

EXECUTIVE SUMMARY

"What should we do about alcohol?" Michael Marmot asked in 2004 (Marmot). In his frequently cited editorial to the British Medical Journal (BMJ) "Evidence based policy or policy based evidence?", he was referring to the situation in the United Kingdom, characterised by a rate of alcohol consumption that had risen by about 50 % in the previous 30 years. Conversely, average consumption in Europe reached its lowest point in 2012 since 1961 (European Commission, 2016; Marmot, 2004). Such averages may, however, disguise the underlying heterogeneity. Indeed, while the highest consumption countries have seen a drop, some of the countries with lower alcohol consumption rates have actually seen a rise in the same 50 year period.

Despite this diversity of epidemiologic developments in Europe, there is a shared concern, which brought together partners in Joint Action on Reducing Alcohol Related Harm (RARHA). Europe remains the world region with highest alcohol consumption rate. The significant harm associated with consumption of alcohol at this level creates a need for identifying the most effective measures to counter the harm and it was this need, which motivated the creation of this tool kit.

At the core of the document are criteria, which were used to qualify the evidence base of submitted interventions. In alcohol prevention, a wide chasm exists between expectations of prevention scientists who are rarely content with anything other than randomised-controlled trials (RCTs) and the reality of prevention in practice - a reality in which the majority of interventions are not evaluated at all. To bridge this divide and provide practitioners and policymakers with hands-on advice, we adapted a Dutch classification system of the National Institute for Public Health and the Environment (Veerman, & van Yperen, 2007). The system is described in the country report of the Netherlands of Joint Action Chrodis (Hamberg-van Reenen, van Dale, van Gils & van den Berg, 2014). It rates interventions along a continuous scale of evidence levels, ensuring that a number of minimum requirements are met. With this approach, we were able to identify and classify interventions other than RCTs. Using this methodology, 26 out of a total of 43 assessed interventions were accepted.

Sometimes, the same evidence can lead policymakers to different conclusions, depending on the underlying values, as Marmot convincingly argued. It is the purpose of this document to inform policymakers about the tools for the assessment of available evidence.

For the tool kit, three areas for preventing alcohol related harm were chosen: early interventions, public awareness interventions and school-based interventions.

Some authors (Anderson, Chisholm, & Fuhr, 2009; Babor, 2010) advocate the so-called "best buys" for reducing alcohol related harm: increasing taxes, restricting access to alcohol and banning advertising. While the debate on the exact mechanism of average aggregate consumption and alcohol related harm is ongoing, there is ample evidence that the law of demand applies to alcohol and that aggregate alcohol demand drops when prices go up (modest price elasticity).

Among the three approaches we assessed, "early interventions" (e.g. motivational interviewing) have long been held in higher esteem due to comprehensively demonstrated efficacy and effectiveness, than school programmes or public awareness campaigns. Why then did we limit our selection of measures to a number of activities that are sometimes considered relatively ineffective compared to regulatory measures?

RARHA is a joint initiative of EU member states as well as Iceland, Norway and Switzerland. But taxation and many regulatory measures are the prerogative of national governments and go beyond the mandate of joint action. Furthermore, stakeholders place great importance on education, in schools and through public awareness campaigns. Governments have an ethical mandate to inform *all* citizens about health risks. Public awareness campaigns may stimulate public debate and prepare the implementation of new policies. While interventions in some areas may be less effective than regulatory measures overall, the effectiveness of an individual intervention is ultimately not determined by the category it belongs to (school, public awareness, early intervention, etc.). Although a certain category may generally not provide much favourable evidence of effectiveness, an individual intervention may work well (as proven by the examples in the tool kit). Conversely, a methodological approach with proven effectiveness in general public may have less empirical backing in certain populations, as in a case of brief interventions conducted in school settings (Carney, Myers, Louw, & Okwundu, 2016). The effect of public awareness campaigns may be small but their reach is large and interventions in schools offer easy access to a target population, in other words to "get up close and personal."

Working as a multi-national team, we have learned that values, ethics and context all matter and that there is no "one-size-fits-all" approach to effective alcohol prevention. Epidemiological developments differ between and within countries and so do value systems and cultures. This should be taken into account. At a minimum, this tool kit will help choosing a highly evaluated and effective intervention over a poorly evaluated and ineffective one.

Additionally, it will make readers aware of the importance of values in alcohol prevention: rather than clouding rational thinking, values help us to select an appropriate intervention. The same

applies to context: if epidemiology differs, governmental responses should take this into account when designing policies.

Ultimately, this tool kit is not so much about saying what approach is "the best" in a certain context. Science simply cannot make that decision for us. The scientific method just helps us to tell apart good evidence from bad.

As in penal law, the most drastic sanctions may often be the most effective ones. In European liberal democracies, however, a range of subtler non-regulatory measures should be included in the portfolio of governmental responses and factors such as effectiveness and cost-effectiveness should not be the only guidance. Or as Michael Marmot would put it: "Scientific findings do not fall on blank minds that get made up as a result. Science engages with busy minds that have strong views about how things are and ought to be" (Marmot, 2004).

If the goal is to reduce alcohol related harm it is necessary to build up a cultural norm where drinking little and avoiding drunkenness and binge drinking is the normal thing to do. To reach that goal it is necessary to use a combination of methods. Laws and regulations are the strongest signals to the population, price and tax are strong economic incentives as well as restrictions on marketing, whereas mass media campaigns (including drink – driving campaigns), if repeated for many years, can be a tool to point out negative health and social effects of alcohol and problems and thereby support healthy norms. In the same way norm setting from health or social professionals through brief interventions is helpful, and education can as part of this whole strategy be helpful. At last a qualified alcohol treatment system is necessary for the families where a person is drinking. So there is no choice of a single effective method which can make a country reach the goal. It is the combination of methods in a strategy for all levels in society which are important. Or as a Babor said in his famous book *Alcohol no ordinary commodity*: "A complementary system of strategies that seek to restructure the total drinking environment is more likely to be effective than single strategies... Full spectrum interventions are needed to achieve greatest population impact." (Babor, 2010).

Science asks what is, not what ought to be and it would thus be fallacious to derive political decisions from scientific evidence (Uhl, 2015). To highlight that values not only influence our perception, but that they may guide our decision-making, we included a chapter on ethics in the annex, which sets out a number of empirical findings about effectiveness that need to be counterbalanced with value-based considerations of social justice, personal freedom and proportionality. The chapter also includes a brief introduction to a framework for ethical evaluation, which has recently been developed (Marckmann, Schmidt, Sofaer, & Strech, 2015).

Recently, there has been increasing interest in the creation of frameworks that attempt to integrate empirical evidence, values and context in the formulation of public health policies. The authors of one such framework describe it like this: "The goal is therefore to foster a dialogue among stakeholders that will promote decisions that are more nuanced, more transparent and, ultimately, more likely to have an impact on improving health. Nonetheless, decision-making remains an inherently iterative and often somewhat disorganized process, especially as we move towards population-based and global-level decisions" (Andermann, Pang, Newton, Davis, & Panisset, 2016).

We hope that this document provides you with some tools that will help you make decisions in alcohol prevention that are grounded in the best available evidence, while making explicit the values and context that guide your decision.

References

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