centres and rehabilitation centres.

V.2 INTERVENTIONS AND ASSISTANCE FOR FAMILY MEMBERS OF PEOPLE WITH ALCOHOL DEPENDENCE

1. Recognizing that harmful alcohol consumption and alcohol dependence can harm the health, safety and development of family members;
2. Effective legislative, executive, administrative and other measures necessary to promote the widespread delivery of support and help for the family members of people with harmful alcohol consumption and alcohol dependence should be implemented;
3. The following principles should be taken into account;

   - ☞ A comprehensive community-based system which includes close cooperation between the police, social workers, the courts and judicial system, non-governmental organizations and professional diagnostic and counselling services for family members who suffer alcohol-related violence, should be developed;

[19] Special attention should be paid to the alcohol industry, whose employees are at particular risk of harmful alcohol consumption and alcohol dependence, and which was one of the first industries to implement successful workplace programmes.

- ☞ Children of parents with harmful alcohol consumption and alcohol dependence should be a high priority for psychosocial assistance and programmes to prevent social exclusion; and
- ☞ Programmes for diagnosing and counselling adult family members of people with harmful alcohol consumption and alcohol dependence should be established in health care facilities, specialized centres and rehabilitation centres to prevent and help with emotional and psychological disorders.

VI. IMPLEMENTING POLICIES

1. Each European country (and, where relevant, local community, municipality and region within a country), and the European Union as a whole, should develop, implement, periodically update and review comprehensive multisectoral alcohol policy strategies, plans and programmes;
2. When developing and implementing comprehensive multisectoral alcohol policy strategies, plans and programmes, the following principles should be taken into account:

- ☞ Country and European (and where relevant local community, municipal and regional) coordinating mechanisms or focal points for alcohol policy should be established or reinforced and financed[20];
- ☞ Effective legislative, executive, administrative and/or other measures in developing appropriate policies for preventing and reducing the harm done by alcohol, and the harm done by other people's drinking should be adopted and implemented;
- ☞ The setting and implementing of public health policies with respect to alcohol policy should be protected from commercial and other vested interests of the alcohol industry;
- ☞ Cross-border cooperation in the formulation of proposed measures, procedures and guidelines for the implementation of policies, plans and programmes to reduce the harm done by alcohol should be adopted;
- ☞ Cooperation, as appropriate, should be made with competent international and regional intergovernmental organizations and other bodies to achieve the implementation of policies, plans and programmes to reduce the harm done by alcohol, including the European Commission and the World Health Organization;
- ☞ The effective implementation of policies, plans and programmes to reduce the harm done by alcohol should be adequately financed; and
- ☞ For the purpose of effective alcohol policy, legislative action or the implementation of existing laws should be used to deal with criminal and civil liability, including compensation where appropriate.

[20] Where mechanisms, structures or organizations currently exist, these should not be replaced, but rather strengthened or redefined as appropriate.

VII. RESEARCH, SURVEILLANCE AND EXCHANGE OF INFORMATION

1. Research and research programmes, surveillance, and exchange of information at the local, regional, country and European levels in the field of alcohol policy should be developed and promoted;
2. Principles should include:

- The initiation, promotion and encouragement of transparent and independent research that addresses the determinants and consequences of alcohol consumption, the harm done by alcohol, the effectiveness of polices and programmes to reduce the harm done by alcohol, and the effectiveness of strategies and approaches to implement effective policies and programmes to reduce the harm done by alcohol;
- The promotion and strengthening of training and support for all those engaged in alcohol policy activities, including research, implementation and evaluation;
- A system for the epidemiological surveillance of alcohol consumption and related social, economic and health indicators should be established;
- Cooperation should be made with the European Commission and World Health Organization in the development of general guidelines or procedures for defining the collection, analysis and dissemination of alcohol-related surveillance data;
- Establishment of programmes for regional, country, and European surveillance of the magnitude, patterns, determinants and consequences of alcohol consumption and the harm done by alcohol. Alcohol surveillance programmes should be integrated into regional, national, and European health surveillance programmes so that data are comparable and can be analysed at the regional, country and European levels, as appropriate;
- Alcohol surveillance and exchange of information between regions and countries should be established;
- The exchange of publicly available scientific, technical, socioeconomic, commercial and legal information, as well as information regarding practices of the alcohol industry should be promoted and facilitated;
- Annual reports of the alcohol industry for shareholders should include reports on how the alcohol industry has minimized the harm from its products in terms of production, marketing and sale, and any infringements of existing laws, regulations and codes of practice;
- An updated database of laws and regulations on alcohol policy and, as appropriate, information about their enforcement, as well as pertinent jurisprudence, and cooperation in the development of programmes for regional, country and European alcohol policy should be established and maintained;
- Updated data from regional, country and European surveillance programmes should be maintained; and
- A Europe wide system to regularly collect and disseminate information on alcohol production, manufacture and the activities of the alcohol industry which have an impact on alcohol policy activities should be established and maintained.

ANNEX

WHO EUROPEAN CHARTER ON ALCOHOL

Ethical principles and goals

In furtherance of the European Alcohol Action Plan, the Paris Conference calls on all Member States to draw up comprehensive alcohol policies and implement programmes that give expression, as appropriate in their differing cultures and social, legal and economic environments, to the following ethical principles and goals, on the understanding that this document does not confer legal rights.

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.

2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.

3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.

4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.

5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

Ten strategies for alcohol action

Research and successful examples in countries demonstrate that significant health and economic benefits for the European Region may be achieved if the following ten health promotion strategies for action on alcohol are implemented to give effect to the ethical principles and goals listed above, in accordance with the differing cultures and social, legal and economic environments in each Member State.

1. Inform people of the consequences of alcohol consumption on health, family and society and of the effective measures that can be taken to prevent or minimize harm, building broad educational programmes beginning in early childhood.

2. Promote public, private and working environments protected from accidents and violence and other negative consequences of alcohol consumption.

3. Establish and enforce laws that effectively discourage drink–driving.

4. Promote health by controlling the availability, for example for young people, and influencing the price of alcoholic beverages, for instance by taxation.

5. Implement strict controls, recognizing existing limitations or bans in some countries, on direct and indirect advertising of alcoholic beverages and ensure that no form of advertising is specifically addressed to young people, for instance through the linking of alcohol to sports.

6. Ensure the accessibility of effective treatment and rehabilitation services, with trained personnel, for people with hazardous or harmful alcohol consumption and members of their families.

7. Foster awareness of ethical and legal responsibility among those involved in the marketing or serving of alcoholic beverages, ensure strict control of product safety and implement appropriate measures against illicit production and sale.

8. Enhance the capacity of society to deal with alcohol through the training of professionals in different sectors, such as health, social welfare, education and the judiciary, along with the strengthening of community development and leadership.

9. Support nongovernmental organizations and self-help movements that promote healthy lifestyles, specifically those aiming to prevent or reduce alcohol-related harm.

10. Formulate broad-based programmes in Member States, taking account of the present European Charter on Alcohol; specify clear targets for and indicators of outcome; monitor progress; and ensure periodic updating of programmes based on evaluation.

A POLICY ON ALCOHOL FOR EUROPE AND ITS COUNTRIES[1]
REDUCING THE HARM DONE BY ALCOHOL[2] - BRIDGING THE GAP[3] POLICIES

PREAMBLE

The partners of the 27 countries[4] of the European Bridging the Gap project,

Determined to give priority to the right to protect European public health and social welfare,

Determined to give priority to reduce the health, social and economic burden caused by alcohol,

Recognizing that the harm done by alcohol is a European problem with serious consequences for public health and social welfare that calls for the widest possible international cooperation and the participation of all European countries in an effective, appropriate and comprehensive international response,

Recognizing that scientific evidence has unequivocally established that alcohol consumption can cause premature death, disease and disability, as well as accidents, violence and intentional and unintentional injuries to both the user and people other than the user,

Recognizing that alcohol consumption is responsible for at least 9% of the total annual burden of ill-health and premature death in Europe, the third most important risk factor, after smoking and raised blood pressure, and a net figure taking into account any potential benefits from alcohol,

Recognizing that in Europe violent deaths and deaths related to alcohol consumption and smoking dominate premature mortality amongst young men and account for more than 30% of all premature deaths,

Recognizing the compelling evidence of the strong relationship between individual and population consumption and risk of harm; and the evidence that overall

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[1] This document was prepared by Peter Anderson, policy advisor to Eurocare on behalf of the Alcohol Policy Network of the Bridging the Gap project. The document was discussed at the first meeting of the network, June 2004 in Warsaw, and subsequently revised by members of the Network and finalized during October 2004.

[2] Alcohol is responsible for a wide range of harm, which can be reduced by alcohol policies (for example, increases in alcohol taxes reduce deaths from cirrhosis of the liver and drink driving fatalities). This is what is meant by a policy to reduce the harm done by alcohol. This is not the same as harm reduction policies (for example safer drinking glass design to prevent injuries in fights), whose limited and targeted purpose is to reduce harm in specific situations, without necessarily reducing alcohol consumption.

[3] The Bridging the Gap project is co-financed by the European Commission, Norwegian Policy Network on Alcohol and Drugs (ACTIS), IOGT-NTO Sweden, and the Government of Norway, in partnership with the European Cultural Foundation, the European Public Health Alliance, the European Youth Forum and the World Health Organization.

[4] The partners represent governmental, non-governmental, health professional and research organizations from Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey and the United Kingdom.

reductions in consumption would not have adverse effects on deaths or illness from coronary heart disease,

Concerned about the increase in the use of alcohol, binge drinking[5] and the harm done by intoxication amongst young people, particularly in public settings, such as cafes, pubs and bars,

Concerned that alcohol consumption is likely to increase following economic development in new Member States and increased earning capacity of women and young adults,

Concerned about designer drinks[6] marketed to young people,

Concerned about the impact of all forms of advertising and promotion[7] and sponsorship[8] aimed at encouraging the use of alcohol products[9],

Recalling the preamble to the Constitution of the World Health Organization, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition,

Recalling Article 12 of the International Covenant on Economic, Social and Cultural Rights, adopted by the United Nations General Assembly on 16 December 1966, which states that it is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,

Recalling that the Convention on the Rights of the Child, adopted by the United Nations General Assembly on 20 November 1989, provides that Parties to that Convention recognize the right of the child to the enjoyment of the highest attainable standard of health,

Recalling resolution WHA57.16 of the World Health Organization, which urges Member States to promote strategies to reduce the adverse physical, mental and social consequences of harmful use of alcohol,

Recalling the 1995 European Charter on Alcohol of the World Health Organization (see Annex), which states that all people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption,

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[5] "binge drinking" means a pattern of heavy drinking that occurs during a single occasion, commonly defined as six alcoholic drinks (60g of alcohol) consumed on a single occasion.

[6] "Designer drinks" includes flavoured alcoholic drinks and pre-mixed spirits, manufactured with an alcoholic strength commonly ranging from 1.2% to 5.5% made from any alcoholic base, which are traditionally sold in 27.5 and 33cl bottles often designed to appeal to young people. Also known as alcopops and ready-to-drinks.

[7] "advertising and promotion" means any form of commercial communication, recommendation (including product placement) or action with the aim, effect or likely effect of promoting an alcoholic product or alcohol use either directly or indirectly.

[8] "alcohol sponsorship" means any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting an alcoholic product or alcohol use either directly or indirectly.

[9] Different countries have different definitions of an alcohol product. In this document, "alcohol products" means any product that contains more than 1.2% alcohol by volume which is manufactured to be orally consumed. It is proposed that countries with a definition of a higher concentration reduce it to 1.2%, and countries with a definition of a lower concentration maintain that definition.

Recalling the 2001 Stockholm Declaration on Young People and Alcohol of the World Health Organization, which states that public health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests,

Recalling Article 3 of the European Community Treaty which states that the activities of the Community shall include a contribution to the attainment of a high level of health protection,

Recalling Article 95 of the European Community Treaty, which states that the Commission, in its proposals concerning health, safety, environmental protection and consumer protection, will take as a base a high level of protection, taking account in particular of any new development based on scientific facts,

Recalling Article 152 of the European Community Treaty, which states that a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health,

Recalling that the Constitutional Treaty of 18 June 2004 (which to enter into force requires ratification by all the Member States in accordance with their respective constitutional provisions) gives the Community the competence to establish incentive or other measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol,

Recalling the programme of European Community Action in the field of Public Health (2003-2008) which should contribute to ensuring a high level of human health protection in the definition and implementation of all Community polices and activities, through the promotion of an integrated and inter-sectoral health strategy and to encouraging co-operation between Member States in the areas covered by Article 152 of the Treaty,

Recalling the Recommendation of the Council of the European Union of 5 June 2001 on the drinking of alcohol by young people, in particular children and adolescents (2001/458/EC), which, amongst other issues, stresses that (a) producers do not produce alcoholic beverages specifically targeted at children and adolescents; and (b) alcoholic beverages are not designed or promoted to appeal to children and adolescents,

Recalling the Conclusions of the Council of the European Union of 5 June 2001 on a Community strategy to reduce alcohol-related harm (2001/C 175/01), which stresses the need for a co-ordinated range of Community activities in all relevant policy areas, and a high level of health protection in the definition and implementation of Community activities, in fields such as research, consumer protection, transport, advertising, marketing, sponsoring, excise duties and other internal market issues,

Recognizing that alcohol is no ordinary commodity,

Concerned of the conflict of interest, that alcohol, whereas a threat to public health, also, as a commodity, falls under the rules for free market competition and common agricultural policy,

Determined that agreements of the World Trade Organization, the General Agreement on Trade in Services (GATS) and proposals for a Directive on Services in the Internal Market of the European Community do not undermine the implementation of effective alcohol policy,

Recognizing the need to be alert to any efforts by the commercial alcohol industry[10] to undermine or subvert alcohol policy[11] efforts and the need to be informed of activities of the alcohol industry that have a negative impact on alcohol policy efforts,

Recognizing that the alcohol industry needs to be accountable for its actions, giving accurate information about its products, warning about the consequences of its products, and supplying its products in ways that minimize harm,

Recognizing that evidence based policy that reduces the harm done by alcohol is a public good,

Recognizing that countries that have put into place evidence based alcohol policies to protect the health and welfare of their citizens have the right under the principles of proportionality to protect their existing alcohol policies, even when these are more stringent than other European countries,

Determined to promote measures of alcohol policy that are evidenced based,

Recognizing that comprehensive multisectoral measures and responses to reduce hazardous and harmful alcohol consumption at the local, regional, country and European levels are essential so as to prevent, in accordance with public health principles, the incidence of diseases, premature disability and mortality due to alcohol consumption and other people's drinking,

Recognizing the need to develop, implement and evaluate alcohol policies and programmes that are socially and culturally appropriate to the circumstances and perspectives of different communities, countries and target groups,

Emphasizing the special contribution that nongovernmental organizations[12] and other members of civil society not affiliated with the alcohol industry, including health professional bodies, women's, youth, consumer, cultural and care groups, and academic and health care institutions, can have for alcohol policy efforts locally, nationally and internationally and the vital importance of their participation in local, national and international alcohol policy efforts,

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[10] "commercial alcohol industry" means commercial alcohol manufacturers, wholesale distributors and importers of alcohol products, retailers and the hospitality and pub industry and the social aspects organizations set up and funded by the commercial alcohol industry.

[11] "alcohol policy" means a range of supply, demand and harm reduction strategies that aim, through laws, rules and regulations, to improve the health of a population by reducing the harm done by alcohol.

[12] The European Alcohol Action Plan of the World Health Organization calls on all countries of the European Region to support nongovernmental organizations and self-help movements that promote initiatives aimed at preventing or reducing the harm that can be done by alcohol, including those nongovernmental organizations and networks that have experience and competence in advocating policies at international and country levels to reduce the harm that can be done by alcohol, those non-governmental organizations and networks that have a specific advocacy function within their remit, such as associations of health care professionals, representatives of civil society and consumer organizations, and those nongovernmental organizations and networks that have a specific role to play in informing and mobilizing civil society with respect to alcohol-related problems, lobbying for policy change and effective implementation of policy at government level, as well as exposing harmful actions of the alcohol industry.

Recognizing that every person should be informed of the health consequences, addictive nature and mortal threat that can be posed by alcohol consumption and of the effective legislative, executive, administrative or other measures that should be taken at the appropriate governmental level to protect all persons from exposure to the harm done by other people's drinking,

Recognizing that strong political commitment is necessary to develop and support at the local, regional, national and international levels, comprehensive multi-sectoral measures and coordinated responses, taking into consideration:

a. the need to take measures to protect all persons from the harm done by other people's drinking, such as traffic accidents and violence;
b. the need to take measures to reduce the harm done by alcohol, and to promote and support reductions in hazardous and harmful alcohol consumption and dependence on alcoholic products;
c. the need to take measures to promote the participation of indigenous individuals and communities in the development, implementation and evaluation of alcohol policy programmes; and
d. the need to take measures to address gender-specific risks when developing alcohol policy strategies,

Recognizing that international cooperation, particularly transfer of technology, knowledge and financial assistance and provision of related expertise is needed to establish and implement effective alcohol policy programmes, taking into consideration local culture, as well as social, economic, political and legal factors,

Recognizing that cooperative action is necessary to eliminate all forms of illicit trade[13] in alcohol,

Recognizing that policies and programmes to reduce the harm done by alcohol require funding commensurate with the size of the problem,

Propose that a Policy on Alcohol for Europe and its countries[14], addresses the following issues:

I. REDUCTION IN DRINKING DRIVING

1. Recognizing the heavy burden that drinking and driving[15] places on premature mortality, harm to people other than the driver and economic costs to society;
2. Effective legislative, executive, administrative and other measures necessary to reduce drinking and driving should be implemented;
3. Drinking driving policies should take into account the following principles:
   - ☞ A maximum blood alcohol concentration limit of 0.5 g/L (and breath equivalent) should be introduced throughout Europe with immediate effect; a lower limit of 0.2 g/L should be introduced for novice drivers and drivers of

[13] "illicit trade" means any practice or conduct prohibited by law and which relates to production, shipment, receipt, possession, distribution, sale or purchase including any practice or conduct intended to facilitate such activity.

[14] The partners recognize that the policies stated in this document must be developed and implemented according to the circumstances, perspectives, legislative, executive and administrative structures, and interpretation of the evidence appropriate for each country.

[15] Notwithstanding that drinking can be an important cause of boat, plane and train accidents in some communities, attention is placed on drinking and driving in this policy since alcohol related road accidents far outweigh other alcohol related transport accidents in the Community as a whole.

public service and heavy goods vehicles, with immediate effect; countries with existing lower levels should not increase them;

- ☞ Reducing the maximum blood alcohol concentration for all drivers to 0.2g/L would significantly further reduce the harm done by drinking and driving;
- ☞ Unrestricted powers to breath test, using breathalysers of equivalent and agreed standard, should be implemented throughout Europe;
- ☞ Common penalties for drinking and driving, with clarity and swiftness of punishment, should be introduced throughout Europe; penalties should be graded depending at least on the BAC level, and should include license penalties, license suspensions, fines, prison sentences, ignition locks and vehicle impoundment; all drivers on European roads with a BAC level greater than 0.5 g/L should have an unconditional license suspension for a minimum period of 6 months; and
- ☞ Driver education, rehabilitation and treatment schemes, linked to penalties, including the return of suspended licenses, need to be strengthened and implemented throughout Europe for drinking and driving offenders, including those with evidence of dependence on alcohol, based on agreed evidence based guidelines and protocols.

II. EDUCATION, COMMUNICATION, TRAINING AND PUBLIC AWARENESS

1. Recognizing that education and information approaches can be effective in countering the marketing practices of the commercial alcohol industry and in mobilizing public support for alcohol policy measures, but that unfortunately, in general, it is difficult to show any long-lasting effects of school based education in reducing the harm done by alcohol;
2. Effective and impartial[16] education, communication, training, school, college and university-based programmes, and other alternative forms of education, including culture and the arts, and informal youth based initiatives should be implemented to empower and enable all people to make healthy choices and to raise public awareness;
3. Impartial education, communication and training, should take into account the following principles:

- ☞ Public awareness of alcohol policy issues should be strengthened and promoted using all available communication tools;
- ☞ Broad access to effective and comprehensive school, college and university-based education and on the health risks including the intoxicating and addictive characteristics of alcohol consumption should be provided, based on evidence-based health promotion principles;
- ☞ Public awareness on the health risks including the intoxicating and addictive characteristics of alcohol consumption and on the benefits of reducing hazardous and harmful alcohol consumption should be increased;
- ☞ Public access, in accordance with national law, to a wide range of information on the commercial alcohol industry as relevant to the implementation of alcohol policy should be provided;
- ☞ Effective and appropriate training or sensitization and awareness programmes on alcohol policy to persons such as health workers, community workers, social workers, media professionals, educators, decision-makers, administrators and other concerned persons should be addressed;

[16] Impartial education would preclude, for example, school based education provided by the commercial alcohol industry.

- ☞ Education on the harm done by alcohol and what can be done to reduce it should be provided to all involved in the alcohol production, sales and supply chain; and
- ☞ Awareness and participation of public and private agencies and nongovernmental organizations not affiliated with the commercial alcohol industry in developing and implementing intersectoral programmes and strategies for alcohol policy should be promoted.

III. REGULATION OF THE ALCOHOL MARKET

III.1 PACKAGING AND LABELLING OF ALCOHOL PRODUCTS

1. Recognizing the importance of appropriate packaging and labelling[17] of alcohol products;
2. Effective legislative, executive, administrative and other measures necessary to ensure appropriate packaging and labelling should be implemented;
3. Packaging and labelling policy should take into account the following principles:

- ☞ Alcohol product packaging and labelling should not promote an alcoholic product by any means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics or health effects, including any term, descriptor, trademark, figurative or any other sign that directly or indirectly creates the impression that a particular alcoholic product is more attractive or healthier than another alcoholic product;
- ☞ Alcohol product packaging and labelling should not promote an alcoholic product by any means, including any term, descriptor, trademark, figurative or any other sign that directly or indirectly appeals to minors[18];
- ☞ Each unit package of alcoholic products should carry warnings determined by ministries of health, describing the harmful effects of alcohol when driving or operating machinery, and during pregnancy or other appropriate messages determined by ministries of health; and
- ☞ Each unit packet and package of alcoholic products and any outside packaging and labelling of such products should, in addition to health warnings, contain information on its alcohol concentration (% by volume), alcohol content (grams of alcohol), calorific value and ingredients that might lead to allergies.

III.2 PRICE AND TAX MEASURES TO REDUCE THE HARM DONE BY ALCOHOL

1. Recognizing that price and tax measures are a highly cost-effective and important means of reducing the harm done by alcohol by all segments of the population, including young people and heavier drinkers;
2. Tax policies and, where appropriate, price policies, on all alcohol products, including wine and wine based products, should be introduced by all Member States and the Community as a whole so as to contribute to the health and economic objectives aimed at reducing the harm done by alcohol;

[17] "packaging and labelling" means each unit container (bottle, can, box or other type of container), text, characters or graphics on the unit container, labels on the unit container, and any outside packaging and labelling, where a number of unit containers can be placed in wrapping or in a box.
[18] "minor" is a person under the age set by domestic law, national law or eighteen years, whichever is the higher, to whom the sale of alcoholic products is prohibited

3. Tax policies and tax levels should take into account the following principles:

- ☞ The price of alcohol should take into account the external costs of consumption, the inadequate knowledge that consumers have about the harm done by alcohol and its dependence producing properties;
- ☞ The price of alcohol should be increased in line with inflation;
- ☞ Taxes should be proportional to the alcoholic content of alcoholic beverages, including all beverage types and with no threshold. Higher alcohol concentration beverages such as liquors and spirits should be taxed at a disproportional higher level, in view of their high alcohol concentration;
- ☞ Countries should retain the flexibility to use taxes to deal with specific problems that may arise with specific alcoholic beverages, such as designer drinks aimed at young people;
- ☞ Taxes should be increased throughout Europe up to a minimum level. Countries with higher taxation should not reduce their taxation levels; and
- ☞ A proportion of alcohol taxes can be earmarked (hypothecated tax) to fund programmes to reduce the harm done by alcohol.

III.3 ILLICIT TRADE IN ALCOHOLIC PRODUCTS

1. The elimination of all forms of illicit trade in alcoholic products, including smuggling, illicit manufacturing and counterfeiting are essential components of alcohol policy;
2. Effective legislative, executive, administrative or other measures should be implemented to ensure that all unit packages of alcoholic products and any outside packaging of such products are marked to assist in determining the origin of alcoholic products and any point of diversion and to monitor, document and control the movement of alcoholic products and their legal status.

III.4 TRAVELLERS ALLOWANCES WITHIN THE EUROPEAN UNION

1. Recognizing the failure of an upward harmonization of alcohol taxes within the European Union resulting in a cross-border disparity in alcohol taxes, and recognizing that the standard guidance for individuals to carry across European Union borders without paying excise tax in the country of residence is currently 10 liters of spirits, 20 liters of intermediate products, 90 liters of wine and 110 liters of beer (overall equivalent to about 270 bottles of wine), resulting in a substantial increase in alcohol consumption in some countries that is not reflected in official statistics;

2. Effective legislative, executive, administrative and other measures should be implemented to progressively reduce the personal allowance to about one seventh of the current limit, the equivalent of 40 bottles of wine (a 40 day supply for a heavy drinker, which is equivalent to the current allowance of tobacco which represents a 40 day supply of 20 cigarettes a day).

III.5 RESTRICTIONS ON THE AVAILABILITY OF ALCOHOL

1. Recognizing that reducing the number and density of outlets, including availability in supermarkets and general retail stores, changing the location of outlets and reducing the days and hours of opening can all reduce the harm done by alcohol;

2. Countries that regulate outlets through number and density, location and hours and days of sale should not relax their regulations; countries without such regulations or with very liberal regulations should consider introducing them or strengthening them.
3. Measures to manage the availability of alcohol should take into account the following principles:

- ☞ Impact assessments on health and the social environment should be undertaken when opening new or changing existing outlets.

III.6 SALES TO MINORS

1. Recognizing that alcohol consumption, the harm done by alcohol and binge drinking amongst young people is increasing at an alarming rate;
2. Effective legislative, executive, administrative and other measures necessary to restrict sales to minors should be implemented;
3. Measures to restrict sales to minors should take into account the following principles:

- ☞ The sales of alcoholic products to persons under the age set by domestic law, national law or eighteen years, whichever is the higher, should be prohibited;
- ☞ All sellers of alcoholic products should place a clear and prominent indicator inside their point of sale about the prohibition of alcohol sales to minors and, in case of doubt, request that each alcohol purchaser provide appropriate evidence of having reached full legal age;
- ☞ Within supermarkets and other general retail stores, alcoholic products should be placed in a section clearly separated from the sale of other products that might appeal to minors, such as sweets, snacks, toys, or soft drinks;
- ☞ The distribution of free alcoholic products (including brand related paraphernalia such as t-shirts, ashtrays, glasses, caps, etc.) should be prohibited to minors; and
- ☞ Penalties against sellers and distributors, such as withdrawal of license or temporary and permanent closures, in order to ensure compliance with relevant measures should be implemented.

III.7 ALCOHOL ADVERTISING, PROMOTION AND SPONSORSHIP

1. Recognizing that a comprehensive ban on advertising, promotion and sponsorship would reduce the harm done by alcohol, and that self-regulation is an ineffective mechanism to reduce the harm done by alcohol;
2. Effective legislative, executive, administrative and other measures necessary to strictly regulate advertising, promotion and sponsorship of alcohol products through statutory controls should be introduced both within and across borders;
3. Regulation of advertising, promotion and sponsorship should take into account the following principles:

- ☞ All forms of alcohol advertising, promotion and sponsorship that promote an alcoholic product by any means that are false, misleading or deceptive or likely to create an erroneous impression about its characteristics, health effects, or hazards should be prohibited;
- ☞ All forms of alcohol advertising, promotion and sponsorship that promote an alcoholic product to minors should be prohibited;
- ☞ Appropriate health warnings or safety messages should accompany all alcohol advertising and, as appropriate, promotion and sponsorship;

- ☞ The use of direct or indirect incentives that encourage the purchase of alcohol products (sales promotion) should be prohibited;
- ☞ Expenditures by the alcohol industry on advertising, promotion and sponsorship should be disclosed to relevant governmental authorities;
- ☞ Article 15 of the Television Without Frontiers Directive should be enforced in all Member States under statutory control. Article 15 should be strengthened by adding time limits, programme limits, and limits on concentration of alcohol advertising;
- ☞ All alcohol advertising, promotion and sponsorship on radio, television, print media and, as appropriate, other media, such as the internet, where not part of a comprehensive ban, should be restricted to information about the product only, with messages and images only referring to the origin, composition, means of production, and patterns of consumption;
- ☞ Technologies and other means necessary to regulate cross-border advertising, promotion and sponsorship should be developed;
- ☞ Countries which have a ban on certain forms of alcohol advertising, promotion and sponsorship have the sovereign right to ban those forms of cross-border alcohol advertising, promotion and sponsorship entering their territory and to impose equal penalties as those applicable to domestic advertising, promotion and sponsorship originating from their territory in accordance with their national law; and
- ☞ A proportion of the total expenditure by the alcohol industry on advertising, promotion and sponsorship can be considered for earmarking to fund independent public health programmes to reduce the harm done by alcohol.

IV. REDUCING HARM IN DRINKING AND SURROUNDING ENVIRONMENTS

1. Recognizing that drinking and surrounding environments can impact on the harm done by alcohol;
2. Effective legislative, executive, administrative and other measures necessary to improve drinking and surrounding environments to reduce the harm done by alcohol should be implemented;
3. Measures to improve drinking and surrounding environments should take into account the following principles:

- ☞ Urban planning, community strategies, licensing regulations and restrictions, transport policies and management of the drinking and surrounding environments should ensure that all peoples, and in particular local residents, are free from the injurious, noxious and polluting effects, including noise pollution, that result from alcohol intoxication;
- ☞ Introduction and strengthening of alcohol sales and licensing laws which prohibit the sales of alcohol to minors and intoxicated persons;
- ☞ Adequate policing and enforcement of alcohol sales and licensing laws;
- ☞ Effective and appropriate training for the hospitality industry and servers of alcohol to reduce the harmful consequences of intoxication, harmful patterns of drinking and the risk of drinking and driving; and
- ☞ Server training programmes can be backed up by civil liability for subsequent alcohol related accidents, including drinking driving accidents to increase their effectiveness.

V. INTERVENTIONS FOR INDIVIDUALS AND FAMILIES

V.1 INTERVENTIONS FOR HAZARDOUS AND HARMFUL ALCOHOL CONSUMPTION AND ALCOHOL DEPENDENCE

1. Recognizing the heavy burden that hazardous and harmful alcohol consumption and alcohol dependence place on the health care sector, individuals, families and societies, and recognizing that brief interventions for hazardous and harmful alcohol consumption are amongst the most cost effective of all health sector interventions;
2. Effective legislative, executive, administrative and other measures necessary to promote the widespread delivery of interventions for hazardous and harmful alcohol consumption and alcohol dependence should be implemented;
3. The following principles should be taken into account:
   - ☞ Appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices to promote reductions in hazardous and harmful alcohol consumption and adequate treatment for alcohol dependence should be developed, disseminated and implemented;
   - ☞ Effective programmes aimed at promoting the reduction in hazardous and harmful alcohol consumption, in such locations as educational institutions, health care facilities and workplaces[19] should be designed and implemented;
   - ☞ The identification and management of hazardous and harmful alcohol consumption should be included in national health and education programmes, plans and strategies, with the participation of health workers, community workers and social workers as appropriate; and
   - ☞ Programmes for diagnosing, counselling, preventing and treating hazardous and harmful alcohol consumption and alcohol dependence should be established in statutory and non-statutory health care facilities, specialized centres and rehabilitation centres.

V.2 INTERVENTIONS AND ASSISTANCE FOR FAMILY MEMBERS OF PEOPLE WITH ALCOHOL DEPENDENCE

1. Recognizing that harmful alcohol consumption and alcohol dependence can harm the health, safety and development of family members;
2. Effective legislative, executive, administrative and other measures necessary to promote the widespread delivery of support and help for the family members of people with harmful alcohol consumption and alcohol dependence should be implemented;
3. The following principles should be taken into account;

   - ☞ A comprehensive community-based system which includes close cooperation between the police, social workers, the courts and judicial system, non-governmental organizations and professional diagnostic and counselling services for family members who suffer alcohol-related violence, should be developed;

[19] Special attention should be paid to the alcohol industry, whose employees are at particular risk of harmful alcohol consumption and alcohol dependence, and which was one of the first industries to implement successful workplace programmes.

- ☞ Children of parents with harmful alcohol consumption and alcohol dependence should be a high priority for psychosocial assistance and programmes to prevent social exclusion; and
- ☞ Programmes for diagnosing and counselling adult family members of people with harmful alcohol consumption and alcohol dependence should be established in health care facilities, specialized centres and rehabilitation centres to prevent and help with emotional and psychological disorders.

VI. IMPLEMENTING POLICIES

1. Each European country (and, where relevant, local community, municipality and region within a country), and the European Union as a whole, should develop, implement, periodically update and review comprehensive multisectoral alcohol policy strategies, plans and programmes;
2. When developing and implementing comprehensive multisectoral alcohol policy strategies, plans and programmes, the following principles should be taken into account:

- ☞ Country and European (and where relevant local community, municipal and regional) coordinating mechanisms or focal points for alcohol policy should be established or reinforced and financed[20];
- ☞ Effective legislative, executive, administrative and/or other measures in developing appropriate policies for preventing and reducing the harm done by alcohol, and the harm done by other people's drinking should be adopted and implemented;
- ☞ The setting and implementing of public health policies with respect to alcohol policy should be protected from commercial and other vested interests of the alcohol industry;
- ☞ Cross-border cooperation in the formulation of proposed measures, procedures and guidelines for the implementation of policies, plans and programmes to reduce the harm done by alcohol should be adopted;
- ☞ Cooperation, as appropriate, should be made with competent international and regional intergovernmental organizations and other bodies to achieve the implementation of policies, plans and programmes to reduce the harm done by alcohol, including the European Commission and the World Health Organization;
- ☞ The effective implementation of policies, plans and programmes to reduce the harm done by alcohol should be adequately financed; and
- ☞ For the purpose of effective alcohol policy, legislative action or the implementation of existing laws should be used to deal with criminal and civil liability, including compensation where appropriate.

[20] Where mechanisms, structures or organizations currently exist, these should not be replaced, but rather strengthened or redefined as appropriate.

VII. RESEARCH, SURVEILLANCE AND EXCHANGE OF INFORMATION

1. Research and research programmes, surveillance, and exchange of information at the local, regional, country and European levels in the field of alcohol policy should be developed and promoted;
2. Principles should include:

- The initiation, promotion and encouragement of transparent and independent research that addresses the determinants and consequences of alcohol consumption, the harm done by alcohol, the effectiveness of polices and programmes to reduce the harm done by alcohol, and the effectiveness of strategies and approaches to implement effective policies and programmes to reduce the harm done by alcohol;
- The promotion and strengthening of training and support for all those engaged in alcohol policy activities, including research, implementation and evaluation;
- A system for the epidemiological surveillance of alcohol consumption and related social, economic and health indicators should be established;
- Cooperation should be made with the European Commission and World Health Organization in the development of general guidelines or procedures for defining the collection, analysis and dissemination of alcohol-related surveillance data;
- Establishment of programmes for regional, country, and European surveillance of the magnitude, patterns, determinants and consequences of alcohol consumption and the harm done by alcohol. Alcohol surveillance programmes should be integrated into regional, national, and European health surveillance programmes so that data are comparable and can be analysed at the regional, country and European levels, as appropriate;
- Alcohol surveillance and exchange of information between regions and countries should be established;
- The exchange of publicly available scientific, technical, socioeconomic, commercial and legal information, as well as information regarding practices of the alcohol industry should be promoted and facilitated;
- Annual reports of the alcohol industry for shareholders should include reports on how the alcohol industry has minimized the harm from its products in terms of production, marketing and sale, and any infringements of existing laws, regulations and codes of practice;
- An updated database of laws and regulations on alcohol policy and, as appropriate, information about their enforcement, as well as pertinent jurisprudence, and cooperation in the development of programmes for regional, country and European alcohol policy should be established and maintained;
- Updated data from regional, country and European surveillance programmes should be maintained; and
- A Europe wide system to regularly collect and disseminate information on alcohol production, manufacture and the activities of the alcohol industry which have an impact on alcohol policy activities should be established and maintained.

ANNEX

WHO EUROPEAN CHARTER ON ALCOHOL

Ethical principles and goals

In furtherance of the European Alcohol Action Plan, the Paris Conference calls on all Member States to draw up comprehensive alcohol policies and implement programmes that give expression, as appropriate in their differing cultures and social, legal and economic environments, to the following ethical principles and goals, on the understanding that this document does not confer legal rights.

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.

2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.

3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.

4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.

5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

Ten strategies for alcohol action

Research and successful examples in countries demonstrate that significant health and economic benefits for the European Region may be achieved if the following ten health promotion strategies for action on alcohol are implemented to give effect to the ethical principles and goals listed above, in accordance with the differing cultures and social, legal and economic environments in each Member State.

1. Inform people of the consequences of alcohol consumption on health, family and society and of the effective measures that can be taken to prevent or minimize harm, building broad educational programmes beginning in early childhood.

2. Promote public, private and working environments protected from accidents and violence and other negative consequences of alcohol consumption.

3. Establish and enforce laws that effectively discourage drink–driving.

4. Promote health by controlling the availability, for example for young people, and influencing the price of alcoholic beverages, for instance by taxation.

5. Implement strict controls, recognizing existing limitations or bans in some countries, on direct and indirect advertising of alcoholic beverages and ensure that no form of advertising is specifically addressed to young people, for instance through the linking of alcohol to sports.

6. Ensure the accessibility of effective treatment and rehabilitation services, with trained personnel, for people with hazardous or harmful alcohol consumption and members of their families.

7. Foster awareness of ethical and legal responsibility among those involved in the marketing or serving of alcoholic beverages, ensure strict control of product safety and implement appropriate measures against illicit production and sale.

8. Enhance the capacity of society to deal with alcohol through the training of professionals in different sectors, such as health, social welfare, education and the judiciary, along with the strengthening of community development and leadership.

9. Support nongovernmental organizations and self-help movements that promote healthy lifestyles, specifically those aiming to prevent or reduce alcohol-related harm.

10. Formulate broad-based programmes in Member States, taking account of the present European Charter on Alcohol; specify clear targets for and indicators of outcome; monitor progress; and ensure periodic updating of programmes based on evaluation.