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THE GLOBE

World Bank Pronounces on alcohol



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World Bank pronounces on Alcohol

The World Bank has released a fact sheet on alcohol, as part of its "Public Health at a Glance" series of summaries that aim to provide World Bank staff and others with quick, easy access to the state of the art in key areas of public health, preventive and curative services. The fact sheet is designed to be useful to project teams in the Bank and to others making investment decisions designed to improve health and nutrition.

In March 2000, the World Bank Group adopted a Note on Alcohol Beverages (www.miga.org/screens/policies/arp/arp.htm). In the Note, the Bank decided to increase its efforts to prevent alcohol-related problems in client countries and to take the public health situation regarding alcohol into account when considering investments in alcohol production. Since the Note was adopted, there have been no new investments by the Bank in alcohol production. We are grateful to the World Bank for permission to reprint the fact sheet.

Why is reducing alcohol-related problems a priority?

Alcohol abuse is one of the leading causes of death and disability worldwide. Alcohol abuse is responsible for 4 percent of global deaths and disability, nearly as much as tobacco and five times the burden of illicit drugs (WHO). In developing countries with low mortality, alcohol is the leading risk factor for males, causing 9.8% of years lost to death and disability. Alcohol abuse contributes to a wide range of social and health problems, including depression, injuries, cancer, cirrhosis, dependence, family disruption and loss of work productivity. Health and social problems from drinking often affect others besides the drinker. While men do the bulk of the drinking worldwide, women disproportionately suffer the consequences, including alcohol-related domestic violence and reduced family budgets. Heavy

alcohol use takes a particular toll on the young, and has been linked to high rates of youthful criminal behaviour, injury, and impaired ability to achieve educational qualifications. Many deaths and much disease and suffering could be prevented by reducing alcohol use and related problems.

Alcohol-related harm.

The level of harm from alcohol is related to the pattern, including level, of drinking in a country. Time series analyses in western Europe find that overall mortality rises by 1.3% for every extra litre of pure alcohol consumed per capita. But for Russia, where intoxication and hazardous drinking are more prominent, the corresponding figure is 2.7%. Patterns and levels of alcohol consumption, alcohol dependency and alcohol abuse are determined by many factors: availability, income per capita, retail

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process, individual factors (genetic and environmental) such as age of first use, family history, education, peer group pressure, psychosocial factors, cultural and historical context, and government policies, such as taxation and restrictions on advertisement and promotion.

Alcohol and poverty.

Alcohol-related mortality is often highest among the poorest people in a society (Mäkelä, 1999a). Alcohol is often a significant part of family expenditure: Romanians spent an average of 11% of family income on alcohol in 1991, Zimbabwean households averaged 7%. However, national averages conceal the impact on families of drinkers: families with frequent-drinking husbands in Delhi spent 24% of family income on alcohol, compared to 2% in other families. Surveys among the urban poor in Sri Lanka found that 30% of families used alcohol and spent more than 30% of their income on it.

Alcohol and youth.

Alcohol is of particular risk to adolescents and young adults: in Latin America and Eastern Europe respectively, 36% and 41% of deaths among 15-29 year olds were due to alcohol use. Effective policies and prevention for youth have immediate payoffs, in addition to longer-term effects from forestalling development of alcohol dependence or alcohol-related chronic diseases.

Approaches to reducing alcohol abuse

The most effective approach to reduce alcohol-related problems is

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to implement a comprehensive set of measures to reduce alcohol consumption and related problems. Policy options include price increases, restrictions on availability (i.e. limits on the times and conditions of alcoholic beverage sales or service, minimum-age limits), strong drink-driving legislation and ready access to treatment. Some countries have succeeded in reducing per capita consumption substantially, and consequently have reduced liver cirrhosis deaths, a common indicator of alcohol-related problems in a society. Efforts to reduce alcohol consumption and related problems face formidable obstacles: alcohol dependence; social pressures; aggressive alcohol marketing and promotion; other pressing health problems competing for limited resources. But there are many good practices that can be replicated with political will, and broad support.

Global action: The overall trend is towards stricter laws and increased enforcement in some areas such as drinking-driving. Provision of treatment for drinking problems has increased in many places in recent

decades. But national and local alcohol controls have been undercut by a tendency at the global level to treat alcohol as an ordinary commodity, and to weaken or eliminate effective controls in the interests of liberalising markets and trade. Trade agreements, structural adjustment programs, and GATT/WTO dispute settlements usually fail to recognise alcohol's special status as a commodity which adversely affects health. In this context, actions like the World Bank Group's decision in 2000 to take "public health issues and social policy concerns" into account in considering investments in alcoholic beverage production are important first steps. (See World Bank Group Note on Alcohol Beverages). There is a need for strengthened global action and commitment to reduce alcohol abuse and address the related health and social effects.

Regional action: Regional commitment to reducing alcohol abuse has been evident, for instance during the 1990s in Europe, where the World Health Organisation European Regional Office led 53 European nations in adopting aggressive goals for reducing alcohol use and problems. As a

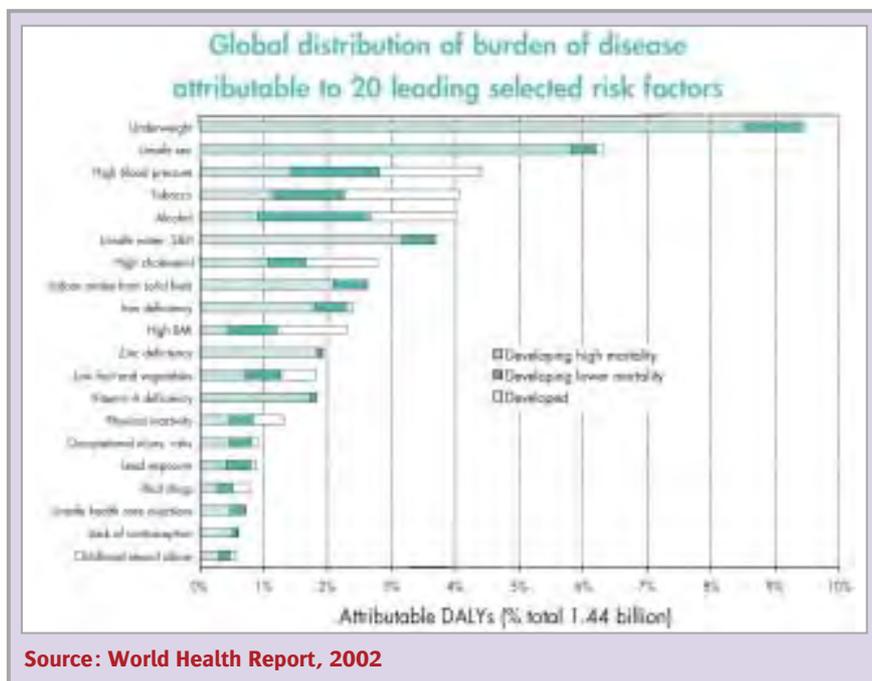
result, many countries in that region have strengthened alcohol policies and interventions. However, elsewhere in the world, efforts at alcohol control lag far behind alcohol's significance as a risk factor in poverty and health.

National action: Alcohol control efforts are often dispersed among Ministries, including Health, Social Welfare, Education, Traffic, Justice, Finance, Agriculture, Labour and Industry, Trade, and even Tourism and Culture and Sports, without effective coordination. Furthermore, much of the responsibility for alcohol control is often provincial/regional or local, and coordination between levels of government is also often an issue. Religious and women's organisations, physician associations and other public health groups, NGOs, youth and other groups play key roles in some countries. Ministries of Finance and tax authorities are important because higher alcohol taxes are one of the most effective ways to reduce use, while in most cases increasing government revenue. Other stakeholders include media, retailers, and sports groups (sponsorship).

Q&A about alcohol:

Does the level of alcohol consumption in populations matter? Yes. The levels of alcohol-related problems tend to rise and fall with changes in per capita alcohol consumption (Edwards et al., 1994; Babor et al., 2003).

What about the health benefits from alcohol use? A protective effect for coronary heart disease (CHD) from moderate alcohol consumption has been documented in men over forty. The data on whether a similar effect exists for women remain contradictory. In younger age groups, alcohol consumption at all levels increases mortality, and the net effect of alcohol at population level is negative in all regions.



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Are some alcohol beverages more harmful than others? The pattern of drinking is more important than the type of beverage. There is little basis for treating various types of alcoholic beverages differently with respect to trade, control or investment decisions. The consequences of alcohol use are similar, regardless of the type of alcoholic beverage. The predominant beverage of young adult males in a society (e.g. beer in the US) usually has the strongest relation to alcohol problems.

Should alcohol be treated like other commodities? No. Alcohol should be classified as a special substance because of its dependency producing properties and severity of associated problems (WHO).

What works?

A comprehensive set of policy options, including:

- Drinking-driving countermeasures have proven effective in a wide range of countries and cultures; especially “per se laws” that set maximum levels for blood alcohol concentrations for drivers, with random breath-testing and clear and immediate sanctions such as loss of driving privileges, and/or fines.
- Regulation and enforcement are key. Unless measures are enforced, they will have little impact. Public education helps build a social normative consensus that increases compliance and supports strong enforcement. The magnitude of artisanal production and smuggled beverages is often underestimated and has to be considered in regulatory actions to limit access. Countries need a strong regulatory framework governing alcohol availability. Many developing societies have minimal alcohol regulatory structures, leaving a large gap as traditional systems of social control of drinking erode.
- Price increases are among the most effective tools to reduce/deter use of alcohol by young people. Minimum age drinking laws and restrictions on availability are also effective, but may be costly to enforce.
- Government monopolies of all or part of the retail or wholesale market have often been effective mechanisms for implementing alcohol control measures. The usual disadvantages of government monopolies are offset in the case of alcohol by many factors:
 - (a) the limited number of sales outlets and restricted hours of opening common with such monopolies constrain alcohol consumption and problems;
 - (b) a stable and professional staff help avoid sales to the under-aged and already drunk; and
 - (c) private profit motivations for expanding sales are absent.
- Education and public information campaigns have not been found to be effective on their own in reducing alcohol use or problems. These campaigns can build awareness of alcohol problems and support for effective policies and interventions, but are not cost-effective unless linked with proven interventions such as higher taxes, restrictions on availability, minimum-age limits, and drinking-driving countermeasures.
- Brief outpatient interventions aimed at changing attitudes and drinking behaviour are as effective in most circumstances as longer and more intensive treatment. Treatment for alcohol problems is an important part of an integrated national alcohol policy. Treatment can be effective for those who seek it. But for the population as a whole, treatment is not a cost-effective means of reducing societal rates of alcohol problems.

Resources

People in the World Bank, IMF and WHO

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WHO: Leanne Riley (riley1@who.int)

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www.bks.no/biblio.htm

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Effective Interventions to reduce death, disease, disability and social problems related to alcohol abuse

Objective: Reduce death, disease, disability, and social problems caused by alcohol abuse.

INTERVENTIONS	BENEFICIARIES/TARGET GROUP	PROCESS INDICATORS
<p>Higher taxes on alcoholic beverages</p> <p>Non-price measures</p> <p>Deterrence through sanctions on drinking-driving, such as laws against driving while at or above a defined blood-alcohol level</p> <p>Regulating availability through minimum legal purchase age; government monopoly of retail sales; restrictions on hours or days of sale, density of outlets, or availability by alcoholic strength</p> <p>Harm reduction via greater implementation of general safety measures such as seatbelts, airbags, sidewalks, as well as bar/tavern server and manager training</p> <p>Comprehensive bans on advertising and promotion of all alcoholic beverages, their logos and brand names¹.</p> <p>Better consumer information: counter-advertising, media coverage, research findings</p> <p>Help for heavy drinkers who wish to quit or reduce their drinking, including access to treatment for alcohol dependence, whether professional or voluntary (e.g. Alcoholics Anonymous)</p>	<p>drinkers (heavier drinkers particularly affected) potential drinkers (especially youth)</p> <p>drinkers, traffic crash victims</p> <p>youth (minimum legal purchase age)</p> <p>drinkers (heavier drinkers often particularly affected)</p> <p>general public bar/tavern staff and drinkers</p> <p>drinkers and potential drinkers (especially youth) societal attitudes to drinking</p> <p>drinkers and potential drinkers societal attitudes to drinking</p> <p>heavier and problematic drinkers</p>	<p>✓ price of alcoholic beverages (adjust for inflation)</p> <p>✓ tax as % of final sales price</p> <p>✓ drinking-driving laws, regulations, extent to which respected/enforced</p> <p>✓ laws, regulations, extent to which respected/enforced</p> <p>✓ level of government control of market (i.e. lack of smuggling, illegal production and/or sale, etc.)</p> <p>✓ number and trends in number of outlets</p> <p>✓ laws, regulations, extent to which respected/enforced</p> <p>✓ incentives for server and manager training programs</p> <p>✓ laws, regulations, extent to which respected/enforced</p> <p>✓ knowledge of health risks, attitudes towards drinking</p> <p>✓ number of persons in treatment, treatment waiting lists</p>

Impact / surveillance Indicators for alcohol use and problems (from survey data except as indicated):

Per capita alcohol consumption: average consumption of alcohol by persons 15 and older (from production, sales and/or taxation statistics, with survey data on unrecorded consumption as needed), as well as per capita consumption of higher risk drinks, e.g. very cheap or high strength categories, proportion of beer sold >3.5%, or other local high risk drink

Number of abstainers: percentage of male and female adult population who do not drink

Pattern of drinking: frequency of getting drunk or drinking >60 grams of ethanol (5+ drinks), usual quantity per drinking session, fiesta drinking, drinking in public places, not drinking with meals, and not drinking daily; frequency of days when consumption exceeds 40g for men and 20g for women; percentage of country's total alcohol consumption that is above 40g for men and 20g for women.

youth use: % at age 12, at age 15, at age 18 who currently drink any alcoholic beverage (defined as having drunk any alcoholic beverage on one or more days in a set period); similarly, % who drink 60+ grams of ethanol on a single occasion in the period; frequency of drinking 60+grams

alcohol-involved traffic crashes/injuries: (police or health statistics)

alcohol-involved crimes: (police statistics)

hospitalizations and deaths from strongly alcohol-involved causes: liver disease (if rates of hepatitis B and C are low), alcohol-specific causes such as alcoholic liver disease, alcohol dependence, acute intoxication and alcoholic psychosis (mortality and hospitalization statistics)

other alcohol-related problems: problems with family, friendships, work, police, financial, health, alcohol dependence (as reported by the drinker in population surveys)

problems from others' drinking: family, friendships, work, injury, property loss, public nuisance (as reported in population surveys)

1. If full bans are impossible, strong restrictions and significant counter-advertising should be pursued.

Rising per capita alcohol consumption and drinking-related harm:

Suggestions for meeting the challenge¹

Norman Giesbrecht

Alcohol consumption and high risk drinking

After a long period of gradual decline in per capita consumption in Canada, around the mid-1990s the official sale of alcohol per capita began to slowly increase. For example, it rose from 7.3 litres of absolute alcohol per adult (aged 15+) in 1997-98 to 7.7 litres in 2001-02 (fiscal years).

A likely outcome of a rising rate of consumption is an increase in drinking-related damage, as indicated by extensive international research², including recent work in Europe³ and Canada. Publications by Skog and Ramstedt, focusing on Canada, note that as consumption increases one can expect an increase in motor vehicle crash mortality⁴ and liver cirrhosis mortality⁵. Other research, also focusing on Canada's experience over the past five decades, points to strong associations between changes in the rate of consumption and death classified as due to drinking, and other types of harm, including suicides, homicides and mortality from all causes.⁶

There are also signals from at least one Canadian province, Ontario, that with an increase in consumption, high-risk drinking is not becoming less common. In the 1998 general population survey, 61.3% of drinkers reported having had 5 or more drinks on at least one

occasion in the past 12 months, and 15.2% reported that this was at least weekly; for 2002 the percentages were 66.5% and 14.4%, respectively.⁷

Trends in consumption and drinking patterns

There are signs that alcohol consumption will continue to increase in Canada. The Canadian economy is strong and with a high disposable income per capita and no sign of a significant increase in alcohol prices, rates of drinking will probably continue to rise. Although the change in total alcohol outlets per capita has been modest, the direction of this change, and several others, such as hours and days of sale, involves more rather than less access, and probably contributes to stimulating alcohol sales.⁸ There is extensive marketing of alcohol products, both by most provincial liquor boards and alcohol producers.⁹ While evidence on the contribution of marketing and

promotion to consumption rates is subject to debate,¹⁰ these marketing initiatives signal that alcohol is a normalized ordinary commodity. Such marketing practices dramatically overshadow the occasional public message that raises concerns about drinking-related risks. Furthermore, it appears that those who manage alcohol distribution and sales are not concerned about rising rates of consumption, but instead are oriented to stimulating sales.¹¹

An accurate understanding of the multiple factors behind changing rates of consumption and patterns of drinking is elusive. Yet there is a strong body of knowledge, research and experience about appropriate goals of prevention and effective interventions. The dismantling of alcohol controls with the resultant increased access to alcohol in many western countries in the past few decades, has ironically contributed to a better knowledge of measures which reduce damage at the population level.¹²

Based on recent WHO estimates of the global burden of death, disease and disability from alcohol, it has been projected¹³ that if alcohol policy and interventions do not become more effective, damage from alcohol will be likely to increase. In order to reduce the

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harm from alcohol, prevention strategies need to be based on evidence of impact and, as an interim step, reduce both the population-level drinking rate and frequency of high-risk consumption.

Goals of prevention

Three general goals of alcohol-related prevention strategies are to promote health,¹⁴ to reduce damage and disability, and to prolong life. With regard to damage and disability, this includes chronic and acute physical problems associated with drinking, as well as relevant social harms and economic hardship.¹⁵ In assessing the effectiveness of different interventions, it is appropriate to use their harm reduction impact at individual and population levels as criteria.

Intervening Variables and Interventions

Several interim steps are associated with the desired outcomes, for example,

- (1) reducing overall rates of drinking in the population;
- (2) reducing the frequency of heavy-drinking occasions;
- (3) reducing binge drinking;
- (4) separating alcohol use from certain behaviours -- such as driving motor vehicles, operating boats or snowmobiles, and raising awareness of the associated risks with alcohol consumption.

In Canada, more attention is paid to the two latter intervening variables and less to the three first broader ones, even though the broader variables are critical to promoting health and reducing harm.¹⁶ Information and persuasion campaigns generally raise awareness about the risks of heavy drinking and drinking in connection with activities (e.g., driving) or conditions (e.g., pregnancy), or contexts (e.g., workplace), or offer a



counter message that challenges the promotion of alcohol through marketing, advertising and sponsorship. Health or safety messages may encourage health-oriented dialogue about risks of drinking and delineate personal options in handling pressures to drink. However, the evidence suggests they are unlikely to reduce consumption or drinking-related harm.¹⁷

Despite their popularity, information and education campaigns are the weakest of the interventions noted above. The extensive resources devoted to them are likely to have little, if any, impact on drinking rates or damage from alcohol use.

They are not sufficiently geared towards the special needs of the high-risk drinkers and may be more commonly viewed by the 'converted', that is the modest drinkers or abstainers. Their potential may be enhanced by using them as a supplement to interventions with a demonstrated impact, rather than as stand alone initiatives. They could also be refocused to offer the public a rationale for changes in alcohol policy, encouraging dialogue about alcohol promotion, marketing, and other activities of the alcohol

industry.¹⁸ While changing social norms about alcohol appears, in principle, to be an important step, it is unclear how this is done without using effective policies or regulatory measures. Nor is it necessarily the case that changes in social norms need to precede a change in alcohol policy.

Telling people to avoid high-risk drinking is unlikely to produce results in the absence of other initiatives. These include, for example, server intervention programs – including instructions on server liability for over-serving, serving to minors, and allowing intoxicated customers to drive away, and active enforcement of other on-premise regulations.¹⁹ Unfortunately, it is not yet a requirement that all persons who serve alcohol either in an off-premise or on-premise venue, including special occasion permit events, are required to take a server intervention program. Other strategies include managing access to alcohol by controlling days and hours of sale, density of outlets or having prices of alcoholic beverages at least keep pace with consumer prices indices.

The Canadian provincial and federal governments appear to have made significant strides in tackling

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drinking and driving. There is a national legal BAC threshold of 0.08, administrative license suspension for lower thresholds in most provinces, and graduated licence programmes for first time licensees of motor vehicles.²⁰ Periodic roadside spot checks, which are common during the Christmas holiday season, are frequently implemented in most parts of Canada. These efforts facilitate the separation of driving from drinking. It is feasible that they may eventually have a broader beneficial impact in reducing high-risk drinking in general.

Next Steps

This overview has made a case for phasing out or refocusing some interventions, such as education campaigns, and for giving more attention to others, such as controls on access to alcohol and on-site interventions involving the service and sales of alcohol. The next paragraphs propose several steps forward, grouped into four categories: perceptions, structures, research, and action.

Perceptions: There is a noteworthy contrast between the messages about alcohol that dominate the media and public opinion among Canadians about alcohol policy topics. The promotional material in the media and in-store displays, as well as promotions and other inducements, conveys the message that this is a benign product, suitable for almost any occasion, that might be integrated into daily activities without major risks. In contrast, surveys of representative adults show that almost half would like to see advertising banned,²¹ most are not in favour of greater access to alcohol,²² and the majority are concerned about over-service to intoxicated customers.²³

A more costly and possibly less effective option is to provide sufficient resources and advertising

talents in order to raise awareness about the burden of disease, death and disability from alcohol. These “counter” messages might also outline the impacts of alcohol promotion upon views of youth about alcohol,²⁴ and the relative effectiveness of alcohol policies and intervention strategies.²⁵ Furthermore, through debate about policy options and their enforcement, perceptions among the public and policy leaders may also be encouraged to become more oriented to health and safety agendas. However the impact of counter-advertising is likely to be modest. A more cost-effective approach is to implement alcohol control policies and other interventions noted by Babor and colleagues.²⁶

Structures: Several changes at the organisational level are proposed that will likely facilitate a more effective response to alcohol problems. Currently, most provincial liquor control boards report to a provincial Ministry that is responsible for commercial agendas. Although the liquor boards have a mandate to control harm, in at least some provinces the commercial, marketing and aggressive retailing functions have dominated their activities in recent years. This transformation seems to be influenced by the threat of privatisation on the one hand, and desire to generate higher government revenue each year on the other, combined with an apparent desire to excel in state-of-the-art marketing practices. One way of reinforcing a more balanced view²⁷ is to change the reporting arrangements, so that liquor boards report directly to a small cabinet committee with an alcohol management mandate and representation from ministries responsible for health, traffic, public safety and commerce, or to the Ministry of Health for each province.

Federal and provincial governments would benefit from establishing alcohol advisory groups²⁸ with diverse representation, for example, from public health and safety organisations, research community and business and retailing sectors. The mandate of these advisory groups should include the review of developments in drinking-related harm in the relevant jurisdiction as well as proposals for changes in regulation and policy. Their mandate might include that of commissioning background papers to assess the potential impacts of proposed changes and sponsoring evaluations of pilot experiments in alcohol policy and alcohol distribution arrangements.

Both provincial and federal governments would be well advised to collaborate in developing an Action Plan with regard to alcohol. Experiences from Europe provide a very useful model. Several phases of a European Alcohol Action Plan were approved by the WHO, starting in 1995, and provided guidance to countries and communities with regard to goals and interventions designed to reduce drinking rates, high risk drinking and related damage.²⁹ While this proposed action plan is not in itself a structural change, it might provide a vision and a pulling together of resources in ways that are more effective in reducing harm than is currently the case.³⁰

Monitoring and research: Further work is needed to understand how alcohol policy decisions are made and what determines the allocation of resources for their enforcement. Studies that monitor the activities of the alcohol industry are rare but would be useful in understanding the dynamics of alcohol policy priorities. Of particular interest are trade agreements³¹ and the position of federal and provincial agencies with regard to the protection of alcohol as a unique and high-risk

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commodity.³² Other work might look at changes in access to alcohol and alcohol promotion and their impacts on consumption rates, drinking patterns and alcohol-related problems. Case studies of community experiences in harm reduction have not been systematically documented. Annual monitoring of drinking patterns, drinking-related harm and public opinion on alcohol issues – at the provincial level -- would provide a resource for assessing the effect of policy changes and prevention efforts.³³ Research conducted elsewhere on the proportion of total alcohol consumed by high-risk drinkers³⁴ also might be undertaken with regard to Canadian experiences in order to explore what proportion of total sales is linked to chronic or sporadic heavy consumption.

It is uncommon to find a priori social impact assessments in the alcohol field with regard to policy changes.³⁵ If this were to become the standard protocol prior to the implementation of proposed changes in access to alcohol, a very useful resource would be created for the advisory committees proposed above, and for policy-makers. Natural experiments with baseline and post-change data also provide a basis for assessing the impact of policy changes.

Finally, the means of disseminating key findings to policy advisors and decision makers and other interested persons needs to be enhanced in all provinces. A useful model is the Alcohol Policy Network in Ontario.³⁶ Other provinces may wish to develop similar networks with links to a national network.

Action: An important interim goal is that of reducing per capita consumption.³⁷ If effective action is to be taken towards reducing the harm associated with alcohol, it will require an acknowledgement by governments that both rising rates



of alcohol sales as well as high risk drinking patterns are matters of concern. While changing the rate of consumption will not necessarily reduce all types of harm related to drinking, it has been linked to a wide range of acute and chronic damage from alcohol use, and the international evidence indicates that it is an important intervening step in effective prevention.³⁸

A recent WHO-sponsored publication offers the following list of best practices: minimum purchase age, government monopoly of retail sales, restrictions on hours and days of sale, outlet density restrictions, higher alcohol taxes, sobriety check-points, lowered BAC limits, administrative licence suspension, graduated licensing for novice drinkers and brief interventions for hazardous drinkers.³⁹ This analysis provides concrete and practical guidance moving us beyond mere lip service to the term "evidence-based". The strategies outlined deserve more resources and attention. If the central intent of prevention is to reduce harm from drinking, then those strategies with a

demonstrated track record should receive the highest profile.

There are encouraging signals at several levels. For example, senior staff of the Federal department of Foreign Affairs and International Trade recently indicated that they were not planning to give in to pressures to encourage the dismantling of alcohol monopolies that might arise from international trade discussions.⁴⁰

Through deliberations about new research opportunities⁴¹ it is hoped that further studies of the impacts of alcohol policies and analyses of policy development experiences will be funded.

Although the province of Alberta privatised their alcohol retailing system in 1993, so far, no other province has completely followed this lead. Nevertheless, partial privatisation is underway in British Columbia, and there have been occasional threats of this option being undertaken in Ontario and Nova Scotia. Thus the potential for a liquor board with a strong control mandate exists in most provinces, although a rediscovery of their control and harm reduction

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agendas would be a worthy priority.⁴² What is worrisome is that marketing and promotion, using state-of-the-art techniques, appear to be a dominant activity of some provincial liquor boards.⁴³

In many municipalities and cities there are citizen's groups and town councils that seek to control drinking-related problems by implementing alcohol policies and seeking to limit the number of outlets or encouraging responsible sales and service. However, the municipalities often lack the power to enact the most effective interventions relevant to all sales in their jurisdiction while being expected to deal with the damage from heavy drinking. Robin Room has stated:

*Ensuring that communities and local government are not hamstrung at state, national or supranational levels from responding to their local problems is thus a more and more pressing issue. It is counterproductive and even cynical to assign communities the responsibility for preventing the problems while denying them the policy tools needed for effective action.*⁴⁴

Experiences in tackling drinking and driving in Canada and elsewhere, and the central role that policies and law enforcement played in successfully reducing this rate, provide a useful model for addressing other chronic and acute problems related to drinking.

With regard to tobacco, another legal product with addictive and harmful side effects, Canada has seen remarkable progress, despite some setbacks, in implementing effective policies. These experiences also offer lessons for the alcohol field.

It is also worthwhile to observe alcohol promotion and prevention initiatives in Europe, the United States and other jurisdictions. The relevance of the European Alcohol

Action Plan has been noted above. In the United States, for example, alcohol distribution and promotion are more aggressively pursued than they are in Canada; at the same time community activism in promoting effective alcohol policies and law enforcement also appear to be more advanced. More generally, the newly formed Global Alliance offers a venue where Canadians can share their experiences and, in turn, find out about developments in other countries and global regions in promoting effective alcohol policies.

In conclusion, several inter-related action steps are recommended:

- get a place at the policy-making table;
- strengthen and expand partnerships intent on using the most effective interventions to reduce drinking-related harm;
- increase public awareness of alcohol as not an ordinary commodity and draw attention to its potential to inflict damage;
- reduce high risk drinking and per capita consumption;
- support enforcement of effective regulations designed to reduce drinking-related damage;
- assess the expected impacts of policy changes prior to decisions to implement them;
- direct resources and attention to the most effective prevention strategies.

The challenges are significant and so are the human resources required to meet them. However, there are some positive signals, useful lessons to draw on, and guidance with regard to which interventions have a demonstrated track record. Public opinion is supportive of effective interventions. With appropriate vision and leadership from those who influence policy decisions and manage resources, one can imagine a time when rates of drinking, high risk drinking events and alcohol-related harm are measurably reduced.

Dr Norman Giesbrecht is a Senior Scientist with the Centre for Addiction and Mental Health, Toronto, Ontario, Canada

References

- 1 This paper is based, in part, on a presentation at the a meeting of the Global Alcohol Policy Alliance, Westminster College, Cambridge, England, September 24, 2003. Thanks are extended to Lise Anglin for providing information and copy-editing suggestions, and to Peter Anderson, Colleen Anne Dell, Jürgen Rehm and Patrick Smith for providing information cited here. The views and opinions expressed herein are those of the author.
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Corruption affair challenges Swedish retail monopoly

Sven-Olov Carlsson

Towards the end of 2003 a main topic of the news bulletins was the growing bribery scandal in Systembolaget. Some eighty employees, most of them shop managers of the Swedish alcohol retail monopoly, are suspected of taking bribes.

Luxury trips to Monte Carlo, Madrid and Munich, mopeds, beautiful watches and video cameras from glossy catalogues are just some of the items that the head buyers of Systembolaget could choose as a "bonus" for introducing the products of various alcohol suppliers to the range of goods on sale or giving them a conspicuous position in displays. Points given for sales could sometimes be exchanged for commodities or cash.

The bribery scandal which was revealed and made public at the end of the year, has astonished the Swedish media. Thirty-five of Systembolaget's shop managers are under suspicion of serious bribery. Ten have been dismissed, although there has not yet been conviction in the courts. According to the national unit against corruption, more than one hundred people in all are suspected of taking bribes. Three suppliers of wine and spirits are included in the police investigation, one of which is under suspicion of offering bribes.

The Managing Director of Systembolaget, Anita Steen, is determined to sort out the mess which has been going on for more than ten years – although it probably escalated after suppliers other than state owned Vin & Sprit (Wine and Spirits) were allowed

into the Swedish market. In an emotional letter to her employees she wrote: "When you cut an abscess, it spills over."

It was hoped that an internal investigation would finish its report before the end of 2003, which seemed rather optimistic. There are 1,200 employees to be investigated in the company's own scrutiny of the bribery affair, and it is now expected that it will be finished in early 2004.

A question raised, especially by political opponents of the Social Democratic Government, is whether Anita Steen will be able to remain in office after a scandal as big as this. Ms Steen is not only the Managing Director of Systembolaget

but also the wife of the Swedish Prime Minister, Göran Persson.

So far the Board of Systembolaget has not lost its confidence in their managing director. Furthermore, a majority of the MPs in the Parliament's Trade and Industry Committee were satisfied with the information they got during a meeting with the Minister of Trade and Industry, Leif Pagrotsky, and the Chairman of the Board of Systembolaget, Olof Johansson.

Be that as it may, whilst confidence in the company has suffered, the affair does not seem to have given the European Commission the means of delivering a deathblow to the Swedish retail monopoly.

"As far as I understand, this is a case of suspected corruption, and thus it is a matter for Swedish authorities, and not for the Commission," says Jonathan Todd, spokesman for the Commissioner responsible for the inner market, Frits Bolkestein.

Sven-Olov Carlsson is President of IOGT-NTO.



An Italian success story

By Ennio Palmesino

History

The foundation of the Clubs of Alcoholics in Treatment is connected with the revolutionary movement which took place in psychiatry in the 1950's. At that time some advanced countries started to develop the "open door policy" in psychiatry, which meant unlocking the doors of psychiatric institutions, releasing psychiatric patients from various coercive measures, introducing therapeutic communities, group work, and new drugs into psychiatric treatment.

Professor Vladimir Hudolin spent the years 1952/53 in Great Britain and Sweden on a WHO scholarship, and thus directly participated in this new approach. He worked in Maxwell Jones' Therapeutic community at the Belmont Hospital in small psychotherapy groups with Joshua Bierer, and in large psychiatric hospitals (in London, Leeds, Inverness, Edinburgh, Aberdeen). When he returned to Zagreb, he was appointed deputy head of the Neuropsychiatric Department at the Dr M. Stojanovic Hospital, and there he introduced, in turn, the "open

door policy" in the psychiatric system, with a therapeutic community, work in small groups, and a family approach. Many psychiatric institutions in Croatia and elsewhere did the same, but much later, and some have yet to follow suit.

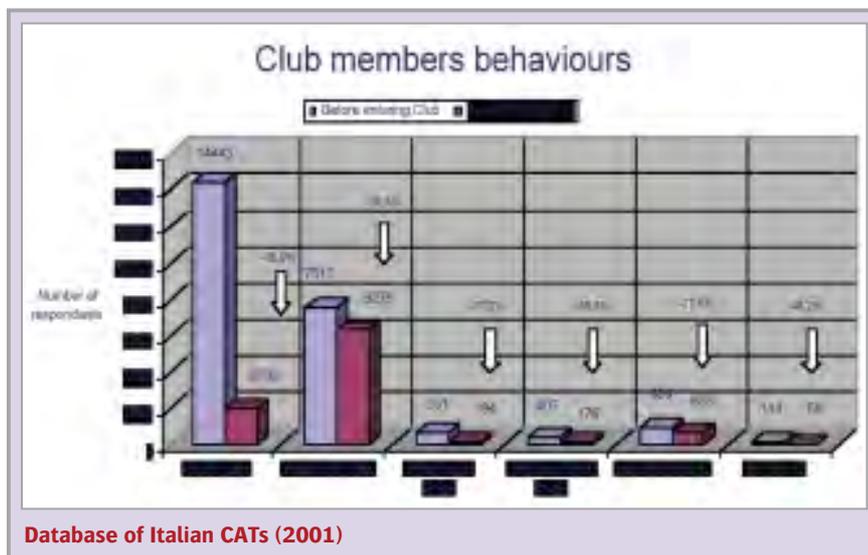
During this work, Professor Hudolin noted that a large percentage of admittances, especially urgent cases, were alcoholics, and it is still so in many psychiatric institutions. Alcoholics were admitted, they recovered, stopped drinking, were discharged, and after a short time,

had to be re-admitted for another treatment. The discharge papers regularly had the remark "improved". Moreover, as it is often the case in psychiatry, after every discharge, the situation appeared to have improved, but in the long run it had in fact deteriorated.

These negative results encountered whilst working with alcoholics, along with long-term experience with therapeutic community in psychiatry, and his own reflections, persuaded Professor Hudolin to remove alcoholics from the psychiatric department and to start working with them in separated therapeutic communities, or in smaller groups (or clubs) in the presence of their families and a therapist, outside the hospital structure. This is how the Clubs of Alcoholics in Treatment were born, on April 1st, 1964. Ironically, the address of the Hospital was in Vineyard Street.

Clubs of Alcoholics in Treatment were opened in several Zagreb municipalities and soon spread to other parts of Croatia and Republics of former Yugoslavia. Before the Patriotic War began, there were about 300 Clubs of Alcoholics in Treatment in Zagreb, about 1,000 in Croatia and about 2,000 in Yugoslavia. They became involved from the beginning in the development of a territorial network of support for alcohol related problems.

The importance of organising and promoting education, training, and continuous updating of the Clubs' members, as an integral part of Clubs' work, also emerged. In the first place, it was decided to train the professional personnel in alcoholism, and specific courses were organised, providing basic information and



guidelines for the practical work almost from the first day. Firstly, the School for Social Psychiatry, Alcoholism and other Addictions (The Zagreb Alcoholism School) was founded, then a one-week long course (50 hours) was organised on the medical-social approach to alcohol related problems (as it was called at the time). There followed a six-month school of specialisation in alcoholism and a two year post-graduate course at the University of Zagreb.

Gradually, also the Club members, and other volunteers from the local communities, were invited to attend the 50 hours course, thus providing more and more volunteers, to carry on the enormous task of caring for all the alcoholics in the Clubs, as there were not enough professionals to do all this work.

Evolution

At the end of 1979 Professor Hudolin and his associates were invited to hold the first 50-hour course in the Udine Hospital in Italy. Shortly after that, the first Club of Alcoholics in Treatment was founded in Italy, initially at Mr and Mrs Pitacco's house in Trieste. Professor Hudolin and his associates were the first servant-teachers in that Club, and this is how the project began in Italy. Today there are more than 2,200 Clubs in all Italian regions, and in other twenty-eight countries throughout the world.

One of the most important stages in Clubs of Alcoholics in Treatment development was the Congress of Clubs of Yugoslavia and Italy held in 1985 in Opatija. On that occasion, Professor Hudolin stated in his introductory paper that, in his opinion, alcoholism was not a disease but a disorder in behaviour and lifestyle. Resistance appeared immediately after the lecture, mainly from the alcoholics themselves. They much preferred to be ill, they wanted to be ill, to be protected, without

personal responsibility for their behaviour and lifestyle. Experts in various fields also showed resistance, and some still do today. Medicalisation and psychiatrisation, when working with alcoholics, appear quite often, and can be considered a form of relapse of behaviour. The Clubs gradually accepted the stand that alcoholism is a behavioural and lifestyle disorder.

Club operation

The Clubs of Alcoholics in Treatment have gone through a number of stages, contemporary developments, scientific ideas, and personal reflections, but the basic concept changed only slightly. Their goal was to help families in trouble through a systematic family approach, to reach sobriety, and to achieve a change in behaviour and life style. Club members are contributors and consumers at the same time. They are part of the problem, but are also part of the solution.

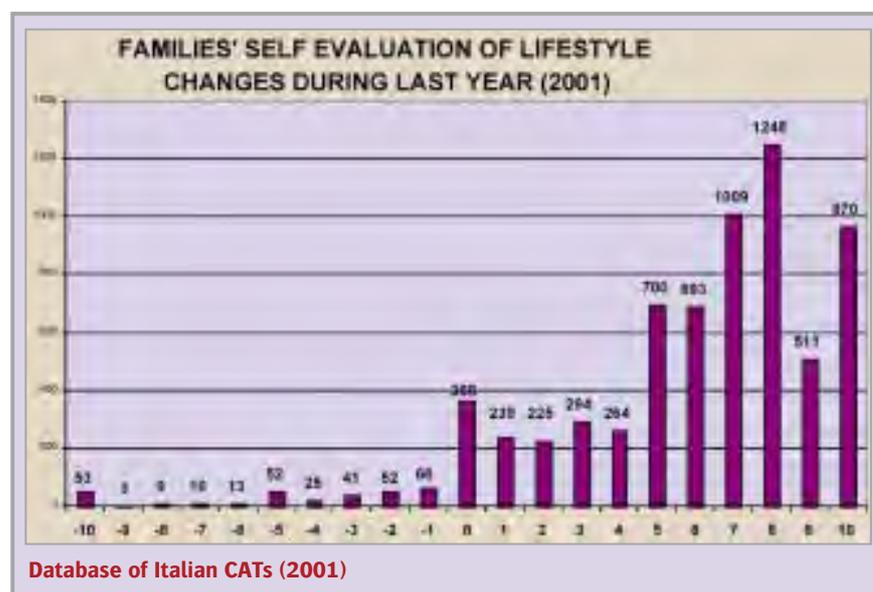
In the first stage, one-year long abstinence was considered an optimum. Later, experience showed that abstinence had to last much longer, even a lifetime. Today, Club membership is considered permanent or, as Professor Hudolin often said, "till the flowers".

On the territory covered by a Club, members can receive and give most in the primary, secondary and tertiary prevention of alcohol related problems. Research carried out during the last six years shows that in areas where more than one per cent of the population is included in the programme, the whole community goes through a gradual change of behaviour and lifestyle.

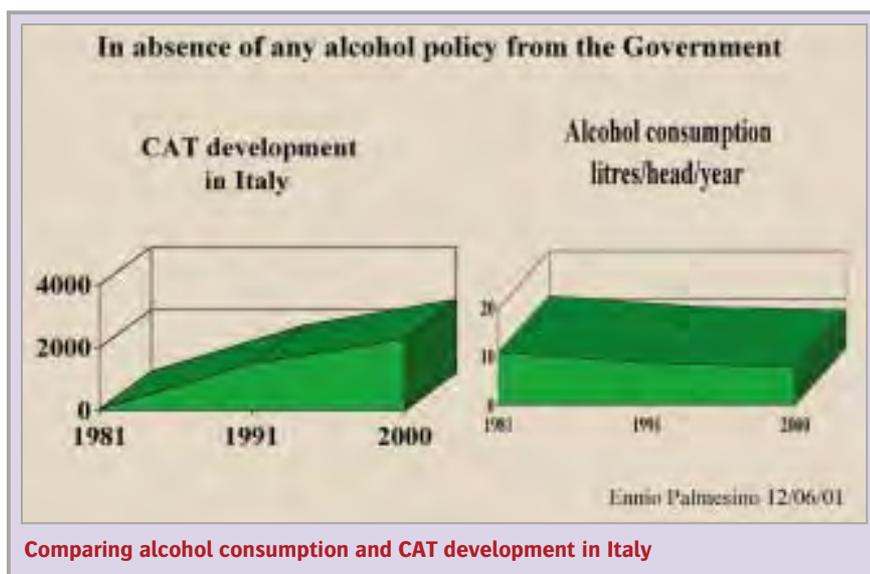
The Clubs of Alcoholics in Treatment is a multi-family community consisting of a minimum of two and a maximum of twelve families, along with a servant-teacher, included in its territorial community. It is self-governed, self-reliant, and independent of any official or private organisation. When the Clubs of Alcoholics in Treatment were founded in Croatia, they were registered as groups of citizens.

Achieving the sobriety of the whole family holds an important place in the work, but this is the easiest part of it. It is much more important and difficult to bring about changes in behaviour and life style, which is a long-term process.

There are no strict rules in the work of Clubs of Alcoholics in Treatment, the few basics would in any case be part of any socially acceptable behaviour. They are: regular weekly



An Italian success story



attendance at Clubs' meetings, punctuality, no smoking at the meetings; a Club is not a selected group and must accept anyone who feels the need to join; no one can be rejected; when the thirteenth family joins, the Club has to split in two, because a big Club cannot provide good mutual contacts and interaction for all family members; members shall not report information of a personal character learnt in the Club. Anyone with a problem has to be able to report and discuss it in the Club, but in the Club no advice is given, members share their own experiences, which are in fact messages to other Club members, from whom feedback is expected. Even the servant-teacher should not give any advice.

The process of splitting-up (multiplication) is a self-reproduction process, making it possible for new families to join a Club. The work of the Club is a continuous, long-lasting process in which only members and Club servants can participate. No admission is possible for guests, observers, probationers, or trainees. Servant-teachers from the same area should meet once a month, to discuss their experiences, problems, and difficulties, which serves as a kind of self-supervision.

The Clubs of Alcoholics in Treatment has its own structure. It is important

for every member to have a role and particular duty. All the duties in the Clubs of Alcoholics in Treatment are elective and last for a fixed term of office, so that in time all the members get a chance at performing all the duties. The Club has elective offices of president, one or two vice-presidents, secretary, and treasurer. The term of office is from six to twelve months.

A Club meeting lasts about one and a half hours. It is chaired by a chairman chosen at the previous meeting. The chairman is a Club member, never the servant-teacher. A report is drawn-up by a reporting person chosen at the previous meeting.

The servant-teacher is a Club member whose role is to provide a catalyst for the process in the Club and thus significantly contribute to the main goal, which is to change the members' behaviour and life style. In addition to not giving advice, the servant-teacher should not manage the Club or the meetings. In order to become a servant-teacher, a person has to attend a Course of Sensibilization (that is: raising awareness), and then attend, from time to time, the various updating courses. Today, almost 70 per cent of the servant-teachers are volunteers, without a professional background, the remaining 30 per cent have some sort of background connected with health.

Results

Professor Hudolin used to suggest that we should put in writing what we do, if we want to give scientific dignity to our work. After a few attempts made on a regional basis, AICAT, who has the responsibility to represent the Club world at public level, both in Italy and abroad, decided to start nationwide research at the beginning of the 2000s. We needed a tool that could summarise the efforts that are being made by over 20,000 families and nearly 3,000 volunteers acting as servant teachers in the Italian Clubs. What we got is the National Data Base, which in its latest edition, incorporates data from as many as 19,000 persons who attend the Clubs' meetings regularly. It is the picture of a huge organization.

It is important to point out that the research is not done by someone else on the Clubs. On the contrary, the families themselves do it. The Club members are, at the same time, the subject and object of the research. The results must be used by the families themselves, in the first place, because they must know the level of effectiveness and quality achieved by the work that they themselves carry out in the Clubs. Only at a later stage can the results be used by AICAT to raise awareness, in both Italy and abroad, on the existence of this methodology and its results.

The database of the results of the work done in the Clubs, and the self-evaluation that the families provide about the way they have changed their lifestyle, are the backbone of the research. As can be seen from the charts, it is evidenced that about 85 per cent of Club members do abstain from alcohol consumption, and a number of them also abstain from illegal drugs, from tobacco, and self prescribed drugs. It also appears that the large majority of the families are satisfied about their own change in life style.

Advertising and price effects on adolescent drinking

Heavy advertising on the part of the alcohol industry in the United States has such a considerable influence on adolescents that its removal would lower underage drinking in general and binge drinking in particular. These results come from a study by Henry Saffer and Dhaval Dave*. In addition, Saffer and Dave conclude that large price increases could have a similar effect.

Public health advocates have for many years been claiming that advertising plays an important role in adolescent drinking. Equally vehemently, the alcohol industry has invariably rejected any such connection. The drink companies insist that their advertising is aimed at adults and is intended to influence brand choice and not the initial decision as to whether to begin drinking in the first place. The debate has raged back and forth, often creating more smoke than light.

Saffer and Dave enter into the controversy by carrying out this study which examines underage drinking between 1996 and 1998 as recorded in two thorough, long-established surveys of youth behaviour: the University of Michigan's Monitoring the Future survey, which effectively samples some 63,000 high school students across the country; and the 1997 National Longitudinal Survey of Youth Behavior, which is carried out by the Federal Bureau of Labor Statistics. Saffer and Dave compare data from these surveys with detailed reports on the prevalence of alcohol advertising in local markets during the same period. These latter data come from Competitive Media Reporting, a well-respected, independent research company which principally

works for the advertising industry.

The economic analysis shows that alcohol advertising, the majority of which is aimed at consumers of beer and spirits rather than wine, "has a positive effect" on the decision young people make on whether to drink and on how much they consume having made that decision. In other words, alcohol advertising encourages underage drinking. The researchers found that the relationship is especially pronounced in the case of underage female drinkers.

Saffer and Dave do not claim that the alcohol industry deliberately sets out to target young people. They merely report that, whatever its intention, advertising seems to have influenced the pattern of underage drinking. The analysis "suggests that the complete elimination of alcohol advertising could reduce adolescent monthly alcohol participation from about 25 per cent to about 21 per cent. For binge participation, the reduction might be from about 12 per cent to about 7 per cent." Binge drinking is defined by most researchers as the consumption of five or more drinks at one session.

Saffer and Dave also consider the effect of pricing on drinking behaviour and reach the conclusion



that doubling prices would reduce underage drinking by 28 per cent and underage binge drinking by 51 per cent. "As a result, both advertising and price policies are shown to have the potential to substantially reduce adolescent alcohol participation," they say.

The authors further point out that at the moment "both the level of alcohol consumption by adolescents and the level of alcohol advertising are considerable." They quote data from the Monitoring the Future survey which indicates that 7.7 per cent of those in the 8th grade, 21.9 per cent of those in the 10th grade, and 49.8 per cent of those in the 12th grade report having consumed alcohol in the past thirty days. Meanwhile, Competitive Media Reporting "estimated that alcohol producers spent about \$1.5 billion on advertisements in 2001, a 25 per cent increase on 1998. Saffer and Dave point out that this figure is for "measured media" only and may account for as little as a third of total promotional expenditures. It does not include spending on such things as the sponsorship of events, Internet sites, product placement in films, or point-of-purchase advertisements.

* Alcohol Advertising and Alcohol Consumption by Adolescents (NBER Working Paper No. 9482)

Bridging the Gap

European Alcohol Policy Conference
16th – 19th June 2004, Warsaw , Poland

“Alcohol policymaking in the context of a larger Europe: Bridging the Gap”

Organiser:

The Conference is sponsored and organised by Eurocare with the financial support of the European Commission.

Co-Sponsors:

World Health Organization
European Cultural Foundation
European Public Health Alliance
European Youth Forum
State Agency for Prevention of Alcohol Problems, Poland
Directorate for Health and Social Affairs, Norway
The Norwegian Policy Network on Alcohol and Drugs
IOGT NTO Sweden
Pacific Institute for Research and Evaluation, USA

The organisers of Bridging the Gap, the European Alcohol Policy Conference to be held in Warsaw in June, 2004 (see Globe Issue 3, 2003) intend that participants in the conference should provide a specific range of expertise, specialism, and national and international association, and any reader of the Globe who wishes to express an interest should contact Florence Berteletti Kemp at the

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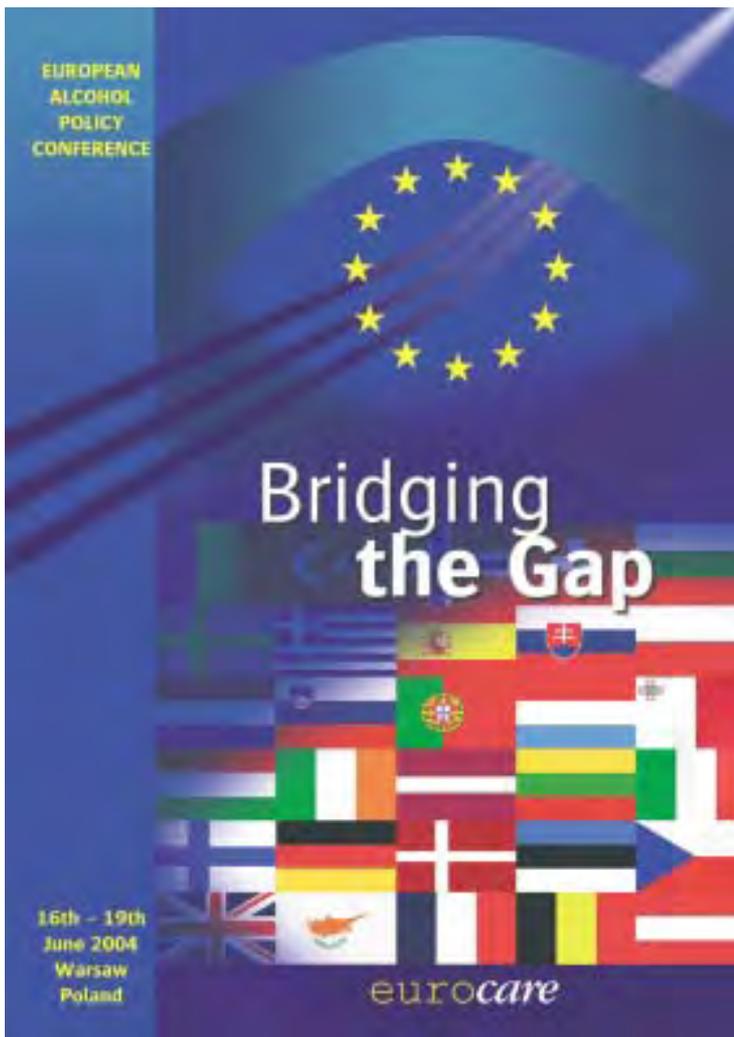
Why?

Alcohol consumption plays a major role in morbidity and mortality on a global scale. In Europe, where the greatest per capita consumption is found, the total burden of alcohol-related disease, injury, and premature death is between 8% and 10%. Considerable progress has been made in the scientific understanding of the relationship between alcohol and health but results of this rarely reach policy makers. The aim of the Eurocare conference is to bridge the gap which exists between research and those who have the power to put effective alcohol policy into practice. The conference will look at the problems policy makers encounter whilst trying to reduce the harm done by alcohol and will provide the basis for an alcohol policy and advocacy tool kit designed to help them in their work.

The conference forms part of the project co-financed by the European Commission, “Alcohol Policy Network in the Context of a Larger Europe” running from 2004 – 2006.

Where?

By choosing to hold the conference in Poland, Eurocare is emphasising the fact that there is much to learn in alcohol policy and the delivery of programmes between the applicant countries and existing Member States of the European Union. The conference is supported locally by the State Agency for Prevention of Alcohol Problems and the Institute of Health Psychology.



What?

The Eurocare Conference will emphasize the need for a mix of policies to address the harm done by alcohol. It will begin with an outline of the most recent advances in alcohol research which have relevance to the development of alcohol policies and programmes at all levels. In looking at the most pressing issues, there will be a focus on modifying drinking contexts, drinking and driving countermeasures, regulating alcohol promotion, education and persuasion strategies, regulating the physical availability of alcohol, price and taxation, mobilizing local communities, and treatment and early intervention services.

The conference will aim to help governments view their alcohol policies in a co-ordinated fashion.

How?

The Eurocare conference hopes to promote the policy discussion necessary to find an agreed way to promote health and social reform. Specialised workshops will attempt to bridge the gap between scientists, policy makers, and programme implementers.

For Whom?

The conference is for policy makers, programme implementers, health promoters, prevention specialists and prevention planners working in governmental

and non-governmental organisations at the local, national, and European levels, as well as researchers, clinicians, and addiction service providers. It is designed to be of interest to policymakers and programme implementers who have direct responsibility for public health and social welfare as well as those who work in other sectors, such as finance, road safety, consumer and family affairs, education, entertainment, communications, marketing and advertising. Particular emphasis will be made to ensure participation from the applicant countries.

By Whom?

Speakers include scientists from leading alcohol research centres and representatives of European health and alcohol policy organisations, including Eurocare and the World Health Organization. Participants are invited to submit proposals for workshops and parallel sessions. Professional facilitators and moderators have been chosen to ensure that dialogue is constructive. A media strategy has been devised in order to get national and European media impact.

Conference outcome

The conference is the first in a series of activities to bridge the gaps between scientists, policy makers and programme implementers. The conference material will lead to an edited Eurocare publication and a Eurocare alcohol policy advocacy training manual that meets the needs of policy makers and programme implementers. Two advocacy schools are being prepared for 2005 and 2006. A conference charter, 'Bridging the alcohol policy gap in Europe' will be endorsed and widely disseminated.

Eurocare conference timetable of events

16-19th June 2004

eurocare

Wednesday 16/06/04 - Sofitel Victoria Hotel

Hours	Subject
12.00-18.00	Registration Hand out conference packs Possibility for participants to organize fringe meetings and to book the conference facilities to network, make presentations, discuss their own projects.
18.00-21.00	Reception Theatre performance – Wybrzezak Theatre Group Meeting Point for the participants - networking

Thursday 17/06/04 - Sofitel Victoria Hotel

Hours	Subject	Speaker/Organisation
08.00-17.00	Registration	
09.30-10.30	An Enlarged Europe: perspectives, expectations and key issues	World Health Organization European Commission The Government of Poland
10.30-11.00	Coffee break	
11.00-12.00	Keynote presentations: Bringing science to the people of Europe Poland at the European crossroads	Professor Sally Casswell Centre for Social and Health Outcomes Research and Evaluation, New Zealand Professor Jerzy Mellibruda Polish State Agency for Prevention of Alcohol Problems
12.00-12.30	Methodology to follow for the conference Aim, objectives and methodology of the parallel sessions Introduction to the advocacy toolkit	Florence Berteletti Kemp and Dr Peter Anderson Eurocare
12.30-14.00	Lunch - Included in the conference fee	
14.00-15.30	Keynote presentations: The risk of alcohol to Europe The financial costs and benefits of alcohol Threats to world health: trade agreements	Dr Peter Anderson International Consultant in Public Health Professor Christine Godfrey Centre of Health Economics, University of York, England Leanne Riley World Health Organization
15.30-16.00	Coffee break	
16.00-17.30	Working groups and parallel sessions on the themes of the conference	

Friday 18/06/04 - Sofitel Victoria Hotel

Hours	Subject	Speaker/Organisation
07.45-08.45	Breakfast Teach-ins [Topics to be confirmed]	
09.00-10.30	Keynote presentations:	
	Loi Evin	Dr Alain Rigaud President, National Association for the Prevention of Alcoholism, France
	Communicating about alcohol	Professor Gérard Dubois CHU - Hôpital Nord, Amiens, France
	Driving to alcohol free roads in Europe	Dr Hans Laurell Alcohol, Drugs and Traffic Safety, Traffic Department, Sweden
10.30-11.00	Coffee break	
11.00-12.30	Working groups and parallel sessions on the themes of the conference	
12.30-14.00	Lunch - Included in the conference fee	
14.00-15.30	Keynote presentations:	
	Alcohol policy and young people	Dr Ann Hope Department of Health and Children, Ireland
	Mobilizing local communities in Europe	Dr Vesna-Kerstin Petric WHO Liaison Office, Slovenia
	Alcohol and families in Europe	Andrew McNeill Institute of Alcohol Studies, UK
15.30-16.00	Coffee break	
16.00-17.30	Working groups and parallel sessions on the themes of the conference	
17.45-18.30	Walking through the streets: a different view of the city of Warsaw	Architecture and history students
19.00	Conference dinner	

Saturday 19/06/04 - Sofitel Victoria Hotel

Hours	Subject	Speaker/Organisation
07.45-08.45	Breakfast Teach-ins [Topics to be confirmed]	
09.00-10.30	Keynote presentations:	
Plenary session	Towards a comprehensive treatment strategy	Professor Kaija Seppa Tampere University, Finland Professor Gerhard Bühringer Institut für Therapieforchung, Germany Dr. Antoni Gual Unitat d'Alcoholologia de la Generalitat de Catalunya, Spain Professor Harald Klingemann Institute for Social Planning and Social Management (ISS), Switzerland
10.30-11.00	Coffee break	
11.00-12.30	Working groups and parallel sessions on the themes of the conference	
12.30-14.00	Lunch - Included in the conference fee	
14.00-15.00	Round table discussion with the speakers Moderated by the grand witness	
15.00	Adoption of the conference charter Closing remarks	Derek Rutherford Eurocare
15.30-16.00	Coffee break	

Call for workshops and parallel sessions

During the Eurocare conference, there will be workshops and parallel sessions grouped broadly under five themes of the conference:

- 1 The harm done by alcohol
- 2 Threats to health and alcohol policy
- 3 Marketing and communicating about alcohol
- 4 Success stories from the national to the local, in settings and on the roads
- 5 Public health approach to treating alcohol problems

The workshops and parallel session will run throughout the conference (see conference timetable).

At any one time, there will be the opportunity for up to eight workshops and parallel sessions. The final number will depend on how many proposals are received.

Types of sessions

We are inviting proposals for workshops or parallel sessions, whereby the invitee making the proposal will agree to organize the whole workshop or parallel session. We wish to ensure that a workshop really is a workshop, with a clear aim and objective.

Throughout the duration of the conference, Eurocare will be running a four session advocacy training school, where delegates will be invited to join all four of the training sessions.

The workshops are an opportunity for networks and other collaborative projects on alcohol to present their experiences and findings.

Submission of proposal

If you would like to propose a workshop or parallel session, please

provide the following information on a maximum of one side of A-4 paper:

Your name

Your organization

Your country

Your e-mail and telephone number

What kind of session do you think it mainly is? (Workshop/information giving/discussion/ debate)

Is it a one off session or a series throughout the conference (if so, how many)

Title of session

To which of the five themes does it relate?

Aims and objectives of session

How is the session going to be organized?

Who is going to deliver the session?

For whom is the session intended?

Your preferred number or maximum number of participants

Any other relevant information.

Fees and expenses

We are not able to provide any fee for undertaking this work, nor are we able to cover travel and accommodation expenses in attending the conference. However, if your proposal is accepted, we will waive one registration fee for the conference for the main organiser of the session.

Timetable:

Submit proposal up to:
29th February 2004

Confirmation of whether or not accepted by: 31st March 2004

Final preparation of description of session by: 30th April 2004

Proposals should be sent to:
Dr Peter Anderson

(PDAnderson@compuserve.com), to whom any questions or queries about the sessions should be addressed.

Sofitel Victoria

is a five star hotel. It is located in the centre of the city, only a short walk to the Royal Castle and the old town of Warsaw. The hotel overlooks the Saxon Gardens with the Monument of the Unknown Soldier and the Opera. Rooms are equipped with the whole range of five star hotel accommodations: air-conditioning, pay TV, voice mail, a 24 hour room service, dry-cleaning, pressing, indoor swimming pool, Internet connection in rooms via LAN is free of charge.

The Europejski hotel

is a three star hotel. It is located in the centre of the city, only a short walk to the Royal Castle and the old town of Warsaw. The hotel is a combination of a historical design (built in 1857) with modern convenience. It overlooks the Pilsudski Square and the National Opera. The conference is taking place just three minutes away from the Europejski. All rooms are equipped with satellite TV and direct telephone line.

PARPA Training Centre

is offering basic accommodation for approximately 35 EUR per night - priority will be given to participants from accessing countries. Further information and enquiries about payments should be made directly to Mazurkas Travel - Congress Bureau at BtG@mazurkas.com.pl



Further publications available from the Institute of Alcohol Studies

Counterbalancing the Drinks Industry

Counterbalancing the Drinks Industry: A Report to the European Union on Alcohol Policy

A response to a report published by the European drinks industry and a defence of the WHO Alcohol Action Plan for Europe.

Alcohol Policy and The Public Good

Alcohol Policy and the Public Good: A Guide for Action

An easy-to-read summary of the book written by an international team of researchers to present the scientific evidence underpinning the WHO Alcohol Action Plan for Europe

Medical Education

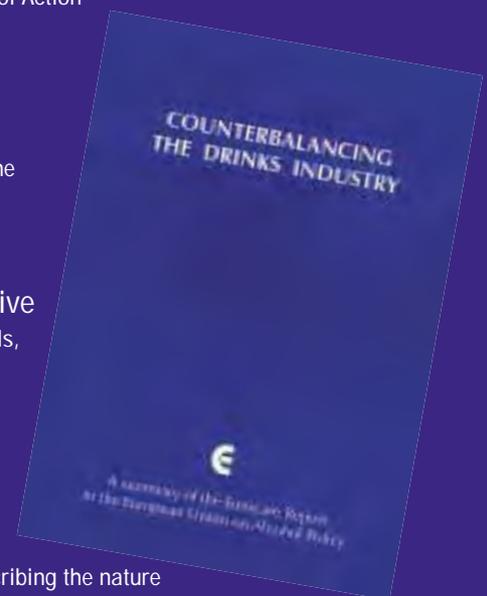
Medical Education in Alcohol and Alcohol Problems: A European Perspective

A review of educational programmes on alcohol and alcohol problems in European medical schools, identifying gaps in provision and proposing guidelines for a minimal educational level within the normal curriculum of under- and post-graduate medical students.

Alcohol Problems in the Family

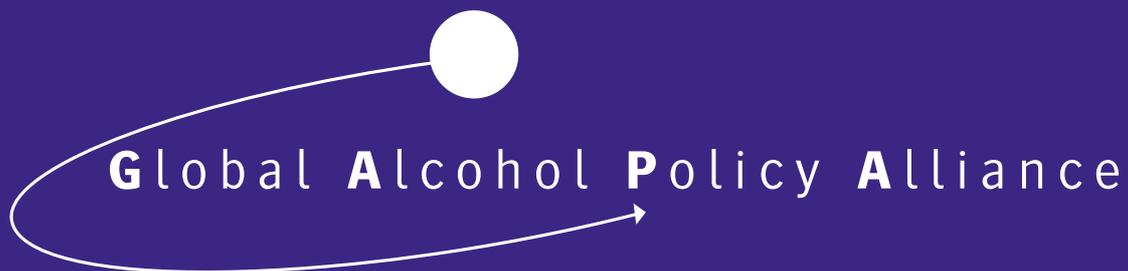
Alcohol Problems in the Family: A Report to the European Union

A report produced with the financial support of the European Commission describing the nature and extent of family alcohol problems in the Member Countries, giving examples of good practice in policy and service provision, and making recommendations to the European Union and Member Governments.



Marketing Alcohol to Young People

Children are growing up in an environment where they are bombarded with positive images of alcohol. The youth sector is a key target of the marketing practices of the alcohol industry. The booklet depicts the marketing strategies of the industry and shows how advertising codes of practice are being breached.



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