

Issue 2 2009

THE GLOBE



**Alcohol
responsible
for 1 in
25 deaths
worldwide.
Is more
protection
needed?**

THE GLOBE

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**Published by the Institute of
Alcohol Studies for**

The Global Alcohol Policy Alliance

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ISSN 1460-9142

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Front Cover from the Alkokutt Campaign, Norway and Stay Dry Campaign, UK

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Protective alcohol policy requires legislative action

Governments have been rightly concerned about the impact of the ‘credit crunch’ on the economic life of their people. This is a problem that is partly due to the effects of deregulation, an unfettered financial market and the lack of effective oversight by governments. Immediate and positive action has been undertaken. Unfortunately the same cannot be said for the global crisis in alcohol consumption that is adversely affecting the social and health well being of the world’s people.

Alcohol accounts for 1 in 25 (3.8%) of global deaths. In people under 60 years of age the proportion of deaths is 5.3%.

The alcohol attributable disease burden lies more with younger than older people. Of years lived with disability attributable to alcohol, 34% were experienced by people aged 15 to 29 years of age. Europe, with the highest levels of consumption, experiences 1 in 10 deaths attributable to alcohol and up to 9 million children living in families adversely affected by alcohol.

Where alcohol policy strategies are initiated, they are weakened by the lobbying tactics of an over powerful drink industry. The drink industry’s mantra is that the answer is education and the personal responsibility of drinkers - a mantra conveniently accepted

by decision makers. Education without legislation is ineffective. The Commission on Social Determinants, set up by the WHO, recognises the need for legislation. The report maintains that a society without effective alcohol policies is likely to experience a sharp rise in alcohol problems. It sees the Framework Convention on Tobacco Control as an excellent example of coherent global action to restrain market availability of a lethal product. It goes on to urge WHO to initiate a discussion with Member States on regulatory action for alcohol control.

Derek Rutherford

Sally Casswell: champion for communities tackling alcohol

The Chair of the Scientific Advisory Panel of GAPA is Professor Sally Casswell. Professor Casswell is a social scientist and is the Director of the Centre for Social and Health Outcome Research and Evaluation at Massey University in New Zealand.

Here, Professor Casswell is profiled by Kelly Morris.

Every conference held by Sally Casswell, director of the Centre for Social and Health Outcomes Research and Evaluation (SHORE) at Massey University, New Zealand, starts and ends with a Maori blessing, says Derek Rutherford,

chair of the UK’s Global Alcohol Policy Alliance. “This is not lip service”, says Rutherford. Casswell, he says, has a sensitivity and appreciation of the cultural heritage of the Maori people and deep concern for the health and social wellbeing of Pacific Islanders. As one of the founders of the Global Alcohol Policy Alliance and the Asia Pacific Alcohol Policy Alliance “her recognition of the advocacy role of non-governmental organisations in the field of alcohol policy can be seen at international and regional levels”, he notes.

Maori people have higher rates of alcohol abstention but heavier



Professor Sally Casswell

drinking than Pakeha (non-Maori) people. Since Casswell emigrated to New Zealand in the 1970s, she has witnessed a “renaissance of power and influence of Maori in various

sectors". SHORE works in partnership with the largest Maori social science research group in the country, which is "terribly exciting and a learning experience for Pakeha", she says. Community concern by various groups was what led Casswell to become a leading researcher and developer of alcohol policy. Unregulated markets and social changes led to an increase in alcohol consumption in New Zealand, which resulted in community pressure on the government to respond to the issue. Casswell is now looking at the broader effects of heavy drinking on such areas as child protection, drink driving, the workplace, and the family, as well as finding out how specific ethnic groups respond to marketing by the alcohol industry.

Research on alcohol marketing is so vital, Casswell notes, because the alcohol industry needs to continue to recruit new cohorts of young drinkers who drink as much as, or more than, the previous cohort. This policy is driven by obligations to shareholders, and has led to an expansion in marketing and promotion initiatives. What is interesting, she says, is that more than 50% of alcohol-marketing budgets is now spent outside of the traditional mass media, often in viral marketing, such as when local radio and the internet are used to encourage friends to exchange information as part of competitions for alcohol-sponsored events with free drinks. Policy experts, she says, "are unexposed to this sort of marketing", which is part of the same drive that has resulted in the development of many sugary, coloured alcoholic drinks "and associates the brand and drinking with the key elements of the identity of young people".

"Not for her to leave the findings of research to gather dust on some university library shelf but with belief in the validity of those findings, Casswell will actively advocate their implementation", says Rutherford, who describes her as "a practical, 'hands-on' social scientist". Casswell admits that she is known for being forthright—prepared to stick by what she believes the evidence shows. For example, classroom-based education about alcohol is ineffective, she says, and money must not be wasted on it. Good school-based education can increase knowledge and change attitudes but does not change behaviour in the long term. "We do need to change people's environment", she insists. To change production or demand is incredibly hard, she explains, since it involves regulation of producers or reduction of social inequalities and other measures to change the relation between alcohol use and vulnerable people. Instead, she points to the effectiveness of various measures, from implementation of legal drinking ages and taxation that also changes the social ideas and norms about alcohol consumption.

Casswell moved to New Zealand from the UK to join a former mentor from Sheffield University, Professor Peter McKellar, and did her PhD on cannabis and human behaviour. But she subsequently began to research alcohol as the major recreational drug of choice. Several years of work with Griffith Edwards, ex-editor in chief of *Addiction*, as part of a panel of unpaid experts led to publication of the groundbreaking books *Alcohol Policy and the Public Good* and *Alcohol: No Ordinary Commodity*. Alcohol is not an ordinary commodity, she insists. "It's a

hazardous substance and more unregulated than any other drug". She was a member of WHO's expert committee that reported on alcohol-related harm in 2008 and since then Casswell has been calling for a Framework Convention on Alcohol Control, developed and regulated by WHO with support from health-care and law-enforcement professionals.

Casswell is pleased that she drank little as a young person growing up in the UK at a time when drinking levels were lower, especially now more is known about the effects of alcohol on the developing brain. She enjoys a glass of wine and the occasional cocktail party, but she balances this with yoga, tai chi, and a love of nature, the bush, and the beaches of New Zealand. She is proud of her son at university and is sustained by her family and friends. But what also sustains her is her coffee addiction and being a self-confessed "research junkie". "A five-star person in the modern public-health field", and someone who is distinguished by their ability to use evidence to direct policy recommendations is how Edwards describes Casswell, adding that "She cares about the person in the street. She can think in terms of both populations and individuals."

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Vol 373 June 27, 2009

Alcohol: The Global Challenge

Derek Rutherford writes:

Today hardly any region of the world remains unaffected by the present epidemic of social and health harm caused by alcohol. Globalisation, economic liberalisation, growing disposable income and aggressive marketing have all contributed to the industry's global outreach.

This has resulted in the development of similarities in patterns of drinking in different cultures. Traditional protective cultures are on the wane. While protective factors have become weaker, pressures on young people to drink have increased. There is now a global drinking culture.

The editorial in the Kenyan Daily Nation(April 2009) commented: "A generation of young Kenyan people between the ages of 15 and 29 is in the grip of alcoholism. Across all provinces, with the exception of North Eastern, the prevalence of the epidemic paints a picture of a generation that is in serious trouble."

The World Health Organization Regional Office for the Western Pacific (WIPRO) reports that drinking by young people is of growing concern throughout the Western Pacific Region. The general picture emerging in the Region is of growing and heavier use of alcohol by young people. In the Pacific Island countries binge drinking has been identified as a common practice.



In South East Asia the age of initiation of drinking is occurring at younger ages in many countries and binge drinking is on the rise as well. Consumption among girls in some countries (especially Latin America) has begun to approach or even surpass that of young men.

The 2007 World Development Report expressed concern about the range of health risks from non-communicable diseases:

"The developing world's 1.3 billion young people aged 12-24 are its next generation of economic and social actors. As a result of epidemiological transition from communicable to non-communicable diseases

young people are exposed to a different range of health risks than before." It goes on to remind politicians of the "importance of building human capital in youth" and of the need to create the right climate since "missed opportunities to invest in and prepare this generation will be extremely costly to

reverse, both for young people and society."

Drink Industry representatives, at their meeting with the WHO in November 2008, maintained that they did not target under-age drinkers. Marketing strategies to 'capture' the legal youth market are bound to influence the drinking patterns of under-age drinkers.

Over the past decades the drink industry has viewed the youth market as a prime target. In the UK, Kevin Brain, in a paper for the Institute of Alcohol Studies entitled “Youth, Alcohol and the Emergence of the Post-Modern Alcohol Order”, has described how, from the 1980’s in the UK, the industry had to ‘remodel’ its product. The brewing industry was confronted with the possibility of losing a new generation of alcohol consumers to a post-modern consumer leisure order of raves, clubs and illicit recreational drugs. There was a need to target a new generation of youth drinkers, both male and female, who demanded a greater range of alcohol products.

Comments of senior brewing industry figures well illustrated the concern of the Industry. Fraser Thompson, then strategic development director at Whitbread, noted:

“Young people seem less prepared to sip beer for hours, culturally they like short sharp fixes ... five years ago there were less alternatives to getting a buzz or getting high. The challenge for the industry is to make alcohol part of that choice’.

Richard Carr, chairman of Allied Leisure, the entertainment arm of Allied-Tetley-Lyons noted:

‘Youngsters can get Ecstasy for £10 or £12 and get a much better buzz than they can from alcohol ... it is a major threat to alcohol-led business.’

Faced with losing its traditional market and losing out in the psychoactive youth consumer market, Brain comments:

“The industry’s response was to accelerate the process of re-commodifying alcohol products that it had begun in the eighties. The term re-commodification is deliberately chosen to capture the fact that alcohol was being redeveloped as a ‘new’ consumer product. In effect, the brewing industry created a post-modern alcohol market.”



The journalist Jim Carey (1997) has described the attempt by the brewing industry to recapture the youth drugs market as a recreational drugs war. Brain in his paper writes “The ways in which the brewing industry has embraced youth drugs culture is obvious from the design and naming of a whole new set of alcohol products most notably represented by alcopops.

The key transformations were as follows:

- a whole new range of alcohol products -ice lagers, spirit mixers, white ciders, alcopops and buzz drinks. They have become known as designer drinks;
- The strength of alcohol products were increased in a direct attempt to compete in the psychoactive market and appeal to the new generation of psychoactive consumers;
- Alcohol products have been increasingly advertised as lifestyle markers in sophisticated campaigns to appeal to and develop market niches

Early products in the alcopops range bore names such as ‘raver’, ‘blastaway’, DNA, (a play on the initials MDMA which denote the drug ecstasy). The form of alcopops as ‘soft drinks’, the design of labels with sleek graphics and characters all helped to secure the appeal of the drinks to a sophisticated youth consumer market steeped in contemporary club culture. “

In the USA, researchers from the Center on Alcohol Marketing and Youth, Georgetown University and Virtual Media Resources of Natick, Massachusetts analysed the placements of 2,033,931 alcohol product advertisements aired on television between 2001 and 2007 and placed at a cost of 6.6 billion dollars. The key findings of the research are:

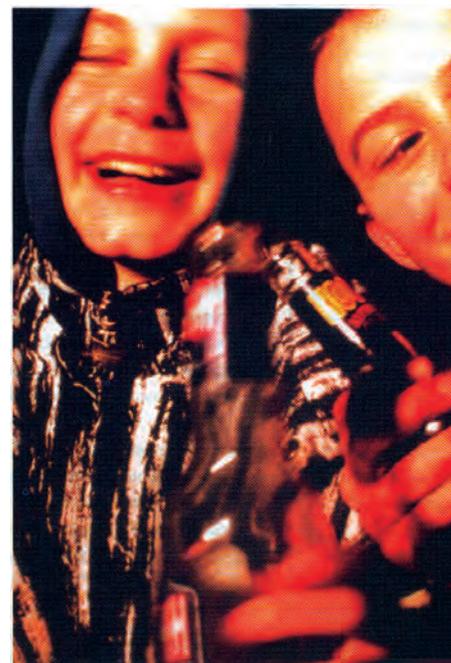
- In 2007, more than 40% of youth exposure to alcohol advertising on television came from ads placed on youth-oriented programming, that is, programs with disproportionately large audiences of 12-to-20-year-olds.
- Almost two-thirds (63%) of these overexposing ad
- Between 2001 and 2007, alcohol companies aired 73,565 “responsibility” advertisements on television. Youth ages 12 to 20 were 22 times more likely to see an alcohol product advertisement than an alcohol-industry-funded “responsibility” advertisement.

we strongly oppose marketing or sale of our products to under-age youth”. But apparently not to all youth as can be seen from the 2004/2006 annual reports of UB (India) – a member of GAPG.

“The entire Indian map is changing. There has been a huge explosion of disposable income among the young; moreover, social drinking has increased. And today users are looking for products that are aligned with global trends; the demand for new age flavours is increasing. The Indian market is ready for alcohol beverages with exotic fruit flavours.”

“RTD, being a low-alcohol beverage, will be a stepping-stone for SEC-A youngsters and women to enter the alcoholic beverages segment. Especially women, who are used to fruit juices and would readily make the transition to one with a low alcohol content.”

“Youngsters seeking western lifestyles typically begin by drinking beer and move into spirits. The brand positioning of UB Spirit Brands are designed to attract these upwardly mobile and aspirational customers.”



placements in 2007 were on cable television, which generated 95% of youth overexposure to alcohol advertising on television.

- Of the youth overexposure on cable in 2007, 53% came from beer advertising, and 41% came from distilled spirits advertising.
- In a comparison of individual brands on the basis of their abilities to comply with industry voluntary codes on advertising placement and to avoid youth overexposure in 2007, 10 brands stood out, accounting for 41% of youth overexposure and 52% of advertisements placed above the industry’s voluntary standard of a 30% maximum for youth in its audiences.

Again in the USA a Rand study also found that children’s exposure to alcohol advertising during early adolescence appeared to influence both beer drinking and their intentions to drink a year later. This study of children in the sixth and seventh grades found that those exposed to alcohol advertising at high levels – from television, magazines, in-store displays and promotional items like T-shirts and posters – were 50 percent more likely to drink and 36 percent more likely to intend to drink than children whose exposure to alcohol advertising was very low.

The Global Alcohol Producers Group (GAPG) at the WHO roundtable stated: *“Every single company in our group has a strong public track record of working to reduce the harmful use of alcohol....*

Led by Elizabeth Crossick of Brown Forman, the drinks industry has announced a £100M campaign to promote responsible drinking due to be launched in September 2009 in the UK.

The campaign is to run over five years, targets binge drinkers and includes advice such as eating before drinking and alternating alcoholic drinks with soft drinks. The tagline is ‘Why let a good night go bad?’

Don Schenker of Alcohol Concern said “This new initiative appears to be yet another example of the drinks industry trying desperately to avoid mandatory legislation to pass on health information to consumers”.

Professor Ian Gilmore, president of the Royal College of Physicians and chair of the UK Alcohol Health Alliance, said he was sceptical the campaign would work.

“There is very little evidence that health messages work to prevent binge or harmful drinking.”

“Instead, all the international evidence shows that increasing the price and reducing the availability of alcohol, together with bans on advertising, are the main methods of reducing alcohol-related harm.”

“We need strong government action in these areas right now”

Sports sponsorship has a key role in the industry’s global outreach.

Freeke de Wette, Sport sponsorship manager Heineken International, reported in April 2006 that:

“We are delighted to have extended our sponsorship of the Rugby World Cup. The Heineken brand is enjoyed in almost every country throughout the world. As such, Heineken is the

perfect partner for rugby’s premier global tournament. Over 3.5 billion people view the Rugby World Cup across 209 countries.”

Sponsors of the 2002 World Soccer Cup Tournament in Japan and Korea had direct access to 1 in 6 people on the planet.

In preparing for the World Cup, David Goadby, Custom Marketing Director at Scottish and Newcastle, remarked:

“Tournaments such as these are critically important for our customers.... Five times more people watch the World Cup than watch domestic football.”

Sports sponsorship drives a coach and horses through advertising codes that prohibit implications that alcohol consumption improves physical performance and the targeting of minors. It contradicts another statement of GAPG

“recognizing that underage persons cannot be removed entirely from exposure to mass media advertising targeted to adult consumers, the GAP Group companies have, in many mass media markets, instituted prohibitions on advertising in media programming where the ads will reach a substantial percentage of viewers or listeners who are below legal drinking age. In most cases, these rules are also applied to live sponsored events.”

Earlier this year, Formula One Motor Racing champion Lewis Hamilton was engaged by Diageo to campaign against the Scottish Government’s proposal to raise the age for purchasing alcohol in supermarkets and off-licences from 18 to 21 years of age.

The Drinks Industry and its social aspect organisations are opposed to legislative action. Their mantra is education. Since 1977 the UK government regarding education about alcohol has relied largely on conveying ‘sensible limits’ of consumption.

The original limits set were for men not to drink more than 21 units and women no more than 14 units of alcohol per week (1 unit is about 8 grams). Any objective assessment of the outcome of the campaign over three decades must be that it failed. One reason for its failure must be that, when the limits were set, 29 million people drank below the limit and only 6 million drank above it.

In the UK the success story has been drink drive legislation.

The educational message of not to drink and drive was first used in the 1930s. It was not until the introduction of the breath test in 1967 that drink drive casualties were reduced.

The Commission on Social Determinants has seen the need for legislation and urges WHO to initiate a discussion with Member States on regulatory action for alcohol control.

As WHO prepares its global strategy to reduce alcohol related harm there is clear need to establish and sustain a global movement. A movement able to mobilize civil society to accept ownership of the alcohol problem and help to create a political will, free from commercial influence, to successfully reduce the global burden of disease caused by alcohol.



The alcohol industry has a public responsibility relating to the marketing of its product, since its use is illegal for more than 80 million underage Americans.

— The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, 2007

Alcohol Marketing and Youth: An Overview

The Center on
Alcohol Marketing and *Youth*

AROUND 1 IN 25 DEATHS WORLDWIDE ATTRIBUTABLE TO ALCOHOL

Worldwide, 1 in 25 deaths and 5% of years lived with disability are attributable to alcohol consumption. Disease burden is closely related to average volume of alcohol consumption, and, for every unit of exposure, is strongest in poor people and in those who are marginalised from society. These are among the conclusions of the first in a Series of three papers on alcohol in a recent edition of the UK medical journal, *The Lancet*. The paper on global mortality was written by Dr Jürgen Rehm, Centre for Addiction and Mental Health, Toronto, Canada, and colleagues.

The industrialisation of production and globalisation of marketing and promotion of alcohol have increased both the amount of worldwide consumption and the harms associated with it. Alcohol-use disorders, especially for men, are among the most disabling disease categories for the global burden of disease. And while there have been some positive effects on cardiovascular disease associated with regular drinking, these beneficial effects have been controversial and are far outweighed by the detrimental effects of alcohol on disease and injury. The authors say that two different dimensions of alcohol consumption affect health: average drinking volume, and patterns of drinking including binge/heavy drinking.

Some diseases and injuries are caused by alcohol by definition, eg, (alcohol-use disorders, alcoholic liver disease) meaning they would not exist if alcohol were not consumed. A wide range of other diseases and injuries has been deemed to have an alcohol attributable effect, eg, mouth and throat cancer, colorectal cancer, breast cancer, depression, stroke, road traffic accidents, violence, poisoning, and many others.

The authors found that, globally, average alcohol consumption is the equivalent of 6.2L of pure ethanol per year, or around 12 units per person per week (1 unit = 10 ml ethanol). In Europe, the figure is higher at 11.9 L ethanol per person per year or 21.5 units per week. Corresponding figures for North America are 9.4L/18 units; The Americas as a whole 8.7L/17 units; and the WHO eastern Mediterranean region was the lowest at 0.7L/1.3 units per week. The authors say: “In all regions worldwide, men consume more alcohol than do women, although the exact ratio varies, with women in high-income countries consuming a larger proportion than those in low-income countries. In the interpretation of these numbers, we should keep in mind that most of the adult population worldwide actually abstains from drinking alcohol (45% of men and 66% of women), most of them for their lifetime.”

For 2004 (the latest year with comparable data available on a global level) 3.8% of all global deaths (around 1 in 25) were attributable to alcohol - 6.3% for men and 1.8% for women. Most of the deaths caused by alcohol were through injuries, cancer, cardiovascular disease, and liver cirrhosis. Overall, alcohol-attributable deaths have increased since 2000 mainly because of increases in the number of women drinking. In people under 60 years, the proportion of alcohol-attributable deaths was higher at 5.3%. Europe had the highest proportion of deaths related to alcohol, with 1 in 10 deaths directly attributable. Within Europe, the former Soviet Union countries had the highest proportion at 15%, or around one in seven deaths. Relative to volume of alcohol consumed per head, the rates of alcohol-attributable mortality were higher in developing countries, especially southeast Asia. Globally, alcohol-attributable mortality rates for men were more than five times those for women.

In contrast with other traditional risk factors such as high blood pressure or cholesterol, the alcohol-attributable disease burden lies more with younger people than older populations. Of all years lived with disability attributable to alcohol, 34% were experienced by people aged 15-29 years, 31%

by those 30-44 years, and 22% by those aged 45-59 years.

The authors provide two country-based analyses, including a high-income (France, USA, Scotland, Canada) vs middle-income (South Korea, Thailand), looking at costs attributable to alcohol. Among their findings were that alcohol-attributable cost per head in high-income countries ranged from I\$358 in Scotland to I\$837 in the USA; in middle-income countries, South Korea (I\$524) had more than four times greater alcohol-attributable cost per head than did Thailand (I\$122). All countries spent more than 1% of their GDP PPP, with the highest in the USA (2.7%) in the selected high-income countries, and in Korea (3.3%) in the selected middle-income countries. A further analysis of the 10 most populated countries in the world gives a breakdown of different disease categories and the proportion of years lived with disability due to alcohol in each.

The authors say: "Globally, the effect of alcohol on burden of disease is about the same size as that of smoking in 2000, but it is greatest in developing countries... This finding is not surprising since global consumption is increasing, especially in the most populous countries of India and China." They conclude: "We face a large and increasing alcohol-attributable burden at a time when we know more than ever about which strategies can effectively and cost-effectively control alcohol-related harms. The next papers of this series will therefore discuss ways in which to decrease this burden."

MAKING ALCOHOL BOTH MORE EXPENSIVE AND LESS AVAILABLE, AND BANNING ADVERTISING, ARE HIGHLY COST-EFFECTIVE STRATEGIES TO REDUCE ALCOHOL-RELATED HARM

Of the interventions to reduce alcohol-related harm, making alcohol both more expensive and less available, and banning advertising are the most cost-effective strategies. School-based education does not reduce harm, although it does have a role in providing information. The various measures to reduce alcohol-related harm are detailed in the second paper in The Lancet series on Alcohol and Global Health, written by Dr Peter Anderson, University of Maastricht, Netherlands, and colleagues.

The authors review the effect of alcohol policy for the nine policy target areas included in the report by WHO to the 2008 World Health Assembly. On availability, the authors say that extending alcohol sale times can redistribute the times alcohol-related incidents occur, but does not reduce them. Reducing days or hours of alcohol sale leads to fewer alcohol problems, including murder and assault. A rise in alcohol prices leads to less alcohol consumption and related harm in both high-income and low-income countries. Policies that increase alcohol prices delay the start of drinking, slow young people's progression towards drinking large amounts, and reduce young people's heavy drinking and binge drinking activity.

As well as availability and affordability, the authors found that brief advice at a family doctor's surgery was an effective healthcare

intervention for those with hazardous and harmful alcohol use but not yet severely dependent. Establishment of a legal blood-alcohol limit, and reducing it, is effective in reducing drink-driving casualties, as is intense random roadside breath-testing by police. Other measures with evidence of effectiveness are a lower or zero blood-alcohol limit for new drivers, driving licence suspension, and an ignition interlock which prevents a car being started when the driver is intoxicated.

The authors then looked at the cost effectiveness of policies in these nine areas, and concluded that reducing availability, increasing price and banning advertising were the most cost-effective measures to reduce alcohol-related harm. The authors say: "Taxation policies cost fairly little to implement but reap substantial health returns."

The authors recommend six key policy approaches for countries in which alcohol is normally available:

1. Minimum tax rates for all alcoholic beverages, at least proportional to alcoholic content, should be introduced and increased regularly in line with inflation.
2. Government monopolies for retail alcohol sales should be established, with a minimum purchase age of 18-21 years; if not feasible, a licensing system should be introduced restricting outlet density and hours of sale.
3. A ban on direct and indirect alcohol advertising.
4. Legal concentrations of blood alcohol for driving should be established, and gradually reduced.

5. Widespread simple help should be made available in general practices and other primary healthcare facilities.
6. Educational programmes should not be implemented in isolation, but to increase awareness ahead of implementation of other more effective intervention packages.

They conclude: “Making alcohol more expensive and less available, and banning alcohol advertising, are highly cost-effective strategies to reduce harm. In settings with high amounts of unrecorded production and consumption, increasing the proportion of alcohol that is taxed could be a more effective pricing policy than a simple increase in tax.”

INTERNATIONAL FRAMEWORK CONVENTION ON ALCOHOL CONTROL, SIMILAR TO THAT FOR TOBACCO, IS NEEDED TO CONFRONT ALCOHOL DISEASE BURDEN

Despite clear evidence of the major contribution alcohol makes to the global burden of disease and to substantial economic costs, focus on alcohol control is inadequate internationally and in most countries. International health policy, in the form of a Framework Convention on Alcohol Control (FCAC), is needed to counterbalance the global conditions promoting alcohol-related harm and to support and encourage national action.

This is part of the call to action in the third paper in *The Lancet Alcohol* series, written by Professor Sally Casswell, Massey University, Auckland, New Zealand, and

Dr Thaksaphon Thamarangsi, Ministry of Public Health, Bangkok, Thailand.

The authors say: “Expansion of industrial production and marketing of alcohol is driving alcohol use to rise, both in emerging markets and in young people in mature alcohol markets. Cost-effective and affordable interventions to restrict harm exist, and are in urgent need of scaling up. Most countries do not have adequate policies in place. Factors impeding progress include a failure of political will, unhelpful participation of the alcohol industry in the policy process, and increasing difficulty in free-trade environments to respond adequately at a national level. An effective national and international response will need not only governments, but also non-governmental organisations to support and hold government agencies to account.”

The paper contains a number of key messages:

- Countries spend more than 1% of their GDP on the economic costs attributable to alcohol
- Relative to its harm, alcohol is not high on the global health agenda
- The role of vested interests (eg, alcohol producers) in hindering public health responses to alcohol harm is similar to that seen for tobacco
- Cost-effective interventions exist (eg, availability and affordability) and are focused on total populations

- Some governments have implemented effective policy but a strengthened response is needed
- WHO and other agencies, as well as NGOs, are showing increased concern and engagement with alcohol
- An FCAC, similar to that for alcohol, is needed to spur national action.

In the call to action which concludes the paper, the authors call on: governments to formulate and implement alcohol control policies on the basis of cost-effectiveness; on NGOs/civil society to push alcohol up the agenda; on academics to research control policies, working independently of commercial interests; on WHO member states to call on WHO to begin developing the FCAC; on WHO and other appropriate agencies to provide technical support to low- and middle-income countries to develop, implement and assess alcohol control policies; on global and regional non-governmental organisation networks to support the FCAC process; and on the alcohol industry to withdraw subversive efforts to influence effective policy development, health promotion efforts, and research agendas.

The authors conclude: “To enable this response we need: an active process of negotiation in which the international focus on alcohol is expanded; national governments to be supported and strong in their response; and non-governmental advocacy to increase both internationally and nationally. Use of international law to achieve a forum for cooperation and negotiation - an FCAC - is

essential, and the initial steps that have been undertaken urgently need to be scaled up.”

ALCOHOL MUST BE GIVEN POLITICAL PRIORITY

In a Comment which accompanies the alcohol Series, Professors Robert Beaglehole and Ruth Bonita, University of Auckland, New Zealand, say that, despite the parallels between alcohol and tobacco, ‘there seems to be little immediate chance of WHO or member states supporting the complex process of developing a Framework Convention on Alcohol Control’. They say: “To gain traction, this framework will need dedicated support and pressure from a few committed countries, supported by a strong global network of non-governmental organisations. Non-governmental organisations in the alcohol field need to strengthen their international presence and learn from the tobacco-control area.”

They conclude: “The power imbalance between industry and health groups is a key reason for the continuing neglect of alcohol as a global health issue. Other impediments include the absence of clarity on the alcohol control message, the political context that gives priority to an individual’s responsibility for health, and the close connection of alcohol with many aspects of social and cultural norms. Generation of political priority for alcohol as a global health issue is the crucial next step.”

MINIMUM ALCOHOL PRICE OF 50 PENCE PER UNIT COULD LEAD TO 100,000 FEWER HOSPITAL ADMISSIONS PER YEAR IN UK

In a second Comment which accompanies the alcohol series, Professor Ian Gilmore, President of the Royal College of Physicians(RCP), discusses the industry friendly policies that have led to a 33-fold increase in alcohol consumption in Thailand over just 40 years.

He also discusses the recent suggestion by England’s Chief Medical Officer Sir Liam Donaldson to set a minimum price of 50 pence (0.5GBP) per unit, which was flatly rejected by the Prime Minister Gordon Brown - on the basis it would punish sensible, moderate drinkers due to the excesses of a small minority. Professor Gilmore says: “However, setting a minimum price of 50 pence per unit would likely increase the average weekly spend on alcohol of moderate drinkers by only 23 pence per week, but would decrease the consumption by underage and heavy drinkers by 7.3% and 10.3% respectively. The estimated benefits would be a reduction of 100,000 hospital admissions per year in England and a decade’s health saving of £1.37 billion.”

The RCP has recently formed the UK Alcohol Health Alliance, bringing together 25 non-governmental organisations with an interest in alcohol misuse - to agree policy priorities. Professor Gilmore says: “We need to replicate this sort of model within nations and across nations.”

He concludes: “A Framework Convention on Alcohol Control seems a long way off, but it will not happen unless health professionals speak out to give our governments the courage to adopt life-saving policies that tackle price, availability, and marketing of alcohol. This Series of three remarkable articles leaves no excuse for avoiding the issues - we must speak out.”

Russia: alcohol responsible for more than 1 in 2 premature deaths

A new study reported in the Lancet calculates that more than half of all the premature deaths in Russian adults aged 15-54 are attributable to alcohol.

The study concludes that sudden changes in alcohol drinking patterns account for most of the large fluctuations in Russian mortality since 1984, and tobacco and excessive alcohol use account for the large difference in adult mortality between Russia and Western Europe. The study is authored by Professor David Zaridze, Russian Cancer Centre, Moscow, Professor Sir Richard Peto, Clinical Trial Service Unit and Epidemiological Studies Unit (CTSU), University of Oxford, UK, and colleagues.

The study looked at mortality in three typical Russian industrial cities-Tomsk, Barnaul, and Biysk. The addresses of some 60,000 residents who had died at ages 15-74 years in the period 1990-2001 were visited during 2001-05. For 50,066 of them a family member was still present, and from 97% (48,557) of these, information was provided on the deceased’s

past alcohol use and other lifestyle factors.

A total of 43,802 deaths (cases) were from external causes or from diseases that the authors judged beforehand could well be substantially affected by alcohol or tobacco; the 5475 deaths from other diseases acted as controls. The main case-control analyses are restricted to ever-drinkers, and the relative risks (RRs) compare the reference category (defined as usual weekly consumption always less than 250ml vodka and maximum daily consumption also less than 250ml vodka) versus other drinkers, classified by usual weekly vodka consumption into three categories: less than 500ml, 500-1499ml, and 1.5L or more (mean 2.7 litres).

The researchers found that, in men, the greatest absolute excesses of alcohol-associated mortality were in the deaths from accidents and violence (RR 5.9 for the highest versus the lowest alcohol consumption category); alcohol poisoning (RR 21.7); and acute heart disease other than heart attack (which included some from mis-certified alcohol poisoning) (RR 3.0). There were also excesses of throat cancer (3.5) and liver cancer (2.1). A further five disease groups had RRs of more than 3.0 in the highest alcohol category: tuberculosis (4.1), pneumonia (3.3), liver disease (6.2), pancreatic disease (6.7), and ill-specified conditions (ie, deaths where the person certifying the death did not find out what disease had caused it) (RR 7.7).

After correction for reporting errors, alcohol-associated excesses accounted for 52% of all study deaths at ages 15-54 years (men 8182 [59%] of 13968; women

1565 [33%] of 4751), and 18% of those at age 55-74 years. The authors say: "Allowance for [the] under-representation [in our study] of extreme drinkers would further increase alcohol-associated proportions. Large fluctuations in mortality from these ten strongly alcohol-associated causes were the main determinants of recent fluctuations in overall mortality in the study region and in Russia as a whole."

The authors argue that the excess mortality from liver cancer, throat cancer, liver disease, and pancreatic disease is largely or wholly because alcohol caused the disease that caused death. The excess mortality from tuberculosis and pneumonia may be partly a result of increased exposure to infection, reduced immune competence, or decreased likelihood of cure.

The authors suggest that, without alcohol, mortality rates in Russia would be much less than double the rates in Western Europe. However, the actual Russian mortality rate in people aged 15-54 years was more than five times (for men) and three times (for women) the rate in Western Europe. They say: "This ... is consistent with alcohol being responsible for about three quarters of all male Russian deaths at ages 15-54 years and about half of all female Russia deaths at these ages - ie, [proportions] even greater than in our study population."

They end: "We conclude that alcohol is the main cause (and perhaps the only major cause) of the large fluctuations in Russian adult mortality since 1980, and that alcohol and tobacco account for most or all of the large difference in premature adult

mortality between Russia and western Europe."

In an accompanying Comment, Dr Robin Room, Turning Point Alcohol & Drug Centre, Melbourne, and University of Melbourne, Australia, and Dr Jürgen Rehm, Centre for Addiction and Mental Health, Toronto, Canada, say: "In estimating that more than 50% of all adult premature deaths are attributable to alcohol, the study is a stark reminder that most of these deaths are avoidable with more effective alcohol policies. The findings are a wake-up call that needs to be heeded both in national policy making and at international levels as WHO moves toward the institution of a Global Alcohol Strategy. In view of the ongoing globalisation of the alcohol market, a framework convention for alcohol control, analogous to the tobacco convention, would contribute to reducing the alcohol-attributable disease burden not only for Russia, but also worldwide."

A linked Editorial in the *Lancet* concludes, that in addition to implementing the proven policies outlined in *The Lancet Alcohol Series* (see separate releases), "Russia must stop or tax the illicit production of spirits, believed to account for at least 50% of consumption in the country. This in turn means confrontation with organised criminals and corrupt officials. But the time has never been better for Russia to shake off the chains of alcohol. The country has strong and ambitious leaders, the recently launched National Priority Project for health can provide a framework, and income from vast energy reserves can offset costs. All that is needed is the political will to make public health a priority."

How to fill the budget gap - increase alcohol taxes

The Marin Institute in the USA is advocating a particular solution to the deficits in public finances being experienced by many countries as a result of the global financial crisis – increasing taxes on alcohol products. Increasing alcohol taxes, the Marin Institute says, not only increases state revenues, it also reduces the burden of costs arising from alcohol harm.

In its home state of California the Marin pressed Governor Arnold Schwarzenegger and other senior politicians to include a new 25 cent-per-drink alcohol tax in any new budget proposal to help the state recover from its current economic meltdown.

“California’s budget has tanked, the Governor’s propositions have failed, and now is the time for true leadership in Sacramento,” said Marin Institute Executive Director Bruce Lee Livingston. “The citizens are waking up to the failure of policymakers. The alcohol tax should be back on the table to help ease California’s budget crisis.”

The Marin explained that despite being the largest alcohol market in the USA, California’s current beer, spirits, and wine excise tax rates, which have not been raised in 18 years, were lower than the national average. Only Louisiana has a lower wine tax rate than California.

An across the board quarter-a-drink increase in California’s alcohol excise tax would produce \$3.44 billion in new revenue for the state’s general fund. The new alcohol tax revenues would help solve significant budget shortfalls and fund critical programs such as prevention, treatment, emergency room and trauma care, healthcare, mental health, crime prevention and traffic safety.

“Not only will the state budget benefit from this rising tide of new revenue,” said Livingston, “but alcohol tax increases will reduce alcohol-related harm in the state.”

According to the American national Institute on Alcohol Abuse and Alcoholism, higher alcohol taxes lead to reductions in the frequency of drinking and heavy drinking among youth, lower traffic fatalities, and reduced incidences of alcohol-related crime.

Alcohol Tax Calculator

As part of its campaign for higher alcohol taxes the Marin has devised an alcohol tax calculator. While the Marin’s calculator applies only to the United States, the idea could of course in principle be extended to any jurisdiction, so long as the required data are available.

“It looks simple,” said Michele Simon, research and policy

director at Marin Institute. “But the calculations behind the scenes are anything but simple. This is a serious tool for lawmakers and advocates who need fast, accurate numbers.”

The powerful online program works for every state, as well the federal government and the District of Columbia. The user just enters the amount of new tax (nickel or dime a drink, for example) for beer, wine or spirits (or any combination). Then the program instantly estimates additional annual revenue, based on a variety of factors specific to that particular jurisdiction.

The Marin developed the tool in response to inquiries from states looking for new revenue sources while holding ‘Big Alcohol’ accountable for the enormous harm its products cause.

“Our new alcohol tax calculator will help state lawmakers raise significant new funds to help solve budget shortfalls and fund critical programs such as prevention, treatment, emergency room and trauma care, healthcare, mental health, crime prevention and traffic safety,” added Simon. “An increase in federal alcohol taxes (not raised since 1991) could also fund President Obama’s healthcare agenda. It’s a win-win solution for governments and the people.”

The user-friendly calculator can be found at www.MarinInstitute.org.

Almost half of all Australian homicides involved alcohol

Almost half of all Australian homicides between 2000 and 2006 were found to have involved the consumption of alcohol.

A paper released by the Australian Institute of Criminology (AIC) showed that of the 1,565 homicides recorded over the six-year period, 746 (47%) were classified as alcohol related and that in 60 percent of these incidents both the victim and offender had been consuming alcohol.

The Alcohol and Homicide in Australia paper was based on data collected from the AIC's National

Homicide Monitoring Program and utilised victim toxicology reports, making it one of the most comprehensive studies on alcohol-related homicide to date.

AIC General Manager, Research, Dr Judy Putt, said eight-in-ten homicides which occurred in recreational venues were classified as alcohol related and homicides which occurred on weekends or evenings were most likely to have involved alcohol.

"Factors like gender, employment status, age, the relationship between victim and offender as well as

whether those involved were of Indigenous backgrounds affected the likelihood of alcohol being involved," Dr Putt said.

"Homicides involving male victims, unemployed victims and young offenders were also identified as most likely to have been alcohol related."

Additionally, the paper shows that 44 percent of intimate partner homicides were alcohol related. The study found homicides where a male victim was killed by a female intimate partner were highly likely to be related to alcohol consumption (73%) indicating that it is a far more significant factor in intimate partner homicide than indicated by previous studies.

"Eighty-seven percent of intimate partner homicides among the Indigenous population were alcohol related, making it the highest proportion of alcohol-related homicide of all factors studied," Dr Putt said.

Alcohol and homicide in Australia
Trends and issues in crime and criminal justice no. 372

Jack Dearden and Jason Payne
ISSN 1836-2206
Canberra: Australian Institute of Criminology, July 2009

Table 1 Incident details in alcohol related homicides in Australia 2000–06

	Alcohol-related (n)	Non alcohol-related (n)	Alcohol-related (%)	Bivariate odds ^{a,b}
Day of incident				
Sunday	127	109	54	1.40*
Monday	66	131	34	0.54*
Tuesday	76	123	38	0.67*
Wednesday	77	123	39	0.68*
Thursday	95	109	47	1.00
Friday	132	135	49	1.15
Saturday	154	103	60	1.90*
Time of incident				
12 am – 6 am	239	179	57	1.79*
6 am – 12 pm	42	163	20	0.25*
12 pm – 6 pm	101	200	34	0.51*
6 pm – 12 am	329	254	56	1.88*
Unknown	18	40	31	0.50*
Location of incident				
Offender's home	72	65	53	1.30
Victim's home	269	463	37	0.47*
Other home	51	32	61	1.89*
Recreation	45	11	80	4.93*
Open area	88	63	58	1.68*
Car	26	40	39	0.74
Street	155	93	63	2.16*
Other	10	40	20	0.28*
Unknown	13	29	31	0.51*
Cause of death				
Gunshot	59	162	27	0.39*
Stab wound	285	260	52	1.42*
Beating	266	194	58	2.94*
Strangulation	41	103	28	0.48*
Other/unknown	72	99	42	0.81

a: Bivariate odds ratios indicate the odds that a homicide was classified as alcohol-related compared to the average of all other categories of that variable

b: Bivariate odds are calculated within the category of intimate-partner homicides only

*statistically significant at p<0.05

No alcohol in pregnancy safest choice



Australian child health researchers have come out in support of new official national guidelines advising against alcohol in pregnancy and urged community support to help women avoid alcohol in pregnancy and if planning a pregnancy.

The research team has also produced a new resource manual for health professionals in regard to alcohol problems in pregnancy.

Professor Carol Bower, who heads the Alcohol and Pregnancy Project based at the Telethon Institute for Child Health Research in Western Australia said the new National Health and Medical Research Council guidelines advising against alcohol during pregnancy sent an important message.

“There is no doubt that avoiding alcohol is the safest choice for women who want to ensure that

their babies are not affected by alcohol before birth,” Professor Bower said.

“Women need to be supported in this choice rather than being falsely reassured that alcohol won’t cause any harm. The bottom line is that there is no research that enables us to guarantee to women what quantity of alcohol is safe at any time during pregnancy.”

Professor Bower said that women who had consumed alcohol already during their pregnancy should not be alarmed, but should discuss any concerns with their health professional.

“We also encourage health professionals to routinely ask women about their drinking habits so that they can ensure that their patients are aware of these important guidelines and the

consequences of alcohol use during pregnancy.”

The consequences of alcohol use in pregnancy may include physical, mental, behavioural, and learning disabilities with possible lifelong implications. Fetal Alcohol Spectrum Disorder (FASD) is a general term that describes the range of effects that can occur in an individual who was exposed to alcohol during pregnancy.

The Alcohol and Pregnancy Project (www.childhealthresearch.com.au/alcoholandpregnancy) has been made possible by funding from Healthway and the (Australian) National Health and Medical Research Council.

The new guidelines can be found at: www.nhmrc.gov.au

Prosecutors to oppose alcohol sale in 2014 World Cup in Brazil

The Associated Press has reported that Brazilian prosecutors are promising to fight FIFA, the international governing body of football (soccer) if alcohol is allowed to be sold in stadiums during the 2014 World Cup in Brazil. One of FIFA’s main sponsors is beermaker Anheuser-Busch.

“We will do everything we can to stop this from happening,”

prosecutor Paulo Castilho told the official government news service, Agencia Brasil. “In defence of society, we will use every weapon we have against this.”

The prosecutor said economic issues should not interfere with the well-being of fans and society in general.

The Brazilian Football Confederation prohibits alcohol sales in Brazilian stadiums, but it is not a law passed by congress and it could be easily reversed during the World Cup. “A powerful (brewer) coming here should not take control of things,” Castilho said.



The Swedish Presidency Union: alcohol

Reducing harm from alcohol consumption has been designated one of the main health priorities of the Swedish Presidency of the European Union. Other priorities include preparedness for the influenza pandemic, effective use of medicinal products and access to effective antibacterials.

On alcohol, the Swedish government stated that it recognised the major threat posed by alcohol to public health, social welfare and economic development in many EU member countries. It stated that the goal of the Swedish Presidency is to support the implementation of the horizontal EU alcohol strategy introduced in autumn 2006, and the establishment of long-term preventive work at both EU and national level. In the long term, the goal is to reduce alcohol-related harm in Sweden and the Union.

The Swedish Presidency is giving particular priority to reducing the impact of alcohol advertising and marketing on young people. Other issues to which the Presidency wants to draw attention include the influence of price on the development of alcohol related harm and the effects of harmful alcohol consumption on healthy and dignified ageing.

The EU Alcohol Strategy

The Strategy addresses the adverse health effects of harmful and hazardous alcohol consumption in the EU, where it is estimated to cause the deaths of 195,000 people each year. The priorities identified in the Communication are to protect young people and children; reduce injuries and deaths from alcohol-related road accidents; prevent alcohol harm among adults and reduce the negative impact on the economy; raise awareness of the impact on health of harmful alcohol consumption; and help gather reliable statistics.

The implementation process for the Strategy has four main pillars. There is a Committee on National Alcohol Policy and Action on which the representatives of the EU Member States exchange information and ideas; a Committee on data collection, indicators and definitions, intended to ensure compatibility of the official statistics of alcohol consumption and harm across the Member States; and there is the European Alcohol and Health Forum which brings together economic operators, public health bodies, NGOs and other stakeholders, all the members of the Forum having to commit to making some definite contribution to the reduction of alcohol harm. The fourth pillar is a commitment

to working across other EU policies, on transport, youth, agriculture etc to ensure their compatibility with the Alcohol Strategy.

Alcohol and Health Forum

Many of the commitments made by the economic operators who are members of the Forum concern educational initiatives. However, the Forum has also considered other policy measures as well as education, special reports being prepared on the price and affordability of alcohol in EU countries, and on the impact of advertising and marketing of alcohol, especially on young people.

On advertising, a review of the available evidence by the Science Group established by the Forum found that, overall, the studies reviewed found consistent evidence to demonstrate that “alcohol marketing increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol”.

This finding, the Group commented, was all the more striking, given that only a small part of a total marketing strategy had been studied. The Group stressed that the studies came from countries with a long history of advertising and with relatively high levels of alcohol consumption, and

ncy of the European in the spotlight



that it was difficult to speculate about the size of the impact of marketing in cultures with either a short history of advertising or low alcohol consumption.

These conclusions are likely to influence considerably the outlook of the Swedish Presidency, possibly increasing the political pressure for greater quantitative restrictions on alcohol advertising as well as on the content of advertisements.

EU Alcohol Strategy: Progress Report

The Swedish Presidency coincides with the production of an initial status report on what has happened at EU and national level since the alcohol strategy was adopted. The report is being prepared by the European Commission's Directorate General for Health and Consumers (DG SANCO).

The status report will be presented at the expert conference on alcohol and health organised by the Swedish presidency in cooperation with DG SANCO in September 2009.

This status report, together with the results of a conference of experts on alcohol and health, which the Presidency is arranging in September, will form a basis for the Council's discussions. The Presidency's hope is that the

Council will adopt conclusions at its meeting in December to support the EU alcohol strategy.

"Long term, patient efforts are required to reduce the harmful effects of alcohol. The EU's alcohol strategy is a good tool", said Sweden's Minister for Elderly Care and Public Health Maria Larsson. "We must ensure that the measures to counteract the harmful effects of alcohol remain high on the EU's agenda."

Eurocare Response

Eurocare, the European Alcohol Policy Alliance, which campaigned for many years for an alcohol strategy to be implemented at EU level and is a founder member of the Alcohol and Health Forum, welcomed the production of the interim status report and plans to make its own contribution to the process of assessing the success of the Strategy so far by producing its own 'shadow report' on progress, based on a survey of the Eurocare member organisations and other public health stakeholders.

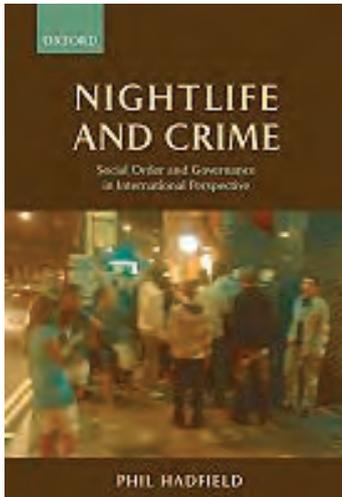
Eurocare's Shadow Report is still being prepared at the time of writing, but it is understood that while the Eurocare members express strong support for the aims and objectives of the EU Strategy, most are sceptical that the Strategy will, of itself, significantly

reduce the casualties from alcohol harm, and some elements of the implementation strategy are controversial.

The chief cause of controversy is the high level of involvement in the Strategy of the alcohol industry, particularly in respect of the Alcohol and Health Forum. While the Commission's view appears to be that the multi-stakeholder approach, in which all the main parties with an interest in alcohol policy have the opportunity to participate, is essential and possibly provides a model for other parts of the world, some Eurocare members and others on the public health side are worried that the alcohol industry is being given the opportunity to obstruct progress and divert activity into areas such as educational campaigns which the scientific evidence suggests are relatively ineffective as measures to reduce harm.

It is believed that other reservations likely to be expressed by Eurocare members are that the EU member states may not be taking the Alcohol Strategy very seriously, and that there appears to be only very limited progress in ensuring that other areas of EU policy, such as policy on excise duties, are made consistent with the requirements of the Alcohol Strategy.

Nightlife and Crime: Social Order and Governance in International Perspective



Review of Hadfield, P. (ed) *Nightlife and Crime: Social Order and Governance in International Perspective*, Oxford University Press, 2009.

Dr Hadfield has followed *Bar Wars*, in which he described “the night time economy [as posing] the greatest threat to public order in Britain today,” with an international review of associations between nightlife and criminal disorder, the role of the state, and governance of public space.

The structure of *Nightlife and Crime* testifies to Hadfield’s belief that the comparative study requires a close understanding of local conditions, “from the bottom up,” before any higher order interpretations are possible. Three dozen prominent and promising researchers explore the social contexts and regulatory environments of nightlife and criminal disorder in seventeen countries on four continents.

Eighteen chapters comprise a worldwide survey, focused predominantly on English speaking countries including Hong Kong, plus The Netherlands, Norway and Finland, a Mediterranean bloc of Greece, Italy and Spain, and Hungary from the former Soviet bloc.

One of the sub-themes of this book is the struggle over the responsibility and role of the state in controlling the availability of and access to alcohol, and the circumstances in which it is consumed. As I was reading it the new Chief Police Commissioner in Victoria, Australia, denounced the state’s licensing rules for allowing “any idiot [to] get a liquor licence”. Yet, as Tanya Chikritzhs describes in her chapter on Australia, the dismantling over two decades of Victoria’s once formidably restrictive liquor licensing system, in order to achieve an open and competitive market for the sale of alcohol, has been used as a model by other Australian states keen to duplicate Melbourne’s “vibrant bar culture” and “24-hour city.” Significantly, Chikritzhs also points out that while the number of liquor outlets doubled in Victoria between 1991 and 2006, the rate of increase of alcohol-attributable hospitalizations in Melbourne for the period 1999-2004 was double that of the rest of the country.

A similar loosening of alcohol controls in Norway, New Zealand, England, Wales and Scotland led to outcries over increased levels of risky drinking and violent crime,

though there is not a necessary linear relationship because other variables are influential. Seymour and Mayock point out that Ireland’s ambivalent attitude to intoxication, higher disposable incomes, and more time expended by young people in venues where confrontation is likely, all exacerbate the risk of conflict. The authors of a chapter on South Africa perceive a “hegemonic masculinity”, which requires young males to act out an exaggerated version of manhood, as an important factor underlying high rates of nocturnal violence.

Another theme concerns how, as the state gives up its traditional powers, new forms of governance are called into being through the “privatisation of responsibility,” or arise through the non-government sector. Licensees are required to regulate themselves by, for example, acquiring private security agents, training bar staff in responsible service, joining voluntary licensing accords and adhering to other codes of practice. Meanwhile charities that provide outreach on night-time economy streets to care for the intoxicated, sick or lost incidentally reduce street level crime, thereby forming a substitute police service.

Nevertheless demands for external controls on alcohol have not disappeared. After New Zealand expanded the class of businesses that sell alcohol and dropped the age at which people could purchase it, and experienced a rise in harmful drinking by young people, the government tried to reverse the age

change. In Fiona Hutton's summary: "... although policy makers have done all they can to encourage drinking they are now wringing their collective hands about the problems associated with increased alcohol consumption."

Perhaps the same could be said of Scotland, for having introduced the super-pub, increased off-licences, extended trading hours, and grown alarmed at the link between "...over consumption of alcohol and ... crimes of violence," is rethinking alcohol policy. This is one of the most intriguing chapters. Proposals to make public health

an objective of licensing, to levy a social responsibility fee on liquor premises, to set a minimum price for alcohol and to limit purchase of packaged liquor to 21 year olds are being watched carefully in the Antipodes.

Apart from the analysis of the major themes, authors broach new drinking trends. These include an apparent polarisation wherein the proportion of abstainers and risky drinkers are both increasing within certain populations; the convergence of male and female drinking trajectories; the practice of preloading before visiting night

time precincts, and the rise of "glassing" incidents in late night venues.

Nightlife and Crime is a most valuable work that breaks new ground and is sure to lead to further research and comparative studies in alcohol related violence, as well as other factors that contribute to heavy rates of night time offending.

Geoff Munro
National Policy Manager
Australian Drug Foundation

New Zealand to reform Liquor Licensing Laws

A public consultation in regard to reform of the legislation governing sales of alcohol has been launched by the New Zealand Law Commission.

Announcing the consultation, Law Commission President the Rt Hon Sir Geoffrey Palmer said that the evidence suggested the time had come to review the policy settings to reduce the excesses and curb the harm from alcohol. That view, he said, had wide support from a range of highly credible groups, including judges, medical specialists and police.

Sir Geoffrey continued:

"Not everyone drinks in a manner that is harmful but the consequences of harmful drinking affect us all. Alcohol is a contributory factor to a range of social harms. Some of these problems are very visible such as antisocial behaviour and aggression associated with intoxication in public places.

"Alcohol's association with other problems is less visible but still has potentially devastating effects on those involved – accidents, road fatalities, fires, drownings, suicides, alcohol dependency disorders and a range of health problems.... There is also strong new evidence that young people face increased risks of harm, of both short term and longer term harm, from early and high volume drinking."

Sir Geoffrey explained that the effects of alcohol use on the level of criminal offending in the community was a key issue in the report on which the public's views were being sought. So were the health effects of alcohol use."

Among the options the Law Commission put forward for public consideration are:

- A complete new Sale of Liquor Act
- Measures aimed at curbing harmful drinking including

options designed to reduce the availability of cheap alcohol products which tend to be favoured by price sensitive young and heavy drinkers

- Reducing excise tax on low alcohol products to encourage consumption over products with higher alcohol content
- Reducing the hours within which alcohol can be purchased
- Introducing a split purchase age for alcohol allowing young people to drink on a licensed premise at 18 and to purchase from an off-licence at 20
- Expanding the criteria under which a licence can be declined
- Expanding the range of conditions that can be imposed on licensees
- Introducing graduated licensing fees to ensure low risk operators are not unfairly burdened.

New Publications

Three papers by Diyanath Samarasinghe, professor at the University of Colombo, Sri Lanka, published as FORUT booklets, explore various aspects of alcohol, with special reference to developing countries.

Professor Samarasinghe discusses the role of unrecorded alcohol; connections between alcohol and poverty, and things that can be done to reduce alcohol harm.



UNRECORDED ALCOHOL

In regions where the unrecorded alcohol consumption is high, this fact necessarily has to be taken into account when planning strategies and interventions to reduce alcohol-related harm. Interventions directed to the formal, legal production and sale have to be combined with actions to control the unrecorded market. It is in the interests of government from both a fiscal and a policy perspective to move towards eliminating illicit production and sale and to bringing informal supply under the taxation system.



REDUCING ALCOHOL HARM: things we can do

This booklet is for someone who is interested in learning how to make even the smallest actions count. Successful results are dependent on selecting not only the right approaches, but also appropriate and realistic targets. Building on some general background, 14 steps for action are suggested.



ALCOHOL AND POVERTY: some connections

In the third booklet Professor Samarasinghe explores the complex connections between alcohol and poverty. The impact of alcohol on poverty is more than through just the money spent on it. The converse influence, of poverty on alcohol, has far more to it than found in the simplistic explanation that heavy consumption is the result of the harshness of poor lives.

The booklets can be ordered in paper versions from FORUT or be downloaded in printer friendly versions from the ADD web site <http://www.add-resources.org/three-new-booklets.4610561-76188.html>

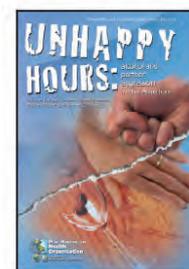
THE PAN AMERICAN HEALTH ORGANIZATION

Unhappy Hours: Alcohol and Partner Aggression in the Americas

Unhappy Hours: Alcohol and Partner Aggression in the Americas (edited by Kathryn Graham, Sharon Bernards, Myriam Munné, & Sharon Wilsnack) is the latest contribution in the Organization's effort to better understand partner violence and, in so doing, find more effective interventions to right this wrong.

The book explores the relationship between alcohol consumption and partner violence and for the first time gets information from both the aggressor's and victim's perspective. It brings to light evidence of alcohol's impact on partner aggression from 10 countries in the Americas (Argentina, Belize, Brazil, Canada, Costa Rica, Mexico, Nicaragua, Peru, Uruguay, and the United States), and represents an unprecedented effort to collect and analyze information from the general population that can be compared across countries. Despite wide differences between countries and cultures, there are common characteristics and trends across countries regarding the relationship between alcohol and partner violence.

This publication will be of interest to a variety of audiences, including the academic and research communities, students, health promoters, health professionals, communicators, ministries of public health, and the victims of partner aggression.



2008 • 258 pp.
ISBN 978 92 75 11631 9
Order code: SP 631 Price:
US\$ \$24.00 in Latin American
and the Caribbean/
\$30.00 elsewhere.
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“Reducing alcohol-related harm worldwide by promoting science-based policies independent of commercial interests”

The Global Alcohol Policy Alliance is a developing network of non-government organisations and people working in public health agencies who share information on alcohol issues and advocate evidence-based alcohol policies.

Resource centres affiliated to GAPA are already operating in the EU, USA, South America, India, South East Asia and Western Pacific regions. It is envisaged that the Alliance, in the not too distant future, will be able to establish centres in Africa.

History

An international consultation of experts and advocates met in 2001 in the USA to exchange views and experience and to find a way of co-ordinating efforts. At the consultation it became quite clear that there was a commonality of interest in the alleviation of alcohol problems. An urgent need to monitor the marketing strategies undertaken by the global alcohol industry as it seeks to increase sales and circumvent health promotion policies was recognised. Although impossible to match the financial resources of the international drinks companies and the “social aspect” groups which speak for them, it became clear that with a sharing of scientific knowledge and expertise we could become a united resource in helping governments around the globe to formulate strategies to counter the health and social problems created by alcohol consumption.

The meeting resolved that the Global Alcohol Policy Alliance be established.

Mission Statement

The GAPA mission is to reduce alcohol-related harm worldwide by promoting science-based policies independent of commercial interests.

Objectives

- Provide a forum for alcohol policy advocates through meetings, information sharing, publications, and electronic communications; with the purpose to disseminate information internationally on effective alcohol policies and policy advocacy;
- Bring to the attention of national governments, international governmental and non-governmental agencies and communities the social, economic, and health consequences of alcohol consumption and related harm; with the purpose to advocate for international and national governmental and non-governmental efforts to reduce alcohol related harm worldwide;
- Co-operate with national and local organizations and communities to alleviate alcohol-related problems;

- Encourage international research on the social and health impact of the actions of the multinational alcohol beverage industry;
- Monitor and promote research on the impact of international trade agreements on alcohol-related harm;
- Monitor the activities of the alcoholic beverage industry;
- Place priority on research and advocacy regarding those parts of the world where alcohol problems are increasing;
- Ensure that member groups in those areas have the technology and support capacity to participate in a global network for communication and action.

Board Members

Listed below are the members of the GAPA board:

Mr Derek Rutherford, UK, Chairperson
Dr Sally Casswell, New Zealand, Chairperson, Scientific Advisory Panel
Mr Øystein Bakke, Norway, Secretary

Dr S Arulraj, India
Mr Sven Olov Carlsson, Sweden
Dr Michel Craplet, France
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