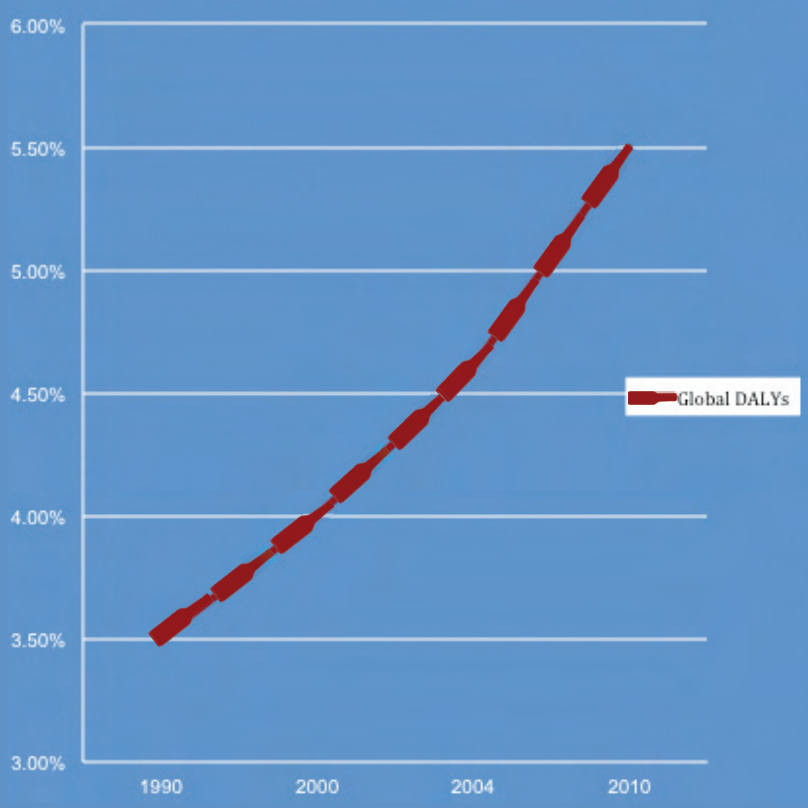
Issue 1 2013

THE GLOBE

Lancet 2010

Global Burden of Disease findings on alcohol:



- Third leading risk factor for death and disability
- Leading risk factor for 15 – 49 year olds
- Proportion of alcohol-related disability adjusted life years lost rising from 3.5% to 5.5% over 20 year period
- Causally linked to 4.9 million deaths

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ISSN 1460-9142

Printed by:
Langham Press Limited
Foxton, Cambridge, England

Alcohol grows as risk factor for death and disability in 2010 GBD Study

On December 14, 2012, *The Lancet* together with the Institute for Health Metrics and Evaluation (IHME) hosted an event at the Royal Society in London to present the findings of the Global Burden of Disease, Injuries, and Risk Factors Study 2010. The launch of the 2010 GBD Study featured discussion of comparable estimates of mortality, causes of death, years lived with disability (YLDs), and disability-adjusted life years (DALYs) for 291 conditions and 67 risk factors, for 21 regions and three time periods – 1990, 2005, and 2010. The results reveal substantial shifts in the burden of disease from children to younger adults, from premature mortality to morbidity and disability, from communicable, maternal, neonatal and nutritional conditions to non-communicable diseases.

The 2010 analysis of 67 risk factors and risk factor clusters for death and disability reported in the special issue of *The Lancet* (Lim et al., 2012) found that alcohol was the third leading risk factor for death and disability accounting for 5.5% of disability adjusted life years (DALYs) lost globally, i.e. 136 million years of life lost through dying early or living with an alcohol-related disability. This is up from the 4.6% reported in 2004 and 4.0% in 2000 (Rehm et al., 2003, 2009), though it should be noted that these percentages are not entirely comparable due to the variations in the methodologies used. The increase is mainly accounted for by including the burden associated with alcohol use on infectious diseases such as tuberculosis and pneumonia. In terms of comparable results, the impact of alcohol use proportionally went up about 30% from 1990 to 2010, and in deaths alone in 2010 alcohol is estimated to be causally linked to 4.9 million deaths globally, up from 3.7 million in 1990.

Various outcomes were linked to alcohol use and heavy drinking including, among others, tuberculosis, lower respiratory infections, various cancers, ischaemic heart disease and ischaemic and non-ischaemic stroke, epilepsy, cirrhosis of the liver, pancreatitis, transport injuries, falls, drowning, poisonings, intentional self-harm, interpersonal violence and alcohol use disorders.

After reworking the data to ensure comparability, in 1990 alcohol was ranked as the 6th leading cause of death and disability. Based on 2010 data, alcohol is ranked 3rd in terms of risk after high blood pressure and smoking. This article, furthermore, indicates that alcohol was the leading risk factor for death and disability in large parts of the world including Southern sub-Saharan Africa, Eastern Europe and most of Latin America. In Southern sub-Saharan Africa alcohol-related road traffic, unintentional and intentional injuries together with alcohol-related tuberculosis played a key role in alcohol contributing so greatly to death and disability. If the impact of alcohol on HIV/AIDS had been included, alcohol-attributable burden in this region would have been even higher.

The *Lancet* article (Lim et al., 2012) also highlights the increasing burden globally caused by non-communicable diseases (NCDs). According to this article, 33% of ischaemic heart disease DALYs lost globally were individually attributable to alcohol. Globally, for persons aged 15-49 years the leading risk factor for death and disability was alcohol use followed by tobacco smoking, high blood pressure, high body mass index, a diet low in fruit and vegetables, drug use and occupational risk factors for injuries. These findings support the call by the World Health Organization for countries to give greater priority to addressing harmful alcohol via evidenced-based population level intervention strategies (World Health Organization, 2010).

Jürgen Rehm and members of the Alcohol Use Expert Group, Global Burden of Diseases, Injuries, and Risk Factors Study will be preparing a detailed

paper on alcohol as a risk factor for death and disability using 2010 data.

References

- Lim, S.S., Vos, T., Flaxman, A.D., et al. (2012). The burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions 1990-2010: A systematic analysis. Lancet, 380, 2224-2260.
- Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., Teerawattananon, Y., Patra, J. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. Lancet; 373: 2223-2233.
- Rehm, J., Room, R., Monteiro, M., Gmel, G., Graham, K., Rehn, N., Sempos, C., & Jernigan, D. (2003) Alcohol as a risk factor for global burden of disease. European Addiction Research 9, 157-164.
- World Health Organization. (2010). Global Strategy to reduce the harmful use of alcohol. Geneva: Author.

Weblinks

- http://www.thelancet.com/themed/global-burden-of-disease
- http://www.healthmetricsandevaluation.org/research/project/global-burden-diseases-injuries-and-risk-factors-study-2010

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Parry and Rehm were co-authors on the Lim et al. (2012) article

'Global health c H

A modest increase in taxes on alcohol and tobacco in countries seriously affected by HIV and TB could generate enough income to cover the costs of antiretroviral treatment, TB treatment and malaria treatment and prevention, as well as reducing the incidence of non-communicable diseases caused by alcohol and tobacco, according to modelling work presented at the 19th International AIDS Conference (AIDS 2012) in Washington DC.

Andrew Hill, of Liverpool University, said that other taxes could potentially raise millions for the global HIV response, as well as for other public health priorities.

Presenting what he dubbed a "Global Health Charge," Hill suggested that a one-US-cent tax per ten millilitres of alcohol (the equivalent of 2 Kenyan shillings per bottle of beer) and a 10-US-cent tax on a pack of 20 cigarettes (8 Kenyan shillings) could generate enough money in 10 of the 20 countries facing the highest burden of HIV not only to fund universal access, but also to spur efforts to fight TB and malaria.

By considering the adult population size; annual alcohol and tobacco consumption; the cost of universal access per person per year (which he pegged at a conservative US$861, a figure that includes

charge' on alcohol and tobacco could cover IV drug costs in 10 countries

treatment, diagnostics, and medical care); and the number of people in need of HIV treatment, Hill showed that, for example, in Kenya alone, US$63 million could be raised annually, paying for 73,000 of the 277,000 Kenyans in need of ART.

If the Global Health Charge were raised only marginally higher in the Kenyan model – up to five cents on alcohol, and 25 cents on cigarettes – universal access could be achieved.

With only a one-cent charge on alcohol, and a 10-cent charge on tobacco, universal access could be funded in Nigeria, Uganda, Botswana, Thailand, Vietnam, India, Brazil, Russia, Ukraine, and China. Implementing such a tax in these countries would raise a total of $2.57 billion a year, allowing 3,011,000 patients to be placed on treatment – with money left over for HIV prevention, TB, malaria, and other diseases.

In Nigeria for example, the tax would raise $1.1 billion – enough to cover the cost of treatment for just over one million people, while leaving $223 million to combat TB and malaria.

In Uganda the tax would raise $259 million – enough to cover the cost of treatment for 281,000 people.

In South Africa, a tax of 3 cents on beer and 25 cents on a packet of cigarettes would raise enough to fund universal access to treatment for South Africa's citizens.

In Cameroon, Ivory Coast, the Democratic Republic of Congo, Kenya, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe, the tax would raise a total of $923 million, enough to provide treatment for 35% of the people still in need of it. Higher tax rates would achieve correspondingly greater coverage.

Hill noted that in low- and middle-income countries, which are disproportionately affected by HIV, tax rates on cigarettes are often far below the 70% rate suggested by the World Health Organization. High-income countries, conversely, which face a relatively low burden of HIV, have much higher tax rates: while 79% of high-income countries have tax rates on cigarettes that are at least 50% of the retail price, only 31% of low- and middle-income countries have tax rates of at least 50%.

Hill added that by increasing tax rates, not only could much-needed money be raised for HIV and other public health priorities, but alcohol abuse and cigarette use could be discouraged: in 2010 alone, alcohol and tobacco use together accounted for over 8.5 million deaths.

"People are not just dying of HIV, but they are dying of tobacco in very high numbers, and they're dying of alcohol. A decrease in the consumption of alcohol and tobacco would have associated public health benefits," he said.

Hill noted that other so-called "sin taxes" could be used to fund a myriad of health issues. "We don't want to be accused of AIDS exceptionalism here," he said. "There is an opportunity for other 'sin' taxes to be used for other … diseases."

Reference

Hill A, Sawyer W. *Funding universal access through a "global health charge" on alcohol and tobacco: feasibility in the 20 countries with the largest HIV epidemics.* 19th International AIDS Conference, Washington DC, abstract M0AE0306, 2012.

As reported by 'nam aidsmap'. http://www.aidsmap.com/

WHO develops E-health technologies and opens portal on alcohol and health

Innovative portals on alcohol and health with a web-based self-help intervention tool have been developed with support from the WHO in four pilot countries, Belarus, Brazil, India and Mexico. The portals were launched in December, 2012, and provide information not only for policymakers and professionals, but also for the public at large. They include a self-screening tool for hazardous and harmful use of alcohol and a fully computerized self-help programme for people who wish to reduce or stop drinking alcohol.

The WHO e-health project on alcohol and health has been implemented by WHO Department of Mental Health and Substance Abuse in collaboration with Trimbos Institute in the Netherlands, and institutes and organizations from Belarus, Brazil, India and Mexico. One of the key results of the project is the development of a generic portal on alcohol and health that can be easily translated into other languages and adapted to different cultures. Developing such a generic portal and making it available to interested organizations and institutions is a part of WHO's implementation of the WHO Global strategy to reduce the harmful use of alcohol. The portal provides an overview of relevant information for policymakers and professionals, while the online intervention offers an innovative method of facilitating and supporting self-help strategies for those who want to reduce alcohol consumption or stop drinking.

Online self-help programs for different health conditions and risk factors are emerging in many countries. These programs have many advantages: they are user-friendly, available round the clock, don't require waiting or travel time, are anonymous and free of cost. Young people, who are traditionally difficult to reach, and women are particularly attracted by help via the internet. Such programs for hazardous and harmful drinking are not a substitute for professional treatment and care, but they allow to reach out to many people with access to internet who risk their health through drinking alcohol and who otherwise may not receive advice on how to reduce alcohol consumption or stop drinking.

There is growing research on the effectiveness of web-based self-help interventions. A meta-analysis showed that, for people with hazardous and harmful use of alcohol, computerized self-help is approximately as effective as a face-to face brief intervention. It is also likely to be cost-effective. Online self-help might be the first part of stepped care and it offers an option when health professionals are scarce. The self-help program developed in the framework of this project is fully computerized and is based on a program developed by Trimbos Institute, which uses techniques from cognitive behavioural therapy and motivational interviewing that have proven efficacy.
The content of the self-help intervention is based on existing WHO materials. Further support to the users of the self-help programme is offered via a moderated forum.

The institutes and organizations in the four pilot countries own their portals and have adapted and tailored them to their needs. Following the launch the project will focus on testing the uptake and user-friendliness of the portals and implementing the necessary further adaptations. If evaluation results are positive, the generic portal will be offered to other interested countries for translation, local adaptation and development according to the national contexts. In the future the scope of the portals might extend to other psychoactive substances.

This project received funding from the Government of the Netherlands.

For more information about the project, contact: msb@who.int

Minimum pricing of alcohol receives set-back from EU

The cause of minimum unit pricing of alcohol pursued by the Scottish government has received a set-back by being rejected by the European Commission as incompatible with EU law on the free movement of goods, not the best means of the achieving the stated objectives and possibly even counterproductive by encouraging retailers to increase sales of alcohol.

Since the Scottish government notified the Commission of its intention to introduce minimum unit pricing (MUP) several other member countries have lodged objections to the proposal, and the Commission's 'Detailed Opinion' now delays the consultation process until late December 2012 and significantly reduces the chances of the Scottish proposal being approved by the European Court.

In its Detailed Opinion, the Commission expresses sympathy with the intentions behind the Scottish proposal, but states that, while EU legislation does not prohibit MUP as such, any policy to introduce it must be compatible with other provisions of EU law, including rules on the free movement of goods. It states that EU case law is unequivocal that MUP falls within the remit of Article 34 of the Treaty, and would count as having an effect equivalent to a quantitative restriction on trade, impeding imports of alcohol products.

The Opinion states that MUP might discriminate against imports by preventing foreign manufacturers from benefiting from lower production costs. MUP could also constitute a barrier to entry into the Scottish market of new products, by denying goods seeking to enter the market lower prices to encourage supermarket listing and consumer trial.

Moreover, in the Opinion of the Commission, MUP fails the required proportionality test: the same results could be obtained by measures less distorting of the market.

The Opinion states:

"The Commission is fully aware of the importance of reduction of alcohol consumption among the population as a whole and in particular among the harmful drinkers. The Commission further acknowledges that the measure proposed is within Member States' competence and - from a public health point of view - within the scope of the goals and objectives of the EU strategy to support Member States in reducing alcohol related harm (COM(2006)625) ….. However, the measure at issue raises doubts as to its compatibility with the principle of proportionality …..

Keeping in mind that most of the studies prove and there is a general agreement that affordability does have effect of drinking patterns, the question is only about the best way to exploit this tendency. Hence, the Commission does not disagree with the proposition that increases in the prices of alcoholic drinks could, other things being equal, be expected to lead to reduced demand for those drinks. The focus in this opinion is rather on whether a MUP policy, which would lead to higher prices of many alcoholic drinks and hence to an expectation of reduced consumption, is likely to be the least market distorting policy that could be introduced to produce such an outcome. If the goal is, for health policy reasons, to reduce alcohol consumption via increasing the prices of alcoholic beverages, that goal can be achieved by raising alcohol taxation across the board.

The price of alcohol would thus increase without causing the market distortions that ….. can be expected to flow from MUP. It is the Commission's view that there is at least one alternative, regulatory option to MUP that is less restrictive of trade and less distorting of competition in relevant drinks markets … (Furthermore, other economic distortions) might arise as a consequence of the MUP. These potential distortions arise because the MUP will create greater incentives for retailers and supermarkets in particular, to sell more alcoholic beverages as a result of the fact that they will make higher margins on products affected by the policy. This will give retailers incentives to allocate increased resources to the sale of products affected by the MUP compared

with what could be expected to be the case if, for example, similar average retail price increases were caused by an across-the-board increase in duty, which is an alternative policy option for reducing consumption. In economic terms, this makes MUP a less effective means of reducing consumption than duty increases.

Indeed, Union legislation provides the Member States with the possibility to control the prices of alcohol and hence choose their level of health protection by setting the excise duties. The Scottish government provided explanations in the Regulatory Impact Assessment in page 46 of why the taxation alternative was not considered as the best option.

The Commission would like to address them accordingly at the same time stressing that raising of alcohol duties is probably the more suitable measure:

1) As regards the statements that the increase of duties will affect all alcohol on the market and not only cheap alcohol and will also affect the on-trade sales, the Commission would like to note issue is to reduce overall drinking that is shown by the chosen level of the minimum price that will affect 73%/66% of the off-trade market. Accordingly, the raising of duties option seems to be the most suitable to achieve that goal without providing any adverse effects on competition. Furthermore, the negative effects on the on-trade market can be reduced by adjusting the taxation system accordingly.

2) The Scottish authorities also claimed that increases in taxation of alcohol will not necessarily result in a proportionate or indeed any increase in the price of alcohol, as alcohol tax and duty increases are not always reflected in the price the consumer pays as some retailers engage in below cost selling to varying extents. To this effect, it could be mentioned that the second study of RAND 2012 carried out for the Commission examined to what extent changes in alcohol taxes are passed through to consumer prices. The findings indicate that changes in consumer prices depend to a large extent on reactions in the retail sector. Sufficient data for analysis was available from four countries. The pass-through is full when for example a €1.00 increase in excise duty for a product is associated with a €1.00 increase in the consumer price (or a duty reduction is similarly associated with a drop in the price). More than full pass-through means that the price increases more than that needed to cover the duty raise. Less-than full pass-through means the price increases less, as retailers cover the tax raise from other sources. In the countries studied, pass-through in the off-trade for changes in beer duties was less than full in two cases, and more than full in two cases. There was similar variation in the pass-through for changes in spirits duties. Comparison between off-trade and on-trade was possible for one country: there was no marked difference in between off-trade and on-trade was possible for one country: there was no marked difference in the pass-through for beer, but for spirits the pass-through was more than full in off-trade and less than full in on-trade. Hence, the Commission would like to note it is not definite that the rise in prices will not be passed through as showed by the examples.

Furthermore, in the case Commission v Hellenic Republic (C-216/98) the Court addressed that question stating that "The ability of manufacturers and importers not to pass on increases in excise duty on their products is in any event limited by the extent of their profit margin, with the result that excise duty increases are sooner or later incorporated in retail selling prices"…..

Moreover, there are other additional measures which the Scottish Government could adopt. For instance, according to information available health related harms are concentrated in particular areas of Scotland. Measures which are specifically targeted at these areas are likely to be more effective than measures aimed at the total population.

In conclusion, the Opinion states that:

"Following the above observations the Commission concludes that the draft at issue may create obstacles to the free movement of goods within the internal market contrary to article 34 TFEU and appears to be disproportionate under article 36 TFEU. The UK authorities are invited to abstain from adopting the draft legislation at issue."

Alcohol Focus Responds

Alcohol Focus Scotland quickly issued a scathing rebuttal of the Commission's legal opinion, accusing it of being selective, partial, misleading and in places factually inaccurate. For example, a key argument of the Commission's opinion is that MUP would, in effect, discriminate against imported products. However, AFS point out that the figures show that in regard to the spirits market, MUP would have more impact on domestically produced spirits than imported products.

More generally, AFS complains that a number of legitimate questions that have been raised with the Commission about the ability of taxation to curb the affordability of alcohol have not been acknowledged or properly addressed. For example, "*the Commission opinion omits to acknowledge that despite having some of the highest alcohol excise duty rates in the EU, affordability of alcohol in the UK has increased by a greater amount than most other EU countries. The opinion fails to acknowledge the differential impact of alcohol taxation on the on- and off-trade and that a shift to off-trade can act as a driver of increased affordability. The opinion fails to acknowledge the differential impact of different pricing controls on different categories of drinker and related harms, and the importance from a public health perspective of targeting the cheapest alcohol products. The opinion asserts that taxation can be used as an alternative to minimum pricing, but does not specify the level of taxation increase required to achieve a 50ppu minimum price. In not specifying the level of tax increase required, no determination can be made on which measure is less trade restrictive.*

In disregarding much of the evidence, the opinion fails to address the complexity of the issues. It is our view that the Commission should consider all the available evidence, and present a balanced assessment."

In regard to the percentage of the alcohol market affected by taxation compared to minimum pricing, AFS criticises the Commission's opinion for claiming that there is equivalence between taxation and minimum pricing as regards the extent of the market affected by the two measures, and therefore taxation should be preferred as it is less trade-restrictive.

AFS refutes this statement as misleading. "Alcohol excise duties are fixed as a specific amount and apply to cheap and expensive, on-trade and off-trade products equally. This is not the case with minimum pricing. At the proposed level of 50ppu, minimum pricing in Scotland will affect mainly off-trade sales, and it will affect off-sales retailing below 50ppu by varying amounts depending on the difference between the current retail price and the proposed minimum price."

With respect to the issue of whether increases in alcohol taxes are passed on to the consumer, AFS attacks the Commission's opinion for ignoring evidence from the UK on the practice of below-cost selling of alcohol by large supermarket retailers that account for 84% of off-trade sales of pure alcohol in Great Britain. "*This evidence, referred to in both the Scottish Government's BRIA and the first 2009 RAND report , relates to a 2007 UK Competition Commission inquiry into the groceries market that found supermarkets routinely engaged in below-cost selling of alcohol as part of their competitive sales strategy. If it has been established that retailers sell alcohol at a loss in the UK, then there is no certainty that the ability of manufacturers and importers to absorb alcohol tax increases is limited by the extent of their profit margin, as suggested by the opinion's reference to the Commission v Hellenic Republic (C-216/98) court ruling.*"

Other additional measures

AFS is particularly dismissive of the Commission's insistence that, aside from taxation, there are other additional measures that the Scottish Government could adopt to reduce alcohol harm. "*It asserts that there are targeted measures that could be implemented that are likely to be more effective than measures aimed at the total population, but omits to mention what these targeted measures are.*

As the availability of alternative measures is central to the question of legality, we find the Commission's unsubstantiated claims on this point inappropriate. If the Commission has evidence of more effective interventions, then its opinion should make clear what those measures are. Comparing effectiveness requires two or more known quantities. To assert that some unspecified, unknown measure is more effective is, in our view, not verifiable.

International evidence is clear that whole population interventions and particularly pricing interventions are highly effective in reducing harmful alcohol consumption. Minimum pricing is a measure aimed at tackling a rise in harmful consumption in Scotland that is specifically associated with the increased affordability and availability of cheap alcohol. To be considered an alternative to minimum pricing, a measure must tackle affordability and must be as effective in reducing alcohol-related harm. A targeted measure that does not tackle affordability is not an alternative to minimum pricing."

Eurocare Supports MUP

A number of alcohol producers across the world have been sending letters to the European Commission arguing against minimum pricing. Eurocare has sought to redress the imbalance by writing to the EU President Manual Baroso in support of the pricing strategy. In their letter Tiziana Codenotti, President of Eurocare and Mariann Skar, General Secretary, point out that, among health professionals, there has been increasing awareness of the effect of the price of the cheapest alcohol and this is why Scotland has favoured the approach of Minimum Unit Pricing in preference to overall price increases. Attention is drawn to the study on the impact of minimum pricing in Canada published in Addiction 2011. The conclusion from the study seems clear, longitudinal estimates suggest that a 10% increase in the minimum price of an alcoholic beverage reduced its consumption relative to other beverages by 16.1%. Increases in minimum prices of an alcoholic beverage can substantially reduce alcohol consumption. The letter also drew attention to the RAND Report prepared for DG Sanco in 2009 on "The affordability of alcoholic beverages in the European Union Understanding the link between alcohol affordability, consumption and harms." In nearly all countries examined, alcohol had become more affordable over the last twelve years. In six countries (Lithuania, Estonia, Latvia, Finland, Slovakia and Ireland) affordability of alcohol increased by 50% or more.

Eurocare states that it is "firmly convinced that addressing the price of cheap alcohol would assist in reduction of alcohol related harm and Member States should be supported by the European Commission to take such actions. It hopes that the European Commission will demonstrate its dedication to protection of health of the European citizens by supporting the Scottish Government plans to introduce minimum pricing for alcoholic beverages."

Canada

Meanwhile, in Canada, new alcohol pricing research papers support the case for minimum pricing and confirm that changes to price policy can reduce alcohol-related harm.

Written by Gerald Thomas, Senior Research and Policy Analyst with the Canadian Centre on Substance Abuse, the alcohol pricing series examines drinking trends in Canada, the retail environment, and existing price policies in six provinces. It endorses the price policy recommendations first proposed in the 2007 report, Reducing Alcohol-Related Harm in Canada: Toward a Culture of Moderation, which provides the framework for Canada's national alcohol strategy.

"Addressing alcohol-related harm in Canada requires a targeted approach aimed at the regular heavy and high-risk drinkers, as well as a population-wide approach to address the large number of people who sometimes drink in risky ways," explained Mr Thomas.

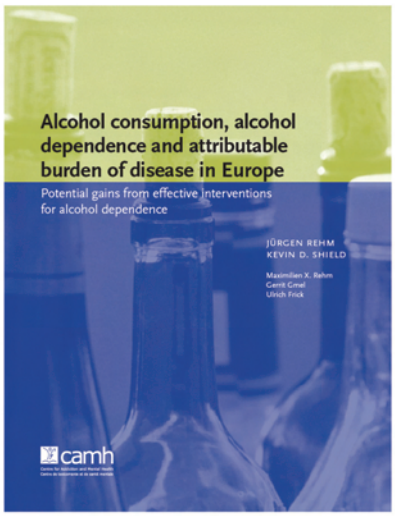
Research has shown that price policies can reduce alcohol consumption and correspondingly, the likelihood of injuries, violence, cancers and even death.

One of the report's key recommendations is for the provinces and territories to implement minimum alcohol pricing consistently to remove inexpensive sources of alcohol from the market.

"Cheap, high-strength alcohol is often favoured by heavy drinkers and young adults," said Mr Thomas. "Establishing minimum pricing will deter risky drinking. Light to moderate drinkers will be less affected, particularly those who choose low- to regular-strength alcohol products."

The complete alcohol pricing series, including the price policy brief, is available for download on the CCSA web.

Alcohol dependence: the biggest alcohol and health issue in Europe



The bulk of the harm associated with alcohol harm in Europe arises from heavy drinking and alcohol dependence, according to a new report from the Canadian Centre for Addiction and Mental Health.

The report examines the large impact of alcohol on mortality in the European Union, and calculates that almost 95,000 men and more than 25,000 women, in both cases aged 15 to 64 years, died of alcohol-attributable causes in 2004. This means that 1 in 7 male deaths and 1 in 13 female deaths in this age category were caused by the consumption of alcohol, with the proportional contribution to morbidity and disability being even higher.

Heavy drinking was responsible for almost 80% of all male alcohol-attributable net deaths and approximately 67% of all female alcohol-attributable net deaths. Alcohol dependence accounted for more than 70% of the overall alcohol-attributable net mortality before age 65, and proportionally more in the younger age groups.

The authors state that given the burden of alcohol dependence in the EU, it is surprising that less than 10% of Europeans living with alcohol dependence receive treatment. This lack of mental-health care is alarming, they say, since several effective treatment options are available. Increasing treatment coverage is a realistic goal, and would provide measurable results in lowering alcohol-related harms including mortality, even in the short term.

To assess the impact of increasing the number of people with alcohol dependence treated in the EU, the authors modeled the effect of increasing the percentage of people with alcohol dependence who are also treated to 40%. They found that if 40% of all people with alcohol dependence in the EU were treated with pharmacotherapy, the result would be a reduction of 10,040 male deaths and 1,700 female deaths in just the first year. This decrease is substantial, and represents a decrease of 13.3% of alcohol-attributable deaths of men and almost 9.3% of alcohol-attributable deaths of women. Almost the same effect could be reached if brief interventions would be given in hospitals, i.e. to problematic drinkers with other diseases or injuries already present and thus at elevated risk for mortality.

Given the substantial health burden attributable to alcohol dependence in the EU, the authors conclude that alcohol policy should strive for an integrated package of various forms of effective prevention measures, such as taxation increases, limitations on availability, and bans on advertising, supplemented by interventions for problem drinkers and people with alcohol dependence.

The report was written by Jurgen Rehm and Kevin Shields, with WHO Europe supporting the calculations of alcohol-attributable harm. The report was funded by the pharmaceutical company Lundbeck A/S.

'Alcohol consumption, alcohol dependence and attributable burden of disease in Europe'.

Permission to reprint front cover of the report given by the Canadian Centre for Addiction and Mental Health

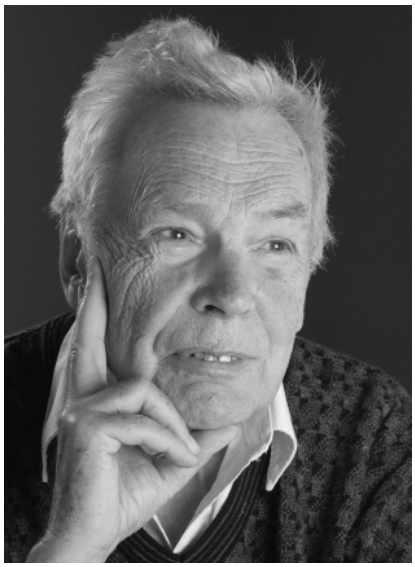
Professor James Griffith Edwards
3 October 1928 - 13 September 2012

Professor Griffith Edwards, one of the leading alcohol researchers of the last half century and an inspiration to many, has died in London after a short illness.

Professor Eilish Gilvarry, President Society for the Study of Addiction, issued a statement on behalf of the Society:

It is with great regret that I must report the death of Professor Griffith Edwards, CBE. Emeritus Professor of Addiction Behaviour at the Institute of Psychiatry; in 1967 founder and Director of the Addiction Research Unit at the Institute of Psychiatry, later to become the National Addiction Centre; author, contributor to and editor of numerous books including 'Alcohol Policy and the Public Good'; 'Alcohol, the world's favourite drug'; 'Matters of substance: Drugs – and why everyone's a user'; 'Alcohol: the ambiguous molecule' and 'Drug policy and the public good'; adviser to governments of the UK and the USA, and the WHO; and editor, commissioning editor and editorial adviser of the Society's journal, Addiction from 1978 until his death, he was one of the most significant figures in addiction research of the last half-century.

Throughout his career his approach combined the clinical and basic sciences of addiction with the more applied and social sciences, and he sought to promote a scientifically informed, evidence-based approach to addiction policy. He was also an



extraordinary intuitive clinician and an inspirational teacher and mentor, as evidenced by the many whose lives and careers he touched.

As a tribute to Professor Edwards, we are re-printing the text of an interview carried out for the magazine of the Institute of Alcohol Studies, UK Alcohol Alert, in the winter of 2000.

Griffith Edwards is a world expert in alcohol and drug addiction. The founder of the National Addiction Centre, and adviser to governments throughout the world, from Bolivia to Russia by way of the White House, he is a medical scientist who has studied the problem for forty years. To mark the publication of his major new book, Alcohol: the ambiguous molecule, he is interviewed for Alert by the Institute of Alcohol Studies's Andrew McNeill.

AM: May I ask you about the primary purpose of your new book? Who did you have in mind when you were writing it?
GE: I won't say that it is for "the educated layman" because that is such a patronising phrase. I dislike segregating people into the intelligent elite and the rest. I suppose I wanted to see people on trains reading the book. But I have no ideas of revolutionising the world - an easy madness when you write a book. I wanted it to contribute to public debate and to encourage people to think about alcohol, not just about addiction. So it was a book to address and engage the public.
AM: At the end of the book you describe two possible futures for this country: the first is a 'let it rip', twenty-four hour a day drinking binge in which we all drink ourselves to death; the second is alcohol going somewhat out of fashion. You seem to think the second is more likely. Why?

GE: I think you need to look at historical processes and the ways in which certain reactions occur. There have been times, such as the present, when society's use of alcohol has become damaging. For example, I tried to do some calculations on what it would have been like at the beginning of the 19th century at the time of the birth of the Temperance Movement and I am not surprised the Movement came into being. It is quite clear that in the 1700s and 1800's the

scenes of public drunkenness on the streets of this country were unimaginable. It was the appalling upswing in cancer deaths, sudden and tragic, which brought about the change in attitude towards tobacco. It took a long time for the reaction against tobacco, but it came. Today you can find mothers rising against heroin abuse on their council estates. Eventually the people may say enough. Of course, one can see that in certain Latin countries like France, drinking has declined. It is no longer cool to drink a lot of wine at lunchtime if you are a young French person. You will find that nowadays many French professional families have wine no more than once or twice a week.

We swim in the sea of public attitudes and I think that people have become more conscious of health. With that in mind, it is possible that our drinking behaviour will move towards a different pattern from the one we have seen in post war years. In some ways, these were years with a 'let it rip' attitude, although we never got back to the Georgian dining table where a gentleman slipped under the table towards the end of the evening. That sort of behaviour would not do one's professional reputation any good today but it once was alright. Once it was perfectly acceptable for a judge or a doctor pass out drunk. So there are profound changes in fashion and I believe that fashions are to some extent affected by the slow infiltration of science. My book might make a microscopic contribution to that process. But changes in attitude must be supported by wise legislation. Legislation is educative. From the research angle, I think having 24 hour drinking is an interesting experiment. But, of course, it is also a very negative message educationally.

AM: Do you feel that there is a difficulty in getting the alcohol message across to the public in a positive rather than a negative way?

GE: Yes. It is easy to be accused of being a health fascist. I expect to take such statements with good will and a little laughter. I think I am trying to provide scientific information rather than reacting emotionally. But, of course, I am not merely a calculating machine. I have my own ethical values and I rejoice in our society, in its culture, and its civilisation. To me health is something to do with the health of all the people. I am not a doctor treating individuals only. Compassion for individuals is very important but not enough. You cannot individualise the whole thing. You can't deal with smoking just by helping the next person in an anti-smoking clinic. You have got to be concerned with the entirety and that is as real to me as the health of the individual.

AM: We are at the moment awaiting the national Alcohol Strategy. There may be a call for more research. Can I put the point to you that we actually know enough already in order to put into place a strategy for reducing alcohol-related harm? Do you agree with that?

GE: Yes, I think I do. We have very good science in this arena and it has been revolutionised over the last thirty years. On the other hand, consider what happened with tobacco. Sir Richard Doll showed us the connection between cigarette smoking and cancer in the early 50's. Some people said that it was unnecessary to do any further research: that the answer was simply to stop people smoking by raising the tax. But during the last fifty years there have been huge research advances in cigarette issues and I think it's a good thing we didn't shut down our research base when Sir Richard published his work. In our own field, we have enough research to get an Alcohol Strategy underway but I think there is far more needed to make it as effective and strong as possible.

AM: In relation to that, do you believe that there is a satisfactory mechanism in existence for feeding the findings of scientific research into the alcohol policy making process?

GE: In relation to alcohol, having looked at the situation in other countries, I think it is difficult to make a relationship between science and policy and scientists ought to be modest in their claims: politicians, after all, are there on the vote of the people. Alcohol policy has to be formed against a background of many political decisions and multiple considerations - including, of course, getting re-elected. I have never expected to do more than inform the government of my concerns. I won't get angry if they don't take my advice but I will come back to them and inform them, inform them and

inform them again. At present I don't think that there is a good mechanism for the voice of those working with alcohol issues to reach government. There is such a mechanism in relation to drugs. The Advisory Council on the Misuse of Drugs (ACMD) has extraordinarily independent responsibility. It isn't a poodle of the government and it can set up working groups which examine all the evidence, prepare a scientifically thought out case, and report to ministers. What is more, there is a statutory responsibility of ministers to respond point by point to that report. They don't have to swallow it whole but they do have to come back and say whether they like it or don't like it and what they are going then to do.

AM: Would you like to see the same arrangement for alcohol?

GE: The temptation is to say that we should have exactly the same set-up for alcohol. I think the ACMD is a good model but I am not sure that it should be imitated in every detail. The ACMD puts the viewpoints of experts and practitioners in the field together with those of different government departments: for instance, the Department of Trade and Industry, the Department for Education and Science, the Home Office; the Departments of Health and Social Security. There is no tension because we are all on one side serving our country as best we can. The difficulty on the alcohol front arises with the drinks industry. This is because a government with an Alcohol Policy may say that an important part of it must be considerations of profit or the protection of the Scotch whisky industry. They will say that there must be a balance between health issues and employment issues, or advertising revenue, or whatever. So the drinks industry has to be given a voice. I think that it would be difficult to get good policy advice in those circumstances. It would be better to say that alcohol policy advice was related to health and social welfare where I think that the drinks industry is not a legitimate actor. The industry has a legitimate role as a producer but I think that the issue becomes too broad if you put those interests in with the total package of policy concerns. I am not against the drinks industry but out of courtesy to them I would not want to put them into a forum where their presence is inappropriate.

AM: What sort of things would you like to be in a National Strategy? What do you think it should be aiming to do? Do you think it should be concentrating on controlling consumption or on changing the culture?

GE: Partly on dealing with individual problems as they come: the questions of public order, lager louts; the issue of drinking and the young; drunk driving. There is a very big issue of alcohol and crime. These need to be dealt with separately from the drinks industry which is necessarily compromised by a fundamental conflict of interests. The industry has produced a report saying that there is no relationship between drinking and crime. Of course, that is simply not true but commercial interests force them to say it. I would say to anyone advising the government that many individual issues need to be taken on the hoof. There is always then the question of putting individual issues within a larger frame so that you have a sense of background issues and foreground issues.

You ask whether one should control the drink supply and hope the rest will look after itself? Controlling the drink supply is important but there are plenty of other small things which are important too. I think it is easier to deal with problems which are of immediate social and political concern. When you get into very abstract debate you usually get lost and ministers don't want to hear. I hope an alcohol policy forum will approach large and difficult questions such as the acceptable national level of drinking as well as the smaller ones but I think the important thing is to get it up and running and you make sure you have got around the table civil servants from every department. I think you then need some people who are front line actors such as probation officers, magistrates, and teachers. You don't need it crowded with heavy scientists. You do need some people with academic research background. We need quick action. We would certainly need to tap expertise from other countries. I don't believe that these issues can be dealt with by little England alone.

AM: In the last few years you have been very much involved in the relationships between science and policy making. Do you feel

there is a tension between the role of scientist and the role of advocate? Or do you think the two things need each other?

GE: I don't think there needs to be a strong line taken that scientists should keep clear of advocacy. Richard Doll never bothered about it but Charles Fletcher, another leading researcher, helped set up an activist organisation in ASH. I am willing to tell the truth as I see it but I am not willing to exaggerate or distort the truth, however good the cause. An honest activist doesn't do that either but there are activist skills, which I don't have. I want to keep my scientific credentials. On a good day I think I am a scientist, on another day I think I am a jobbing researcher. I don't want to be swept into any sort of partisan position. I live in a world where other people are going out and doing things like defacing billboards. I would probably fall off the ladder. So I think that when advocacy uses science well and honestly you have very strong movements. For example, the relationship between health advocates and science is very strong in tobacco, it is quite strong in food. It is quite strong in poverty issues. Honesty in both scientists and advocates is vital. There is no need for trumpeting the latest exaggerated horror story or to claim to have all the answers when only one tenth of them are available. I want science to be used for the public good and I am happy sometimes to be a player in that endeavour provided that none of us accidentally compromises the integrity of science.

Treatment for alcohol dependence dramatically reduces the financial burden of addiction on families

The financial effects of alcohol dependence on the family members of addicts can be massive, but little is known about whether treatment for alcoholism reduces that financial burden. A study of 48 German families published online in the journal Addiction reveals that after twelve months of treatment, family costs directly related to a family member's alcoholism decreased from an average of €676.44 (£529.91, US$832.26) per month to an average of €145.40 (£113.90, $178.89) per month. Put another way, average costs attributable to alcohol dependence decreased from 20.2% to 4.3% of the total pre-tax family income.

Among those 48 families, two of the largest family expenditures directly related to dependence were for alcoholic beverages (averaging €252.13/£197.51/$310.29 per month) and cigarettes (averaging €92.98/£72.83/$114.43 per month). Twelve months into treatment, those costs had reduced to €70.63 (£55.32, $86.92) and €64.21 (£50.29, $79.04) per month.

Also, after twelve months of treatment, the average amount of time spent caring for the affected family member dropped from 32.2 hours per month to 8.2 hours per month. Using the minimum wage in Germany for employees in the nursing industry (€8.50 per hour), informal care provided by family members initially piled on an additional financial burden of €274.30 (£214.87, $337.66) per month, which reduced to €69.79 (£54.67, $85.88) per month after one year of treatment.

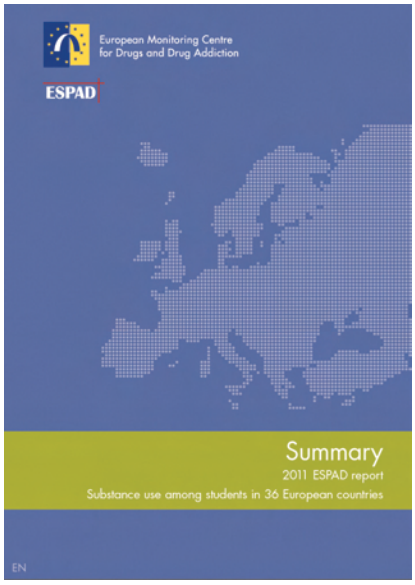
Even in cases of relapse, treatment for dependence still reduced the financial burden on families, but only by €65.22 (£51.09, $80.26) per month on average.

Lead author Dr Salize (Central Institute of Mental Health, Mannheim, Germany) said, "We're opening up an area of addiction research that doesn't receive much attention. When they look at effects on families, addiction studies mainly focus on problems such as domestic violence and depression, not on the financial burden of caring for an alcoholic. But when health services and policymakers study the costs and benefits of treating alcoholism, they need to know that treatment has an immense financial effect not just on the alcoholic but also on his or her spouse, partner, children, and parents. The benefits of treatment reach well beyond the individual patient."

Salize H.J, Jacke C., Kief S., Franz M., and Mann K. Treating alcoholism reduces financial burden on caregivers and increases quality-adjusted life years. Addiction, 107: doi:10.1111/j.1360-0443.2012.04002.x.

EUROPEAN SCHOOL SURVEY PROJECT ON ALCOHOL AND OTHER DRUGS (ESPAD)

New ESPAD study shows overall stable drug use among school students and a reduction in 'heavy episodic drinking', but no decrease in cigarette smoking



Overall, there has been a reduction in binge drinking (heavy episodic drinking), and the use of illicit drugs among 15–16-year-old school students appears to have stabilised, according to the latest European study of this group published by the European school survey project on alcohol and other drugs (ESPAD).

The report is based on a 2011 survey in 36 European countries. This was the fifth data-collection wave conducted by the ESPAD project, with multi-national surveys carried out every four years since 1995. Over 100,000 school students took part in the latest survey. Of the countries participating, 23 were EU Member States.

The 2011 ESPAD data show that over three-quarters of school students (79%) had consumed alcohol in the past 12 months and over half (57%) in the last 30 days, continuing the small decreases witnessed since 2003. In total, 11 countries reported a fall in alcohol use over the past 30 days and in 'heavy episodic drinking' over the same period (the latter had increased by 8 percentage points between 1995 and 2007). Also reported is the small decrease to 38% in this drinking pattern among girls, in contrast to the striking increase seen in the last round of the survey (29% in 2003, rising to 41% in 2007). Among boys, the figure was also slightly lower in 2011 (43% compared with 45% in 2007). Across 22 countries, more boys than girls still report 'heavy episodic drinking' in the past 30 days, although the gender gap shrank from 12 percentage points in 1995 to five in 2011.

The new survey results also show that the increase seen in the use of illicit drugs among this age group in ESPAD countries between 1995 and 2003 has since stalled, with the average prevalence remaining unchanged at 18% between 2007 and 2011 (11% in 1995; 20% in 2003). The overall trend in cigarette smoking in the last 30 days in the participating countries also remained unchanged between 2007 and 2011, following decreases between 1999 (35%) and 2007 (28%). In the countries with data from all five surveys, 29% had smoked cigarettes in the past 30 days.

EMCDDA Director Wolfgang Götz said: "Through its repeated surveys, the ESPAD project offers us a crucial window onto country differences and changes in adolescent substance use in Europe. Today's report underlines an important commitment to monitoring and understanding substance use in this important adolescent population and provides valuable data for further analysis. The EMCDDA presents a summary of the ESPAD findings as part of an enhanced and multilingual dissemination strategy of the project's results. This essential data will help inform policy makers, promote scientific understanding and facilitate the development of effective interventions for young and vulnerable school students across Europe."

ESPAD surveys are available for 1995, 1999, 2003, 2007, 2011.

http://www.espad.org/en/Reports--Documents/ESPAD-Reports/

Even moderate drinking in pregnancy can affect a child's IQ

Relatively small levels of exposure to alcohol while in the womb can influence a child's IQ, according to a new UK study*, by researchers from the Universities of Bristol and Oxford using data from over 4,000 mothers and their offspring.

Current advice to pregnant women about moderate alcohol consumption during pregnancy is sometimes contradictory, with some official guidelines recommending complete abstinence and others suggesting that moderate use is safe. Previous studies have produced conflicting and inconsistent evidence on the effects of moderate alcohol intake on a child's IQ. This may be because it is difficult to separate the effects of moderate alcohol consumption from other lifestyle and social factors, such as smoking, diet, affluence, mother's age and education.

This study, believed to be the first substantial one of its kind, used genetic variation to investigate the effects of moderate (<1-6 units of alcohol per week) drinking during pregnancy among a large group of women and their children. Since the individual variations that people have in their DNA are not connected to lifestyle and social factors, the approach removes that potential complication.

Four genetic variants in alcohol-metabolising genes among the 4,167 children were strongly related to lower IQ at age eight. The child's IQ was, on average, almost two points lower per genetic modification they possessed.

But this effect was only seen among the children of women who were moderate drinkers. There was no effect evident among children whose mothers abstained during pregnancy, strongly suggesting that it was the exposure to alcohol in the womb that was leading to the difference in child IQ. Heavy drinkers were not included in the study.

When a person drinks alcohol, ethanol is converted to acetaldehyde by a group of enzymes. Variations in the genes that 'encode' these enzymes lead to differences in their ability to metabolise ethanol. In 'slow metabolisers', peak alcohol levels may be higher and persist for longer than in 'fast metabolisers'.

It is believed that the 'fast' metabolism of ethanol protects against abnormal brain development in infants because less alcohol is delivered to the fetus, although the exact mechanisms are still unclear.

Previous studies have relied on observational evidence, but this is problematic. Observational studies often find that moderate drinking is beneficial compared to abstention, but this is because mothers who drink in moderation during pregnancy are typically well educated, have a good diet and are unlikely to smoke – all factors which are linked to higher IQ in the child, and which mask any negative effect that exposure to alcohol may have.

This study, on the other hand, looked at moderate (rather than high) alcohol intake in over 4,000 women and used a novel technique known as Mendelian randomisation, which is a scientifically robust way of investigating the links between exposures and later diseases, using genetic variants which modify exposure levels and which are not influenced by lifestyle or other factors.

The mothers' alcohol intake was based on a questionnaire completed when they were 18 weeks' pregnant. It included questions on the average amount and frequency of alcohol consumption before the current pregnancy, during the first trimester, and in the previous two weeks or at the time when they first felt the baby move. One drink was specified as one unit of alcohol.

Around 32 weeks of gestation the mother completed another questionnaire in which she was asked about her average weekday and weekend alcohol consumption, from which weekly intake was derived. Any woman who reported drinking, even if it was less than one unit per week either in the first trimester or when she felt the baby first move was classified as drinking during pregnancy.

At approximately 18 and 32 weeks of pregnancy, the women were also asked on how many days during the past month they had drunk two pints of beer (or the equivalent amount of alcohol). Any woman who reported doing this on at least one occasion was classified as a binge drinker for the purposes of this analysis and was excluded. The children's IQ were tested when they were aged eight using a shortened version of the Wechsler Intelligence Scale for Children from which overall age adjusted total scores were derived.

Speaking about the findings, the report's main author, Dr Sarah Lewis, said: "Our results suggest that even at levels of alcohol consumption which are normally considered to be harmless, we can detect differences in childhood IQ, which are dependent on the ability of the foetus to clear this alcohol. This is evidence that even at these moderate levels, alcohol is influencing foetal brain development."

Dr Ron Gray from the University of Oxford, who led the research, added: "This is a complex study but the message is simple: even moderate amounts of alcohol during pregnancy can have an effect on future child intelligence. So women have good reason to choose to avoid alcohol when pregnant."

* *'Fetal alcohol exposure and IQ at age 8: evidence from a population based birth-cohort study' by Lewis, S et al is published in PLOS ONE.*

Children with Foetal Alcohol Spectrum Disorder 19 times more likely to end up in prison

Meanwhile, in New Zealand, Kim Workman, Director of Rethinking Crime and Punishment, a strategic initiative to raise the level of public debate about the use of prison and alternative forms of punishment, has supported the NZ Children's Commissioner's comments about an increase of children with Foetal Alcohol Spectrum Disorders (FADS).

Mr Workman cited research in Canada and the USA showing that children with FASD are 19 times more likely to end up in prison than those who are not affected. According to this research, about 35% of young people with FASD end up in the criminal justice system, and over half have been in trouble with the law. Canadian research with young offenders showed that more than one fifth are behaviorally impaired due to prenatal alcohol consumption.

Mr Workman said:

"While there has not been any local research into the incidence of FASD in prisons, there is every reason to believe that the situation is much the same here. It would be a forward step if all prisoners were screened for FASD, and then managed appropriately.

"These are typically the offenders who lack impulse control and have trouble thinking through the future consequences of their behaviour. They can't connect cause and effect, lack empathy toward victims, have difficulty taking responsibility for their actions, and make really bad decisions. In short, they are incapable of doing all the things we expect offenders to do after they commit a crime."

"Offenders with FADS are often the ones who get talked into committing crime by their mates, or who confess to crimes they didn't commit. They often break the law without intending to do so; such as touching people when it is unwanted, or taking property because they are attracted to it."

If they are unfortunate enough to end up in prison, there's very little that can be done for them. They often are manipulated by other prisoners, and victimised. Therapeutic programmes rarely work. They are better placed in an environment where they can get job training, family and community support, and proper medical care."

"While they may not commit serious crime, they are often repeat offenders engaging in the same sort of crime time and time again; for example theft, burglary and car conversion."

"Offenders with FASD represent a significant recurring cost within the criminal justice system. This is one of those cases where legislation which limits the access of alcohol to young pregnant mothers, would have a huge economic and social return on investment."

Cognitive changes may be only sign of foetal alcohol exposure

Distinct facial features not seen in many cases, NIH study finds

Most children exposed to high levels of alcohol in the womb do not develop the distinct facial features seen in foetal alcohol syndrome, but instead show signs of abnormal intellectual or behavioral development, according to a study by researchers at the US National Institutes of Health and researchers in Chile.

These abnormalities of the nervous system involved language delays, hyperactivity, attention deficits or intellectual delays. The researchers used the terms functional neurologic impairment to describe these abnormalities. The study authors documented an abnormality in one of these areas in about 44 percent of children whose mothers drank four or more drinks per day during pregnancy. In contrast, abnormal facial features were present in about 17 percent of alcohol-exposed children.

Foetal alcohol syndrome refers to a pattern of birth defects found in children of mothers who drank heavily during pregnancy. These involve a characteristic pattern of facial abnormalities, growth retardation, and brain damage. Neurological and physical differences seen in children exposed to alcohol prenatally - but who do not have the full pattern of birth defects seen in fetal alcohol syndrome - are classified as fetal alcohol spectrum disorders.

"Our concern is that in the absence of the distinctive facial features, health care providers evaluating children with any of these functional neurological impairments might miss their history of foetal alcohol exposure," said Devon Kuehn, M.D., of the Epidemiology Branch of the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the NIH institute involved in the study. "As a result, children might not be referred for appropriate treatment and services."

The Center for Disease Control and Prevention provides information on the treatments for FASD.

Dr Kuehn conducted the study with NICHD colleagues Tonia C. Carter, Ph.D., Mary R. Conley and Jim Mills, M.D, as well as researchers at the National Heart, Lung and Blood Institute, the National Capital Consortium, in Bethesda, Md., and the University of Chile in Santiago.

Their findings appear online in *Alcoholism: Clinical and Experimental Research.*

The research was conducted as part of a long-term study of heavy drinking in pregnancy known as the NICHD-University of Chile Alcohol in Pregnancy Study. To conduct the study, the researchers asked over 9000 women at a community health clinic in Santiago, Chile about their alcohol use during pregnancy. They found 101 pregnant women, who had four or more drinks per day during their pregnancies and matched them with 101 women having similar characteristics but who consumed no alcohol when they were pregnant. After these women gave birth, the researchers evaluated the infants' health and conducted regular assessments of their physical, intellectual and emotional development through age 8.

The researchers documented differences in the rate of children affected in the following areas:

	Alcohol exposed	**Unexposed**
Abnormal facial features	17 percent	1 percent
Delayed growth	27 percent	13 percent
Cognitive delays (including intellectual)	35 percent	6 percent
Language delays	42 percent	24 percent
Hyperactivity	27 percent	2 percent

Some of the women with heavy drinking habits also engaged in binge drinking (5 or more drinks at a time). Even though these women already had high levels of alcohol consumption, the researchers found that this habit increased the likelihood of poor outcomes for their children.

Bid to promote wine culture to French children

Moves are afoot in France to teach children as young as six about wine making and the culture of wine. According to the French wine industry which is behind the move, the initiative is needed because current 'anti-alcohol' public policies mean that French children are being denied knowledge of their wine heritage.

As reported in Decanter.com, which describes itself as the world's best wine magazine, The Bordeaux Wine Bureau (CIVB) has launched a programme called La Gironde Verte with regional junior schools, which can apply to send students to local vineyards. The programme is aimed at junior school students from ages 6 to 10 or 11.

With the help of various booklets, pupils are taught to identify different seasons in the vines, are prompted to taste grapes to see if they are ripe, and are given questions to ask winemakers such as "What's your favourite piece of equipment?" and "What do you like most and least about your job?"

Separate booklets are provided to teachers, winemakers, and local mayors explaining the aims of the programme and what it would mean to create a Vign'école or Vine School.

CIVB president Georges Haushalter told Decanter.com, "We are hoping this will be an effective way to introduce the young people of our region to the environmental and economic importance of the wine industry." He added: "Our objective is to protect the heritage of our region, while promoting an understanding of the civilisation of wine."

Additionally, a book 'Vines and Wines: A World to Discover' aims to tell 7 to12-year-olds how lucky they are to live in a country where the culture of the vine plays such an important role.

With the help of illustrations it explains the cycle of vine-growing and the cultural role that wine plays in France, and tells the story of wine from the Romans to the present day.

Editor Emmanuelle Garcia, whose idea the book was, told Decanter.com that "France's draconian anti-alcohol laws meant children weren't learning about wine as they should".

"We felt there were increasing gaps in the knowledge being transmitted to our children about the cultural role of wine. There has been no negative reaction so far, but we will see… I explain each time that we are not promoting wine itself, but explaining a culture. We have really worked hard at ensuring the layout and language of the book is clear. This is about the heritage of France."

An initial run of 200,000 copies has been printed, with plans to export the book to Quebec and other French-speaking countries. The publisher is also considering an English translation.

Commenting on the initiatives for The Globe, Claude Riviere, Responsible for European and International Affairs for ANPAA (Assocation Nationale de Prevention en Alcoologie et Addictologie) said:

"What the editors call 'France's draconian anti-alcohol laws' are Public Health laws voted by parliament and which aim to protect people and especially youngsters from alcohol marketing. Since the laws were adopted, the alcohol industry and the wine producers have constantly tried to have the laws rescinded by lobbying the members of parliament. Is this behaviour worthy of people who claim to educate our children? Under the guise of environmental education the industry is trying to promote an alcoholic culture."

The Southern Africa Alcohol Policy Alliance established in Johannesburg

Around 45 delegates were gathered in Johannesburg the first week of November for the first Southern Africa Alcohol Policy Forum. They represented civil society organizations from seven countries in the region, as well as NGOs from Kenya, Sierra Leone, Sweden and Norway. The purpose of the Forum was to build competence on the alcohol situation locally and globally, to exchange experiences from policy and prevention work and to discuss a closer regional collaboration.

On the last day of the Forum, the 8th of November, the delegates decided to establish The Southern Africa Alcohol Policy Alliance involving at this point NGOs from South Africa, Malawi, Zambia, Botswana, Lesotho, Namibia and Madagascar. The Alliance will now apply for affiliation to The Global Alcohol Policy Alliance (GAPA).

The meeting elected a board for the new alliance. Savera Kalideen from Soul City in South Africa became the first Chair while Lovemore Mughandira from Blue Cross Namibia was elected Secretary of the Board. Other members are Nelson Zakeyu, Drug Fight Malawi; Jonas Ngulube, YMCA Zambia; Fanjanirina Holiarisoa, Blue Cross Madagascar; Mphonyane Mofokeng, Anti Drug Abuse Association of Lesotho and Smart Kachipare, Blue Cross Botswana. At the opening of the Forum the participants painted a picture, by drawing on their national experiences, of alcohol policy challenges in the region and how alcohol issues are linked to other key development concerns in the Sub-Saharan region. The linkages between alcohol use and poverty, HIV/AIDS and gender-based violence came out as special concerns and so did also the undue interference by the alcohol industry in policy formulation.

The new SAAPA board; from right to left: Kalideen, Mughandira, Mofokeng, Ngulube, Zakeyu, Kachipare and Holiarisoa.

Lack of competence among politicians, civil servants and NGO leaders, as well as weak policies and poor implementation of policies, were defined as a serious problem in most countries. The lack of reliable data on the alcohol situation was described as an obstacle both to policy development and effective advocacy work.

The Regional Forum was organized by the two Norwegian NGOs, FORUT and Blue Cross together with The Global Alcohol Policy Alliance. Co-sponsors were the WHO Regional Office for Africa, The Medical Research Council of South Africa, International Blue Cross (IFBC) and The African Journal of Drug and Alcohol Studies.

In her opening address the new Secretary General of IFBC, Anne Babb, expressed an

opinion which later proved to reflect the ambition of all the participants: "We have come here to make a difference". She made reference to the now existing international evidence-base on effective alcohol policies, a topic which was elaborated by several presenters later in the program.

Dr Sarah Barber from the WHO country office in South Africa represented The World Health Organization at the opening of the Regional Forum. She presented the WHO Global and Regional Strategies for Reducing the Harmful Use of Alcohol and the particular challenges for African countries in the alcohol field. Dr Barber concluded by pointing at some key challenges in the way forward with national follow-up in Africa: Firstly, to place alcohol as a country priority, not only for health but for development also. Secondly, to develop comprehensive and multi-sectoral responses which include regulatory measures, pricing policies and community mobilization. Thirdly, to address alcohol as a cross cutting health risk factor, related to both communicable diseases like HIV/AIDS and TB and to the so-called non-communicable diseases (NCDs).

In their presentations, Professor Isidore Obot from Nigeria and Dr Neo Morojele from South Africa elaborated further on the relations between alcohol use and HIV/AIDS, TB and NCDs with a particular emphasis on the African situation. Even though not all causalities are scientifically established, these presentations showed that there is overwhelming evidence that risky alcohol consumption must be addressed if programs to reduce HIV/AIDS, TB and NCDs shall be more effective.

In another sequence of the program Joanne Corrigal from South Africa and Øystein Bakke and Dag Endal from FORUT presented the activities of the multinational alcohol industry, both in Africa and globally. In several rounds of discussions many of the participants gave examples of how vested interests intervene in the policy arena in their respective countries with the purpose of avoiding government regulations which are proven to be effective and which could reduce alcohol consumption and reduce alcohol-related harm.

From left: Dr Neo Morojele and Professor Isidore Obot

GAPA Board meets in London, November 2012

Planning took place for the GAPA Conference in Seoul 7 - 9 October 2013. The theme will be "Alcohol, Civil Society and Public Health; From local and national action to global change". The Secretariat is the Institute of Alcohol Problems, Sahmyook University, Korea. The website address is www.GAPC2013.com

Dr Evelyn Gillan, Chief Executive of Alcohol Focus Scotland, and Professor Thomas Babor, Physicians Health Services Chair in Community Medicine & Public Health, University of Connecticut Health Center, USA, were appointed to the Board.

Back row from left to right:
Associate Professor, David Jernigan, Vice Chair of the Scientific Committee (USA), Professor Charles Parry (South Africa), Mr Derek Rutherford (UK Chairman), Mr Øystein Bakke, Secretary (Norway), Dr S Arulrhaj (India), Dr Ronaldo Laranjeiro (Brazil)

Front row from left to right:
Dr Michel Crapet (France), Miss Katherine Brown (Assistant to the UK Chairman, GAPA), Dr Evelyn Gillan (Scotland), Professor Sungsoo Chun (Korea), Professor Udomsil Srisangnam, Vice Chair (Thailand), Professor Isidore S Obot (Nigeria), and Mr George Hacker (USA)

Time Restrictions on TV Advertisements Ineffective in Reducing Youth Exposure to Alcohol Ads

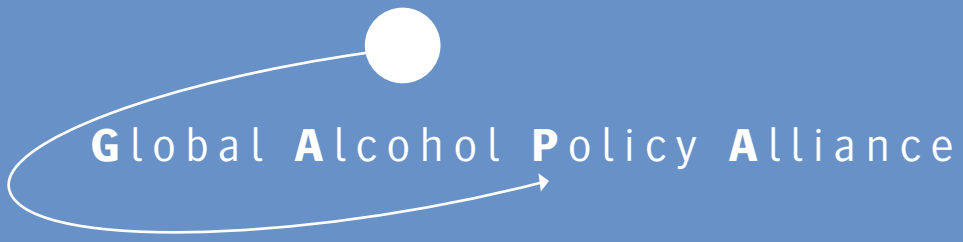
Teenage Exposure to Alcohol Advertising Actually Increased Following Implementation of Daytime and Evening Ban in the Netherlands

Efforts to reduce underage exposure to alcohol advertising by implementing time restrictions have not worked, according to new research from the Center on Alcohol Marketing and Youth (CAMY) at the Johns Hopkins Bloomberg School of Public Health and the Dutch Institute for Alcohol Policy. The report, published in the Journal of Public Affairs, confirms what Dutch researchers had already learned in that country: time restrictions on alcohol advertising actually increase teen exposure, because companies move the advertising to late night. In 2009, Dutch regulators sought to reduce youth exposure to alcohol advertising by restricting times during which alcohol ads may be aired on television or radio. Under this restriction, alcohol advertising was prohibited between the hours of 6 am and 9 pm. In 2010, compliance with the time restriction on television was close to 100 percent. CAMY researchers used simulation analysis to model what would happen if a similar policy were applied to U.S. television advertising for alcohol, taking into account the program type and audience demographics. They found that time restrictions do protect viewers under age 12, but they actually increase the exposure of the young people most likely to start drinking, that is, teens aged 12 to 20. This happens because teens increase as a percentage of the nighttime television audience after 9 pm.

"In light of the policy in the Netherlands and the recommendations for similar policies in other countries, including Ireland and the United Kingdom, determining the impact of time restrictions on youth exposure is a public health priority," said lead author and CAMY researcher Craig Ross, MBA. "In the wake of time restrictions, alcohol companies push their ads onto late night programming, when the adolescent/teenage audience is more highly concentrated, thus increasing advertising exposure for this high-risk group." Alcohol is the drug most frequently used and abused by adolescents in the U.S. and in the Netherlands. At least 14 long-term studies have found that the more young people are exposed to alcohol advertising and marketing, the more likely they are to drink, or if they are already drinking, to drink more. "With growing numbers of adolescents in the U.S. having a television in their bedroom, forcing alcohol advertisers to move ads into late night television is akin to inviting them to have a private conversation with adolescents every evening," concluded study co-author and CAMY director David Jernigan, PhD. "For countries such as the U.S., where alcohol advertising is protected as commercial speech, policies that restrict alcohol advertising to programs where the underage audience is not over-represented are likely to be more effective." This policy is endorsed in the U.S. by the National Research Council, the Institute of Medicine, and 24 State Attorneys General.

The Center on Alcohol Marketing and Youth monitors the marketing practices of the alcohol industry to focus attention and action on industry practices that jeopardize the health and safety of America's youth. The Center was founded in 2002 at Georgetown University with funding from The Pew Charitable Trusts and the Robert Wood Johnson Foundation. The Center moved to the Johns Hopkins Bloomberg School of Public Health in 2008 and is currently funded by the Federal Centers for Disease Control and Prevention.

For more information, visit www.camy.org.



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