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Alcohol & HIV

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Alcohol, HIV and Public Health

The 2nd International Conference on Alcohol and HIV hosted by the International Center for Research on Women was held in New Delhi in September 2010

Dr K J Bryan, Alcohol HIV AIDS Co-ordinator at NIAAA launched at the conference Alcohol, Research and Health Vol 33 (3) Pages 165-288 Special Supplement on Alcohol & HIV AIDS

Here Adrian Bonner reviews the latest knowledge.

Hazardous drinkers have a significantly higher risk of HIV/AIDS and tuberculosis (TB) than the general population. In the case of TB the risks have been attributed to a reduction in efficiency of the immune system and social exclusion. The underlying drivers of the increased risk of HIV/AIDS and alcohol use appear to be more complex than is the case for TB, in that a range of personality factors, unsafe sex and poor compliance with antiretroviral therapy have been implicated. An understanding of these causal factors is important in developing effective interventions.

Alcohol and HIV in India

The second international conference on alcohol and HIV, September 2010[1], provided an opportunity to review the current state of our understanding of alcohol, which is associated with increased risky sexual practices, increasing the probability of sexually transmitted infections. One of the main conclusions from the conference was that traditional HIV prevention programmes will not be effective without addressing the underlying potentiation of alcohol, particularly by vulnerable groups such as young people, sex workers and homosexual males.

In India, research into alcohol and HIV prevalence during recent years includes alcohol as a predictor of HIV or other sexually transmitted infections and alcohol use and sexual risk in special populations, in particular tea estate workers, migrants, injecting drug users and commercial sex workers. Gender violence, alcohol use and sexual risk and the role of alcohol in treatment adherence have also been studied. An understanding of the complex interplay between cultural and biomedical dimensions of sexual behaviour is essential to increase the potential outcomes of tailored public health strategies geared to specific regions in India.

> *" Alcohol use, like the dry kindling on the forest floor, provides the fuel for the fire to ignite and continue to burn."*
>
> Dr K J Bryn, Alcohol HIV AIDS Coordinator NIAAA

Since the Vedic period (1500 to 700 BCE) the Islamic invasions (1100 to 1800 CE), the period of British rule (1800 to 1947) and the period of post-independent India, the consumption of alcoholic beverages has changed considerably. Hazardous and excessive drinking is commonplace in India and various researchers have indicated that moderate social drinking is a minority practice. These drinking patterns are clearly important in developing programmes which seek to combat the spread of HIV/AIDS. The consumption of strong distilled alcoholic beverages is deeply embedded in cultural patterns in both tribal and non-tribal people in nearly all regions of India. The preference for strong drinks is partly due to the complex history of Government programmes and alcohol manufacturing policies during the colonial and post-colonial periods. Alcohol consumption in many parts of India is influenced not only by the spread of modern lifestyles but also through the needs of local State Governments to increase revenue from taxation.

Current statistical analysis has shown a steady increase in alcohol production, supply availability and consumption from 1990 onwards. During this period, international and domestic alcohol manufacturers were expanding their markets to an ever-increasing Indian

middle- and upper-class with resources to spend on leisure-time activity. In parallel with the significant growth in alcohol consumption, the HIV/AIDS epidemic is believed to be accelerating dramatically, with concern for vulnerable, high-risk populations such as sex-workers, truckers and injecting drug users. There is a reported high frequency of homosexual behaviour in migrants in South India, increasing the spread of HIV infections.

Alcohol and HIV South Africa

From a global perspective sub-Saharan Africa (SSA) is the region with 67% of all HIV infections. Within SSA, South Africa, there were reportedly 350,000 deaths due to AIDS in 2007 (WHO, UNAIDS and UNICEF, 2008). Paradoxically, although 55% of males and 69% of females abstain from alcohol, annual per capita consumption, per drinker, is very high. Charles Parry[2], has reviewed the linkages between alcohol and HIV. Whilst there appears to be a consistent association between alcohol use and the incidence of HIV, the relative contribution of personality traits, such as sensation seeking, psychiatric dimensions of impulsivity and other situational factors, is presently unknown. A number of individual studies and a meta-analysis by Fisher et al[3], (2007) point to a variety of HIV risk behaviours and problematic alcohol use. There appears to be an increasing risk of HIV infection due to alcohol consumption before sexual activity, which is related to the amount of alcohol consumed. This risk is reduced with moderated alcohol consumption and abstinence. As in the case of TB, the immune system is compromised by alcohol consumption. Despite the potential confounding influence of other psychological and psychiatric variables, Shuper et al[5],(2010) in a systematic review, concluded that alcohol alone is the predominant factor in the progression of and remission from the disease. Abnormalities in T and B lymphocytes, depression of CD4 count, and decreased lymphocyte function to produce Interleukin-2 have all been implicated in the biological effect of alcohol on the incidence of HIV/AIDS.

Deaths due to alcohol-attributable HIV/AIDS are the fourth highest cause (12%) of mortality in South Africa, and one fifth highest alcohol-related disability adjusted life years lost (DALYS)[4] in males. In males, 29% of all alcohol-related DALYs result from alcohol-related injuries, 9.7% are lost due to alcohol-attributable HIV/AIDS. However, in females, the greatest number of alcohol-related DALYS lost (27.8%) are due to alcohol-attributable HIV/AIDS.

In reviewing the implications of this research, Parry et al[2] have drawn attention to the WHO Global Strategy to reduce the harmful use of alcohol by implementing strategies to "… reduce availability ..." and "... pricing policies ...", "... regulating marketing ...", " developing effective systems of surveillance of marketing …". These brief reviews from India and South Africa also suggest that targeted interventions in high risk venues and high risk populations, such as peer-education facilitation, should be considered. The impact of "... server intervention ..." and "... bar-based brief interventions" appear to be minimal.

In summary, the authors suggest that a combined intervention mode, the need to include alcohol issues in HIV/AIDS treatment programmes, and HIV/AIDS prevention activities, should all underpin the development of future strategies. Although there are large differences in socio-cultural and public health practices in India and South Africa, there is an urgent need to consider the Global Strategy for Reducing Harmful use of Alcohol, as endorsed by WHO as a key component of a public health approach to tackling HIV/AIDS. Clearly evidence-based interventions are needed but identifying region-specific differences will be important in the effective reduction of alcohol-related harm.

References

1. Kalichman S.C., (Ed) 2010. Current Issues in Alcohol Use and HIV Research and Prevention in India. Aids and Behaviour 14, Supplement 1, August 2010-11-29
2. Parry C., J.Rehm, N.K. Morojele (2010). Is there a causal relationship between alcohol and HIV? Implications for Policy, Practice and Future Research. African Journal of Drug and Alcohol Studies 9 (2)
3. Fisher, J.C., H.Bang, S.H. Kapiga (2007). The association between HIV infection and alcohol use: A systematic review and meta-analysis of African studies. Sexually Transmitted Diseases, 34. 856-63.
4. Rehm,J., T. Kehoe, M. Rehm, J. Patra (2009) Alcohol Consumption and related harm in WHO Africa region in 2004. Toronto, Canada: Centre for Addiction and Mental Health
5. Shuper, P.A., M. Neuman, F. Kanteres, D.Baliunas, N. Joharchi, J. Rehm (2010) Causal considerations on alcohol and HIV/Aids – a systematic review. Alcohol and Alcoholism, 45 , 159-166.

Alcohol and tobacco 'more harmful than cannabis and ecstasy'

The present systems for classifying drugs in the UK and other countries have little relation to the evidence of harm, and they should be replaced by systems that facilitate the more aggressive targeting of alcohol harms, according to Professor David Nutt and his colleagues at the Independent Scientific Committee on Drugs in the UK.

In a paper published in the medical journal, The Lancet, Professor Nutt and his colleagues repeat the claims that in 2009 got him sacked by the then Labour government as chairman of the government's Advisory Council on the Misuse of Drugs. The then Home Secretary, Alan Johnson, demanded Professor Nutt's resignation on the grounds he had lost confidence in him as an impartial adviser to the government. Mr Johnson said that Professor Nutt could not be an adviser to government while simultaneously campaigning against government policy, in particular for advocating a 'softer' line on cannabis than the government was inclined to take. (See UK Alcohol Alert Winter 2009)

Professor David Nutt

The new paper in the Lancet re-works the arguments that Professor Nutt and colleagues have been advocating for some years. In the paper, they identify three main factors that together determine the harm associated with any drug of potential abuse:

- the physical harm to the individual user caused by the drug
- the tendency of the drug to induce dependence
- the effect of drug use on families, communities, and society

Within each of these categories, they recognized three components, leading to a comprehensive 9-category matrix of harm. Expert panels then gave scores, from zero to three, for each category of harm for 20 different drugs. All the scores for each drug were combined to produce an overall estimate of its harm.

In order to provide familiar benchmarks, for comparison with illicit drugs, five legal drugs of potential misuse (alcohol, khat, solvents, alkyl nitrites, and tobacco) and one that has since been classified (ketamine) were included in the assessment.

The process proved simple, and yielded roughly similar scores for drug harm when used by two separate groups of experts.

The new ranking placed alcohol and tobacco in the upper half of the league table. These socially accepted drugs were judged more harmful than cannabis, and substantially more dangerous than the Class A drugs LSD, 4-methylthioamphetamine and ecstasy.

Heroin, crack cocaine, and metamfetamine were ranked the most harmful drugs to individuals, whereas alcohol, heroin, and crack cocaine were the most harmful to others. Overall, alcohol was the most harmful drug, with heroin and crack cocaine in second and third places.

Professor David Nutt, lead author on the paper, said: "Drug misuse and abuse are major health problems. Our methodology offers a systematic framework and process that could be used by national and international

regulatory bodies to assess the harm of current and future drugs of abuse."

Professor Colin Blakemore added: "Drug policy is primarily aimed at reducing the harm to individual users, their families and society. But at present there is no rational, evidence-based method for assessing the harm of drugs. We have tried to develop such a method. We hope that policy makers will take note of the fact that the resulting ranking of drugs differs substantially from their classification in the Misuse of Drugs Act (in the UK) and that alcohol and tobacco are judged more harmful than many illegal substances."

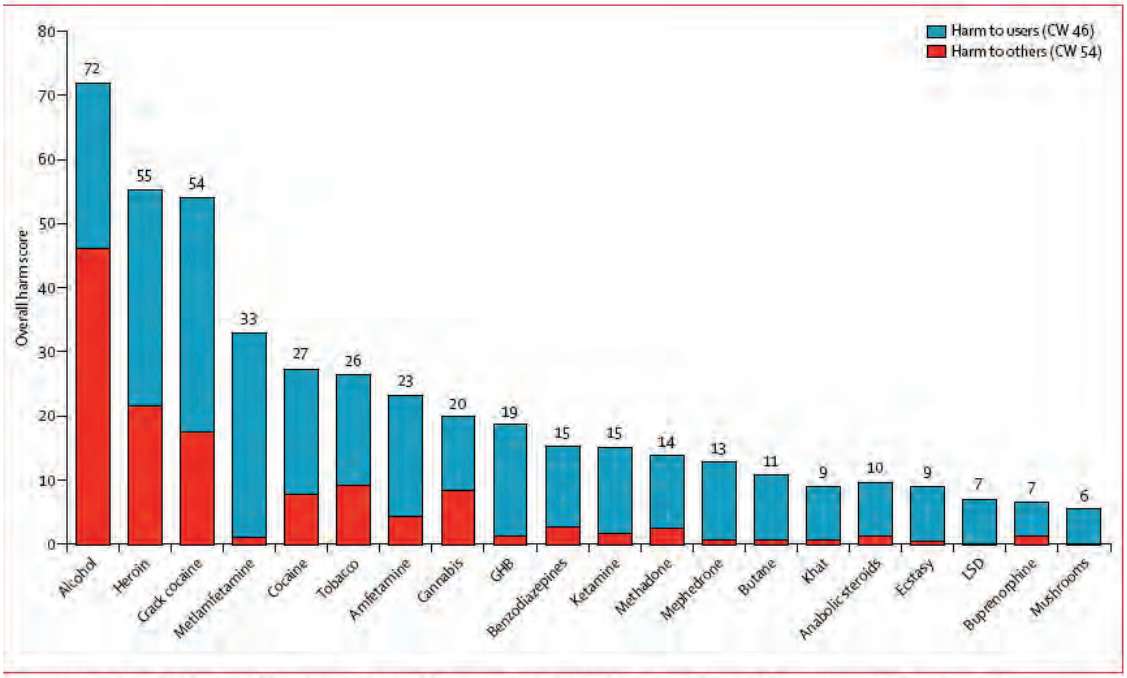


Figure 2: **Drugs ordered by their overall harm scores, showing the separate contributions to the overall scores of harms to users and harm to others**
The weights after normalisation (0–100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for all the criteria to others, 54). CW=cumulative weight. GHB=γ hydroxybutyric acid. LSD=lysergic acid diethylamide.

Reaction

Publication of the Lancet paper generated extensive media coverage, not only in the UK but also internationally. A common feature of the coverage however was that the media appeared to misunderstand the message of the paper, headlines frequently stating that 'experts had found alcohol to be more dangerous than heroin or cocaine'. In reality, the conclusions of the paper are more ambiguous than these headlines suggest. The key to the ambiguity is that the paper distinguishes between the dangerousness of a drug, in respect of the risk of harm to the user, from its harmfulness, the damage its use inflicts on people other than the user and on the wider society.

As can be seen from the graph, the paper clearly ranks alcohol as less dangerous to the user than heroin or cocaine, though it is more harmful overall because of the damage inflicted on third parties and the wider society. Presumably, however, the amount of damage to others is a reflection of how extensively any given drug is in use in any given society, and, as some critics pointed out, if cocaine were used as extensively as alcohol the picture might look different. Indeed, in an earlier paper Professor Nutt and his co-authors themselves explained that "direct comparison of the scores for tobacco and alcohol with those of the other (illegal) drugs is not possible, since the fact that they are legal could affect their harms in various ways, especially through easier availability".

Another, more fundamental criticism, perhaps, is that Professor Nutt's ranking system gives a spurious air of scientific objectivity to a system which in reality is as subjective and arbitrary as the classification system it is intended to replace. Critics suggest that weighing different kinds of harm against each other is always going to be an exercise in comparing apples and pears. If, as reported, cigarette tobacco kills half the people who smoke it, ranking it as less harmful than alcohol is at bottom a value judgement rather than a scientific finding.

David J Nutt, Leslie A King, Lawrence D Phillips, on behalf of the Independent Scientific Committee on Drugs.
Drug harms in the UK: a multicriteria decision analysis.
Lancet 2010; 376: 1558–65

Tax increases 'superior to minimum prices'

The attempt by the Scottish Government to introduce a minimum price for a unit of alcohol has attracted international attention. Most public health advocates in the UK have adopted the cause of minimum alcohol pricing, seeing it as a key element in an effective policy to reduce alcohol harm, and many of their counterparts in the European Union and elsewhere in the world have also expressed support for the idea.

Now, however, the cause of minimum pricing has received a setback, with its abandonment from the Alcohol Bill introduced into the Scottish Parliament. Despite an intensive campaign, the minority Scottish National Party government could not win sufficient support from the other political parties to carry the measure. During the debate on the Bill, Scottish Health Secretary Nicola Sturgeon accused opposition MSPs of opposing minimum pricing for party political reasons, adding: "This is a sad day for the parliament. If this parliament refuses to take action to deal with a monumental problem and I think, in the fullness of time, Scotland will judge those who vote against this policy very harshly indeed."

However, Labour health spokeswoman Jackie Baillie replied that her party was opposing minimum pricing, not on political grounds, but because "we do not believe it works - and that is a view that is shared by the main opposition parties in this chamber."

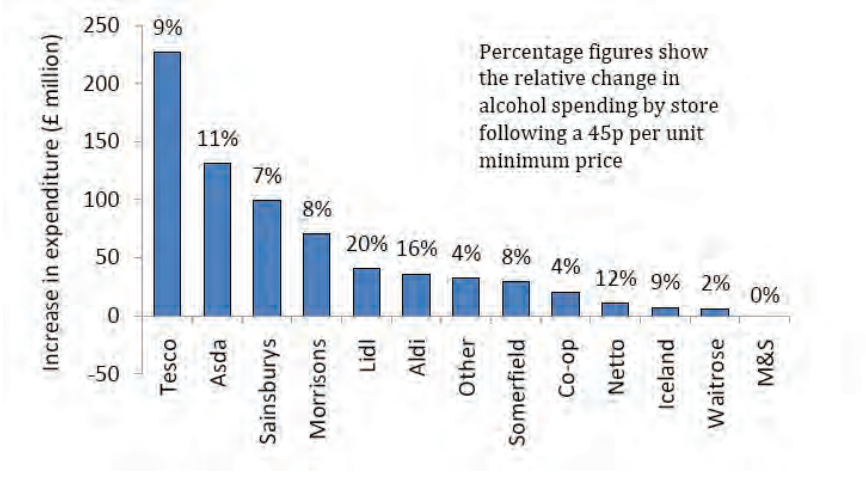
Ms Baillie continued: "There are three main concerns. It is untried and untested, it is possibly illegal and it will put £140m per year into the pockets of supermarkets."

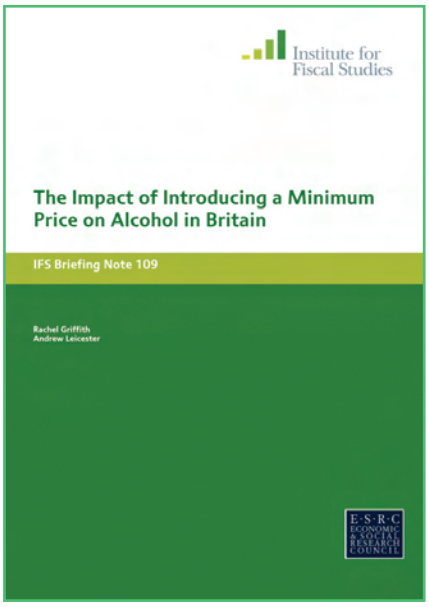
IFS Report

It is possible that some opposition Members were influenced by a report from the prestigious and influential Institute of Fiscal Studies (IFS), which concluded that minimum pricing is not such a good idea after all, and that increasing alcohol taxes is to be preferred as a measure to prevent alcohol harm.

IFS researchers estimate that if minimum pricing of 45 pence per unit was rolled out across Britain it could transfer £700 million from alcohol consumers to retailers and manufacturers. This contrasts with increases in alcohol taxes, which largely result in transfers to government in the form of much needed tax revenue. In the long-term, it would be desirable to restructure alcohol taxes so that they were based on alcohol strength, thus allowing the tax system to mimic the impact of a minimum price but ensuring the additional revenues went to the Government rather than firms.

The figure below shows the estimate of the total transfer to different retailers, though some of the gains would likely be shared with alcohol manufacturers. The largest beneficiaries are those stores which sell the most alcohol:





the supermarket chains Tesco, Asda and Sainsburys. In relative terms, the biggest beneficiaries are stores that sell alcohol most cheaply: the discount retailers Lidl, Aldi and Netto. Those stores which do not sell much cheap alcohol – Waitrose and Marks and Spencer – gain relatively little.

Percentage figures show the relative change in alcohol spending by store following a 45p per unit minimum price
Note: bars show change in alcohol expenditure by store after the introduction of a 45p per unit minimum price, assuming all households have a common own-price alcohol elasticity of demand of -0.5 and that stores increase prices below the minimum to the minimum but do not change any other prices. Percentage figures are the increase relative to pre-policy store alcohol expenditure.

The other main findings of the research are:

- Almost 85% of off-licensed alcohol units sold for less than 45p in 2007, including 91% of lager units, 90% of cider units and 87% of spirits units. Only 9% of alcopop units sold below this price.
- The average unit of cider sold for only 25p, compared to 33p for lager and 69p for alcopops.
- 80% of those with incomes under £10,000 per year bought alcohol during 2007, compared with 95% of those with incomes above £70,000. However, low income households bought cheaper alcohol: those on under £10,000 paid 33p per unit on average compared to 41p for those on more than £70,000.
- Assuming that all households reduce their alcohol demand by 5% when prices rise by 10%, the off-licensed alcohol consumption of those on less than £10,000 would fall by 25% following the introduction of a 45p per unit minimum price. The fall would be 12% for those on more than £60,000.
- Households that purchase a lot of alcohol not only buy more units but also buy cheaper units. Those buying less than 2 units per adult per week on average pay more than 40p per unit, compared with 32p per unit for those buying more than 35 units per adult per week.
- The structure of alcohol taxes is governed by European Directives that mean it is not possible at present to tax the number of units directly for wine or cider, but it is possible for beer and spirits.
- Current implied taxes per unit are 17.3p for beer and 23.8p for spirits. However, a 75cl bottle of 9% strength wine is effectively taxed at 25.0p per unit whereas a bottle of 14% strength wine is taxed at only 16.1p per unit. It would be desirable to change this so that all alcohols could be taxed according to the number of units.

The response to minimum pricing would probably be complex. Different consumers would respond to different extents, including substituting alcohol purchases towards pubs and bars which would be less affected by a minimum price. Retailers could change the price of alcohol currently sold above 45p per unit and change non-alcohol prices. Manufacturers could switch production into more expensive, higher quality products. Estimating the impact of these wider responses would require a more detailed model of behaviour.

"The impact of introducing a minimum price on alcohol in Britain" by Andrew Leicester and Rachel Griffith available on the IFS website: www.ifs.org.uk.

Front cover reprinted with kind permission of the Institute for Fiscal Studies

Facebook updates alcohol guidelines

Facebook, the global social networking service, has updated its advertisement policy guidelines with significant new restrictions to advertisements for or depicting alcohol. All alcohol advertisements must now be targeted by country; they cannot target any users in a set of predominantly Middle Eastern countries but also Norway, and they are not permitted to use any approach that misleads users into thinking that alcohol is healthy, suitable for minors, or a contributor to success.

The new guidelines appear to be an attempt by Facebook to conform to local laws and regulations regarding alcohol advertising, something they have been criticised for not doing previously. They essentially restrict alcohol brands' access to the consumers based on the information the consumers have provided in their profile. This should restrict the alcohol industry's ability to target underage drinkers.

Facebook was launched in February 2004 and is operated and privately owned by Facebook, Inc. It was founded by Mark Zuckerberg when he was a college student at Harvard with some of his college roommates. The website's membership was initially limited to Harvard students, but it was expanded to other colleges in the Boston area, the Ivy League, and Stanford University. It gradually added support for students at various other universities before opening to high school students, and, finally, to anyone aged 13 and over.

As of July 2010 Facebook had more than 500 million active users, approximately one person for every fourteen in the world. The sheer scale of the service makes it a potentially powerful influence, especially among young people. Users utilise the service to create a personal profile and to interact with others, adding other users as friends and exchanging messages. Additionally, users may join together with others to form common interest user groups, such as those based on workplaces or schools.

The biggest change to the alcohol policy is that previously Facebook required that all alcohol advertisements that targeted a country comply with age restrictions of that country, or operate an age 21 and over restriction if there was no specific age requirement for that country. However, advertisers could circumvent this guideline by not targeting a specific country. Now, all alcohol advertisements must include country targeting.

In terms of content, alcohol advertisements can no longer depict anyone who is or who appears to be under the age of 25. Before, advertisements simply could not depict anyone under the legal drinking age of the country where they were shown.

Regardless of a user's age, alcohol advertisements can no longer be targeted to Afghanistan, Brunei, Bangladesh, Egypt, Kuwait, Saudi Arabia, United Arab Emirates, Yemen, and Norway, "or any other market where such advertisements are prohibited."

Additional new guidelines prohibit portraying abstinence from alcohol negatively; depicting alcohol as "causing or contributing to the achievement of personal, business, social, sporting, sexual or other success"; or suggesting alcohol has medical benefits. Some new guidelines also include prohibiting association of alcohol consumption with sports, or other hazardous activities; or with "violent, dangerous or antisocial behaviour." Alcohol ads must now also comply with local industry guidelines, and advertisers must list a "permanent address if required by local law."

Below is the full text of Section 10 "Ads for Alcoholic Beverages" from the September 1st revision of Facebook's ad guidelines. All additions since the June revision to the guidelines are shown in bold.

1. Ads for Alcoholic Beverages
    1. To the extent permitted by law and these

guidelines, ads may only be targeted to the following age groups:

1. **25 years or older in India and Sweden;**
2. 21 years or older in US;
3. **20 years or older in Japan;**
4. 19 years or older in Canada;
5. **18 years or older in Australia, Denmark, Finland, France, Italy,** Ireland, **Germany, Greece, Malaysia, Netherlands, Singapore, Spain, Turkey** and the UK; **or**
6. 21 years or older in any country not listed above.

2. All ads must:
    1. Be age and **country targeted** (where a user's age or country cannot be determined, the ad cannot be displayed to the user in question);
    2. **Comply with all local required or recommended industry codes, guidelines, notices and warnings, licenses and approvals; and**
    3. **List your permanent address if required by local law.**
3. No ads may ever:
    1. Include content (including but not limited to celebrities, characters, imagery, or the depiction of situations) that is intended to appeal to anyone younger than the permissible targeted age group or is otherwise associated with youth culture (this could include, by way of example only, implying that the consumption of alcoholic beverages is fashionable or the accepted course of behavior for those who are underage);
    2. **Portray or be targeted at pregnant or nursing women;**
    3. **Contain ad creative that includes any person that is or appears to be under the age of 25 or is otherwise suggestive of the presence of anyone younger than the permissible targeted age group;**
    4. Be untruthful or misleading about alcoholic beverages, their use, effects or properties;
    5. Portray people consuming or encourage people to consume alcohol rapidly, in excess, or irresponsibly;
    6. **Portray abstinence from alcohol consumption or moderate alcohol consumption negatively;**
    7. Portray or promote intoxication or make references to the intoxicating effects of alcohol;
    8. Portray the strength of the alcoholic beverage being advertised as positive property;
    9. **Portray the consumption of alcoholic beverages as causing or contributing to the achievement of personal, business, social, sporting, sexual or other success;**
    10. **Portray alcoholic drinks as being healthy, offering medical or therapeutic benefits, aiding relaxation, alleviating individual or collective problems, or having other benefits;**
    11. **Associate the operation of any vehicle or engagement in any sport or potentially hazardous activity as having taken place during or after the consumption of alcohol;**
    12. **Associate violent, dangerous or antisocial behavior with the consumption of alcohol;**
    13. Promote any alcoholic beverage tastings, giveaways of alcoholic beverages, or other giveaways as a reward for purchasing alcoholic beverages;
    14. **Advertise any beverage with more than 22% alcohol by volume if targeted to users in Finland; or**
    15. **Target any users (irrespective of age) in Afghanistan, Brunei, Bangladesh, Egypt, Kuwait, Norway, Saudi Arabia, United Arab Emirates, Yemen or any other market where such ads are prohibited.**
4. It is recommended that all ads contain text that promotes drinking responsibly (for example "Drink Responsibly", "Drink Smart" or other similar text customarily used in the targeted market).

To learn more about Facebook advertising and the policies that govern it, check out the Facebook Marketing Bible – the most comprehensive resource for Facebook advertisers and marketers anywhere.

Facebook has also stripped out the portion of the guidelines regarding its Demographic Restrictions for Pages, but Platform ads still must use FMBL tags to restrict those underage from seeing alcohol content or ads. Advertisers must follow these and all other parts of Facebook's ad guidelines or their ads may be rejected or removed.

Eurocare Presses for Ingredient Labeling on Alcohol

The European Commission has adopted a proposal on the provision of ingredient labeling on food products but despite their potential for harm has exempted beer, wine and spirits from the scope of the proposal. In a communication to MEPs Eurocare takes up the issue.

What is NOT on the label?

EUROCARE (The European Alcohol Policy Alliance) calls upon the European Institutions to place the protection of European citizens' health above the economic interests of the alcohol industry.

The European Parliament and the Council are currently debating the Commission's proposal on the **"Provision of Food Information to Consumers". Unlike soft drinks and juices; beer, wine and spirits have been exempted from the obligation to list ingredients and provide nutritional information.**

Consumers have the right to be aware of the ingredients contained in beverages. Many alcoholic drinks are high in calories and certain ingredients can cause allergies or intolerances.

Allowing the alcohol industry to not provide information on the labels of their products is yet another missed opportunity for reducing alcohol-related harm in Europe.

Alcohol producers should provide information not only on ingredients, but also about the risks associated with alcohol consumption: damages to health (liver cirrhosis, cancers) risk of dependence, dangers associated with drinking alcohol during pregnancy, when driving, operating machinery and when taking certain medication.

79% of Europeans support having health warning messages on alcoholic beverages. (Eurobarometer, 2010)

Alcohol is no ordinary commodity and trade regulations should recognize its distinction. Labeling should be part of a comprehensive strategy to provide objective information and educate consumers about alcohol.

Eurocare calls upon politicians to include beer, wine and spirits in the 'Provision of Food Information to Consumers' proposal and request health warning messages on alcoholic beverages.

Convergence in teenage drunkenness in Western countries

Levels of drunkenness in school age children are converging across the Western world as the number of teenagers reporting getting drunk rises in Eastern Europe but declines in most countries in Western Europe and in North America.

This is the conclusion of a team of researchers who analysed the results of the Health Behaviour in School-Aged Children Surveys.* These showed a significant increase of about 40% in the mean frequency of drunkenness in all 7 participating Eastern European countries. This increase was evident among both genders, but most consistently among girls. However, the frequency of drunkenness declined in 13 of 16 Western countries, about 25% on average. Declines in Western countries were particularly notable among boys and in North America, Scandinavia, the United Kingdom, and Ireland.

Despite this gender convergence, with few exceptions (Greenland, Norway, United Kingdom boys continued to have a higher frequency of drunkenness in 2005/2006 than girls.

In terms of policy implications, the researchers argue that the convergence indicates that adoption and implementation of evidence based measures to mitigate the frequency of adolescent drunkenness such as tax increases and restricting alcohol access and advertisement should get the same priority in Eastern European countries as in Western countries. Policy measures that might facilitate decreases in drunkenness such as server training and the promotion of alcohol-free leisure-time activities should be reinforced in Western countries. The gender convergence implies that prevention policy should be less exclusively focused on male adolescents.

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Cultural and Gender Convergence in Adolescent Drunkenness
Arch Pediatr Adolesc Med.
Published online October 4, 2010

Table 2. Mean Frequency of Drunkenness Among 15-Year-Olds in 1997/1998 and 2005/2006 According to Gender and Country[a]

	Boys, Mean Frequency			Girls, Mean Frequency		
Country	1997/1998	2005/2006	Change	1997/1998	2005/2006	Change
Eastern European						
Czech Republic	2.12	2.30	+0.18	1.07	1.79	+0.72[b]
Estonia	2.93	4.06	+1.12[b]	1.28	2.38	+1.11[b]
Hungary	2.48	2.80	+0.32	1.07	1.91	+0.84[b]
Latvia	2.97	3.35	+0.38	1.13	2.15	+1.02[b]
Lithuania	1.81	3.91	+2.10[b]	1.13	2.80	+1.67[b]
Poland	2.50	2.84	+0.34	1.10	1.51	+0.41[c]
Russian Federation	1.85	2.57	+0.72[b]	1.40	1.79	+0.39[c]
Total	2.23	3.14	+0.90[b]	1.18	2.11	+0.93[b]
Western						
Austria	3.31	2.99	−0.32	2.42	2.12	−0.30
Belgium	2.00	2.11	+0.11	1.04	1.25	+0.21
Canada	3.18	2.41	−0.77[b]	2.93	2.26	−0.67[b]
Denmark	5.54	4.41	−1.13[b]	4.76	3.89	−0.88[b]
Finland	3.77	3.48	−0.29	3.96	3.03	−0.94[b]
France	1.79	1.85	+0.07	1.11	0.99	−0.11
Germany	2.45	2.10	−0.35	1.74	1.62	−0.12
Greece	1.39	1.32	−0.07	1.08	0.88	−0.19
Greenland	3.60	2.54	−1.06[d]	3.36	2.85	−0.51
Ireland	3.69	2.58	−1.11[b]	2.42	2.10	−0.32
Norway	2.62	1.76	−0.86[b]	2.81	2.05	−0.77[b]
Portugal	1.64	1.44	−0.20	0.63	0.94	+0.31[c]
Sweden	2.72	1.86	−0.86[b]	2.78	1.75	−1.03[b]
Switzerland	1.69	1.93	+0.24	0.95	1.08	+0.14
United Kingdom	4.49	3.22	−1.27[b]	3.91	3.33	−0.58[b]
United States	2.60	1.39	−1.21[b]	1.97	1.29	−0.67[b]
Total	3.08	2.46	−0.63[b]	2.46	2.01	−0.46[b]

[a]Standard errors and other statistics are available on request.
[b]$P<.001$ by t test performed on the down-weighted sample (see "Methods").
[c]$P<.01$ by t test performed on the down-weighted sample (see "Methods").
[d]$P<.05$ by t test performed on the down-weighted sample (see "Methods").

Forty young Europeans murdered every day: new WHO report shows these deaths can be avoided

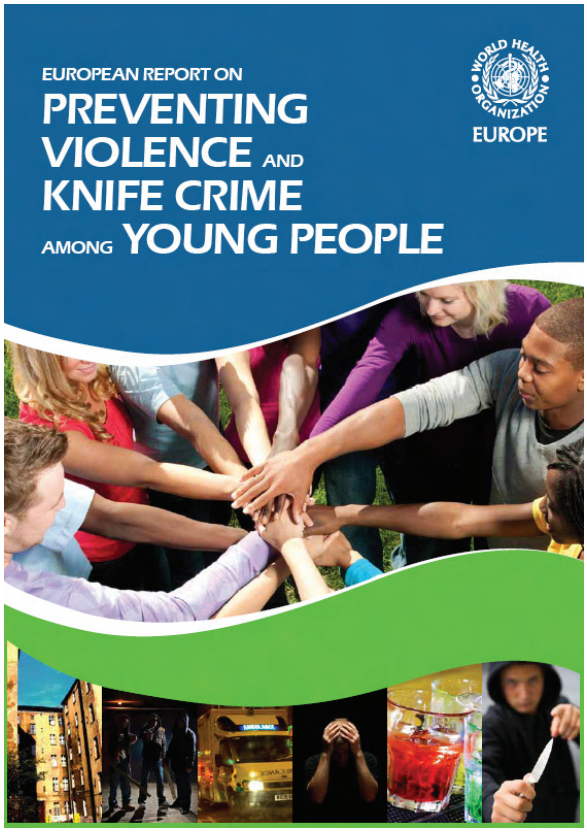
Alcohol and other drugs strongly implicated

Violence claims the lives of 40 young people every day in the WHO European Region – over 15,000 each year – according to a new report from WHO Europe* ; 4 out of 10 of these homicides are perpetrated with knives.

The report on preventing violence and knife crime among young people is the first comprehensive report published in Europe on young deaths from violence and stabbings. It highlights the enormous loss to society from youth violence in European countries and the huge benefits of a public health approach, complementing the criminal justice approach. The report was sponsored by the Department of Health in England and the Government of the United Kingdom.

Violence is spread unevenly

Interpersonal violence is the third leading cause of death in Europe among those aged 10–29 years, accounting for 15,000 homicides yearly. This is only the tip of the iceberg, as estimates suggest that for every young person who dies, 20 more are admitted to hospital. Some 40% of homicides, or 6,000 yearly, are carried out with knives and other sharp weapons. Knife-carrying is relatively common in many countries (up to 12% of young people carry them) and increases the likelihood of serious injury or death. Other means of committing homicide include firearms and strangulation.



Wealth and gender influence violence: 9 of 10 homicides occur in low- and middle-income countries in the Region, and there is a 34-fold difference between the countries with the highest and the lowest death rates. In all countries, irrespective of country income, poorer young people are much more at risk of violence than those who are better off. Males bear a heavier burden than females, with 80% of homicide victims being male.

Causes of violence

Many factors – adverse experiences in childhood, exposure to fear of and forms of violence in schools and the community, association with violent or delinquent peers, alcohol and drug use, and freely available weapons in the community – can increase the risk of being involved in violence and carrying weapons in adolescence. Important contributing factors include: low levels of neighbourhood resources, social capital and income; social inequality; and social and cultural norms that tolerate violence.

The report summarises the links between violence and alcohol and other drugs:

Alcohol use and violence among young people are strongly associated. Alcohol use can directly affect cognitive and physical functioning, reducing

self-control and awareness of risk and increasing emotional lability and impulsivity. This can make drinkers more likely to resort to violence in confrontation and reduce their ability to recognize warning signs in potentially dangerous situations.

The broader links between alcohol and violence are complex and can be affected by a range of individual, situational and sociocultural factors. However, young people who start drinking at an early age, who drink frequently and who drink large quantities are at increased risk of being both perpetrators and victims of violence. Data from the European School Survey Project on Alcohol and Other Drugs for 15- to 16-year-old schoolchildren found a significantly higher prevalence of alcohol-related aggression in countries in which alcohol intoxication was more common (alcohol-related aggression ranged from 1.2% in Greece to 16.0% in Denmark). Drinking alcohol and getting drunk have also been associated with increased risks of weapon-carrying. In Israel, 11- to 16-year-olds who reported binge drinking (drinking five or more drinks in one sitting in the past 30 days) were more than twice as likely to be perpetrators of bullying (in the current school term), four times as likely to have been injured in a fight (in the past year) and almost five times more likely to have carried weapons (in the past 30 days) than non-binge drinkers.

Young people consume considerable alcohol in pubs, bars and nightclubs. The presence of large numbers of alcohol-consuming young people in such environments can mean that they and their surroundings are key locations for confrontation, and individuals who visit them regularly show increased risks of violence. In such settings, the wide availability of glass drinking vessels means that these can be used, often opportunistically, as weapons in violence.

A study of patients presenting to emergency departments with facial injuries in the United Kingdom found that half of assaults involving the use of glasses or bottles as weapons had occurred in a public house and that 97% were alcohol-related (the victim or perpetrator had consumed alcohol in the four hours before the incident). Increases in alcohol consumption among young women are likely to have contributed to an increase in violent offences within this group.

Other drug use

Young people who smoke tobacco or use illicit drugs have an increased risk of being involved in violence. Smoking tobacco is likely to be a proxy for risk-taking behaviour among young people rather than a cause. Although the same can be true for illicit drug use, the pharmaceutical effects of some illicit drugs may make people more vulnerable to violence. Substances such as cocaine and amphetamines have been particularly linked to violence. A study of 14- to 17-year-olds in Belgium, the Russian Federation and the United States of America found that those who smoked or used marijuana or other illicit drugs were more likely to have been a victim of violence (although associations between marijuana and victimization were not significant in the sample in the United States of America). Illicit drugs and violence can also be linked through other mechanisms, including using violence to gain resources to purchase drugs and to control drug trades.

Smoking, using illicit drugs, trying illicit drugs at an early age and engaging in polydrug use (using more than one type of substance) have also been associated with increased risks of weapon-carrying in adolescents). Among schoolboys aged 11–16 years in Scotland, one fifth (20%) of non-drug users reported having carried weapons versus 63% of drug users Among both sexes, the proportion of students who had carried weapons increased with the number of illicit drugs they had used, from 21% of those who had used one drug to 92% of those who had used five or more illicit drugs.

***European report on preventing violence and knife crime among young people. WHO Europe 2010**

Alcohol Monopolies 'Protect Health'

Privatising Sweden's government monopoly on the sale of alcohol will significantly increase alcohol-related violence and other harms, according to a study published in the scientific journal Addiction. Depending on the type of privatisation, experts predict that total alcohol consumption in Sweden will increase by 17 - 37%, with thousands more alcohol-related deaths, assaults, and drunk driving offences per year and up to 11 million more days of sick leave.

Systembolaget, the Swedish Alcohol Retail Monopoly, currently controls the off-premises sale, within Sweden, of all beverages over 3.5% alcohol by volume. The legality of the monopoly has been under scrutiny since Sweden entered the EU in 1995. But dismantling Systembolaget is likely to produce grim consequences. Experts from seven alcohol research centres in Sweden, Finland, Norway, Canada, and the United States considered the effects of two models of privatisation that might one day replace Sweden's monopoly.

In the first scenario, Systembolaget's 400 stores would be replaced by about 800 government-licensed alcohol shops, doubling the number of retail outlets. Compared with Systembolaget's stores, private shops are likely to stay open longer, sell discounted alcohol, sell alcohol to underage drinkers, and use advertising to boost sales, all of which have been shown to increase alcohol consumption. Experts predict that the change to specialty alcohol shops will result in a 17% rise in drinking per person, 770 more deaths per year, 8,500 more assaults, 2,700 more drinking driving offences, and 4.5 million additional days of sick leave.

The second scenario, letting grocery stores sell alcohol, brings even worse consequences. There are currently 8,000 Swedish grocery stores that sell beer with alcohol content below 3.6%. If all of those food stores chose to sell other forms of alcohol, the number of retail outlets in Sweden would increase by a factor of twenty. Like specialty stores, grocery stores would likely involve longer opening hours, lower prices, increased sales to underage drinkers, and promotions and other forms of advertising. In this scenario, experts predict a 37% rise in alcohol consumption, with annual increases of 2,000 alcohol-related deaths, 20,000 assaults, 6,600 drinking driving offences, and a stunning 11 million sick days.

The researchers point out that even though the study was based on the best available evidence, there are considerable confidence intervals involved in this kind of work. Hence, the projections are to be seen as what may plausibly happen, rather than as exact predictions.

Addiction researchers in other nations are watching the situation in Sweden with great interest. According to Professor Thomas Babor at the University of Connecticut (USA), "These findings have implications not only for Sweden, but for all countries where state monopoly systems have been successfully operating since the 1930s. With increasing pressure from the alcohol industry to dismantle or weaken alcohol monopolies in the USA and other countries, it is important to remember the public health benefits of maintaining reasonable controls over the distribution and marketing of alcoholic beverages, and the tremendous risks of removing them."

In the USA, the states of Virginia and Washington are considering ending their state-monopoly sales of spirits at the retail level. Based in part on the model in this paper, co-author Ted Miller estimates that "if either state privatizes its monopoly, spirits sales will rise by 21% and total alcohol consumption by 6%-7%." Miller states that "increased consumption will cause an estimated $50 million per year in harm paid from state coffers (mostly criminal justice costs) and $1 billion per year in total costs. It also will reduce annual state alcohol revenue by $200-300 million."

Norström T., Miller T., Holder H., Österberg E., Ramstedt M., Rossow I., Stockwell T. Potential consequences of replacing a retail alcohol monopoly with a private license system: Results from Sweden. Addiction 2010; 105: DOI: 10.1111/j.1360-0443.2010.03091 <http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2010.03091.x/abstract>

U.S. Senators Tell FDA Alcoholic Energy Drinks 'Unsafe and Possibly Illegal'

Marin Institute campaign makes progress

Senators Charles E. Schumer (D-NY), Dianne Feinstein (D-CA), Amy Klobuchar (D-MI), and Jeff Merkley (D-OR) have joined forces in a recent letter to the U.S. Food and Drug Administration (FDA) calling on the agency to "immediately make public its findings from an investigation into possible health risks posed by so-called 'energy drinks' that combine alcohol and caffeine."

The senators also say that "alcoholic energy drinks appear to be marketed to underage teens, misleading parents and law enforcement by designing labels and containers so the products resemble non-alcoholic energy drinks." The senators want the FDA to complete its investigation and issue a report of the findings to the public.

Back in November of 2009 the FDA announced it was investigating the safety and legality of alcoholic energy drinks. It sent letters to nearly 30 manufacturers of alcoholic energy drinks (also known as caffeinated alcoholic beverages) demanding that these manufacturers produce evidence within 30 days that their products were safe and indicated that the FDA would take appropriate regulatory action, including possible product seizures if these manufacturers could not provide adequate proof of safety. However, to date, no further action has been taken by FDA, which makes the senators' letter all the more important.

The Marin Institute in California has been at the forefront of the fight to get potentially dangerous alcoholic energy drinks off the market and commended the FDA last year for its actions in 2009. The Marin also recently thanked Senator Schumer for his earlier letter to the Federal Trade Commission on this issue. The Marin says it hopes that the addition of three more U.S. senators in this call to action will encourage the FDA to take action to remove these potentially dangerous products from the market place once and for all.

Subsequently, the FDA issued warning letters to four makers of caffeinated alcoholic beverages stating that these beverages *present a public health concern.*

The letter warned the four companies that the caffeine added to their malt alcoholic beverages was an "unsafe food additive" and it said that further action, including seizure of their products, was possible under federal law.

FDA's action follows a scientific review by the Agency. FDA examined the published peer-reviewed literature on the co-consumption of caffeine and alcohol, consulted with experts in the fields of toxicology, neuropharmacology, emergency medicine, and epidemiology, and reviewed information provided by product manufacturers. FDA also performed its own independent laboratory analysis of these products.

"FDA does not find support for the claim that the addition of caffeine to these alcoholic beverages is 'generally recognized as safe,' which is the legal

standard," said Dr. Joshua M. Sharfstein, Principal Deputy Commissioner. "To the contrary, there is evidence that the combinations of caffeine and alcohol in these products pose a public health concern."

Experts have raised concerns that caffeine can mask some of the sensory cues individuals might normally rely on to determine their level of intoxication. The FDA said peer-reviewed studies suggest that the consumption of beverages containing added caffeine and alcohol is associated with risky behaviors that may lead to hazardous and life-threatening situations.

The agency said the products named in the Warning Letters were being marketed in violation of the Federal Food, Drug, and Cosmetic Act (the FFDCA). Each Warning Letter requests that the recipient inform the FDA in writing within 15 days of the specific steps that will be taken to remedy the violation and prevent its recurrence. If a company does not believe its products are in violation of the FFDCA, it may present its reasoning and any supporting information as well.

If the FDA believes that the violation continues to exist, the agency may pursue an enforcement action that could include seizure of the products or an injunction to prevent the firm from continuing to produce the product until the violation has been corrected.

Michigan bans alcohol energy drinks

The Marin Institute's campaign has been given a major boost by the decision of the U.S. State of Michigan to ban alcohol energy drinks.

The Michigan Liquor Control Commission has issued an Administrative Order banning the drinks on the basis of 'a reasonable belief that alcohol energy drinks present a threat to the public health and safety'.

The Order, dated November 2010, states additionally that twenty-nine Attorneys General from across the United States are also of the opinion that consumption of Alcohol Energy Drinks is increasing among college students and underage drinkers and the safety of ingesting a mixture of stimulants and alcohol has not been established.

The Order continues:

In the light of the several public hearings and studies regarding Alcohol Energy Drinks, the widespread community concerns aired by substance abuse prevention groups, parent groups and various members of the public, as well as the FDA's decision to further investigate these products, the Commission believes the packaging is often misleading, and the products themselves can pose problems by directly appealing to a younger customer, encouraging excessive consumption, while mixing alcohol with various other chemical and herbal stimulants. The recent events regarding minors in Washington State and other concerns from emergency room doctors quoted throughout the country have promoted the Commission to take action.

THEREFORE, in order to protect the public health, safety and welfare of the citizens of the State of Michigan, it is the Order of the Commission that all prior approvals and registrations for Alcohol Energy Drinks as listed on the *Products with Stimulants* listing attached as part of this order BE RESCINDED.

FURTHER, that effective 30 days from the date of this Order, Alcohol Energy Drinks shall not be sold or offered for sale in the State of Michigan and these products are banned from sale and distribution in this State unless otherwise approved through Order of the Commission.

FURTHER, all Manufacturers of Alcohol Energy Drinks have thirty (30) days from the date of this Order to remove the Alcohol Energy Drink products from all marketplaces in the State of Michigan in which they are sold.

Curbs on Drinking Limits Harm

The Western Cape province in South Africa through an amendment to the 2008 Western Cape Liquor Act will from 2011 limit on-site consumption sales of alcohol from 11 am to 2 am the next day and off-site consumption sales of alcohol from 9 am to 6 pm, seven days a week. The City of Cape Town (situated within this province) has passed a bylaw that will see even more stringent restrictions coming in from 1st January 2011. City bottle stores will, in addition, be prohibited from trading on Sundays, and on-site consumption sales of alcohol in outlets operating in residential areas will only be allowed up until 11 pm. The Western Cape province and the City of Cape Town are jurisdictions where the Democratic Alliance, the major opposition party in the National Assembly, currently holds the majority of seats in the respective legislatures.

The article below discusses issues related to these policy changes and provides evidence supporting the move towards greater restrictions on alcohol sales. It appeared in the Weekend Argus newspaper in South Africa on 24th October 2010 and has been reprinted with permission.

Professor Charles Parry

Does it make sense to cut back on liquor trading hours in the City of Cape Town? What evidence is there that the city's amended bylaw that will come into effect in January 2011 will have the intended consequences? Among other things the amended bylaw will outlaw bottle stores from selling alcohol on Sundays and will limit off-premise consumption sales on other days to between 9 am and 6 pm. It will also restrict restaurants, taverns and night clubs in residential areas to selling alcohol between 11 am and 11 pm, but premises zoned for business purposes may sell alcohol for consumption on their premises between 11 am and 2 am the next day. Businesses are crying foul, claiming that it will affect their profits and impact jobs. Questions are being raised as to whether this policy will work in an environment where perhaps as many as 80% of liquor outlets are unregulated.

In order to address these legitimate questions it is essential to look briefly at the context in which decisions have been made to reduce liquor trading hours by both the Western Cape provincial government and the City of Cape Town. Contrary to the mantra of the liquor industry that their products are misused by only a small proportion of their customers, the evidence clearly shows this not to be the case. One in four South African drinkers drink at hazardous or harmful levels over weekends, a phenomenon that seems to be getting worse. There is also evidence of increases over time in levels of binge drinking by youth, with past month binge drinking by males in grades 8 to 11 increasing from 29% in 2002 to 34% in 2008. For females the corresponding percentages are 18% and 24%.

In terms of negative consequences alcohol has been shown to be the third largest risk factor for death and disability in South Africa accounting for roughly 7% of all years lost through premature death or years lived with a disability, with the burden coming largely as a result of alcohol's impact on infectious diseases such as HIV and TB, intentional and unintentional injuries, and neuropsychiatric disorders. The cost of alcohol misuse to the public sector has

been conservatively calculated as being in excess of R17 billion per year, with total costs to society estimated to be around 2% of GDP, or roughly R43 billion annually. Research has shown the Western Cape to be particularly burdened by alcohol-related crime and violence, and also by problems associated by foetal alcohol syndrome.

The World Health Organization's draft global strategy has recently been endorsed by health ministers at the May 2010 World Health Assembly in Geneva. This strategy urges the governments to implement evidence-based strategies. One of the most comprehensive reviews of what works in addressing alcohol problems in different countries is contained in the book *Alcohol: No ordinary commodity – Research and Public Policy (2010),* which was a collaborative effort of a group of international alcohol policy experts.

These experts reviewed 42 strategies in terms of evidence for effectiveness, breadth of research support, cross-national testing and other considerations such as the population reach, the target group for the intervention, feasibility of implementation, adverse side effects and cost to implement and sustain. Several strategies were rated highly, including increasing alcohol taxes, lowering blood alcohol concentration legal limits for drivers, making brief interventions available for at risk drinkers, and increasing alcohol testing of drivers. Also included in the top 15 strategies were enforcing restrictions on young people's exposure to alcohol advertising and regulating hours of sale and days of sale. With regard to the latter, there is strong and consistent evidence from several countries that changing the hours or days of trade has a significant effect on the volume of alcohol consumed and on the levels on alcohol-related problems. Most of the research has been on the impact of increasing hours of sale and it has been clearly demonstrated from studies in Australia, Brazil, Canada, Nordic countries, and the USA that when hours and days of sale are increased, consumption and harm increase.

A few studies have also shown that cutting hours and days of trade reduces the consumption of alcohol and leads to reduced alcohol-related harm. A study in Diadema in Brazil, for example, found that a new law mandating on-premise consumption alcohol outlets to close at 11 pm had the effect of reducing murders by 106 per year, or 30 per 100,000 population (approximately 9 per month). Prior to the new law most bars traded 24 hours a day. Diadema is an industrial city of 360,000 persons located near to São Paolo which, like parts of Cape Town, has poor socioeconomic conditions and high levels of interpersonal violence.

Less rigorously controlled studies in Australia and in South Africa have also shown positive effects resulting from cutting back on hours of alcohol sales. For example, in Tennant Creek in the Australian outback, an aboriginal community group successfully mounted a campaign to close off-premise consumption outlets on the days pay checks arrived and to limit bars on Thursdays and Fridays to opening only after 12 noon. Off-premise consumption sales were limited to between noon and 9 pm on other days. Alcohol-related admissions dropped by 34% and admissions to a womens' shelter dropped by almost half.

In Siyahlala, an informal settlement of around 1,300 dwellings in the Brown's farm area of Nyanga, a suburb of Cape Town with the highest murder statistics in South Africa in 2006/7, a broad-based community crime prevention initiative was implemented between May 2006 and June 2007. Over this time crime figures plummeted in Siyahlala from between 5 and 8 murders a month to zero and between 30 and 38 assault cases a month to between 10 and 17. One of the interventions involved getting shebeens to close by 9 pm. The drop in violent crimes correlated closely with the enactment of these early closures and this was backed up by the views of shebeen owners.

With regard to studies of the effects of removing bans on particular days of selling alcohol and reinstating such bans, a study in the US state of New Mexico found that the removal of a ban on Sunday off-premise consumption alcohol sales resulted in a 42% increase in alcohol-related crash fatalities on Sundays. Counties that reinstated the bans experienced a subsequent reduction in alcohol-related crashes to near where they had been before the removal of the ban.

Reducing hours and days for on- and off premise alcohol sales alone will not be a magic bullet by which to reduce the burden of alcohol. However, if Cape Town could achieve even a third the reduction in murders of Diadema in Brazil, i.e. 10 per 100,000 per year, that would result in 350 less murders in the city each year (or 29 per month). Other benefits are also likely, such as reduced traffic accidents. This is not a strategy we should lightly ignore. Yes, there may be a reduction in the profits of establishments selling alcohol, but the rights of such establishments and the rights of consumers to buy alcohol after 11 pm in a residential area or after 2 pm in a business district must be weighed against the duty of the state to protect the broader population from unnecessary harm and economic burden. There may be other negative consequences, for example, people may leave residential areas to find places to purchase alcohol in business areas after 11 and then drive home in the early hours of the morning under the influence of alcohol. Others may buy several drinks just before 11 pm in drinking establishments in residential areas or before 2 am in business areas, and then leave after having consumed several drinks in a short period of time. This problem can, however, be addressed through more roadblocks testing alcohol levels of drivers. The fact is, with the new restrictions on hours of sale, consumption levels will drop and alcohol-related harm of various kinds *will* be reduced.

The success of this particular strategy will, however, require resources to be expended on enforcement – ensuring that liquor outlets do not get away with selling outside of the allowable hours. This will require not only getting the police and liquor inspectors to monitor the behaviour of liquor sellers, but also the support from community members who need to play a role in putting pressure on outlets to comply.

To be really effective in bringing down alcohol-related harm in South Africa we need a focused, inter-sectoral alcohol strategy where the different components (e.g. reduced hours of sale, improved training of liquor sellers, more testing of drivers, and provision of treatment to persons requiring it) complement each other. It will also be essential to monitor the effects of different interventions and report back to the broader public on things like compliance with the new liquor outlet bylaws and indicators of alcohol-related crime (such as murders and drunk-driving fatalities) in order to make changes where necessary and also to facilitate ongoing public support.

Charles Parry is the Director of the Alcohol & Drug Abuse Research Unit at the Medical Research Council and an Extraordinary Professor in Psychiatry at Stellenbosch University. He has recently been appointed to the Board of GAPA.

GAPA Board meets in London

Two new Members were appointed to the GAPA Board at its meeting in London in November.

Charles Parry, Director, Alcohol & Drug Abuse Research Unit, Medical Research Council and Extraordinary Professor, Department of Psychiatry, Stellenbosch University, South Africa, and

Sungsoo Chun, MPH, Ph.D., President, Korean Society of Alcohol Science (KSAS), Executive Director for the International Affairs, Korean Society for Health Education and Promotion (KSHEP), Professor & Chairman, Department of Public Health, Graduate School of Health Science and Welfare, President, Korean Institute of Alcohol Problems (KIAP), Sahmyook University and Editor-in-Chief, Korean Public Health Research

Board Members meeting at Alliance House

Higher density of alcohol outlets related to increased risk of binge drinking and alcohol-related harm

Having a number of off-licenced liquor outlets within walking distance (1 km) of home seems to increase the risk of binge drinking, according to University of Otago researchers in New Zealand.*

The researchers found that people with more off-licences close to their home were more likely to be binge drinkers. Off-licences are places where alcohol is bought for consumption elsewhere, and include supermarkets, liquor stores and convenience stores.

Professor Jennie Connor

As well as this, for each type of outlet (bars/pubs, clubs, restaurants and off-licences), there was a clear association between the number of outlets and the level of harm due to drinking reported by people living within 1km. The types of harm surveyed included effects on performance at work, on relationships, on physical health and finances.

This study used a national survey to assess individual alcohol drinking patterns, and self-reported harm from alcohol. The participants' addresses were then mapped and compared with location of alcohol outlets. The researchers pinpointed the location of all pubs, bars, clubs, restaurants and off-licences in New Zealand and counted the number of each type within 1 km of each participant's home.

"With each extra off-licence alcohol outlet within 1 km, the odds of binge drinking increased by about 4%," says study lead author, Professor Jennie Connor of the Department of Preventive and Social Medicine.

Although a 4% increase doesn't sound like much, Professor Connor points out that, compared with five off-licences in an area, having 15 means 48% more binge drinking and a 26% increase in alcohol-related harm.

"This is an important finding considering that national alcohol policies are currently under review. We need to rethink the ease of obtaining liquor licenses and how many alcohol outlets are appropriate," says Professor Connor.

Dr Marion Poore, Medical Officer of Health in Dunedin, agrees:

"Turning around New Zealand's heavy drinking culture is a whole of community issue. Citizens should ask new Councils to act now, by developing local alcohol plans that limit the number and location of outlets. The challenge for Local Government is how to balance the overall wellbeing of the community with the perceived economic benefit from an increasing number of outlets."

The researchers say that while this study cannot prove that increased outlet density causes these problems, it does demonstrate that the link seen in international research is also found in New Zealand. Other characteristics of the people and neighbourhoods have been taken into account, making it less likely that the findings have an alternative explanation.

"It is very likely that outlet density is making a contribution to harm, and it is an area where better policy could improve health and a range of social problems," concludes Professor Connor.

*Higher density of alcohol outlets related to increased risk of binge drinking and alcohol-related harm *Journal of Epidemiology and Community Health.* November 2010

Children supplied alcohol by others 6 times more likely to binge drink

Children who are supplied with alcohol by people other than parents are more likely to drink and to consume larger amounts. This has been shown in a study, the results of which have been released by the Australian Drug Foundation (ADF).

"We know that when young people binge drink, they are more at risk of harms such as sexual assault, injury or even death. It can also set children up for a lifetime of heavy drinking," said John Rogerson, CEO, Australian Drug Foundation. Mr Rogerson reminded parents that most states and territories still allow any person to provide alcohol to children without parental consent or knowledge. The Australian Drug Foundation says an effective measure to protect children is a law that puts parents in control of their children's drinking.

Mr Rogerson pointed to best practice laws in place in Queensland and Tasmania that penalise the reckless and irresponsible supply of alcohol to people under 18 years without parental consent.

John Rogerson

"We believe children in Victoria, South Australia, the ACT, Western Australia and the Northern Territory are at greater risk of alcohol-related harms without this legislation," stated Mr Rogerson. "Medical researchers advise that alcohol can cause irreparable damage to the developing brain and children should be encouraged to delay drinking. We need stricter laws to protect our children from the harms associated with drinking alcohol, particularly as adolescence is such a critical time for brain development."

The Australian National Health and Medical Research Council have reported that adolescents are at an increased risk to alcohol-related harms due to their smaller physiques, preferences or drinking spirits and lower alcohol tolerance.

"Many people don't realise that a teenager's body just can't handle alcohol the way that a fully developed adult can, which leaves them vulnerable to more harm," said Mr Rogerson.

Deakin University's School of Psychology is due to release a paper on these findings in the coming months. Researchers from the University surveyed 3668 students from 231 schools across Victoria, Queensland and Western Australia, aged 10-14 years, as part of the Healthy Neighbourhoods Project. The study investigated the factors that influence underage drinking and sources of alcohol supply.

Key findings include:

- Children who get alcohol from people other than parents are up-to six times more likely to binge drink.
- Children living in 'more disorganized' communities (e.g. higher levels of graffiti, crime, drug selling) are
  - o More likely to be given alcohol by people other than their parents
  - o More likely to binge drink.
- Adolescents reporting the presence of family conflict are more likely to obtain alcohol from a person other than a parent
- The more friends a child has who drink alcohol, the more likely that child is to obtain alcohol from people other than a parent.

In response to the findings of the new study, The Australian Drug Foundation is calling on concerned parents, politicians or members of the community to visit www.adf.org.au and register their support for a law prohibiting the provision of alcohol to children without the knowledge and consent of their parents.

As part of the campaign the ADF is circulating a letter to concerned parents seeking their support.

australian drug FOUNDATION
Healthy people. Strong communities.

Dear Parent,

Are you concerned about your child drinking alcohol? You have every right to be. Australian research shows that 90 percent of kids under the age of 15 have tried alcohol and one in six students aged 16-17 years is drinking at harmful levels.

Why should you be concerned?
Research suggests young people's brains can be seriously damaged from drinking alcohol. There is now evidence to suggest that binge drinking destroys the developing brain's ability to relay messages between cells. We also know that the brain doesn't stop developing until the age of 25 years.

Drinking contributes to the three leading causes of death among adolescents – unintentional injuries, homicide and suicide. This is something we have the power to prevent.

What can you do?
As a parent, you are the most important role model for your child. Your attitude to alcohol and personal behaviour will have a big influence on your child and the decisions they make:

- *Talk to your child and be involved in their life* – if you know what is going on and can talk openly, you are more likely to be able to influence your child's attitude towards drinking.
- *Know where your teenager is* – check where the parties are going to be, whether they are supervised and if alcohol is being served.
- *Talk to other parents* – presenting a united front makes it easier for everyone.
- *Use alcohol responsibly yourself and be a responsible host.* Show your children that you can also have fun without alcohol too.
- *Encourage your child to delay their drinking until at least 16 years old.*
- *Point out the risks* – don't be afraid to disapprove of unsafe drinking behaviour.
- *Inform yourself* – log onto **www.adf.org.au** for more information.

What are we doing?
In most Australian states and territories, it is still *legal* for anybody to provide your child with any amount of alcohol on private property, without your permission. Without the right laws in place, there is nothing to protect young people against drinking a damaging amount and drinking without parental consent.

In Queensland, New South Wales and Tasmania, it is illegal to supply alcohol to kids under the age of 18 without a parent's permission. We believe the protection of young people in those cases should be extended to all young Australians regardless of where they live.

The Australian Drug Foundation is campaigning to strengthen Australia's laws to protect young people. Register your support for all states and territories to adopt this law at **www.adf.org.au**

Yours sincerely,

John Rogerson CEO
Australian Drug Foundation

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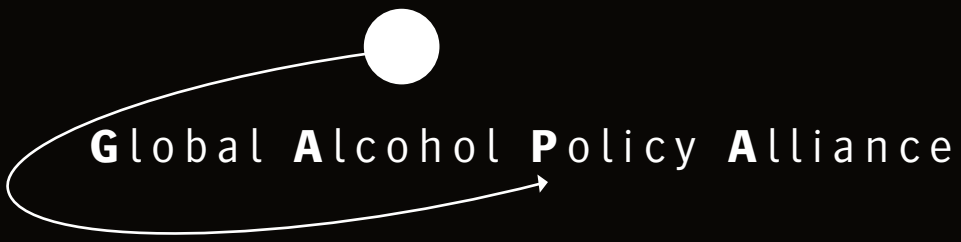

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