



**Meeting report  
Third MOPAC project meeting**

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CHAIR: DR CARINA FERREIRA-BORGES (WHO)

## Part I – Alcohol consumption and harm

**Mr Daniel Kleinberg (Head of Health Improvement Division, Scottish Government)** officially opened the third Monitoring of national policies related to alcohol consumption and harm reduction (MOPAC) project meeting. In his welcome address, Mr Kleinberg noted that he was pleased that the meeting was taking place in Scotland, following the recent year's progress in introducing evidence-based policy measures. Mr Kleinberg noted that the most important development of the last decade is minimum unit pricing (MUP) and emphasised the importance of experiences and expertise from the international community during the legal process. He said that MUP would not have been possible without the international cooperation, access to the international evidence base and the solidarity from other Member States. **Dr João Breda (Head, Prevention and Control of noncommunicable diseases (NCDs), WHO Regional Office for Europe, Moscow)** thanked Scotland for hosting this meeting. The current focused work on NCDs within the UN and WHO means that there is a strong agenda for reducing the harmful use of alcohol due to its clear link as a risk factor. Dr Breda outlined some of the key outcomes he sees as important from the MOPAC project, and also outlined the way forward. He noted that the longstanding collaboration between Member States, WHO and the European Commission (EC), has had a positive impact, an impact that extends beyond EU Member States, but he also stressed that there is still a significant amount of work to be done as Europe leads the global league of regions when it comes to alcohol consumption. Today more tools than ever are available to combat alcohol harm and it is "time to deliver", he said, reiterating the theme of the 3<sup>rd</sup> UN High-Level Meeting on NCDs from New York in September. **Dr Breda then gave the floor to Mr Cees Goos, Chair of the Alcohol Policy Network (APN)**, who gave an opening remark on behalf of APN, co-organiser of the meeting. Mr Goos said he was very pleased to be in a country where there is courage to take the alcohol issue seriously. He acknowledged that the United Kingdom (UK) has been leading public health for decades; specifically through strong support of physicians' organisations that have taken a clear stand on alcohol policy, which is not seen in many other places. Mr Goos said APN were happy to collaborate with WHO for this meeting, which gives the meeting a better reputation, more content and more opportunities. He ended his speech by thanking the Royal College of Physicians Edinburgh (RCPE) and Scottish Health Action and Alcohol Problems (SHAAP) for hosting the meeting. **Dr Peter Rice (SHAAP)** gave an overview of SHAAP. Its creation was based from the view upon the medical profession as an important collaborating partner in preventing alcohol problems. The organisation's starting point was from the book *Alcohol no ordinary commodity* and the WHO *Global strategy to reduce the harmful use of alcohol*. Dr Rice concluded by stating that collaboration with international organisations is important to SHAAP and is not taken for granted. Finally, **Mr Dag Rekve (WHO**

**headquarters**) expressed his great pleasure to be in Scotland for this occasion. He had the pleasure of announcing that the UN Interagency Task Force on the Prevention and Control of Noncommunicable Diseases (UNIATF) has awarded the Alcohol Policy Team, Scottish Government, United Kingdom, for “Outstanding contribution on NCD prevention and control”. On behalf of the Alcohol Policy Team, Mr Daniel Kleinberg received the prize from the WHO regional and global level representatives, Dr João Breda, Dr Carina Ferreira-Borges and Mr Dag Rekve.

### **Prof Jürgen Rehm – Trends in alcohol consumption and alcohol-attributable mortality in the European Union, Norway and Switzerland**

Prof Rehm opened the first session of the meeting, on alcohol consumption and harm, by walking the participants through the technical parts of the upcoming extensive WHO report. The new report includes data from the 28 European Union (EU) Member States, Norway and Switzerland (EU+). Within EU+, the northern and southern countries have lower levels of consumption, whereas central and eastern EU+ countries have higher levels of consumption. In regard to changes since 2010, some countries are showing increases and some decreases. At aggregate level, however, no change in total alcohol consumption is seen.

Prof Rehm continued by presenting updated mortality and disease burden; in 2016, 5.5% of deaths in EU+ were caused by alcohol. The absolute number equates to approximately 300 000 people per year in the EU+ countries, whereas in the wider WHO European Region the number is close to one million. The data also shows that alcohol-attributable deaths in the younger age groups (<24 years) are proportionally higher than in the older age groups. Prof Rehm highlighted that observed changes in age-adjusted years of life lost (YLL) 2010–2016 shows that implementation of comprehensive alcohol control policies in some countries appear to have reduced harm in a relatively short period of time. However, increased life expectancy overall in Europe is the main contributing factor to decreases in alcohol-related harm. As a final remark, Prof Rehm highlighted that an important factor to address is the widening income inequality within countries as this will have an impact in alcohol-attributable burden.

### **Dr Lars Møller – Alcohol policies in the European Union**

Dr Møller gave a short overview of the policy chapter of the new publication, for which Prof Rehm had discussed the consumption and harm data. Dr Møller noted that the policy measures presented in the new publication are summarized using the policy scoring tool developed in 2017. Using the policy scoring tool, the new report gives an indication of the overall implementation of the *European action plan to reduce the harmful use of alcohol 2012–2020* at the regional level as well as on country level. Country-level data will be presented in a country snapshot document, which will provide useful data for Member States to explore which policy measures that need

strengthening. Dr Møller noted that overall Member States score high in two areas; “Leadership, awareness and commitment” and “Drink-driving policies and countermeasures”. An area where the mean score is low is pricing policies. The distribution of scores for the action area on marketing is wide; however, several Member States have introduced new measures very recently, which were not reflected in the 2016 survey, for example Lithuania and Estonia. Finally, Dr Møller noted that implementation in the area of reducing the negative consequences of heavy episodic drinking and binge drinking, an area which is a particular focus for the Committee on National Alcohol Policy and Action (CNAPA) -endorsed *Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) 2014–2016*, has been limited and scores for individual countries are on average below 40 (out of 100).

### **Mr Dag Rekve – The WHO SAFER Initiative**

Mr Rekve, from WHO headquarters, started by outlining developments reducing harmful alcohol use and alcohol-related harm at the global level by noting that Africa has low levels of consumption, but proportionally the highest level of harm. Mr Rekve also noted that compared to tobacco, there has not been strong advocacy from organisations focusing on a specific disease. Mr Rekve suggested that cancer advocacy groups can be champions for change, alongside the many organisations and professionals already involved in alcohol policy.

In September 2018, WHO launched a new policy resource called SAFER, which follows on from the previous policy documents and resources, including the *Global strategy to reduce the harmful use of alcohol*, the *Global status report on alcohol and health*, the *Global Action Plan for the Prevention and Control of NCDs 2013–2020*, and *Alcohol no ordinary commodity*. The UN declaration on NCDs has created a stronger agenda and commitment to work on reducing the harmful use of alcohol. The SAFER initiative was developed in collaboration with the UN Interagency Taskforce on NCDs, United Nations Development Programme (UNDP), NCD Alliance, Global Alcohol Policy Alliance (GAPA), IOGT International, and Vital Strategies. SAFER focuses on five areas; restricting availability, enhancing drink driving counter measures, screening and brief interventions (SBI), comprehensive marketing and advertising policies, and increasing prices on alcoholic beverages. The SAFER package with the five key intervention areas will be a resource for implementation at the national and local levels. Mr Rekve concluded his presentation by giving a brief overview of WHO’s workplan for 2019–2020, which includes establishing governance structure and implementation mechanisms, continued development of technical tools and a web portal, and a specific SAFER monitoring and surveillance system.

CHAIR: MR CEES GOOS

## **Part II – Developments on alcohol control policies**

### **Dr Eric Carlin (SHAAP)**

Dr Carlin gave an overview of the development of alcohol policy in Scotland. A shift was seen in the early 2000s, when the alcohol began to be addressed hidden problem of alcohol across the society in all age groups, rather than an issue just among young people. There were several important documents that guided the policy developments in Scotland, including the *Global strategy to reduce the harmful use of alcohol* and *Alcohol no ordinary commodity*. The work by WHO was highly influential for how the Scottish Government came to develop *Changing Scotland's Relationship with Alcohol: A Framework for Action* in 2009.

Dr Carlin then focused specifically on the introduction of MUP, for which the international community and research evidence played an important role. Whilst progress has been achieved over the past decade, Dr Carlin noted that alcohol-attributable death rates in Scotland are still higher than in England and Wales. A new report from SHAAP, *Dying for a drink - Circumstances of, and contributory factors to, alcohol deaths in Scotland*, puts mortality statistics in context with lived experience. The report shows that there still is work to be done to reduce the level of alcohol-related harm in Scotland. Finally, the political leadership has been instrumental in implementing effective, evidence-based policy measures; the First Minister has an interest in the issue and continues to support driving it forward. In 12–24 months' time the first data will be available to follow-up the effects of MUP on alcohol consumption and population health in Scotland.

### **Ms Suzanne Costello (Alcohol Action Ireland)**

Ms Costello gave an overview of recent developments in Ireland, where the Public Health (Alcohol) Bill was accepted in October 2018 by the parliament. According to Ms Costello this developments were heavily influenced by the WHO Strategy. Ireland has seen progress in the field since 2012, due the national substance misuse strategy. Drops in consumption following the recession led to progressive policy strategies being contested as there was less of a strong argument for introducing stronger policy measures. Ms Costello noted that alcohol industry influence has been a challenge and that the statement made by Dr Margaret Chan, the former Director General of WHO, supported the actions planned in Ireland, such as MUP. Part of the challenge was that the alcohol industry attempted to be a key source of risk communication, which led to mobilization of experts in Ireland to develop evidence-based communication to the public.

The measures in the Alcohol Bill (now written into law) aim to create an environment that makes the healthy choice an easier choice. Examples of central parts are introduction of MUP, restrictions on content of advertising, prohibition of advertising in certain places, and minor sponsorship restrictions. Nongovernmental organizations (NGOs) and medical colleges collaborated to get the Bill through the parliament, as well as conversations with organisations and stakeholders involved in the MUP process in Scotland. Another key factor to the success of the Bill was establishing a cross-party parliamentary group on alcohol.

#### **Mr Lauri Beekman (Nordic Alcohol and Drug Policy Network)**

Mr Beekman discussed alcohol control policy developments in the Baltic countries. Estonia had the EU presidency in 2017, however there was limited work on alcohol during that period with the exception for the issue of cross-border trade. Recent policy developments, however, have included the significant raise in taxes in Lithuania and Estonia, a total ban on alcohol advertising and increase in minimum legal purchase age to 20 years in Lithuania. According to Mr Beekman, in 2019, additional alcohol policy control measures will be introduced regarding the availability and accessibility to alcohol in Estonia, meaning that alcohol has to be separated from other products in the store and cannot be visible from the outside of the shops. A major issue for Estonia, however, is cross-border purchases from Latvia; about 25% of alcohol consumed by Estonians is purchased in Latvia. Currently, excise duty is 149% higher in Estonia than in Latvia. Plans in Latvia include increasing the excise duty rates. Finally, Mr Beekman noted that parliamentarians and governmental representatives met for the Baltic Assembly in Vilnius, where alcohol policy as an issue for Estonia, Latvia and Lithuania was discussed.

#### **Dr Joan Colom (APN)**

Dr Colom reported the development of policies to prevent Fetal Alcohol Spectrum Disorders (FASD) and support children affected by FASD. Dr Colom noted that according to recent estimates, Spain has a relatively high rate of Fetal Alcohol Syndrome (FAS). Furthermore, 83% of children who were adopted from other parts of Europe came from Russia and an earlier research report had found that FASD was common in this group of children. This led to a prevalence study, which showed that 50% of the children, whose foster parents consented to the study and were assessed, had FASD, and 20% had FAS. This indicated that this is a population with rates much higher than the general population and it is important to give them appropriate support. Work in Catalonia now being planned focuses on a number of areas, including providing families with wider information about alcohol-free pregnancy, training for health care professionals (screening, diagnosis and follow-up), and the development of special services for children with FASD.

### **Ms Nina Rehn-Mendoza (Nordic Welfare Centre)**

Ms Rehn-Mendoza started by outlining that the cornerstones of Nordic alcohol policy are: removing private profit, restricting physical availability, and maintaining high taxes on alcoholic beverages. Four Nordic countries have retail monopolies, however, changes over time have included more premises and outlets, increased opening hours, and/or option of home delivery. In Finland, only 33% of alcohol consumed comes from the retail monopoly. Ms Rehn-Mendoza noted that the introduction of the Alcohol Act in 2017 was a political process with strong lobbying from the alcohol industry. The key change in the Act is the maximum alcohol by volume (ABV), now increased to 5.5%, that can legally be sold in shops other than the retail monopoly (Alko). In addition, independent breweries and microbreweries can now sell their own craft beers off-premise, and on-premise sales for take away is now permitted. Serving hours have been increased to 4am with one hour drink up time. During the first seven months since the Act came into force on 1 March 2018, total alcohol sales increased by 1% but sales of alcoholic beer and cider increased by 200%. Data from the police show an increase in police interventions, and violence between 5am and 6am increased by 65% compared to the previous year. Ms Rehn-Mendoza noted that currently there is political and economic pressure for also making wine available in retail stores. This is likely to be an important political issue in the parliamentary election next year, and if granted, there is very little justification left for the Finnish alcohol retail monopoly.

## **Keynote presentations**

### **Dr Jyotsna Vohra – Alcohol and cancer**

Dr Vohra started her presentation by stating that a key issue with informing the public about the risks with alcohol is that the public perception is that it is only associated with consuming excessive amounts. In the UK, the Chief Medical Officer's guidelines for alcohol consumption were revised to state that men and women should drink no more than 14 units (112 grams of pure alcohol) a week to keep risk to health low. Dr Vohra stated that research by Cancer Research UK (CRUK) shows that only one tenth of surveyed people from the general public in the UK are aware that alcohol causes cancer. Key focus for CRUK therefore is to increase the public's understanding and awareness of the link between alcohol and cancer, which may increase public support for alcohol control policies. However, Dr Vohra noted, the current situation for the UK approaching Brexit makes it difficult to get policies adopted. Dr Vohra concluded her presentation by saying that if further interventions are not put in place now, alcohol-related cancers will mean a cost of £2 billion to the National Health Service (NHS) over next 20 years.



**Ms Anne Lise Ryel - Civil society role on policy measures to reduce the risk of alcohol-attributable cancer**

Ms Ryel opened her speech by highlighting that NGOs and civil society need to be forward-thinking and innovative in the field of alcohol policy. The Norwegian Cancer Society attempts to create new, evidence-based, ways of working on this issue. Ms Ryel noted that although NGOs have been working in the area of alcohol policy for centuries, there has lately been an increase in new types of organisations advocating for alcohol policies, such as cancer societies. NGOs, having learnt how to advocate against the tobacco industry, have experiences that can be applied to alcohol, and can also often permit themselves to take bolder action than governments can. Ms Ryel mentioned that alongside a Norwegian campaign, called “One drink less”, Norway aspires to follow Ireland by introducing mandatory cancer warning labels on alcohol containers.

CHAIR: PROFESSOR NICK HEATHER

**Part III – The role of primary care in Screening and Brief Intervention (SBI)**

**Dr Peter Rice (SHAAP)**

Dr Rice opened his presentation by emphasizing the legacy Scotland holds to SBIs, as it was the site for the first randomized controlled trial (RCT) for SBIs. In Scotland, the Scottish Intercollegiate Guidelines Network (SIGN) guidelines on management of harmful drinking and alcohol dependence in primary care were published alongside specialist treatment guidelines in 2004. In 2008, SHAAP compiled the evidence around SBIs, which timely informed the national SBI programme which was introduced in 2008. Dr Rice noted that by establishing a national screening programme and guidelines, alcohol was prioritized in similar ways as major conditions like the flu and cervical cancer. The national SBI programme created targets for screening patients for harmful alcohol use among GPs in primary care, however later other settings were also included for delivery of SBIs. The target of 60 000 interventions per year has been met, however the number of brief intervention sessions in primary care has reduced along with an increase in other settings, despite limited evidence of the effectiveness of SBIs in those settings.

**Dr Frederico Rosario (Alcohol-Related Problems Project at the Dão Lafões Primary Health Care Center Grouping, Portugal)**

Dr Rosario reported on his systematic review of the evidence around barriers to implementation of SBIs in primary care. Evidence for effectiveness of the method in reducing harmful alcohol use, Dr Rosario noted, is good and there is also some evidence for cost-effectiveness in primary care settings. Challenges for health care professionals to screen patients and deliver brief intervention are primarily related to three issues; capability, motivation, and

opportunity. Capability barriers include not feeling adequately trained, not remembering to ask patients about alcohol, and difficulties in breaking the habit of not asking the patient. Examples of barriers related to motivation are health care professionals' perception that delivering SBIs is not part of their role, and beliefs that asking about patients' drinking and counselling high risk drinkers is difficult. Environmental barriers include such as lack of tools, organisation, or structure in place to enable this often new way of working. Aspects such as competing social influence and for example the positive representation of alcohol in the media are also mentioned as reasons for finding SBIs difficult to deliver. Dr Rosario concluded by arguing that identified challenges and barriers may vary across countries and settings, and overcoming them will require different strategies. SBI implementation will therefore need to be tailored to fit the setting.

**Prof Emanuele Scafato (WHO Collaborating Centre, Italy)**

Prof Scafato started his presentation by telling the participants that work around SBI in Italy commenced in 1983. Early on in this process there were no developed tools to help primary health care services in addressing alcohol with their patients. Italy has a national health system and has engaged with projects led by WHO as well as the Alcohol Public Health Research Alliance (AMPHORA) network. Prof Scafato noted that work has commenced in Italy to train general practitioners (GPs) and other health care practitioners; work carried out with support from the Ministry of Health. A needs analysis for the content of the training was carried out by the Council of Physicians in Rome. The *WHO alcohol brief intervention training manual for primary care*, published in 2017, has now been translated into Italian to support the training of primary care physicians. However, other groups of health care professionals are also being trained, and the scope of the training is also for wider community settings. Finally, Prof Scafato informed that feedback has been gathered about the experience in implementing the WHO training manual, which can benefit other Member States who consider implementing it.

**Ms Tadeja Hočevar (National Institute of Public Health, Slovenia)**

Ms Hočevar started her presentation by providing context to the situation in Slovenia; a wine growing country. Overall per capita consumption, harmful alcohol use and levels of alcohol-related harm is high, with annual costs of harm estimated to €153 million. In Slovenia, SBI is implemented at family doctors and GPs, however data shows realization at only 16%. This has led to the conclusion that there is a need for an interdisciplinary and more in-depth approach. In 2016, a project funded by the EC was developed with the aim to encourage responsible attitudes to alcohol. The project is taking an interdisciplinary approach and includes more than just SBI, such as ways to de-stigmatise the issue, building capacity with the help of experts, NGOs, media, etc. Currently SBI is being piloted in 18 local areas in the country, with a proposal for system-level implementation. Piloting commenced in October this year and the project will be evaluated once it finishes in 2020, after which a proposal will be

developed for full system level implementation. Targets are 60 000 screened, 9000 treated with BI, and at least 540 successfully treated.

### **Ms Lidia Segura (APN)**

Ms Segura started her presentation by also providing the context underpinning SBI work in Catalonia, where wine and beer production is prominent. Work around SBI work started in 2002, the model used is SBIRT (screening, brief intervention and referral to treatment). This model has led to implementation of a network of physicians and nurses in primary health care centres, and psychiatrists, medical doctors and psychologists in specialist centres. The work has been given particular priority by the government, which has supported strategic planning. Training was initially carried out by specialists, whereas after 2006, trainers were public health professionals. Barriers to SBI implementation to overcome included low rates of advice, poor monitoring tools, and insufficient coordination and communication. Incentives were introduced for screening, which increased screening rates. Other identified barriers are being addressed by the development of a monitoring platform and an online education tool. Simultaneously, the need for increasing public awareness about alcohol as a problem is being addressed by an awareness week and an online self-assessment tool.

### **Discussion**

Following the presentations, several questions were raised from the audience. Firstly, Dr Ferreira-Borges asked whether there is evidence of uptake of smoking interventions in health care and if there is any research comparing implementation of smoking cessation programmes with SBI. Dr Rice suggested that the structure of the work for alcohol is similar to that of tobacco, for example by setting a national target. Data from Scotland show differences at the local level rather than between health boards (regional level); some general practices deliver few SBI sessions and some deliver a high number. Therefore, Dr Rice suggested, the issue is not that the interventions are not being delivered but that the uptake varies significantly. Mr Maik Dünnbier from IOGT International noted that SBI ties into the policy conversation in terms of the general policy interventions, but asked whether there is a way to address the cognitive dissonance in doctors about their own drinking and appropriately deliver SBI. Dr Rosario suggested that the strategy of showing data that contradict misconceptions that health professionals might have, can work in changing practice. Prof Sven Andréasson from Karolinska Institutet argued that despite several decades of work, the field has not made progress in the field of effectiveness – the evidence for efficacy is there but not effectiveness, which might need a different approach to screening. To ask physicians to fulfil a public health role, when framing SBI as a public health project, may lead to resistance. Furthermore, it is possible, Prof Andréasson argued, for GPs to deal with alcohol dependence in primary care. He also emphasized that an adaptation of method may be needed in countries with less developed

health systems and lack of psychiatrists, which impact on the delivery of SBI in primary care.

CHAIR: PROF EMANUELE SCAFATO

## **Part IV (WHO Session) – Evaluation of European Action Plan on Youth Drinking**

### **Prof Kim Bloomfield – Presentation of the evaluation report and main findings**

Prof Bloomfield outlined in her presentation the MOPAC deliverable number seven; an evaluation report of the CNAPA-endorsed *Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge Drinking) 2014–2016*. Prof Bloomfield provided an overview and background to the Action Plan and the challenges in harmonizing the data collected using different methodologies. Importantly, indicators in these data sources were not set out with the intention to evaluate the Action Plan *per se*, leading to difficulties in, for example, having data to cover the same period as the action plan (2014–2016). Prof Bloomfield gave a short description of the key findings of the report, which show that overall, Member States have been engaged in all six areas of the CNAPA Action Plan. Whilst activities have been partial, actions that have been undertaken are mainly towards strengthening regulations or other policies addressing youth drinking and heavy episodic drinking.

Following Prof Bloomfield's presentation, Ms Mariann Skar from EURO CARE highlighted the importance of not under-estimating the significance of the Action Plan and the actions that have been taken in EU MS. Prof Bloomfield clarified that an editorial meeting of the draft report had been carried out the previous day, as this question had been discussed and will be addressed in the revised document. Ms Triinu Täht, from the Estonian Ministry of Social Affairs, followed on by clarifying that the editorial meeting had focused on discussing the nature of CNAPA and described processes and developments which have happened over time, as well as specific aspects of the structure of CNAPA that Ms Täht noted would be more or less impossible for a researcher to fully comprehend without input from CNAPA members.

### **Dr Gražina Belian – Case studies on the implementation of the action plan: Lithuania (2014–2016)**

Dr Belian started her presentation by stating that Lithuania stands out in the per capita alcohol consumption data; within the European Region as well as globally. Whilst decreases youth drinking are evident over time, Dr Belian noted that acceleration in reductions is needed to reduce harm. Lack of strategic actions on alcohol policy has historically meant increases in alcohol consumption and alcohol-related harm; such lessons have been learned for contemporary policy actions.

Several policy control measures that have been implemented in Lithuania. Particularly, the Lithuanian experience of discussing tax increases in the parliament, Dr Belian explained, has been objections from the alcohol industry, insisting that tax increases will lead to tax revenue losses. Most policy actions have been on amendments of the law on alcohol control to specifically target young people, introducing a ban on advertising, raising the minimum legal purchase age to 20 years, and an obligation for age verification for purchaser who look like they are under the age of 25 years. Positive developments following the implementation have been noted; reductions have been made in the number of inpatients for causes due to alcohol and deaths due to accidental alcohol poisoning. Dr Belian said that she is cautiously optimistic about the effects of the policy implementations. Finally, Dr Belian noted that the introduction of stricter measures led to circulation of false media stories, indicating resistance to the measures from parts of the Lithuanian society.

#### **Mr Rafn Jónsson – Case studies on the implementation of the action plan: Iceland**

Mr Jónsson provided an overview of the consumption rates in youth in Iceland, a country outside of the EU and CNAPA. In the 1970s, media in Iceland were commonly reporting on the issue of high alcohol use among young people, which continued into the 1980s when there was also a lack of organised activities for young people, leading them to meet in town centres and drink alcohol. Data also showed increasing trends in youth cannabis use, daily smoking, and alcohol consumption in the 1990s. Due to these trends, the Alcohol and Drug Prevention Council was established in 1998, with the aim to mobilise work to prevent alcohol and substance use among young people by focusing on four core risk/protective factors: i) family, ii) extracurricular activities and sport, iii) general well-being, and iv) peer group. The concept of Drug Free Iceland focused on changing attitudes and behaviour, environment, and strengthening collaborations between multiple professions.

Mr Jónsson noted that the approach for Drug Free Iceland was comprehensive, including the government, municipalities, parents, and youth centres. One percent of the state income from alcohol tax was earmarked for this purpose. Interventions included ensuring that young people had free of cost access to sports activities and leisure centres, raising the minimum legal purchase age, reducing access alcohol, and a night curfew for young people without parents/caregivers. Data show that time spent with parents has increased over time, whilst the proportion of young people reporting having never been drunk and reporting any alcohol use has shown an unprecedented decrease.

**Dr Lukas Galkus – Case studies on the implementation of the action plan: experience from the Alcohol Policy Youth Network (APYN)**

Dr Galkus started his presentation by giving a brief description of APYN, which aims to empower young people and influence policy at the local and national level. The network has members in 30 countries across Europe. Dr Galkus noted that whilst in many countries there are policies in place, it does not mean getting complacent and the network's work is to drive progress forward. Good examples over the last few years include Estonia, Ireland, Lithuania and the UK; strengthening of policy in one country can have a domino effect in progressing policy in other countries. Dr Galkus noted that in relation to youth drinking and heavy episodic drinking, restricting marketing is an important aspect. There are currently several European projects and national actions which attempt to connect young people with governments. Dr Galkus noted that in some parts of Europe, youth NGOs are strong and policy makers are listening to their messages. Examples where there is a strong bottom-up approach includes youth NGOs working in Lithuania, Portugal and Slovenia. This approach is important in places where a commitment in working top-down with international or European alcohol policy is lacking, and Dr Galkus ensured that APYN will continue to support Member States.

**Dr Carina Ferreira-Borges, Mr Daniel Kleinberg, Dr Peter Rice, Mr Bernt Bull, Ms Triinu Täht, Dr Manuel Cardoso, Prof Emanuele Scafato – Panel discussion on the MOPAC project: Key achievements, opportunities and way forward**

Dr Ferreira-Borges opened the final session, which aimed to discuss key achievements of the MOPAC project and perceptions from Member States of these achievements. Dr Ferreira-Borges noted that key outcomes of MOPAC, in addition to the two reports presented today by Professors Rehm and Bloomfield, were the Alcohol Policy Timeline Database, the SBI training toolkit *WHO alcohol brief intervention training manual for primary care* (2017), the report *Prevention of harm caused by alcohol exposure in pregnancy: Rapid review and case studies from Member States* (2016), and the updated European Region monitoring system for key alcohol indicators.

Dr Rice noted that he has been very involved in driving alcohol policy forward in Scotland, however it was relatively late that the need to engage with international organizations was generally acknowledged. This became clear when the European Court of Justice got involved in the legal case for MUP. Dr Rice also linked to Dr Bloomfield's presentation on the evaluation report of the CNAPA Action Plan, and emphasized that it is important to address not only implodents, but to also acknowledge that many countries are already doing well. Mr Kleinberg emphasized that it needs to be acknowledged that Scotland is part of a Member State and that alcohol policy also sits within a UK context. The evidence that WHO produces sets an international

discussion about consumption and harm, which for Scotland is a reminder that alcohol is a global issue; action needs to be taken at the national as well as global level. The international community was essential for the MUP case. For example, the Scottish Government received support from international experts and NGOs going into the legal case, not only about the content of the policy but also its implementation.

Ms Täht continued by stating that alcohol policy in Europe tends to focus on one action at the time. With organisations like WHO and EU complementing each other, and with work in project form such as the MOPAC project, the work can be more dynamic and standstills in policy processes can be prevented. Mr Bull commented that the benefit of the work by WHO is that it can be used to bring the evidence forward in a political language; the normative language used by WHO can be used to advocate for policy action. Mr Bull also noted that the data collection process for the WHO alcohol survey is a useful means to learn about your own country context. He also admitted the need for country experts to disseminate within countries information and data from international organisations like WHO. Dr Cardoso agreed that WHO sends a clear message about consumption and harm in countries, which you can use for implementation of national alcohol policy. Dr Cardoso also expressed his concern for the WHO European Region counterpart meetings, which have not been organized for several years, and called for resuming them now that MOPAC and its specific project meetings will no longer take place. Prof Scafato concurred that the WHO European Office should be seen by the European Commission as a resource. Dr Ferreira-Borges concluded by noting that whilst there is optimism within the Alcohol programme at WHO Regional Office for Europe, funding to consolidate the organisation of counterpart meetings is an issue. She agreed that the discussions held at WHO meetings are important to share with the European Commission to facilitate reflection on the way forward for Europe.

Finally, Dr Møller was asked to recapitulate the discussion, as he is a person who had been engaged in MOPAC from start. There have been three collaboration projects with the EU similar to MOPAC, and previously there was always a plan for a subsequent project. This time there is no new project following on from MOPAC with EU funds, which has been an important funding source for the WHO Alcohol Programme. Dr Møller expressed his concern that without dedicated funds it is difficult to organize counterpart meetings. However, there is currently a unified European alcohol monitoring system in place and the forthcoming alcohol report with country-level data will be a very important instrument for national work to prevent alcohol harm. Dr Ferreira-Borges concluded by thanking all participants for their contributions in the meeting and wishing everyone a safe journey home.