Global Perspectives on Implementation of Screening and Brief Intervention

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Global Perspectives on Implementation of Screening and Brief Intervention

1. SBI in context
    1. alcohol interventions a generation ago
    2. expectations
    3. realities
2. Screening (and reflections on the AUDIT), brief intervention, implementation
3. The world of electronic interventions
4. Global initiatives : the work of WHO

Alcohol Interventions a Generation Ago

Primary intervention (Prevention)

- **Alcohol use and problems**: a wealth of research showing the close correlation between :
  - Per capita alcohol consumption and alcohol-related morbidity and mortality
  - Cost of alcohol (in relation to disposable income) and per capita consumption
  - Effect of increasing restrictions and taxation in reducing per capita consumption and harm
  - Effect of decreasing restrictions and lowered cost in increasing per capita consumption and harm
- **Containerisation**, the "standard drink" concept, labelling, the "right to know" what you are consuming
- Some enthusiasm for **educational approaches**
- Increasing **concern among professional bodies** about alcohol-related harm
- Articulate advocates for **central control (restrictive) measures**

In 1980 what did I expect to be achieved in the next 15-20 years?

Primary intervention (Prevention)

- Alcohol would be regarded as a luxury item
- Alcohol would be classified by governments as a special product requiring regulation to ensure its use is compatible with the public good
  - appropriate tax imposts
  - regulation of availability – location, time
  - stringent licensing requirements
- Alcohol companies regulated like utilities (water, gas, electricity)
  - agreed level of profit
  - disconnect between profit and turnover
- Nordic approach to be influential worldwide
- More educated general community

Instead, what happened?

Primary intervention (Prevention)

- Alcohol has become less expensive
- Much more widely available (in supermarkets, extended hours of opening of licensed outlets)
- More prevalent binge drinking among young people (men and women)
- Substantial increase in alcohol-related morbidity and mortality
- Dominance of economic considerations over the public good
  - "harmonisation" of EC laws
  - free enterprise (competition) laws hold sway
- Globalisation
- Increasingly sophisticated alcohol promotions
- A dominant and inadequately regulated alcohol industry
- Government inaction

Alcohol Interventions a Generation Ago

Secondary Intervention (Screening and Brief Intervention)

- Very little interest in identification of risky patterns of alcohol consumption
- No brief intervention techniques
- No concept of intervening early ("curious view of the world")
- No system for screening and brief intervention (unlike hypertension, diabetes, cervical cancer screening)
- Virtually no focus on primary care as a potential setting for intervention
- WHO Expert Committee established in 1978, which reported in 1980.

In 1980 what did I expect to be achieved in the next 15-20 years?

Secondary Intervention (Screening and Brief Intervention)

- Techniques to identify people whose drinking would put them at risk of dependence and disease (e.g. developments such as GGT)
- Techniques to identify emerging dependence and disease in its early stages (e.g. biochemical indicators, breath tests:

  Saunders J.B., Lewis K.O. and Paton A. Early diagnosis of alcoholic cirrhosis by the aminopyrine breath test. Gastroenterology 1980; 79: 112-114).
- Inclusion of questions on alcohol and biological markers in multi-risk factor health screening
- Some approach to providing intervention to risky drinkers
- Increasing involvement of general medical practitioners and primary care overall in the identification and treatment of hazardous alcohol consumption and alcohol-treated problems

Instead, what happened?

Secondary Intervention (Screening and Brief Intervention)

- Development of the AUDIT questionnaire and derivates or similar instruments to screen for and identify people with hazardous (risky) alcohol consumption
- Development and limited introduction of new biological markers (e.g. CDT)
- Development of brief intervention techniques for hazardous alcohol consumption - based on abbreviated versions of cognitive-behaviour therapy, motivational enhancement
- A huge body of evidence demonstrating the effectiveness of these approaches in reducing hazardous alcohol use
- Meta-analyses showing reduction in consumption, reduced problems and reduced mortality following brief interventions
- Limited uptake of screening and brief interventions in the health care system
- In general, little involvement of primary health care in prevention

WHO Collaborative Studies on Early Intervention, 1983 - 2006

Phase I :	Development of simple screening instruments to detect hazardous and harmful alcohol consumption (AUDIT and the Clinical Screening Procedure)
Phase II :	Development of simple methods of intervention and evaluation in a randomised controlled trial
Phase III :	Assessment of current practices and perceptions of primary care professionals, and controlled trial of techniques for disseminating early intervention
Phase IV :	Implementing country-wide screening and brief intervention in primary health care

WHO Phase I: the AUDIT

- The WHO Phase I Collaborative study had as its aim the characterisation of alcohol use and related problems in simple and valid ways that would be applicable across various cultures.
- Revised goals (JBS, 1985):
  - to produce a screening and early detection instrument that would enable the detection of persons with hazardous and harmful alcohol consumption
  - the instrument should also identify more severe alcohol use disorders
  - the instrument should be useful as a framework for intervention
  - it should be conceptually sound and conform to the then recently introduced bi-axial model (dependence and problems) – in fact the proposal was a tri-axial model, including intake
  - its performance should be tested according to accepted standards for screening instruments

Development of the AUDIT

- A provisional instrument was presented in the report of the WHO Phase I Collaborative study (Saunders and Aasland, 1987)
- It consisted of 10 items covering three domains
  - Alcohol intake – frequency, quantity and binge drinking
  - Alcohol drinking experiences and behaviours (dependence-type items)
  - Alcohol-related problems – including proxy items
- The questions were selected on the basis of:
  - being the most representative for their domains (item-to-total correlations);
  - offering good discrimination overall between persons with hazardous and harmful alcohol use and those without any alcohol use disorder or excessive intake
  - Having high face validity
  - Being useful for the purpose of intervention

Development of the AUDIT

- There followed a phase of broad consultations, further analyses, and further assessment of its cross-cultural appropriateness
- This resulted in a modified instrument – nine questions remained the same, one question, " ... difficult to get alcohol out of your mind? being replaced by " ... not able to stop drinking once you had started?)
- The revised instrument was named the AUDIT –the Alcohol Use Disorders Identification Test
- It received the imprimatur of WHO as its approved alcohol screening instrument

The AUDIT

Select from the answers below and place the number that corresponds with your answer in the box

1. How often do you have a drink containing alcohol?					**Score**
0 Never	1 or less	2 2 to 4 times a month	3 2 to 3 times a week	4 4 or more times a week	o
2. How many standard drinks do you have on a typical day when you are drinking?					
0 1 or 2	1 2 to 4	2 5 or 6	3 7, 8 or 9	4 10 or more	o
3. How often do you have six or more drinks in one occasion?					
0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily	o
4. How often during the last year have you found that you were not able to stop drinking once you had started?					
0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily	o
5. How often during the last year have you failed to do what was normally expected from you because of drinking?					
0 Never	1 Less than monthly	2 Monthly	3 Weekly	4 Daily or almost daily	o
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	o
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	o
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	o
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	o
10. Has a relative, a friend, a doctor or another 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	o
				RECORD TOTAL OF SPECIFIC ITEMS HERE	o

Characteristics of the AUDIT

- All questions have high face validity
- Focuses on events in the last 12 months, but includes a screen for previous problems
- Captures different levels and patterns of alcohol consumption
- Elicits different features of dependence - behavioural, physiological
- Elicits different aspects of problems - psychological, trauma, medical
- Inbuilt screen for physiological dependence on alcohol
- Provides a total score, and scores for subsets of questions
- Can be linked to a decision tree for management
- Offers a framework for therapy, viz. feedback, advice and problem-solving

AUDIT References

- WHO Report
  - Saunders J.B. and Aasland O.G. WHO Collaborative Project on Identification and Treatment of Persons with Harmful Alcohol Consumption. Report on Phase I. Development of a Screening Instrument. Geneva: World Health Organization, 1987.
- References:
  - Saunders J.B., Aasland O.G., Amundsen A. and Grant M. Alcohol consumption and related problems among primary health care patients: WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption I. Addiction 1993; 88:349-362.
  - Saunders J.B., Aasland O.G., Babor T.F., de la Fuente J.R. and Grant M. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption II. Addiction 1993; 88:791-804.
- Guidelines
  - Babor T.F., de la Fuente J.R., Saunders J.B. and Grant M. AUDIT. The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care. Geneva: World Health Organization, 1989.

The AUDIT

- Not just a screening instrument

WHO Phase II Brief Intervention Trial: Findings from the Sydney Centre

Average weekly alcohol intake (grams)

Condition	Intake at Recruitment	Intake at Follow up (9 months)	% reduction
Control	402	402	0
Simple advice	424	307	27.5
Advice and counselling	480	341	29.0
Extended counselling	460	285	38.0

Four-year Outcome after Brief Intervention

	Treatment	Control
Medical use (48-months postbaseline)	(*n* = 392)	(*n* = 382)
Emergency department visits	302*	376*
Days of hospitalization	420**	664**
Motor vehicle events (48-months postbaseline)		
Motor vehicle crash with fatality	0	2
Motor vehicle crash with non-fatal injuries	20	31
Motor vehicle crash with property damage only	67	72
Operating while intoxicated	25	25
Other moving violations	169	177
Legal events (48-months postbaseline)		
Assault/Battery/Child abuse	8	11
Resist/Obstruct officer/Disorderly conduct	8	6
Controlled substance/Liquor violation	2**	11**
Criminal damage/Property damage	2	1
Theft/Robbery	3	3
Other arrests	6	9

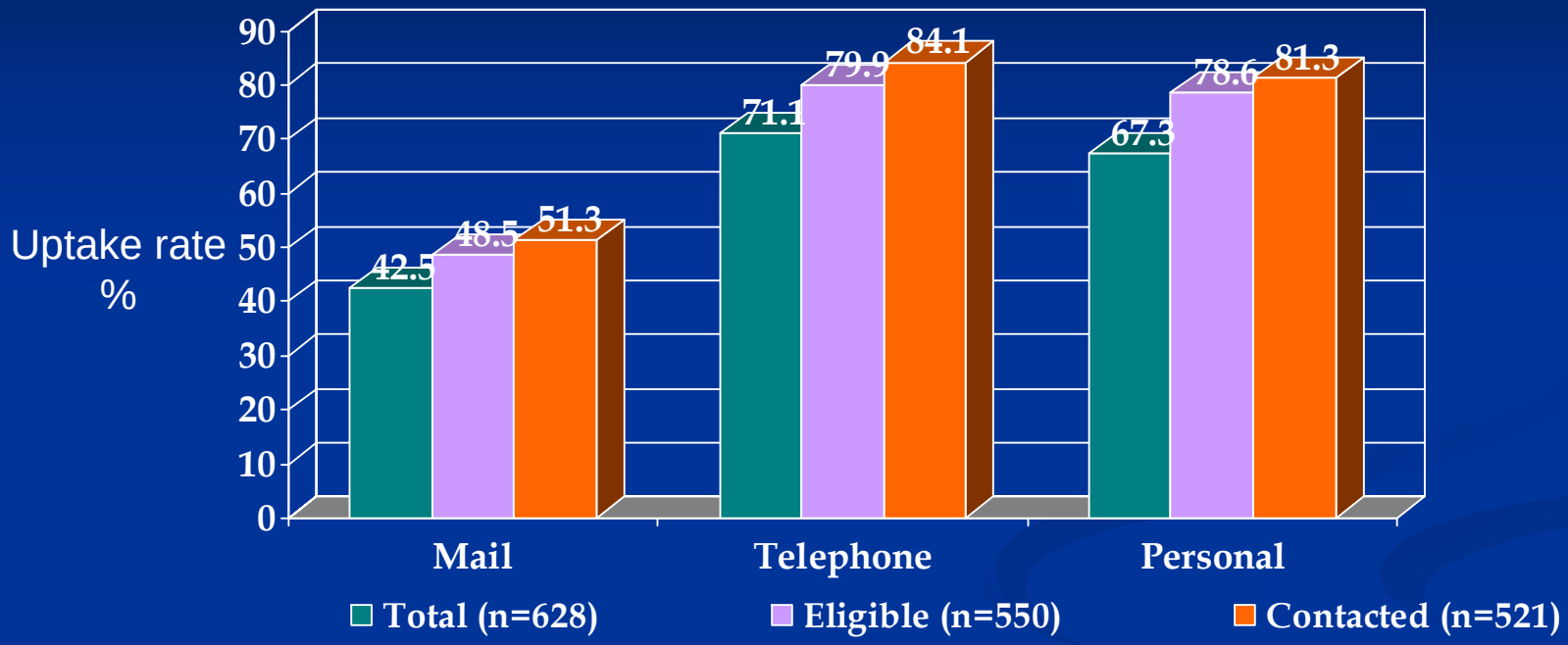
* $p < 0.10$
** $p < 0.05$

Fleming et al (2002)

WHO Phase III: Implementation

- Strand 1: studies of the role of primary health care, current involvement in a range of preventive interventions
- Strand 2: key informant interviews
- Strand 3: controlled trials of implementation

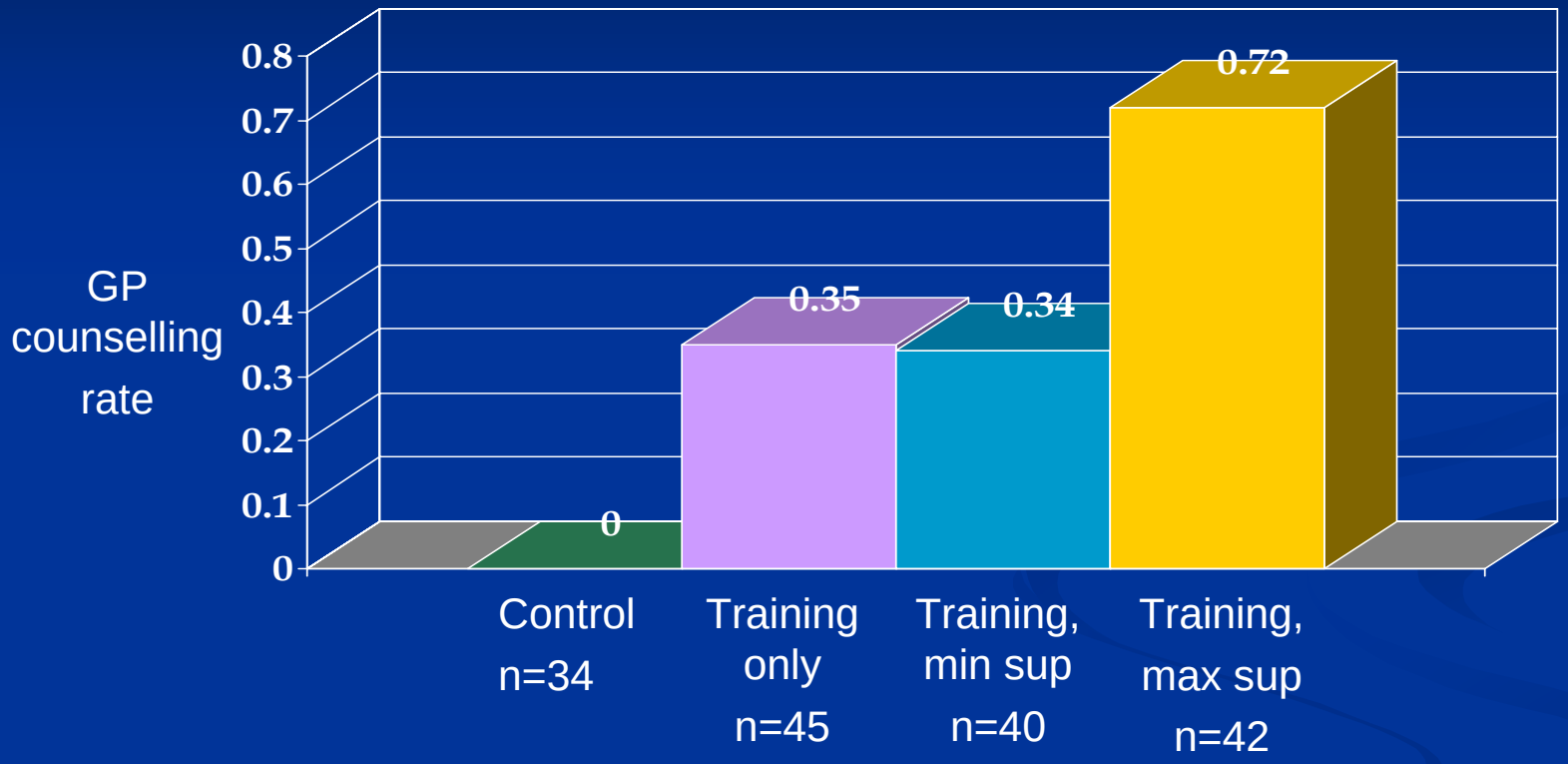
Uptake Rates for Marketing Conditions



Marketing Condition

- based on estimates of the eligible and contacted population
- Direct mail versus telemarketing and personal marketing (x^2=46; df=1;P=0.00)

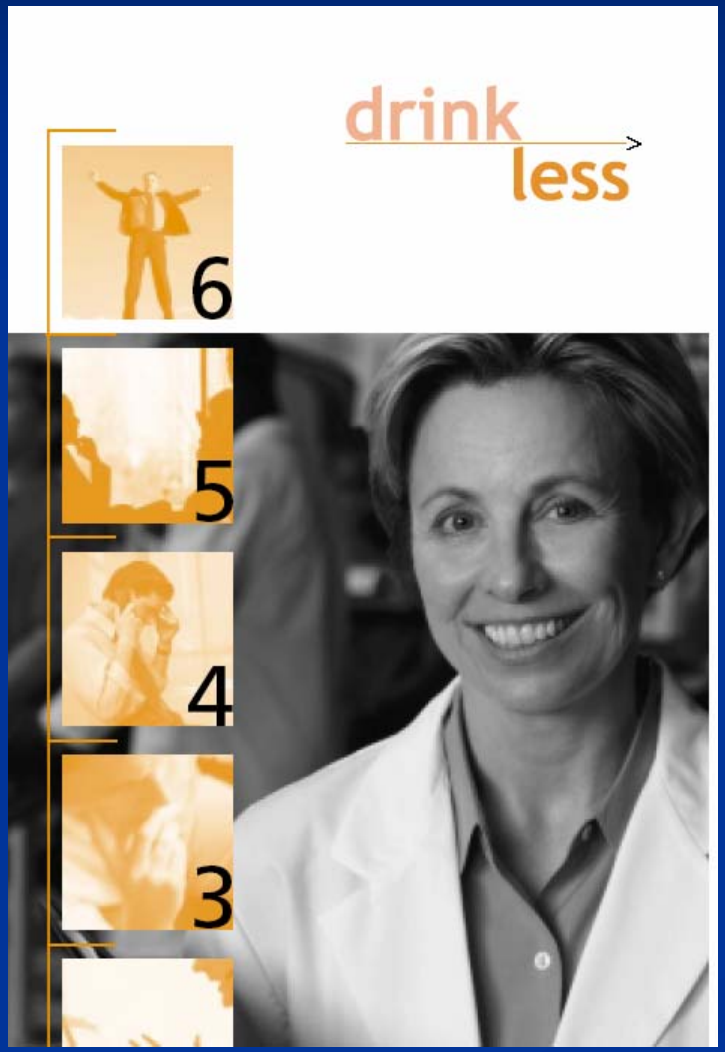
Median Brief Intervention Rates for GPs in the Training and Support Conditions

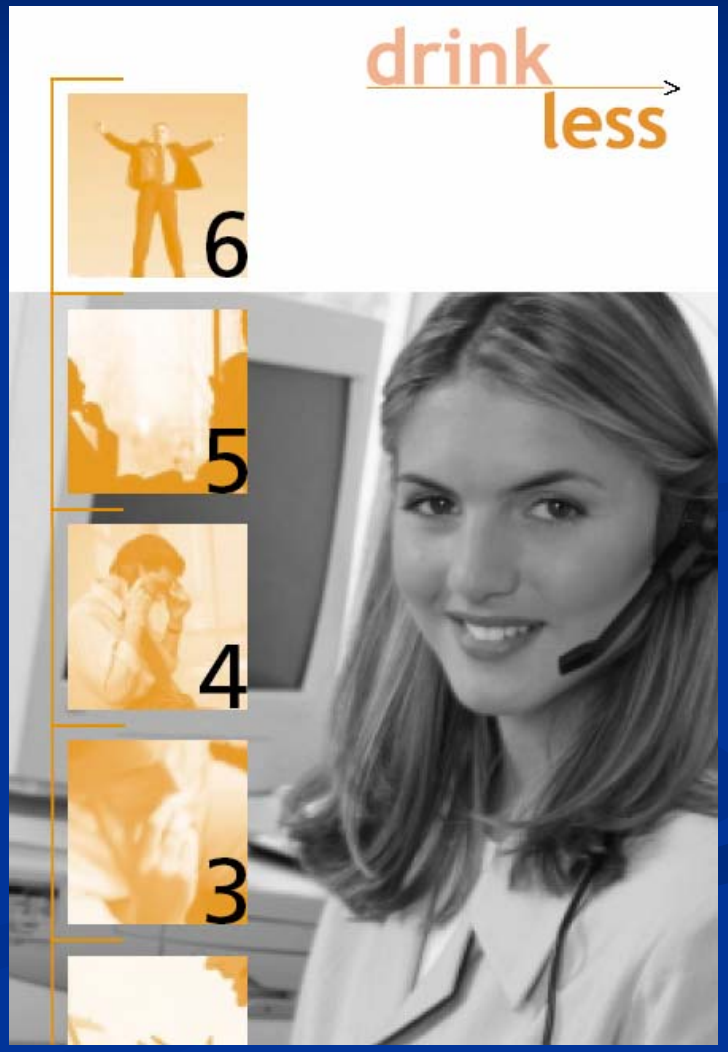


Training and Support Conditions

Max vs No	Z=2.51; p=.01
Max vs No & Min	Z=2.53; p=.01
Max vs Control	Z=2.31; p=.02
Max vs Control, Min & No	Z=2.77; p=.006

Drink-less: getting started





Handycard

drink less

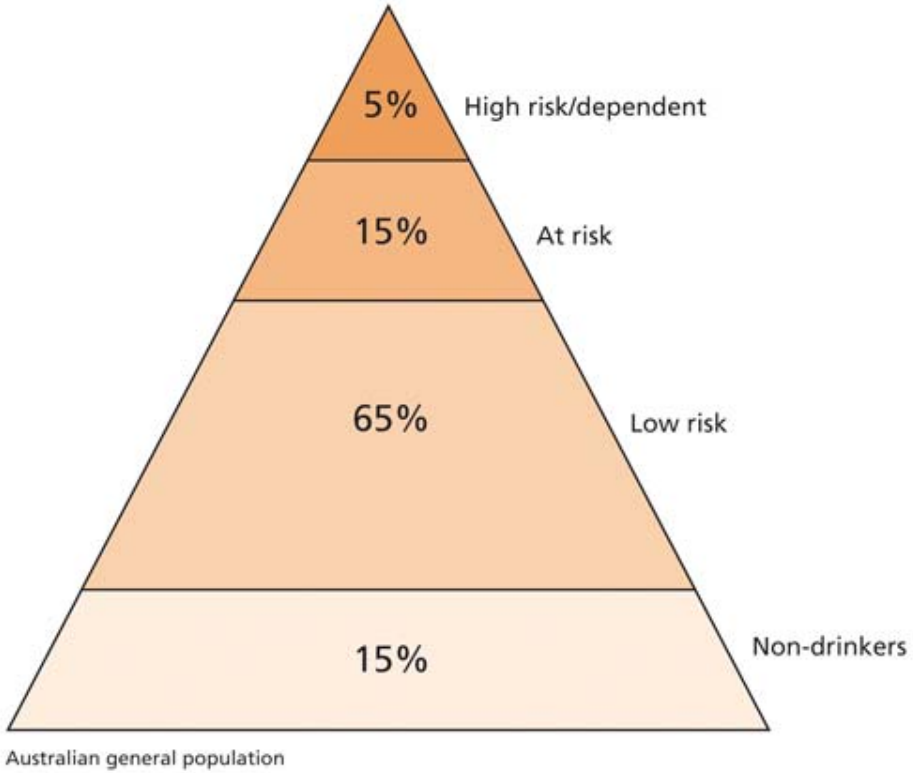
1 Feedback – Are **YOU** at risk from drinking alcohol?

Score	Common Effects
0-7 **low risk**	• Increased relaxation • Reduced risk of heart disease • In some situations even moderate drinking can pose a risk (e.g. driving, pregnancy, some medical conditions) • Even occasional heavy drinking can put you at risk of injury
8-12 **at risk**	• Less energy • Insomnia • Poor co-ordination • Less ability to think clearly • High blood pressure • Depression/stress • Impotence • Risk of injury • Danger in driving & operating machinery
13+ **High risk of dependence**	• The above risks plus: • Damage to liver, brain, memory • Physical dependence (addiction)

drink less

Handycard

What is everyone else like?



2 Have **YOU** thought about changing your drinking?

3 What benefits will you get from cutting down?

- sleep better
- more energy
- lose weight
- no hangovers
- better memory
- better physical shape
- improved mood
- less family hassles
- more money

Reduced risk of

- high blood pressure
- liver damage
- brain damage
- cancer
- drink driving
- injury (to you and others)

drink less

Handycard

4 Goals

Who	How many drinks per day?	Alcohol-free days
• Men	• No more than 4 standard drinks	• 2 per week
• Women	• No more than 2 standard drinks	• 2 per week
• Pregnant women	• No more than 1 standard drink 2 days per week	• 4 to 5 per week (avoid alcohol on most days)
• Special conditions e.g. driving, some medical conditions or medications	• Lower limits will apply	
• Everyone with physical damage from alcohol or dependence	• No drinks are safe	• Every day

• 7+ drinks (for men) or 5+ (for women) on any one occasion puts you at risk of harm

1 standard drink =

OR

middy of beer (285mls)

OR

small glass of wine (100 mls)

nip of spirits (30 mls)

drink less

Handycard

5 Strategies

How do I cut down?

- Drink only with food
- Have a glass of water to quench thirst and between drinks
- Switch from schooners to middies
- Switch to low-alcohol beer
- Avoid going to the pub after work
- Avoid or limit time spent with 'heavy drinking' friends
- If under pressure to drink, say "my doctor has told me to cut down"

Alternatives

- Plan other activities or tasks at a time when you usually have a drink
- When stressed, take a walk or exercise instead of drinking
- Explore new interests

Tips for keeping on track

Questions to ask yourself

- What are the most difficult times?
  Plan to avoid these situations or plan activities to help you cope.
- How am I doing?
  Occasionally, try writing down how much you have to drink over a week.
- Am I losing motivation?
  Remind yourself of your reasons for cutting down.
- Do I need more help?
  Don't feel embarrassed to come back for help. Specialist services are also available.

One Year Later

- Comments from follow-up study:
  - "Interesting to do some research"
  - A "special project"
  - The extent of some patients' drinking was a surprise to many GPs
  - Approx.10% were still offering SBI but "when indicated"
  - Some were using the materials as part of drink-driver programs
  - Most had ceased involvement
- Debate about the role of primary care:
  - Who owns the consultation?

Conclusions by the late 1990s

- Need to:
  - Promote structural incentives (including financial ones) in primary health care
  - Explore other methods and settings for screening and brief intervention

The World of Electronic Interventions

- Development of web-based and other computer-presented electronic interventions
- Electronic SBI (eSBI) delivered in university primary health care services reduces heavy drinking and related problems by 15-30% for at least 6-12 months
- Key publications:
  - Kypri K, Saunders JB, Williams SM et al. (2004). Web-based screening and brief intervention for hazardous drinking: a double-blind randomised controlled trial. *Addiction 99,* 1410-1417.
  - Kypri K, Langley JD, Saunders JB et al. (2007). Assessment may conceal therapeutic benefit: findings from a randomized controlled trial for hazardous drinking. *Addiction 102*, 62-70.
  - Kypri K, Langley J, Saunders JB et al. (2008). Randomized controlled trial of web-based alcohol screening and brief intervention in primary care. *Archives of Internal Medicine 168,* 530-536.

Electronic SBI compared with Practitioner-delivered BI

Effect sizes

	eSBI	BI
Consumption measures		
6 weeks:	0.40	0.67
6 months:	0.15	0.16
Alcohol-related problems		
6 weeks:	0.45	0.30
6 months:	0.44	0.14

Project Thrive

- A nationwide eSBI approach to hazardous alcohol use among student populations

  Principal investigators: K. Kypri, P. Howat

THRIVE

STUDENT HEALTH ONLINE

ALCOHOL SURVEY

Feedback | Facts | Tips | Support

Thanks for completing the survey John.

Here you will find some feedback based on the answers you have provided as well as some other information on staying safe whilst drinking which you may find useful.

YOUR ALCOHOL USE

0-7	Moderate Drinking
8-14	Hazardous Drinking
15-19	Harmful Drinking
20-40	Alcohol Dependence

Some of the questions you answered regarding your drinking come from the Alcohol Use Disorders Identification Test, a questionnaire developed by the World Health Organisation to determine whether a person's drinking might be becoming problematic.

Your AUDIT score was 20

MODERATE DRINKING (0-7) Low risk of alcohol related harm.

HAZARDOUS DRINKING (8-14) High risk of experiencing alcohol related harm and some people in this range may already be experiencing significant harm.

HARMFUL DRINKING (15-19) A person scoring in this range will already be experiencing significant alcohol related harm.

ALCOHOL DEPENDENCE (20-40) A person scoring in this range may be alcohol dependent and advised to have a clinical assessment of their drinking. To find out some services that might be useful go to the support page.

The main way to reduce your risk level (and AUDIT score) is to reduce the number of drinks you consume per occasion. You may like to check out the tips section for ideas on reducing your consumption.

Median completion time:

5.2 mins

(IQR: 4-7)

YOUR BLOOD ALCOHOL CONTENT

Your estimated Blood Alcohol Content (BAC) for your heaviest drinking occasion is 0.23%

Your BAC is an indication of how intoxicated you are, with a higher BAC corresponding with a greater likelihood of experiencing alcohol-related harm, especially when driving.

This estimate takes into account you gender, weight, the number of standard drinks consumed and the number of hours over which you reported drinking this amount.

At a BAC of 0.15 and above you are 380 times more likely to be killed in a single-vehicle crash than a driver with a zero BAC.

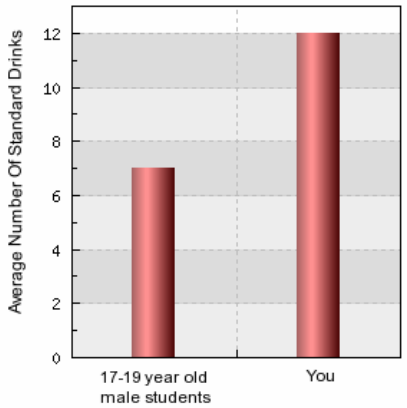
YOUR MONEY

Depending on where you buy your drinks (i.e. a bottle store, pub or club), you have spent between $936 and $3744 on alcohol in the last year.

YOUR DRINKING AMOUNT COMPARED

Standard Drinking Consumed Per Occasion

You reported having approximately 12 drinks on a typical occasion. The graph on the right shows how this compares to other people your age and gender.



THRIVE Summary outcome data

	Median (range)			
	Control		Intervention	
Frequency of drinking (number of drinking days)				
1 month	7	(0-28)	6	(0-28)
6 months	8	(0-28)	7	(0-28)
Typical occasion quantity (drinks per typical drinking occasion)				
1 month	6	(0-30)	6	(0-25)
6 months	6	(0-30)	6	(0-30)
Volume consumed (drinks per week)				
1 month	10.5	(0-140)	8	(0-140)
6 months	11.25	(0-120)	9	(0-143)
Personal, social, sexual, and legal consequences of episodic heavy drinking (# of problems – APS score)				
1 month	2	(0-14)	2	(0-12)
6 months	2	(0-14)	2	(0-14)
Consequences related to academic role expectations (AREAS score)				
1 month	1	(0-19)	1	(0-15)
6 months	1	(0-17)	1	(0-16)
Proportion exceeding NHMRC guidelines for *acute* harm				
1 month (n=944 control, 966 intervention)	58.6%		54.1%	
6 months (n=767 control, 813 intervention)	54.5%		52.9%	
Proportion exceeding NHMRC guidelines for *chronic* harm				
1 month (n=944 control, 966 intervention)	22.1%	→	15.1%	
6 months (n=767 control, 813 intervention)	25.0%	→	18.7%	

THRIVE Treatment effects	Rate ratio: Intervention / Control	(95% CI)
Frequency of drinking (number of drinking days)		
1 month	0.89	(0.84 to 0.94)
6 months	0.91	(0.85 to 0.96)
Typical occasion quantity (drinks per typical drinking occasion)		
1 month	0.93	(0.88 to 0.98)
6 months	0.97	(0.91 to 1.02)
Volume consumed (drinks per week)		
1 month	0.83	(0.78 to 0.89)
6 months	0.87	(0.81 to 0.94)
Personal, social, sexual, and legal consequences of episodic heavy drinking (# of problems – APS score)		
1 month	0.97	(0.90 to 1.04)
6 months	0.98	(0.91 to 1.06)
Consequences related to academic role expectations (AREAS score)		
1 month	0.94	(0.83 to 1.05)
6 months	0.95	(0.84 to 1.08)
Risk of exceeding NHMRC guidelines for *acute* harm	Adj. Odds Ratio	
1 month (n=944 control , 966 intervention)	0.85	(0.71 to 1.02)
6 months (n=767 control, 813 intervention)	0.93	(0.76 to 1.13)
Risk of exceeding NHMRC guidelines for *chronic* harm		
1 month (n=944 control , 966 intervention)	0.61	(0.48 to 0.78)
6 months (n=767 control, 813 intervention)	0.65	(0.51 to 0.84)

NNT = 16

Summary of Thrive Findings

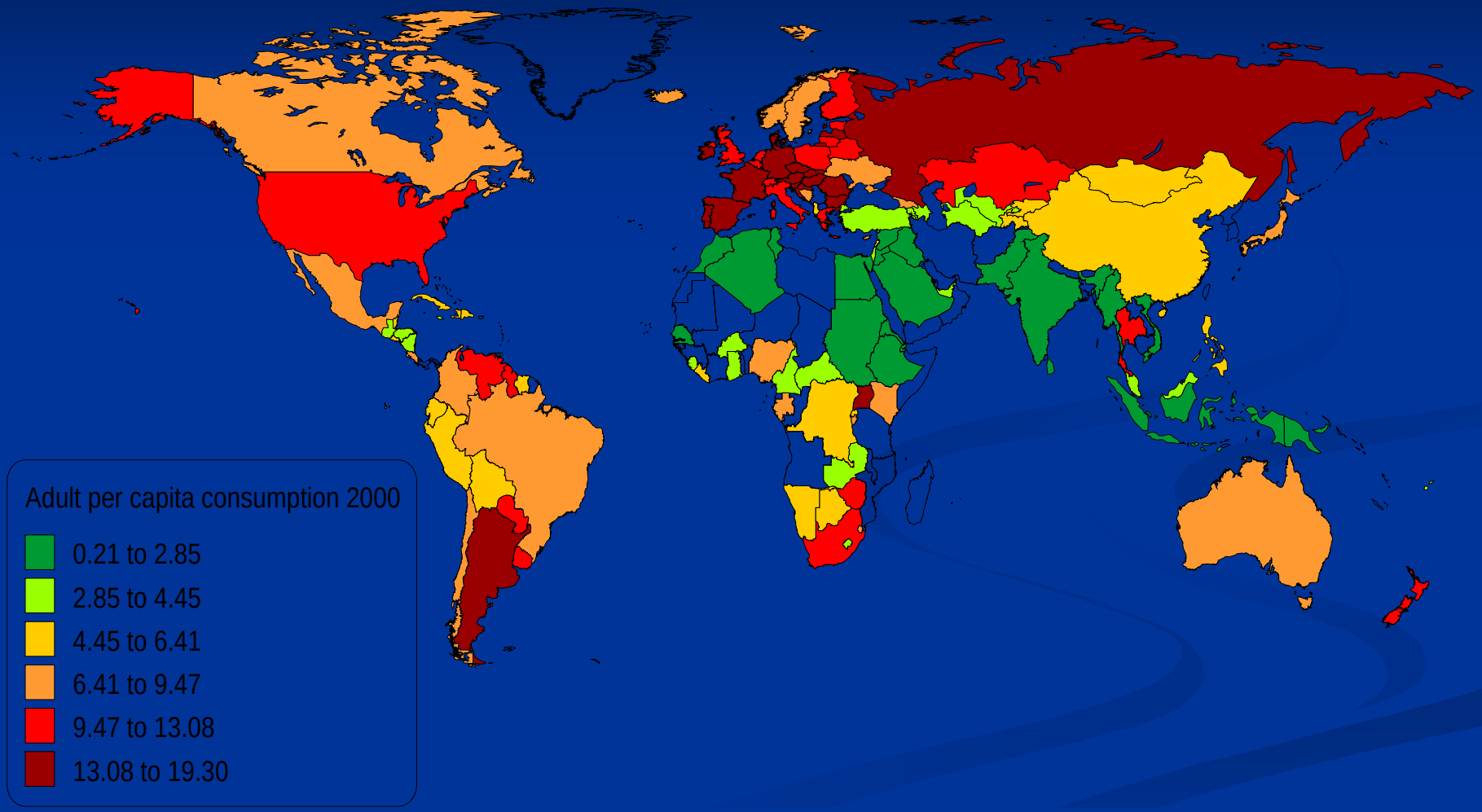
- <10 mins of e-SBI produced reductions in weekly drinking volume of 13% in this heavy drinking population group, lasting at least 6 months
- It reduced the odds of high-risk drinking (NHMRC guidelines) by 35% at 6 months (NNT=16)
- It almost doubled the odds of help-seeking behaviour
- e-SBI can be implemented on a large scale and participation can be maintained over time

K. Kypri, P. Howat, et al.

Global Initiatives: the work of WHO

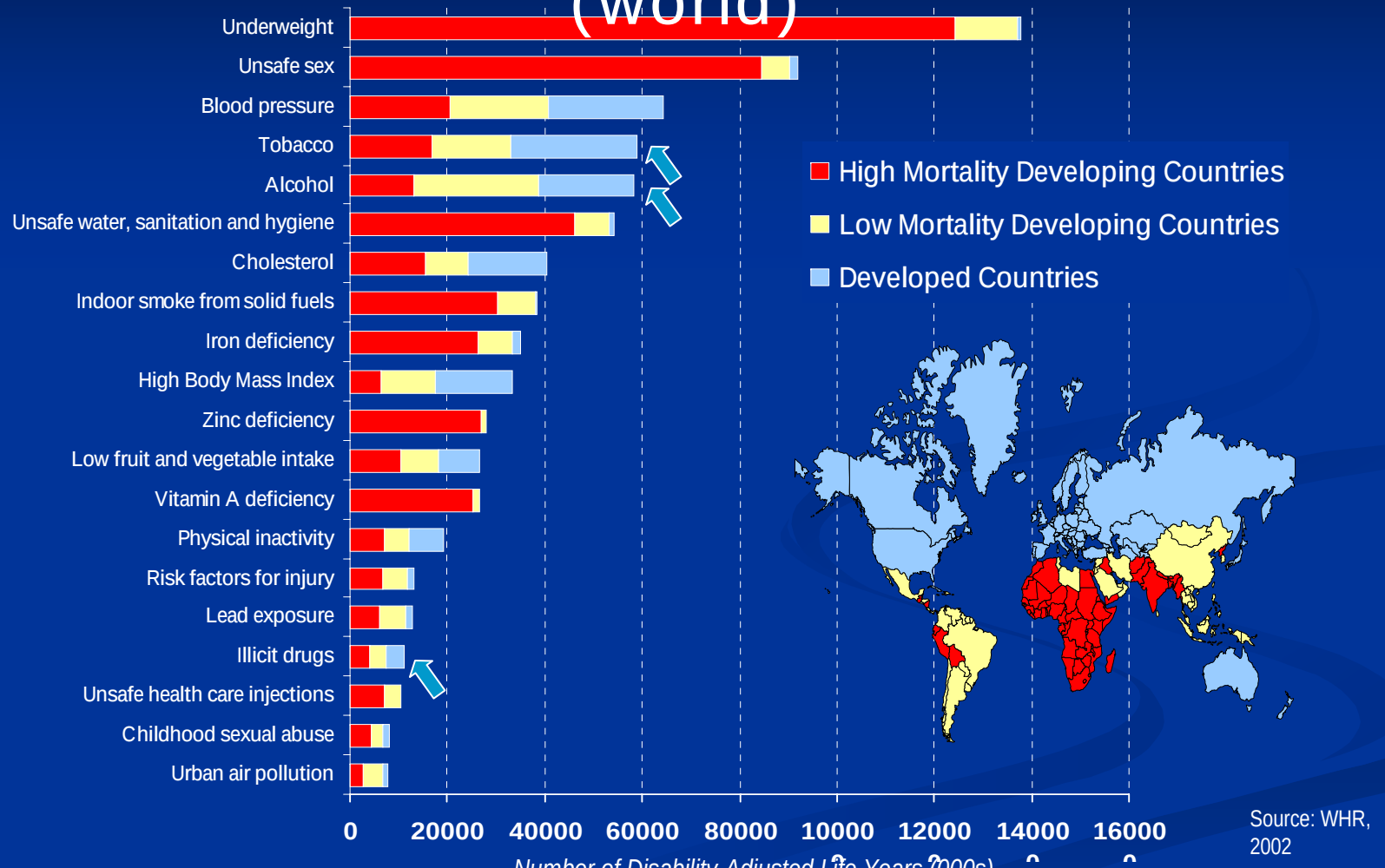
- WHO has promoted prevention and brief intervention efforts for over 30 years
- WHO Global Alcohol Strategy approved by the World Health Assembly, 2010
- Practical initiatives to support screening and brief intervention globally
- Includes the Mental Health Gap Action Program (mhGAP) of the Department of Mental Health and Substance Abuse (Director (until early 2010): Dr. B. Saraceno; now Dr. S. Saxena), which aims to ensure basic standards of health care in eight priority areas of mental health and substance use disorders

Adult per capita alcohol consumption



Source: Ezatti et al. 2004

Disease burden (DALYs) in 2000 attributable to selected leading risk factors (world)



Source: WHR, 2002

World Health Organization

WHO Public Health Priorities: Substance Use and Dependence

- ***Support early identification and interventions for hazardous and harmful substance use***
- Outreach to other health care sectors and beyond health care sector for promoting public health approaches to substance use disorders and substance use associated harm
- Strengthen public health perspectives in education and training of health professionals
- Promote research agenda of public health significance
- Educate the public

WHO mhGAP Program

- Aims to ensure that the populations of low- and middle-income countries have access to health care in eight priority areas
- Two of these areas are (1) alcohol use disorders, and (2) drug use disorders
- mhGAP work involved
  - a review of the evidence base,
  - scrutiny by an expert committee (the GDG)
  - production of recommendations, and
  - clinical and other resource materials

WHO mhGAP Program

Effect of brief interventions versus no intervention or standard care in persons with hazardous or harmful alcohol use?	
Relative (95% CI)	**Absolute**
Heavy drinking (follow-up mean 1 year[1]; self report)	
RR 0.68 (0.57 to 0.81)	173 fewer per 1000 (-103 to -233)
Alcohol related injury (follow-up 6-12 months; interview)	
RR 0.59 (0.42 to 0.84)	82 fewer per 1000 (-32 to -116)
Alcohol consumption (gm/wk) (follow-up 1 year; measured with: self report	
-	MD 38.42 lower (54.16 to 22.67 lower)
Mortality (follow-up 1-10 years)	
RR 0.47 (0.25 to 0.89)	17 fewer per 1000 (-4 to -24)

WHO mhGAP Program Recommendations

- Screening and brief interventions for hazardous and harmful alcohol use are recommended in non specialist health care settings, except in areas of low prevalence. The brief intervention is still relevant in low prevalence areas, population groups)

  STRONG
- Screening for hazardous and harmful alcohol use should be conducted, using a validated instrument that can be easily incorporated into routine clinical practice (e.g. AUDIT, AUDIT-3, AUDIT-C, ASSIST). In settings in which screening is not feasible or affordable, practitioners should explore alcohol consumption in their patients when relevant.

  STRONG

WHO mhGAP Program Recommendations

- Patients with a hazardous and harmful alcohol use should receive a brief intervention. The brief intervention should comprise a single session of 5-30 minutes duration, incorporating individualised feedback and advice on reducing or ceasing alcohol consumption, and the offer of follow-up.

  STRONG
- Patients identified as having dependence or not responding to brief intervention should be offered a more intensive intervention or referred for specialist care.

  STRONG

Conclusions (1)

- Screening and brief intervention research has developed valid tools to identify alcohol use disorders and and effective interventions to reduce risky use and its consequences
- Techniques to promote SBI in primary health care are available
- Despite the compelling research evidence, the potential for SBI has not been realised in health care
- WHO's advocacy is now a powerful help
- Financial and other structural incentives will be crucial to success in the health care sector
- Replication of a structures "research" approach cannot be expected of health care providers
- SBI may well be better offered "direct to consumer" using techniques such as electronic interventions

Conclusions (2)

- SBI needs to be accompanied by evidence-based preventive efforts
- Threats to the profitability of the alcohol industry will be met by formidable resistance
- Preventive efforts will require alcohol to be classified as a special product, in recognition of the public health consequences of its use
- Profitability for the producers will be a key aspect of negotiations
- Whether government, the alcohol industry and the public health sector can accept the goals of (1) the public good and (2) the right to profit is the ultimate question

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Disclosures

- I am not in receipt of any funding from commercial alcohol companies or any organisations supported by them.
- I have not received any form of funding from a tobacco company in my entire professional career.
- I do not receive any research or other regular funding from pharmaceutical companies. I receive lecture fees and travel expenses periodically from them, but the total amounts to less than 1% of my income.
- I hold a portfolio of shares in Australian and international companies. I do not hold any shares in companies that produce alcohol, tobacco or pharmaceuticals.

Unlabeled/Unapproved Uses Disclosure

- Nothing to disclose.