

# **EUROPEAN ALCOHOL ACTION PLAN**

**Alcohol, Drugs and Tobacco Unit,  
Lifestyles and Health Department,  
Regional Office for Europe,  
World Health Organization,  
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## SUMMARY

Europe has the highest alcohol consumption in the world. Per capita consumption in 1990 exceeded 8 litres of pure alcohol in 15 of the 26 Member States for which data are available. After a period of rapid growth in consumption between 1950 and 1980 there was a period of stabilization in the early 1980s. In the latter part of the 1980s, alcohol consumption was increasing in 10 of the 26 Member States for which data are readily available. Since 1989, a rapid increase in consumption has been seen in some central and eastern European countries.

Health and social services, transportation, the workplace, and criminal justice systems bear the brunt of alcohol-related harm. In some of the countries of Europe, the economic burden is estimated to account for 2-3% of gross national product (GNP), and alcohol can be responsible for 8-10% of deaths in the age range 16-74.

The aim of the European Alcohol Action Plan is to help Member States prevent the health risks and social consequences arising from alcohol use. To achieve this, two things are needed: a reduction in overall alcohol consumption and measures to combat high-risk behaviour.

To ensure that the Plan has a rapid impact, five areas are proposed for immediate action:

- 1) Public policies which relate to alcohol in Member States
- 2) Consensus with international agencies on joint action
- 3) Settings that promote health
- 4) Primary health care
- 5) Support systems

WHO's Regional Office for Europe will:

- i) coordinate implementation of the Plan;
- ii) develop an effective network of appropriate partners; and
- iii) provide staff resources and financial support from its regular budget.

To ensure that it has a sustained impact, the Action Plan will continue until the year 2000. Its success will depend on commitment and active participation by international organizations, Member States, and governmental and nongovernmental agencies at national and local levels.

# THE EUROPEAN ALCOHOL ACTION PLAN

## INTRODUCTION

Alcohol is of particular concern for Europe because of the high level of its production, trade and consumption, and the extent of harm associated with its use. Europe faces a trend towards political liberalization and an inability to predict the effect of political and economic changes in its central and eastern countries. Many forces could lead to increased alcohol consumption; these include urbanization and industrialization; migration and changes in family structure; increased purchasing power and reduction in the real price of alcohol; greater international travel; over-production of wine; and intensive marketing of alcoholic beverages.

Because of the severity of problems associated with its use (most if not all of which are preventable) and its dependence-producing properties, alcohol should be viewed as a special commodity. Effective measures can be taken to reduce consumption, and consequently ill health and premature death. They offer considerable benefits in economic and health terms. Objectives and targets can be set and progress towards them monitored.

For many people in Europe, drinking is a normal part of social life. It can be a source of well-being, though some prefer not to drink and others cannot do so for health reasons. A substantial minority drink to excess and this is almost always harmful. Health messages that dwell on the harm caused have less impact, however, than those that stress the positive benefits of reduced drinking. There is also a need for a safe environment free from the danger of alcohol-related accidents and domestic and public violence.

**The strong correlation between the average alcohol consumption in a country and the number of heavy drinkers suggests that the main aim of any policy should be to reduce consumption across the whole population, as well as targeting high risk behaviours.**

All 20 European countries which replied to a consultation letter from the WHO Regional Office for Europe in 1991 on future alcohol policies requested the development of an action plan; 19 asked for immediate implementation of such a plan. Nine strategic objectives have therefore been drawn up, action on which can start at once and be taken forward in two operational phases. Alcohol-related problems are not limited to Europe, of course, and action on the harm done by alcohol use is of global concern.

## TRENDS IN EUROPE

In spite of problems with comparability and accuracy of data, it is generally agreed that per capita consumption of alcohol increased rapidly throughout Europe as a whole from 1950 to 1980. There was a period of stabilization in the early 1980s. In the latter part of the 1980s, alcohol consumption was increasing in 10 of the 26 Member States for which data are readily available. A rapid increase in drinking has been seen in some central and eastern European countries since 1989.

**Europe has the highest alcohol production, export trade and consumption in the world. Annual per capita consumption in 1990 exceeded 8 litres of pure alcohol in 15 of 26 Member States for which data are readily available.**

In all countries, levels of per capita consumption are strongly correlated with the health, social and economic problems resulting from alcohol use: as consumption rises most problems increase, and when it falls they are reduced. For individuals, the risk of health problems rises with increased consumption - the so-called dose-response relationship.

Although sound estimates of alcohol-related problems for Europe as a whole are lacking, data from individual Member States indicate that alcohol:

- 1) is a cause of considerable expense through lost productivity and costs to the health, social welfare, transportation and criminal justice systems. The economic burden has been estimated at 2-3% of gross national product (GNP);
- 2) causes a substantial amount of ill health, contributes to the death rate (particularly to premature death) and places a heavy burden on health care systems. As much as 8-10% of all deaths among people aged 16-74 years of age and 6-20% of all acute hospital admissions can be related to alcohol. Significant health problems include raised blood pressure and cerebrovascular disease, cancers (including those of the female breast and the upper airways and digestive tract), cirrhosis of the liver, psychological harm and dependence;
- 3) is related to more than one in three traffic accidents and is an important factor in domestic, recreational and work-related accidents;
- 4) is implicated in many public order problems, including crime, homicide and violence;
- 5) is a major cause of family disruption, domestic violence and child abuse, and places a heavy burden on social welfare systems;
- 6) reduces productivity through absenteeism, accidents and impaired work performance; and
- 7) is associated with the use of tobacco and other drugs, and can act with them and other risk factors to increase ill health and death rates.

Evidence suggests that, in some populations, alcohol can be protective against coronary heart disease. There can be no important protective effect of drinking against coronary heart disease for men under age 35 and premenopausal women. It appears that most of the protective effect for coronary heart disease can be gained with very light drinking; for instance, by drinking one drink less often than daily.

Alcohol-related health and social problems are not only related to excessive consumption and alcohol dependence but also arise from lower levels of drinking. Because of the large numbers of such drinkers in the population, the resultant problems have the greatest health, social and economic significance for society.

## **NEED FOR ACTION**

Target 17 in the policy for health for all (HFA) in Europe states that:

**"By the year 2000, the health-damaging consumption of dependence-producing substances such as alcohol, tobacco and psychoactive drugs should have been significantly reduced in all Member States."**

The subtext continues:

**"This target can be achieved if well balanced policies and programmes in regard to the consumption and production of these substances are implemented at all levels and in different sectors to:**

**-reduce alcohol consumption by 25%, with particular attention to reducing harmful use".**

If all Member States are to achieve this target, effective action at international, national and local levels will be required. Insufficient progress over the past decade has resulted from i) a lack of recognition of and action on alcohol as a serious public health problem; ii) a lack of comprehensive, healthy public policies at all levels; and iii) a trend towards the liberalization of existing policies.

Reductions in relative prices and removal of controls on availability coexist with a softening of public attitudes towards drinking and intensive marketing of alcohol. The result has been an increase in consumption. Without positive action and widespread popular support, Member States are unlikely to achieve their target.

The Parliamentary Assembly of the Council of Europe (recommendation 1136, 1990), the Council of the European Communities (resolutions 86/C 184/02 1986; 90/C 329/01 1990) and the Nordic Council (resolution A 1014/s, 1993) have all called for policies and programmes on alcohol and cooperation with WHO.

## STRATEGY

**A significant reduction in the health-damaging consumption of alcohol can be achieved through the combination of:**

- i) a population-based approach reducing overall consumption, and**
- ii) a high risk approach targeting high risk behaviours.**

The population based approach is needed because:

- i) an overall reduction results in less problems at all levels of drinking;
- ii) heavy drinking and its problems are particularly sensitive to this approach; and
- iii) influencing perceptions of reduced levels and patterns of drinking has important long-term cultural consequences. An environment in which light drinking is the norm would exert pressure on heavy drinkers to reduce their consumption, thereby potentiating the high risk approach.

The high-risk approach is primarily concerned with identifying and helping individuals with special problems. The two strategies are complementary. Measures that benefit the population may at first offer little motivation to individuals at risk, but an environment in which light drinking is the norm should eventually put pressure on heavy drinkers to reduce their consumption.

## ACTION AREAS

Nine strategic action areas are incorporated in the Action Plan, designed both to prevent and to manage the harm associated with alcohol consumption.

### Policies in Member States

**Well balanced alcohol policies have been shown to have clear preventive value.**

Although all Member States have alcohol policies with varying degrees of emphasis on control of production, distribution and promotion, and on health education and treatment services, few are comprehensive. Liberalization is exerting pressure on many national policies, while the removal of state controls on alcohol production and distribution in parts of eastern Europe effectively removes them.

All Member States will need support to safeguard their alcohol policies, while those in which controls have been dismantled will need special assistance.

**Effective legislative measures should be embodied in a comprehensive policy, which includes a minimum drinking age, price and taxation mechanisms, and controls on availability and marketing.**

#### Consensus with intergovernmental organizations

Many of the policies of intergovernmental organizations, such as the European Community, the Council of Europe and the Nordic Council, have a significant impact on alcohol consumption. The European Community's directives on taxation, for example, could reduce the price of alcohol in some member states (Denmark, Ireland, United Kingdom) while raising it in others (Portugal, Spain). Differential prices already create significant crossborder trade, for example between Denmark and Germany, and this is likely to create pressure to reduce prices also in countries close to the European Community.

**Through the development of intergovernmental policy on alcohol, partners should be able to negotiate increased contributions to promoting health. The right of Member States to have policies that are more ambitious or stringent than the minimum should be safeguarded.**

#### Preventive practices in the alcohol and hospitality industries

The alcohol and hospitality industries are large employers and earners of national income and revenue. The European alcohol industry is also a major exporter. A small number of firms control much of the global alcohol trade. It should therefore be possible to negotiate a common approach towards policies for marketing and distributing alcoholic beverages. These industries have an interest in prevention (for example in promoting safer drinking venues and in discouraging drinking and driving), in education about the hazards of drinking and pregnancy, and in developing alcohol policies for employees.

**European and international codes of practice need to be developed for self-regulation in the marketing of alcoholic beverages, supported by restrictions on advertising.**

#### Settings that promote health

**Homes, schools, workplaces, and health care establishments offer opportunities to encourage healthy behaviour, improve social support, and strengthen attitudes that favour lighter drinking.**

Plans need to be developed and implemented through Europe-wide networks such as WHO's Healthy Cities, Healthy Promoting Companies, Health Promoting Schools and Health

Promoting Hospitals projects, as well as by focusing attention on programmes directed at family health and young people's drinking.

### Community action

Community programmes and local actions of all kinds are one important way of supporting healthier lifestyles, as well as of securing public and political support for modifying the sale and use of alcohol. In addition to the development of local policy, local action can exert a powerful influence on national and even international policy. Comprehensive community programmes have been shown to reduce heart disease and increase support for preventing harmful alcohol use.

**Every community has potential for preventive action and greater effort should be put into encouraging, strengthening and supporting local action.**

### Safer alcohol drinking

Mass media campaigns against the harm done by alcohol are important not only for their potential impact on drinkers, but also because they increase public attitudes in favour of controls on the sale and use of alcohol.

**Educational programmes and mass media campaigns are unlikely to succeed unless supported by stricter controls on marketing by the alcohol industry. Such programmes should present the advantages of reduced consumption rather than the dangers of heavy alcohol use.**

### Health care systems

Health care systems, traditionally involved in the management of alcohol problems, must play a greater role in the detection and prevention of alcohol related harm. This is particularly true of primary health care, but it should also apply to hospital care. The former is an important setting for identifying individuals at risk from heavy drinking and helping them to reduce consumption. It is also the major supporter of families and self-help groups, and acts as an advocate of public health for local communities. A high-risk strategy based on primary health care can also complement population-based initiatives.

**Intervention by primary health care can help reduce individual alcohol consumption by between 25-35% and the proportion of excessive drinkers by 45%.**

### The social welfare system



The social welfare system is often the first to come into contact with problems associated with alcohol use. It is important for both identifying and assisting individuals and families at risk from heavy drinking and acting as a leading welfare advocate for local communities.

**There is an urgent need to train workers in the social welfare system about alcohol issues and appropriate responses, and to provide intensive support for their advocacy role.**

### The criminal justice system

A considerable proportion of the workload of the criminal justice system, through cautions, arrests, sentencing, imprisonment, probation and aftercare, relates to alcohol. Extensive opportunities exist to alleviate alcohol problems through community education and the prevention of drink driving, domestic violence, public disorder, unintentional injuries and criminal damage.

**An urgent need exists for training on alcohol issues and appropriate responses in the criminal justice system, and for intensive support to that system's community education role.**

## **ROLE OF THE WHO REGIONAL OFFICE FOR EUROPE**

An essential requirement for attaining European HFA target 17 is that alcohol consumption is recognized and acted on as a serious health problem. Successful promotion of the Action Plan will depend on commitment and active participation by Member States. Enough resources and time need to be allocated to the Action Plan to give it high visibility and to demonstrate the necessary political support for international cooperation. This will lead to a sustained and uniform European movement, and will ensure the efficient use of resources through sharing of materials and experience. Successful implementation will require joint work with national and local counterparts, intergovernmental organizations and European, national and local nongovernmental groups and partners.

The Regional Office will take the lead in the international coordination of implementing the Action Plan, in line with its mandate to prevent the harm done by alcohol use. Its responsibilities will include: consulting and advising Member States on development and implementation of the Action Plan; negotiating partnerships at international, national and local levels; establishing and maintaining networks for research, consultation and development of resources in each member state; monitoring and evaluating progress; and reporting results to the Regional Committee.

The Regional Office will have four main roles:

### Advocacy and agenda-setting

WHO will actively promote and disseminate the Action Plan as a way of stimulating activity and building public health alliances at all levels. The Regional Office will aim to link new networks to the Action Plan. It will promote implementation through its collaborative networks for fostering supportive environments.

In association with professional organizations such as physicians', nurses' and pharmacists' associations, teaching institutions and groups such as the Association of Schools of Public Health in the European Region (ASPHER), the Office will take the lead in ensuring the development of core curricula, minimum standards and training activities, and the implementation of model programmes in primary health care and the social welfare and criminal justice systems.

It will seek close cooperation with the Commission of the European Communities, the Council of Europe, the Nordic Council and other appropriate organizations, to ensure that their activities can be mutually supportive and properly timed to develop a concerted response to alcohol-related harm. The Office will continue to facilitate collaboration between European countries and work actively with international and national non-governmental organizations.

### Mediation

WHO will establish a dialogue with the international alcohol industry. In cooperation with intergovernmental organizations it should foster a code of practice for self-regulation of the marketing of alcoholic beverages, supported by legislation restricting advertising by the international media. It should join forces with the latter to launch a European prevention campaign.

### Dissemination of information and policy consultancy

The Regional Office has already issued a large number of studies and reports covering epidemiological, social, policy and programme issues concerned with alcohol. An extensive body of information is also available from other sources throughout Europe. An effective strategy will be developed to ensure that this material is regularly updated and that it reaches the intended political, managerial and professional decision-makers, programme implementers and practitioners.

The Office will enhance its consultancy service on alcohol policy and will suggest a network of information centres to act as a clearing house for educational materials, manuals on community action projects, and training resources for primary health care and the social welfare and criminal justice systems.

### Promotion of research and development

The extensive range of scientific knowledge already available will be applied in developing and implementing the Action Plan, and a strategy to expand the knowledge base will be supported.

A network of research and development centres is proposed to support the Action Plan, with the aim of building centres of excellence that represent the various parts of the Region and cover the relevant knowledge and disciplines. The network would support a strategy to improve data collection and analysis and to strengthen research and development.

## **TARGETS, INDICATORS AND EVALUATION**

### Targets

Target 17 set for Europe calls for a 25% reduction in alcohol consumption in all Member States between 1980 and the year 2000, with particular attention to reducing harmful use. The Office will support the development of detailed targets to reduce harm at regional, subregional, national and subnational levels. Areas for such targets would include rates of injuries, accidents and drink driving and the prevalence of selected diseases such as cirrhosis of the liver.

### Achievement indicators

One of the first priorities will be to obtain agreement on targets, indicators, and monitoring and reporting systems for local, national and international use. The existing information base will be strengthened and regularly updated. Measurability and accessibility of data will be criteria for setting targets and selecting indicators.

Annual per capita consumption in litres of pure alcohol will remain a useful indicator for measuring progress and making comparisons. Further work will be initiated on developing other relevant indicators that allow for comparability.

### Evaluation

A process and impact evaluation framework will be used to monitor implementation of the Action Plan. Progress in drawing up and carrying out individual projects will be assessed against the objectives, activities and time scales set for each project. Quantitative and qualitative indicators will be used to identify factors that contributed to or hindered attainment of objectives.

## **RESOURCES**

The active involvement of Member States, the provision of strong advocacy at international level, the commitment of expertise, time and money to country and intercountry projects, and the building of partnerships at national, regional and local levels will all be required.

The Regional Office will provide staff and finance from its regular budget, as part of the work of the newly established alcohol, tobacco and drugs unit. This will be in addition to the value of the political visibility that WHO can secure and the database and networks of expertise that it can offer. Full implementation can be undertaken only with additional resources, however. Some Member States have already offered to help, and others will be asked to do so. As more resources become available, work can be extended beyond the proposed objectives.

## **OPERATIONAL PHASES**

The Action Plan will be completed in two phases. Five outputs are proposed for phase I, running until 1995; these have been chosen in the light of the current state of alcohol policies and programmes, their effectiveness for public health, and the feasibility of early implementation. For each output, a number of activities are planned, whose implementation will depend on the availability of sufficient resources. Phase II will begin as soon as more resources become available. The first five outputs are summarized below:

### Alcohol Policies in Member States

#### **Policy development**

National alcohol policies are in a process of continuous change reflecting new understanding and perception of alcohol use and alcohol problems, a changing international environment and developments in the economic, political and social context in which alcohol policies are formulated and implemented.

The experience gained through these changes and the innovations in adapting alcohol policies into the new contexts should be evaluated and exchanged on a continuing basis. Comparative studies will be undertaken and experiences will be exchanged and evaluated. This could be done on a sub-regional basis.

A dialogue with the alcohol and hospitality industries needs to be initiated to develop international codes of practice for the self-regulation of the marketing and selling of alcohol beverages. Self-regulation would need to be complemented by restrictive legislation. The dialogue with the industries will be supported by studies on the marketing practices of the industries and the experiences of self-regulation.

#### **Alcohol and Public Policy Project**

A comprehensive report, Alcohol Control Policies in Public Health Perspective was first published in 1975. The publication had a major influence on the development of alcohol policy in Europe and other parts of the world. The Alcohol and Public Policy project, a WHO Collaborative project reassesses alcohol policy in a public health perspective nearly twenty years on. The project has had an important influence on the European Alcohol Action Plan and its findings will be published by 1995.

#### **Policy support for countries of central and eastern Europe**

The new economic, political and social development in the countries of central and eastern Europe creates the need for a review and restructuring of alcohol policies. In many countries of central and eastern Europe alcohol use and problems are increasing. A special emphasis will be given to studies and lessons from experience that helps these countries to formulate comprehensive alcohol policies. Continued support will be given to the Baltica Project, a study of social problems around the Baltic Sea.

## **European drinking and driving campaign**

A media campaign against drunken driving is proposed. The campaign could be organized in parallel by WHO, European intergovernmental organizations, European mass media organizations, European non governmental organizations, the private sector and Member States.

### Consensus with intergovernmental organizations

## **Consultations for partnership**

A series of consultations is foreseen with intergovernmental organizations, such as the Commission of the European Communities, to gain their support to the promotion of health through reduced consumption of alcohol.

## **IGO alcohol policy review**

A review of the alcohol-related policies of the main intergovernmental organizations in Europe is planned. The review could form the basis for consultations with intergovernmental organizations and inform the Member States about the opportunities of developing alcohol policies together with such organizations.

### Settings that promote health

## **Community intervention demonstration project**

Comprehensive community programmes have been demonstrated to have a positive impact on the control of cardiovascular disease in Europe. It is planned to support similar comprehensive community programmes to reduce the harm done by alcohol use, as part of a WHO collaborative project.

## **Guidelines on community and municipal action on alcohol**

The studies that have been carried out on community responses to harmful alcohol use and other published material provide the basis for developing guidelines and training materials to assist the development of community and municipal action projects.

## **Urban action on alcohol**

The Healthy Cities Project includes a series of multi-city action plans through which cities in the WHO project network cooperate in defining the issues in a key problem area and developing policies and programmes to deal with them. A multi-city action plan concerned with alcohol is being undertaken with appropriate support from WHO. Consideration will be given to joint action plans on alcohol, tobacco and drugs.

## **Healthy workplaces**

Through the Health Promoting Companies Project, attention will be paid to strengthening contact with trades unions, employers' organizations and selected companies in order to embark on a Europe-wide effort for alcohol free workplaces.

## Primary health care

### **Health workers consultation**

National associations of physicians, nurses, pharmacists and other primary health care personnel can play an important role in raising awareness of alcohol issues among these professions and promoting changes in training and provision of care. A series of consultations are planned with representatives of these associations to secure their active support. An combined approach to alcohol, tobacco and drugs is considered.

### **Training materials**

In general, medical and nursing schools give relatively low priority to alcohol, tobacco and drug issues. Securing an effective approach to detection, diagnosis and brief interventions through primary health care will require a change in professional training. Guidelines for basic and continuing education supported by training modules and materials and training courses are planned.

### **Primary health care development**

Support is needed for training and for implementing screening and intervention programmes in primary health care, as well as to facilitate and strengthen primary health care's advocacy role. Support will be achieved through involvement of professional associations.

### **Collaborative studies**

Two WHO collaborative studies will be supported: the first is an ongoing project, an International Collaborative Study of Alcoholics Anonymous as a Social Movement, which will be completed during 1993, and the second, which will commence in 1993, is a study of strategies to enhance the capacity of primary health care to respond to persons with harmful alcohol consumption.

## Support systems

### **Marketing of the Action Plan**

The European Alcohol Action Plan will require publication and active dissemination. A series of key papers on the scientific evidence which supports implementation of the action plan will be published and disseminated.

### **A European conference on alcohol**

A European conference on alcohol is proposed for early 1995 to reach agreement on the principles and strategies for preventing the harm done by alcohol use. The conference will give the Action Plan high visibility and provide impetus for its implementation. Participants would include various ministries from each Member State, intergovernmental organizations, nongovernmental organizations and other partners in the public, private and voluntary sectors. The preparation of background papers for the conference will be supported by the Alcohol and Public Policy Project.

### **Monitoring and evaluation**

Evaluation and monitoring of action on alcohol in Europe will be based on an evaluation booklet which is being produced to support the action plan.

### **Research network**

A network of research centres will be developed to feed into the Action Plan. Cooperation with the research centres will improve data collection and analysis, enable international comparative research and encourage high quality alcohol research in Member States.

### **Advocacy network**

A network of alcohol and health advocacy groups is needed to support the nongovernmental action at local, national and international levels in line with the Action Plan. WHO will help in creating this network, and will provide support by active dissemination through publications or other forms of communication.

### **Counterpart network**

A network of national counterparts for the European Alcohol Action Plan will be created to exchange experiences, plan activities, evaluate actions and provide international support for action at national and community levels.

### **Phase 2 of the Action Plan**

Phase two of the Action Plan will run from 1996 to the end of 1999. A number of phase 1 projects will continue into phase 2. In addition, phase 2 will focus on some or all of the following projects:

## Action Plans for supportive environments and community projects

### **Health Promoting Schools**

A component on alcohol, tobacco and drugs is proposed for the Health Promoting Schools Project.

### **Health Promoting Hospitals**

A project to provide opportunities for hospitals to develop health oriented objectives and structures is being developed. This project will provide opportunities to influence hospital practices and services as they concern alcohol.

### **Informal controls**

Informal controls through families and neighbours are important keys to achieving community wide changes in lifestyles. A project will be undertaken to explore how informal controls can be strengthened.

## Developing personal skills

### **A common educational message**

There is variation in the educational messages for drinking practices between Member States and the messages appear to lack a common scientific base. Development of messages appropriate for Member States is needed. An international exchange of expertise in planning campaigns, developing materials, and securing media access is needed, as well as exchange of material itself.

An educational campaign focusing on young people's drinking across Europe could be used to test practical cooperation.

### **Multinational visibility and public education programme**

The Council of Ministers of the Commission of European Communities has proposed an alcohol information initiative. A joint project to raise public awareness of alcohol issues and to promote the theme of the Alcohol Action Plan is proposed. This could include publicity and education materials for use in several countries as well as television material to be used on satellite channels.



## **Education and resource centre**

One aim of the Action Plan should be to increase the priority given by Member States to information and education appropriate to different cultures and settings. In addition, a variety of community action materials have been developed throughout the Region. These include publicity materials, self-help guides, training materials, local resource studies and bibliographies. Provision needs to be made to establish an information and education centre, through which access to various kinds of community and education materials, marketing materials and expertise can be provided.

## Reorienting health services

### **Treatment model studies**

There are at present a variety of specialized models for treatment of harmful alcohol use and dependence in various Member States. There is however no system through which expertise can be exchanged. A number of centres of excellence could be selected as focal points for development and an exchange system established to promote communication between them, with a view to monitoring the effectiveness of different models and ensuring that there is a reorientation towards the most effective and efficient treatment services.

### **Strengthening the contribution of the social welfare and criminal justice systems to preventing and managing the harm done by alcohol use**

Resources and methods of communication appropriate to the social welfare and criminal justice systems require development. WHO will seek cooperation with relevant international and national centres to initiate this activity.

## **ALCOHOL AND PUBLIC POLICY PROJECT**

This project brings together a collection of international scientists in collaboration with the World Health Organization Regional Office for Europe, with the aim of assessing the current state of the evidence of the influence of alcohol policy measures on alcohol consumption levels and patterns and on levels of alcohol related harm. The project will complete the first phase of its work in 1994. Working papers prepared for the project have informed the public health policy process in the preparation of the European Alcohol Action Plan.