

**WHO Collaborative Study  
on  
Alcohol and Injuries**

**REPORT  
of the Second Meeting of Principal Investigators**

**Mexico City, Mexico. November 26-28, 2001**

**Instituto Nacional de Psiquiatría**

**“Ramón de la Fuente”**



**World Health Organization  
Department of Mental Health and Substance Dependence  
Department of Violence and Injuries Prevention**

# Content

Introduction .....	1
Background .....	1
Participation .....	2
Opening Remarks .....	2
Expected Outcomes of the Meeting .....	2
Country reports .....	3
Summary Of Issues Identified From The Site Reports .....	9
Analysis Plan.....	11
Parallel Working Groups.....	13
Authorship and Publication .....	16
Web-site .....	16
Integration of the Country Reports: .....	17
Literature Review .....	19
Journal Papers To Be Written.....	19
Future Developments in each Country.....	21
Priorities for Further Research.....	24
ANNEX 1 - LIST OF PARTICIPANTS .....	25
ANNEX 2 - PROGRAMME OF THE MEETING- Revised.....	27



**Second Meeting of Principal Investigators  
WHO Collaborative Study on Alcohol and Injuries  
Mexico City, Mexico. November 26-28, 2001**

**REPORT**

---

This report was prepared for the WHO Department of Mental Health and Substance Dependence by Dr. Guilherme Borges & Mrs. Rita Varela, using the notes from Dr. J. Rehm & Dr. M. Peden

**INTRODUCTION**

The second meeting of principal investigators from the WHO Collaborative Study on Alcohol and Injuries was convened at the National Institute of Psychiatry "Ramon de la Fuente" in Mexico City, Mexico, November 26-28, 2001. This was a follow up of a previous meeting held in Prague in May 2000. The basic goal of this meeting was to review the current status of data gathering in the different collaborative sites and discuss data analysis and dissemination of the study results.

**BACKGROUND**

In 1998, about 5.8 million people died of injuries worldwide and injuries caused 16% of the global burden of disease (WHO, 1999). Nearly 90% of injury deaths occur in the developing world. Despite the magnitude of the problem, injuries are not yet recognized as a public health priority. Young people in their most productive periods of life are particularly prone to injuries and violence.

Alcohol involvement in injuries has been demonstrated in numerous studies. The problem of alcohol-related injuries is particularly alarming in many developing countries, where alcohol consumption is increasing, injury rates are extremely high, and appropriate public health policies have not been implemented. However, the role of alcohol in injuries is not yet well understood and documented for development of adequate policy responses, and a system of registration and reporting of alcohol involvement in casualties is still lacking in many developing and developed countries.

Acknowledging this problem, WHO through the departments of Mental Health and Substance Dependence (MSD) and Injuries and Violence Prevention (VIP) coordinated and supported the participation of several countries in a joint project on the role of alcohol in injuries in the emergency rooms. During the years 2000 and 2001 participants of the previous meeting held in Prague developed a study protocol to be followed by each site, constructed questionnaires, a programme for data entry and developed the training materials for a common research project. Each participating site agreed to collect 500 patients attending the emergency department of a selected hospital in their country. During this period, each country embraced the task of contacting hospitals, adapting the protocol and collecting data according to the

protocol. The New Zealand site also developed under a contract with WHO/MSD a website and made it available to the project investigators (<http://forums.aphru.ac.nz>).

This second meeting was scheduled to review the work done by the participating sites. The main goals were:

- to review the progress made to date in each site,
- to review initial data analysis for each site,
- to discuss the plan of publications,
- to set up priorities and planning next stage of activities.

Prior to the meeting, the participating countries provided a report on activities. The reports for the following countries are available on the website: **Canada, Czech Republic, China, India, Mexico, Mozambique, New Zealand, South Africa and Sweden.**

## **PARTICIPATION**

A total of 16 participants from 11 countries (Belarus, Brazil, Canada, Czech Republic, Mexico, Mozambique, New Zealand, South Africa, Sweden, Switzerland and USA,) attended this meeting in Mexico (Annex 1 presents the list of participants). The representatives of Argentina, India and People's Republic of China were unable to attend the meeting. However, they provided their progress reports which were discussed at the meeting.

***November 26, 2001***

## **OPENING REMARKS**

In his opening remarks *Dr. Vladimir Poznyak* welcomed the participants of the meeting on behalf of Dr. Benedetto Saraceno, Director of WHO Mental Health and Substance Dependence Department, and Dr. Maristela Monteiro, Coordinator of the Management of Substance Dependence Team. *Dr Margie Peden*, from Violence and Injuries Prevention, Non-communicable Diseases and Mental Health Cluster, co-sponsor of the meeting, also welcomed the participants on behalf of Dr Etienne Krug, Director, VIP.

*Dr. Guilherme Borges*, host of the meeting, from the National Institute of Psychiatry "Ramón de la Fuente" and on behalf of WHO Country Representative in Mexico (PAHO office), welcomed the participants and described the goals of the Institute regarding research and health services in the field of alcohol and substance abuse.

*Dr. Ma. Elena Medina-Mora*, Director of Epidemiological and Psychosocial Research from the National Institute of Psychiatry "Ramón de la Fuente", welcomed the participants and stressed that previous research in this area had been a great help to public policy in this field. She, and other authorities of the Mexican Institute of Psychiatry, expect that this new research will also contribute to public health policy.

## **EXPECTED OUTCOMES OF THE MEETING**

As a first step Dr. Jürgen Rehm was elected a rapporteur for the meeting and Dr. Robin Room was elected a chairman.

Dr Vladimir Poznyak and Dr Margie Peden presented the goals for the meeting. The following specific **objectives** were identified:

### **Specific issues in the design and outcome of the study**

- the feasibility of Y90 and Y91 codes in emergency rooms (Do they work? If yes, under what circumstances?)
- the link between alcohol use and injuries in different cultural settings
- the feasibility of cross-over design in emergency rooms

### **Further work and procedural agreements**

- the feasibility of alcohol use and injury surveillance
- an analysis plan.
- publication and dissemination plan
- recommendations on methodology
- training package for monitoring and studying alcohol involvement in injuries in the ER
- web-site
- the structure of final reports and local dissemination plans
- literature review (discussion papers of Judith Roizen on methodology and findings)
- literature review about policy implications by Sally Casswell
- priorities for WHO for further research
- how methodology could be adapted to include other drugs

The agenda for the day was presented and the logistics were discussed (Annex 2 presents the three-day agenda, after amendments).

### **COUNTRY REPORTS**

Preliminary results from individual centers were presented. Bellow is a summary of these presentations. The following countries provided electronic presentations available on the project's web site: **Brazil, Czech Republic, India, Mozambique, New Zealand, South Africa, and Sweden.**

#### ***Argentina***

*Dr. Cheryl Cherpitel, from the Alcohol Research Group in Berkley, California, presented a report from Argentina, since Dr. Mariana Cremonte, PI in Argentina, was not able to attend.*

Dr Cherpitel assisted with the training in Argentina. 15 Doctors were trained to do the clinical assessment – no nurses were included since they have no formal education. When a patient is admitted they are clinically assessed by a doctor not working in the ER (but in a ward nearby) to facilitate the rapid movement of patients through the ER. This could present potential biases since the study aimed to assess the feasibility of using Y90/91 codes by the doctors working with the patients in the ER.

Because of a lack of space in the hospital, interviews had to be conducted in the corridor. This was particularly problematic when a patient was in custody and police officers would not leave the patient's side. In these cases, the interview was terminated in order to maintain the patients confidentiality.

Despite having to extend the data capture period because hospital staff went on strike, the data capture has been completed. A final report on results should be available by the end of the year.

There is currently no systematic collection of data of any type in the ER. This facility needs an Injury Surveillance System put in place as a first step.

### **Belarus**

*Professor Roman Evsegneev, Department of Psychiatry, Belorussian Academy of Postgraduate Medical Education.*

Official alcohol consumption in Belarus was 9.9 litres in 2000 but probably as high as 20 litres. Most injuries in Belarus are treated in Outpatients clinics – trauma centres. The 2<sup>nd</sup> outpatients clinical in Minsk city serves approximately 13,000 cases of injuries/trauma per year. It deals with 90% of injuries from the catchment area.

Total sample size 514 patients in Trauma Center. The proportion of patients with alcohol intoxication by observational assessment was n=118 (23%).

Analysis has only been conducted on the first 100 patients. Demographics: 51% male and 49% female. Majority of patient seen from 18:00 to 24:00 hours. The majority of patients had been injured in falls and trips (44%) while 24% were the result of a stab, cut or bite. The most common beverage consumed was vodka (45%).

Alcohol intoxication was recognised

- By the observational assessment in 25%
- By the quick observational assessment in 24%
- By breathalyser in 27%
- Very severe 1%
- Severe 8%
- Moderate 6%
- Mild 12%

There was a very good correlation between observational and breathalyser. Breathalyser slightly more sensitive. Doctors are taught to clinically assess for alcohol during their training so they are used to using this methodology. Y codes use a less tedious method of alcohol assessment compared with their current methods and so doctors were happy to use them because they were quicker to conduct. However, most still preferred using the breathalyser.

### **Brazil**

*Dr Neliana Buzi Figlie, Alcohol and Drug Research Unit, Federal University of São Paulo (UNIFESP).*

The field work was done at the University Hospital in Sao Paulo city, a large trauma centre (250,000 persons per year). This is a public hospital which is open to everyone. The PIs had no ethical problems with the study.

The PI reported that 14% of the population have been treated for an injury in their lifetime. They included the assessment of cannabis, cocaine and benzodiazepines using the Drug Abuse Screening Test (DAST) and the Drug Use Disorders Identification Test (DUDIT). They also used the Quick Assessment Tool (QC-A) for assessing alcohol intoxication.

They included 518 patients in the study – 66% of whom were men. The average age of patients was 35.4 years. One-third has been injured as a result of a trip/fall, followed by stabbing (18.5%) and traffic-related injuries (16.6%).

13% of patient were found to have a positive breath alcohol level. Furthermore, 13% were positive for cannabis and 6% for cocaine. Dr Figile had not yet performed KAPPA statistics to compare breathalyser versus clinical assessment results but her results looked like doctors tended to under estimate the level of alcohol.

### **Canada**

*Dr. Scott Macdonald, Center for Addiction and Mental Health (CAMH), , London, Ontario & Dr. Norman Giesbrecht, Center for Addiction and Mental Health (CAMH), Toronto, Ontario.*

Canada have not yet started collecting data. They have identified a hospital in Orangeville, Ontario where they will conduct the study. This hospital sees about 36000 patients a year the majority of which are due to unintentional and sporting (skiing) injuries.

Nurses will be trained to use the observational assessment. A few country specific questions have been added to the questionnaire. Data collection is planned for February 2002.

The proposal has been cleared by the ethics committee but the committee insisted that they include a statement that says that the police can subpoena the information if it is required for a litigation case.

They would like to introduce injury surveillance into the ERs.

### **Czech Republic**

*Dr Hana Sovinova, National Institute of Public Health, Prague.*

The study was conducted in the University hospital in Prague. Thye had no problems with ethical consent and subjected their clinicians to intensive training prior to data capture.

The study took place between January – June 2001, after piloting the study in the beginning of the year. Approximately 3% of patients were found to be alcohol positive. They found that people tend to deny their alcohol drinking and also because the legal limit for driving is 0, patients stay away from the hospital until they have sobered up.

The study found that the Y91 codes were not reliable. There was only a weak correlation between Y91 codes and the breathalyser results. Depending on the method used to assess alcohol intoxication between 3 and 15% of the patients were intoxicated at the time of their presentation to hospital.

Many patients were excluded from the study because their injuries were more than 5 hours old. Furthermore, a number of patients refused to participate because they were wary that field workers were from health insurance companies.

### **Mexico**

*Dr Guilherme L. G. Borges, Instituto Nacional de Psiquiatria "Ramón de la Fuente", and Universidad Autonoma Metropolitana. Mexico City, Mexico.*

The PI from Mexico reported several problems with the project. Data collection has not started, due to the political situation in the large ER setting that had been chosen. The new administration in the city is under close scrutiny because of questions on health care delivery, especially Y codes and breathalyzer that may give rise to problems regarding liability and underreporting. They do not want to do anything in the hospitals which could call attention to the health care delivery in the city. Management is very nervous about the doctors having to do clinical assessment versus breath analysis. They were scared there would be suing etc. by patients if the doctors do poorly.

Gave up to the city hospital and have moved to a general hospital of medium size. Have a medium size ER, level II trauma centre. Started discussion with this hospital. Have piloted in this second hospital and have completed this last week. Data capture is scheduled to start in the third week of January (2002) and will run until March.

No big problems with the pilot. Doctors are willing to participate. No ethical issues in this second hospital. There is interest also in screening for substance use, since cocaine is a problem in Mexico City over the last 5 years.

### **Mozambique**

*Dr Otilia Neves, Emergency Department Director, C/o Emergency Services, Maputo Central Hospital, Maputo.*

The study was done at Maputo Central Hospital. Since this is a referral hospital there was over-representation of more severe cases. Clinical assessment was conducted by Junior doctors after a training session conducted by the South African team.

The data collection was done between October 2001 – November 2001, after a pilot August. The questionnaire was translated into Portuguese. There were no ethical issues with the study.

A total of 461 patients were included in the study, but there was a high exclusion rate because of the 6 hour cut off point (many patients are referred from other hospitals). The results show that 18% of patients are intoxicated at the time of presentation to hospital after an injury (using the breathalyser and clinical assessment). Alcohol was strongly associated with violence, however, they need to do further statistical analysis on the data. No KAPPA done on the data but preliminary results suggest that there was only a correlation between clinical assessment and breathalyser in those patients who had taken no alcohol.

### **New Zealand**

*Professor Sally Caswell & Dr. Gayl Humphrey, New Zealand Alcohol and Public Health Research Unit, University of Auckland School of Medicine, Auckland.*

The first part of the study was done in Auckland, in December 2000, in a level I trauma hospital with significant throughput. 23% of patients refused participation. The final sample

size was 166 patients. The second part of the study will be done later in 2002 – they are awaiting further funding. If they receive funding they will conduct the study at a further 3 sites in New Zealand.

Main results of the study showed that there were 59 patients (18%) who were alcohol positive (self-report or Breathalyzer or observed). Of those who were positive, 61% had levels greater than 90ml (70g) They found a dose relationship with case-crossover.

A total of 15% of the patients were positive for getting re-injured. There was a strong dichotomous variable agreement; bad agreement with Y91 classification with degrees (underestimate). This was the only site to have performed KAPPA statistics on association between the observational method and breath alcohol. The study showed that doctors systematically under-report alcohol intoxication using the Y91/91 codes.

### **South Africa**

*Dr Sandra Marais, Crime, Violence and Injury Lead Programme Medical Research Council, Cape Town.*

This study was done in the City of Cape Town, and forms part of the South African Community Epidemiology Network on Drug Abuse. The hospital is located in a very violent neighborhood, high urban poverty. It has a rape unit connected to the hospital. The doctors in trauma unit were observers and no substance abuse treatment was available. The study was done between July and September 2001. 809 patients were interviewed and 501 were included in the study. The principal reason for exclusion was mostly by 6 hour rule. Proportional sampling was used for the majority of the sample. For the last week, disproportionate sampling was used. This will need to be factored in when data is combined.

There were some problems with language, intoxication, anonymity.

The main results shows that violence was the leading cause of injuries at this facility. Fifty percent of patients who presented to the facility were alcohol positive using the breathalyser.

There was a poor relationship between clinical assessment and breathalyser levels. Doctors were able to judge whether a patient had not taken alcohol or was very severely intoxicated, but not the levels in between. Further indepth statistical analysis is required to assess the true reliability of Y91 codes.

The doctors were not happy to perform the clinical assessment because it meant that they had to leave the patient they were currently attending to assess a new patient – they complained that it broke the continuity of their work.

### **Sweden**

*Dr Martin Stafström, Department of Community Medicine, Malmö University Hospital, Malmö, & Dr Robin Room, Centre for Social Research on Alcohol and Drugs, Stockholm.*

The PI (Dr. Stafström ) had to apply for ethical approval first. This was because nurses and doctors have to write down everything they know about a patient in a medical report. If they wrote down the BAC in the notes then medical insurance companies can subpoena the

results. Had to explain that the alcohol results would not be divulged to the treating doctors so would not be written down in the notes. In the selected hospital in Malmö, 9% of all patients had an injury, 92% of which were unintentional

The study started on the first week of August and up to this point they have 394 completed interviews and 658 exclusions, mostly due to the 6 hour rule. Analysis has only been performed on the first 86 patients. Only two were found to be alcohol positive. This low incidence may be because patients tend to stay away from a health facility until they have sobered up because if they are found to be intoxicated the medical insurance will not pay.

### ***United States***

*Dr Cheryl Cherpitel, Associate Director, National Alcohol Research Center; Senior Scientist, Public Health Institute, Berkeley.*

In the USA, the PI planned to do the study in Texas, as part of a four-site grant proposal for a study on alcohol and drugs. However, the ethics committee refused permission because they were concerned that the data from the breathalyser would be linked to the persons name and that this could be linked to police data. The PI has never had a problem in any of her other studies, but she could not make this clear to the review board. The ethics committee asked her to change the consent form to say that the data could be used against them. Since she did not agree with this she decided to abandon the study at the site.

Dr Cherpitel has conducted many similar studies in the USA. These sites may be included in this collaborative study.

### ***China/India***

**Prof. Hao Wei and Dr. Vivek Benegal**, as mentioned before, were unable to attend the meeting. However they sent information that was delivered by Dr Vladimir Poznyak, Management of Substance Dependence Unit, Department of Mental Health and Substance Dependence, WHO, Geneva.

**China:** The study is being conducted in Changsha at the Hunan Medical University which is a WHO collaborating centre. Data collection is almost complete and will be available by the end of December, 2001. They made no modification to questionnaire except for definition of drinks. They also included all injured patients over the age of 15.

**India:** The study is being conducted in Victoria Hospital, a large hospital in Bangalore. This hospital sees approximately 32 000 patients a year of which 15 789 are medico-legal cases. Just over 28% of these cases are due to driving under the influence of alcohol while a further 28% are the result of violence.

The data collection has been completed. They conducted proportional and disproportional sampling techniques to obtain their 658 cases – 500 proportional and 158 disproportional. They needed to make a number of alterations to the questionnaire in order to accommodate the local brews in India and different strengths of commercially sold alcohol.

Doctors in the ER were trained to assess alcohol clinically but were poorly motivated to conduct such a lengthy assessment and so generally went on the smell of alcohol or slurring

of speech. Consequently there was a poor association between breath alcohol and the severity of intoxication judged clinically.

The study found that 34.5% of injuries were definitely linked to alcohol, i.e. either the victim or perpetrator had been drinking. A further 24% were possibly alcohol-related.

### **Summary of Presentations**

After the presentations for individual countries, Dr Jürgen Rehm, Research Director, Addiction Research Institute, Zurich summarised a number of points from the discussions that followed the presentations. They were:

- comments on the relationship between alcohol and other drugs;
- the issue of drug testing (time horizon and issue of intoxication);
- how to deal with intoxication and consents (how could an intoxicated person give informed consent);
- intoxication and the validity of information;
- the minimal requirements of reporting (see below for Country Reports);
- the issue of observational assessment being done immediately (implications for Y codes);
- the need to implement weighting schemes at some sites;
- ASSIST (the WHO Alcohol, Smoking and Substance Involvement Screening Test);
- Y90/Y91 reliability;
- interest in brief intervention among participating sites;
- attitudes of emergency room workers and possible threats for future implementation of surveillance;
- stigma and legal problems in some societies;
- the general acceptability of alcohol in several cultures and how it would affect intervention;
- the impact of culture and social influences on relationship between alcohol and accidents;

On a more broad perspective, Dr Jürgen Rehm presented a summary of the main points from the individual site reports. They were:

### **SUMMARY OF ISSUES IDENTIFIED FROM THE SITE REPORTS**

- Specific issues in the design and outcome evaluation of the study – methodological issues
- Specific issues in the design and outcome evaluation of the study – content issues
- Alcohol and other drugs
- Intervention designs
- Attitudes of ER workers – a thread for future monitoring systems

#### **1. Specific Issues in the Design and Outcome Evaluation of the Study**

- Feasibility of Y90 and Y91 codes in emergency rooms (Do they work? If yes, under what circumstances and after what training assessed by whom?)

- Link between alcohol use and injuries. How to incorporate information about dropouts and time lags into estimates of attributable fractions?
- Feasibility of cross-over design in emergency rooms
- How do we incorporate weighting in the combined analysis?
- Additional suggestions:  
6 hour cut-off point should be scrapped in those sites that have not collected their data yet. Also it is needed to look at age cut off points in the analysis.  
The use of the breath analysis in the emergency room should be looked at.  
Exclusion of certain people, e.g. domestic violence

All these issues have to do with the analysis plans, that would be discussed on Nov. 27.

## 2. Link between alcohol use and injuries

- What is the role of culture and society and other intervening variables (stigma, norms in talking about alcohol, base rate of females vs. males in ER, acceptability of alcohol etc.)?
- Do we have to collect additional variables to understand the relation between alcohol and injuries?

## 3. Alcohol and other drugs

- Alcohol and other drugs in the ER? Some participants mentions that in their countries alcohol should be considered together with other substances
- Issue of drug testing for drugs other than alcohol (time horizon and issue of the role of other drugs in the judgment of intoxication by experts)
- Chemical and social interactions between alcohol and other drugs
- Future activities

## 4. Intervention designs

- How could ER studies be combined with (brief?) interventions to decrease alcohol-related harm? There is a general interest to move in the near future to a proposal that incorporates brief intervention in the ER.
- Venues for another round of activities?
- Future activities

## 5. Attitudes of ER workers – A tread for future monitoring systems

- In many sites, the key informant interviews showed reluctance about routine incorporating alcohol into the routines of ER. This may have important consequences for planned monitoring and surveillance systems. It was mentioned that there was a planned session on November 27 on monitoring and surveillance.

**November 27, 2001**

During the second day of the meeting a great amount of time was dedicated to discussing plans and proposals for data analyses.

## **ANALYSIS PLAN**

### 1. Additional data needed on site environment

(needed by end of January, 2002)

Material about the exclusions need to be analysed systematically. Sites were asked to keep a register which indicated why patients were excluded. The data from this register needs to be tabulated. Dr. G. Humphrey will make a model of how this needs to be presented. This is in the country report model (SEE BELOW).

### WHO project : Comparative Risk Analysis (CRA)

This WHO CRA project has already gathered alcohol consumption data from several of the countries that are participating in the ER project, in particular the questionnaire on drinking and drinking patterns for each of the countries should be included in the study.

There is no need to duplicate efforts - the following information will be available to all the sites (courtesy of Jürgen Rehm):

- Basic figures on drinking – per capita consumption
- Quantity and frequency of drinking, including heavy drinking occasions (from surveys or from expert judgements)
- Typical descriptions of drinking situations which are relevant to outcomes – link alcohol to health outcomes
  - Drinking with meals
  - Drinking in public places
  - Norms on drinking and violence

CRA questionnaires were sent out in September and 50 countries have responded.

These data have been summarised as well as individual results for all the countries around the table. In addition, information about legal drinking age and limits for drink driving as well as the price of one drink will be requested. Participants are asked to scrutinise these data and feedback information to him where there are discrepancies.

Participants should consult the global alcohol database as well: [www.alcoholinfo.org](http://www.alcoholinfo.org)  
For country-specific injury mortality and morbidity data from the WHO Global Burden of Disease study go to the WHOSIS database on the internet: [www.who.int/evidence](http://www.who.int/evidence) (look under Cause of Death for mortality data, and Burden of Disease for morbidity data)  
Pricing of alcohol – this will have to be collected for countries.

## 2. Model for in country analysis/national report

(report needed by end of February- Dr. Caswell will be in charge)

Each country must present their final report by the end of February 2002. The guide which follows should be used so that the results are comparable across sites..

After several drafts, a complete set of templates are available and already put as a separate document at our website. Please refer to it at

<http://forums.apfru.ac.nz/resources/ReportTemplate1.ppt>

You may also see below under "Integration of the Country Reports" for a text version of the what Country Reports should include.

## 3. Plans for combined data analysis for project

A report on the analysis of combined data is required by end of June. The New Zealand site will be responsible for producing this report.

### General considerations

#### Descriptive

Identification of relevant variables

Statistical comparisons across sites based on scale level of variables (ANOVA, ANCOVA, Comparison of rates, etc)

The Analytic- Plan for Hierarchical data analyses presented by Dr. Rehm. It was proposed that at the analytical phase of the project, we can make use of new approaches for data analyses that would take into account all the richness of the information across sites. A model was presented:

- The design of the study
- Influences at the individual level (e.g. consumption before injury, usual consumption, SES, etc)
- Influences at regional level: pattern of drinking in the culture, poverty of the region, etc
- Hierarchical data structure (see Jürgen model)
- Multilevel regression model

The characteristics of the sites, even if only qualitatively assessed (e.g. categorical variables) should and could be incorporated to explain the relations between characteristics of alcohol consumption and injury risk. This is possible by using hierarchical designs which by now are so flexible that they are not restricted to linear models. Hierarchical designs are used in comparison of hospitals, analysing data sets from different countries by WHO, comparing schools. Specific packages incorporate weighting.

### Specific analysis for Y90 / Y91 codes

Different sources on status and level of intoxication (self-report, breathalyser, clinical judgements)

Comparisons again from simple to more analytical

Simple: comparison of rates, table analysis (e.g. kappa, and weighted kappa)

## Analytical

Multinomial logistic regressions on which factors influence differences between sources including symptoms counts

Latent trait models to look at all four sources simultaneously

Mimic models to identify influencing factors on shared characteristics

### 4. Plans for coordinated analysis with other projects

#### ER Studies

Dr. Cherpitel presented her current work and experience doing research in ER in several countries. She has 5 years of funding to analyse 8 countries and 33 ERs on alcohol and injuries. She is doing multi model analysis and inter country analysis. Study data include several ERs in Mexico, Italy, Spain, Australia, Canada, USA. She has included contextual information in these studies and uses similar methodology and questionnaire to our study. It is proposed that we merge her study data with ours in order to have a huge multicountry study. She has 5,000 cases who arrived within 6 hours, added to our 6,000 = 11,000. She has written a grant proposal to NIH to combine data and analyse it in collaboration with Dr. Poznyak and Dr. Peden. If not funded, she has money to continue to analyse data until June next year (2002). If she gets the money she will make the whole dataset available to all the participants for multi-author analysis and involvement. If she gets funding it will be from June 1<sup>st</sup> over 3 years. She is also writing a book on alcohol and ER data which this information would link into. She is also planning an international conference on alcohol and injuries. Participants had no objections to combining her data with the WHO dataset.

### 5. WHO Comparative Risk Analysis for Global Burden of Disease 2000 Study

(FU: Dr. Rehm)

For the information of the group, Dr. Rehm presented an update of the current status of the WHO project on the role of alcohol for the global burden of disease study. He requested permission to use some of the information obtained by participants to validate information he has already collected for the Alcohol Chapter for the next World Report. Participants had no objections to using data from the current study for the WHO Global Burden of Disease project.

## **PARALLEL WORKING GROUPS**

After the session on analyses and plans for new projects, the meeting split into two groups, one for a discussion on training manual and the other one on monitoring.

### **1. Training Manual**

#### Refining training materials for doing this study in further sites

The main objective of this session was to draft a content outline of the training manual that could serve as a resource material for the researchers and clinical staff worldwide in monitoring alcohol involvement in injuries in emergency rooms and trauma centers.

Results of discussions in a working group on the training manual.

**Provisional title of the manual:** "Who Training Manual for Assessing Role of Alcohol in Injuries in Emergency Settings"

**Target groups:** researchers in alcohol and injury fields  
physicians, nurses and staff in emergency rooms and trauma centers.

- Content:**
- I. Introduction
    - Global burden of injuries
    - Role of alcohol in injuries based on prior studies
    - Magnitude of the problem of alcohol-related injuries
    - History of research in emergency clinical settings
    - Objectives of research and monitoring
      - Alcohol's presence at the time of the emergency visit
      - Alcohol at the time of injury
      - Type and Cause of injury
      - Basic demographic description (age and gender)
      - Usual drinking patterns
      - Alcohol dependence
    - What can be achieved
    - Implication for policy
  - II. Ethical and Legal Considerations for Research on Alcohol in Injuries
  - III. Methodology
    - 1. Design – cross-sectional
    - 2. Sampling schemes, inclusion and exclusion criteria
    - 3. Recruitment procedures
    - 4. Classification of alcohol intoxication (Y90/Y91) codes and injuries
    - 5. Methods of estimating blood alcohol level
      - Blood or urine analysis
      - Breath analysis
        - procedures
        - calibration
        - problems...
    - 6. Methods of estimating level of intoxication
      - Clinical signs of alcohol intoxication
      - Observational assessment
      - Agreement between BAL and clinical assessment
    - 7. Interview
      - General principles of interviewing
      - Core modules
      - Optional modules
  - III. Training of staff
    - Reference to training slides in appendices
  - IV. Practical Considerations
    - Organization of the study in emergency rooms
    - Managing intoxicated and non-compliant clients
  - V. Management of data and analysis

VI. Implications for patient management and policy  
Dissemination of data

VII. References

VIII. Appendices  
Glossary  
Study protocol – example  
Quantifying absolute alcohol  
Training slides

The training manual should incorporate common mistakes, problems and their solutions based on the experiences of the WHO Collaborative Study on Alcohol and Injuries. The New Zealand team agreed to undertake a task of development a training manual in accordance with the above-mentioned outline together with the WHO staff.

## **2. Developing monitoring and surveillance methods & systems for alcohol (and drugs) in ER**

### Injury Household Surveys

WHO is currently developing a manual for conducting injury household surveys. This is an opportunity to include a module on alcohol. Sub-committee suggested that the following questions be included in such a model:

- Drinking prior to injury
- Quantity and frequency including binge drinking
- Whether anyone else involved in the injury had consumed alcohol
- Whether the injured person thought that the injury would have occurred even if they had not been drinking

There could be a core of about 5 questions and then a couple of optional questions. Dr. Peden will obtain information about suggested questions from literature from Jürgen Rehm. Would need to include methods for calculating absolute alcohol consumed.

### Repeated ER cross sectional studies

Sub-committee discussed the possibility of obtaining funding to extend the current study (to other countries) and modify the questionnaire (reduce dramatically) and conduct in ERs in multi-centres in countries. Design would be cross sectional conducted every 2 to 5 years depending on funding. The questionnaire should not take longer than 10 minutes to conduct and this should be supplemented with breath alcohol levels. WHO will assess the feasibility of obtaining funding for such studies. This would link up with the training manual which is being developed by the WHO and discussed in the small group lead by Dr. Poznyak.

## **AUTHORSHIP AND PUBLICATION**

The meeting agreed to standard WHO method of authorship and introductory paragraph to be included in all studies. Dr. Peden will develop legal agreement to be signed by all PIs and circulate for comments. This agreement will also be posted at the website. All publications must be sent through WHO. WHO will give feedback within 6 weeks. Publications written in languages other than English – an English abstract should be sent to WHO.

See extended discussion on publications discussed on 28 November.

### **Authorship and Publication Arrangements**

The authorship arrangements of WHO were laid out and discussed. Dr. Peden will distribute the final document to all participants.

Given planned reports:

- 1) Final report
- 2) National reports (End of February 2002)

Several article have been laid out and the PIs will update on the content (see below).

Additionally the following arrangement was decided about ideas for proposal and development of new articles:

- 1) Send concept paper proposal to WHO for article to  
put on web  
other groups to join
- 2) Consent from others
- 3) Deliver within X time (e.g. 6 months). If not delivered, topic is free again.

### **WEB-SITE**

Web-site is an important and useful tool to put information on and access it. It has a record of the processes of the study and it is possible to see how the chain of events unfolds. Large documents can be posted to the site. Many issues could have been bypassed if the web had been used to optimum.

Some problems encountered in the website:

- Don't know how to post information
- Get bounced off the server in 30 minutes (this is a security issue)
- Can New Zealand simplify the way information is posted to the web?
- When you log on you cant see what is new. Put a link on what's new
- Link the web with a list serve for discussions
- After the general discussion on the web-site, Dr. Humphrey offered a hands-on demonstration to interested participants.

## **INTEGRATION OF THE COUNTRY REPORTS:**

(note that a ppt version is available at the Project Web-Site)

The following outline for country reports was decided upon

### **Introduction**

- Contextual (2-4 pages double spaced )
  - Rates of mortality/homicide/DALYs
  - Brief description of religious/cultural/SE context
  - Drinking age/driving limits/ type of enforcement
  - Dominant beverage
  - Retail price of most common drinks
  - Licensing system
  - Differences between region and country
  - Average & patterns
  - Drinking context
- ER setting
  - Clientele
  - Description of setting (patient throughput in ER; % injuries)
  - Alternative treatment options
  - Role of clinicians/expectations/professional background
  - How is intake handled?
  - Role of different professions in intake?
  - Waiting time (serious vs. non-serious cases)
  - Routine data collections on injury and alcohol

### **Methods**

- Modifications to core questionnaire
- Additions and use of options
- Modifications to protocol
  - Weighting
  - Sample definition (age, times covered)
  - 6 hours rule
  - Exclusions
  - Blinding
- Experiences with ethics committee/IRB
- Description of training Y90/Y91
- Who collected data and why (Y90/Y91 QCA; breathalyzer; interview)?
- Description of recruitment process
- Pilots

### **Results (tables with labels)**

- Sample description (demographics)
- Attrition overview (% excluded for 6 hours rule, patient refusal, patient unavailable, other refusals, police, sexual cases, intoxicated) in the form of a tree
- Description of attributors (age, sex, observed intoxication)
- Implication of attrition
- Type of injury

- Location of injury

### **Main Findings**

- % distribution injured with positive breath tests
- % distribution injured with self-reported drinking prior to injury
- % distribution injured with observed intoxication (Y91)
- Analysis of agreement between breath analysis with self-reported consumption, intoxication and observed intoxication (short observational form if you used it)
- % distribution of perception of alcohol as contributing factor in injury
- % distribution of alcohol injured sample (BAC level, within 6 hrs) by gender, age, SES, ethnicity
- % distribution of frequency of drinking 5-11, 12+ by alc injured sample, and non-alc injured
- % distribution of frequency of drinking 5-11, 12+ by alc injured (violent, non-violent), and non-alc injured (violent, non-violent),
- % distribution of typical quantity (define categories) by alc injured vs. non-alc injured
- % distribution of typical quantity (define categories) by alc injured (violent, non-violent), vs. non-alc injured (violent, non-violent)
- Comparison of quantity prior to injury with typical quantity of alc injured (violent, non-violent)
- % reporting that person involved was intoxicated (alc injured, non-alc injured)
- % reporting previous visit to ER in previous 12 months by alc involved injured/non-alc injury by violent/non-violent
- % distribution of drinking locations of alc involved injured (violent/non-violent)
- % distribution of injury locations of alc injured (violent/non-violent)
- % distribution of time from past drink to injury of alc involved injured
- RAPS results

### **Key Informant Data**

- Alcohol's impact in the emergency room
- Current alcohol recording process in ER and barriers
- Current injury reporting processes & barriers
- Current interventions
- Attitudes of staff to collecting data on alcohol in ER
- Other key issues

### **Discussion Section**

- Changes if study is done again
- Implications for continued surveillance
- Implications for future ER studies
- Policy implications for ER
- Policy implications for alcohol policy and other regional/national policies
- Local dissemination and consequences

**November 28, 2001**

## **LITERATURE REVIEW**

As part of the WHO project, a literature review on alcohol and injuries in the emergency room was commissioned to Dr. J. Roizen. The participants of the meeting received a copy of Dr. Roizen's paper and there was general discussion about it. As a general procedure, it was mentioned that any comment and relevant additional literature should be sent to Dr. J. Roizen (copy to WHO).

The main points of the discussion on the paper were summarized as follows:

- Need to add some results from research;
- She addresses limitations that have not been addressed in the methodology for the study;
- Dr. Roizen would appreciate grey literature to present literature, especially from developing countries;
- Missing areas: strengths and limitations of using self report and observational methods;
- Could take the selection bias further and how to deal with these biases;
- Add section for directions for further research;
- There are a number of ER studies which are missing;
- Needs a better discussion of the epidemiological studies, i.e. cross over studies;
- Dr. Jürgen suggests using Rapid assessment – combines key informant interviews with data already available. The approach outlines who to interview, etc. Developed by UNDP and WHO. Mental health is using the approach in a multicountry study. There are several manuals available on Rapid Assessment from WHO and UNDP;
- Suggestion from participants is rather to make ER studies simpler to conduct for other countries since Rapid Assessment and interview with key informants is diverse within countries;
- PAHO have a rapid assessment that includes ER studies;
- Modifications – little on social and cultural variables;
- Used ICECI not E codes since these are difficult to use in non-fatal injuries. Dr. Peden will feed this back to Dr. Roizen.

## **JOURNAL PAPERS TO BE WRITTEN**

A discussion followed related to the contents of reports and papers that would be written, the process to propose a paper of interest and the main responsible for the proposed papers.

### **Reports**

Individual country reports – due by February 2002. Participants should follow the outline set out in this report.

Overall results in format of final report: The New Zealand collaborating centre has been contracted to produce this final report with input from the WHO coordinators. Draft to the WHO will be sent by the end of June.

## Journal articles

1. *Topic:* Main results of study (could be 3 papers)- Basically descriptive data of main findings.  
*Main author:* Prof. Sally Caswell (All other PIs are invited and should get involved on these series of papers).  
*Journal:* Addiction and an Injury journal like Injury Prevention, or Safety Promotion, WHO Bulletin (short version)  
*Due draft date:* End 2002
2. *Topic:* Process methodology: Mainly qualitative approach and set up of the research in transcultural environment.  
*Main author:* Dr. Gayl Humphrey  
*Other authors:* Dr. Sandra Marais  
*Journal:* International Journal of Health Promotion  
*Due draft date:* End 2002
3. *Topic:* Validation of Y90/91 codes (could be two papers)  
*Main Author:* Dr. Cheryl Cherpitel  
*Stats:* Jürgen Rehm  
*Other authors:* Dr. Robin Room, Dr. Vladimir Poznyak, Dr. Margie Peden, Dr. Norman Giesbrecht  
*Journal:* Journal of Trauma, BMJ and JSA or Addiction for methodological paper  
*Due draft date:* End 2002
4. *Topic:* Case crossover analysis (2 papers involved)  
*Main Author:* Dr. Guilherme Borges  
*Other authors:* Dr. Jürgen Rehm, Dr. Cheryl Cherpitel, Dr. Scott MacDonald  
*Journal:* AJPH, International Journal of Epi, Bulletin of WHO  
*Due draft date:* End 2002
5. *Topic:* Hierarchical analysis (probably three papers)  
*Main Author :* Dr. Jürgen Rehm  
*Other authors:* Martin, Robin, Scott, Gui  
*Journal:* AJPH, Public Health  
*Due draft date:* End 2002
6. *Topic:* Policy implications  
*Main author:* Prof. Sally Caswell  
*Other authors:* Dr. Margie Peden, Vladimir Poznyak  
*Journal:* Public Health, Addiction  
*Due draft date:* mid to end 2003 (after other papers)
7. *Topic:* Attrition problems  
*Main author:* Dr. Norman Giesbrecht  
*Other authors:*  
*Journal:*

## **Project journal papers**

revisited (authors not yet finalized):

- main results of study (all are authors; lead: Prof. Sally Caswell)
- methods study (got changed to more content on roles of different players from key informant) (lead: Dr. Gayl Humphries & Dr. Sandra Marais)
- hierarchical analysis (lead: Dr. Juergen Rehm, other authors Dr. G. Borges, Dr. M. Stafström, Dr. R. Room, Dr. S. Marais)
- Y90/Y91 codes (lead: Dr. Cheryl Cherpitel, analysis Dr. J. Rehm; other authors Dr. M. Peden, Dr. N. Giesbrecht, Dr. R. Room, Dr. V Poznyak)
- case crossover (lead: Dr. Guilherme Borges: other authors Dr. C. Cherpitel, Dr. J. Rehm; for hierarchical part, Dr. S. Marais)
- policy implications (lead: Dr. Sally Casswell)
- influence of attrition (lead: Dr. Norman Giesbrecht)

Finally, it was agreed that more clear descriptions and updates on authorship would be available from lead authors.

## **FUTURE DEVELOPMENTS IN EACH COUNTRY**

Each PI participated on a round of propositions for future work in each country.

### ***Argentina/USA***

Dr Cherpitel is working on the merged data of the multi country study. Soon beginning to analyse data with the PI in Argentina. She has collected WHO 500 plus another 1,000 using Dr. Cherpitel's questionnaire, which has 500 injury plus 500 medical patients. Beginning an emergency study room study in Poland. 1,000 patients both injured and non-injured in Warsaw plus another 1,000 cases from Krakaw. She wants to implement the short form of the observational form which can be combined with the data from our study. Pending work – with funding she will analyse the combined data from her studies with the WHO studies. See abstract on Cross-National Analysis of Alcohol and Injuries. People who are reluctant to include their data in this study should talk to Vladimir Poznyak. She has a research project, which she has to resubmit in March at 4 sites (Mexico and USA). The funding is from the drug institute so the focus on the study is on drugs but has alcohol and drugs included.

Wants to write a grant to NIAAA to develop brief intervention study. Unfortunately been little implementation after all of Dr. Cherpitel's studies in ERs. She has made the data available to the ERs and left breathalysers, but these only get used until the batteries run flat and then they stop using them.

### ***Belarus***

Study information can be used to raise the public awareness. Would like to address the results to the ministry of health, politicians and the mass media. They are implementing ICD10 in the coming months. This will require a lot of education. They need to look at the cost of alcohol and injuries in the country. As a long-term goal, they want to try to change the patterns of drinking in the population. They will produce their own training materials for all the ER staff and doctors based on the results of the project. Finally they would like to introduce a brief intervention at the primary health level. The European Union office might

come up with funding to add a number of ERs in other cities in the country. The WHO representative in the country is behind this idea.

### ***Brazil***

Finished collecting data and will disseminate to the public by means of the newspaper. They will go to the Health Ministry to talk about training for the physicians and the nurses. The study is being used as a Masters thesis for two students at the university. Papers will be written about alcohol and injuries in the workplace and also look at gender issues.

### ***Canada***

The PI is planning to start collecting data in February for about 6 weeks. This will give the hospital a better understanding of what injuries come in. They don't have a surveillance system. The information will also feed into prevention plans in the community. The hospital might be interested in a brief intervention. After the project they will provide the results and the methods to the ministry of health to promote other ERs to think about doing a scaled down model of the study. The hospital involved in the study are interested in seeing how their hospital compares with some of the other hospitals around. There is the Ontario trauma surveillance system, which involves 12 hospitals. There is another surveillance system for all children (CHIRP) which is across the country. A long term goal for the site is to move towards surveillance which includes alcohol, but it is costly. In Orangeville they are interested in developing rates. If WHO ran a study including brief interventions they would be interested in participating. Margie Peden will send the WHO Injury Surveillance Manual to Canada.

### ***Czech Republic***

The Czech Republic is a candidate country to become a member of the European Union. One of the initiatives of the European Union is to have a surveillance system to monitor the issue of injuries in the country. At this point they are only monitoring in-patients. They have a question about the reason about the injury but alcohol is not included. The PI will try to influence them to add a module on alcohol into the current system. Their surveillance system started in 1999 and they have a database of more than 2 million cases at this time. 8% of these were due to injuries. Czech is now developing health 21 and is working on the individual subtasks and Dr. Hana Sovinova is trying to include the injury and alcohol questions in this strategy. The EU alcohol strategy plan is also being implemented in Czech and they are working on their national version. They are negotiating with the health insurance companies – they can request the information from health care facilities. Health workplace and health city are in place in the country for tobacco control and they can use the same contacts and try to get alcohol in place.

### ***Mexico***

Will collect the data from January. They will try to speed up the time for capturing the data into the computer to make it available in April. Working with Dr. Cherpitel in the 4 city study on alcohol and other drugs. The hospitals are interested in the brief interventions.

### **Mozambique**

A injury surveillance project has been running for 1 year in Mozambique. They have data on more than 26,000 cases. Interested in looking in more detail at the alcohol relatedness in traffic and violence. She wants to include the surveillance and alcohol assessment into the routine work of the doctors currently in the ER. Will be doing study on rehabilitation and disability of patients as a result of injuries. Want to look at alcohol among fatally injured patients. Wants to do a study with psychologists to look at the drinking patterns of people in Maputo. Need to analyse the content of alcohol in traditional drinks.

### **New Zealand**

Initiated two other projects. One project will be on brief interventions and another one on the expansion on study to other sites. It is in three sites in Auckland, which should be generalisable to all attendees of ERs in New Zealand. The three sites have different cultures. Doing alcohol and drug surveys nationally. They had a question in the 2000 survey at the same time they did the ER study that will add value to the study and act as a control. Results have been reported back to the hospitals, which have got more people interested in the area. Aiming to devise an intervention which is feasible and convenient to run in the ER for brief interventions. Waiting for finance – should be through in June. New edition of the AUDIT and a booklet on brief interventions will be ready from the WHO at the end of the year. They will be up on the web within a couple of weeks.

### **South Africa**

The PI will become involved in writing up the methodology with Dr. Gayl Humphrey. South African researchers will continue to collect alcohol information as part of the fatal injury surveillance system and self-reported alcohol usage in the non-fatal injury surveillance system. They also do annual multi-country studies which look at alcohol and drugs in injured patients using urine analysis. They would like to expand this latter system to more cities but possibly do them less often than once a year.

There is an initiative by local government (Ministry of Health) called the Sensible Drinking Initiative, which was started because of the problem of alcohol and injuries in the province. It is a very practical approach to try educate people about the negative effects of drinking. On policy issues Charles Parry has the SACENDU initiative, which feeds into policy issues. Information is on the web site and they can contact Dr. Sandra Marais on the model used in South Africa.

### **Sweden**

Unsure about how the data will be used to develop strategies. ER is interested in using Y91 codes if they prove to be useful. They will get the nurses to use these codes – these nurses already have a bachelor's degree in nursing. If they use the Y91 codes this might spread to the other 6 hospitals in the area. They will present the methodology and results of their study in a local journal. Brief intervention in Sweden would not be done. No one would be willing to commence such a project. There have been too many projects, which have not been successful in the past. The doctors would not be interested.

## **PRIORITIES FOR FURTHER RESEARCH**

New WHO information on AUDIT and brief interventions in primary health care settings, linked to AUDIT scores, will be available after January 2002.

WHO had a meeting to discuss what might be priorities

- Brief interventions
- Effective dissemination and training package
- Implications for surveillance
- Dissemination of experience – make available as much as possible

### **Additional suggestions**

Relationship between alcohol and violence is different in different cultures. Study involves young Swedes, 16 to 24. Telephone survey. 1 000 cases. Would like international is, or at least do it in the European Union.

Trying to change the patterns of drinking

Road traffic injury prevention and alcohol. Also EIP risk assessment and cost analysis.

Link between alcohol use and suicide

Research and program priorities for WHO in the alcohol and injury field in addition to subjects already talked about attitudes on drinking and violence to change the culture (Dr. R. Room)  
road accidents (Dr. M. Peden)  
alcohol and suicide (Dr. V. Poznyak)

### **Project timelines- Revised**

(Dr. Poznyak)

Finally, the meeting discussed the next timelines for the project:

1. Data sets: due at the end of January. Canada/Mexico: due at the end of March.
2. National report: due at the end of February (provision will be made for Canada/Mexico to delivery at a latter date).
3. Cross-national report: due at the end of June.

### **Conclusion of the meeting**

In conclusion of the meeting Dr Margie Peden on behalf of the WHO expressed a gratitude to the representatives of the National Institute of Psychiatry in Mexico for an excellent organization of the meeting and to all the participants for their invaluable contributions to its success.

**Meeting adjourned at 15:00.**



**THE WHO COLLABORATIVE STUDY ON ALCOHOL AND INJURIES:  
SECOND MEETING OF PRINCIPAL INVESTIGATORS**

**Mexico, D.F. México / November 26-28, 2001**

**ANNEX 1 - LIST OF PARTICIPANTS**

**BELARUS**

Professor Roman Evsegneev  
Department of Psychiatry  
Belorussian Academy of Postgraduate  
Medical Education  
Novinky Psychiatric Hospital  
22305 MINSK. Belarus  
Tel.: + 375 17 289 80 31  
Fax: + 375 17 289 80 31  
E-mail: [bpa@cervus.unibel.by](mailto:bpa@cervus.unibel.by)

**BRAZIL**

Dr Neliana Buzi Figlie  
Alcohol and Drug Research Unit  
Federal University of São Paulo  
(UNIFESP)  
Pedro de Toledo 781. Brazil  
Tel.: + 55 11 557 20 448  
Fax: +55 (11) 55790640  
E-mail: [neliana\\_figlie@uol.com.br](mailto:neliana_figlie@uol.com.br)

**CANADA**

Dr Norman Giesbrecht  
Center for Addiction and Mental Health  
CAMH  
33 Russell Street  
TORONTO, Ontario M5S 2S1. Canada  
Tel.: + 1 416 535 8501, Ext.: 6895  
Fax: + 1 416 595 6899  
E-mail: [norman\\_giesbecht@camh.net](mailto:norman_giesbecht@camh.net)

Dr Scott MacDonald  
Center for Addiction and Mental Health  
CAMH  
33 Russell Street  
TORONTO, Ontario M5S 2S1. Canada  
Tel.: + 1 416 535 8501, Ext.: 6895  
Fax: + 1 416 595 6899  
E-mail: [scott\\_macdonald@camh.net](mailto:scott_macdonald@camh.net)

**CZECH REPUBLIC**

Dr Hana Sovinova  
National Institute of Public Health  
Srobarova 48  
100 42 PRAGUE 10. Czech Republic  
Tel.: + 420 2 670 823 28  
Fax: + 420 2 673 102 91  
E-mail: [sovinova@szu.anet.cz](mailto:sovinova@szu.anet.cz)

**MEXICO**

Dr Guilherme Luis G. Borges  
Instituto Nacional de Psiquiatria  
Ramón de la Fuente Muñiz  
Calzada México Xochimilco No. 101  
Col. San Lorenzo Huipulco  
C.P. 14370  
México, D.F., México  
Tel.: + 52 5655 28 11 ext. 197  
Fax: + 52 5513 3446  
E-mail: [guibor@imp.edu.mx](mailto:guibor@imp.edu.mx)

**MOZAMBIQUE**

Dr Otilia Neves (*VIP funds and TA*)  
Emergency Department Director  
C/o Emergency Services  
Maputo Central Hospital  
MAPUTO. Mozambique  
Tel.: + 258 82 302 391  
Fax: + 258 1 493 571  
E-mail: [oneves@teledata.mz](mailto:oneves@teledata.mz)

**NEW ZEALAND**

Professor Sally Caswell  
New Zealand Alcohol and  
Public Health Research Unit  
University of Auckland  
School of Medicine  
Private Bag 92019  
AUCKLAND 1. New Zealand

Tel.: + 64 9 3737 524  
Fax: + 64 9 3737 057  
E-mail: [s.casswell@auckland.ac.nz](mailto:s.casswell@auckland.ac.nz)

Dr Gayl Humphrey  
New Zealand Alcohol and  
Public Health Research Unit  
University of Auckland  
School of Medicine  
Private Bag 92019  
AUCKLAND 1, New Zealand  
Tel.: + 64 9 3737 524  
Fax: + 64 9 3737 057  
E-mail: [g.humphrey@auckland.ac.nz](mailto:g.humphrey@auckland.ac.nz)

#### **SOUTH AFRICA**

Dr Sandra Marais  
Crime, Violence and Injury Lead  
Programme  
Medical Research Council  
P.O. Box 19070  
Tygerberg 7505  
CAPE TOWN, South Africa  
Tel.: + 27 21 938 0216  
Fax: + 27 21 938 0381  
E-mail: [marais@mrc.ac.za](mailto:marais@mrc.ac.za)

#### **SWEDEN**

Dr Robin Room  
Centre for Social Research on Alcohol  
and Drugs  
Sveaplan, Stockholm University  
S-106 91 STOCKHOLM, Sweden  
Tel.: + +46-8-674-7047  
Fax: + 46 86 747 686  
E-mail: [robin.room@sorad.su.se](mailto:robin.room@sorad.su.se)

Martin Stafström  
Department of Community Medicine  
Malmö University Hospital  
Lund University  
SE-205 02 Malmö, Sweden  
tel: +46-40-336303  
fax: +46-40-337096  
E-mail: [martin.stafstrom@smi.mas.lu.se](mailto:martin.stafstrom@smi.mas.lu.se)

#### **SWITZERLAND**

Dr Jürgen Rehm  
Research Director

Addiction Research Institute  
CH-(postal code) Zurich, Switzerland  
Tel.: + 41 1 273 4024  
Fax: + 41 1 273 4064  
E-mail: [jtrehm@isf.unizh.ch](mailto:jtrehm@isf.unizh.ch)

#### **USA**

Dr Cheryl Cherpitel  
Associate Director  
National Alcohol Research Center  
And Senior Scientist  
Public Health Institute  
2000 Hearst Avenue  
Berkeley, CA 94709, USA  
Tel.: + 1 510 642 0164/642 5208  
Fax: + 1 510 642 7175  
E-mail: [cherpitel@arg.org](mailto:cherpitel@arg.org)

#### **SECRETARIAT**

Dr Margie Peden (*VIP funds and TA*)  
Violence and Injuries Prevention  
Non-communicable diseases and  
Mental Health Cluster  
World Health Organization (WHO)  
20 Avenue Appia  
CH-1211 GENEVA 27, Switzerland  
Tel.: + 41 22 791 3910  
Fax: + 41 22 791 4332  
E-mail: [pedenm@who.int](mailto:pedenm@who.int)

Dr Vladimir Poznyak  
Medical Officer,  
Department of Mental Health and  
Substance Dependence  
World Health Organization (WHO)  
20 Avenue Appia  
CH-1211 GENEVA 27, Switzerland  
Tel.: + 41 22 791 4307  
Fax: + 41 22 791 4851  
E-mail: [poznyakv@who.int](mailto:poznyakv@who.int)



## WHO Collaborative Study on Alcohol and Injuries: Second Meeting of Principal Investigators

Instituto Nacional de Psiquiatría "Ramón de la Fuente"  
Mexico City, Mexico. November 26-28, 2001

### ANNEX 2 - PROGRAMME OF THE MEETING- REVISED

#### 26 November, Monday

- 9.00-10.30 Opening of the meeting (Dr Margie Peden, Dr Vladimir Poznyak)  
Welcoming remarks (Representative of the Instituto Nacional de Psiquiatria)  
Introduction of participants  
Election of a Chair and Rapporteur  
Administrative issues (Secretariat)  
Review of objectives and agenda of the meeting (Dr Vladimir Poznyak, Dr Margie Peden)
- 10.30-11.00 Coffee-break
- 11.00-12.45 Preliminary results of the study: reports of principal investigators (25 minutes for each PI (**presentation - 20 minutes, questions and comments - 5 minutes**)).  
Dr G. Borges (Mexico)  
Dr Ch. Cherpitel (for Argentina and USA)  
Dr Figile (Brazil)  
Dr McDonald (Canada)
- 14.00-15.00 Lunch
- 14.00-15.00 Preliminary results of the study: reports of PIs (continued).  
Dr V. Benegal (India)  
Prof. W. Hao (China)  
Dr G. Humphrey (New Zealand)  
Dr S. Marais (South Africa)
- 15.15-15.45 Coffee-break
- 15.45-17.00 Preliminary results of the study: reports of PIs (concluded).  
Dr O. Neves (Mozambique)  
Prof. R. Evsegneev (Belarus)  
Dr H. Sovinova (Czech Republic)  
Dr M. Stafstrom (Sweden)

#### 27 November, Tuesday

- 9.00-9.15 Summary of the previous day (rapporteur).
- 9.15-10.30 Wrap up of site reports:  
 Prof. Evsegneev (Belarus presentation)  
 Dr. Poznyak (Indian site data summary)  
 Dr. Rehm (Summar of issues identified from the site reports)
- 10.30-11.00 Coffee-break
- 10.50-12.45 Analysis Plans
- 14.00-15.00 Lunch
- 14.00-15.00 Parallel working groups:
  - Refining training materials for doing this study in further sites (Dr. Poznyak)
  - Developing monitoring and surveillance methods and systems for alcohol in ER (Dr. Peden)
- 15.15-15.45 Coffee-break
- 15.45-17.00 Outline of the final products of the study. Publications and authorship. Dissemination of the results of the study (Dr Margie Peden). Web-site development (Dr Gayl Humphrey). Introduction of issues posed by Dr. J. Roizen.

### **28 November, Wednesday**

- 9.00-9.15 Summary of the previous day (rapporteur).
- 9.15-10.30 Literature review (Dr. Roizen & Dr. Poznyak).  
 Project journal papers, revisited. Web-site, revisited.
- 10.30-11.00 Coffee-break
- 14.00-15.00 Future developments in each country: planned activities & ideas for possible future work and programs.  
 Research and program priorities for WHO in the alcohol and injury field
- 14.00-15.00 Lunch
- 14.00-15.00 National reports, revisited (Dr. Caswell)  
 Project timelines, revisited (Dr. Poznyak)  
 Conclusion of the meeting

