Community and municipal action on alcohol
Publication Series of the European Alcohol Action Plan

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*Approaches to alcohol control policy*, by Juhani Lehto.

*The economics of alcohol policy*, by Juhani Lehto.

*Alcohol and the media*, by Marjatta Montonen.

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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this Organization, which was created in 1948, the health professions of over 180 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world of a level of health that will permit them to lead a socially and economically productive life.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region embraces some 850 million people living in an area stretching from Greenland in the north and the Mediterranean in the south to the Pacific shores of Russia. The European programme of WHO therefore concentrates both on the problems associated with industrial and post-industrial society and on those faced by the emerging democracies of central and eastern Europe and the former Soviet Union. In its strategy for attaining the goal of health for all the Regional Office is arranging its activities in three main areas: lifestyles conducive to health, a healthy environment, and appropriate services for prevention, treatment and care.

The European Region is characterized by the large number of languages spoken by its peoples, and the resulting difficulties in disseminating information to all who may need it. Applications for rights of translation of Regional Office books are therefore most welcome.
Community and municipal action on alcohol

by

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Introduction

The Member States of the WHO European Region have strongly endorsed the European Alcohol Action Plan as a positive set of guidelines for countries to follow. In particular, Member States are urged to review and, if necessary, reformulate their alcohol policies so as to ensure that they are comprehensive and broadly in line with the principles set out in the Action Plan. Countries are also asked to ensure effective implementation of such policies in order to prevent the health risks and socioeconomic problems often associated with alcohol consumption, recognizing the importance of multisectoral action and the major role of local communities.

Community programmes and local action 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.

Every community has the potential for preventive action, and greater effort should be put into encouraging, strengthening and supporting local action. Homes, schools, the workplace and health care establishments offer opportunities for encouraging healthy behaviour, improving social support and strengthening attitudes that favour lighter drinking. Action on alcohol at the local level should be incorporated into local health promotion action and, where appropriate and feasible, should be coordinated and combined with action on other dependence-producing substances, including illicit drugs and tobacco.

Following the studies that have been carried out on community responses to harmful alcohol use, the WHO Regional Office for Europe embarked on two further projects to support local action. The
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first was the implementation of a demonstration and evaluation project for a comprehensive programme to prevent the harm done by alcohol use, based in the city of Lahti, Finland. The second was through the Healthy Cities project, which includes a multi-city action plan on alcohol, by which 15 cities in the WHO project network cooperate in developing policies and programmes to deal with alcohol-related issues.

Drawing on the experience gained through WHO projects and other initiatives, this booklet has been prepared to provide support for sustained action at the community level against the harm done by alcohol use.
Community and Municipal Action

WHO has set targets for health for all (1) in the European Region. Attaining these targets is the responsibility not only of governments but also of communities and individual Europeans. Target 17 of the health for all policy is concerned, inter alia, with attaining significant reductions in the level of alcohol consumption in the population:

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 text goes on to state that the target can be achieved if well balanced policies and programmes in regard to consumption and production are implemented at all levels and in different sectors to reduce alcohol consumption by 25%, with particular attention to reducing harmful use.

The European Alcohol Action Plan (2) is a major initiative towards achieving this target. One of the strategic objectives of the plan is to initiate and strengthen community and municipal action on preventing and managing the harm done by alcohol use (3). The health for all policy in Europe recognizes the importance of enhancing the quality of life and improving environments. This strategy is reinforced by the tenets of the Ottawa Charter for Health Promotion (4), which emphasizes the importance of healthy public policies and integrated action between different sectors of community life. The WHO Healthy Cities movement (5) provides evidence of the feasibility of bringing the health for all strategy to the local level, and is one useful
model for the implementation of municipal action of this kind. The Regional Office project on community response to alcohol-related problems has been a further important influence in understanding the diverse formal and informal mechanisms that have evolved for balancing the costs and benefits of alcohol use, and exploring ways of reducing the harmful consequences.

These guidelines are essentially practical and contain approaches that can be adapted to different settings. They can serve as a template around which to build the methods and experiences that are unique to particular communities. They are designed to stimulate local interest and the creation of a detailed local action plan.

This booklet comprises chapters that address specific areas of community life where there are good prospects for developing effective alcohol policies. The emphases and priorities for action will, of course, depend on local priorities and preoccupation (6):

The compilation of a guide to local action is not easy. It requires skill and resourcefulness to see prevention possibilities which, to those who are not looking for them, might be overlooked.

**WHY ALCOHOL?**

Europe is a major producer and consumer of alcohol, and alcohol-related problems make a major impact on health, social welfare and the economy. The economic burden has been estimated at 2–3% of gross national product. Despite these costs, many communities continue to regard alcohol problems solely as a medical or even a narrowly psychiatric issue. A much broader view is essential if a community’s interest and commitment are to be grasped. Changing our understanding of alcohol-related problems is one of the key objectives of this strategy. The means of achieving this will be by ensuring that accurate information about alcohol use and its effects and locally relevant statistical information are made available to communities, so that they can count the cost of the social implications of drinking behaviour and judge the appropriate responses for themselves.
The social costs of alcohol use (2) can be set out as follows.

- Alcohol use causes considerable expense for society through lost productivity and costs to the health, social welfare, transportation and criminal justice systems.

- Alcohol use places a heavy burden on health care systems. It has been estimated that 6% of deaths among people under 75 years of age and 20% of all acute hospital admissions are related to alcohol use. Significant health problems associated with alcohol use include raised blood pressure and cerebrovascular disease, cancers (particularly of the upper airways and digestive tract), cirrhosis of the liver and harm to mental health, including dependence and other behavioural problems.

- Alcohol use is related to more than one out of every three road traffic accidents and deaths and is an important factor in domestic, recreational and work-related accidents.

- Alcohol use is implicated in a considerable proportion of public order problems, including crime, homicide and violence.

- Alcohol use is a major cause of family disruption, domestic violence and child abuse and places a heavy burden on the social welfare system.

- Alcohol use decreases labour productivity through absenteeism, accidents and reduced work performance.

- Alcohol use is associated with other substance use and acts synergistically with other risk factors to increase morbidity and mortality.

**BASIC ASSUMPTIONS**

These guidelines provide a framework for transforming the community’s potential for preventive action into an active policy. They are designed to be used at the local level in a variety of rural or urban communities with different sociopolitical structures. There are a number of assumptions underlining these guidelines.
Community and municipal action on alcohol

- It is assumed that alcohol use has benefits as well as harmful consequences, and that the community wishes to maximize the former while minimizing the latter.

- It is assumed that a certain number of individuals in each community are drinking in a hazardous or harmful way. The level of harmful use will be related to the consumption per head in the area, mediated by the prevailing patterns of drinking and the characteristics of the community.

- Local authorities have a responsibility to protect the environment and will therefore be concerned about healthy policies in their own area. The current project would link with the WHO Healthy Cities, healthy schools and healthy hospitals projects, and the countrywide integrated noncommunicable diseases intervention (CINDI) programme.

- The guidelines will apply equally to rural and urban areas, although each will have its own specific requirements. Health for all encompasses a number of principles including equity of service provision and an emphasis on health promotion, which stresses the need for community participation and multisectoral collaboration. It also gives prominence to dealing with health problems at the primary health care level.

- The context of local action is ideally located within a national plan coupled with optimum international collaboration. It would be wrong, however, to wait for national policies to evolve before instituting local action.

- It is advantageous to set targets in economic, social and health terms, for instance, and to break these down into more specific goals at the local level (see Chapter 2).

WHO SHOULD BE INVOLVED?

Developing a Plan: the Alcohol Action Group

Problems associated with the use of alcohol manifest themselves in many different spheres of community life. The very breadth of these problems shows clearly that many sectors will already be dealing with them, knowingly or otherwise. One primary objective, therefore, is to
identify those sectors of community life that are currently working with problem drinkers or experiencing social or economic costs due to alcohol problems, and to help them to collaborate in a concerted plan of action. Some communities may also wish to consider a combined approach to community action on alcohol, drugs and tobacco.

The first step in advancing the action plan will be to form an Alcohol Action Group to develop a community-wide alcohol strategy that involves gaining interest and commitment from many partners, including health, social welfare, education, the youth service, the media, the police, penal policy, licensing, commerce, recreation, tourism, voluntary agencies, employers and employee groups. The members of the Alcohol Action Group will need to coordinate with other community activities on drugs and tobacco. They will need to liaise with a wide range of other interest groups and sections of the community. One of their main tasks at first will be to raise awareness about the role alcohol plays in the community, and to build up a network of understanding between groups and individuals involved with and concerned about alcohol policy at the local level. It is better to use existing networks if possible before creating new systems of communication and to identify potential allies, not only individuals but also organizations and institutions.

In most circumstances, the Group will be given responsibility and authority for developing an alcohol action plan by local government, often with the support of national government. Political support is important, and wherever possible should be reinforced by municipal resolutions committing the local authority to enacting and evaluating the alcohol action plan. A particular department, such as health or education, may be assigned the lead role for initiating the local plan and coordinating its activities. It will also be expected to report, after a specified interval, on achievements in relation to targets.

While this is often the optimum approach, it is clear that many effective and innovative plans have their origins outside the sphere of government or official municipal departments. The effectiveness of consumer groups and voluntary organizations sometimes lies in their capacity to act independently, away from administrative constraints that may inhibit government action. It is quite possible for a lead role
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to be taken by nongovernmental sectors of the community, but they would be wise to try to forge an alliance with local government departments at an early stage.

The pervasive nature of alcohol-related problems and of alcohol use should encourage a high degree of interagency collaboration, enlisting interest from many different parts of the community (see Box 1).

| Box 1. Groups concerned in the formulation of an alcohol action plan at local level |
|---------------------------------|---------------------------------|
| Municipal and regional councils and authorities | Consumer groups |
| Health authority: specialist services, primary health care, public health, health promotion | Consumer groups |
| Police | Ethnic minority groups |
| Legal/Judicial bodies (licensing) | Occupational and environmental health organizations |
| Education (primary, secondary and tertiary) | Alcohol, beverage and hospitality industry |
| Youth services | Employers’ and trade union organizations |
| Voluntary organizations, self-help groups | Recreational and municipal amenities: leisure, recreation, tourism organizations |
| Women’s groups | Highway and traffic authorities |

Effective guidelines or formulae for action prescribed in a national plan need to be infused with local flavour and commitment. It is essential that a sense of ownership is engendered in the community. The community comprises the consumers or customers, who know the problem and can help identify solutions, which should be “their” solutions. It is often beneficial for the Alcohol Action Group to have the support of an Advisory Forum made up of a larger group of interested parties, who can debate and guide policy as it is developed. The Forum should also consider the desirability of a combined approach to alcohol, drugs and tobacco.
Advisory Forum

Intersectoral collaboration in developing a harm reduction strategy has many benefits. It should ensure that policies formed in one area do not conflict with or, worse, contradict those in another. It also generates a greater respect for each agency’s point of view, its priorities and the limits that it may be able to set on cooperation. A broadly based Forum provides a focus for debate and an acceptable environment in which critics and sectoral interests can voice their views. It also legitimizes preventive work, which is often seen as a low priority by many agencies. It is most important that the alcohol action plan is well balanced, so that one activity interlinks with and reinforces others rather than each activity being approached piecemeal. For example, the introduction of new licensing laws can be associated with public education and changes in attitudes, and may also afford a chance to review alcohol use in the high-risk occupations of the drinks and hospitality industry. In general, local community workers will best adopt a pragmatic approach, seizing opportunities when they arise.

It is important that the Action Group and the Advisory Forum have clear remits concerning their goals and activities. These could, for instance, include a requirement to develop strategies to minimize alcohol-related harm, to promote sensible drinking practices, to promote appropriate training, and to ensure that the relevant national and local data are collected and made available.

In most communities it would be necessary to establish a small “office” team, which would comprise the staff that support the Alcohol Action Group and administer the action plan. Finance for this may come from national or local sources. It is not realistic to expect significant gains in harm reduction without local investment in the process, although this may be achieved in a variety of ways.

The Action Group and the way in which it is formed can be crucial to the success of the plan. The process of forming an Alcohol Action Group is discussed in Chapter 2.
PREVENTIVE STRATEGIES – REDUCING ALCOHOL-RELATED HARM

A sense of health and wellbeing is often engendered by a rewarding interaction between the members of the community and their physical, social and political environments. Alcohol is an important part of that environment and needs to be used sensibly. Health promotion encourages this, and ensures that individuals are given understandable and correct information about alcohol so that they can make informed and, it is hoped, healthy choices about their way of life.

It is traditional to think in terms of primary prevention, which aims to stop problems arising, and secondary prevention, which is concerned with early recognition and minimization of harm. Finally, tertiary prevention is concerned with optimum rehabilitation. Although relevant to the prevention of alcohol problems, the model is decidedly medical in concept and there is in practice considerable overlap between these categories in planning at the community level. Another model is one that classifies preventive strategies according to their emphasis on the individual drinker, the social context in which drinking occurs and prevailing patterns of consumption, and finally on alcohol itself and its availability. Again, the distinctions can be misleading and overlap in practice.

The Preventive Paradox

It is known that alcohol consumption and alcohol problems exist on a continuum. Allowing for the importance of differences in patterns and contexts of consumption, it is generally true that those who drink more are more likely to develop a range of alcohol-related problems. The aim of reducing alcohol-related harm can be achieved by measures to reduce overall levels of consumption (the population-based approach) or by measures directed towards specific risky types of behaviour (the high-risk approach). A high-risk strategy that concentrates exclusively on the heaviest drinkers would not produce the most benefit to the community. Because moderate drinkers are the largest group in most circumstances, they account for the largest number of alcohol-related problems. Often these are problems related to intoxication. This preventive paradox (7) shows why a local action plan must concern itself with all the drinkers in a community, not just high-risk groups. High-risk strategies are usually more acceptable.
policies with the public because they do not impinge on the behaviour of the majority. They can certainly form part of an action plan, but are not sufficient in themselves. Different emphases may prove more acceptable in different sectors.

**A COMPREHENSIVE APPROACH**

It is most important that the local action plan concerning alcohol is broadly based and emphasizes elements that are of proven efficacy (8), such as:

- high-profile random breath testing for drink-driving offences;
- the benefits of visible policing of public order in and around places where alcohol is consumed;
- the efficacy of brief, focused intervention for individuals drinking in a hazardous way who are identified through primary health care and hospitals;
- the impact on hooliganism of the availability of alcohol at sporting occasions;
- education on alcohol use, with emphasis on pregnant women; and
- the economic benefits of effective employee assistance programmes in the workplace.

The context in which drinking occurs is very important. Alcohol use may be harmless in one situation and highly dangerous in another; an obvious example is the danger associated with drinking and driving, which becomes evident at levels of consumption that in other situations would be acceptable.

The Alcohol Action Group will have to work out a philosophy for health promotion that is aware of existing research evidence about the nature of alcohol-related problems, and is in accordance with local customs and preoccupations. Evidence based on local experience is most credible.
Collection of Background Information

It is important to obtain a clear picture of the extent and pattern of alcohol use in the community and the costs and benefits of this use. National data are useful, but often lack the quality of specificity and relevance that is so important in stimulating local interest. If feasible, it is far better to extract local data from national statistics and compare these with national evidence. Local surveys of drinking habits can be very costly and time consuming; the need for more research should not become an excuse for inaction.

The Alcohol Action Group will be responsible for collating existing information drawn from a number of different areas. The data available will vary greatly from one community to another. The process of collecting data from a number of different sources can often be a prelude to stimulating interest and collaboration and building alliances with other sectors of the community. The evidence helps agencies identify and appreciate the extent to which the subject of alcohol is already adding to their workload. Information can be used to facilitate informed choices and encourage action. The data obtained can also be used as a basis for monitoring changes and the impact of the innovations.

Thorensen & Pedersen (9) provided an excellent illustration of the use of data collected and presented to the City of Copenhagen as part of the Healthy Cities project. They provided data on consumption, treatment rates, alcohol-related mortality, drunkenness offences, and the availability of licences and extended opening hours. This was an invaluable basis for dialogue with the local community and for monitoring change.

Simple surveys about local drinking habits and attitudes can sometimes be conducted quite quickly with the help of social survey agencies (though these are often expensive) or by enlisting the help of academic departments such as schools of nursing or psychology. Postal surveys can also provide information rapidly, although compliance is often poor. Telephone surveys are relatively easy to conduct but the population that responds is often unrepresentative, particularly of poorer sections of the population, the homeless and those who are frequently out of the house.
Community and municipal action

Even if a local survey of drinking habits is neither available nor readily obtainable, it is still possible to amass information about the role of alcohol in the community. In some countries, information on the sale of alcohol and local tax revenue from alcohol is available annually. This is particularly useful for trend analysis. Household surveys and consumer surveys often contain questions on alcohol use and provide useful information.

Almost every community will have some information about harm related to alcohol. Box 2 shows some of the common indices. Some will only be available as national statistics but it is often possible to obtain mortality and morbidity data, arrest figures and data on road traffic accidents at the provincial or municipal level (see Evaluation and monitoring of action on alcohol, the first in this series of booklets).

<table>
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<th>Box 2. Some indices of harm related to alcohol use</th>
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<td><strong>Health</strong></td>
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<td>Mortality from, for example: cirrhosis, pancreatitis, violent death (accidents, suicide and homicide), cancer (lip, oral cavity, pharynx, oesophagus and larynx), alcoholism, alcohol dependence and alcoholic psychosis</td>
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<tr>
<td>Morbidity from, for example: liver damage, parasuicide, hypertension, head injury and other accidents, alcohol dependence, alcoholism and alcoholic psychosis</td>
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<tr>
<td>Health agency data based on assessing the extent of alcohol-related problems among the clients of: primary health care workers, casualty departments, general hospitals and psychiatric clinics</td>
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<td><strong>Social factors</strong></td>
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<td>Social welfare payments, invalidity pensions (the extent to which alcohol is mentioned on claims itself reflects an attitude) and homelessness</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
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<tr>
<td>Work impairment, accidents, absenteeism and sickness, and unemployment.</td>
</tr>
<tr>
<td><strong>Crime</strong></td>
</tr>
<tr>
<td>Offences related to drunkenness, road traffic, underage drinking, hooliganism, family disputes and violence, and police time devoted to dealing with alcohol-related problems</td>
</tr>
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The police, the courts, hospitals and primary health care teams often do not systematically report the role that alcohol plays in the incidents that they record. With a little extra effort they could institute simple recording systems that note the presence or absence of alcohol as a factor associated with various incidents. This kind of case recording can be a valuable source of local data, which can be used to illustrate the nature of problems as a stimulus to local media interest and debate. It can also be used as a baseline for subsequent monitoring and evaluation.

It is also important to collect information about other aspects of alcohol-related activity in the community, including:

- licensing hours, the numbers of licensed premises, exceptions to normal practice and trends in licensing;
- the prevalence and distribution of outlets for alcoholic beverages, factors influencing changes and distribution policy;
- education policy on alcohol in schools and centres of higher education, and the extent and type of alcohol education;
- the training available for professionals in detecting and treating alcohol problems, nationally and locally;
- examples of workplace policies on alcohol, including the frequency of such policies and whether they are implemented;
- the involvement of the alcohol and hospitality industry in education and prevention, notably the policies on training staff;
- how alcohol problems are portrayed in the media, the current preoccupations and debates about alcohol, and local controls on advertising; and
- attitudes towards the availability of alcohol at sports clubs and events, and the prevalence of outlets, sponsorship, etc.

The acquisition of data of this kind must not become an end in itself; it is only valuable when it serves the strategy of the action plan. It is important to concentrate on data that are already available and easy to collect before commissioning new research projects.
Finding information can often aid the process of networking and raising interest throughout the community. It can sometimes be combined with studies whereby key members of organizations are interviewed in a semi-structured way as to their views on alcohol and alcohol-related problems. These views, although not necessarily representative of the community at large, are often very helpful in understanding attitudes and preoccupations surrounding action about alcohol.

The Lahti Project

The Lahti project in Finland is part of the WHO European Alcohol Action Plan, and aims to reduce alcohol and drug problems within a small urban community. Two research workers combined the roles of researchers and evaluators and undertook the task of meeting key informants, bringing interested groups together and facilitating collaboration in the early stages of the project. As a consequence, the local government and its health, social work and education departments learned a great deal about each other’s work with alcohol-related problems, and developed a series of interlinked modules for community action.

The project was created in cooperation with interested individuals, officials and decision-makers in the community, and with alcohol researchers and educators. The activities were organized as modules, each being linked with research. Each module concentrated on its own specific field, and the different modules were coordinated through project meetings. The project was led by a team consisting of the local coordinator, the project coordinator, the module coordinators and alcohol educators. A scientific support group consisting of specialists in the field was also formed.

Cooperation between the professionals in Lahti and the researchers makes it possible to develop realistic and effective tools for prevention. The experience gained will be useful beyond the city of Lahti, in national and international work aimed at preventing health and social problems arising from alcohol use.
Orienting Municipal and Local Authorities

Orienting municipal councils towards health is a means of ensuring their policies and actions reflect a commitment to health. The council itself needs to adopt the target of reducing alcohol consumption by the year 2000. It needs to show its determination by, for instance, not providing too much alcohol as part of hospitality or providing it at a reduced price; it also needs to be responsible for ensuring that the promotion and advertising over which it has control do not encourage excessive drinking. Personnel departments should promote good employee assistance programmes and alcohol policies in the workplace. Planning and environmental health departments need to ensure that premises that sell alcohol are suitably located, and that alternative leisure pursuits are widely available. They need to ensure that high standards of accident prevention and health and safety at work are maintained in a way that recognizes the major contribution alcohol makes to health problems.

Without the active support of local authorities, a concerted action plan is unlikely to succeed. Some authorities will already understand the importance of healthy public policies, while others may need to be convinced of their merits, still seeing health as an issue narrowly confined to their health departments. The Alcohol Action Group will need to use its data and its experience to help the authorities recognize that alcohol is an important topic for the majority of their departments. The Group should familiarize itself with the procedures of local government and find ways of placing alcohol and the prevention of alcohol-related problems on the relevant agendas.

In many cases the local authority will have taken the lead in establishing the Alcohol Action Group, and will help to establish its credibility and influence. None the less, the Group should not allow itself to become ensconced within a health or social welfare department, and must stress from the outset the broad range of departments and interest groups involved.

A holistic approach to health implies that a wide range of concerns will be involved in planning an effective response. The Action Group will need the support of local authorities, but it will also have close links with community and consumer groups outside the conventions of political and professional boundaries. Health advocates
have to learn to share power with people rather than wield power over them; this means giving fewer directives and participating in negotiations. It also means that, although a structure to facilitate the process is important, the process needs more attention and the structure less. The structures that are implemented should be more collegial and less hierarchical. These structures and processes should enhance collaboration rather than competition (5).
Forming the Alcohol Action Group

It is likely that the Alcohol Action Group will either be formed in response to an external directive from a national, provincial or regional department of government, or will arise from within the local community. Whatever the origins, it is most important that the community quickly gains a sense of ownership of the local alcohol action project. A basic tenet of WHO’s health for all strategy has been that individuals and families should contribute to their own development and to the promotion of health in their communities.

Such a philosophy can seem empty rhetoric unless a determined effort is made to inform all members of the community about the issues involved, and to ensure their participation in the planning process. The ideas inherent in the alcohol action plan should spread like ripples across water, and be changed by the cross-currents of opinion and resistance that they encounter. The final shape needs to have the unique signature of the community.

THE PROCESS

The process by which the strategy develops will often prove more crucial than the structure. It is the process that attracts interested collaborators; discussion within communities elicits novel ideas and understanding. The initial development of the Action Group is crucial, because those first involved will often signal the direction it will take. The lead organization assigned the task of forming the group will want to form alliances with other relevant groups and departments,
and ensure that the Group is not too large or too distanced from the task ahead.

People with differing skills and motives are likely to be drawn into the Group. They might be arbitrarily classified as enthusiasts, influential people, officials, "experts" and researchers. In some instances an individual may encompass all or at least some of these roles. Each can make an important contribution, but one without the other may inhibit or distort an effective strategy.

**Enthusiasts**

It is unlikely that the plan would advance without a core of individuals who are deeply concerned about their community, their environment and the problems associated with alcohol. They would be a driving force, often giving exceptional time and energy to the plan. They may none the less present some difficulties, particularly if they are identified with extremist or marginal interests that may distort the broad consensus approach that will be needed in the long term; for example, some preventive campaigns have proved less effective when they have taken on a strong temperance lead or have been thought to be associated with prohibition. In other cases a major lead taken by the drinks industry can be misconstrued. Professional rivalries between health and social welfare departments, for instance, can also lead to difficulties when one sector is seen as taking too prominent a position. Over-identification with one political or religious group or other single agency can be counterproductive in a pluralistic society.

**Experts**

The Group will need individuals who have an expert knowledge of alcohol problems and the local laws concerning alcohol. These specialists will often be drawn from the health, social welfare and law enforcement fields, but educationalists, sociologists, psychologists, anthropologists and criminologists are among other professionals that can contribute specialist knowledge invaluable in advancing the plan. In some areas there will be virtually no specialists, while in others there will be several who may hold differing or even conflicting views about appropriate responses, which will need to be debated within the Action Group.
Community and municipal action on alcohol

Officials

It is very important that official representatives of the community or municipality be closely associated with the Group. It is unlikely that senior members of local government, or even their principal officers, will have time to devote to detailed planning. They should, however, be linked in some way with the planning process and give their blessing to the developments. Without this link it is quite possible for an action plan to be developed with great enthusiasm, and yet have no real impact because it lacks official sanction. Such individuals are usually very acutely aware of the political and financial implications of the issues being raised.

Influential People

In most municipalities it is often relatively easy to identify people who are well regarded and influential. It is important that some of the members of the Group have such an influence, so that they can make an impact on important sectors of the community, and can speak for the plan when it is being critically examined. Examples of such individuals will include prominent politicians, major employers, trade union leaders, academics and representatives of consumer groups and the media.

Researchers

The Group will need to have a coherent means of assessing the reliability of the information obtained, and of evaluating the impact of procedures introduced. Without an awareness of research issues, the Group is very liable to rest on insubstantial claims and evidence.

The Group should also make sure that it is representative of the many sections of the community, and well balanced in terms of gender, age, social background and ethnicity. Obviously, it would be quite unrealistic to expect the Group to cover all these requirements without becoming impossibly large. The important point is to ensure that the various interests within the community are reflected and have a voice, so that their needs are carefully considered and appropriate advice is sought. There are many ways of achieving a suitable management structure for the plan. One model would be to combine a small Alcohol Action Group of 6–10 members with a much larger
Advisory Forum representing the sectional interests considered above and listed in Box 1 on page 8.

Although there are impressive examples of projects that have been developed with minimal resources, it will rarely be possible for the plan to advance without some investment in staff. A coordinator with some secretarial support is probably a minimum requirement for most municipal areas. In villages or rural communities with much smaller populations, it may well be possible to develop the plan on a purely voluntary basis by ensuring the cooperation of key individuals. In the long term, many of the achievements of the plan will have to be gained by utilizing existing resources and redirecting their efforts or forming new alliances. The secretariat function could well be integrated into a broad framework and activities for health promotion within the community.

RELATIONSHIP TO NATIONAL PLANS

Ideally, the Action Group will function within a coordinated alcohol policy that has been agreed at the national level (10). As mentioned earlier, the absence of such a policy or plan should not deter local action, but in most circumstances close collaboration between national, provincial and local strategies will be desirable. Concentration on a national plan and on the objectives that can best be achieved at that level can divert attention from the range of prevention resources available locally. In most cases decisions such as those on taxation or legislation will be determined centrally, but there is great scope for purely local initiatives. Alcohol action groups may also serve as essential links by liaising with each other and becoming a network to inform national government about the impact of national policies, and to provide an understanding of local issues.

A WIDER FORUM

The Alcohol Action Group will ideally be small, with a full-time paid coordinator to advance the plan, collect data, organize meetings and promote the ideas that are developed. The range of tasks and the number of potential participants in the strategy can seem dauntingly
large. It is helpful to break the tasks down into spheres of action and to set priorities, identifying the groups responsible for each area.

Maintenance is an important consideration. The creators of the action plan should ensure that it does not rely solely on the charisma of one individual. Structures need to exist that will ensure its capacity to persist and to adapt to changing circumstances, such as new staff or new political priorities. One means of ensuring this continuation is for the plan to have a recognized place within municipal planning. It is important that the Alcohol Action Group and the Advisory Forum avoid operating in a vacuum, sealed off from the planning and funding process of local government and health and social work management. The plan needs to be accepted by relevant officials at an early stage and a political commitment to action and funding ensured. Another and equally important requirement is to promote a sense of ownership. The plan should not be imposed from the top – its strength should lie in its capacity to empower localities and individuals.

The Advisory Forum would contain representatives of the groups listed in Box 1. It would provide a reference point for the Alcohol Action Group, providing direction, legitimacy and a place where sometimes opposing views can be argued in confidence. It is important that the Forum avoids becoming a debating chamber for like-minded people; conflicting interests should be expressed. The Forum and the Action Group should not be seen as anti-alcohol or as promoting any one philosophy, but should strive to be well informed about alcohol and take attitudes and views that are representative of the community. Common interests can often be identified, even between groups who seem totally opposed; for instance, those with health interests and the drinks and hospitality industry have been known to cooperate on such issues as under-age drinking and server training. The Forum will often have responsibility for voicing the voluntary, statutory and commercial interests in formulating an alcohol plan, and implementing and monitoring it as it evolves.

Communities should also consider the desirability of combined action on alcohol, drugs and tobacco, as opposed to action solely on alcohol. A combined approach may not be acceptable or the preferred option in some countries or cultures, but in others it may be
appropriate to foster sharing of expertise and the efficient use of scarce resources (11).

TARGETS

The Alcohol Action Group should set targets that define the objectives of each programme, and should monitor the community’s progress towards those targets. A strategic approach to health care planning requires the identification of specific goals for improvement in the population’s health, which can be interpreted in terms of quality as well as quantity of life (health gain). To chart progress towards such goals, it is often helpful to identify intermediate objectives not only for health but for important determinants of health and the processes that lead to changes in those factors.

One disadvantage of numerical targets is that they can give a spurious priority to concepts that are measurable. If taken in isolation they can become a simplistic description of the policy. Unless the target levels are carefully chosen, they can appear unrealistic and be easily dismissed as unattainable.

The collection of background information described in Chapter 1 will provide data that can form the basis for setting targets. Specific aspects of target setting will be addressed further in subsequent chapters, but it should be possible for the Action Group to set targets in some of the following areas:

- health problems, such as injuries, illnesses and deaths due to alcohol-related problems;
- social harm, such as alcohol-related domestic violence, child abuse, homelessness and unemployment;
- criminal justice problems, such as public drunkenness, assault involving alcohol, drink-driving, road traffic accidents, licensing violations and the illicit production of alcohol; and
- problems in the workplace, including absenteeism and accidents.

Other targets would be concerned with changing community responses, such as:
the availability, quality and uptake of education about alcohol and of skills education concerning alcohol;

- the availability and activity of services aimed at health promotion and early intervention, the proportions of health care staff trained to recognize and respond to alcohol-related problems and offer health promotion services, and the equity and accessibility of services;

- evidence of an improved capacity of the social welfare services to recognize and respond effectively to alcohol-related problems;

- the proportion of workplaces with effective policies that promote healthy working environments and provide appropriate care; and

- adequate recognition of the needs of ethnic minorities and the homeless, and of the specific requirements that are unique to age and gender.

Whenever possible, local targets should be in line with those established at the national or international level.

**SETTING PRIORITIES**

It may be an advantage for the Forum to agree priorities for action and to identify subgroups that will work in these areas towards specific goals, giving them dates by which certain objectives should be achieved. The first step would be to define short-term goals to be met within 6–12 months; these would form the basis of an implementation plan or short-term programmes. The second step would be to identify clear tasks, the individuals responsible for these and target dates for completion, and the third step would be to nominate a member of the Alcohol Action Group to prepare an overview report every six months, monitoring progress towards the targets.

**BOUNDARIES**

The project will often be confronted with difficult choices about administrative and geographical boundaries. The term community, used frequently in this publication, has many different meanings, extending
from a neighbourhood of people living together in close proximity to a group or network of people sharing some common identity or geographical or administrative locality. Communities are in some senses symbolic constructions (12), their boundaries being more in the mind than on a map. Religious, ethnic or economic allegiance may characterize and define communities for many. In the context of this publication, community will mean an area bounded by a common municipal responsibility. Administrative boundaries may not fit with the inhabitants’ perception of what constitutes their community. Spheres of administrative responsibility for health, social work, the police and other agencies may not be coterminous. Some services are provided on a supra-municipal basis, others may be managed within a locality. A perfect fit will rarely occur, and it is important that the lead agency in the Alcohol Action Group consult widely on this issue and arrive at an appropriate formula. The Group’s focus should be relevant to the community concerned, while acknowledging and utilizing the impact and importance of interests from outside its immediate boundaries.

POLITICAL SUPPORT

Ensuring strong political support is an important factor in the long-term success of projects of this kind (5). It entails political leaders’ understanding and accepting the principles and functions of the project. It is crucial to keep key politicians regularly informed about the development of the alcohol action plan – they need ready access to the strategic planning process within the municipality. The project, however, needs to avoid becoming linked exclusively with the enthusiasm of a single politician; a broad approach incorporating a wide range of interests is preferable.

Projects should stress their relevance to a wide range of municipal departments, and build healthy alliances. This will be easier to achieve if background data can show the costs engendered by alcohol-related problems to the health and social services and the police, for example. Support should be given to other community initiatives that are in accord with the concerns of the project, such as drink-driving campaigns.
THE DRINKING CULTURE

Alcohol consumption per head and the style of drinking in a community will influence the character and prevalence of hazardous drinking and the way in which alcohol-related problems are construed. Alcohol consumption varies greatly throughout Europe. The character of the alcoholic beverage industry also varies from peasant farmers who produce wine for consumption by their own families and neighbours to enormous multinational corporations with diverse interests. This will influence the role and significance of the industry in local action. People's perception of locally produced beverages often differs from that of imported drinks. Wine, for instance, has often been viewed as an essential component of the diet in wine-producing areas.

Cultural attitudes towards alcohol use may be closely linked with the history, religious influences and traditions of a locality. These factors often coalesce to form the informal controls that are so powerful in promoting and constraining drinking habits, such as never drinking except with food, always buying one's round, not mixing drinks, never drinking alone and women never drinking alone in bars. Custom may dictate the beverages that are deemed acceptable to, for example, a certain age or gender. The family is often crucial in transmitting drinking habits and attitudes; it is also the environment in which much learning about drinking occurs. There is also evidence that the way in which families respond to deviant or problem drinking is of critical significance. It will be a measure of the action plan's success to see how far it engages families in its strategy.

The alcohol action plan needs to be sensitive to the habits, customs, values and resources of the community, and build on their strengths. Within most municipalities there will be a range of drinking cultures and attitudes, often grounded in traditional social roles defined by, for instance, gender, age, occupation, socioeconomic status, religion or ethnicity. Drinking mores differ with social class (13). In some areas the roles will seem fixed, while in others they may be experiencing rapid change. The recent transformation in the style and visibility of women's drinking in many countries is a particularly striking example (14).

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Forming the alcohol action group

The consequences of migration and the needs of ethnic minorities are further examples of the importance of plans being formed that are responsive to change. The needs of minority groups are commonly overlooked, or programmes developed for them on the basis of hearsay and unproven assumptions rather than evidence. Some alcohol action groups have surveyed attitudes and drinking patterns among minority groups.

For example, a project in the Greek and Turkish Cypriot community in London identified special needs in this group, the majority of whose members did not utilize existing services. The level of reported alcohol consumption was generally higher than in the overall population. Drinking was often done at home or within the group, and those with problems and families that experienced the harmful consequences knew little about the help that might be available.

The investigator recommended education on the “myths and beliefs” about what constituted “healthy” patterns of consumption (15). She concluded that representatives of the community should be invited to participate and share in the management, planning and policy committees, and to take responsibility for shaping their character. An effort should be made to obtain the full consultation of ordinary members of the community, not only employees of the relevant authorities. The community should be involved at all levels in using programmes, services and resources, and in monitoring and evaluating them.

The Alcohol Action Group needs to gain an understanding of the way in which the community is organized, and how decisions are made about issues of common concern. These differ between rural and urban areas, between voluntary and statutory organizations and between different political frameworks. In proposing strategies, it is usually best to negotiate rather than dictate; the aim should be for small successes and the encouragement of community participation at each stage. Plans are often most readily accepted if they are based on structures that are already familiar (16).

The economy of a community and its resources will influence the character of the action plan. In some areas there will be elaborate data sets describing alcohol use and traditions of alcohol research; in
others the information available will be largely anecdotal and the resources minimal. Economic and political forces will often dictate the priorities that the Alcohol Action Group can realistically pursue. In parts of eastern Europe, the change from centralized control of alcohol production to an economic philosophy based on free trade and an entrepreneurial style has left a vacuum in alcohol control policy that may present problems in some communities. This may be particularly true where there is an understandable resistance towards any policies that appear to support the imposition of centralized control (17).

The Alcohol Action Group will need to think about the optimum sequencing of its plans. There are a number of different issues; if we think of these as seats on a roundabout, it is possible to start on any and then move around. Choice of seat will be dictated by ease of access, salience, feasibility, likelihood of success and cost. The momentum with which the plan is driven is all-important. The Group can gradually take up each issue, and the Advisory Forum will guide its choices tempered by feedback from the community. There should be a short-term plan and a long-term strategy. Issues that often confound plans include insufficient funding, too short a time scale, overambitious goals, conflicting expectations and failure to pay sufficient attention to genuine empowerment of the community.
The Role of Primary Health Care

Individuals are becoming more conscious of their right to good health and their responsibility for maintaining it. As a result, they have come to expect advice and information about healthy lifestyles from primary health care workers, who often need to be trained to provide appropriate help in health promotion. Information about hazardous drinking practices and advice on changing one's drinking habits should become an integral part of health care (see Alcohol and primary health care, the sixth in this series of booklets).

In the United Kingdom (with a consumption per head of 9 litres of pure alcohol in 1991) it has been estimated that, in a general practice serving 2000 people, approximately 55 would be drinking at levels that bring a high risk of harm and over 200 would be at intermediate risk. Between 9% and 11% of men and 3% to 5% of women registered at medical practices have been shown to be problem drinkers (18). Individuals with the highest alcohol consumption attend primary health care services more frequently than other patients. In one study the consultation rate for problem drinkers was as much as twice that of matched controls. Problem drinkers had four times the social and interpersonal problems of controls (19). There is no doubt that these patients attend because they are concerned about their health, although they may not spontaneously mention their drinking. A sensitive but targeted enquiry will not add significantly to the workload or indeed to the time involved in the consultation, and may prevent further attendances.
There is good evidence that regular enquiries about drinking habits, coupled with straightforward advice to those who are found to be drinking in a hazardous way, is often extremely effective (20–22). Primary health care staff often do not address the question of alcohol use, either because they believe they lack the necessary knowledge or skills required to intervene or because they feel very pessimistic about helping such individuals. Some are also embarrassed to ask about such a sensitive topic. There is evidence that this reluctance is misplaced, as in many countries patients expect their doctor or nurse to ask them about matters related to healthy lifestyles (23).

The primary health care clinic is particularly well placed for detecting alcohol-related problems because most people in the community attend such a clinic at least once in the course of three years; it is accessible, familiar and non-stigmatizing. Health professionals are usually well regarded and their advice is accepted. Once a successful approach is identified, it can be adopted easily and economically throughout the community primary health care network. It is also a good locus for opportunistic case identification and screening or for organizing a more systematic screening procedure.

An international clinical trial organized by WHO (21) involved not severely dependent heavy drinkers from a range of primary care settings in different countries. Eight centres, with a total of 1490 patients, randomly assigned heavy drinkers either to a control group who were assessed only, to a group where this assessment was followed by brief advice or to a third group who were in addition given a fifteen-minute session of counselling and a self-help booklet. At follow-up 6–9 months later, men in the intervention group had reduced their consumption 25% more than those in the assessment-only group. For women, reductions in consumption were observed in all three groups, but the advantage in reduction for the intervention group was 10%. No further advantage was obtained by the addition of extended counselling. These findings are encouraging because they show that brief interventions can have a worthwhile impact in many different settings.

For those sceptical about the prevalence of alcohol-related problems in their case loads, an additional strategy would be to invite a small number of primary health care teams to conduct simple
screening of all their clients as a demonstration project. These projects will undoubtedly reveal that alcohol problems are widespread. This needs to be followed up in light of the evidence that simple interventions at the primary health care level can improve health.

In the United Kingdom a number of practices recruited patients by the use of a simple questionnaire survey that enquired about their drinking practices. Men drinking more than 35 units a week and women drinking more than 21 units a week were allocated at random to two groups. Those in one group were interviewed by their general practitioner, and given advice and information about reducing alcohol consumption, along with a drinking diary for them to keep. The control group received no advice unless it was specifically requested.

After one year this brief intervention produced a reduction of about 20% in the number of patients, both men and women, drinking to excess. The authors noted that an intervention of this kind throughout the United Kingdom could lead to some 250,000 men and 67,500 women reducing their alcohol consumption from excessive to safer levels each year (20). Controlled studies demonstrating the value of brief intervention in non-dependent drinkers have now been conducted on over 4000 patients in medical practice (24).

ACTIVATING PRIMARY HEALTH CARE

Despite the suitability for interventions of this kind, there is considerable evidence that primary care physicians and nurses are reluctant to enquire about clients’ drinking habits. As mentioned, the reasons for this resistance include reported lack of skill and knowledge, shortage of time and a fear that raising questions about drinking, which they believe embarrassing, may alienate patients. This combination of factors makes the training of primary health care workers in recognizing and responding effectively to hazardous drinking an obvious priority. They need to be encouraged to see that interventions of even the simplest kind are worth while, and reassured that support will be available for dealing with the more time-consuming and severe cases. The relationship between primary level and specialist services (if such exist) needs to be carefully worked out at an early stage.
A training scheme should be instituted to help physicians and nurses to acquire these skills. It is important that these training opportunities be presented in a way that is sensitive to the role and experience of primary health care workers. It is best if primary care physicians are part of the team responsible for developing the training programme, and an advantage to have a medical person involved in the training of other clinicians. Specialist alcohol services should also play a part in developing the training programme.

Primary health care teams need to become familiar with the range of support available in the community, including voluntary agencies, the social services and self-help groups such as Alcoholics Anonymous. It is important to recognize potential misunderstandings and note conflicts between specialists and primary health care teams. The former may feel that their skills are being devalued, or there may be profound differences in treatment philosophy. These need to be honestly addressed; most often they have their origin in a failure to recognize that the services are directed to different points on the spectrum of alcohol-related problems.

Incentives for primary care teams undertaking work of this kind can be created by means of financial or other rewards for engaging in health promotion. It is important to stress that the task is not to “hunt the alcoholic” but to develop brief intervention techniques for individuals drinking in a hazardous or harmful way, but not yet physically dependent or severely impaired by alcohol. Time needs to be devoted to making it clear that most health problems associated with alcohol arise from intoxication or regular excessive use rather than physical dependence, and that influencing the drinking habits of moderate drinkers will have a much greater public health impact than concentrating exclusively on the most severely impaired.

**COMPETENCIES**

WHO (25) has identified the following 12 competencies that primary health care physicians and teams need for the successful management of patients with potential or established alcohol problems:
The role of primary health care

1. a knowledge of the prevalence of hazardous and harmful alcohol consumption, and of related physical, psychological and social problems;
2. a knowledge and appreciation of the effects of patients’ alcohol problems on their partners and families;
3. an awareness of the patient’s attitude to alcohol;
4. the ability to identify the various physical, psychological and social indications of a drinking problem;
5. the ability to communicate accurate information on alcohol and alcohol-related problems, in an appropriate context, to patients or their relatives;
6. the ability to distinguish between low-risk, hazardous/harmful and dependent levels of alcohol consumption;
7. the ability to manage the physical consequences and complications of acute intoxication;
8. the ability to take an accurate drinking history;
9. the ability to recognize signs of alcohol-related disease;
10. the ability to interpret laboratory results accurately;
11. the ability to choose an appropriate management plan, that is, brief advice/intervention or referral to appropriate colleagues or clinics; and
12. the ability to direct and manage patient detoxication at home.

An intervention strategy usually involves identifying cases, screening for those who are to be referred elsewhere, careful assessment, intervention and follow-up (see Box 3).

SCREENING

There are a number of screening instruments available. They should be simple and sensitive (able to detect most cases) and specific: that is, there should be few false positives. They should also be reliable and brief. Ideally they should be questions that can be introduced into
Box 3. A basic strategy for early intervention

1. Detect early
   - Socially stable individuals at earlier stages of problem drinking have a better prognosis

2. Conduct a systematic assessment
   - Determine quantity and frequency of alcohol use
   - Measure degree of alcohol dependence
   - Check medical status and psychosocial functioning
   - Note alcohol on breath

3. Engage in brief intervention
   - Review assessment findings with patient and family
   - Give feedback on mental or physical effects of drinking (e.g. raised gamma glutamyl transferase, mean corpuscular volume, carbohydrate deficient transferrin)
   - Set drinking goals (abstinence or moderation)
   - Set goals in other key areas
   - Emphasize responsibility of the patient and family for working on goals
   - Refer (if needed) to other agencies/professionals

4. Provide self-help manuals if available, or write down agreed plan

5. Conduct periodic follow-up
   - Have patient keep a daily drinking diary
   - Monitor physical indicators of heavy drinking
   - Review progress on goal attainment

an ordinary clinical interview. Screening can be approached in a systematic way by interviewing every client registered with a particular practice, by interviewing all newly registered clients as part of a
The role of primary health care

routine health check, or even by advertising in the local media. In many circumstances it is easier to adopt an opportunistic approach to screening, by asking clients systematic questions at the time of their attendance. Nurses and other health professionals can take a major part in these procedures.

Quantity/Frequency Questionnaires

These typically ask about the frequency of drinking over a period of time such as a week, and the quantity consumed, from which it is possible to calculate the average weekly intake. It is helpful to calculate this using conventional units or grams of alcohol; for example, a convention in the United Kingdom recognizes one standard of unit of alcohol as being equivalent to one glass of wine, a half-pint of ordinary strength beer or a single measure of spirits. Each of these contains approximately 10 g ethanol. Although this will have to be adapted to different cultures and settings, the important point is to have a measure that the patient can readily understand and use.

Drinking diaries are another means of obtaining information about patients' drinking habits, and are often valuable in relating the quantity consumed to the events of the week. This can then be used as a basis for advice given during the intervention stage, because it identifies high-risk times and helps the patient think about other ways of dealing with these situations.

There are a number of questionnaires on the psychosocial consequences of drinking. Many of these are concerned with relatively late stages of alcohol problems, for example the CAGE instrument (26), the Michigan alcoholism screening test (27) and the Munich alcoholism screening test (28). A very useful questionnaire that has been used in the identification of harmful drinking is the AUDIT instrument (29) that has demonstrated its effectiveness in a number of European countries and a wide range of settings including primary health care (see Box 4).

Two cut-off points are suggested, depending on the purpose of the screening programme. A score of eight or more produces higher sensitivity, while a score of ten or more results in higher specificity.
Box 4. The AUDIT questionnaire

Circle the number that comes closest to the patient’s answer.

1. How often do you have a drink containing alcohol?

<table>
<thead>
<tr>
<th>(0) NEVER</th>
<th>(1) MONTHLY OR LESS</th>
<th>(2) TWO TO FOUR TIMES A MONTH</th>
<th>(3) TWO TO THREE TIMES A WEEK</th>
<th>(4) FOUR OR MORE TIMES A WEEK</th>
</tr>
</thead>
</table>

2. How many drinks containing alcohol do you have on a typical day when you are drinking? (code number of standard drinks)

<table>
<thead>
<tr>
<th>(0) 1 OR 2</th>
<th>(1) 3 OR 4</th>
<th>(2) 5 OR 6</th>
<th>(3) 7 OR 8</th>
<th>(4) 10 OR MORE</th>
</tr>
</thead>
</table>

3. How often do you have six or more drinks on one occasion?

<table>
<thead>
<tr>
<th>(0) NEVER</th>
<th>(1) LESS THAN MONTHLY</th>
<th>(2) MONTHLY</th>
<th>(3) WEEKLY</th>
<th>(4) DAILY OR ALMOST DAILY</th>
</tr>
</thead>
</table>

4. How often during the last year have you found that you were not able to stop drinking once you had started?

<table>
<thead>
<tr>
<th>(0) NEVER</th>
<th>(1) LESS THAN MONTHLY</th>
<th>(2) MONTHLY</th>
<th>(3) WEEKLY</th>
<th>(4) DAILY OR ALMOST DAILY</th>
</tr>
</thead>
</table>

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

<table>
<thead>
<tr>
<th>(0) NEVER</th>
<th>(1) LESS THAN MONTHLY</th>
<th>(2) MONTHLY</th>
<th>(3) WEEKLY</th>
<th>(4) DAILY OR ALMOST DAILY</th>
</tr>
</thead>
</table>
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) NEVER  (1) LESS THAN MONTHLY  (2) MONTHLY  (3) WEEKLY  (4) DAILY OR ALMOST DAILY

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) NEVER  (1) LESS THAN MONTHLY  (2) MONTHLY  (3) WEEKLY  (4) DAILY OR ALMOST DAILY

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) NEVER  (1) LESS THAN MONTHLY  (2) MONTHLY  (3) WEEKLY  (4) DAILY OR ALMOST DAILY

9. Have you or someone else been injured as a result of your drinking?

(0) NO  (2) YES, BUT NOT IN THE LAST YEAR  (4) YES, DURING THE LAST YEAR

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

(0) NO  (2) YES, BUT NOT IN THE LAST YEAR  (4) YES, DURING THE LAST YEAR

a In determining the response categories it has been assumed that one “drink” contains 10 g alcohol. In countries where the alcohol content of a standard drink differs by more than 25% from 10 g, the response category should be modified accordingly.

Record sum of individual item scores here _________.

Source: Babor et al. (29)
In general, high scores on the first three items in the absence of elevated scores on the remaining items suggest *hazardous* alcohol use. Elevated scores on items 4 through 6 imply the presence or emergence of *alcohol dependence*. High scores on the remaining items suggest *harmful* alcohol use.

Simply asking how much someone drinks usually produces vague responses. It is better to ask specifically, “On average how many days a week do you have a drink?” and “How many drinks do you usually have on these occasions?”. This provides a straightforward answer that can be calculated in terms of units or grams consumed per week. There are, of course, other clues that can alert primary health care staff to the presence of alcohol. Le Go (30) developed a screening instrument based on a number of clues, such as facial appearance and tremor.

The following are useful clinical clues to the possibility of hazardous drinking:

- obesity
- recurrent injuries or accidents
- gastrointestinal complaints
- marital or family stress
- history of absenteeism
- drink-driving offence
- history of anxiety or depression
- high-risk occupation
- a strong family history of drinking problems
- poor sleep
- “tired all the time” syndrome
- raised blood pressure
- radiological evidence of old fractures.
Laboratory Tests

Breath analysis for alcohol can be helpful, as can biochemical markers such as serum gamma glutamyl-transferase (GGT) and mean corpuscular volume (MCV). GGT is reported to be raised in 60–70% of dependent problem drinkers. False positive findings occur with non-alcoholic liver disease and various forms of other drug use. It should also be noted that GGT usually returns to normal within two weeks of stopping drinking. MCV is reported to be raised in 50% of problem drinkers. There are obviously some merits in combining the two investigations; one or both is raised in about 70% of cases. Carbohydrate deficient transferrin is a newer but useful biological marker (31). These markers are also very valuable means of monitoring progress (32).

INTERVENTION

Minimum intervention strategies involve giving straightforward advice to those assessed as drinking in a hazardous or harmful way. Information about sensible drinking levels coupled with individually tailored advice about changing drinking habits, plus a booklet containing self-help information, forms the basic intervention. The form of the booklet and advice needs to be developed locally (21). It is usually helpful to have the patient return in 2–3 weeks to monitor progress and repeat biochemical investigations. Involving the patient’s spouse or close friend or relative in the process facilitates change.

Bien et al. (22) dubbed the process FRAMES:

- feedback to the patient about risk;
- emphasize personal responsibility for change;
- advice;
- a menu of alternative options for change with an approach that is
- emphatic
- and enhances self-efficacy.
INTRODUCING THE SYSTEM AT MUNICIPAL LEVEL

The Alcohol Action Group should identify interested collaborators in primary health care who would introduce the idea and encourage colleagues to join in. The nature and organization of primary health care vary considerably throughout Europe. In some countries individuals are registered with a specific general practitioner; in others the client decides whether to attend a generalist or specialist working from a private office. Elsewhere there are polyclinics where a range of specialists and primary health care clinicians, nurses and allied professionals work side by side. The optimum strategy will depend on knowledge of local arrangements. In essence, the task is to ensure that advice and health promotion are brought as close to the client as possible at a place where there is ready and easy access.

The key staff, including administrative and clerical staff having been identified, the goals and merits of this approach should be clearly stated. The characteristics of those suitable for simple intervention should be outlined, and a system should be set up for dealing with those who are too mentally or physically ill to utilize this type of intervention.

Changing Perceptions

Accessing the primary health care system of the community will necessitate involving key medical and nursing professionals. In most circumstances at least one member of the health department will be involved in the Action Group. There may well be resistance to adding to the workload of the primary health care services, strengthened by a belief that alcohol problems are the concern of specialists alone. The first task for the Action Group will then be to change perceptions about the nature of alcohol problems. This may be achieved by holding seminars about the current views concerning alcohol problems. It will be essential to involve key professionals in this, drawing particularly from primary health care teams themselves. It may well be an advantage to link these programmes with other health issues concerning lifestyle, such as smoking and diet.

The availability of local data will greatly facilitate this process. For example, locally derived national consumption data, showing the prevalence of hazardous drinking, should be included. This could be
coupled with evidence of the morbidity and mortality associated with alcohol problems and thus the merits of prevention. Local surveys on the prevalence of excessive drinking will be very helpful, and could be relatively easily conducted by staff routinely noting the presence of alcohol as a factor in attendances at the clinic.

Having established interest among health professionals, a systematic approach to education, support, screening and early intervention techniques can be introduced (33,34). There is evidence that general practitioners, nurses, psychologists and social workers can be trained to conduct these screening procedures, and to offer simple interventions with considerable benefit (21). Training sessions should initially be introduced with interested practitioners. At a later date it should be possible for seminars on these procedures to gain a regular place in the postgraduate training of nurses and general practitioners, and to ensure that these topics are given due prominence in undergraduate schools in the area.

In some areas it has proved beneficial to employ facilitators to work in primary health care, to demonstrate the potential of early intervention approaches and to stimulate interest throughout a group of primary health care teams.

The St Petersburg Project

An initiative in St Petersburg in 1994 aimed to support primary care workers in “helping people change”. This started from the assumption that, in order to promote good health and prevent ill health, primary care workers are increasingly encouraging their patients to change their behaviour, often focusing on changes in eating, drinking, smoking and physical activity.

A course was organized with the aim of enabling health professionals to:

- explain the concept of risk management in health promotion;
- explain the process of change and the types of intervention that are appropriate at each stage; and
• apply these principles to make brief health promotion interventions regarding smoking, drinking, eating and physical activity as appropriate.

The course recognized that changing people’s habits is never easy, and that it is important to recognize an individual’s state of readiness to change. It covered topics such as the difficulty of raising the issue of alcohol consumption, the purposes of a health check, techniques for helping patients think about means of making changes, influences that will promote or discourage change, and an action plan. A good action plan was perceived to be one that is specific, measurable, agreed to by all those involved, realistic and time limited.

The St Petersburg initiative was clearly very acceptable to primary-level workers, who were then able to pass on their newly acquired skills to colleagues. As far as promoting safer drinking is concerned, the trainers’ aims were to help the participants link their knowledge about alcohol with their intervention skills.

Data Sources

Data at the primary health care level can take the form of survey information showing the prevalence of drinking in different parts of the community. The contribution to health-related events, such as accidents, admissions to general hospital and attendance at primary health care clinics, can also be assessed. Activity measures can also be employed, for instance, by auditing the number of cases identified and counselled in each practice, or monitoring identified hazardous drinkers by noting changes in reported drinking habits and biochemical markers.

Targets

These data can be used as a basis for target setting. Targets would include agreeing and setting objectives for:

• the number of patients screened and counselled per month;
• the uptake of training opportunities; and
• reported changes in drinking patterns, biochemical markers reported and physical health.
In the longer term it may be possible to monitor changes in other health indicators in relation to specific practices.

**Evaluation**

Evaluation could be based on the extent to which the above-mentioned targets have been achieved. It could also rest on the number of primary health care teams that have attended courses to learn about simple intervention techniques, the uptake of self-help materials via primary health care teams and the percentage of clients assessed and counselled. The health targets for primary health care would, of course, also be linked to more general targets.

**Broadening the Response**

The life of an individual who is drinking in a hazardous way is often full of crises and incidents related to drinking, that bring him or her to the attention of a variety of agencies. While primary health care is one of the key points of contact and intervention, others are significant and relevant, including the social services, the probation service, counselling services, the clergy, lawyers, the police, the courts and employers. Alcohol problems and hazardous drinking are also commonplace among patients in accident and emergency departments and in surgical, medical and psychiatric clinics. The model of screening and early intervention described for primary health care can therefore be extended more widely, although there are relatively few examples available from outside the health sphere.

The feasibility of brief intervention with problem drinkers was demonstrated in a general hospital in Edinburgh (35). The presence of an alcohol problem was established by a trained nurse using a structured interview lasting 10 minutes and covering drinking habits, recent and previous medical history and social background. Results of blood tests (MCV and GGT) were recorded in each case. If a patient was found to have an unexpectedly high level in these tests and yet denied alcohol problems, the patient was interviewed again. The criterion for inclusion in the study was that the patient should show some evidence of an alcohol-related problem or hazardous drinking and should not have received prior treatment for an alcohol problem. Those thus identified were randomly assigned to a control group who were simply followed up one year later, or to an intervention group
who were given counselling from a nurse in the presence, if possible, of the patient's spouse. The patient was also given a booklet concerning advice about reducing drinking and abstaining.

A year later both groups were interviewed by a nurse who did not know to which group the patient had been originally allocated. Blood samples were taken and a relative interviewed. The sample comprised 156 men, and follow-up interviews were obtained in 85% of them. Definite improvement was found in a significantly larger proportion (52%) of the counselled patients than of the controls. There was also a significant improvement in GGT levels.

A number of projects have demonstrated the feasibility of helping individuals in hospital settings. Similar approaches could be adopted in nonmedical settings and some are described in the WHO AUDIT project, where educational and community settings were utilized in certain cases (21). Bien et al. (22) have described successful interventions in a variety of nonmedical settings.

SPECIALIST SERVICES

In most parts of Europe there will be some services that are specifically designed for people with alcohol-related problems, often those of the most severe kind. These may be psychiatric inpatient or outpatient clinics, clinics in general hospitals run by physicians, community-based outpatient counselling services, or residential units designed specifically to treat individuals with alcohol problems. In many areas there has been a shift away from intensive inpatient treatment towards a growth in the number of outpatient and community-based services. Although services have focused predominantly on those with established alcohol-related problems and alcohol dependence, there is an increasing interest in facilitating early intervention, often by primary-level agencies of the kind described above.

It is clear that the numbers involved in hazardous drinking are far too large to be the concern of any small group of specialists, and any approach that aims to reduce the numbers at risk is likely to involve education, social change and collaboration among a wide range of
The role of primary health care

health professionals. The expansion of outreach or community services in many countries has resulted in reappraisal of the priorities for specialist services. Many specialist agencies are trying to maintain the intensive inpatient programme, while adding further community work to their activities. In the absence of additional resources, this will result in increasing tension and pressure among clinic staff. There are a variety of ways in which specialist services can facilitate community work, either by providing direct services of the kind described by Chick et al. (35) above, by the provision of detoxification at home (36) or by means of a consultation process through a community alcohol team.

Community alcohol teams have been developed in the United Kingdom and normally consist of nurse, psychologist, psychiatrist, counsellor and social worker (many part-time) all of whom have special training and interest in alcohol-related problems. They may be based at a specialist unit but conduct most of their work in the community, liaising with primary-level agencies providing training and support and often offering to arrange specialist care for those cases that present particular difficulties for the primary-level workers. The target group for their work commonly includes general practitioners, health visitors, community nurses, social workers and probation officers.

Specialist workers, who at first may feel threatened by the move towards an emphasis on primary-level and community intervention, need help in training for a new kind of consultative specialist activity that will include developing instruments and materials for use by primary level staff. This transition needs to be carefully approached in a way that is sensitive to their experience, and provides them with sufficient support and training to adopt a new way of working and to play an active part in developing the treatment and prevention network.

It is likely that many specialists will be very actively involved with the Alcohol Action Group. It is essential to recognize the need to maintain a level of specialist training and interest that can support a wider range of community activities, promote generalist training, and facilitate the early recognition of alcohol problems at the primary
level and the broader involvement of community agencies in responding to alcohol problems.

There has been some concern that the promotion of primary-level intervention might lead to a recession in funding for specialist services. This is unfortunate because, without the advocacy and leadership of those with specialist skills in managing alcohol problems, an essential component of the community's network of treatment and training will be lost. It is also important to acknowledge the crucial significance of voluntary and self-help groups with specialist interests. Self-help groups such as Alcoholics Anonymous provide a fellowship for recovering alcoholics, but they also represent a resource of experience and commitment that makes an inestimable contribution to training and service development.
Alcohol and the Life Cycle

CHILDHOOD

During childhood, an individual passes through one of the most active learning phases of his or her life. Ideas about alcohol and knowledge about its effects, its benefits and the problems it causes form at a very early age (37). The family is the most powerful means by which experience is transmitted from one generation to another. It is hardly surprising, therefore, that parental attitudes and beliefs about alcohol and particularly their personal drinking behaviour have a profound effect. Most children are first introduced to alcohol by their parents, some at an early age, others not until the late teens. Differences in drinking habits and expectations are also transmitted throughout childhood. Religious, social, cultural and community traditions and many of the informal controls that grow up around drinking are passed on in this way. A focus on the family should therefore be a priority for education. The family is often the setting where harmful and excessive drinking habits are first identified and dealt with. Education directed towards the family should help equip its members with the knowledge and skills needed to transmit information about sensible drinking and dealing with alcohol-related problems.

adolescence

During adolescence, children become more independent of family expectations and are often more strongly influenced by their friends and by the role models of idealized young people, pop stars or sporting personalities. Advertising and the image conveyed by alcohol in
the media will also have a significant impact at this time, as indeed they have on people of every age.

It is during adolescence that choices of beverage are made, and that young people begin to define their relationship to alcohol and its personal significance. In many parts of Europe there are now considerable differences in the drinking styles of young people compared with their parents. This seems more evident in urban than in settled rural communities. Habits and styles are changing rapidly, particularly in city centres where teenage drinking occurs far from parental observation and influence. Very often young people who drink heavily are also engaged in other forms of drug use, smoking and other risky behaviour (38).

ADULTHOOD

In many countries, consumption declines as the adult takes on family responsibilities. For many individuals, economic factors also influence the decline in consumption as a new household is established. Parents assume the responsibility of educating the next generation in their drinking habits, an education that is often most powerfully influenced by personal example. The range of factors that influence choice in relation to drinking are shown in Box 5.

<table>
<thead>
<tr>
<th>Box 5. Factors that influence drinking choices</th>
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<tbody>
<tr>
<td>Culture</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Family tradition</td>
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<td>Socioeconomic status</td>
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<td>Age</td>
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<tr>
<td>Civil status</td>
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<tr>
<td>Parental attitudes and behaviour</td>
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<tr>
<td>Genetic factors</td>
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<tr>
<td>Education</td>
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<tr>
<td>Advertising</td>
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<tr>
<td>Influence of friends and companions</td>
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<tr>
<td>Availability of alcohol (including formal controls)</td>
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<tr>
<td>Price of alcohol</td>
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<tr>
<td>Occupation</td>
</tr>
<tr>
<td>Income available for drinking</td>
</tr>
<tr>
<td>Health</td>
</tr>
<tr>
<td>Attitude of spouse and children</td>
</tr>
<tr>
<td>Personality</td>
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</table>
Pregnancy is a time when a woman often becomes very aware of health issues, and particularly the wellbeing of her unborn child. Fathers, too, will often become more conscious of their responsibilities for the future welfare of the family. It is often at such times of transition and uncertainty that education has a powerful impact. Women have proved particularly responsive to health promotion about the hazards to the fetus of smoking and excessive drinking, and advice about this should be part of the activities of every antenatal clinic. Ideally, information about alcohol and pregnancy should be included in the education of young people and be part of pregnancy counselling, whether this is conveyed formally or informally. The effects of large amounts of alcohol on male potency and fertility should also form part of education.

The role and status of older people vary considerably around Europe. Unemployment and retirement are often associated with reduced status in the community. Economic hardship, bereavement and other events add to the stresses of later life, particularly where a supportive household or neighbourhood has disappeared. In these circumstances, alcohol can become a consolation for some individuals. Older people need to be aware of the increased risk of impaired health and accidents as a consequence of drinking. In general, old age is associated with a reduction in consumption, but communities need to recognize and help the minority who continue with or start hazardous drinking at this stage in their lives.

EDUCATION

We must not think of education as occurring only in childhood. There are opportunities and needs for education throughout life. The individual often requires particular information and education at different stages in development. Education is much more effective if given at the “teachable moment” when the information that is genuinely needed is received most willingly. New learning occurs most powerfully at times of crisis.

Examples include transitional periods, such as adolescence or parenthood, and crises such as illness, accidents, marital breakdown, legal problems, job loss or bereavement. A crisis is an opportunity for
change, often requiring new learning and greater self-awareness. As a consequence, those whose work involves encountering others at times of crisis are particularly well situated to proffer information and advice about alcohol use. This is especially true when hazardous drinking has contributed to the crisis, or when people are very open to receiving health promotion advice because they have become concerned about their own health or the health of others.

In schools, there has been a movement towards integrating education about alcohol into various parts of the curriculum, especially into personal and social education. This has many benefits by making children aware of the nature of alcohol and its potential impact on many aspects of their lives, for instance, from the biological, social and behavioural points of view and in its impact on relationships and judgement.

The Alcohol Action Group can ensure that school curricula are reviewed in every community to check that appropriate information about alcohol is being conveyed in a manner that has maximum impact, from primary school to further education and university. A number of studies have cast doubt on the ability of traditional forms of education to influence drinking behaviour, although they have been shown to have a short-term impact on knowledge and attitudes (39). More innovative approaches to alcohol education in recent years have employed peer-centred learning methods and social skills, and the acquisition of techniques to develop a young person’s repertoire of strategies in dealing with anticipated drinking situations. A four-country study (40) suggested that teacher-led programmes were less effective than peer-led groups, which showed an impact for up to two months after the intervention. There are limits to what can be expected of formal education; one basic aim is to ensure that young people emerge from full-time education with a background of factual knowledge and understanding about alcoholic beverages, which in most parts of Europe will play a significant part in their lives.

In most countries, the vast majority of adults will be using alcohol on a regular basis. It is unrealistic to conceal or prohibit information about this activity during the developmental years. Communities also need to respect those individuals, families, households and cultures (including ethnic minority groups) who have a tradition of
Alcohol and the life cycle

abstaining from alcohol. Alcohol education should make it clear that abstinence is a perfectly acceptable choice. Good practices in education can be documented for each country concerned, and the information shared between communities where it needs to be tuned to local custom, attitudes and experience.

Discussion about alcohol use will often form part of a curriculum that covers other forms of substance use and promotes confidence and skills in making choices for a healthy lifestyle. The consensus of reviews of different forms of alcohol education in schools favours a multidimensional approach incorporating a number of strategies. Hansen (41) reviewed all the relevant studies reported between 1980 and 1990 and found that the majority of approaches could be classified under one of 12 headings:

- **information**: targeting knowledge and beliefs;
- **decision-making**: teaching the process of rational decision-making on substance use;
- **pledge**: stating a commitment not to use substances, often in a moral context;
- **value clarification**: an exploration of personal values, and the demonstration of incompatibility of these personal values with substance use;
- **goal-setting**: developing goal-setting skills and encouraging the development of a sense of achievement;
- **stress management**: teaching coping skills such as relaxation techniques, and attempting to improve self-efficacy;
- **self-esteem**: developing the student’s sense of self-worth;
- **resistance skills training**: teaching techniques for coping with peer pressure and other influences on substance use;
- **life skills training**: developing broad areas of interpersonal and conflict resolution skills;
- **norm-setting**: providing a conservative context for the setting of norms, and correcting the inflated perceptions of the prevalence and acceptability of substance use among peers;
Community and municipal action on alcohol

- assistance: providing intervention and counselling to assist in dealing with problems of various kinds; and
- alternatives: activity programmes intended to provide exposure to a variety of activities incompatible with substance use.

**ACTION**

A comprehensive education programme requires clear and realistic goals. In general, education that arouses fear or provides information without positive guidance about appropriate or alternative behaviour is of little value. Teachers in educational institutions need to be adequately trained and prepared for the task and provided with good materials. The Alcohol Action Group will often have the task of raising awareness about the importance of alcohol education in the curriculum, and of linking national and local strategies in this area. In addition to promoting low-risk drinking habits, education should also extend to ensuring that individuals are aware of the particular hazards associated with drinking alcohol in certain contexts, such as driving, sports activities, pregnancy, and so on. It should also ensure that the formal rules governing drinking are understood, for example, the opening hours of licensed premises, conditions for purchasing alcohol and the age at which it is permitted to buy and/or consume alcohol in public. Information of this kind needs to be available to all, and where appropriate it should either be printed or be made available on cassette. Particular thought should be given to the educational needs of newcomers to a community, such as migrant workers and visitors from other countries.

Opportunities for education continue throughout young adulthood into adult life, but they become less institutionalized, more selective and opportunistic. When an Alcohol Action Group is formed, it needs to maximize the opportunities for promoting information and messages about the use of alcohol in many different ways. Examples of settings and opportunities include youth clubs, sporting events, the workplace, recreational and leisure activities, health and safety information, public education, health promotion and the media. It is important to recognize that schools and their activities can become a
focus for community education extending well beyond their traditional role with children.

In many countries, health education will be the responsibility of both national and local departments. In some there will be a background campaign to increase awareness about the use of alcohol as part of a national plan. The local Action Group might ensure that it fully utilizes this material and gives it a specific local dimension. If such plans or materials do not exist, then the local community will have to develop its own and try to coordinate the presentation and availability of health information.

National information campaigns can focus interest and debate. Alcohol action groups should be ready to add a local dimension to these campaigns and to liaise closely with national organizers and the media (42). The efficacy of comprehensive campaigns of this kind remains unproven but they certainly have the merit of placing health issues on the public agenda (43).

Community-based Health Promotion

Drama as a means of education on alcohol has been used in a number of different situations. In England, the Health Education Authority has encouraged a number of projects, such as drama-based work with young people challenging the assumptions in the media and the portrayal of alcohol in advertisements. In another project, a play showing the consequences of drink-driving was presented to young people in a community and stimulated discussion. This was also introduced into the school curriculum in one area.

Other alcohol action teams have encouraged young people to do paintings illustrating the effects of alcohol, and have then selected some for wider display and health promotion. There are many locations where health promotion material can be placed.

Educating Professionals

In most communities, education will be provided through key professionals in schools and health education departments. Certain teachers may be allocated the task of teaching about alcohol, or integrating the teaching of alcohol into a curriculum. It is important that such
teachers examine their own attitudes towards alcohol, receive good training in both the nature of alcohol and the problems it can cause, and possess skills in teaching children about social and behavioural issues of this kind. It is usually better to teach the teachers these skills rather than impose them from outside specialist speakers separated from the rest of the school’s activities and curriculum.

In addition to teachers, a wide range of other professionals need to know about alcohol and its effects. These, of course, include health and social work professionals, but also the police, prison officers, social welfare staff, counselling agencies, the legal profession, bar managers and bartenders.

These groups require training in not only recognizing the effects on their clients of excessive drinking and being able to give them appropriate help and advice but also becoming aware of the broader social issues concerned with alcohol. They need to be on the look-out for ways of minimizing the harm caused by alcohol in the environment, while acknowledging the important part it plays in the community.

The Action Group will also need to educate the existing professionals and key influential individuals in the community. Simply training the next generation is not sufficient unless the most influential members of the present generation are aware of the needs and understand the problems concerned. Part of the day-to-day activity of the Action Group should be to raise awareness and understanding among all the officials, politicians and civil servants that they encounter in developing the plan. The process of developing the plan is one of the best ways of trying to raise interest and awareness among significant sections of the community.

TARGETS

The Alcohol Action Group should ensure that its plan for education includes attainable and measurable targets. These might include:

- increasing the availability of alcohol education programmes for designated categories of schoolchildren and young people;
ensuring that these initiatives are evaluated and the findings used to improve subsequent programmes; and

monitoring the penetration and effectiveness of educational materials in various sectors of community life.

Such monitoring should address questions such as whether the materials have reached their target audience(s), whether any groups may have been overlooked and whether key professionals are sufficiently knowledgeable about the available educational materials.
Alcohol and Work

WHY HAVE A WORKPLACE POLICY?

Throughout Europe, alcohol problems at the workplace are a major factor in accidents, absenteeism and reduced productivity (44). Hangovers and intoxication at work have major consequences for quality, morale and standards. It is not only the decline in efficiency and the loss of time that contribute to the cost, but also the major investment in training that is lost when the employee leaves the company prematurely or becomes incapacitated.

Increased understanding of the contribution that alcohol makes to impaired work performance has led to the development of alcohol policies in employment. Investment in services aimed at helping the impaired employee is quickly recouped by improved productivity and profitability.

Community education programmes should make it clear that alcohol-related problems are widespread throughout the workforce. A company that admits to having an alcohol in employment programme should not feel stigmatized by any suggestion that it is employing “a lot of alcoholics” or having particular difficulties with employees who drink. It should be quite clear to everyone that the company that lacks a programme of this kind is risking the health of its employees, the safety of its workforce and the quality of its products or services.

The workplace is an important focus of community action, because most people with alcohol-related problems are in employment. There is a clear incentive to both the employer and the employee for these problems to be identified at an early stage, and there is a major
opportunity for effecting change by motivating drinkers to change their habits and retain their jobs.

CHARACTER OF WORKPLACE POLICIES

Helping the impaired employee is obviously a priority within any alcohol policy, but there are much wider implications for effective workplace policies. Employers and employees have a responsibility to review all aspects of the work environment that may promote, maintain or impair health. This includes a careful consideration of the pressures to drink engendered by stressful working conditions or undue exposure to alcohol (see Box 6).

<table>
<thead>
<tr>
<th>Box 6. Factors facilitating a high level of alcohol problems at the workplace</th>
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<tbody>
<tr>
<td>Availability</td>
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<tr>
<td>Social pressure to drink at work</td>
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<tr>
<td>Absence of alternative recreation</td>
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<tr>
<td>Freedom from supervision or social controls</td>
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_Source: Hore & Plant (45).

To be effective, workplace policies need to be well known, widely accepted and open equally to all levels of the workforce. They require openness and a positive view of help seeking to counteract the stigma that is often associated with admitting to having an alcohol problem. There should be reassurance that consultations are confidential, and that employees who participate in the programme will have their jobs protected, provided they cooperate with the treatment or counselling that is recommended.

A workplace programme should also include the creation of health-conscious management policies whereby the hazards of alcohol are separated from the working environment, for example, by ensuring that the workplace is alcohol-free and that the role of alcohol in expense account entertaining is monitored. Employers need to formulate an explicit strategy for health promotion so that employees
receive continuing education about alcohol and its hazards, particularly in their working life. There is a clear overlap between policies of this kind and good industrial relations; management and trade unions need to be equally involved in formulating these policies. This necessitates training key members of staff in the recognition of impaired performance and in utilizing a counselling service to help employees seek assistance when necessary.

Employee assistance programmes have become widespread in certain countries as a means of helping impaired employees. There are various models for providing such a service. It can, for example, be part of the occupational health programme of the employer or a separate employee assistance programme within the company; often it is more successfully detached from the company’s management structure, with an external agency providing the service. Whichever model is adopted, it is essential that confidentiality is maintained between the counsellor and the employing organization.

One of the earliest alcohol and employment policies originated in France. In 1960 a meeting concerned with health, safety and sobriety recognized the opportunities available at the workplace for developing both health promotion concerning alcohol and an early intervention strategy. In the former USSR, widespread educational and health services for workers were developed, using specially trained health staff at the workplace in liaison with special advisers in addiction (46). In many parts of Europe it is now accepted that alcohol programmes are concerned with inappropriate drinking rather than specifically with alcohol dependence. As far as the company is concerned, the focus should not be on diagnosing illness but on recognizing changes in work performance. In the past there has been a tendency to regard the acknowledgement of any form of alcohol-related problem as synonymous with alcoholism. This has commonly resulted in only very advanced and widely known cases of alcoholic employees utilizing programmes of this kind. This trend must be reversed if the full advantage of these schemes is to be gained.
GROUPS WITH SPECIAL NEEDS

There are some occupations where there is special risk because of the nature of the work or access to alcohol. These include seafaring, the armed services, the alcohol and hospitality industry, hospitals and the transportation and petrochemical industries, and they will often require specially designed programmes. Multinational organizations also have particular problems in developing appropriate policies across a wide range of different locations. Account will need to be taken of the particular stresses encountered by employees away from their home environment. Migrants, transient workers and those from ethnic minorities often find it hard to fit into conventional programmes, and their special needs must be identified within each community.

SMALL WORKSITES

The larger the number of employees at one worksite, the more likely they are to enjoy an employee assistance programme. In the United States it was shown that these existed in 52% of sites with 750 or more employees but in only 15% of those with between 50 and 99 employees (47). Those who are self-employed or work within very small organizations may need to find a corporate solution, for instance, by means of their trade union, craft guild or professional associations, or by using council-based programmes or non-profit external agencies.

Smaller companies or self-employed people will find it easier to use a centrally situated agency. It may also prove easier to combine alcohol counselling and prevention policies with other issues such as smoking, drug misuse and stress. Means need to be found to make it attractive for employers with very few staff to utilize programmes of this kind (48).

This is an issue that the Alcohol Action Group should consider and monitor. There is considerable variation among countries in the size and disposition of their industries. In many areas there are a large number of very small firms or self-employed individuals, and these latter groups find it harder to fit within the conventional framework of
employee assistance programmes. The community should develop ways of allowing such workers to utilize a centrally situated employee assistance programme that they could use in a non-stigmatizing way.

THE UNEMPLOYED

In some communities in Europe, a sizeable proportion of the workforce has no regular work. This group will not normally have access to workplace policies. In some circumstances, former employers may feel a responsibility to provide services to those who have been with the company in the past. Some companies recognize the stressful impact of redundancy and provide counselling support and advice prior to severance. Job clubs and employment agencies could be a focus for advice about alcohol use, and about the hazards of using alcohol as a means of coping with the consequences of losing a job. Assistance programmes based in trade unions may also be of help to unemployed members.

INITIATING EMPLOYEE ASSISTANCE PROGRAMMES AS PART OF AN ALCOHOL ACTION PLAN

Stimulus may be provided within the community via interested bodies such as trade councils, chambers of commerce, unions or professional organizations, employers' organizations, major employers, health and safety services and occupational health services. Local health services may give a lead by ensuring that they have policies for their workforce.

It helps if the national alcohol plan encourages these schemes by, for instance, providing financial incentives for the creation of healthy workplaces.

The essence of an alcohol policy at work is that it should be agreed between the employer and employee and should command the respect and confidence of all members of the workforce. A policy that seems to operate only for shop-floor workers and is ignored by the board room will soon lose credibility. A company that bans alcohol in
canteens but has alcohol dispensed in the manager’s office will quickly lose respect.

COMPONENTS OF THE POLICY

The policy should be based on an acknowledged agreement with all members of the company. An individual team needs to be identified within the company to take responsibility for the instigation, promotion, development, maintenance and evaluation of the project.

In some countries, such as France, successful projects use selected and trained members of the workforce at all levels as alcohol information officers. These people have a general knowledge of alcohol and drug problems, a basic understanding of psychological and social influences, and the capacity to interview and refer appropriately when needed. An example of an employee assistance programme based on one used by a major insurance company is shown in Box 7.

<table>
<thead>
<tr>
<th>Box 7. An example of a staff policy on problem drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INTRODUCTION</td>
</tr>
<tr>
<td>Most people who use alcohol do so within accepted social limits without risk to health. Those who do drink to excess may develop a dependence on alcohol that can lead to serious illness, impairment of physical and mental health, increased absence from work, decrease in work performance, strained relationships with colleagues or unsafe working practices.</td>
</tr>
<tr>
<td>This policy details the company’s position on problem drinking</td>
</tr>
<tr>
<td>2. APPLICATION</td>
</tr>
<tr>
<td>This policy and the attached procedures apply to all members of staff. This policy does not cover any acts committed while under the influence of drink. These will be dealt with under the company’s disciplinary procedure.</td>
</tr>
<tr>
<td>3. POLICY</td>
</tr>
<tr>
<td>3.1 It is the policy of the company that a staff member who has a drinking problem will be treated in the same way as someone who is suffering from any other type of illness that affects his or her ability to perform the duties for which he or she is employed.</td>
</tr>
</tbody>
</table>
3.2 Responsibilities

3.2.1 The Staff Relations Manager is responsible for the maintenance and review of this policy.

3.2.2 The Staff Relations Manager is responsible for the provision of counselling services (Employee Assistance Programme) to support staff whose drinking causes problems at work and for providing advice to line managers dealing with problem drinkers.

3.3 A staff member who consumes alcohol on company premises, other than at a properly organized and authorized event, may be liable to disciplinary action. This behaviour may, however, be symptomatic of an underlying problem.

4. PROCEDURES

4.1 Any staff member who feels that he or she has a drinking problem may discuss the situation, in confidence, with his or her manager, with a member of Staff Relations or by contacting our Employee Assistance Programme.

4.2 The staff member is put in contact with an external specialist in order that he or she may obtain professional treatment and support.

4.3 Line managers who activate the company’s formal disciplinary procedure in relation to a staff member whose performance or behaviour at work is giving cause for concern may suspend such action if problem drinking is found to be a contributory factor.

Where the actions of a staff member place himself or herself, third parties or any aspect of the company’s business at risk, managers may take limited disciplinary action, short of dismissal, in order to contain the situation. Staff Relations must be contacted for advice where problem drinking is found to be (or is suspected of being) a contributory factor.

If the staff member chooses not to obtain professional help, or subsequently fails to maintain treatment, and his or her performance or behaviour is still giving cause for concern, the full disciplinary procedure should normally be reinstated.

5. DISTRIBUTION

All holders of Staff Policies and Procedures Manual.
HEALTHY COMPANY POLICIES

Managers should be aware of the possible health implications of company policies and encourage those that promote good health. This includes an awareness of the dangers of stress in the workplace, and ensuring that policies avoid associating alcohol with work.

In particular, careful attention should be paid to the question of the availability of alcohol in canteens, board rooms, subsidized bars and any other outlets within the workplace. Guidelines for company hospitality should be clearly set out, and it is essential to ensure that non-alcoholic drinks are available on all occasions when such hospitality is being dispensed. Essentially, the message is that alcohol and work do not mix. On social occasions organized by the company, provision should be made for employees to return home without the risk of drink-driving.

Disciplinary codes concerning the use of alcohol, intoxication on coming to work, drink-driving and so forth should be clearly established.

Whatever the mechanism adopted, the key individuals in the development of the project need special training in understanding the task prior to its commencement.

EDUCATION

Education will ensure that all members of the workforce know and understand the policy and are familiar with the rules governing the use of alcohol at work and any penalties for ignoring them. There should be opportunities to educate employees about alcohol and health, with particular reference to the hazards of their occupation. This can be promoted periodically through newsletters and in-service training sessions. New recruits should receive information as part of their initiation training; this will help to ensure that levels of awareness remain high despite the turnover in staff. Particular attention should be paid to known hazards related to work, such as exposure to alcohol (for example, in the alcohol industry), stress, unsocial hours, long periods of separation from the family, the absence of supervision
Community and municipal action on alcohol

at work and access to free or subsidized alcohol. It is also essential to identify particular hazardous consequences of drinking at work, particularly when operating machinery or in the transport industry.

**IDENTIFICATION**

An essential component of any programme will be the need to establish skills in identifying employees whose work performance is impaired as a result of their drinking. The employer's task is to identify a work-related problem rather than to become skilled in identifying symptoms related to alcohol use. Once a problem has been identified, the worker can be asked to choose between proceeding through the ordinary disciplinary process or seeking help through the employee assistance programme. If the latter route is chosen, people can be referred to an appropriate counsellor and assured that their work status will be preserved, provided they make full use of the policy available.

In some countries there are employee assistance programmes that cater not only for alcohol problems but for a wide range of social, psychological, economic and interpersonal difficulties among employees. In many countries there are now combined alcohol and drug programmes.

Box 8 sets out indicators that may help key personnel, such as managers or occupational health staff, identify the possibility of an alcohol-related problem. Health screening programmes may also identify the possibility of hazardous or harmful alcohol use.

<table>
<thead>
<tr>
<th>Box 8. Factors that point to the possibility of an alcohol-related problem at work</th>
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</thead>
<tbody>
<tr>
<td><strong>Absenteeism</strong></td>
</tr>
<tr>
<td>Multiple instances of unauthorized leave</td>
</tr>
<tr>
<td>Excessive sick leave</td>
</tr>
<tr>
<td>Frequent Monday and/or Friday absences</td>
</tr>
<tr>
<td>Excessive lateness, e.g. Monday mornings, returning from lunch</td>
</tr>
<tr>
<td>leaving work early</td>
</tr>
<tr>
<td>Peculiar and increasingly improbable excuses for absences</td>
</tr>
<tr>
<td>Unusually high absenteeism rate for diarrhoea, colds, influenza, gastritis, etc.</td>
</tr>
<tr>
<td>Frequent unscheduled short-term absences, with or without explanation</td>
</tr>
</tbody>
</table>
Alcohol and work

Box 8 (contd)

High accident rate
- Frequent accidents at work
- Accidents elsewhere (at home, travelling to work)

Difficulty in concentration
- Greater effort required for work
- More time needed to complete tasks

Confusion
- Difficulty in recalling instructions, details etc.
- Increasing difficulty in handling complex assignments
- Difficulty in recalling own mistakes

Spasmodic work patterns
- Alternate periods of high and low productivity
- Increasing general unreliability and unpredictability
- Repeated absences from post, more than the job requires
- Frequent trips to cloakroom, etc.
- Overlong coffee breaks
- Under the influence of alcohol/drugs at work

Reporting to work
- Coming to work in an obviously inebriated condition
- Smelling of alcohol
- Hand tremors
- Increasingly unkempt appearance/lack of personal hygiene

Generally deteriorating job efficiency
- Missed deadlines
- Mistakes due to inattention or poor judgement
- Wasting materials, supplies, etc.
- Making bad decisions
- Improbable excuses for poor work performance
- Lowered productivity

Poor employee relations at work
- Overreaction to real or imagined criticism
- Unreasonable resentment
- Irritability
- Complaints from colleagues
- Borrowing money from colleagues
- Avoidance of boss or associates

Health screening
- Abnormal biological markers suggestive of heavy drinking
CONTINUING REHABILITATION

In many circumstances it should be possible for people to remain at work while receiving appropriate counselling. In other cases, particularly where the alcohol problem has reached an advanced stage, a period off work prior to return will be indicated. In both circumstances there is usually the need for continuing support over a considerable period of time after returning to work. The ability to function effectively on returning to work is crucial. It is wrong to believe that a set period of time in a clinic or other residential setting will on its own provide the cure.

The employer’s interest in the counselling process is simply to ensure that the worker is cooperating. Employers should not be given details of either the problem or its management; otherwise fears of confidentiality will frustrate the development of the scheme. Employers do, however, have a responsibility to ensure that the workplace facilitates and promotes a return to a sober way of life.

COMMUNITY INVOLVEMENT

A commitment to addressing alcohol in employment policies can also become a powerful force for raising community awareness about alcohol-related problems. The model of healthy environments that such companies provide can be utilized to promote wider interest in improving environments. Large companies commonly have widespread influence in the locality, and can support the community by funding or giving voluntary staff time to projects concerned with reducing alcohol problems.

Employers are a significant part of any community and increasingly understand their responsibility to promote health and wellbeing, not only in their workforce but more widely by participating in community action. When mutuality of concern can be established, the community benefits from the resources of local companies, while they in turn benefit by helping to create a more attractive and healthy environment, with benefits to recruitment and satisfaction in their employees.
Health authorities and municipal bodies should take a lead in ensuring that they have alcohol policies for their staff. Hospitals should, of course, include the prevention of hazardous drinking in any healthy hospitals policy. The drinks and hospitality industry, because of its high level of problems and commitment to minimizing harm in this area, is often prominent in promoting alcohol policies in employment.

SETTING TARGETS, MONITORING AND EVALUATION

Employers can monitor the extent to which information has been received and understood by surveying a sample of the workforce. The degree of use made of alcohol in employment or employee assistance programmes, and the extent to which referrals have come from all parts of the company, will provide a good indication of a programme's penetration and acceptability.

Declining sickness levels, improved efficiency, reduced staff turnover and improved output are external measures that may be used as a guide to the efficacy of these programmes. Where regular health screening is undertaken throughout the workplace, it may also be possible to monitor changes in biological markers in the overall workforce. A community target would be to monitor the percentage of companies that adopt a programme on alcohol in employment.
Alcohol Availability

The availability of alcohol is important because it is a major determinant of consumption per head of population (8,49). Many factors influence availability: price in relation to disposable income, commercial and home production and imports, number and accessibility of outlets, laws governing sale and purchase, economic conditions, and competition from non-alcoholic beverages and alternative leisure pursuits. The Alcohol Action Group may think it can have little impact on such factors, but local action can have a significant impact on availability (see Approaches to alcohol control policy, the second in this series of booklets).

LICENSING LAWS

Most countries have regulations on the location and type of sales outlets for alcoholic beverages. These conditions usually involve obtaining a licence from a municipal or district authority, permitting sales within defined limits.

Outlets sell alcohol for consumption either on or off the premises. In countries where there is a state monopoly, alcoholic beverages for consumption off the premises can be bought only from designated stores. In some circumstances beverages with a high alcohol content are available only from designated outlets, while those of lower strengths are more widely available.

Outlets that are licensed to sell alcohol for consumption on the premises include bars, cafés, public houses, clubs and restaurants. The licence usually allows the purchase of alcohol between certain
Alcohol availability

specific hours and by individuals over a certain age. There is a plethora of regulations of this kind, with considerable variation both between and within countries. Some countries have very few regulations, while those in other parts of Europe are numerous and complex. It is often illuminating to trace the history of these local laws, which reveal a lot about the local assumptions, interests and pressures surrounding drinking behaviour.

A primary task for the Alcohol Action Group will be to identify the regulations that exist in its own community, and to see how far they can be employed in the interests of reducing the overall level of alcohol-related harm. A wide range of people is likely to be involved in these issues, including publicans, those who own and serve in off-licences and bars, environmental health officers (concerned particularly with cleanliness and public health), law enforcement officers, various voluntary groups concerned with youth, sport and recreation, law and order and noise abatement, those representing the alcohol industry, hoteliers, tourist interests and sales promotion staff. Finally, there are consumer groups interested in the quality of beers, wines and so forth, and in the character and quality of the drinking environment.

There are numerous points at which the Alcohol Action Group can apply influence. Pressure groups and local politicians have a major role in granting licences and ensuring that public order is maintained. The police commonly play a role in providing information and in monitoring problems arising in and around licensed premises.

DENSITY OF OUTLETS

The location and density of licensed premises can have an important effect on the local availability of alcohol. In some countries the density of alcohol outlets is carefully regulated or their siting restricted, being prohibited near, for instance, schools or factories. In others it is believed the location of public houses and the like is best left to the free market. Godfrey (50) examined data on alcohol sales and availability, and showed that increased density appeared linked to higher beer consumption.
TARIFF BOUNDARIES

Cross-border trading and smuggling are significant issues in some parts of Europe where there exists a large differential in the cost and/or availability of alcohol between adjacent countries. Local alcohol action groups need to consider the implications of policies concerning tariff changes and the presence of duty-free shops in airports or on ships. Customs officers need to be conscious of the health and social implications of illegal trafficking in alcohol, which is usually given much less prominence than other drugs.

DOMESTIC PRODUCTION

Domestic production of alcohol for personal use is permitted in many countries, and this makes a significant contribution to availability. In some, distillation is prohibited but not the preparation of other alcoholic drinks. Home production may be part of a long established tradition, and a change in attitude towards alcohol can only be achieved gradually, in keeping with an appreciation of local customs and values.

CHARACTER AND OPERATION OF LICENSED PREMISES

Restaurants, public houses and other licensed premises depend on the good will of the surrounding community and are commonly attentive to local influence. The Alcohol Action Group can make licensing authorities and bar managers aware of the health and social issues involved in increasing availability. In general, it is preferable to strike a balance between extreme availability and hours that are so restrictive that they concentrate excessive drinking within a short period of time, often leading to public intoxication at closing time. This balance could become a focus for local debate.

The local public house or café is often pivotal in the life of a community, and its merits should not be overlooked by focusing exclusively on the hazards of excessive drinking.
The design of licensed premises has been shown to have an influence on the level of disorder. Research in the United Kingdom indicates that 15–20% of violence in public houses may be attributable to design factors such as discomfort, poor layout, inappropriate heating, sound and light levels, and frustration generated by insufficient serving staff. The type of music played, the presence of equipment for games such as pool and, of course, the availability of food and entertainment influence the likelihood of disorderly behaviour (51).

Many injuries in public houses in the United Kingdom occur as a consequence of glasses or bottles being thrown across the bar or used as weapons in assaults. Accident and emergency staff are concerned about the severity of injuries that occur in this way (52). It is claimed that the use of tempered or toughened glass would result in a significant reduction in these injuries, and there is an active debate about the merits of introducing this form of glass more widely. This is an example of the kind of topic that the Alcohol Action Group could raise to make the local community more aware of the issues and interests involved.

The ambience of public houses, cafés, etc. is also an important issue that may be susceptible both to local licensing and, of course, to local community pressure of a more general kind. Some communities have public houses where virtually the only activity is drinking alcohol, while those in others also offer a wide range of food, non-alcoholic beverages and entertainment. The latter, the “café pub”, is thought to be more conducive to a relaxed style of drinking.

In some countries children are not allowed into many public houses, whereas in other countries their presence is routine and unexceptional. It is argued that the presence of children creates a more balanced, family feel to the environment, and may have a beneficial effect on adults’ drinking practices. Again, this is a debatable issue and can be used as a focus for local interest.

Publicans are commonly given responsibility for maintaining a standard of behaviour on their premises, for example, by not serving people who are manifestly intoxicated or are under the minimum age at which drinking is permitted by law. Licensing authorities and the police can adopt a more vigorous campaign to ensure that such
Community and municipal action on alcohol

responsibility is exercised. Server liability is a further development, whereby publicans and other dispensers of alcoholic drinks may be culpable for serving intoxicated people who subsequently drive and cause injury. Cases of this kind further underscore the importance of training bar staff and ensuring that they understand the issues involved.

Ontario, Canada has a licensing law that gives inspectors a wide range of powers to ensure that complaints about breaches of the regulations, such as serving intoxicated patrons, discount pricing or failure to provide food, are looked into. Their interventions are not viewed as intrusion and have been welcomed by the community (53).

MINIMUM DRINKING AGE

Most countries have some minimum age at which the purchase or public consumption of alcohol is permitted. The laws are often loosely enforced, and a local community could promote more vigorous steps to ensure that the regulations are upheld. Whenever the permitted age has been reduced, for instance, in some states and provinces in North America, it has been accompanied by a rise in traffic accidents among young people (54).

ACTION AND EDUCATION

The Alcohol Action Group should ensure that the community understands the rules governing licensing and the process whereby licences are granted or rescinded. This knowledge will empower citizens to take a more active interest in the process and to know how to intervene. It will be of particular value to those concerned about the quality of the environment and alcohol-related disturbance and damage.

It is helpful to establish a local guide to the licensing laws, which can be made available to all the groups concerned and in all relevant languages. In some areas ethnic minorities may not understand local licensing regulations.
Training courses for judges, licensing magistrates, the police and licensees are beneficial. Their content and aims should be worked out locally, and the extent to which they are utilized can be monitored.

Several countries require that owners of licensed premises, bar managers and servers undergo training (55) to ensure that they have an appropriate understanding of their role, not just from a commercial viewpoint but also in the potential social and health consequences of alcohol use. Such courses could include consideration of:

- licensing law (including underage drinking)
- the effects of alcohol on judgement and behaviour
- drink-driving legislation
- server liability
- management of conflict and intoxication.

In some premises, door staff are employed to regulate entry. They often become the focus of violent disturbance, and could benefit from training in managing situations of this kind.

**MONITORING**

There is considerable uncertainty about the way in which levels of alcohol-related harm are linked to the number, character and distribution of outlets. A careful mapping of the local community and of the distribution of alcohol-related problems in relation to outlets would be one means of investigating and monitoring this link. The police are usually well situated to monitor public disorder in the proximity of licensed premises, and can also keep a record of offences such as underage and out-of-hours drinking. They can also carefully locate the time and place of public order violations and the incidence of alcohol-related accidents, all of which commonly arise in and around public houses and cafés at closing time. Simple measures of this kind will provide background data against which the impact of local changes can be assessed.
ZONING

When it becomes apparent that public intoxication and consequent civil disorder are more common in certain areas of the municipality than in others, some communities have developed drink-free zones (56). Regulations prohibit the consumption of alcohol in public in those areas. The efficacy is at present uncertain, and there are concerns that enforcement simply moves the problem to another area of the town (see Chapter 7).

Local communities where alcohol and drugs are easily available and drunkenness is tolerated provide an environment that does not support prevention. Many countries have developed outreach programmes for young people in these situations. For example, the National Directorate for the Prevention of Alcohol and Drug Problems in Norway has provided specific funding for social workers to establish contact with young people who have lost contact with and seem alienated from society. Youth clubs and independent youth workers can often play a major part in promoting initiatives of this kind.

ALTERNATIVES

In recent years there has been a resurgence of interest in making available alternative leisure pursuits that do not involve alcohol. In the United Kingdom several cities have experimented with "alcohol-free" public houses and the promotion of soft drinks or low-strength or alcohol-free beers and wines. The Alcohol Action Group could monitor the availability of these beverages and their cost relative to alcoholic drinks.

In some countries there is a close and visible link between alcohol and leisure activities in that alcohol is available at sports centres, ski resorts, dance halls, football grounds and so on. Sometimes the profit on the bar subsidizes the club. The Alcohol Action Group can explore ways of separating these activities from the drinking of alcohol, so that those who wish to participate in these leisure pursuits feel no pressure to consume alcohol.
TARGETS

The Alcohol Action Group can agree on targets with the community, such as:

- the percentage uptake of training courses by such people as licensees and members of the judiciary and the licensing authorities;
- a reduction in licence violations and drunkenness in public places;
- the optimum density and number of licensed premises and off-licences;
- the availability of alternatives to alcoholic beverages and their relative cost; and
- the number of leisure activities that are not tied to the availability of alcohol.
The Criminal Justice System

The Alcohol Action Group should ensure that penal policies and practices are pursued in the interests of reducing patterns of drinking that lead to crime, and seeing that those who offend in this way have their drinking problems recognized early and are helped to change their lifestyle.

A community's perception of alcohol-related offences will be influenced by local traditions and attitudes. Where drinking is viewed as an everyday occurrence, then its part in criminal activities may be viewed as entirely incidental. Where drinking is infrequent or regarded as deviant, then alcohol, when present, will be viewed as causal in many crimes. The influence that alcohol is believed to have on a range of social misdemeanours will, therefore, be strongly determined by the past history of that community and its attitudes. It is important to strike a realistic balance between giving undue weight to the contribution that injudicious drinking contributes to offences, and glossing over the significance of its contribution. Alcohol-related offences include the following:

- those offences where inappropriate consumption of alcohol is the essence of the misdemeanour, such as public drunkenness, drunk and disorderly behaviour, drink-driving and drinking when a zero blood level of alcohol is required, as in certain occupations such as airline pilot or train driver;

- offences that contravene licensing and other laws related to the distribution and sale of alcohol, such as selling alcohol to people under the prescribed age limit, serving to an individual who is
already intoxicated, and serving outside permitted hours or from unlicensed premises;

- offences to which alcohol use commonly makes a major contribution, such as assault, vagrancy, sexual misdemeanour, vandalism, domestic violence, child abuse and disturbance of the peace; and

- civil law offences in which alcohol is frequently mentioned as being a significant factor, such as divorce, civil compensation cases and litigation concerning insurance claims.

National and/or federal legislation will usually dictate many of the laws in an individual community. In addition, there are often local laws and bye-laws that can be drawn up by the community and should reflect prevailing views on alcohol policy. There is, however, ample opportunity for local groups to influence the interpretation and enforcement of the main body of law. In addition the local community will, of course, have occasion to pass on its views about alcohol and crime to the national legislature. The Alcohol Action Group can therefore have an impact on the content and particularly the implementation and interpretation of legislation at the community level. It can also have a major influence on the way in which the courts deal with offenders.

**ACTION**

The local Alcohol Action Group can raise awareness and help focus activity. It should identify those individuals who are key participants in the criminal justice system. The media, in their attitude towards and reporting of alcohol-related crime, are allies in raising the quality of public debate so that the community is well informed. Similarly, those voluntary citizens’ groups who have a particular concern about crime or particular crimes can make a significant contribution. Interest groups may also have formed concerning victim support, women’s refuge, the care and resettlement of offenders, and prisoners’ families; all have a legitimate interest in these issues.
THE EXTENT OF THE PROBLEM

An initial task will be to make this wide range of interest groups aware of the extent to which alcohol is contributing to the level of crime in the community. National and local data will commonly be available concerning offences such as drink-driving, public drunkenness and breaches of the licensing laws. In some circumstances the contribution of alcohol to the wider range of crimes described above may be purely anecdotal. In others, surveys focused on particular agencies will have provided some understanding of the percentage of offenders within any particular category for whom alcohol has contributed to the offence, or who are identified as having alcohol-related problems.

A project that collects data on alcohol-related crime from the local police force or courts often underscores the issues very effectively. Data can sometimes be obtained simply by scanning the court proceedings to monitor how frequently alcohol is mentioned as a contributing or mitigating factor. Penal policies vary in their view of the role of alcohol in crime. Some have a separate category for all offences in which alcohol seems to play a part; in others drunkenness has been taken as a plea in mitigation. The majority view is that alcohol is an aggravating factor and certainly not one that excuses the offence. The extent to which alcohol as an additional factor is recorded varies enormously, and it will often prove hard to achieve consistent reporting.

The police can be asked to make a systematic note of the state of intoxication of individuals that they arrest. Prison staff can survey the drinking habits of inmates. Simple surveys of this kind often reveal a very high level of alcohol-related problems. Social workers or probation officers can monitor the prevalence of hazardous or harmful drinking among the offenders they are seeing. Data of this kind can be recorded in a systematic way. This information increases a community’s appreciation of the importance of alcohol among offenders and the drain on resources that this represents; it also provides a baseline from which to monitor the impact of changes. Reports based on local experience provide a sense of immediacy and urgency that may not be generated by national data. The local media can often help disseminate such information about alcohol in relation to crime.
The criminal justice system

and thereby increase community awareness and understanding of the problem.

INCREASING AWARENESS

Although some individuals concerned with criminal justice will be very interested in this topic and share the views of the Alcohol Action Group, in other circumstances training and encouragement will be necessary to gain support.

Training programmes can be initiated for the judiciary, the police, social workers, probation officers, prison officers and rehabilitation staff. The uptake of these programmes and/or their influence on knowledge, attitudes and behaviour can be measured and monitored.

LOCAL ACTION FOR HARM REDUCTION

A number of proven measures can be adopted that, evidence suggests, may lower the level of alcohol-related offences in a community.

Drink-Driving

Drink-driving affords a good example of the effect of local action on harm reduction.

It is well known that drinking alcohol before driving increases the likelihood of road traffic accidents (see Chapter 9). In all European countries drink-driving is now an offence, although the level of alcohol at which an offence is recognized varies considerably. There is also an enormous variation in the extent to which the police enforce the regulations. The attitude towards enforcement is often very susceptible to local influence.

Preventive strategies may focus on education. National and/or local campaigns can demonstrate the hazards of drink-driving, often by highlighting the pain and suffering to the victim or emphasizing the penalties for the driver. Some campaigns have tried to link the evidence about drink-driving with the promotion of alcohol-free or low-alcohol drinks.
Each community needs to address the paradox inherent in our promotion of both driving and drinking. The two popular activities need to be separated (57). Education alone is insufficient and needs to be combined with strategies that encourage and reinforce this separation.

Random breath testing has been shown to be a particularly effective way of reducing the level of drink-driving in a population. It has to be pursued in an organized and regular way, by conducting the tests in a visible and frequent manner, so that the likelihood of detection in the community is very high (58).

Those groups that favour enhanced penalties for drinking and driving may find they have little actual impact on the level of harm in the population. There are clear benefits, however, in ensuring that those who do drink and drive do not have their licences restored for a considerable time.

It is also important that those who have offended change their habits before returning to driving. There is some evidence that this can be achieved by encouraging rehabilitation programmes for offenders, a model that is well developed in a number of European countries.

None of these activities is likely to be effective unless accompanied by a level of public understanding of the issues involved. A coordinated strategy on drink-driving illustrates the way in which many different sectors require to collaborate, including public education, the media, the police, the judiciary, rehabilitation programmes, transport services and the hospitality and drinks industry.

**Public Order**

Community-based projects often arise in response to specific incidents that arouse community concern. These crises can be a stimulus to action, and the Alcohol Action Group can become a focus to facilitate a collaborative response. Offences against public order and disturbances of the peace are examples of crimes that are commonly alcohol-related and provoke concern. Many of these offences occur in and around drinking establishments.
City centre disorder is frequently alcohol-related, and occurs principally among young people who drift to the area in search of entertainment and conviviality. The physical structure of some urban environments may help to shape behaviour. In recent years there has been a trend in town planning towards a segregation of activities, separating residential from shopping, office and entertainment zones. City centres have become service areas where people come by day to shop or work, and this environment may be conducive to trouble at night when the centre has an abandoned character with little formal supervision (59). In the United Kingdom evidence has shown the conflict that is likely to arise at certain points where large numbers of intoxicated young people congregate, such as fast food outlets, taxi ranks and bus stations.

A coordinated approach to city centre management, involving the police, the transport services and the business community, can improve the city environment. A town centre manager might be a focal point for initiatives in this area. Zoning policies that create alcohol-free areas of the town may reduce crime and public disorder. An evaluation of the impact of prohibiting the consumption of alcohol in public in designated areas was conducted in three Scottish towns. In two of the areas there was a significant reduction in public order offences, although in one of them the problem seemed to have shifted to another part of the town. These measures enjoyed a wide degree of public support, and appeared most successful in averting disorder by groups of young people drinking in public (56).

There are other examples in which a police presence has had a preventive effect. For instance, the nightly presence of police in and around public houses, particularly at closing time, was shown to have a significant impact on the level of crime in a community in England (60). A ban on alcohol in and around football stadiums reduced the incidence of hooliganism in some cities in the United Kingdom.

Box 9 lists measures taken by an Alcohol Action Group in an English town to try to solve the problem of public disorder in the city centre.
Community and municipal action on alcohol

Box 9. Points of action to reduce alcohol-related public disorder

Reinforced policing of licensed premises and a more active role in informing licensees of their responsibilities

Meetings of licensees addressed by Group members to inform them of their role in the project

Encouragement of the provision of late-night buses

Relocation of additional taxi ranks to encourage dispersal

Development of a "pub watch" scheme encouraging communication between the police and licensees

Designation of the central area of the city as a no-drinking zone (no drinking in public)

Support for the development of an alcohol-free night club

Involvement in a pilot project with Alcohol Concern (a national organization) for the "Drinkwise" public education campaign

Development of a registration scheme for door staff who oversee entry to some licensed premises, to ensure that they were skilled in managing provocative situations

Development of training for prospective licensees and off-licence managers through a local technical college

Investigation of ways by which there could be greater dispersal of fast food outlets

Encouragement of greater availability of taxis

Integration of approaches between the city council and licensing magistrates

Setting of standards for obtaining and retaining a license to sell alcohol


Public Drunkenness

Public drunkenness often causes concern. Drunks may be unsightly and disturbing to passers-by and, at a more humanitarian level, are commonly homeless and vagrant and in need of medical and social help.
Sometimes community concern is expressed only when somebody with a serious alcohol problem dies in custody following arrest. Nursing and medical services need to be available for such people, and some mechanism needs to be developed to help the police identify those at risk and to provide appropriate assistance. A protocol for interviewing and screening by police officers at the time of arrest will help to improve the identification of alcohol misuse. These measures should also minimize the likelihood of individuals suffering from severe withdrawal symptoms and other physical alcohol-related problems being overlooked in police cells.

This form of offence has been decriminalized in some countries, and detoxification and rehabilitation services provided that take the person out of the criminal justice system. Such people may not be arrested, but they are often neglected. This may prove as unsatisfactory as arrest followed by brief imprisonment and discharge to the same environment. People who are intoxicated and homeless face particularly acute hazards in northern climates, where severe hypothermia is a common risk. They require a safe environment in which to recover, and from which to find a less damaging way of life.

The Alcohol Action Group can work with housing departments, the social services, the emergency medical services and the police to encourage the development of adequate hostel and/or housing accommodation to facilitate rehabilitation.

**Education Programmes for Offenders**

Alcohol can be seen to be a contributing factor in a wide range of offences. There are a number of educational programmes that have sought to re-educate offenders towards more sensible and less hazardous drinking practices (61). These are often promoted by social work, probation or adult education departments.

Many prisoners will describe a past history of major alcohol-related problems. It is helpful to provide rehabilitation programmes in prison, and it is particularly important that these should be linked with active rehabilitation on discharge. Prison officers can be helped to participate in these training programmes for prisoners, and to draw on the help of forensic services, alcohol treatment agencies and voluntary groups such as Alcoholics Anonymous.
Community and municipal action on alcohol

TARGETS

The Alcohol Action Group can publish and monitor the prevalence of alcohol-related offences, such as drink-driving, drunkenness, vandalism and underage drinking, and agree on goals for their reduction.

The percentage uptake of training courses by the judiciary, the police and those in the drinks and hospitality industry can be monitored, and the impact of these courses on knowledge and behaviour can be measured.

The numbers of offenders attending alcohol education courses and the impact of participation on subsequent offending can be monitored.
Alcohol Promotion and Advertising

The advertising and promotion of alcoholic drinks aim to influence brand choice and extend that product’s share of the market; the degree to which they also stimulate overall consumption is debatable. The extent to which countries seek to control advertising and promotion varies enormously (62). In some there is a total ban; in others advertising is permitted only at the point of sale, while in many the content, timing and presentation of advertisements are controlled. Most countries have some form of standards for advertising involving alcohol, such as requiring that there be no suggestion that drinking enhances strength or sexuality, or that there be no link with activities such as driving. Material aimed at young people or shown on television at times when children are likely to be watching is commonly proscribed.

In addition to direct advertising, many forms of sales promotion and sponsorship are susceptible to various forms of control. These affect cultural and sports events, festivals and concerts, beer festivals, team buses and corporate hospitality.

The link between promotions of this kind and consumption levels is not clear. Nevertheless, the way in which alcohol is presented to the population and perhaps particularly to young people is a matter of widespread concern. It is also believed that ubiquitous promotion of alcohol creates a climate of acceptability that may have implications for attempts to limit consumption.
Community and municipal action on alcohol

The amount of advertising and the rules governing it are commonly determined at the national level, and it may be felt that local initiatives can have little impact on this. There is evidence that this is not the case, because local views may influence national policies and have a significant impact on the way in which they are interpreted or presented at the local level. The advent of satellite television has made alcohol advertising international, and these programmes may seem even less susceptible to local views. Local initiatives may nevertheless have an impact on national and particularly local advertising and promotion.

The Alcohol Action Group can identify individuals with a particular interest in the area of advertising and sponsorship. Health promotion workers would be a clear choice, but educationalists, local amenity groups, health and safety staff and those concerned with sports, leisure and the environment should also be included.

MONITORING

An interest group can be formed to monitor the content, location and timing of advertisements, and to identify those that break national agreements and codes. It is important that the community has a clear understanding of the advertising authorities' standards and way of working, and the way in which complaints may be lodged. An interesting example of an action pack for communities to monitor and, if necessary, protest about promotions was prepared for Australia by Saunders & Shoebridge (63).

Evidence that could be monitored would include the nature of advertisements: whether, for example, they linked alcohol use with sports, particularly swimming and boating, or with driving or operating machinery; and whether there were clear messages that alcohol use enhanced sexual prowess or improved social skills. Advertisements focusing on encouraging young people to drink require particular attention.

The timing of advertisements is also important. Are they put out at peak times when young people are likely to be listening or viewing? Are they displayed in particularly conspicuous situations where
young people gather, such as near schools and youth clubs? Are there any contraventions of regulations governing the types of beverage that may be promoted in the media or the times of display?

**LOCAL ADVERTISING**

The Action Group will have more access to advertising in local media. In some communities the municipality may control the posting of advertisements on hoardings and other sites in the area, and can ensure that alcohol advertisements are not placed conspicuously near schools and other places where children and young people gather. Cinemas often show advertisements, and here the local Action Group can ensure that children are not exposed to inappropriate material.

Local radio and television stations will be more susceptible to local influence, and it may be possible to ensure that they meet standards of advertising that are acceptable to that specific community. The Action Group should acknowledge legitimate interests in trade and promotion, and avoid taking an extreme position about alcohol that is totally out of keeping with the views of the majority. In most communities the task will be to strike a balance between control and licence. For children, the goal is often to help them develop a capacity to evaluate realistically the claims of advertisers.

**PROMOTION/SPONSORSHIP**

Sponsorship of the arts or sports by the alcohol industry has become commonplace, many organizations relying on it to continue operating. There is, however, widespread concern at the image of alcohol portrayed, such as the advertising of beer on football jerseys worn by children. Local concern can be expressed by means of the Alcohol Action Group. It should be made clear that there are often other sources of sponsorship that do not link sport with alcohol consumption. While some communities would resist all sponsorship from this source, others would wish only to ensure that it did not mislead. Issues of this kind would, of course, form the basis for local debate.
The drinks and hospitality industry in a locality often has promotions that encourage people to drink more alcohol or particular brands of alcohol. Examples include free entertainment offered to students during their “fresher’s week”, the promotion of new products in stores and restaurants, and offers of “drink as much as you like” for a set payment in an evening. The “happy hour” is a practice introduced from the United States, and is an attempt by licensees to stimulate trade. All of these should become a focus for action groups to raise local debate about their acceptability.

THE MEDIA

The local media have a very significant role in advertising and promotion, but they also make a major contribution to the way in which a community construes the use of alcohol. This is seen, for example, in the way in which alcohol-related incidents are reported, and the prominence given to drinking behaviour that often only concentrates on the beneficial effects or regards it as an incidental background to everyday life. Studies have shown that the level of drinking portrayed in television series far exceeds what actually exists in the community.

An alliance with local radio and television can be very important in changing people’s views about the use of alcohol and delineating alcohol-related problems. It is very helpful to have media representatives on the Alcohol Action Group and to enlist their support in heightening public understanding and awareness. Media outlets are an important means of keeping the community informed of developments, and an influential tool in setting social policy within a community.

The benefits of media campaigns on sensible drinking have been hard to demonstrate, except when they have focused on a specific issue such as drink-driving. The benefits are enhanced when they are linked to local activities and promotions that reinforce the media message. National initiatives of this kind should always be discussed in advance with local action groups so that approaches can be coordinated. For example, self-reported consumption was influenced by a media campaign about changing drinking habits only when
Alcohol promotion and advertising

accompanied by leaflets to individuals supplementing the information. Media campaigns are also useful in providing information to support a local debate, for instance, about hours of opening, public order or sensible drinking levels. Casswell et al. (64) showed that, where local media campaigns existed, they helped sustain support for alcohol control policies in the face of liberalizing trends, whereas areas lacking such campaigns did not resist the trends.
Alcohol and Accidents

Alcohol consumption most commonly contributes to accidents by inducing intoxication, which affects judgement and coordination and other motor skills. There is also the risk of an accident during the hangover period, when the sufferer feels ill and responds slowly. Long-term alcohol use may impair cognitive functioning and contribute to an individual becoming accident prone.

THE EXTENT OF THE PROBLEM

The presence of alcohol in the system of an individual who has had an accident does not prove causality. Nevertheless, controlled investigations have shown that the likelihood of, for example, accidents to drivers and pedestrians increases greatly with increased alcohol consumption. The average driver becomes more likely to have an accident at a level of 50 mg alcohol per 100 ml blood. At 60 mg/100 ml an accident is twice as likely, and at 80 mg/100 ml, four times as likely. Approximately a quarter of road accident fatalities occur in those with a blood alcohol level over 80 mg/100 ml. There is little evidence for any threshold below which driving risks are unaffected. Alcohol is implicated in one third of home accidents, in 15% of work accidents, in 40% of accidental fires, in 25% of deaths from drowning (50% in those aged 20–30 years) and in 43% of those who die as a result of falls (65).

Young and middle-aged males are particularly at risk, with alcoholic poisoning, drowning and falls being significant factors. Communities often regard accidents caused by alcohol at home and during leisure activities as commonplace and unavoidable, and they are often
poorly documented. This leads to little serious action being taken either to document their extent or to institute preventive measures (66).

A French study (67) recorded alcohol as a significant factor in 22% of home injuries and 4% of sporting injuries. Young people are particularly vulnerable to alcohol-related accidents because they combine an enthusiasm for taking risks with a lack of experience in both drinking and a newly developed motor skill.

The risk to elderly people is often overlooked. In the United Kingdom approximately one third of all people aged 65 years and over experience one or more falls a year. Older people tolerate alcohol less well, and a combination of alcohol with medications in a frail individual can readily lead to falls and other accidents (68).

PREVENTION

Health promotion activities should focus on explaining the risks of drinking before driving, at work and when engaging in various sporting activities. Legislation on drink-driving and regulations about drinking and the presence of alcohol at work, particularly in the transport industry, need to be publicized and enforced to be effective.

EVALUATION

Regular monitoring of accidents at the workplace and on the road is a means of assessing the impact of various preventive techniques. A review of accidents in one company showed that 20% of all accidents notified were alcohol-related, and workplace accidents are clustered around mealtimes and occasions when drinking is likely to have occurred.

ACCIDENT AND EMERGENCY DEPARTMENT

The hospital accident and emergency department is an important venue for the detection of alcohol-related accidents and injuries. All
adults and young people attending a casualty department after an accident should be asked if the accident was alcohol-related. If equipment is available, the breath should be tested for alcohol. The trauma questionnaire for detecting harmful drinking is helpful (Box 10). Two or more positive answers are taken as a positive test. The questionnaire has a sensitivity of 66% and a specificity of 80% for harmful drinking (65).

<table>
<thead>
<tr>
<th>Box 10. Trauma questionnaire</th>
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<tbody>
<tr>
<td>The patient should be asked the following questions.</td>
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<tr>
<td>• Have you had any fractures or dislocations to your bones or joints?</td>
</tr>
<tr>
<td>• Have you been injured in a road traffic accident?</td>
</tr>
<tr>
<td>• Have you injured your head?</td>
</tr>
<tr>
<td>• Have you been injured in an assault or fight?</td>
</tr>
<tr>
<td>• Have you been injured after drinking?</td>
</tr>
</tbody>
</table>

Source: Alcohol and accidents (65).

Staff may be trained in identifying alcohol-related problems, and in giving first-level advice to people for whom alcohol has been an important contributing factor in an accident. The hectic activity of most casualty departments may make it difficult to intervene at the time, but the opportunity should be taken to identify the presence of alcohol. This should subsequently be discussed with the patient, or the patient should be given a card encouraging him or her to attend for help at a later stage. Reports sent to family doctors and to other medical staff should highlight the presence of alcohol and, if possible, state the level of alcohol on the breath at the time of attendance at the casualty department. This can be followed up when the patient attends primary health care at a later stage.

THE STOCKHOLM COUNTY PROGRAMME

In Stockholm, there has been an attempt to reduce morbidity and mortality due to alcohol-related accidents through the establishment of an accident prevention unit. This has studied the impact of alcohol on a variety of accidents, and has worked with a network of agencies
in developing an action programme on specific safety issues, such as traffic, work, sport, children and adolescents, the elderly, violence, disasters and bicycle helmets. An injury epidemiology unit is establishing a countrywide injury surveillance system, inviting data on all injuries given medical attention throughout the whole health sector. This includes an estimate of whether alcohol has contributed to the injury.

**ACTION PLAN**

The Alcohol Action Group can raise public awareness about the way in which alcohol contributes to accidents. A subgroup formed around this topic would involve representatives of the police, the accident and emergency services, health promotion, school and youth training personnel, motoring organizations, fire prevention officers, health and safety staff, leisure managers, and voluntary groups with an interest in road safety and accident prevention. The group can collate local information, prepare evidence and present it to community leaders. It can also alert professional groups to the need for education about alcohol and accidents, and promote programmes of early recognition and focused assistance to those who are drinking in a hazardous way.
One aim of a municipal alcohol action plan is to steer the community towards a clear understanding of the nature of alcohol, its hazards and its merits. The plan should at least ensure that people possess reliable information on which they can base decisions about their own health and lifestyle. It can also ensure that municipal departments are well informed and collaborate to achieve an integrated plan that aims to minimize the harmful consequences of drinking for the individual, the family and the environment. Healthy public policies and an environment that supports them should be realistic goals. Alcohol impinges on almost every aspect of municipal life, and the preceding chapters have focused on a selection of the areas in which positive action can be taken.

National and municipal plans should be closely related. It will clearly be helpful if municipal activities fit within a national strategy. Collaboration of this kind serves to reinforce the aims of the alcohol action plan and can allow economies of scale and the optimum use of resources and skills. The merits of highlighting local data against a backdrop of national trends have been mentioned on several occasions in earlier chapters.

The action plan will not succeed if it is regarded as something grafted on to the life of the community, or something that is handed down by officials and experts. To be successful the plan must be owned by the individuals in the area and integrated into the planning processes of the municipality. It also needs to be supported by appropriate funding, research and training for all those whose work will be affected by the policies introduced. Top-down approaches are rarely
successful, and can leave community members feeling even less in control of their own environment than they were at the outset (69).

**EVALUATION**

The need to describe and monitor changes observed has been emphasized throughout this book. Frequent mention has been made of setting targets and evaluating outcomes. The activities of the Alcohol Action Group, the Advisory Forum and the individual projects should all be carefully described in a diary format, so that the process is understood and recorded. In this way it will be possible for one group to learn from another’s experience.

Combining action of this kind with evaluation research is complex. The researcher who participates in the action will gain a true appreciation of the process and will be accepted by the community, but the penalty for this degree of involvement is often an inability to remain non-participant and objective. Action research commonly takes place in an arena affected by the economic and social pressures of everyday life and strong political influences. Given these pressures, it is hardly surprising that very few research projects have effectively examined the impact of multicomponent community-based initiatives (70). Some of the most effective demonstrations have been shown in the field of cardiovascular disease prevention projects, but a small number have demonstrated modest achievements in the fields of alcohol and drugs (71,72). One component of the European Alcohol Action Plan is to evaluate the impact of a multifaceted community strategy towards alcohol use in Lahti, Finland (3).

Evaluating outcomes and demonstrating change over time is one aspect of action research. Process evaluation and monitoring systems are others. It is helpful if the Alcohol Action Group always specifies objectives for each task, obtains baseline measures whenever possible, and then records changes in these over time. Monitoring of this kind is essential and need not be costly in time or resources.

It is essential that careful evaluation of these programmes continue, so that we can identify those components that are effective and those that have little impact.
Community and municipal action on alcohol

TIMETABLE

The alcohol action plan will be most effective when tasks are allotted within a realistic time scale composed of a series of steps, with objectives to be achieved along the way. The strategy needs to be reviewed regularly, at least annually, and the Alcohol Action Group should be expected to make a report on progress to the main stakeholders in the alcohol plan at that time. Reviews of this kind also serve to sustain the public profile of the plan, to raise issues, and to record achievements and shortcomings. The strategy requires regular maintenance and attention if it is to be sustained successfully over several years. Priorities can be set, along with time-scales for their achievement.

NETWORK

The creation of alcohol action plans in municipalities will give rise to a network of key individuals and groups who can then share that knowledge with other like-minded groups and communities. It will be advantageous if local workers from the Advisory Forum and the Alcohol Action Group can establish links with other groups throughout the area. In this way they can come to share materials, research experience, and evidence of efficacy and successful strategies. It will help if national governments can encourage developments of this kind, and promote the sharing of experience by organizing conferences and training opportunities.

COMBINED APPROACHES

This publication has focused exclusively on approaches that will reduce alcohol-related harm. Drinking alcohol is an integral part of social life and leisure for many people. Some may feel that isolating this particular aspect of behaviour from many others is artificial. The European Alcohol Action Plan makes alcohol the focus of attention because of its potential to damage health and social relationships. It is acknowledged that education and concern about alcohol can be integrated within a more general programme of health promotion and the creation of a healthy environment. The hazards of smoking are
Conclusion

well recognized and health authorities throughout Europe are committed to smoking cessation. There is major concern about problems arising from the use of drugs, particularly illicit drugs, although these problems are often much smaller than those related to alcohol. Healthy eating policies and the promotion of exercise are further examples of health promotion initiatives. The optimum means of developing plans for all of these types of behavior is not yet clear. It is important, however, to ensure that awareness of alcohol as a drug is not swamped by focusing on illicit forms of use, or that a prohibitionist campaign directed at smoking diverts attention from rather subtler messages concerning alcohol. In some communities alcohol policy might be combined with those concerned with other drugs, and would certainly have links with experience in smoking prevention activities and other health promotion work. There are many opportunities for these interest groups to collaborate in joint projects and to learn from each other. Alliance with the aims of the Healthy Cities movement is clearly desirable.

The municipal alcohol action plan is one of a number of initiatives contained within the European Alcohol Action Plan. The clearest links will be with the policies concerned with enhancing the capacities of primary health care to recognize and respond to alcohol-related problems (3). Components that will facilitate international and European cooperation should also interact with municipal plans. All components will ideally combine to become a European movement towards a more enlightened approach to alcohol use.
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Europe is a major producer and consumer of alcohol, and alcohol-related problems make a major impact on health, social welfare and the economy. Despite these costs, many communities continue to regard alcohol problems solely as a medical or even a narrowly psychiatric issue. Community programmes and local action 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. Every community has the potential for preventive action. Homes, schools, workplaces and health care establishments offer opportunities to encourage healthy behaviour, improve social support, and strengthen attitudes that favour lighter drinking.

These guidelines are essentially practical and contain approaches that can be adapted to different settings. They can serve as a template around which to build the methods and experiences that are unique to particular communities. They are designed to stimulate local interest and the creation of a detailed local action plan. The book comprises chapters that address specific areas of community life where there are good prospects for developing effective alcohol policies.