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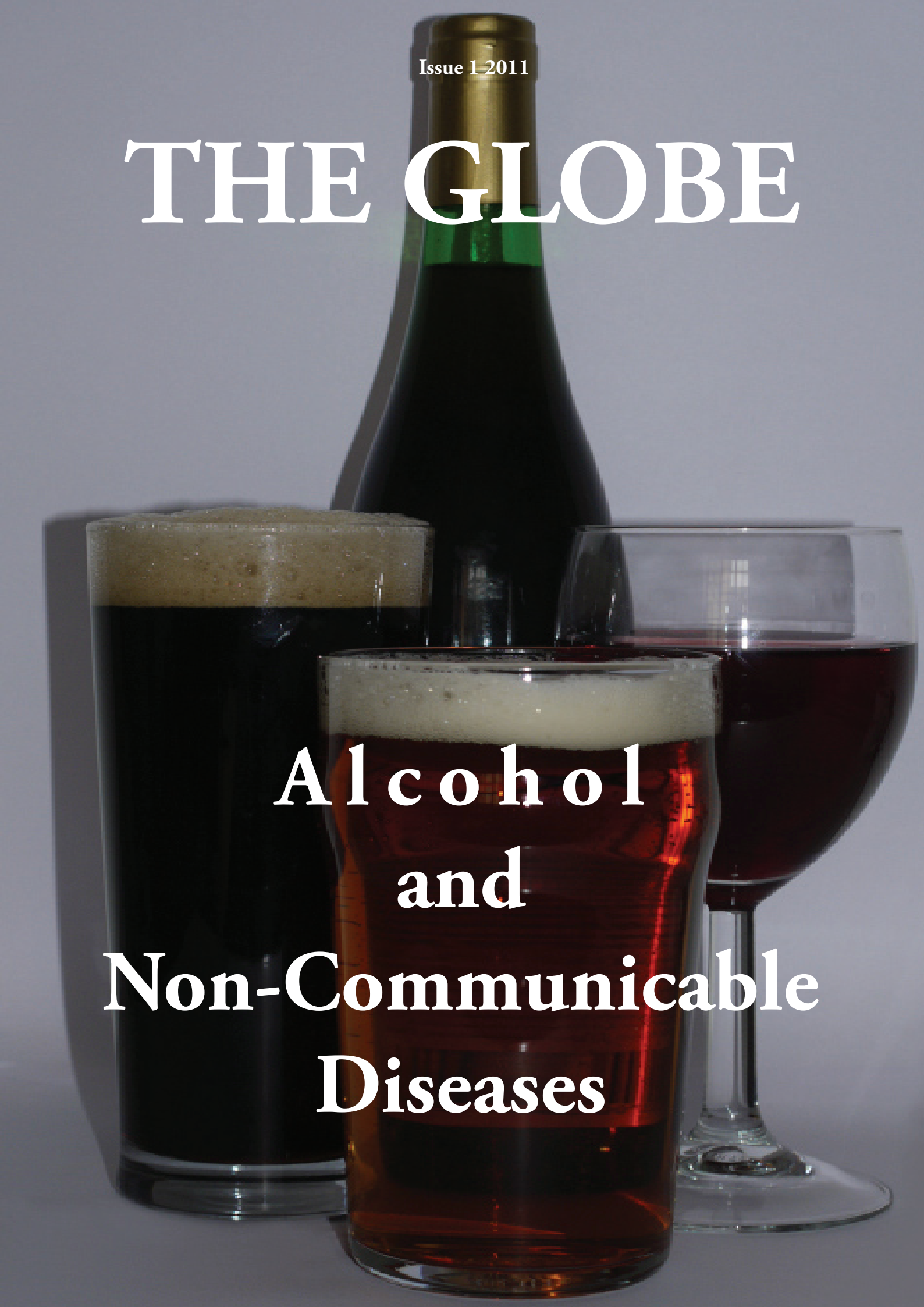
THE GLOBE



Alcohol and Non-Communicable Diseases

THE GLOBE

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As we go to press we have received a publication from the National Institute of Mental Health & Neuro Sciences, Bangalore (NIMHANS) entitled "ALCOHOL RELATED HARM: Implications for Public Health and Policy in India". This will be featured in the next edition of The Globe.

Action needed to reduce health impact of harmful alcohol use

The latest edition of the *Global status report on alcohol and health* has been published by the World Health Organization (WHO). It analyses available evidence on alcohol consumption and provides data in over 100 individual country profiles.

The WHO says that wider implementation of policies is needed to save lives and reduce the health impact of harmful alcohol drinking. The *Global status report* explains that, worldwide, harmful use of alcohol results in the death of 2.5 million people annually, causes illness and injury to many more, and increasingly affects younger generations and drinkers in developing countries.

Harmful use of alcohol is defined as excessive use to the point that it causes damage to health and often includes adverse social consequences.

"Many countries recognize the serious public health problems caused by the harmful use of alcohol and have taken steps to prevent the health and social burdens and treat those in need of care. But clearly much more needs to be done to reduce the loss of life and suffering associated with harmful alcohol use," says Dr Ala Alwan, WHO Assistant Director-General for Noncommunicable Diseases and Mental Health.

The report also recognises that there is a broad range of people adversely affected by the drinking of others. It presents Australian data to show that around 1% of the population was hospitalized due to another person's drinking in the course of a year, and about the same proportion suffered a domestic assault related to alcohol, according to

Dr Ala Alwan

police records. But much larger numbers report being negatively impacted by somebody else's drinking in the workplace, household or public place, and by a family member, friend, stranger or someone not well known to the victim. More than two thirds of the survey respondents were adversely affected by someone else's drinking in the last year. The drinking of a stranger negatively impacted a total of 10.5 million people.

Range and magnitude of alcohol's harm to others in Australia in 2008

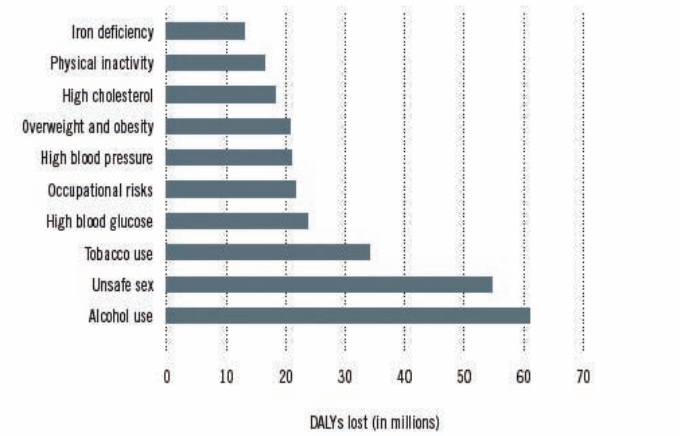
Records based	
Deaths due to another's drinking	367
Hospitalizations due to another's drinking	13 699
Substantiated child protection cases involving a caregiver's drinking	19 443
Alcohol-related domestic assault in police records	24 581
Alcohol-attributable assaults in police records	69 433

Survey based	Affected a little	Affected a lot
Negatively affected by a co-worker's drinking	496 700	120 400
Had one or more children negatively affected by the drinking of a caregiver	888 100	210 700
Negatively affected by the drinking of a household member, relative or friend	2 905 000	1 294 500
Negatively affected by drinking of a stranger or someone not well-known	5 463 900	617 100
Any negative effect of a stranger's drinking	10 536 400	—

Source: Laslett et al., 2010.

The report presents evidence that, measured in terms of Disability Adjusted Life Years (DALYs), alcohol is the leading global risk factor for 15-59 year olds.

DALYs lost attributable to 10 leading risk factors for the age group 15-59 years in the world, 2004



Health implications

Harmful use of alcohol has many implications on public health.

- Nearly 4% of all deaths are related to alcohol. Most alcohol-related deaths are caused by problems resulting from injuries, cancer, cardiovascular diseases and liver cirrhosis.
- Globally, 6.2% of all male deaths are related to alcohol, compared to 1.1% of female deaths. One in five men in the Russian Federation and neighbouring countries dies due to alcohol-related causes.
- Globally, 320,000 young people aged 15-29 years die annually, from alcohol-related causes, resulting in 9% of all deaths in that age group.

The WHO complains that too few countries use effective policy options to prevent death, disease and injury from alcohol use. From 1999, when WHO first began to report on alcohol policies, at least 34 countries have adopted some type of formal policies to reduce harmful use of alcohol. Restrictions on alcohol marketing and on drink–driving have increased, but there are no clear trends on most preventive measures. Many countries have weak alcohol policies and prevention programmes.

Effective strategies

The Global Strategy to reduce the harmful use of alcohol, endorsed by WHO's Member States in May 2010, promotes a range of proven effective measures for reducing alcohol-related harm. These include taxation on alcohol to reduce harmful drinking, reducing availability through allowing fewer outlets to sell alcohol, raising age limits for those buying alcohol and using effective drink-driving measures.

The Global Strategy also promotes screening and brief interventions in healthcare settings to change hazardous patterns of drinking, and treatment of alcohol use disorders, regulating or banning marketing of alcoholic beverages and conducting information and educational campaigns in support of effective policy measures.

Consumption

Worldwide consumption in 2005 was equal to 6.13 litres of pure alcohol consumed per person aged 15 years or older, according to the report. Analysis from 2001-2005 showed countries in the WHO Americas, European, Eastern Mediterranean and Western Pacific regions had relatively stable consumption levels during that time; but marked increases were seen in Africa and South-East Asia during the five-year period.

Despite widespread consumption, most people do not drink. Almost half of all men and two-thirds of women did not consume alcohol in 2005, according to the latest information made available in the report. Abstention rates are low in high-income, high consumption countries, and higher in North African and South Asian countries. But those who do drink in countries with high abstention rates consume alcohol at high levels.

Reducing harmful use of alcohol worldwide

The launch of the Global Alcohol Report coincided with the end of a four-day meeting of officials from over 100 countries working with WHO to reduce harmful use of alcohol worldwide. This first such meeting, hosted by WHO in Geneva, was held to initiate implementation of the Global Strategy to Reduce the Harmful Use of Alcohol. The strategy aims to raise awareness of the problems of harmful alcohol use and help countries to better prevent and reduce such harm.

UK GOVERNMENT PROPOSES DEAL WITH DRINKS INDUSTRY TO TACKLE ALCOHOL HARM

IAS and other leading health organisations walk away from 'Responsibility Deal' talks

The Institute of Alcohol Studies (IAS) and other leading health organisations walk away from 'Responsibility Deal' talks.

The IAS, along with several other leading members of the UK health community, has refused to sign up to a new government initiative; the Public Health Responsibility Deal for Alcohol (RDA).

The RDA forms part of a wider Public Health Responsibility Deal, which is a partnership between Government, industry and health organisations. The Deal has four networks, covering food, physical activity, alcohol, and health in the workplace. The Department of Health states that in these four areas "there may be opportunities to work more effectively in partnership than through top-down Government intervention".

The RDA is co-chaired by Jeremy Beadles, Chief Executive, Wine and Spirit Trade Association and Professor Mark Bellis, Faculty of Public Health, and is supported by Paul Burstow MP, Minister of State for Care Services at the Department of Health.

Each Responsibility Deal network has developed a series of 'pledges', which are voluntary commitments to be delivered by industry. The alcohol pledges cover product labelling, workplace alcohol policies, unit information at point of sale, education programmes and voluntary marketing codes. Critics of the RDA pledges say that they are not based on evidence of what works, and were largely written by Government and industry officials before the health community was invited to join the proceedings.

The IAS, Alcohol Concern, British Association for the Study of the Liver, British Liver Trust, British Medical Association and the Royal College of Physicians have written to the Secretary of State for Health expressing their deep concerns about this approach to tackling the problem of alcohol harm. Their inability to sign up to the Deal is outlined below:

- The overall RDA policy objective is to 'foster a culture of responsible drinking'. This does not adequately address the need to reduce alcohol-related mortality and morbidity

- The RDA drinks industry pledges are not specific or measurable and have no evidence of success

- The RDA process has prioritised industry views and not considered alternative pledges put forward by the health community

- The scope of the RDA is extremely limited. It does not tackle issues of affordability, availability or promotion of alcohol, and focuses on voluntary interventions with no evidence of effectiveness

- There is no evidence that we have seen to show that Government is working towards a comprehensive, cross-departmental strategy to reduce alcohol harm, based on evidence of what works, with rigorous evaluation metrics

- There has been no commitment made on what alternative actions Government will take if the RDA pledges do not significantly reduce levels of alcohol-related harm

Katherine Brown, Head of Research and Communications at IAS, comments:

"We cannot endorse a process in which the alcohol industry is invited to co-create and self-regulate health policy. There is clearly a conflict of interest between industry economic objectives and public health goals of reducing alcohol consumption and associated harms.

The IAS will remain independent observers and monitors of this process, whilst putting pressure on Government to develop a comprehensive, evidence-based, cross-departmental alcohol strategy with rigorous evaluation metrics."

EU FOCUS ON ALCOHOL AND CANCER

For the first time in the European Parliament, the Members of the European Parliament (MEPs) Against Cancer (MAC) interest group, hosted a meeting to evaluate the cancer hazards of alcoholic beverages, and the potential impact of this knowledge on alcohol-related policy, in order to address concerns over a lack of public awareness about the carcinogenicity of alcohol.

MEPs, scientists, representatives from cancer leagues in Europe, DG SANCO and NGOs all voiced their support for immediate action to raise awareness about the health risks of alcohol consumption, especially amongst young people, in relation to cancers of the pharynx, larynx, oesophagus, breast and colorectum.

Despite research dating back to 1987 that conclusively indicates the carcinogenicity of all alcoholic beverages, the connection between alcohol and cancer is often not made in consumer's minds. On the contrary, a Eurobarometer report in 2010 found that 1 in 10 European citizens do not know that there is even a connection between alcohol and cancer. The same study also indicated that 1 in 5 citizens do not believe that there is a connection between cancer and the drinks that millions of us enjoy every week.

Dr Robert Baan, from the International Agency for Research on Cancer presented a history of the research into the carcinogenicity of alcohol which identified the first conclusive links between alcohol and cancer in 1987. Volume 44 of the IARC Monographs found there to be 'sufficient evidence for the carcinogenicity of alcoholic beverages in humans. The occurrence of malignant tumours of the oral cavity, pharynx, larynx, oesophagus and liver is causally related to the consumption of alcoholic beverages.' Since 1987, connections between alcohol intake and cancer of the breast, colorectum and liver have also been identified. Indeed, the 2010 monograph identified a relative increased risk for breast cancer for which 'regular consumption of even 18g of alcohol per day the relative risk is significantly increased'. 18g per day is equivalent to just under 2 regular glasses of wine or champagne, 1.3 pints of beer or nearly 6cl of whisky. Likewise, the monographs confirm an increased relative risk in colorectal cancer for regular drinkers of 50g of alcohol per day. Hence the rationale for the European Code Against Cancer to recommend just one alcoholic drink per day for women, and two for men.

MEPs Alojz Peterle, Liz Lynne, Dagmar Roth-Behrendt, Frieda Brepoels, Pavel Poc, Christel Schaldemose and Nessa Childers expressed support for the underlying need for greater awareness among the general public about the dangers of immoderate alcohol consumption. Pavel Poc took the opportunity to inform

From left to right: MEPs Christel Schaldemose, Liz Lynne, Alojz Peterle, and Dagmar Roth-Behrendt

meeting delegates that his Written Declaration on fighting Colorectal Cancer has been endorsed by an overwhelming majority of MEPs. He was fully aware of the important role healthy lifestyle factors such as reduced alcohol consumption played in the prevention of this cancer. MEP Schaldemose was particularly forthright in calling for preventive action; she urged participants to ask themselves if they really wanted to prevent cancer? If so, then solutions can be found to surmount the challenges in increasing awareness.

Various actions are already being taken in member states such as the UK, Denmark and Portugal, especially by cancer leagues, to raise awareness of the dangers of alcohol. Dr Hans Storm, Head of prevention at the Danish Cancer Society shared his experience in trying to change official alcohol recommendations in Denmark.

He underlined the need to work together using evidence-based materials, and to harness political courage to achieve the most effective results. Dr Storm stated that there could be "7% less breast cancers in 2050 with an immediate reduction of female alcohol consumption to 12g/day". Thus, advocating for the guidelines described by the European Code Against Cancer and the IARC monographs are the most effective way to reduce alcohol related cancer incidence and mortality.

Dr Hans Storm

At the European level, the need for clarity of information was called for by Eurocare in the form of labels on alcoholic beverages that would not only specify the percentage of alcohol contained in the drink, but also the number of calories and health warnings.

Pieter de Coninck from the European Commission's Directorate-General for Health and Consumers presented the Commission's work on alcohol and cancer. He focused on the implementation of the EU Alcohol Strategy, adopted in 2006 and running till the end of 2012. Within the Committee on National Alcohol Policy and Action (CNAPA), a body of Member States' representatives, attention has been paid to the link between alcohol and cancer, and possible policy implications have been discussed. Labelling requirements were mentioned as a possible instrument to inform consumers and raise awareness. Labelling as an instrument to inform consumers more broadly has also been discussed in the European Alcohol and Health Forum, a platform for stakeholder action to reduce alcohol-related harm.

The Association of European Cancer Leagues will explore addressing alcohol and cancer risks during the European Week Against Cancer in May 2011, and in working with Eurocare to encourage Member States through the cancer leagues to call for national initiatives on labelling that could provide impetus for European legislation.

Pieter de Coninck

The European Institute for Women's Health also called for action targeted at women to increase awareness about the risk of breast cancer, as well as iterating the need to focus on young people.

Liver experts' consensus: European citizens are drinking themselves to death

New research and measures to tackle societal alcohol consumption were announced at a liver disease conference in Athens, Greece, in December 2010. Severe diseases, such as liver cirrhosis, are growing at an alarming rate and are affecting people at a younger age than in the past. Since a number of current policies have not been successful in addressing health issues linked with alcohol across Europe, liver experts discussed a range of practical solutions to combat alcohol-related illness and death during a monothematic conference hosted by the European Association for the Study of the Liver (EASL).

Liver disease is the main health burden attributable to alcohol and Europe has the highest rate of alcohol consumption in the world (11 litres of pure alcohol per adult per year). One in fifteen adults suffers from serious health conditions because of alcohol consumption - making it the third largest cause of early death and illness after tobacco and high blood pressure. One in seven European adults (aged 15 or over) consume more than 35cl of alcohol/week (men) or 18cl of alcohol/week (women) on average and over one in five report a heavy drinking episode (44cl of alcohol/week) at least once a week.

One of the key issues addressed at the conference was the increasing number of liver deaths resulting from daily or near-daily heavy drinking in the adult population, in addition to binge drinking in young people. Daily drinking carries more than twice the risk of liver damage compared with intermittent drinking once or twice per week. The risk of liver disease becomes significant at approximately 20cl of alcohol/ week (less than half a pint or a small glass of wine per day), and increases dramatically over 40cl of alcohol/week.

Dr Nick Sheron, University of Southampton, UK, commented: "To evaluate the risks effectively, there is a need for the standardisation of alcohol measures across the EU. There remains a widespread misunderstanding amongst consumers of exactly what comprises a unit of alcohol, making it a challenge for patients to accurately understand how their alcohol intake truly affects their health."

Professor Helena Cortez-Pinto, Faculdade de Medicina de Lisboa, Portugal said: "As experts in liver disease, we are keen to see steps being taken in the right direction to stop the health and societal burden excessive alcohol consumption brings. We know that policies which focus on community programmes, information and education have not proved to be very effective. Other approaches are very effective, like those policies that sanction drink driving or availability of alcohol, but they are often not implemented fully. Probably the major reason relates to the power imbalance between the commitments of the alcohol industry and those of health experts."

Professor Helena Cortez-Pinto

The European Alcohol and Health Forum (EAHF) is an important instrument European institutions use in decreasing alcohol related harm. The EAHF's actions are based on its stakeholders' self-imposed commitments to fight the burden alcohol represents as a health determinant to society. As part of the EAHF, healthcare stakeholders have committed to educate their audiences further and undertake more research on the impact of liver disease and other health issues across Europe. All parties involved also expect to see measurable outcomes based on clear commitments from the industry to decreasing alcohol

related harm through responsible marketing and selling and the promotion of safe drinking behaviour.

At the conference, liver experts proposed the reassessment of the concept of alcohol units across Europe by only referring to centilitres of pure alcohol and standardised screening of all patients' alcohol consumption, particularly amongst obese patients who are at greater risk. Additional new research presented at the event sheds light on why alcohol and diet-related risk factors have additive effects in the development of liver disease. Obesity is the most significant factor for determining the risk of cirrhosis and fibrosis progression: heavy drinkers with obesity-associated diabetes are nine-times more at risk of developing liver cancer compared to those without.

Professor Chris Day, Newcastle University, UK, said: "These studies offer new insights into the importance a number of health determinants, not just alcohol, play in predicting the risk of cirrhosis. In relation to this, we should ensure that patients understand that, in addition to drinking, being obese and suffering from diabetes exacerbates their risk of developing not only heart conditions, but also liver disease."

Professor Chris Day

Professor Mark Thursz

Professor Mark Thursz, EASL Vice-Secretary, said: "Clear messages around healthy drinking need to be developed and communicated to the public. The concept of responsible drinking can be dangerous if it refers only to the detrimental psychosocial effects (addiction, drink driving, disorderly behaviour), as drinking to levels that address these issues is still detrimental to the liver and people's health. This is why so many policies have not been successful overall in addressing alcohol's impact on citizen's health so far."

"As one of Europe's key health determinants, alcohol is under-addressed – particularly compared to smoking and obesity. There is a pressing need for the European Institutions to support more comprehensive epidemiological research that will help establish alcohol's true burden on health. Clear economic and legal sanctions - already the case with obesity - with food labelling, and smoking - advertising and public space bans - are also required."

As the leading association of liver experts in Europe, EASL aims to promote increased awareness of the health risk alcohol poses and new research about liver disease. It is also committed to playing a key role in the development of alcohol policies aimed at preventing liver disease.

About EASL

EASL is the leading European scientific society involved in promoting research and education in hepatology. EASL attracts the foremost hepatology experts and has an impressive track record in promoting research in liver disease, supporting wider education and promoting changes in European liver policy. EASL's main focus on education and research is delivered through numerous events and initiatives, including:

The International Liver Congress™ which is the main scientific and professional event in hepatology worldwide.

Medical Evidence 'Shows Drinking Age Should Be 21'

A new report examining the medical evidence argues that the drinking age should be raised to 21.

The report 'YOUNG PEOPLE & ALCOHOL: What does the medical evidence tell us about the legal drinking age in New Zealand?' was commissioned by the pro-family lobby group Family First NZ, and prepared by UK psychologist Dr Aric Sigman.

Dr Sigman argues that alcohol policies and decisions about a legal drinking age should be firmly based on the health and well-being of New Zealand's young people. However, the medical evidence is of global relevance, and Sigman comments that the effects of alcohol on the brains and bodies of young people in New Zealand are the same as they are on young people on the opposite side of the world. And the social consequences are also highly similar.

Sigman shows that a new generation of evidence from a wide variety of medical and biosciences including neurophysiology, genetics, neuropharmacology, molecular neurobiology, forensic pathology, toxicology, hepatology, teratology, epidemiology and developmental psychobiology have brought into sharp relief the full range of new found effects of alcohol on young people.

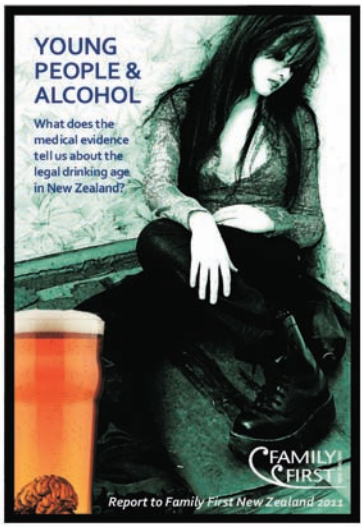
Dr Aric Sigman

> *"A new generation of evidence from a wide variety of medical and biosciences have brought into sharp relief the full range of new found effects of alcohol on young people."*

"New medical evidence on accident probability, disease and brain development makes it absolutely clear that delaying the age at which teenagers and young people have easy access to alcohol will reduce the level of damage they and society suffer at the moment as well as contributing to their future health and well-being," Sigman says.

> *"While children legally become adult at the age of 18, a child's brain doesn't actually reach physical and functional adulthood until they're almost 25 years old."*

He concludes that New Zealand would benefit from adopting a single legal drinking age of 21, even if this is difficult to enforce. "This will send an unambiguous message to young people and society about what is good for young people and will make it easier to exert authority over those of them who increasingly feel entitled to drink."



Family First is welcoming the report which will form part of their submission to the Justice and Electoral Select Committee considering the Alcohol Reform Bill being debated in the New Zealand parliament.

> *"New Zealand would benefit from adopting a single legal drinking age of 21."*

"This report provides compelling evidence that the politicians should immediately increase the drinking age to 21, not for political reasons, but in the best interests of our young people and society," says Family First's Bob McCoskrie.
Dr Sigman is a Fellow of the Society of Biology, an Associate Fellow of the British Psychological Society, and a recipient of the Chartered Scientist Award from the Science Council. He recently addressed the European Parliament Working Group on the Quality of Childhood in the European Union in Brussels.

The Full Report can be downloaded from www.familyfirst.org.nz

ALCOHOL AND NON-COMMUNICABLE DISEASES

Addressing harmful use of alcohol is essential to realising the goals of the UN Resolution on non-communicable diseases (NCDs)

Charles Parry[1] and Jürgen Rehm[2]
[1]Alcohol & Drug Abuse Research Unit, Medical Research Council, South Africa
[2]Centre for Addiction & Mental Health, Canada

Why a GAPA Brief on NCDs?
In May 2010 the UN General Assembly (GA) passed Resolution 64/265 which called for the convening of a high-level meeting of the GA in September 2011 in New York on the prevention and control of non-communicable diseases.[1] This resolution and related documents have stressed the need to recognise the primary role and responsibility of governments to respond to the challenges of NCDs, but also the responsibility of the international community in assisting member states, particularly in developing countries, to generate effective responses.[2] Among the various NCDs, cardiovascular diseases, cancers, chronic respiratory diseases and diabetes have been singled out for attention.[2]

This resolution reflects the growing recognition of NCDs as a major threat to development in developing countries. Furthermore, the resolution is seen as having reframed the global discussion about NCDs into emphasising broader social and environmental drivers of NCDs rather than unhealthy choices made by individuals.[3] It comes with the hope of garnering multi-sectoral commitment and facilitating action on an unprecedented scale to address NCDs.

What is the Brief's purpose?
1. To put forward the case that addressing harmful use of alcohol is essential in moving forward the agenda to meaningfully impact on NCDs by highlighting the strong linkages between alcohol and several of the main NCDs of interest and also to indicate the availability of interventions that have been documented to have an impact on reducing the burden of alcohol on public health.
2. To highlight the relevance of the call made by the World Health Assembly in 2010 for countries to implement effective responses to address harmful use of alcohol and to urge that greater support be given to the WHO to enable it to carry out its mandate in terms of the *Global Strategy to Reduce the Harmful Use of Alcohol*[4] and allied WHO resolutions.
3. To specifically feed into a report being prepared by the Secretary-General of the UN (in collaboration with Member States and WHO) by May 2011 that will serve as input to the preparatory phase for the September 2011 high-level meeting and also feed into an informal interactive hearing with NGOs, civil society organisations, the private sector and academia that is to be held no later than June 2011 and which also aims to provide input into the September meeting.

What is the link between alcohol use and NCDs?
Alcohol has been identified as a leading risk factor for death and disability globally, accounting for 3.8% of death and 4.6% of disability adjusted life years (DALYs) lost in 2004.[5,6] Alcohol was found to be the 8th highest risk factor for death in 2004 (5th in middle-income countries and 9th in high-income countries). In terms of DALYs lost in 2004, alcohol ranked 3rd highest (1st in middle-income countries, 8th highest in low-income countries and 2nd highest in high-income countries). The role of alcohol (and particularly heavy alcohol use and having an alcohol use disorder) in NCDs has been given increasing recognition. For example, at the recent NGO conference in Melbourne on health and the Millenium Development Goals (MDGs) during a session on NCDs, along with tobacco, diet and lack of exercise, *alcohol* was recognised as one of four major common risk factors.[7] In terms of NCDs, alcohol has been particularly linked to cancer, cardiovascular diseases (CVDs) and liver disease. Alcohol has also been clearly linked to mental disorders and in some systems mental health is seen as part of NCDs. However, for the purpose of this Brief we shall not comment on this linkage.[5]

Cancer

- Nine leading environmental and behavioural risks (higher body mass index, low fruit and vegetable intake, physical inactivity, tobacco use, alcohol use, and unsafe sex, urban and indoor air pollution, and unsafe health-care injections) have been estimated to be jointly responsible for 35% of cancer deaths.[6]
- In 2007 the International Agency for Research on Cancer asserted that there was sufficient evidence for a causal link between alcohol and cancer of the oral cavity, pharynx, larynx, oesophagus, liver, colon, rectum, and female breast.[8] All these cancers showed evidence of a dose-response relationship, that is, the risk of cancer increased steadily with greater volumes of drinking.[9]
- The strength of this relationship varies for different cancers. For example, with regard to female breast cancer, each additional 10 g of pure alcohol per day (roughly one standard drink* is associated with an increase of 7% in the relative risk (RR) of breast cancer whereas regular consumption of approximately 50 g of pure alcohol increases the relative risk of colorectal cancer by between 10% and 20%, indicating that the association is stronger for female breast cancer. [9] The relationship of average consumption to larynx, pharynx and oesophagus cancer on the other hand would be markedly higher than the relationship to both breast and colorectal cancer (about about a 100% to 200% increase for an average consumption of 50 g pure alcohol per day).[8]
- Among the causal mechanisms that have been indicated for some cancers is the toxic effect of acetaldehyde which is a metabolite of alcohol.[9]
- Of all alcohol-attributable deaths in 2004, about 20% come from cancer, 19% for males and 25% for females. When considering both the burden from death and disability, cancer is estimated to comprise approximately 9% of all alcohol-attributable DALYs lost, 8% for males and 14% for females.[5]

Cardiovascular diseases (CVDs)

- Eight risk factors (alcohol use, tobacco use, high blood pressure, high body mass index, high cholesterol, high blood glucose, low fruit and vegetable intake, and physical inactivity) jointly account for 61% of loss of healthy life years from CVDs and 61% of cardiovascular deaths. These same risk factors together account for over three quarters of deaths from ischaemic and hypertensive heart disease.[6]
- Chronic, heavy alcohol use has been associated with adverse cardiac outcomes including ischaemic heart disease (IHD), dilated cardiomyopathy, cardiac dysrythmias, and haemorrhagic strokes.[10]
- Alcohol has been identified as the cause of 30% to 60% of cases of patients with new-onset atrial fibrillation, with several causal mechanisms being put forward to explain this association, including increased intra-atrial conduction time, impairment of vagal tone, hyperadrenergic activity during drinking and withdrawal, and direct alcohol cardiotoxicity.[8] Studies vary considerably in terms of the amount of alcohol needing to be consumed and the onset of cardiac dysrhyhmias, ranging from approximately 2 to 5 drinks per day.[9] The detrimental effects of heavy drinking occasions on IHD are consistent with the physiological mechanisms of increased clotting and a reduced threshold for ventricular fibrillation which occur following heavy drinking.[9]
- Of all alcohol-attributable deaths in 2004, about 22% come from CVDs, 23% for males and 18% for females. CVDs are estimated to comprise approximately 9% of all alcohol-attributable DALYs lost, 10% for males and 8% for females.[5] These estimates do not take into account any beneficial effects of alcohol on CVDs. However, it has been estimated that the detrimental effects of alcohol in terms of CVDs outweigh the beneficial effects by a factor of 2.4 (for deaths) and 3.5 (for DALYs), and these benefits typically only occur with low to moderate alcohol consumption (less than 20 g per day) and then only for selected cardiovascular outcomes (e.g. ischaemic heart disease and strokes).[5]

Alcoholic liver disease (ALD)

- Alcohol is associated with various kinds of liver disease, with fatty liver, alcoholic hepatitis and cirrhosis being the most common. The likelihood of developing ALD is a function of both the duration and the amount of heavy drinking.[11]

* In the UK 1 standard drink is 7.9 g of ethanol, in Australia it is 10 g, in South Africa 12 g and in the USA 14g. 12 g is probably the most common mass for 1 standard drink

- For men drinking 30 g of absolute alcohol per day is associated with a RR of 2.8 of dying from liver cirrhosis (7.7 for females). Regarding morbidity, the RRs for males and females for drinking the same amount of alcohol per day were 0.7 and 2.4. For men drinking 54 g of alcohol per day was associated with a relative risk of 2.3 for acquiring liver cirrhosis. For both morbidity and mortality, the RR increases with the volume consumed per day.[12]
- Various mechanisms have been put forward for how alcohol is associated with liver disease, such as the view that the breakdown of alcohol in the liver leads to the generation of free radicals and acetaldehyde which individually damage liver cells.[13,14]
- Of all alcohol-attributable deaths in 2004 about 15% come from liver cirrhosis, 15% for males and 17% for females. CVDs are estimated to comprise approximately 10% of all alcohol-attributable DALYs lost, 9% for males and 13% for females. Alcohol appears to have a greater impact on cirrhosis mortality as compared to cirrhosis morbidity due to the fact that heavy drinking has detrimental effects on the immune system.[5]

Other disease

For pancreatitis a threshold of about 48 g pure alcohol per day has been found, again with increased volume of alcohol consumed per day being associated with increased risk.[15] With regards to diabetes the situation is more complicated. A recent meta-analysis confirmed that there is a U-shaped relationship between the average amount of alcohol consumed per day and the risk of type 2 diabetes.[16] There appears to be a protective effect of moderate consumption of alcohol, particularly among women. Further research appears to be needed to make stronger claims about the negative effects of higher levels of consumption of alcohol and the incidence of diabetes and to allow for greater generalisability of the findings to broader populations globally.

What response is required?

- As part of national efforts to address NCDs, countries need to give priority to implementing the *Global Strategy to Reduce the Harmful Use of Alcohol* approved by the WHA in Geneva in May 2010.[4] Particular attention should be given to implementing evidenced-based strategies that have the potential to reduce the occurrence of heavy drinking episodes and the prevalence of alcohol use disorders that impact on NCDs. Such strategies are likely to include regulating the availability, price and marketing of alcohol and improving the capacity of health services to support initiatives to screen for risk and conduct brief interventions for hazardous and harmful drinking at primary health care and other settings.[17,18,19]
- While there is less evidence to support the efficacy of health education on its own, it nonetheless does seem appropriate that alcohol consumers should be made aware of the risk associated with different levels of drinking and NCDs. Consumers should, for example, be informed that stopping or reducing alcohol consumption will reduce cancer risks, albeit slowly over time.[7]
- Countries must be urged to collect better information on levels of alcohol exposure, e.g. recorded adult (15 years+) per capita consumption in litres of pure alcohol and heavy episodic drinking among adults (15+ years) and alcohol-related harm associated with NCDs (e.g. age-standardized death rates for liver cirrhosis per 100,000 population).[20]
- At a global level support should be given to the WHO to enable it to carry out its mandate in terms of the *Global Strategy to Reduce Harmful Use of Alcoho*l and allied WHO resolutions, in particular with regard to providing technical assistance to low- and middle-income countries to develop and implement policies to reduce the burden of alcohol-related problems; seeing that public health interests regarding alcohol issues are taken into account in global trade agreements, the settlement of trade disputes, and decisions by international development agencies; and ensuring that transnational marketing or major international event marketing does not act against national policies with regard to alcohol advertising and promotion. This needs to come in the form of political support for action and concrete resources to enable WHO to carry out its mandate.
- Opposition from vested interest groups such as the alcohol-beverage industry and associated sectors (e.g. the advertising industry) that benefit from the status quo must be anticipated and countered.[3,7] Addressing the social determinants of NCDs will also require understanding and combating the role of globalisation in promoting such diseases. [21]

Conclusion

Addressing NCDs in countries at all levels of development is now seen as important in ensuring the achievement of MDGs.[21] The way forward is to take concerted and inclusive actions to address the common causes of the most prevalent NCDs. Alcohol has now been recognised as one of four major common risk factors for NCDs. GAPA urges that this reality be factored into documents being prepared for the UN high-level meeting in September 2011.

Not only must the causal association between alcohol use and NCDs be acknowledged, but responses that address the social and environmental drivers of problem drinking must be included in intervention packages that will be highlighted in an Outcomes Statement to be produced at the end of the UN high level meeting. This Statement should be a declaration with clear, binding commitments, measurable targets and long-term agreements and programmes. It should form a clear programme of action for governments, the UN system, and civil society.

The Global Alcohol Policy Alliance (GAPA) is a developing network of non-governmental organizations and people working in public health agencies that share information on alcohol issues and advocate evidence-based alcohol policies.
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GAPA Brief February 2011

Alcohol and public health policies in India

K S Jacob

India is one of the major growth markets for alcohol and there is increasing concern about any commensurate increase in alcohol harm.

Here, K S Jacob argues that both prohibition and the current permissive strategies are counter productive, and he calls instead for a nuanced public health approach to the issue. This paper first appeared in the National Medical Journal of India Vol. 23, No. 4, 2010. Pages 224–5

There is increasing recognition that consumption of alcohol is a major contributor to the burden of disease in India and the developing world, and is indeed a major public health concern.[1,2] The complex relationships between policies, economics and politics of alcohol and public health and between governments, industry and individuals call for a thorough review of the current situation. While public health implications of policies concerning alcohol have long been accepted, the failure to implement many of these policies demands a more balanced and nuanced approach to the problem.

India has experienced social and economic changes since the 1990s. Current trends suggest a steady increase in the production and use of alcohol; these are supported by available data from the organized sector in India.[2] However, a large proportion of alcohol produced in India is illicit and its manufacturing is a 'cottage' industry outside governmental control.[3] Non-commercial alcohol includes traditional beverages brewed using local produce (e.g. rice, wheat, potatoes, molasses and sap from palms and trees) and illicit alcohol spiked with chemicals such as battery acid, urea, ammonium chloride and pharmaceutical medication. The low cost makes it an attractive option for low income groups. The lack of regulation and quality control also leads to mortality and blindness due to methanol poisoning in addition to harmful use and physical morbidity.

Professor K S Jacob

The pattern of consumption of alcohol in India has changed from occasional and ritualistic use to social drinking, and has become an acceptable leisure activity for men.[4] A recent study from Bangalore reported that one-fourth of adult men consumed alcohol.[5] The increase in consumption in urban and semi-urban areas is mainly due to increased and easy availability of commercially produced alcohol. Hazardous drinking has been recorded in subjects from higher educational status and income levels as well as in those from lower socioeconomic backgrounds. Variations in the preference for any particular type of alcohol were related to the socioeconomic indices.[5]

Hazardous patterns of drinking, with excessive and regular use despite major impact on health and functioning, have been linked not only to acute health outcomes (e.g. intentional and unintentional injury, suicide) but also to chronic diseases (e.g. chronic liver disease, neuropsychiatric morbidity, cardiovascular and cerebrovascular disorders and malignancies).[2] Harmful alcohol use also contributes to road traffic injuries and fatalities, violence, occupational, marital and social problems including financial debt.[5] Moreover, harmful use also results in loss of productivity, income and trained manpower. The effects of alcohol aggravate the causes of poverty (e.g. by increasing malnutrition,

absenteeism at work, road traffic accidents and loss of productivity).[1]

On the other hand, the production and sale of alcohol results in substantial excise and sales taxes, which is a major source of revenue for governments. Duties on alcohol constitute nearly one fourth of the budget of some states in India, making it a seemingly attractive revenue-generating option.[6] In addition to the generation of legal revenue for the government, the industry also provides large amounts of non-taxed income (black money) to the economy.

While drinking is portrayed as a consequence of poverty, a detailed study of global consumption suggests that it is also associated with relative affluence.[1] The patterns of drinking are changing rapidly with major changes in economic policies, liberalization, the market economy and growing consumerism in India. The break-up of the traditional joint family system, changes in values and attitudes, including those towards consuming alcohol, have also had an impact on its pattern of use.[5] Cultural and religious controls, which prevented people from drinking alcohol, have been weakening and alcohol use is now seen in all sections of society. Alcohol use is also increasing among groups who were traditionally abstainers such as women, teenagers and the rural rich. The changing economy has brought with it changes in lifestyles and culture.

Election campaigns of political parties often include restrictions on alcohol—a vote winner among women. But these promises are usually not implemented after the formation of government because a complete ban will have a major impact on revenue. High taxation strategies and high cost of alcohol result in the mushrooming of moonshine markets, which lack regulation and quality control and sometimes result in methanol poisoning in addition to loss of revenue to the exchequer. Low taxes, on the other hand, while reducing the demand and supply of illicit alcohol, increase consumption from the organized sector and are associated with increased health risks. The complete ban on the production and sale of alcohol (e.g. prohibition in Gujarat) has resulted in reduced consumption.[7] Though it does not imply that alcohol is not available in the region.[8] The rich and the powerful have easy access while the poor rely on a thriving illicit industry. While the ease of availability is reduced, those who are dependent on the substance will find ways of obtaining it. Extreme policies of prohibition and the current permissive strategies are both counterproductive.

The policies on licensing and restrictions on availability of alcohol, dry days, restricted locations and timings of sales outlets, also have an impact on consumption. Recent trends in sponsorship by the alcohol industry and its sophisticated advertising campaigns, which project successful lifestyles, aim to recruit untapped segments of society. While the alcohol industry is a legitimate operation, its functioning (with minimal checks) results in major health consequences to individuals at risk. The media and mass education campaigns, with their limited budgets, are no match for industry-sponsored promotion.

The statute books have many laws related to alcohol. However, many regulations including those related to drink driving are observed more in the breech with alcohol outlets freely advertising their wares even on national highways. A review of national road safety suggests an increase in road traffic fatalities and the lack of enforcement of drink driving laws and the absence of audits related to new roads and highways.[9] The strict enforcement of laws related to drink driving in the West has led to responsible drinking and responsible driving, which argues for the need for similar implementation in India. Similarly, work-related accidents and absenteeism due to the use of alcohol should be tackled with firm implementation of rules to reduce the loss of productivity and manage alcohol-related problems at an early and reversible stage. There is also a need to support employees who misuse alcohol, and implement policies for prevention of use and promotion of alternative healthy lifestyles.

While psychiatric treatment and rehabilitation do help individuals in quitting the habit, the delay in referral results in seeking help at the end stages of the problem when family, social and financial supports are low and the motivation to quit limited. Early identification of problem drinking at the workplace and by general physicians will pay greater

dividends in breaking the cycle of poor choices.

The only systematic study from India on expenditure related to alcohol, using conservative costs, estimated that while the government spent more every year to manage the direct and indirect consequences of alcohol use than it gained in terms of taxes from the sale of alcohol.[5] While revenue from alcohol appears to help in social and economic development in the short term, it does result in huge costs in the medium and long term.

To view alcohol-related problems as a medical or an individual's issue is to fail to understand the complex dynamics related to policies and politics of alcohol and their impact on individual health and on the consequences of alcohol use. Population and public health interventions have a greater impact on alcohol-related morbidity and mortality than on individual therapy. While holding individuals responsible for their lifestyle choices is crucial, the government cannot abdicate its responsibility and fail to use public health perspectives and approaches, which have a greater impact on the population rates of use, abuse and consequences of excess consumption of alcohol. The enforcement of laws related to alcohol (e.g. drinking and driving) and monitoring alcohol intoxication at work will have a major impact on the consumption of alcohol and on individual health. In addition, personnel and legal departments at the workplace need to implement rules and labour courts should support their enforcement.

India should review policies and support legislation that promote health, prevent harm and address the many social problems associated with the use of alcohol.[10] These should include a broad range of policies and approaches including those related to licensing, taxation, restrictions on availability and purchasing, education and media information campaigns, advertising and sponsorship, laws on drink driving and alcohol-related offences and those related to treatment and rehabilitation. Serious attempts should be made at achieving a balance between economic and political issues related to alcohol current ad hoc policy-making should change to a long term intersectoral perspective and policy. Health perspectives demand increased advocacy to implement public health approaches to reduce alcohol consumption. There is a need to balance regulation by governments, industry and individuals.

The goal of a sustainable and effective alcohol policy can only be achieved by coordinated action by multiple stakeholders. The divergent frameworks used result in confusion and inaction. Multiple agencies including the Ministries of Law, Industry, Agriculture, Revenue, Health, Home, Customs and Enforcement, non-governmental organizations, and medical associations should be involved. Indian society and governments need to take a longer term view of issues and plan a coordinated, comprehensive and balanced approach. While complete prohibition has been shown to be a failure, the current permissiveness without the enforcement of regulations also represents a lack of responsibility from a public health perspective. The WHO's global strategy for alcohol[11] and governmental and non-governmental efforts[12] can be used synergistically to produce sustained action.

CONFLICT OF INTEREST

None declared.

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Calling time: why SABMiller 'should stop dodging taxes in Africa'

Giant UK-based brewer SABMiller, the company that owns Grolsch, is avoiding an estimated £20m of taxes in Africa and India every year - enough money to educate a quarter of a million African children, according to ActionAid's new report, released in November 2010.

The report, 'Calling time: why SABMiller should stop dodging taxes in Africa' reveals for the first time how the company, the world's second biggest brewer, uses a complex system of tax havens to siphon profits out of subsidiaries in developing countries, depriving those governments of significant amounts of tax.

Martin Hearson, a tax specialist at ActionAid and the co-author of the report, said:

"SABMiller conducts its tax affairs behind a veil of secrecy. The company and its subsidiaries siphon money away from African countries and into tax havens in Europe, where the tax rates are far lower. SABMiller is playing the system to avoid paying its fair share of tax in developing countries."

In Ghana, ActionAid found that SABMiller's brewery has paid no corporation tax at all for the last two years.

"The most shocking part of this story is not the huge amounts of tax avoided, but the fact that one woman selling beer outside SABMiller's brewery in Ghana paid more income tax last year than the multi-million pound brewery," continued Hearson.

"SABMiller should stop using tax havens to drain money out of Africa. Instead it should aim to become a market leader for tax justice."

Ghana, along with other developing countries, is trying to develop its tax system to fund essential services including schools and hospitals. The more money it can raise in tax, the less it needs to do to rely on aid to pay for public services. But while small businesses and traders are being brought into the tax system, big companies like SABMiller use their superior resources and multinational structures to find ways of avoiding tax.

One way in which SABMiller avoids tax is by holding valuable trademarks for African beers in Europe rather than in their country of origin. The cost of using the trademarks helps eat into the profits in the African subsidiary, so less tax is paid there.

Other ways of avoiding tax include paying "management fees", mostly to Switzerland, and routing its procurement services via a subsidiary based in Mauritius.

ActionAid has launched a campaign demanding that SABMiller stop using tax havens and that tackling tax avoidance should be a top priority for the company's corporate responsibility programme.

ActionAid also wants SABMiller to make its tax affairs more transparent by publishing a basic set of accounts in every country in which it operates. This would act as a deterrent to tax dodging as companies currently use tax havens in secrecy and with impunity. Hearson concluded: "SABMiller sells billions of pounds worth of beer in Africa alone. Its CEO has even said paying tax is one of the biggest contributions companies can make to developing countries.

"Yet the truth is that SABMiller has avoided paying millions of pounds in tax to some of the poorest countries in the world. This has to change in order to avoid the charge of hypocrisy. Grolsch drinkers are entitled to expect better from a company that claims to be committed to sustainable development."

Preliminary Announcement

Global Alcohol Policy Conference
28 - 30 November 2011
From Global Strategies to Local Action
Bangkok, Thailand

Speakers will include:

Professor Sally Casswell, Director SHORE (Social and Health Outcomes Research and Evaluation), New Zealand

Professor Gerard Hastings, Director of the Institute for Social Marketing and the Centre for Tobacco Control Research, University of Stirling and the Open University, Scotland

Professor Petra Meier, Department of Public Health, The University of Sheffield, England

Professor Charles Parry, Director, Alcohol & Drug Abuse Research Unit, South Africa

Professor Juergen Rehm, Public Health and Regulatory Policy Section, Centre for Addiction and Mental Health, Canada

Professor Robin Room, School of Population Health, University of Melbourne, Australia

Hosted by:

GAPA together with WHO, Thai Ministry of Public Health and Thai Health Promotion Foundation.

Further information is available from:

Secretariat Office (Center for Alcohol Studies)
Soi Satharanasook 6, Ministry of Public Health
Tiwanon Road, Amphur Muang
Nonthaburi 11000 Thailand
Tel: 66 (0) 2590-2376 Fax: 66 (0) 2590-2380
Email: areekul@ihpp.thaigov.net or thaksaphon@ihpp.thaigov.net
Website: http://www.GAPC2011.com

Australia 'fails alcohol test'

More than three and a half million Australians will experience problems of alcohol abuse and dependence during their lifetime but only one in five of these seeks treatment, according to a new study from the National Drug and Alcohol Research Centre (NDARC) at the University of New South Wales. The report, published in the scientific journal Addiction, provides the first ever lifetime estimates of alcohol problems in Australia.

The study, analysing data from the 2007 National Survey of Mental Health and Wellbeing, has found 22 per cent of Australians will have an alcohol use disorder, either alcohol abuse (18 per cent) or dependence (4 per cent), over their lifetime – with nearly a third of men experiencing a problem at some time. Young men were two and a half times as likely to have current alcohol use problems as the rest of the population – with more than 11 per cent of men aged 16 to 24 reporting symptoms consistent with an alcohol use disorder over the previous 12 months.

Lead author of the report, NDARC's Professor Maree Teesson said that Australia has one of the highest rates of alcohol use disorders in the world. It rates on a par with America and New Zealand. She said it was alarming that in the 10 years since the last National Survey of Mental Health and Wellbeing the number with problems remained so high and that there had been no increase in the number receiving treatment.

"One reason for the lack of treatment is that alcohol problems still have a terrible stigma about them," says Professor Teesson. "People are much less likely to want to own up to having a problem with alcohol than they are about other physical or mental illnesses, yet their abuse of alcohol has serious consequences to them personally and around them including getting into fights, drink driving, taking time off work, child neglect, getting into trouble with the Police, and driving while drunk."

Professor Teesson says the alcohol sector needs to learn from the highly successful local and international campaigns that have helped to reduce the stigma around mental illnesses such as depression and which have encouraged people to receive treatment and encouraged prevention of problems before they occur.

"Alcohol problems are most common in young men, so we need better interventions and prevention strategies for young Australians," said Professor Teesson. "People need to know that alcohol abuse which is impacting on their personal, home or work life can be treated."

Professor Paul Haber, Medical Director, Drug Health Services for Sydney South West Area Health Service, said treatment for alcohol problems is generally not readily available to people and requires more funding.

"There is evidence that treatment for alcohol disorders is effective but people are either not confident in the treatment that exists or they simply don't know where, how and when to access it," he said.

The number of women aged 30 to 40 drinking alcohol has increased significantly compared with previous generations but there had been no increase in the number of these women drinking at risky levels. By contrast, there has been a big jump among young men aged 20 to 29 drinking at risky levels.

Disturbingly, 42 per cent of Australians with alcohol problems have at least one co-existing mental illness, such as depression or an anxiety disorder. Yet while close to half of all Australians suffering from depression are being treated, only 22 per cent of people with alcohol related problems receive help.

Key findings from the report:

- A random sample of nearly 9,000 Australians aged 16 to 85 responded to the survey
- 22 per cent of Australians have alcohol disorders over their lifetime – 18.3 per cent experience alcohol abuse and 3.9 per cent are dependent. Only 22.4 per cent with alcohol problems are treated
- One third of men will have a problem at some point compared with 12 per cent of women
- Married people and people from a non-English speaking background are less likely to have a problem with alcohol
- More young women are drinking but no increase is seen in their drinking at risky levels
- Men born between 1978 and 1987 are 1.7 times more likely to drink at risky levels than those born ten years earlier

Teeson M., Hall W., Slade T., Mills K., Grave R., Mewton L., Baillie A., Haber P. Prevalence and correlates of DSM-1V alcohol abuse and dependence in Australia: findings of the 2007 National Survey of Mental Health and Wellbeing. Addiction, 2010; 105: DOI: 10.1111/j.1360-0443.2010.03096.x

No longer a nation of beer drinkers

Beer consumption in Australia has fallen gradually but consistently since the 1960s, while wine and spirits consumption has increased, according to figures released today by the Australian Bureau of Statistics.

At the start of the 60's, beer made up three quarters (76%) of all pure alcohol consumed, but in recent years this has fallen to under half (44%).

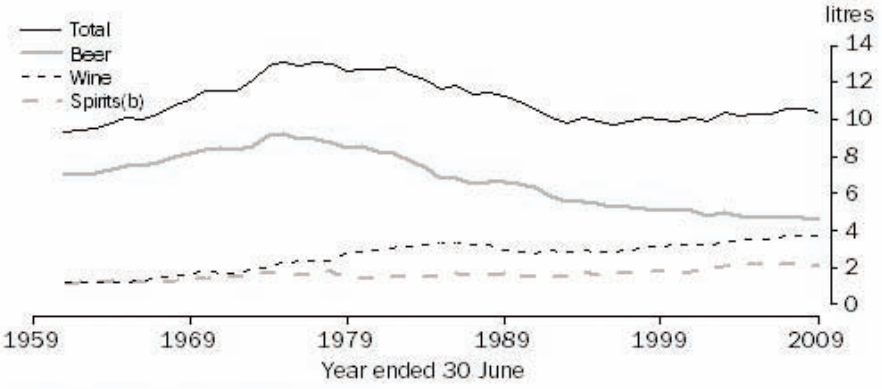
Wine has increased threefold over the same time (12% of all pure alcohol consumed in 1960-61 to 36% in 2008-09) while spirits have nearly doubled (12% to 20%).

In 1960-61 Australians consumed the equivalent of 9.3 litres of pure alcohol per person, climbing to a high of 13.1 litres in 1974-75. Consumption started to fall in the early 80's, hitting a low of 9.8 litres in 1995-96. Since then, it has crept up again to 10.4 litres in 2008-09, which is still a fifth lower than the 1974-75 peak.

In terms of volume, Australia's annual beer consumption increased sharply in the decade after 1944-45, doubling from 77 litres per person to 155 litres in 1954-55. In 2008-09 Australians consumed an average 107 litres of beer. Wine was at its lowest after the war, at only 7 litres per person and has increased to 29 litres in 2008-09.

Further details are available in Apparent Consumption of Alcohol: Extended Time Series, 1944-45 to 2008-09 (cat. no. 4307.0.55.002).

GRAPH 1 APPARENT CONSUMPTION OF PURE ALCOHOL, Per capita(a)



(a) Litres per person aged 15 years and over.
(b) Includes Ready to Drink (pre-mixed) beverages from 2003 onwards.

Changing the alcohol culture in Australia

Alcohol in Australia is often said to be of great cultural importance, and it is used in many celebrations, commiserations and ceremonies. This cultural connection with alcohol is now well entrenched within mainstream Australian society, and alcohol forms a significant element in the Australian sense of national identity.

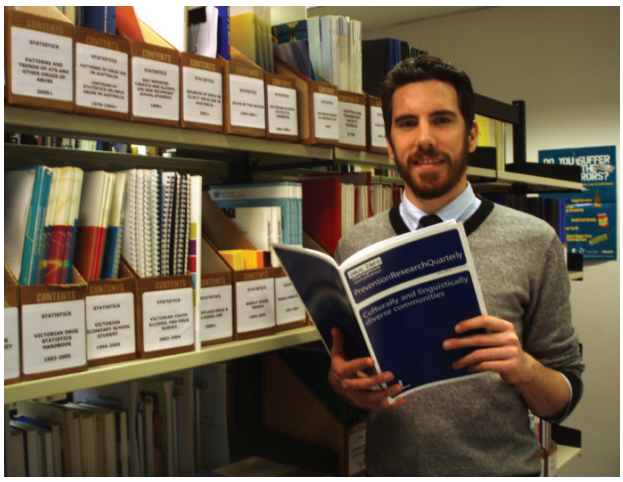
In late 2010 , Clancy Wright, Youth Strategy Officer of the Australian Drug Foundation, undertook a Fellowship, awarded by the Australian Churchill Trust (http://www.churchilltrust.com.au/), to investigate methods for initiating a cultural change around alcohol in Australia by means of legislative reform. He did so by conducting a range of meetings with key organisations and individuals throughout the UK and Ireland.

Here Clancy Wright summarises what he learned from his trip to the UK:

From my investigation I came to understand that three key components are required to achieve the ultimate goal of legislative reform. These are:

Cooperation

Cross sectoral involvement and investment from sectors impacted by alcohol, or whose work influences consumption, to achieve symbiotic outcomes. Such sectors could vary depending on the issue being addressed but could include domestic violence, mental health, childhood development, and housing.



Clancy Wright

Reinvigorated alcohol debate

Changing our approach to the alcohol debate is essential if community support is to be realised. Communities are often ill-informed, unwilling to accept responsibility and out of touch with the real impacts of alcohol. These must be tackled by empowering the community to decide for themselves what, and if, alcohol reform is needed.

Leadership

During my Churchill Fellowship I met with a collection of individuals who best represented the role leaders play in achieving desired outcomes. Leaders are integral to achieving cross sectoral support and provide the mechanism for engaging effectively with specific communities.

Whilst alcohol harms are particularly high in the UK and Ireland and legislative reform has not been achieved there are many lessons from projects and examples Australia could learn from.

The Scottish Alcohol etc. (Scotland) Bill which included minimum pricing for alcohol was passed late last year - but with the exclusion of a minimum price. I watched as the parliament discussed the proposed legislation and whilst the opposition's arguments may have been thin, they unfortunately were representative of the broader Scottish community. A possible generalisation, but one which was echoed by many key stakeholders involved in the push for the pricing reform. The Alcohol etc. (Scotland) Bill obtained quick political support from the ruling Scottish Nationalist Party but little care was taken to educate the public or include and engage relevant sectors outside the alcohol and other drug (AOD) field. Had populous support been garnered and cross-sectoral pressure been

applied the opposition parties would have had a vested political interest to support the legislation. Progressive social legislation will be unlikely to be achieved in the UK, Ireland or Australia until broad community support and subsequent political motivation can be generated.

Community Action Blackburn, is a project funded by Alcohol Focus Scotland but developed, managed and now owned by the Blackburn community. The project was established to assist Blackburn in addressing the levels of alcohol harm in the community. When the project began, community engagement through the form of street-based interviews was difficult and respondents were not engaging. The finger was pointed towards the original project name: Alcohol Action Blackburn. Upon the name change to Community Action Blackburn, and a slightly different approach, the interviewers were able to effectively engage with the community. The exclusion of alcohol, as an issue, from the interviews enabled the interviewees to more comfortably discuss the problems within their community. Subsequently 95% of the problems identified were impact by alcohol. The level of impact varied, however, the Blackburn example, once combined with others, demonstrated a strong community desire to address alcohol harms and impacts but a reluctance to do so under the banner of alcohol.

From this it can be seen that the UK and Ireland have much to teach the Australian AOD sector. Simultaneously, the effective community-based work of Australia would enhance much of the work in the UK and Ireland.

Arguably, one of the most effective and important alcohol projects in Australia was the Living with Alcohol program conducted in the Northern Territory. Implemented in 1992, it included a five cent levy on standard drinks. The levy, too small to result in consumption change, funded an array of community based initiatives to address consumption and harms throughout the Northern Territory. The initiatives focused on treatment, rehabilitation and mass media education programs targeting drink driving and responsible service of alcohol. The Living with Alcohol program resulted in 'reductions in estimated alcohol-caused deaths from acute conditions (road deaths 34.5% other 23.4%) and in road crash injuries requiring treatment (28.3%) '. After four years of implementation of the program, other levies and legislation pertaining to blood alcohol content driving levels were introduced and disturbed the measures of the program. However, and this is particularly relevant to the current discussion in the UK, per capita consumption fell and subsequent harms reduced because the resulting financial gains of an alcohol levy funded programs to address alcohol consumption.

Newcastle, a regional town in NSW, implemented an intervention in 2008 to reduce night-time assaults, including the implementation of a lockout policy for the area. Lockouts relate to the refusal of entry to any patron to a venue after a pre-determined time; the venue will remain open but no patrons can enter or re-enter. Lockouts have been attempted several times in Australia and the Newcastle example is the most effective.

A total of 10 strategies were introduced including:

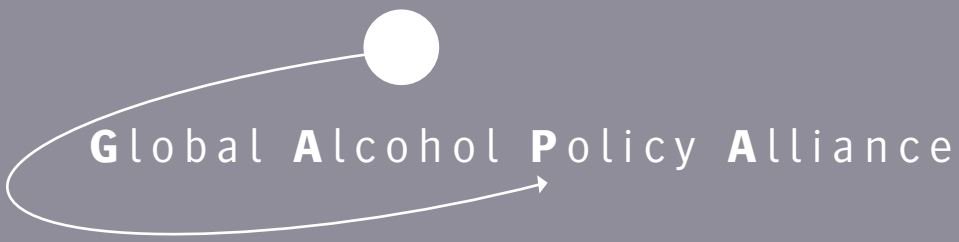
- 1:30am lockout
- earlier closing times
- the restriction of particular drinks
- increased management planning and compliance

As a result there was a downward trend (29%) in night time assaults and a decrease in assaults linked to the 15 venues included in the period, compared to venues within Newcastle exempt from the measures. Importantly there was also no geographical displacement of assaults to other venues exempt from the measures.

Effective programs and models for initiating a cultural change around alcohol exist in different forms in both Australia and the UK and Ireland. At the community level these nations have had mixed results, but an enhanced level of understanding of each others' work and successes would be conducive to more effective cultural change projects now and into the future.

Whilst Australia may be further behind in its work to achieve a legislated minimum price for alcohol, the lessons and examples from the UK and Ireland will assist in the continued development and hopefully the realisation of this goal.

Clancy's full Churchill Fellowship Report can be seen on: http://www.churchilltrust.com.au/fellows/detail/3462/clancy+wright



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