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THE GLOBE

UN Declaration on Non-Communicable Diseases



**Alcohol identified as a major cause
of global 'slow motion disaster'**

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- 3 UNITED NATIONS ADOPT POLITICAL DECLARATION ON NON-COMMUNICABLE DISEASES
- 5 GAPA gives qualified Welcome to the Declaration
- 7 Conflict of Interest Coalition Statement of Concern
- 9 Alcohol consumption guidelines ‘inadequate for cancer prevention’: “No level of alcohol consumption without risk”
- 10 The Size and Burden of Mental Disorders and Other Disorders of the Brain in Europe - “It’s worse than we thought”
- 11 Valuable alcohol resource free to good home
12. Health Officials Advocate Measures to Curb Harmful Use of Alcohol in the Americas
- 13 Excessive Drinking Costs U.S. \$223.5 Billion
- 14 New US Action Guide Offers Strategies to Reduce Alcohol Outlet Density
- 15 RESCHEDULED CONFERENCE DUE TO FLOOD DELUGE IN THAILAND
Norwegian study finds opening bars longer increases violence
- 16 Community organization “can lessen impact of alcohol outlets on neighborhood violence”
- 17 Alcohol industry and ‘Drinkwise’ under attack in Australia
- 18 Safety issue revealed as 1 in 20 Australian workers admits to drinking at work
- 19 Epidemic of alcoholic liver disease in young people in North East England
- 20 WHO Europe seeks to reduce the harmful use of alcohol
- 21 Rising numbers of problem drinkers in Ireland
Youth problems highlighted
Unemployment identified as a factor
- 22 Call for tougher rules on alcohol marketing in Africa
- 23 International Alcohol Control Study in progress

UNITED NATIONS ADOPT POLITICAL DECLARATION ON NON-COMMUNICABLE DISEASES

Alcohol identified as a major cause of a global ‘slow motion disaster’

The United Nations (UN) has adopted, by consensus, a Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (NCDs).

The Declaration was broadly welcomed by the Global Alcohol Policy Alliance despite concerns that it did not go far enough. A particular concern was the potential conflict of interest between commercial interests and public health objectives.

The Declaration was launched at a UN High-Level Meeting on Non-Communicable Diseases in New York in September 2011 attended by representatives of government, NGOs and the corporate sector. The Global Alcohol Policy Alliance was represented at the Summit by Derek Rutherford and Professor Sally Caswell.

The Declaration sets out a raft of concrete actions to launch a global attack on NCDs such as diabetes, heart disease and stroke, chronic respiratory disease and cancer, which cause the death of more than 36 million people every year.

Alcohol is identified in the Declaration as one of the main health determinants of NCDs, alongside tobacco, unhealthy diet and physical inactivity.

Plans by 2013

The Political Declaration calls for governments, industry and civil society to set up, by 2013, the plans necessary to curb the risk factors behind the four groups of NCDs – cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. Global leaders committed to increasing their efforts to prevent and treat NCDs and to improve health care and access to vital medicines necessary to treat those diseases.

They also agreed to implement tax measures to reduce tobacco and alcohol consumption and to monitor the marketing of fast-foods to children.

Specifically in regard to alcohol, the Declaration affirms that Member States should promote the implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol. They should recognize the need to develop appropriate domestic action plans, in consultation with relevant stakeholders, for developing specific policies and programmes, including taking



*UN Secretary-General, His Excellency,
Ban Ki-moon*

into account the full range of options as identified in the global strategy, as well as raising awareness of the problems caused by the harmful use of alcohol, particularly among young people, and calling upon WHO to intensify efforts to assist Member States in this regard.

UN Secretary-General, His Excellency Ban Ki-moon, described the meeting as a landmark event and challenged Member States to step up accountability for carrying out the Political Declaration.

“If this document remains just a set of words, we will have failed in our obligation toward future generations. But, if we give this Political Declaration meaning through multiple, concerted and tough actions, we will honour our responsibility to safeguard our shared future,” he said.

The UN Secretary-General underscored the excellent foundation provided by the Political Declaration and urged Member States to act together to implement its provisions and “bring non-communicable diseases into our broader global health and development agenda”.

Noting that more than 1 million of the people dying from non-communicable diseases succumbed in the prime of their lives, with the vast majority of them living in developing countries, the UN Secretary-General was resolute that “Our collaboration is more than a public health necessity.”

“Addressing non-communicable diseases was critical, not just for global health, but would also be good for the economy, the environment and the global public good,” he stated. He called on governments, individuals, civic groups and businesses to play their part. “There is a well-documented and shameful history of certain players in industry who ignored the science - sometimes even their own research - and put public health at risk to protect their own profits.”

“There are many, many more industry giants which acted responsibly. That is all the more reason we must hold everyone accountable, so that the disgraceful actions of a few do not sully the reputation of the many which are doing such important work to foster our progress,” he added, calling on corporations that profit from selling processed foods to children, including manufacturers, media, marketing and advertising companies, to act with the utmost integrity.



*Director-General of the WHO
Dr Margaret Chan*

Director-General of the World Health Organization (WHO), Dr Margaret Chan, who also addressed the opening plenary, welcomed the Declaration as an excellent turning point in the fight against NCDs. She referred to the High-Level Meeting “as a wake-up call for Governments at the highest level and a water shed event that replaced ignorance and inertia with awareness and right actions immediately”.

Describing the epidemic of NCDs as a “slow-motion disaster” the WHO Director General stated that health practitioners were doing their best but they could not address this mounting challenge on their own. She was convinced that the response to these diseases must come with equal “top-level power that commanded the right protective policies across all sectors of Government.”

Director-General Chan explained that NCDs were largely preventable through cost-effective measures and urged Heads of State and Government to “stand rock hard” against the “despicable” efforts of the tobacco industry and their highly aggressive tactics. She explained

that an increase in tobacco taxes and prices could protect health and bring considerable revenue to Governments. In addition, she stated that salt reduction was among the most cost-effective and feasible public health interventions for those at risk of cardiovascular disease.

The WHO Director-General cautioned that, in the absence of urgent action, the economic costs of NCDs would rise to levels beyond even the reach of the wealthiest countries.

“You have the power to stop or reverse the disaster,” and to ensure that development was moving on a good path.

“We must act now,” she urged.

The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (document A/66/L.1 can be downloaded at: <http://www.un.org/en/ga/ncdmeeting2011/>

GAPA gives qualified Welcome to the Declaration

While GAPA welcomed the UN Summit and the Declaration, it expressed concern about the adequacy of the commitments on alcohol and also disquiet at the potential conflict of interests between commercial needs and public health objectives inherent in the Summit process.

GAPA stated:

Whilst the Political Declaration acknowledges that the global burden of NCDs constitutes one of the major challenges in the 21st Century and calls for “effective responses” and for “greater measures” to prevent and control NCDs, there are areas where it could be more explicit in the measures governments and the UN need to take. WHO Europe in its Regional Framework on alcohol stated that the ability of governments to use some of the most effective tools to prevent and reduce alcohol related harm had been substantially weakened, due to trade agreements. Also SEARO and WPRO Regional Committees have mentioned the hindrance to implement effective alcohol policy due to trade liberalization. The impact of WTO policies on health is not dealt with in the Declaration. The report of the WHO Commission on Social Determinants recommended caution be applied in the consideration of new global, regional and bilateral economic (trade and investment) policy commitments. However, the UN Political Declaration is silent on this issue.

In addition to the failure to address this vital issue, the challenge of restricting the oversupply and marketing by the global alcohol industry has not been addressed. Market analysts concur that the Industry is highly innovative and the sophisticated marketing helps recruit young people to drinking and to influence them to drink more. New product development is a vital factor in its profitability. It has targeted young female drinkers with its alcopops.

WHO Africa Regional Committee (June 2010) Stated:

“There is need to regulate the content and scale of alcohol marketing and the promotion of alcoholic beverages, in particular sponsorship, product placement, as well as internet and promotional merchandising strategies”.

It goes on to say “no other product so widely available for consumer use accounts for so much premature death and disability as alcohol”.

Policies concerning alcohol need to be formulated by public health interests without interference from commercial interests. GAPA believes the alcohol industry must comply with national and international laws and regulations and implement public health friendly policy.

GAPA concurs with the NCD Alliance concern that failure by the UN to address the conflict of interest between commercial corporations and public health will undermine the effectiveness of this initiative to reduce NCDs. National and international governmental bodies and the NGO movement must recognize that the need to promote global increases in sales of products such as alcohol mean that the industry cannot be engaged in partnership in the effort to reduce harm.

Prior to the Summit GAPA joined forces with over 100 other health NGOs to form a Conflict of Interest Coalition. The Coalition issued statements both before and after the Summit had taken place.
See pages 6 - 8.

Conflict of Interest Coalition

Comment on Declaration

The U.N. Political Declaration shows that governments worldwide have achieved a much better understanding of the extent to which poor nutrition and excess alcohol consumption worsen public health, weaken workforce productivity, and drive-up expensive treatment-intensive costs related to cardiovascular disease, cancer, and diabetes. Leaders also acknowledged that prevention must be a cornerstone of global and national responses to NCDs. Such newly acquired top-level awareness is, alone, a great achievement, but a clear commitment to implement prevention policies is still missing.

Effective public policy reform is the first casualty of timid “partnering” with companies that make products that contribute to an increase in disease risks or products that treat disease symptoms. To their credit, governments agreed that tobacco companies should have no place at the table, but risk trusting multi-trillion dollar global purveyors of alcohol, junk food, and pharmaceutical drugs to voluntarily change their for-profit stripes. Governments cannot continue to allow conflicts of interest with the private sector to go unchallenged and unmanaged in the policy-making process. An ethical code of conduct is needed to guide interactions with the private sector, which we must not forget is answerable primarily to shareholders and not to public health.

The Political Declaration is silent on specifics and short on solid commitment to regulations that could, for example:

- Mandate salt and sugar reduction in high-salt and high sugar processed foods;
- Realign food VAT/GST policies for food and agricultural subsidies with sound nutrition science;
- Mandate easy-to-understand front-of-pack nutrition labelling;
- Mandate nutrition information (e.g., sodium and calories) on restaurant menus;
- Prohibit the use of trans-fat-laden partially hydrogenated oils in food;
- Protect children and young people from marketing of products that raise the risk of disease (e.g. banning the promotion of breast-milk substitutes and high-fat, -sugar and -salt foods to children and young people); and
- Prohibit advertising and brand sponsorship for alcohol beverages;
- Increase taxes on alcohol beverages;

- Require and enforce effective restrictions on impaired driving (such as random breath testing), and minimum purchase age; and
- Expand nutritious school meal programs.

The Political Declaration reinforced its support for the World Health Organization’s landmark Framework Convention on Tobacco Control, but defers much of the job of addressing nutrition and alcohol to future work of WHO technical experts, Member States, and future U.N. meetings. Work left undone includes:

- developing tools to navigate the trade law barriers to health policy innovation
- establishing workable, but energetic disease reduction targets and detailed policy implementation schedules, and
- vitally, instituting a mechanism to keep commercially self-interested parties at arms-length and public-interest groups constructively involved.



GAPA representatives together with their Conflict of Interest Partners. From left to right: Bill Jeffery, George Hacker, Sally Casswell, Patti Rundall and Derek Rutherford

Conflict of Interest Coalition

Statement of Concern

The Statement of Concern was sent to the President of the United Nations General Assembly and the co-facilitators of the United Nations High Level Meeting on the Prevention and Control of Non-Communicable Diseases prior to the September meeting. At that time it had been endorsed by 138 national, regional and global networks and organizations working in public health, including medicine, nutrition, cancer, diabetes, heart disease, lung disease, mental health, infant feeding, food safety and development.

The Statement of Concern was developed by the Conflicts of Interest Coalition comprising civil society organisations united by the common objective of safeguarding public health policy-making against commercial conflicts of interest through the development of a Code of Conduct and Ethical Framework for interactions with the private sector.

It focuses on the lack of clarity regarding the role of the private sector in public policy-making in relation to the prevention and control of non-communicable diseases.

It calls for the development of a Code of Conduct and Ethical Framework to help protect the integrity of, and to ensure transparency in, public policy decision-making, by safeguarding against, and identifying and managing conflicts of interest.

We call on the UN to:

1. Recognise and distinguish between industries including business-interest not-for-profit organisations (BINGOs) and public interest non-governmental organisations (PINGOs) that are both currently under the ‘Civil Society’ umbrella without distinction.
2. Develop a ‘Code of Conduct’ that sets out a clear framework for interacting with the food and beverage industry and managing conflicts of interest, and which differentiates between policy development and implementation.

Since the major causes of preventable death are driven by diseases related to tobacco, unhealthy diet, physical inactivity and alcohol drinking, we are concerned that many of the proposals to address NCDs call for ‘partnerships’ in these areas with no clarification of what this actually means.

Public-private partnerships in these areas can counteract efforts to regulate harmful marketing practices.

It is essential that a strong and clear policy on conflicts of interest is established by the international community to provide Member States with guidance to identify conflicts, eliminate those that are not permissible and manage those considered, based on thorough risk/benefit analysis, acceptable. Transparency, although an essential requirement and first step, is not a sufficient safeguard in and of itself against negative impacts of conflicts of interest.

We propose that the following framework be used as a basis for a ‘code of conduct’ for industry

The policy development stage should be free from industry involvement to ensure a “health in all policies” approach, which is not compromised by the obvious conflicts of interests associated with the food alcohol, beverage and other industries, that are primarily answerable to shareholders.

These industries should, of course, be kept informed about policy development, through stakeholder briefings for example, but should not be in an influencing position when it comes to setting policy and strategies for addressing public health issues, such as NCD prevention and control.

While it is important for these industries to be in dialogue during the policy development process, this should be as a means of informing the process relating to practical issues rather than as members of the policy development team.

Industries are both part of the NCD problem and the solution. It is vital, therefore, to engage them in the most appropriate way when implementing policy and not when developing policy, to ensure that public health policy is protected from commercial interests.

Without this approach, WHO's principles of democratic policy-making for health, its constitutional mandate of the attainment of the highest possible level of health for all, and its independence, integrity and effectiveness will be undermined. Without such a policy, conflicts of interest can become institutionalised as the norm, impacting on the authority of governments. Industries with a strong interest in the outcome will increasingly assume greater roles in policy and decision shaping. This can fundamentally compromise and distort international and national public health priorities and policies.

The conflict of interest concern is not limited to the direct involvement of industry. UN agencies, including the WHO, are unanimous in recognising the important contributions NGOs make in the area of public health and are aware of the growth of these organisations in their numbers and influence in health at global, regional and national levels, including in the area of NCDs. However, WHO and others have so far not made a clear distinction between BINGOs (business-interest NGOs not-for-profit organisations that are set up by, representing or closely linked to, business interests) and PINGOs - public-interest NGOs. This failure to distinguish between the two groupings exacerbates any existing lack of transparency and complicates implementation of any procedures which aim to manage the role of these actors in policy and standard-setting consultations. In the Civil Society Interactive Hearing on 16th June, there was no clear differentiation between groups within Civil Society. The voice of Civil Society ought to reflect only public health interests.

The safeguards in Article 5.3 of the Framework Convention on Tobacco Control, the WHO International Code of Marketing of Breast-milk Substitutes, the Resolutions on Infant and Young Child Nutrition and the Global Strategy on Diet, Physical Activity and Health can be used among other helpful tools to establish measures that go beyond individual conflicts of interests, and address institutional conflicts of interest.

In summary, we call on the UN to recognise and distinguish between BINGOs and PINGOs that are currently under the 'Civil Society' umbrella and to develop a 'code of conduct' framework for industry engagement that differentiates between policy development and implementation. We ask for the UN to consider our comments and take them into account for the UN High Level Meeting in September.

This Statement of Concern was made possible thanks to the support of the following organisations:

Baby Milk Action/International Baby Food Action Network, World Cancer Research Fund International, Corporate Accountability International, National Heart Forum, Consumers International, Centre for Science in the Public Interest Canada/International Association of Consumer Food Organizations, Global Alcohol Policy Alliance and the International Obesity TaskForce.

Alcohol consumption guidelines ‘inadequate for cancer prevention’:

“No level of alcohol consumption without risk”

Current alcohol consumption guidelines are inadequate for the prevention of cancer and new international guidelines are needed, according to an analysis by French researchers published in the Canadian Medical Association Journal.

The analysis in the Canadian journal follows on from research on alcohol and cancer in Europe, and a position statement on the subject published by the Cancer Council of Australia, which also advised that there is no safe threshold of alcohol consumption for avoiding cancer (**See The Globe Issue 2 2011**).

The Canadian analysis argues that guidelines on ‘safe’ or ‘sensible’ drinking in some countries are not currently based on evidence for long-term harm. Most guidelines, it claims, are based on studies that assessed the short-term effects of alcohol, such as social and psychological issues and hospital admissions, and were not designed to prevent chronic diseases. As well, in some countries, “alcohol producers were either part of working groups defining sensible drinking or instrumental in dissemination of the guidelines”.

The analysis continues:

“There is increasing evidence that links alcohol consumption to

cancer.” The WHO International Agency of Research on Cancer has stated, based on evidence, that alcohol is carcinogenic in both animals and humans. Several evaluations of this agency as well as the joint 2007 report of the World Cancer Research Fund and the American Institute for Cancer Research warned of the link between alcohol and cancers in the mouth, throat, esophagus, liver, colorectum and breast. Based on the evidence, “there is no level of alcohol consumption for which cancer risk is null”.

“On the whole, alcohol is considered an avoidable risk factor for cancer incidence and, more generally, for the global burden of disease,” stated Dr. Paule Latino-Martel, French National Institute for Agricultural Research (INRA), with coauthors from the French Institute for Prevention and Health Education (INPES) and the French National Cancer Institute (INCa).

“Although drinking guidelines used in the context of a brief intervention have proven effective” to help people who have problems, due to their drinking habits, to reduce their alcohol consumption, they are inadequate to prevent all types of risks including cancer risk. Therefore, “their application to the general population should be revisited,” write the authors. Canadian guidelines for “low-

risk” consumption, set in 1997 at 9 drinks per week for women and 14 per week for men, may be modified when Canada releases its first national guidelines later in 2011.

“Although guidelines are currently practical for health professionals and health authorities, the time has come to reconsider them using a scientific basis independent of any cultural and economic considerations and to discuss the eventuality of abandoning them,” conclude the authors. “Considering our current knowledge of the relationship between alcohol consumption and cancer risk, national health authorities should be aware of the possible legal consequences of promoting drinking guidelines that allow consumers to believe that drinking at low or moderate levels is without risk.”

The full analysis can be downloaded from: <http://www.cmaj.ca/site/embargo/cmaj110363.pdf>.

The Size and Burden of Mental Disorders and Other Disorders of the Brain in Europe – “It’s worse than we thought”

Alcohol highlighted as cause of mental disorder

A study by the European College of Neuropsychopharmacology (ECNP) reveals that mental disorders have become Europe’s largest health challenge in the 21st century. The study also highlights that the majority of mental disorders remain untreated. Taken together with the large and increasing number of ‘disorders of the brain’, the true size and burden is even significantly higher.

The three-year multi-method study, published in *European Neuropsychopharmacology*, covers 30 countries (the European Union plus Switzerland, Iceland and Norway) and a population of 514 million people. All major mental disorders for children and adolescents (2-17), adults (18-65), and the elderly (65+ years) are included, as well as several neurological disorders. The inclusion of the full spectrum of disorders across all age groups, examined simultaneously in a single study, is unprecedented.

The study’s key findings include:

- Each year, 38.2% of the EU’s population – or 164.8 million people – suffer from a mental disorder.
- Mental disorders are prevalent in all age groups and affect the young as well as the elderly, revealing though differences in what diagnoses are the most frequent.
- The most frequent disorders are anxiety disorders (14.0%), insomnia (7.0%), major depression (6.9%), somatoform disorders (6.3%), alcohol and drug dependence (>4%), attention-deficit and hyperactivity disorders (ADHD, 5% in the young), and dementia (1% among those aged 60-65, 30% among those aged 85 and above).
- Except for substance disorders and mental retardation, no significant cultural or country variations were found.
- No indications for increasing overall rates of mental disorders were found, when compared with the previous comparable study in 2005, which covered a restricted range of 13 diagnoses in adults only. The notable exception is an increase of dementia due to increased life expectancy.
- No improvements were found in the notoriously low treatment rates for mental disorders in comparison with the 2005 data. At present only one third of all cases receive treatment.
- These few receiving treatment do so with considerable delays of an average of several years and rarely receive appropriate, state-of-the-art therapies.
- Additionally, many million patients in the EU suffer from neurological disorders such as stroke, traumatic brain injuries, Parkinson’s disease and multiple sclerosis, cases that may have to be counted on top of the above estimates.
- As a result, disorders of the brain, as measured by disability-adjusted life years (DALYs), are the largest contributor to the EU’s total morbidity burden, accounting for 26.6% of the total disease burden, covering the full spectrum of all diseases.
- The four most disabling single conditions (in terms of DALY) were depression, dementias, alcohol use and stroke.

The study also identified the critical challenges to improved basic and clinical research on mental and neurological disorders in the region. These include:

- Disciplinary fragmentation in research and practice, with different concepts, approaches and diagnostic systems.
- The marginalisation and stigmatisation of many disorders of the brain.
- The lack of public awareness about the full range of disorders of the brain and their burden on society.

The study concludes that “Concerted priority action is needed at all levels, including substantially increased funding for basic and clinical as well as

public health research in order to identify better strategies for improved prevention and treatment for disorders of the brain as the core health challenge of the 21st century.”

Principal investigator and joint first author Hans-Ulrich Wittchen says, “To address this challenge, we have to address two high priority issues. First, the immense treatment gap documented for mental disorders has to be closed. Because mental disorders frequently start early in life, they have a strong malignant impact on later life. We have to acknowledge that only early targeted treatment in the young will effectively prevent the risk of increasingly larger proportions of severely ill multimorbid patients in the future”.

“Second, we have to take into account the developmental pathways of both mental and neurological disorders simultaneously. Both groups of disorders share many common mechanisms and have reciprocal effects on each other. Only a joint approach of both disciplines, covering the spectrum of disorders of the brain across the lifespan, will lead to an improved understanding of the causes and improved treatments”.

“The low levels of awareness and knowledge about disorders of the brain, their prevalence and burden, are a major obstacle for progress in this direction. Dramatically increased funding of research on the causes and the treatment of disorders of the brain to reach this goal is needed. In addition, a better allocation of treatment resources and improved



Professor Dr Hans-Ulrich Wittchen

provision of care are priority topics for the more immediate future.”

This paper was prepared in the framework of the European College of Neuropsychopharmacology (ECNP) and European Brain Council (EBC) Task Force project on the Size and Burden and Cost of Disorders of the Brain in Europe 2010, supported by funds of the ECNP Council, the EBC and Lundbeck.

About ECNP

ECNP is an independent scientific association whose mission is to advance the science of the brain, promote better treatment and enhance brain health. The annual ECNP Congress attracts scientists and clinicians from across the world to discuss the latest advances in brain research in Europe’s largest meeting on brain science.

Valuable alcohol resource free to good home

Dr Alan Blum, co-founder, of Doctors Ought to Care (DOC), which focuses exclusively on counteracting the influence of the tobacco and alcohol industries, has written to us offering to donate his archive of alcohol-related resources.

The archive contains material and media coverage on alcohol marketing and problems and could be an ideal resource for exhibitions and monographs or a valuable addition to a library or museum. It includes more than three decades’ worth of print, marketing media, TV and trade journals and Dr Blum hopes that it can serve as an information resource to regional, national and international health organisations, as well as for researchers, journalists and students. Although it consists mostly of US alcohol advertising, Dr Blum considers that it has global significance.

Digital organisation of the resources could be a valuable project for student librarians or students interested in marketing and alcohol policy. The collection is estimated at 20 boxes plus additional material in climate-controlled storage.

If you are interested in finding out more please get in touch with Dr Blum at:

The University of Alabama
Center for the Study of Tobacco and Society, 26 Pinehurst Drive
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Health Officials Advocate Measures to Curb Harmful Use of Alcohol in the Americas

In the Americas, alcohol consumption is linked to nearly 350,000 deaths annually. Top health officials from North, Central and South America and the Caribbean have endorsed a series of actions that the Pan-American Health Organization/World Health Organization (PAHO/WHO) says could significantly reduce the public health impact of alcohol.

Ministers of health and their representatives at PAHO's 51st Directing Council approved a new Plan of Action to Reduce the Harmful Use of Alcohol that seeks to lower levels of per-capita alcohol consumption and reduce alcohol-related harm. It includes measures ranging from increased taxes on alcohol sales and restrictions on marketing to training for primary health care workers in screening and treatment for risky drinkers.

According to WHO data, alcohol consumption was the leading risk factor for deaths and illnesses in the Americas in 2004 and was responsible for more than 347,000 deaths.

The most common pattern of consumption in the hemisphere is the most risky pattern: heavy episodic drinking, mostly by males. This leads to acute and chronic health problems including injuries, mental health disorders, cancers, heart disease,



Dr Maristela Monteiro

hypertension and diabetes. It also negatively affects people other than the drinker, such as victims of drunk-driving car crashes and alcohol-related violence.

“For public health, the big issue is not alcoholism; it’s the quantity and pattern of consumption,” says Dr Maristela Monteiro, PAHO/WHO’s top expert on alcohol and substance abuse.

“The major impact is from over-consumption and risky drinking by people who are not alcoholics. This is what underlies most alcohol-related injuries, illnesses and deaths.”

Monteiro and other alcohol experts say that the drinking pattern that could have a beneficial impact—occasional consumption of limited amounts of alcohol and no episodes of excessive drinking—applies primarily to people 45 years of age and older, and that this pattern in fact may be harmful

among other age groups. “In any case, low-risk drinking is not the prevailing pattern in most of the countries of our hemisphere,” she says.

The approved plan of action calls for countries—with PAHO/WHO technical support—to take actions including:

Set low legal limits on blood-alcohol levels for drinking-and-driving violations and ensure quick and effective consequences for people caught driving with higher levels. Use taxation and pricing to decrease the harmful use of alcohol, for example, through sales taxes based on alcohol content or special taxes on beverages targeted at youths. Consider dedicating some alcohol-tax revenues to prevention and treatment as well as public health counter-advertising. Reduce the availability of alcohol through restrictions on age, type of outlets, and hours for the sale and purchase of alcohol. Ban the sale of alcohol to intoxicated persons and promote bar-owner liability for alcohol-related violence and injuries resulting from intoxication that occurs on their premises. Limit the marketing of alcoholic beverages, especially to young people and vulnerable groups. Monitor industry compliance with voluntary codes of conduct. Train health-care

providers to detect, prevent, treat and rehabilitate men and women—including pregnant women—suffering from harmful use of alcohol in primary health care and across the health system. Promote prevention and interventions in the workplace, on college campuses, and other places where there is a high concentration of drinking and/or alcohol-related problems. Provide supportive environments in schools, communities, and other social settings to protect people from the harmful use of alcohol. Promote research on the health and social effects of harmful drinking on men, women, and different ethnic groups as well as the effects on human capital and economic development. Involve other sectors, including education, labor, transportation, law enforcement and the criminal justice system to increase public awareness about the harmful consumption of alcohol.

The 51st Directing Council also approved a new Plan of Action on Psychoactive Substance Use and Public Health, focused on prevention, screening, early intervention, treatment, rehabilitation, social reintegration, and other health services to reduce the negative consequences of substance use.

PAHO was established in 1902 and is the world's oldest international public health organization. It works with all the countries of the Americas to improve the health and quality of life of the people of the Americas and serves as the Regional Office for the Americas of the World Health Organization (WHO).

Excessive Drinking Costs U.S. \$223.5 Billion

A new study finds that excessive alcohol consumption cost the United States \$223.5 billion in 2006, or about \$1.90 per drink. Excessive alcohol consumption is known to kill about 79,000 people in the United States each year, but a new study released by the Centers for Disease Control (CDC) and The Lewin Group shows that it also has a huge economic impact as well.

According to the new study, the cost of excessive alcohol consumption in the United States reached \$223.5 billion in 2006 or about \$1.90 per drink. Almost three-quarters of these costs were due to binge drinking. Binge drinking is defined as consuming four or more alcoholic beverages per occasion for women or five or more drinks per occasion for men, and is the most common form of excessive alcohol consumption in the United States.

The researchers found that the cost of excessive drinking was far-reaching, reflecting the effect this dangerous behavior has on many aspects of the drinker's life and on the lives of those around them. The costs largely resulted from losses in workplace productivity (72% of the total cost), health care expenses for problems caused by excessive drinking (11% of total), law enforcement and other criminal justice expenses related to excessive alcohol consumption (9% of total), and motor vehicle crash costs from impaired driving (6% of the total).

The study analyzed national data from multiple sources to estimate

the costs due to excessive drinking in 2006, the most recent year for which data were available. The study did not consider a number of other costs such as those because of pain and suffering among either the excessive drinker or others that were affected by their drinking, and thus may be an underestimate. Nevertheless, the researchers estimated that excessive drinking cost \$746 for every man, woman, and child in the United States in 2006.

Reducing the Costs

The CDC says that there are many evidence-based strategies that communities can use to prevent excessive drinking, including the following:

- Increasing alcohol excise taxes
- Reducing alcohol outlet density
- Reducing the days and hours of alcohol sales
- Holding alcohol retailers liable for injuries or damage done by their intoxicated or underage customers

By implementing these evidence-based strategies, it is possible to reduce excessive alcohol consumption and the many health and social costs related to it.

American Journal of Preventive Medicine
Year: 2011, Issue: Vol 41 | No. 5 | November
2011 | Pages 457-550
Economic Costs of Excessive Alcohol
Consumption in the U.S., 2006
Ellen E. Bouchery, et al

New US Action Guide Offers Strategies to Reduce Alcohol Outlet Density

A new publication, *Strategizer 55-Regulating Alcohol Outlet Density: An Action Guide*, outlines available evidence-based community prevention strategies shown to decrease the consequences associated with alcohol outlet density, the concentration of bars, restaurants serving alcohol, and liquor and package stores in a given geographic area.

The US Centers for Disease Control and Prevention's Community Guide to Preventive Services has endorsed reducing alcohol outlet density as an effective strategy for reducing alcohol-related harms.

Developed by the Community Anti-Drug Coalitions of America (CADCA) in partnership with the Center on Alcohol Marketing and Youth (CAMY) at the Johns Hopkins Bloomberg School of Public Health, the guide provides public health departments, community coalitions and other organizations with information and tools for community action designed to regulate and limit the number of places that serve and sell alcohol.

"Excessive alcohol use is a major public health concern and limiting the physical availability of alcohol is one of the most effective ways to reduce excessive drinking and its many health and social problems," said David Jernigan, PhD, the CAMY Director and Associate

Professor at the Bloomberg School's Department of Health, Behavior and Society. "This action guide shows how people can transform their community so that excessive drinking is the exception, not the rule."

"Communities with a large concentration of bars and liquor stores pose a risk to both young people and adults, increasing the likelihood for violence or alcohol-impaired driving. Fortunately, we know from research that by limiting the number of alcohol outlets and their proximity to each other we can reduce the many health and social consequences associated with excessive drinking. This new publication - and the corresponding training curricula we've built in partnership with CAMY - will give communities the tools they need to craft local strategies that reduce alcohol problems," said CADCA Chairman and CEO General Arthur T Dean.

Among the findings in *Strategizer 55-Regulating Alcohol Density: An Action Guide* are

- Higher concentrations of alcohol outlets in an area are associated with increased alcohol consumption and related harms, such as sexual assault, alcohol-impaired driving, violence, and other neighborhood disruptions.
- Excessive drinking causes approximately 79,000 deaths



David Jernigan

per year in the U.S., making it the third-leading cause of preventable death in the nation.

- About 90 percent of the alcohol consumed by underage youth is in the form of binge drinks, defined as five or more drinks in one sitting for men and four or more drinks for women.
- Underage youth who binge drink are at additional risk of poor school performance and interrupted brain development.

"Strategic partnerships between community coalitions and health departments can effectively reduce alcohol outlet density at the local level," said Jernigan. "People have the power to make their neighborhoods healthier and safer."

The new alcohol outlet density Strategizer and other resources are available on the CAMY website, http://www.camy.org/action/Outlet_Density, class="MsoHyperlink" and on the CADCA website, at <http://www.cadca.org/resources/series/Strategizer>.

RESCHEDULED CONFERENCE DUE TO FLOOD DELUGE IN THAILAND

GAPC

Global Alcohol Policy Conference 2012

Monday 13 - Wednesday 15 February 2012
Grand Diamond Ballroom, Impact Convention Center
Nonthaburi, Thailand

Information about the conference, including relevant topics such as program, venue, travel information and on-line registration, is available at www.GAPC2011.com

Our congratulations and thanks to our Thai hosts in overcoming the enormous difficulties that have beset them.

Norwegian study finds opening bars longer increases violence

A new study published in the international journal *Addiction* demonstrates that even small changes in pub and bar closing hours seem to affect the number of violent incidents. The findings suggest that a one-hour extension of bar closing hours led to an increase of an average of 20 violent cases at night on weekends per 100,000 people per year. This represents an increase in violence of approximately 16 percent.

The results suggest that the effect occurs both ways. In other words, reducing trading hours by one hour leads to a decrease in violence of the same magnitude as the increase in violence, seen if closing hours are increased by one hour.

Lead author Professor Ingeborg Rossow said “These findings

echo the results from studies from around the world that you see more violence in cities when you extend trading hours.” The study is based on data from 18 Norwegian cities that expanded or restricted their closing hours by up to two hours in the decade 2000 – 2010. Researchers examined whether these changes affected violence in the city centre on weekend nights. Violence outside the town during the same time window, which was not likely to be affected by changes in closing hours, was used as a control for other factors.

In these 18 cities weekend closing hours were between one and three at night, early by comparison to many cities around the world. These findings come more than a year after the Norwegian government proposed reducing sales hours for on-premises

trading to reduce violence and public nuisance. The proposal was supported by police commissioners but rejected by alcohol businesses and some political parties who claimed that reduced sales hours would not reduce violence.

Study co-author Professor Thor Norström said “These findings hold important implications for communities around the world who are struggling to deal with the massive burden of alcohol-related harm. If you want to reduce alcohol-related harm, restricting trading hours of licensed venues seems to be an effective measure.”

Full citation: Rossow I. and Norström T. The impact of small changes in bar closing hours on violence: The Norwegian experience from 18 cities. *Addiction*

Community organization “can lessen impact of alcohol outlets on neighborhood violence”

The density of businesses that sell alcohol in a community has been tied to local levels of violence, but new research has found that the influence depends on the nature of the community. More stable communities can see little to no influence, but more disorganized communities are not so fortunate.

Communities with greater levels of disorganization, marked by higher percentages of people living in poverty and in women-headed households with children and more rented accommodation, were hit the hardest by the presence of the liquor establishments.

“Common values and stronger social cohesion found in more organized communities usually results in a greater ability to regulate the behavior of local retailers and those who patronize the local alcohol outlets,” said William Alex Pridemore, Professor in the Department



Professor William Alex Pridemore

of Criminal Justice at Indiana University Bloomington. “These communities are more likely to have greater social capital, effective informal surveillance, and even friends who work at city hall. They’re more likely to get the attention of police or authorities who license liquor establishments.”

The study results have policy implications. Changing local and state alcohol policies can be daunting because of its complex political and commercial context but Pridemore said changing alcohol policy, such as restricting the number of outlets that can operate in disorganized neighborhoods, might be easier to achieve than changing neighborhood characteristics like poverty or social disorganization. Citywide policies that establish density thresholds for businesses that sell alcohol might not be necessary, he said, but instead such policies could be targeted to protect the most fragile neighborhoods.

The co-author of the study is Tony Grubestic, Associate Professor in the College of Information Science and Technology at Drexel University.

In earlier research, Pridemore and Grubestic found that adding one off-premise alcohol sales site per square mile would create



Associate Professor Tony Grubestic

2.3 more simple assaults and 0.6 more aggravated assaults per square mile. Increases in violence associated with restaurants and bars were smaller but still statistically significant. Their latest findings demonstrate that this relationship between assaults and the number of alcohol outlets weakened as the social organization of a community increased. The association became stronger, with the number of assaults increasing, as the level of disorganization increased.

Pridemore said greater organization, which can include neighborhood associations and neighborhood watches, likely weakens the association for the following reasons: These communities can informally influence the behavior of patrons who visit local liquor establishments; residents are more likely to demand more responsible business practices from the owners and managers of alcohol sales sites; residents also

are more likely to tap their social connections or otherwise get the attention of police and other authorities when problems arise. The researchers created their models using geocoded police data on assaults and geocoded data on the location of alcohol

outlets in 298 block groups in Cincinnati. Pridemore and Grubestic's research is among the first to apply theories and research techniques used by sociologists and geographers to the long-studied relationship between violence and community

organization, typically the domain of epidemiologists and public health experts.

Pridemore presented the findings to the American Sociological Association's annual meeting in Las Vegas.

Alcohol industry and 'Drinkwise' under attack in Australia

The Australian alcohol industry, its 'Drinkwise organisation' in particular, has been accused of seeking to create an impression of social responsibility while promoting measures for which there is little evidence of impact which are 'are unlikely to hurt profits'. A particular cause for complaint is the 'responsible drinking' message the Australian industry has begun placing on product labels.

New research 'exposes alcohol industry public relations tactics'

The attack on Drinkwise was made by a research team from Deakin University's School of Psychology in Australia. The team examined submissions to the Australian National Preventative Health Taskforce (NPHT) to determine which organisations or individuals discussed positive relationships or work by Drinkwise. They found that all the submissions mentioning Drinkwise were submitted by the alcohol industry or its affiliates as evidence of their social responsibility or in recommending actions that are likely to benefit their bottom line.

"It is clear from our study that Drinkwise is being used by the

alcohol industry for its own benefit," said lead researcher on the project, Dr Peter Miller. "Drinkwise is being used to create an impression of social responsibility while promoting interventions that will have very little to impact on profits and failing to press for measures known to be effective, such as higher taxes on alcohol or curbs on drinks industry promotions."

Dr Miller said the use of organisations known as SAPROs (social aspects/public relations organisation) is common among industries that harm many of their users, such as tobacco and gambling, as they appear to lend credibility to the industry's claims of social responsibility.

"We conducted this study to gain a fuller understanding of the corporate political activity of the alcohol industry in Australia," he said.

"Of the 375 submissions to the NPHT, 33 primarily covered alcohol, and nine of these 33 submissions also discussed Drinkwise. Only industry submissions referred to Drinkwise. "Every industry submission referred to Drinkwise either in

terms of it being evidence for social responsibility and therefore deserving credibility, or in terms of suggesting the industry-friendly actions of Drinkwise as alternatives to the NPHT recommendations in addressing the issues of problems associated with alcohol use and abuse."

Dr Miller also noted that "the recent industry push to implement soft labeling is reminiscent of tobacco industry campaigns and, in light of the findings in this study, the people to determine health information and messages should be the Government and health authorities, not the alcohol industry".

The study, "Alcohol industry use of social aspect public relations organisations against preventative health measures", is published online on the Addiction website: [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1360-0443/earlyview](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1360-0443/earlyview)

Warning labels 'too soft'

The industry's 'responsible drinking' messages have been criticized as inadequate by the Australian Alcohol Policy

Coalition. The Coalition called for larger warnings with outcome-driven health messages, such as “alcohol causes damage to young people’s brains”.

“The alcohol industry’s move to put warnings on some products is a step in the right direction, but it appears they’ve a way to go when it comes to effective health messages,” said Professor Robin Room, Director for the AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre.

Professor Room suggested the labels be mandated by law and come from national health experts, such as the Government’s new National Preventive Health Agency. “This is not about telling people what they can and can’t drink, it’s about giving consumers all of the facts to make informed decisions”, Professor Room added.

The Alcohol Policy Coalition recommends alcohol labels should:

- include text and graphic warnings about the range of health and safety risks of alcohol consumption
- occupy at least 25 percent of the package surface; and
- rotate with alternating specific, outcome-related health messages.

Professor Room continued:

“We’ve seen with the tobacco experience that industry will try to pre-empt stronger government regulation with soft, ineffective options. At least 43 countries already require some form of on-product labeling, with 14 of these having mandatory health labels primarily around alcohol use and pregnancy. It’s time Australia caught up with the rest of the world.”

“We’ve seen the alcohol industry fighting labeling changes in other countries around the world and this is no different. There is no reason why alcohol, which is inherently harmful, is subject to less regulation than a carton of milk. We know the community wants government to make health information and labels mandatory rather than a voluntary system implemented by the alcohol industry.”

Research shows health labels can influence the choices people make because they target consumers at that critical point of decision making – when they buy alcohol and when they drink it. They can also influence actions after a person has been drinking, like deciding against driving or operating machinery.

Every week, alcohol hospitalises more than 1500 Australians and kills 60.

Safety issue revealed as 1 in 20 Australian workers admits to drinking at work

A national survey has found that more than one in twenty Australian workers report using alcohol while at work or just before work, and more than one in fifty report taking drugs during or just before work. These findings, published in the journal *Addiction*, have obvious implications for workplace safety.

Researchers used data from the 2007 National Drug Strategy Household Survey (NDSHS), which polled over 23,000 Australian residents aged 12

and over on their use of alcohol, tobacco, and other drugs. The resulting statistics showed that working while under the influence of alcohol or drugs was more likely to happen in the hospitality, construction, and financial services industries. Young, male, never married workers with no dependent children were likelier than other groups to work under the influence of alcohol or drugs. Managers showed the highest prevalence of alcohol use at work, while tradespeople and unskilled workers were most likely to use drugs at work.

The most commonly used workplace drugs were painkillers and amphetamines and methamphetamines (stimulants), followed by cannabis and ecstasy. But alcohol was by far the most popular intoxicating substance used at work.

The survey also revealed that a substantial portion of workers who use alcohol or drugs at work appear to underestimate their negative effect on workplace safety. For example, only 17% of those who reported using alcohol at work also reported attending work while under the influence

of alcohol, a discrepancy that suggests the respondents did not associate drinking at work with potentially dangerous impairment. Workplace drug users showed a similar discrepancy: they used drugs at work but did not think they were drug-impaired. The discrepancy may be because some drinking

and drug use occurs among co-workers after work but before leaving the workplace, in places like canteens, lunchrooms, and changing rooms. Says lead author Ken Pidd, "People may not think of a drink or a joint in the parking lot after work as a 'workplace' activity, but it does negatively affect workplace

safety. Out of the 295 Australian workplace fatalities reported in 2006 and 2007, almost a third were caused by auto accidents while travelling to and from work. Showing up at work and leaving work while under the influence of alcohol or drugs may have a lot to do with those high numbers."

Epidemic of alcoholic liver disease in young people in North East England

The number of hospital admissions for people in their early 30s with alcoholic liver disease has increased by more than 400% in the North East of England in 8 years– the national increase stands at 61%.

Research carried out by Balance, the North East Alcohol Office, reveals that North East hospitals recorded 189 hospital admissions for 30-34 year olds with the disease last year, compared to just 37 in 2002.

In total there were 778 admissions for 30-34 year olds with alcohol liver disease between 2002 and 2010, costing the NHS an estimated £1.8m. Disturbingly there were a further 482 admissions for under 30s, with some people admitted even being under the age of 20.

For all age groups, in the last 8 years there have been a total of 21,798 alcoholic liver disease admissions across the region at an estimated cost of £51.7m.

Dr Chris Record, a liver specialist at Newcastle University and Newcastle Hospitals, said: "Only a few years ago alcoholic liver disease was very unusual in this age group and unless

our drinking habits change, the problem is only set to worsen. "The earlier the age at which children drink, and the more they drink, the greater the chance of developing serious liver disease in adult life. Many patients are now presenting with terminal liver disease in their late twenties and early thirties. Adults need to drink within the recommended limits and we need to discourage young people from drinking and perhaps even raise the legal age for alcohol consumption from below 5 to below 15. Unless we do something soon, liver specialists across the region are going to be dealing with more and more young people whose lives have been ruined by alcohol."

Death rates linked to alcoholic liver disease have risen by over two-thirds (69%) in the last 30 years. The disease does not usually cause any symptoms until the liver has been extensively damaged but starts with fat deposits in the liver leading to inflammation (steatohepatitis), fibrosis (scar tissue) and ultimately liver failure from Cirrhosis. Alcohol also causes death from high blood pressure (hypertension) heart disease, stroke, pancreatic

disease and cancer and, by directly damaging the brain, frequently causes dementia at an early age.

Colin Shevills, Director at Balance, commented "We have created a society where alcohol plays too central a role in our lives. This needs to change. We are currently running a campaign to protect children and young people from exposure to alcohol through advertising, which encourages them to drink earlier and to consume more.

"Our campaign has already received support from thousands of North Easterners and they have signed our petition at www.balancenortheast.co.uk to restrict alcohol advertising and stop the detrimental effect it is having on young people and their health, both now and in the future."

WHO Europe seeks to reduce the harmful use of alcohol

An action plan to reduce the harmful use of alcohol has been endorsed by the 53 countries in the WHO European Region, meeting in Baku, Azerbaijan. In the European Region, alcohol is the second largest risk factor for the death and disease burden, just after tobacco use.

“The harmful use of alcohol is a priority public health concern. The evidence supporting this action plan is large, diverse and persuasive,” said Zsuzsanna Jakab, WHO Regional Director for Europe. “Countries are well aware of the expensive and devastating damage it causes and our action plan is intended to provide them with technical guidance and support on what can and should be done to reduce this harm.”

The WHO European Region is the heaviest drinking region in the world, with a prevalence of heavy episodic drinking in over 20% of adults. Alcohol consumption reportedly decreased during the 1990s, then increased and stabilized at a higher level between 2004 and 2006. Consumption varies greatly among countries, with a European average of the equivalent of 9.24 litres of pure alcohol consumed per person per year. The overall tendency is that consumption has decreased in western Europe and increased in eastern Europe during the last 15 years, although there are huge

differences among countries – see *the European status report on alcohol and health 2010*.

The *European action plan to reduce the harmful use of alcohol 2012–2020* gives a comprehensive overview of the problem and provides policy options proven to reduce alcohol-related harm. Policies such as regulating alcohol pricing, targeting drink-driving, and restricting alcohol marketing are known to be effective. The health sector has a central role in recognizing and responding to alcohol problems, but this issue goes beyond the health sector. There is convincing evidence on the efficacy of:

- alcohol taxes;
- restrictions on outlet density and on days and hours of sale;
- a minimum purchase age;
- lower legal blood alcohol levels for driving and random breath-testing; and
- brief counselling programmes and treatment for alcohol use disorders.

The harm done by alcohol

Alcohol harms people other than the drinker, whether through violence on the street or in the family, or simply by using up government resources. Most alcohol is drunk at binges, or other heavy-drinking occasions, which worsen all risks as they are a cause of all types of intentional

and unintentional injuries, and of ischaemic heart disease and sudden death.

Alcohol use accounted for over six years of difference in life expectancy between western and eastern European men aged 20–64 years in 2002. The amount of alcohol consumed over a lifetime increases the risk of dying from an alcohol-related disorder. There is no safe level of drinking, and in many societies no difference in the risk for men and women. Regularly drinking six drinks (60g alcohol) a day over a lifetime gives an adult a 1 in 10 risk of dying from alcohol.

The total tangible cost of alcohol (costs of health care, production losses, welfare provision, injuries and violence, research and education) to the European Union, as it existed in 2003, has been estimated at €125 billion, 1.3% of gross domestic product. Actual spending on alcohol-related problems accounts for €66 billion of this, while potential production lost due to absenteeism, unemployment and premature mortality accounts for a further €59 billion. Aside from these tangible costs (actual spending on alcohol-related problems of €66 billion and unrealized potential production of €59 billion), alcohol use results in an intangible cost of between €152 and €764 billion.

Europe as a global leader

Europe has been at the forefront of action to reduce the harm done by alcohol. It was the first WHO Region to approve an alcohol action plan in 1992. Today, every European country has some form of alcohol action plan or strategy. Nevertheless, no matter how comprehensive or strict its alcohol action plan, every country will benefit from reviewing, adjusting and strengthening it, using the European action plan to reduce the harmful use of alcohol 2012–2020. The five main objectives of the plan build on previous European plans, and align with the WHO global strategy on alcohol, to:

- raise awareness of the magnitude and nature of the health, social and economic burdens due to alcohol;
- strengthen and disseminate the knowledge base;
- enhance capacity to manage and treat alcohol-related disorders;
- increase mobilization of resources for concerted action;
- and
- improve surveillance and advocacy.

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Rising numbers of problem drinkers in Ireland

Youth problems highlighted

Unemployment identified as a factor

The number of treated cases of problem alcohol use rose 43% in the republic of Ireland in the period between 2005 and 2010, according to the Irish Health Research Board. The report identifies 42,333 cases treated for problem alcohol use in those six years. Half of the treated cases had started drinking by the time they were 16 and one in five cases reported problem use of other substances such as cannabis, cocaine, ecstasy and benzodiazepines.

Key findings from the report include:

- 42,333 cases were treated for problem alcohol use in the six-year period. There were 5,525 cases in 2005 which rose to 7,866 cases in 2010, an increase of 43%.
- 22,626 (53%) were new cases who had come for treatment for the first time, while 18,396 (44%) were treated previously.
- 61% increase in cases who had been treated previously, from 2, 229 cases in 2005 to 3,583 cases in 2010.
- Half of all cases treated were aged 39 years or younger.
- 145% increase in new cases aged under 18, from 109 cases in 2005 to 267 cases in 2010.
- Half of all cases treated had started drinking alcohol by the time they were 16.
- 50% of new cases had used

alcohol for 19 years or more before seeking treatment.

- 40% of cases were drinking on a daily basis.
- The proportion of all cases in employment fell from 39% in 2005 to 24% in 2010.

Dr Suzi Lyons, senior researcher at the HRB said,

“The number of recorded cases treated for problem alcohol use increased over the six years due to an increase in reporting to the National Drug Treatment Reporting System (NDTRS) but it is also likely that it reflects a true increase in the number of people requiring treatment for problem alcohol use. Given that some treatment services are yet to participate in the reporting system, the figures underestimate the true extent of treated alcohol use in Ireland.”

While one out of every two cases treated for problem substance use in Ireland between 2005 and 2010 were treated for alcohol, many of those also had problems with other drugs.

Dr Lyons added,

“What we see is that almost one in five of those treated for alcohol also have problems with other drugs, with cannabis being the most common, followed by cocaine, ecstasy

and benzodiazepines. Poly-drug misuse presents a challenge for treatment services.”

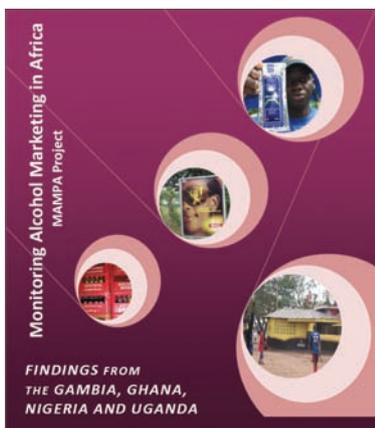
New fields recently added to the NDTRS reporting form will allow future Trends Series papers to provide additional data on specific alcohol-related questions, such as the clients preferred type of alcohol, volume of alcohol consumed on a typical drinking day, number of days on which alcohol was consumed in the month prior to treatment, and the extent of the drinking problem. These data will further enable service providers to understand more fully the extent of the problem.

Dr Lyons concluded by saying that NDTRS data is an important source of information for helping to inform health care policy in this area;

“As the government develops a new, integrated National Substance Misuse Strategy to address alcohol and other drugs issues in the Irish population, there continues to be a clear need for complete and accurate data on those entering treatment for problem alcohol use.”

The full paper HRB Trends Series 11, Trends in treated problem alcohol use in Ireland, 2005 to 2010 is available; from the HRB website at www.hrb.ie/publications.

Call for tougher rules on alcohol marketing in Africa



A new report; “Monitoring Alcohol Marketing in Africa”, released by the Africa Regional Office of the World Health Organization (WHO), has called for more effective controls on alcohol marketing to protect young people and to prevent alcohol beverage companies from using marketing techniques in Africa that are regarded as unacceptable in Europe.

The study, which was commissioned by WHO Afro in 2010, is the first product of cooperation between, EUCAM the European Centre for Monitoring Alcohol Marketing, STAP the Dutch Institute for Alcohol Policy and the WHO. It investigated alcohol advertising and promotion in Uganda, Nigeria, Ghana and Gambia. An important aim of the project was to develop a method to monitor alcohol marketing in low-income countries. Findings of this preliminary monitoring exercise have resulted in some early recommendations to protect

young people from the harmful effects of exposure to alcohol advertising.

A main finding of the investigation was that marketing practices that are seen as unacceptable in Europe are used widely in Africa by well-known companies such as Carlsberg, Anheuser-Busch and Heineken.

According to most self-regulatory codes in Europe and most company rules, alcohol advertisements may not be placed within 500 feet of schools (eg Diageo Code of Conduct) or when more than 30 percent of the expected spectators are underaged (eg AB InBev Code and European Self-regulation Code). Nevertheless, the WHO report shows illustrations of alcohol billboards in front of elementary schools, secondary schools and playgrounds.

According to EU law (AVMSD 2007) and most self-regulation codes (eg European self-regulation code art 3.1) alcohol marketing communications should not depict images, impressions, symbols, music, characters (either real or fictitious) that primarily appeal to persons below 18 years-old.

Nevertheless, global alcohol companies use cartoons to market their product on African television.

Connections between alcohol and wealth are used commonly in alcohol advertisements, e.g. Nigeria's Star Big Life campaign markets the message that drinking Star beer is the beginning of the 'big life'. The latter is especially disturbing when realizing that drinking alcohol is one of the indicators that predict poverty.

The voluntary rule of Diageo restricts alcohol advertisements on Nigerian television before 9 pm. However, the report shows that the company does not adhere to its own rules.

Legislation is an important tool to limit unethical alcohol advertising. EUCAM, the author of the report, state that the investigation revealed:

1. Ghana and Uganda rely fully on self-regulation. Their alcohol marketing is solely

regulated and monitored by the alcohol companies themselves. The aggressive alcohol marketing practices described in the report show a need for additional legislation that restricts the large volumes of alcohol marketing and the attractive content of the ads to young people.

2. Nigeria has a watershed of 8 pm on alcohol marketing on television and radio. The limited hours of television monitored in this pilot study already showed no adherence to the extended watershed of 9 pm by the Nigerian Guinness' self regulatory code. Although the watershed is a good start, young people are still exposed to much alcohol marketing on television and radio after 8 pm. Moreover, alcohol marketing is highly prevalent in Nigeria in non-broadcast media and not

regulated by law. A more comprehensive alcohol marketing regulation is required.

3. Alcohol marketing is strictly regulated in the Gambia. The preliminary monitoring of alcohol marketing in the Gambia shows that an effective alcohol marketing policy in the African continent seems feasible. Besides national characteristics of the country that support a strict alcohol marketing policy, the case of the Gambia shows that a clear alcohol marketing regulation limits the prevalence of alcohol marketing in society.

The full report can be found online at the website of WHO African Region. More information is available from Avalon de Bruijn (adebruijn@eucam.info) or the website www.eucam.info.

International Alcohol Control Study in progress

Koreans, Mongolians and Thai researchers and a representative from the Western Pacific Regional Office of WHO were in Auckland New Zealand at the end of November 2011 in order to attend a Working Meeting held at the SHORE and Whariki Research Centre, School of Public Health, Massey University. The Working Meeting was held to plan for and provide training on the implementation of the International Alcohol Control (IAC) study in these countries next year.

The IAC project, which is modelled on the International Tobacco Control study, has

been designed and implemented in New Zealand in 2011 by SHORE and Whariki researchers, funded by the Alcohol Advisory Council. The aim is to evaluate the effect of changes in alcohol policy and it measures, for the first time, a comprehensive overview of key issues such as how alcohol is obtained, where and when it is purchased, how much is paid and exposure of respondents to alcohol marketing as well as detailed measures of alcohol consumption.

'This is an important project internationally as well as domestically' says Professor Sally Casswell who leads the New

Zealand project. 'It aims to provide usable tools for countries without long histories of alcohol research in order to provide evidence for policy makers on what policy changes will make a difference, and to help assess if changes do have the predicted impacts.' Other countries seeking funding to participate include England, Scotland and Australia. 'Implementation in countries with such very different alcohol markets provides a challenge but should be very worthwhile' Professor Casswell adds.

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