WHO Public Hearing on Harmful Use of Alcohol

Volume II

Received contributions from:

- WHO Member States
- Government institutions
- Intergovernmental organizations
- Academia-research

World Health Organization

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World Health Organization

Department of Mental Health and Substance Abuse
World Health Organization
Geneva, 2009

Background

On 24 May 2008, the Sixty-first World Health Assembly (WHA) adopted an important resolution on "Strategies to reduce the harmful use of alcohol" (WHA61.4). The resolution calls for the development by 2010 of a draft global strategy to reduce the harmful use of alcohol that is based on all available evidence and existing best practices and that addresses relevant policy options. The strategy will be submitted to the Sixty-third World Health Assembly in May 2010 through the 126th session of the WHO Executive Board in January 2010.

In addition to the request to develop a draft global strategy, resolution WHA61.4 also asks the WHO Secretariat to collaborate and consult with Member States, as well as to consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol. In response to this, the WHO Secretariat has embarked on a broad and inclusive consultation process with different stakeholders.

To follow up this latter request, a web-based public hearing was organized by the WHO Secretariat from 1 October to 15 November 2008, giving Member States and other stakeholders an opportunity to make submissions on ways to reduce harmful use of alcohol. In addition, two separate round tables, one with representatives of nongovernmental organizations and health professionals and one with economic operators, were organized in Geneva in November 2008 to collect their views on ways they could contribute to reducing harmful use of alcohol. The Secretariat is planning consultations with selected intergovernmental organizations in 2009.

Contributions to the public hearing could be submitted via a dedicated website or by fax in any of the six official UN languages (Arabic, Chinese, English, French, Russian and Spanish) from 1 October to 15 November 2008. Contributions were sent in by individuals, civil society groups, WHO Member States and government institutions, academic and research institutions, economic operators and other interested parties. In providing their contribution, the participants were encouraged to focus on the following questions.

- What are your views on effective strategies to reduce alcohol-related harm?
- From a global perspective, what are the best ways to reduce problems related to harmful use of alcohol?
- In what ways can you or your organization contribute to reduce harmful use of alcohol?

This report contains received summaries of the submissions received in the WHO Public Hearing. All submissions are presented in their original languages. Some comments in the summary sections may have been edited before posting. This summary of the contributions together with the unedited full text submissions are available on the WHO website www.who.int//substance_abuse/activities/hearing/. In a few cases, no summaries were receveveid, as such they are listed in the summary section with a reference to the full text. All submissions are categorized in one of the following categories: WHO Member States, government institutions, intergovernmental organizations, academia-research, nongovernmental organizations, alcohol industry, trade and agriculture, other entities and organizations or individual submission, depending on the information given by the participants.

The views expressed in this publication are those of the participants in the WHO Public Hearing and do not necessarily represent the stated views or policies of the World Health Organization. The authors only are responsible for their submissions, and the readers only are responsible for the interpretation of these submissions, whether edited or not.

The World Health Organization accept no responsibility whatsoever for any inaccurate advice or information that is provided by sources reached via hyperlinks in this publication or by linkages or reference to this publication.

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Received submissions

SUBMISSIONS FROM WHO MEMBER STATES

Argentina: Ministerio de Salud de la Nación

Estado Miembro de la OMS
País: Argentina
Página web: http://www.msal.gov.ar

Resumen de la contribución:

El Ministerio de Salud de la Nación hace hincapié en la decisión política de atender las problemáticas de los usuarios abusivos de alcohol en el Sistema Público de Salud, tanto desde la calidad asistencial como desde la accesibilidad y desde conceptos como universalidad, equidad e integralidad de la Salud Comunitaria basados en la Atención Primaria de la Salud, por lo que es responsable del desarrollo de políticas sanitarias eficientes y eficaces de atención, pero estas se deben insertar dentro de políticas socio sanitarias públicas junto a los Ministerios de Educación, Trabajo, Justicia y desarrollo Social.

Este Ministerio encara las acciones desde el marco que el uso nocivo de alcohol, es una patología social, que debe ser prevenida y asistida integralmente por el sistema sanitario en Red referencial, con estrategias de promoción e inclusión desde los sistemas sociales y las comunidades locales.

Contribución íntegra: Nr. 120

Belgique

Etat Membre de l'OMS
Pays: Belgium
Adresse du site Web:
https://portal.health.fgov.be/portal/page?_pageid=56,11334501&_dad=portal&_schema=PORTAL

Résumé de la contribution:

La Déclaration Conjointe sur la politique future en matière d'alcool a été adoptée en juin 2008 par les Ministres ayant en Belgique la santé dans leurs attributions. Ces Ministres se sont mis d'accord sur un certain nombre de principes qui doivent, ensuite, être négociés et élaborés, le cas échéant, avec les autres Ministres compétents et des acteurs pertinents. En tout cas, ceux-ci ont choisi d'une manière explicite d'œuvrer à la mise en place d'une politique intégrée et coordonnée, avec un suivi scientifique des éléments prioritaires tels que les programmes de prévention et le traitement.

Afin de permettre à la population de prendre conscience de l'existence de risques liés à la consommation d'alcool (risques sur la santé, impact sur la famille ou la société), les pouvoirs publics et organisations concernés (communautés, écoles, associations, etc.) tentent d'implémenter et de mettre en œuvre diverses méthodes de prévention.

En ce qui concerne la prise en charge des individus pour qui la consommation d'alcool s'avère avoir des effets négatifs sur leur santé (considérée globalement), les objectifs poursuivis sont les suivants : améliorer la qualité de vie des personnes au plan psychique, physique et social, en respectant leur autonomie. En cas de consommation problématique, l'évolution doit être surveillée, et les soins ou la prise en charge adaptés en fonction de la situation. L'offre d'assistance doit être suffisamment flexible, en couvrant tout un panel d'actions et de niveaux d'interventions. Ici, déceler et intervenir précocement constituent des missions essentielles dans l'approche et sont essentiellement de la responsabilité des acteurs de première ligne. Dans le cas de l'alcoolisme, la « post-cure » et la prévention de rechute constituent également des éléments essentiels. Dans une approche globale des conduites à risques, l'entourage familial et professionnel du sujet doit être soutenu.

La Déclaration Conjointe énonce trois objectifs généraux. Tout d'abord prévenir et réduire les dommages liés à une consommation problématique d'alcool, qu'ils soient physiques ou psychologiques. Ensuite, combattre la consommation inadaptée, excessive ou risquée d'alcool – et non pas seulement la dépendance. Enfin avoir une politique orientée vers des groupes cibles et des situations à risques : les mineurs et les femmes enceintes sont visés.

La Déclaration conjointe pointe quelques catégories de mesures. Une première vise à interdire la vente d'alcool dans certains lieux déterminés (comme les stations services ou les distributeurs automatiques) ; elle cible également la présentation des alcools dans les rayons des supermarchés. Une deuxième concerne le marketing et la publicité ; elle vise surtout les jeunes qu'il conviendra de protéger, entre autres en leur apprenant à faire preuve de sens critique vis-à-vis des pratiques de marketing. Une troisième a trait à l'alcool et à la conduite automobile : la Déclaration plaide pour une intensification des contrôles routiers et pour des sanctions plus sévères à l'égard de ces conducteurs. Une quatrième, enfin, se focalise plus spécifiquement sur les femmes enceintes, en sensibilisant les professionnels de la santé qui sont concernés (médecins généralistes, gynécologues, sages-femmes).

Contribution intégral: Nr. 199

Costa Rica: Instituto sobre Alcoholismo y Farmacodependencia - Ministerio de Salud

Estado Miembro de la OMS
País: Costa Rica
Página web: http://www.iafa.go.cr

Resumen de la contribución:

República de Costa Rica
Ministerio de Salud de Costa Rica
Instituto sobre Alcoholismo y Farmacodependencia

El tema de los problemas de salud pública provocados por el consumo de alcohol se debe introducir en la agenda pública de los Gobiernos y a partir de ello, se manifieste un compromiso político claro, decido y concreto, reflejado en políticas públicas para dar respuesta a este problema.

En el marco de una estrategia amplia de prevención una actividad prioritaria a realizar es la introducción de pruebas y de intervenciones breves y el ordenar la participación de las redes de organismos comunitarios y organizaciones no gubernamentales (no afiliados a la industria del alcohol).

Hay que favorecer los enfoques basados en la población, que afectan el contexto social de consumo y la disponibilidad de bebidas alcohólicas, ejecutar medidas que controlen el suministro de alcohol y afecten la amplia demanda de bebidas alcohólicas de la población.

Además, es necesario contar estrategias para reducir el daño y limitar los problemas relacionados con el alcohol, en particular los relacionados con la conducción bajo los efectos del alcohol y la violencia intrafamiliar.

Hay promover la consideración de un convenio marco para el control del alcohol, similar al Convenio Marco de la OMS para el Control del Tabaco, para que se ejecute en forma sostenida un paquete de políticas y programas eficaces, cuya combinación genere un mayor beneficio para la sociedad en cuanto a la salud pública y el bienestar social.

Las políticas y planes de acción nacionales que se formulen para reducir el suministro, la demanda y los daños generados por el alcohol, requieren de desarrollo de campañas regionales y mundiales de sensibilización, actividades de promoción, investigación y fortalecimiento de la capacidad.

La adopción de un paquete de medidas reguladoras de la accesibilidad, disponibilidad y comercialización de las bebidas alcohólicas y el compromiso efectivo de garantizar el cumplimiento de estas restricciones, pueden reducir significativamente la oferta de estas sustancias y la tolerancia social con que cuenta su consumo y la aceptación de la ebriedad pública.

Abogamos por que se incorpore a las estrategias para reducir el suministro, la demanda y los daños generados por el alcohol, un componente de “Otras Políticas Públicas”, en donde se pueda considerar las estrategias de educación y persuasión, el desarrollo de campañas de publicidad e informativas y el fomento de la investigación.

Costa Rica ha formula una “Política del Sector Salud para la Atención de los Problemas derivados del Consumo de Alcohol, Tabaco y Otras Drogas”, cuyo propósito es posibilitar el acceso a la atención integral en condiciones de seguridad y habitabilidad, en especial para aquellas personas que están en mayor situación de vulnerabilidad y exclusión social.

En Costa Rica las medidas asumidas se agrupan en:
a) Disponibilidad del alcohol
b) Medidas dirigidas a la conducción bajo la influencia del alcohol
c) Restricción a las comunicaciones comerciales
d) Intervenciones educativas - persuasivas.

Contribución íntegra: Nr. 178

Cuba: La Misión Permanente de la República de Cuba en Ginebra

Estado Miembro de la OMS
País: Cuba

Résumé de la contribution no disponible.

Contribución íntegra: Nr. 80

Finland: The Finnish Ministry of Social Affairs and Health

WHO Member State
Country: Finland

Summary:

1. Effective strategies to reduce alcohol-related harm

In general effective strategies should recognize and acknowledge three main facts:

- Evidence shows that alcoholic beverages are no ordinary commodities
- Evidence shows the extraordinary nature of alcohol-related harm not only to the drinker but also in particular to others
- Evidence shows what strategies work

2. Global perspective on reducing alcohol-related harm

It has become more and more difficult to maintain effective national and local alcohol policy measures with the growth of globalisation and international trade. This gives rise to a serious concern with regard to public health and social considerations.

In the opinion of the Ministry of Social Affairs and Health there should be an legitimate sphere of action for national alcohol policies. At the same time there is a pressing need for more international co-operation aimed at reducing the negative consequences of alcohol.

Hence we would very much like to support the WHO efforts to reduce alcohol related harm globally. For this we would need, inter alia, a global convention.

Full text: Nr. 330

Japan

WHO Member State
Country: Japan

In developing a global strategy on harmful use of alcohol, the Government of Japan would like to emphasize the importance of the following three principles.

1) A global strategy on harmful use of alcohol should be in line with the resolutions adopted in the past WHAs or any regional committees.

2) All member states should take harmful use of alcohol seriously and respond to the problem by adopting evidence-based and cost-effective policies.

3) Measures to address the problem should take into account country-specific conditions such as economic, social and cultural background and the nature of problems caused by harmful use of alcohol in respective countries.

Suisse: Office Fédéral de la Santé Publique en Suisse

Etat Membre de l'OMS
Pays: Suisse
Adresse du site Web: http://www.bag.admin.ch

Résumé de la contribution:

Audition publique sur les moyens de réduire l'usage nocif de l'alcool

A. Stratégies efficaces pour réduire l'usage nocif de l'alcool

Selon les expériences faites en Suisse, des stratégies efficaces pour réduire l'usage nocif de l'alcool devrait être fondée sur les postulats suivants:

- Il convient d'aménager la politique en matière d'alcool selon le principe de l'evidence based policy.
- La politique met prioritairement l'accent sur la réduction de la consommation problématique.
- La priorité revient à l'application des dispositions de protection de la jeunesse existantes et à la prévention.
- La politique vise davantage la réduction des conséquences négatives de la consommation pour les proches et pour la société (violence, accidents et sport).
- La prévention comportementale et la prévention structurelle doivent être prises en considération.
- La mise en œuvre d'une stratégie mondiale doit être organisée en un processus ouvert et transparent pour toutes les parties prenantes.

- Dans le cadre de la mise en œuvre de la stratégie, il faudra assurer l'information et l'acquisition de données ainsi que l'évaluation et la formulation de recommandations sur les actions à entreprendre.
- L'efficacité de la stratégie doit être évaluée. Les objectifs d'efficacité concrets devraient être définis.

B. Activités en Suisse: Programme national alcool 2008–2012 (PNA)

La Confédération suisse renforce actuellement son engagement dans le cadre d'un Programme national alcool. Le programme est fondé sur la vision suivante : «Celles et ceux qui boivent de l'alcool le font de façon à ne nuire ni à eux-mêmes ni aux autres.»

Pour préciser cette vision, le programme retient 7 objectifs principaux:

1. La société ainsi que les milieux politiques et économiques sont sensibilisés à la vulnérabilité particulière des enfants et des adolescents et soutiennent les mesures adéquates de protection de la jeunesse.
2. La consommation problématique d'alcool est en diminution.
3. Le nombre de personnes dépendantes de l'alcool a diminué.
4. Les conséquences négatives de la consommation d'alcool sur les proches et l'entourage ont considérablement diminué.
5. Les conséquences négatives de la consommation d'alcool sur la vie sociale et sur l'économie ont diminué.
6. Les acteurs publics et privés du domaine de l'alcool coordonnent leurs activités et contribuent ensemble à une mise en œuvre réussie du Programme Alcool.
7. La population connaît les effets négatifs de la consommation d'alcool et soutient les mesures appropriées prises pour les réduire.

C. Champs d'action et orientations stratégiques

Pour chacun des objectifs (mentionnés sous lettre B), le Programme national suisse définit 10 champs d'action avec des mesures spécifiques. Ces propositions de mesures nous semblent également applicables à un niveau global:

1. Protection de la santé, promotion de la santé et dépistage précoce
2. Thérapie et intégration sociale
3. Réduction individuelle et sociale des risques
4. Réglementation du marché et protection de la jeunesse
5. Information et relations publiques
6. Collaboration institutionnelle
7. Recherche et statistique
8. Application du droit, directives internationales
9. Ressources, financement
10. Assurance qualité, formation de base et continue

Contribution intégral: Nr. 156

Thailand: Office of Alcoholic beverage control committee, Department of Disease Control, Ministry of Public Health

WHO Member State
Country: Thailand
Web site: http://www.moph.go.th

Summary:

From our perspective, the effective approach to reduce alcohol-related harms must obtain few characteristics. First of all it must rely on existing knowledge, which can help stakeholders better structure the problems. The technical knowledge is also important to clarify myths and delusions, which are obstacles to the development of alcohol policy. These include those policy discourses that are created by stakeholders with conflict of interest with intention to protect their profit. Therefore, the effective approach should create global climate and better understanding to support the development and better implementation of alcohol policy at all levels.

Secondly, it should have comprehensive policy framework and focus on all policy targets. The appropriate alcohol policy framework must cover three policy mechanisms; consumption control, harms deterrence, and harms recovery. These three mechanisms function differently, therefore cannot replace each others.

Alcohol policy interventions differ in their effectiveness and cost-effectiveness. Evidences suggest that interventions to control consumption and those aim at general population are more effective and cost-effective. Despite their value, these interventions have increasingly lost their popularity. And this vicious trend must be addressed and curbed urgently. The effective approach must address and alleviate the existing limitations and threats, and to raise policy momentum for those population-based interventions aim to control consumption and marketing.

The transparency and integrity of the process and stakeholder participation are as of paramount importance. The stance and interest of those stakeholders with conflict of interest to alcohol policy should be recognized. Other stakeholders must well concern on the cost and potential consequences of letting those economic operators to involve in alcohol policy development process, as well as direct and indirect relationship with the alcohol industry and its nominee. The independency of stakeholders, from the influence of the alcohol industry and related entities, should be addressed. Further, the Global Strategy should clarify the appropriate role of stakeholders with conflict of interest, including the appropriate relationship of those stakeholders to others.

Taking these points into concern, WHO must have a leading role in creating ownership and commitment of stakeholders with no conflict of interest to concertedly tackle alcohol problems, supporting knowledge generation and utilization, creating that alcohol is a non-ordinary that should be treated differently from other commodities, supporting and guiding stakeholders to develop effective alcohol policy, protecting any threat to the alcohol policy development, and promoting the development of supra-national alcohol policy. But first of all, WHO must show it commitment to this issue, keeping alcohol off priority list is no more acceptable.

Full text: Nr 102

United Kingdom: Department of Health

WHO Member State
Country: United Kingdom of Great Britain and Northern Ireland
Web site: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4001740

The Department of Health would like to bring to your attentions two recent reviews on alcohol:

1. Document Title: Alcohol-attributable fractions for England
   Description: The most up-to-date review of the relationships between alcohol consumption and alcohol-related harms. This report examines the major causes of ill-health and mortality due to alcohol and determines what proportion of cases in England are caused by alcohol. Figures presented include the latest data for levels of hospital admission and number of deaths.
   Authors: Lisa Jones, Mark A Bellis, Dan Dedman, Harry Sumnall, Karen Tocque.
   Date Published: 22/07/2008 http://www.nwph.net/nwpho/publications/forms/dispform.aspx?ID=186

2. Document Name: The Independent Review of the Effects of Alcohol Pricing and Promotion. Summary of Evidence to Accompany Report on Phase 1:
   Description: In Safe. Sensible. Social: next steps in the national alcohol strategy, the Department of Health committed to commission an independent review of the relationship between alcohol price, promotion and harm. The review is being conducted by the School of Health and Related Research at the University of Sheffield. This Phase 1 report is a comprehensive summary of international evidence. Phase 2, reporting in the autumn of 2008, will provide detailed policy models.
   Published: 22 July 2008
   http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4001740?IdcService=GET_FILE&dID=178732&Rendition=Web
   Phase 2 report available here after publishing:
   http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4001740

SUBMISSIONS FROM GOVERNMENT INSTITUTIONS

Bureau of Substance Abuse Services, Massachusetts Department of Public Health

Government Institution
Country: United States of America

Massachusetts Bureau of Substance Abuse Services recommends comprehensive environmental strategies to reduce the harmful use of alcohol. We recommend that multiple strategies be instituted at once rather than one at a time. These may be most effective in developed countries.

Classify

- Require clear classifications of beer, wine and spirits. Make sure manufacturers categorize and sell new products correctly. (E.g. The alcohol industry has labeled some beverages with very high alcohol content as beer rather then as spirits.)
- Require clear, consistent classifications of drink sizes across all serving venues.

Limit access

- Bring alcohol tax structure up to date – raise taxes. Use these resources to fund prevention and treatment programs.
- Communities can and should have control over the density, location and hours of operation of retail outlets
- Compliance checks can be effective – though they're frequently under-funded.
- Supplement checks with random observations of purchaser "shoulder taps" by youth
- Create and enforce social host laws and keg registrations
- Set up random sobriety checks

Regulate advertising

- Limit or ban alcohol advertising in public spaces – on public transportation, near schools, at sporting events, at community, town or state fairs.
- If that can't be done, require a prevention or treatment referral ad for every alcohol ad.
- Require point of purchase advertising about fetal alcohol spectrum disorders
- Limit free distribution of T-shirts and other items advertising specific alcohol brands

Training

- Require server training on how to effectively refuse alcohol to underage purchasers and inebriated adult purchasers.
- Require state medical boards and specialty board certification panels to add questions about screening and intervening for risky use, and about referrals for unhealthy use to all physician, nurse and other health care provider board exams.

Canadian Association of Liquor Jurisdictions

Government Institution
Country: Canada
Web site: http://www.calj.org

Summary:
Each of Canada's 13 provinces and territories has a liquor board or commission that oversees the control, distribution and sale of beverage alcohol in its jurisdiction. While each of these bodies is unique, they are all committed to working together through The Canadian Association of Liquor Jurisdictions (CALJ) on liquor-related issues of common interest.

The heads of each of Canada's liquor boards and commissions meet at CALJ to discuss topics ranging from operations and trade to alcohol policy and social responsibility.

CALJ's mandate is to:

- promote and encourage frank, open and ethical practices concerning the control, purchase and/or sale of alcoholic beverages;
- co-operate with all provincial, territorial and federal agencies concerned with the control, sale and taxation of alcoholic beverages;
- improve the provinces' and territories' systems of control and distribution of alcoholic beverages by co-operation and free flow of information among the members of the Association and by regular meetings or conferences of the members of the Association and comparable jurisdictions outside Canada.

With regard to social responsibility and moderate drinking initiatives, CALJ mandated the jurisdictions to meet and review various programs and to determine the feasibility of implementing an annual national programme. Representatives of all jurisdictions meet to discuss the issues and plan national programmes on a yearly basis.

Since 2000, the committee implemented national programmes aimed at under age drinking, on issues related to responsible hosting and the responsible use of off-road vehicles (Personal watercraft, Snowmobiles and ATV's).

Moreover the different Liquor Jurisdictions believe that they have a responsibility to sell alcohol in the most rigorous manner and according to the highest moral standard. No sales to minors, no sale to intoxicated people are only but the least we can do as Alcohol Monopolies. But CALJ's members also consider they must do their share as collaborators in the field of public health. Of course, we are liquor jurisdictions and we don't have to be preachy and give "orders" to our customers. But we certainly can give them advice on how to best enjoy the products that we put on the market and sell. We are making sure that people enjoy the products we sell and do not harm themselves and others. This is what we convey to our customers.

Therefore, in the last ten years all CALJ members not only believe in the effect of prevention and education as an efficient tool to protect people from the harmful effects of alcohol abuse and misuse but also have implemented many programmes for that purpose. All jurisdictions have Alcohol and pregnancy programmes, Don't drink and drive initiatives, Training for servers in licensed establishments, Anti-binge drinking campaigns, Responsible hosts programmes and many others.

CALJ members strongly believe that alcohol is no ordinary commodity and therefore have a responsibility to support and promote public health. We see our educational and awareness initiatives as part of the solution to moderate, responsible drinking and to avoid/reduce the harmful effects of alcohol abuse.

Full text: Nr 165

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention, Alcohol Program

Government Institution
Country: United States of America
Web site: http://www.cdc.gov/alcohol

Summary of CDC Comments to the World Health Organization on the Development of a Global Alcohol Strategy

As noted in the WHO's Strategies to Reduce the Harmful use of Alcohol, harmful alcohol use causes 2.3 million premature deaths worldwide each year (3.7% of global mortality), and is responsible for 4.4% of the global burden of disease. In the United States, the harmful use of alcohol – that is, excessive alcohol use - is responsible for an average of 79,000 deaths per year and 2.3 million years of potential life lost (30 years of life lost per death), making it the third leading preventable cause of death in this country. Binge drinking, usually defined as the consumption on a single occasion of 5 or more drinks for a man or 4 or more drinks for a woman, typically leads to acute impairment and accounts for over half of these deaths and two-thirds of the years of potential life lost.

Similar to tobacco, alcohol consumption is strongly influenced by the environment within which people make their drinking decisions. Based on systematic reviews of the scientific literature, evidence-based strategies for preventing excessive alcohol consumption and related harms include enforcing an age 21 minimum legal drinking age, limiting alcohol outlet density, and increasing alcohol excise taxes. Screening and brief counseling has been shown to be effective in reducing excessive alcohol consumption. In addition, it is important to improve public health surveillance on excessive alcohol use and build public health capacity within member states to address this key health risk behavior.

The Alcohol Team in the CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) is involved in strengthening the scientific foundation for the prevention of excessive alcohol consumption. To accomplish this mission, the Alcohol Team conducts public health surveillance on excessive alcohol use, particularly underage and binge drinking, and related health outcomes; leads applied public health research on alcohol-related health impacts and population-based strategies to prevent excessive alcohol consumption; builds state public health capacity in alcohol epidemiology; provides public health leadership and collaborates in national initiatives to prevent underage and binge drinking.

Full text: Nr 321

Centro Alcologico Regionale Toscana

Government Institution
Country: Italy
Web site: http://www.alconline.it

No summary available.

Full text: Nr. 121

Child Protection Special Service of Budapest

Government Institution
Country: Hungary
Web site: http://www.tegyesz.hu

Summary:

1. An effective strategy against the excessive and improper alcohol drinking can not be based upon on the overall prohibition. The European approach must be professionally and methodologically well-thought out, which development reaches beyond the health-related aspects. Alcoholism in terms of its effects and consequences is an extremely complex problem. This must be mirrored in the "complexity" of the participants and strategy-creators, thus in their entire representation.

2. There is no one, beatific solution for the European countries against the excessive consumption of alcohol. A joint platform can be developed in terms of methodological approach and of defining common basic principles, goals and priorities. Prevention of the teenagers' alcoholism and mitigating the deviancies ruining families are pivotal problems for every European country.

3. My personal experience is that elaborating and realizing complex programs with the involvement of the mostly endangered teenagers is an important aspiration of the social workers, psychologists and educators working in the Hungarian child care. Complexity is extremely significant because for instance we can take measures against teenagers' excessive alcohol drinking if we are able to affect their social and economic environment.

Full text: Nr. 37

Habeb Public Mental Hospital, MOH Somalia

Government Institution
Country: Somalia

In providing our contribution based on our wish to focus on the following issues:

Question 1: What are your views on effective strategies to reduce alcohol-related harm?

Question 2: From a global perspective, what are the best ways to reduce problems related to harmful use of alcohol?

Question 3: In what ways can you or your organization contribute to reduce harmful use of alcohol?

1. Alcohol imported from Kenya/Ethiopia, while there are no national policies, programs and interventions of substance, due to the absence of effective infrastructure made the status to be worst, young stars fail education, increase criminal cases and insecure condition.

2. We think that the global perspective in this aspect should be to:

- •Raise community awareness global, internationally and by country level advise the harmfulness of alcohol related problems.
- • Share global information data/skills require concern the subject and make update those involve health programs particularly mental health member of staff.

3. We run/operate mental health hospital and rehabilitation center, we receive medicine and technical support from WHO Somalia only. Alcohol and Alcohol abuse is rapidly increasing and claiming lives in the Somali capital Mogadishu and in the lower shabelle region.

The interventions we perform include several activities at different stages like : -

- During admission of patient with drug addict like those of Alcohol consumers, we conduct Detoxification exercise.
- Psychosocial services and family counseling are the commonly used methods in Habeb public mental hospital and rehabilitation center.

Shortage of personnel. MNH professional workers are inadequate in number, in about 11 regions with estimated population of 8.5 million there are only four senior psychiatric Nurses available for mental health services. We strongly recommend as part of the strategy to obtain more and more psychiatry qualified personnel. We are planning to launch a Psychiatric institute very soon and this new power force might help us to facilitate/work on mental health activities in the long run.

Currently we are doing community awareness program related to drug addiction particularly Alcohol, Chat, Hashish and Alaq, which are widely used substance. And it is needed to increase the frequency of air time through the common radio in the region

We know that most of the new drug addicts are the young/adolescent of intermediate/secondary school age, so as to commence earlier we will add to our plan to prepare lectures to address the subject and to teach the risk/disadvantage of all type of drugs.

We strongly appreciate for your comments/advice on the subject

The Director of 2 mental hospitals in Mogadishu Somalia
Also National Mental Health Focal point MOH Somalia
Abdurahman Ali Awale

Komenda Wojewódzka Policji w Poznaniu

Government Institution
Country: Poland
Web site: http://www.wielkopolska.policja.gov.pl

Re: 1

Effective measures of combating alcohol-related problems include:

- Class therapy for the abused.
- Obligatory correction programmes for individuals convicted of crimes committed under the influence of alcohol.
- Comprehensive and multi-dimensional prevention commenced at early stages of education, combined with a national-scale campaign.
- Introduction of meetings with professionals into school curricula.
- Limiting material damages should be followed by the perpetrator's work in order to repair or make good the damage.
- Limiting psychological damage, e.g. by means of co-operation between the family and public organizations and specialists.
- Limiting social damage is a cohesive, tight and consistent national programme, assuming for providing assistance at all possible levels.
- The producers' participation in preventive measures.
- Instigating obligatory rehabilitation treatment and simplifying the related procedures.
- Social assistance targeted at individuals credible in their declared willingness to overcome addiction.
- Submitting rehabilitation treatment motions before local committees for solving alcohol-related problems.
- Submitting motions before family courts and other relevant institutions to apply measures to the addicted and their families.

Re: 2

According to Kompania Piwowarska, the best ways to alleviate the problems related to harmful drinking from the global perspective include:

- Adopting education and information measures aimed at decreasing the number of drunken drivers.
- Propagating a healthy lifestyle.
- Undertaking activities targeted at offering adolescents attractive alternatives of spending leisure time.
- Improving the quality of rehabilitation treatment and the national system of support for individuals combating addiction.
- By means of media campaigns and propagating alcohol drinking culture.

Re: 3

The police may contribute to limiting the damage caused by alcohol abuse by:

- Enhancing the skills of policemen involved in intervention related to people under the influence of alcohol.
- Improving the skills of district constables dealing with the underage in motivating and recognizing symptoms of alcohol addiction and violence.
- Consistent application of the law related to alcohol consumption.

- Education and repressive measures against drunk individuals on the roads and streets, especially drunken drivers.
- Education and repressive measures against owners of on-premise facilities and shops in the realm of the Act on Upbringing in Sobriety and Counteracting Alcoholism, especially the ban on selling alcohol to the underage.
- Large-scale preventive measures at schools, educational organizations, universities, churches etc.
- Close and large-scale cooperation with assistance institutions.
- Monitoring families with alcohol problems.
- Appropriate service organization, including venues where the law may be broken.
- Removing the drunk from public space.

Marin County Mental Health Board

Government Institution
Country: United States of America
Web site: http://www.co.marin.ca.us/depts/bs/members/mcbds/Brdpage.cfm?BrdID=53

Summary:

The Needs and Services Committee of The Marin County Mental Health Board is reviewing the county mental health program to find pluses and problems therein. In our review process, one re-occurring theme is lack of or cuts in funding for alcoholism and co-occurring disorders.

The Marin Mental Health Board is investigating the opportunity to charge those businesses in Marin County licensed to sell alcoholic beverages a per serving fee, including servings available in products sold at off site retail establishments. We are recommending these fees should be restricted for the costs of emergency services and treatment of alcoholism and mental heath co-occurring disorders. We believe this fee may be an opportunity to free up current available funds for other mental health issues.

Buena Ventura, CA adopted a municipal code in 2005 to recover costs of municipal emergency services. While municipalities currently may have more authority than counties to assess fees, we believe it important that these per alcohol fees be assessed at the county level and restricted for use to recover costs occurred for treatment of alcoholism and co-occurring disorders.

I have included a spreadsheet showing potential revenues at varying fee levels. The frequency data was provided by Marin Institute.

I believe this or a similar approach may be useful for all counties. Failure to address this funding crisis will result in higher health, crime, related prison costs and an increase in homelessness.

Gary G Scheppke Sr
Secretary, Marin County Mental Health Board
Chairman, Needs and Services Committee
615 Arlington Circle
Novato, CA 94947-4903
415-609-7451

Full text: Nr 261

National Supervisory Authority for Welfare and Health (Valvira)

(Former National Product Control Agency for Welfare and Health)
Government Institution
Country: Finland
Web site: http://sttv.fi (after 1.1.09 www.valvira.fi

Summary:

As summary, the Product Control Agency concludes, that alcohol markets and marketing are increasingly internationalized. Thereby, national regulations and restrictions are not enough, but we need international regulation about the advertising of alcohol and health education. The Product Control Agency would very much like to see in future WHO alcohol strategies global restrictions the alcohol marketing only to product information without images as well as health warnings in all alcohol packages and advertisings.

Full text: Nr. 103

New Mexico Department of Public Safety - Special Investigations Division

Government Institution
Country: United States of America

In approximately 90% of all citizen request for service (police assistance) alcohol is involved.

New Mexico Prevention Network

Government Institution
Country: United States of America

Question 1: What are your views on effective strategies to reduce alcohol-related harm?

Specifically to reduce harm; youth as well as adults need to be educated on a realistic level regarding harm. Creating an intense system of learning and letting youth and adults know and understand what to do in a harmful situation such as a friend being poisoned by alcohol, is one strategy. In addition, interlocks or some other non invasive form of alcohol detection in every vehicle would reduce harm both globally and locally. All drug/ alcohol related offenders should be restricted from purchasing alcohol.

Societal and cultural norms must change and early (prior to onset) prevention is one of a must use strategy.

Last but not least, there should be a handle on alcohol advertising. Each community should be able to tax alcohol as needed by their related needs.

Question 2: From a global perspective, what are the best ways to reduce problems related to harmful use of alcohol?

Problems with regard to the harmful use of alcohol, although similar, vary in every community, culture, country; local control with set parameters/guidelines is the best most effective approach. Also, communities need significant resources to battle the harmful effects of alcohol and the industry as well as individual responsibility.

Question 3: In what ways can you or your organization contribute to reduce harmful use of alcohol?

Our organization will continue to educate our individual communities. We will also participate in creating and supporting any new legislative policies that will assist in the reduction in alcohol related harm. We will continue to use evidence based programs, practices and policies to change the norms of our communities. We will continue to provide opportunities for our youth to develop into productive citizens. We will continue to utilize a comprehensive multisystem approach and we will continue to participate in the change that we want to see in our world and our communities.

New Mexico State Attorney General's Office

Government Institution
Country: United States of America
Web site: http://nmag.gov

Last fall the US Surgeon General spoke in New Mexico to unveil his 2007 Report, “Surgeon General’s Call to Action to Prevent and Reduce Underage Drinking”. Among other findings, the Surgeon General noted that:

- 38% of alcohol-related traffic deaths involve underage drinkers; and
- 32% of youth homicides involve alcohol

On top of this, the Journal of the Study of Alcohol and Drugs recently reported that 20% of all alcohol is consumed by underage drinkers.

As a result, one of my legislative priorities in 2009 will be to address this crisis in underage drinking. Numerous research reviews have determined that increasing excise taxes, along with other pricing policies that increase the cost of alcohol, is one of the most effective strategies for curbing abuse of alcohol. With this in mind, I plan on seeking enactment of the following tax legislation to curb the harmful use of alcohol by underage drinkers:

- Increase the Tax on “Flavored Malt Beverages” (aka “Alcopops”).
- Give Every County the Option For Taxing Alcohol at a higher rate to generate revenue for substance abuse programs

In addition, I am proposing:

- A Ban on Alcohol with Caffeine and other stimulants (aka Alcohol “energy” drinks)
- A Prohibition on Alcohol Consumption By Minors
- Regulation of alcohol advertising to youth

From a global perspective, the best ways to reduce alcohol-related harm are:

- Globally, public health interests must be represented in global trade negotiations, and trade agreements need to make exceptions for commodities like alcohol that pose a serious threat to public health and safety.
- Global public health leadership is needed, in the form of WHO identifying and training governments and NGOs in how to implement best practices in monitoring and controlling alcohol-related harm.
- Leadership from WHO and governments in the developed world in providing support and resources to developing nations to insure effective alcohol policies that are based on public health and safety principles and to offset the influence of the global alcohol industry.
- Global networks are needed among NGOs to strengthen coordination, share lessons learned and peer support, and provide a civil society alternative to the globally well-organized and coordinated alcohol industry

Programa de Salud Mental Barrial del Hospital Pirovano, Bueno Aires

Government Institution
Country: Argentina
Web site: http://talleresdelpirovano.com.ar

Summary:

The idea is to help population pointing to the heart of the problems that have influence in alcohol or other substances or object abuses.

To promote real and vivid values, not only fear and emotionally empty information about the consequences of abusing of alcohol.

Also it is important to have strict control over publicity in order to protect minors and not to allow the association between discontrol, happiness and having social status with the drinking of alcohol or the possession of consume objects.

It is fundamental to educate against the idea of a materialistic world as a Utopia.

The possibility of having significative relationships, to avoid loneliness and the possibility of having healthy projects that make life meaningful is very important too to avoid the abuses. Abuse has to do with lack of personal and community horizons. It is not the substance's fault, humans are the ones that use this and they do it in order to feel better. We have to try to discover what makes people feel bad, not only try to destroy alcohol.

Full text: Nr. 274

Public Health Institute and Directorate of Health

Government Institution
Country: Iceland
Web site: http://www.lydheilsustod.is

The contribution is a view from two governmental institutions. It is our belief that the best way to reduce harm is to address availability, price and access to treatment. Also minimum taxes on alcohol in the region and ban on advertising directed to young people.

It is well documneted that availability to alcohol is one of the main factor to reduce harmful use of alcohol. In Iceland we have monopoly on sale of alcohol and it is our beliefe that keeping this form for sale of alcohol is a very important resource to diminish the harmful use of alcohol. In addition to monopoly we have fairly high taxes on alcohol whith higher taxes for stronger types of alcohol. The real price of alcohol has been decreasing for the last ten years and numbers of monopoly outlets have increased. At the same time we have experienced a significant increas in the total alcohol consumption per capita 15 years and older.

From the public health perspective the two institutes (Public Health Iinstitute & The Directorate of Health) recomends strategies that focus on availability and affordability of alcohol, access to treatment and brief intervention in the primary health care. In addition there should be a minimum European or global taxes on alcohol and a ban on alcohol advertising that are directed to young people and in relation to sports events and leisure activities.

Our organisations can tribute to reduce the harmful use of alcohol by monitoring the development of alcohol policies, put pressure on and advice the government, municipalities and relevant institutions to implement strategies that are relevant and evidence based. Also by monitoring recent deveopments in strategies and disseminate the knowledge.

Full text: Nr. 312

South Shore Health; South West Health; Annapolis Valley Health

Government Institution
Country: Canada

Summary:

Effective strategies to reduce alcohol-related harm need to address the contexts, the culture and the environments in which alcohol is consumed. We must be a part of fostering the environments most conducive to the healthiest possible behaviours, thereby reducing the likelihood of harm. As per best practice approaches to reducing alcohol-related harm, we are looking at helping shape environments with public policy so that the healthier choices will be the easier choices. Before public policy is addressed, however, a readiness in our communities must exist. In order to prime and ready our audiences, we must start from the grassroots. At this level, we are encouraging community capacity building by supporting a network of concerned citizens. The following describes the early stages of our communities' attempts at increasing readiness for change, as the network grows.

At Addiction Services in the South Shore, South West and Annapolis Valley Health Districts in Nova Scotia, Canada, alcohol strategy staff are working on population-based approaches to reduce alcohol-related harm within the framework of the Provincial Alcohol Strategy. The five key directions identified in the Strategy are as follows: Community capacity and partnership building; Communication and social marketing; Strengthening prevention, early intervention and treatment; Healthy public policy; Research and evaluation.

The approaches outlined in the Strategy include ways in which to address and challenge common notions about alcohol and its uses. Canadian culture and more specifically, Nova-Scotian culture has normalized over-drinking, and has come to see it used as a coping mechanism, an escape, and even a way in which to increase social prestige. It is these messages that we are asking our friends, colleagues and neighbours to pay closer attention to and to question the subtle cultural influences that these messages convey.

At a grassroots level, we are engaging with community members, asking them to look at the environments in which they live and encouraging a closer look at daily alcohol influences and influencers within their neighbourhoods. Some issues that have arisen include: the growing ease of access to alcohol including increased hours and days of operation of alcohol outlets, the alcohol industry within schools and alcohol proliferation in the media.

The continued fostering of an advocacy network is key in supporting long term and sustainable change. In looking at the overall goal of Nova Scotia's Alcohol Strategy, i.e., to change the culture of alcohol use in the province, it is imperative that there is a level of readiness for this change among community members. Supporting the growth of this network as one of the key pieces of the Strategy will help create the contextual, cultural and environmental readiness for the appropriate kinds of changes that will reduce the types and patterns of drinking that are most harmful.

Full text: Nr. 299

Taipei City Hospital, Taipei

Government Institution
Country: Taiwan

Strategies to reduce the harmful use of alcohol
Vickey huang and Shih-ku Lin
Taipei City Hospital and Psychiatric Center

We would like to propose some ideas regarding the reduction of hazardous drinking

As to strategies and policy element in Health sector:

- List alcohol as one of the potential toxic substances despite there was some limited positive health effects of low levels of alcohol consumption in some population. The latter fact will bring some rationalization background for certain groups who usually bear greater damage from alcohol consumption.
- Provide regular public education about not only the physical dangers or a variety of alcohol-related comorbidity but also the mental, social and cognitive impairment caused by alcohol consumption, as well as its dependence-producing properties. The educational programs should be started as early as elementary school to reduce the adolescent drinking which will increase the likelihood of adult alcohol dependence.
- Advocate the concept of moderate drinking if the drinking occasion is unavoidable. Meanwhile, incorporate the drinking behavior items, e.g. the frequency and quantity of alcohol consumption, into the nation-wide health surveillance to raise the attention of general population about the drinking-related problems.
- In addition to health promotion, early identification of hazardous and harmful alcohol consumption is vital to prevention of those vulnerable patients from the progression to alcohol dependence which is, to some extent, not reversible. The use of screening tools to identify hazardous (or problematic) drinking must be routinely

used in health-providing setting whenever unhealthy alcohol use is suspected, in court for drunk-driving and alcohol-related violence, in health-care system for intentional(e.g. suicide) and unintentional (traffic accidents) injuries or transmission of certain infectious disease, or for vulnerable groups, such as young people and pregnant women.

- Appropriate monitoring system for those hazardous or problematic drinker is mandatory. The strategy of brief intervention, or any evidence-based intervention, is needed to help those vulnerable cases.
- For those whose drinking severity reaches alcohol dependence, abstinence is exclusively the treatment goal. There is no safe or moderate drinking for them.

U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Government Institution
Country: United States of America
Web site: http://www.niaaa.nih.gov

Summary:

The National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health is pleased to submit a brief summary of current research on effective strategies to reduce alcohol related harm. The summary suggests a life span approach to prevention, as the misuse of alcohol poses different threats at various stages of human development. Where possible, links to supporting documents have been provided. As a research institute, NIAAA does not make policy recommendations.

Full text: Nr. 71

ФГУ "Центральный Научно-Исследовательский Институт Организации и Информатизации Здравоохранения Минздравсоцразвития России", Научно-исследовательская организация

Government Institution
Country: Russian Federation
Web site: http://www.mednet.ru

No sussmary available

Полный текст Nr. 335

SUBMISSIONS FROM INTERGOVERNMENTAL ORGANIZATIONS

Secretariat of the Pacific Community

Intergovernmental organization
Country: New Caledonia
Web site: http://spc.int

No summary available.

Full text: Nr. 224

SUBMISSIONS FROM ACADEMIA-RESEARCH

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Canadian Foundation on Fetal Alcohol Research

Academia-Research
Country: Canada
Funding or support from alcohol industry? Yes
Web site: http://www.fasdfoundation.ca

Summary:

The Canadian Foundation on Fetal Alcohol Research (CFFAR) is an independent, non-profit foundation created to promote interest and fund research related to the short and long-term bio-medical, psychological and social effects of alcohol consumption during pregnancy, and the prevention of fetal alcohol spectrum disorders (FASD). FASD is the leading cause of developmental and cognitive disabilities among Canadian children. CFFAR was established in 2007 through an initial contribution of $1 million over five years from the Canadian brewing industry. In 2008, following a peer review process based on standards set by the Canadian Institutes of Health Research, CFFAR selected its inaugural grant applications. This work, and the work of future grantees, will advance knowledge of bio-medical, psychological and social aspects of alcohol consumption during pregnancy. It will also enable the development of improved tools and strategies for healthcare professionals, improved medical and psychosocial assistance for individuals and their families living with FASD. While research can never replace a network of support and education, it is the key ingredient to understanding the causes and effects of FASD, and to developing ways to address them. Most importantly, the goal of CFFAR is to help launch a new generation of Canadian researchers dedicated to increasing our understanding of the effects of alcohol consumption during pregnancy. The Canadian approach recognizes that FASD is a public health and social issue, affecting individuals, communities, cultures, families and society as a whole. All sectors are called on to continue to make efforts to prevent FASD and support those who must live with it. CFFAR believes that the strategy and actions in Canada have applications to addressing FASD on a global level.

Full text: Nr. 129

Centre for Addiction and Mental Health

Academia-Research
Country: Canada
Funding or support from alcohol industry? No
Web site: http://www.camh.net

No summary available.

Full text: Nr. 301

Centre for Social and Health Outcomes Research and Evaluation (SHORE), Massey University, Auckland

Academia-Research
Country: New Zealand
Funding or support from alcohol industry? No
Web site: http://www.shore.ac.nz

Summary:

The SHORE Centre strongly supports the development of a WHO global alcohol policy strategy. However, to ensure that this receives full political commitment by all member governments, we believe this will need to have the status of a Framework Convention on Alcohol Control.

In regard to effective policies, the SHORE Centre supports the recommendations of WHO's Expert Committee on Problems Related to Alcohol Consumption on the effectiveness of regulating availability, enforcing appropriate drink-driving policies, reducing demand through pricing and taxation, as well as raising awareness and support for these policies.

The SHORE Centre also supports the Expert Committee's recommendations of policy to counter increasingly sophisticated methods of marketing alcohol, focusing on limiting the amount of alcohol promotion of both global and local brands. Its recommendations include include effective regulation or banning of alcohol advertising and sponsorships of cultural and sports events, in particular those that have an impact on younger people.

In addition, the SHORE Centre recommends that the global alcohol policy strategy address the public health implications of increased trade in alcohol. International trade agreements can have impacts on alcohol availability and consumption and also on the implementation of effective national policies. This issue is already included in the WPRO Regional Strategy and addressing it in a WHO global alcohol policy strategy will help ensure that member governments' public health goals are not overridden by trade principles, as at present. SHORE supports the Expert Committee's recommendation that WHO should work more closely with WTO and other relevant UN agencies to address trade issues as part of its work towards a global alcohol policy strategy.

A strong global leadership role by WHO is needed to assist member governments in responding to the globalised, marketing-driven alcohol industry. The time is right for a WHO global alcohol policy strategy, laying out the most effective and cost-effective strategies. This should be supported with detailed information on implementation, monitoring and enforcement at the national level. This support is important to counter the influence of the industry and its organisations, such as ICAP who offer information and policy advice that best suits industry interests. To this end SHORE recommends the creation of a WHO Cabinet Office focused on alcohol, working with the network of WHO Collaborating Centres including the SHORE Centre.

The SHORE Centre has been a WHO Collaborating Centre since 2004. Its Director Professor Sally Casswell is a member of the WHO Expert Committee on Problems Related to Alcohol Consumption. SHORE contributed to background papers and a Resource Book for the WHO WPRO Regional Strategy to Reduce Alcohol-related Harm and continues to provide technical contributions to the work of the WHO Secretariat at both the global and regional level related to the reduction of alcohol related harm. SHORE has contributed research and policy advice to New Zealand policy-makers, government agencies, local government and community projects on a wide range of alcohol policy issues.

Full text: Nr. 249

Faculty of Public Health Medicine, Royal College of Physicians of Ireland

Academia-Research
Country: Ireland
Funding or support from alcohol industry? No
Web site: http://www.rcpi

Summary:

Alcohol consumption is linked to more than 60 diseases and conditions affecting nearly every organ in the human body and is the third highest risk factor for premature death and ill-health in the European Union. Alcohol-related harm include such problems as accidents, injuries, chronic ill-health, premature death, public safety, violence, child neglect, marital problems and lost productivity due to absenteeism or poor performance at work.

There is extensive harm caused by alcohol in Ireland.

- 34% of those seeking legal advice due to marital breakdown cite alcohol as the main cause
- 31% of road deaths are alcohol related
- Alcohol related admissions to hospitals increased by 95% between 1995 and 2002.
- Every 8th new patient attending A/E is there because of alcohol related injury
- Intoxication in a public place increased by 470% from 1996 to 2002
- Cost to the economy in 2003 was €2.65 billion.
- Alcohol related mortality Ireland 1992-2002
- Mortality from alcohol acute conditions + 90%
- Mortality from alcoholic specific chronic conditions + 61%
- Whilst overall mortality fell by - 14%

Repeated ESPAD studies show Ireland's young people to be amongst the very highest for consumption and for binge drinking. Young people are particularly susceptible to advertisements and the promotion of alcohol and most likely to be harmed by drinking. It is vital to delay the age of onset of drinking by young people, as recommended by the WHO.

Effective Strategies to reduce alcohol related harm

The more a population consumes the greater the degree of alcohol related harm. Strategies therefore should concentrate on reducing our overall consumption. The following strategies are required to reduce consumption and alcohol related harm:

1. An increase in price through taxation
2. A minimum price on alcohol in particular for off sales
3. A decrease in the physical availability of alcohol through restrictions on hours of sale and the number of premises available to sell alcohol

4. A ban on advertising of alcohol
5. A ban on the sponsorship of sporting events by alcohol companies
6. Targeted action in respect of road safety with the reduction of the legal limit for driving to 50mgs% for drivers and to 20mg% for learner and professional drivers.

As alcohol related harm effects every sector of the population there is a need for a strong leadership and a coordinated approach at government level across all departments. There is a need for one government body or agency to coordinate the required actions.

For strategies to be effective there has to be an acceptance by governments that alcohol is no ordinary commodity and that alcohol is a legitimate health concern and not just an industry. The need for alcohol companies to increase profits for their shareholders is a barrier to reducing consumption, yet alcohol industry representatives have a greater influence on governments' alcohol strategy than those advocating for healthy public policy.

There is a need for a framework convention on alcohol to be developed as is the case for tobacco.

Full text: Nr. 168

Institute on Lifestyle & Health, Boston University School of Medicine, Boston, MA, USA

Academia-Research
Country: United States of America
Funding or support from alcohol industry? Yes

Summary:
Comments on the WHO Initiative for Reducing the Harmful Use of Alcohol

The Institute on Lifestyle & Health has been monitoring scientific publications on alcohol and health for the past 14 years. It has become apparent that there are often exaggerations of both the benefits and dangers from alcohol intake. Based on our critique of thousands of papers, we have reached a few conclusions, summarized below. The faculty of the Institute strongly agree with the need for measures to try to curb the serious problems with alcohol abuse around the world. It is hoped that our observations will be considered by WHO as it develops focused and effective programs against abuse, programs that at the same time will not reduce the healthful use of alcoholic beverages by the majority of mature adults in many of our societies.

(1) Heavy drinking and binge drinking generally have no health benefits but often are associated with both acute and chronic harms to health.

(2) The most important determinant of health effects appears to be the pattern of drinking (regular moderate use versus irregular excessive use), and is not necessarily captured when assessing only the average intake over a period of time.

(3) The major demonstrable health benefits of moderate alcohol intake are among middle-aged or older adults, and relate to the risk of many of the diseases of ageing (e.g., coronary heart disease, ischemic stroke, osteoporosis and fractures, dementia).

(4) For most, moderate alcohol consumption should be considered as a component of a "healthy lifestyle," one that also includes (1) not smoking; (2) avoiding obesity; (3) getting regular exercise; and (4) consuming a diet high in fruits, vegetables, and whole grains. Even among individuals who follow other components of a healthy lifestyle, the addition of moderate drinking provides additional large health benefits.

(5) Societal norms and cultural influences appear to be key factors that relate to whether a society consumes alcohol in a moderate and responsible way or tends to drink to excess. Within Italy, for example, in areas such as Tuscany and Umbria, 80% of the population consumes alcohol, but there are low rates of alcohol abuse, whereas in other areas fewer people consume yet abuse is greater. One effective approach for decreasing acute alcohol abuse is surely through cultural changes, making it "socially unacceptable" to be intoxicated in public.

(6) Measures to decrease alcohol misuse should be focused so that they do not achieve reduction of abuse at the cost of reducing benefits among those engaging in healthful consumption of alcohol. Abraham Lincoln, the sixteenth president of the US, stated that alcohol problems arose not from "the use of a bad thing, but from the abuse of a very good thing."

R. Curtis Ellison, MD, MSc
Yuqing Zhang, MD, DSc
Luc Djoussé, MD, DSc

Full text: Nr. 66

International Health Policy Program

Academia-Research
Country: Thailand
Funding or support from alcohol industry? No
Web site: http://ihpp.thaigov.net

Summary:

Four major characteristics for the effective approach to reduce alcohol-related problems are; clear policy direction and strong policy commitment, effective policy content, effective policy implementation, and being transparent or free from influence of commercial interest. To promote these characteristics, WHO should show its commitment to this problem, including by upgrading alcohol unit, and through the development of international alcohol policy in the line with FCTC. Further, WHO should take a key role in inducing other international and national agencies to pay attention in reducing alcohol-related problems.

From our point of view, the Global Strategy should, firstly, aim at strengthening the capacity of three main sectors; technical knowledge, political involvement, and social support (or civil society). Secondly, the bridge between these three pillars should be created and strengthened in order to synergize these social assets. The third principle is on the integrity and transparency of the process. Conflict of interest should be a major concern. Stakeholders with conflict of interest should have appropriate role in appropriate space, where their status and interest are well aware of by others.

According to these three principles, five missions for the Strategy are 1) setting up policy direction at all levels, 2) identifying and minimizing policy gaps in three sectors, by prioritizing areas that are hardly addressed by other agencies, 3) strengthening knowledge management including generating of knowledge-in-need and its utilization, 4) setting up and promote the use of connection mechanism, and 5) set up the appropriate role of stakeholder with conflict of interest.

For the first area of priority, we would like to see the Strategy to focus on alcohol consumption control at aggregate level, aiming to control drinker prevalence, drinking frequency and consumption per occasion. Three major tools the Strategy should address are taxation, physical availability control and marketing control. The Strategy and stakeholders should be aware of the poor effectiveness of industry-friendly alternatives. The second priority for the Strategy is to promote the global climate toward effective alcohol policy. This includes clarifying ambiguity and myth on alcohol policy, and creating global awareness that alcohol is an obstacle for health, well-being, human achievement and social development, and awareness on the interest of economic operators and their nominee, as well as negative impact to public from the participation of stakeholders with conflict of interest.

Alcohol Policy Research Program (APR) under the International Health Policy Program (IHPP), and its supporter the Center for Alcohol Studies (CAS), are alcohol-specialized technical entities, quite uncommon in low and middle income countries. Being integrated into the Ministry of Public Health, APR and IHPP can connect both official and technical spheres, support the role of Thai officials on the international forums, and be an active technical facet for cross-border knowledge sharing and joint research. Locating in an emerging market zone, APR can also be the focal point on alcohol policy for WHO and other agencies, with no conflict of interest, for the Southeast Asia region and neighboring countries.

Full text: Nr. 73

International Network of Brief Interventions on Alcohol Problems

Academia-Research
Country: Spain
Funding or support from alcohol industry? No information
Web site: http://www.inebria.net

Summary:

INEBRIA strongly supports the development of a global strategy to reduce the harmful use of alcohol, that is based on the implementation of evidence based environmental policies, such as price and regulations on the availability and marketing of alcohol products, since such environmental policies are likely to augment the impact of brief advice programmes delivered in primary care. INEBRIA notes that as the main providers of health care, the many millions of health workers worldwide can contribute substantially to reducing and preventing harmful use of alcohol.

INEBRIA recommends that health care systems should ensure that early identification and brief advice programmes for hazardous and harmful alcohol consumption are widely available for all alcohol users. In particular, individuals with co-morbid conditions, for example hypertension, and those attending STD and HIV/AIDS clinics, should be offered screening for hazardous and harmful alcohol use, and advice and treatment as appropriate to reduce their alcohol consumption. INEBRIA agrees that identification and brief advice programmes are most effective when

supported by sound policies and health systems and integrated within a broader preventive strategy. INEBRIA also agrees that health-care providers should concentrate on clients' health improvement and satisfaction through evidence-based and cost-effective interventions, and governments, in improving health systems, should take into consideration services for alcohol-use disorders and interventions for hazardous and harmful use of alcohol.

Full text: Nr. 223

National Drug Research Institute

Academia-Research
Country: Australia
Funding or support from alcohol industry? No
Web site: http://www.ndri.curtin.edu.au

No summary available.

Full text: Nr. 137

Royal College of Nursing

Academia-Research
Country: United Kingdom of Great Britain and Northern Ireland
Funding or support from alcohol industry? No
Web site: http://www.rcn.org.uk/

Summary:

The Royal College of Nursing (RCN) is the UK's largest professional association and trade union for nurses, with over 390,000 members. The RCN works locally, nationally and internationally to promote high standards of care and the interests of patients and nurses, and of nursing as a profession. We welcome this opportunity to respond to the above document.

Nurses work in diverse areas and are faced with the consequences of excessive alcohol consumption on a daily basis. This ranges from having to deal with violent and aggressive patients in A&E, to caring for people and their families suffering from long term conditions as a direct result of drinking alcohol.

In England, hospital admissions directly attributable to alcohol are rising by 80,000 people a year. The cost of alcohol consumption to the NHS is estimated to be £2.7 billion (€3.4 billion) a year, this does not take into account the social costs that could be attributed to excess alcohol consumption such as crime and disorder, lost days at work and the detrimental effects it can have on family life.

People living in deprived areas suffer the highest levels of disease and hospital admissions due to alcohol abuse . This contributes to the inequalities in health suffered by those living in deprived circumstances.

We hope, through this response to contribute to a global reduction in the harm caused by alcohol by providing a summary of some of the successes and failures of a number of approaches that have been used in England and a number of measures suggested by the RCN to further reduce this harm.

KEY POINTS

1) The RCN favours the introduction of mandatory retailing code for all premises that sell alcohol. This code should include provision for the protection of public health. Voluntary industry codes are not working. A mandatory code for both on and off license retailers would deter premises selling alcohol from engaging unsafe and unscrupulous practices by creating a degree of accountability.

2) The RCN favours the introduction of mandatory unit labeling for alcoholic products together with a warning to women who are pregnant or trying to conceive. Consumers have a right to know how much they are drinking and that drinking to excess can have a harmful effect on health.

3) The RCN believes that reducing the harm caused by alcohol should be a public health priority. A multi-faceted approach is favoured. Engagement at the local level including nurse run intervention programmes is key. It is vital that adequate resources are available. i.e. sufficient number of school nurses are needed if nurse lead alcohol education sessions are able to be effectively conducted in schools.

Full text: Nr. 147

School of Public Health, Central South University

Academia-Research
Country: China
Funding or support from alcohol industry? No

Although we know a little alcohol drinking is helpful for our health, we have difficulties in limit the amount of alcohol if we drink, this is especially so for the disadvantage populations. The disadvantaged persons are more likely to drink more to balance their lost respect or dignities. As a result, alcohol is a triggering factor for them. To avoid the infeasibilities, I prefer to take a radical attitude: forbid drinking in every place at any time. Of course, many opponents might protest that this will violate their freedom. We have to come to the balance between human right/freedom and health. If we want to prohibit drinking alcohol, there will be lots of obstacles in front of us, such as culture, politics, and freedom. In China, persons who drink more alcohol than others gets more advantages than the others, particular for a man. This potential rule has been recognized by most Chinese.

Second University of Naples

Academia-Research
Country: Italy
Funding or support from alcohol industry? No information

Summary:
The relationships occurring among alcohol abuse and diseases/disability/mortality are well known. Similarly, the misuses of alcohol by young people across Europe is well known. Little known are, on the contrary, the concepts about the potential toxicity of ethanol also at low daily doses, as a "cofactor" of a large series of diseases. In fact, the duration of alcohol use, more than its amounts, is related to the occurrence of diseases of the liver, of diabetes, of hypertension, etc.
Alcohol enhances the toxicity of drugs, of smoke, of various foods, such as those containing fructose or polyunsatured fats, etc. The actual main characteristics of young people from industrialized countries are: the spontaneous indiscriminate use of various drugs, frequently as herbal products, that, in the majority of cases, are uncontrolled by institutions, the use of "fast foods", rich in fructose, in satured and polyunsatured fats, the use of alcohol, moderate or not. Liver steatosis, metabolic syndrome and obesity, are all pathologies of young European people.
An European strategy of intervention on the problem "alcohol", could necessarily involve a more large discussion about the total life style of our young people. We suggest to discuss about alcohol, not only as a substance dangerous for the nervous system and for the dependence, but also as a substance that, particularly in young subjects, may induce or facilitate the occurrence of a large series of diseases, from the liver to the cardiovascular system.

Full text: Nr. 39

Strengthening Families Center at University of Utah

Academia-Research
Country: United States of America
Funding or support from alcohol industry? No
Web site: http://www.strentheningfamilies.org and www.strengtheningfamiliesprogram.org

Summary:
The most effective method for reducing alcohol misuse in adolescents is to implement evidence-based parenting and family skills training programs. When the Director of the US Center for Substance Abuse Prevention (CSAP), Dr. Karol Kumpfer, funded 150 communities in the USA to pick one of the evidence-based family programs to imlement from a list of 34 excellent program from a government web site (www.strengtheningfamilies.org), the rapidly increasing substance abuse rates in adolescents began to decrease. Tested theories of the causes of alcohol and drug use in teenagers suggests that the strongest protective factors are three family mediating variables (parent/child bonding and attachment, family supervision and monitoring, and family norms and values) (CSAP, 2000; Kumpfer, Whiteside, & Alvarado, 2003).

Because of the effectiveness of family interventions, the UN Office of Drugs and Crime under the leadership of Dr. Gilberto Gerra organized an expert panel of parenting and family researchers from all over the world in November of 2007 in Vienna to develop a protocol for cultural adaptation and dissemination of the best parenting and family programs. A global search in the past year by Dr. Kumpfer and associates as consultants for the UNODC has revealed over 450 parenting and family interventions for the prevention of alcohol and drug misuse. About 50 of these programs were judged to have high levels of evidence of effectiveness based on multiple randomized control trials with about 20 of them having independent replications. Given that the WHO (2007) and Cochrane Collaboration Reviews by Foxcroft and associates (2003) at Oxford Brooks University have found that the two best

universal alcohol prevention programs in the world are family-based programs, it appears that the UN approach of disseminating these effective parenting programs globally is a very effective strategy for reducing the harms causes by alcohol misuse. Program descriptions and contact information should be on the UNODC website by next spring. Targeting youth for alcohol and drug information or even skills training is not as effective as changing their long-term family environment with parents communicating more effectively the harms and consequences of alcohol misuse and serving as positive role models. Hence, this long-term environmental strategy appears to be very effective. In fact, very cost effective as well. A meta-analysis of the cost-benefit ratios by Aos and associates was reanalyzed by Kumpfer into the different family and youth centered interventions. It was found that family skills training approaches had the highest cost/benefit ratios. In fact, Foxcroft and associates (2003) found the Strengthening Families Program (10-14) to be three times as effective as the best youth only interventions using life skills training and twice as effective as the next best program which was a parenting and youth skills training program but didn't include the family skills training component. Hence, it would appear that to reduce alcohol initiation and binge drinking in youth, implementing evidence-based family skills training approaches should be recommended by the WHO and UN globally. Luckily many of these have language translations, cultural adaptations, and tested positive outcomes in other countries.

Full text: Nr. 220

The Australian Wine Research Institute

Academia-Research
Country: Australia
Funding or support from alcohol industry? No information
Web site: http://awri.com.au

Summary:
In summary, to change the behaviour of an individual is complex, and price and labelling are simplistic interventions. Interventions to reduce harmful or risky alcohol drinking must make an individual: feel personally susceptible to a health (or other) risk; believe that the risk can cause a significant harm; and know what actions can be taken to avoid the harm, and also know the cost or benefit of the actions; if the costs outweigh the benefits, the action to avoid the harm is unlikely to be taken.

Full text: Nr. 230

Western Michigan University

Academia-Research
Country: United States of America
Funding or support from alcohol industry? No
Web site: http://www.wmich.edu/shc

Summary:
Much research has been done in the United States since the 1990's to find effective ways to prevent and reduce the harms of underage and binge drinking. Several models have been developed that incorporate the key approaches in environmental prevention, which use the strategies of health education to focus on social norms, laws and policies, media and access. Social norms theory has found that using positive statistics on actual drinking behaviors is an effective way to dispel myths and encourage responsible drinking. In terms of behavior management a shift has taken place in the field of public health prevention that focuses on harm reduction as opposed to abstinence only education. On a broader level, like the tobacco and fast food industries, we must hold the alcohol industry accountable for their blatant attempts to target at risk and vulnerable communities and shed light on the inconsistency and hypocricy of an industry which has a political stronghold and a monopoly on the advertising market. We must closely analyze the ways in which we model our own drinking behavior and the messages which we deliver to the public that promote binge drinking, drinking alcohol makes you sexy, and it is the only way to have fun. By doing this we can achieve many of the success that we have seen from the instrumental work in obesity prevention and tobacco prevention and cessation. We must move beyond the approach of managing and treating individuals with substance abuse issues, by creating additional resources to implement evidence based, effective, targeted, broad and population based strategies. We must hold our elected officials accountable who take money from the alcohol industry, and work together as a global community to engage in a multisectoral collaboration under the common goal of protecting the public health and safety of our world.

Full text: Nr. 90

Wisconsin Initiative to Promote Healthy Lifestyles

Academia-Research
Country: United States of America
Funding or support from alcohol industry? No
Web site: http://www.wiphl.com

There is ample research on evidence-based alcohol prevention strategies. One nice summary, produced by the US National Institute on Alcohol Abuse and Alcoholism, is available at www.collegedrinkingprevention.org in the section on Stats and Summaries. Perhaps the most effective way to reduce risky and problem drinking in a population is to increase alcohol taxes, and the revenue can be used to support prevention, intervention, and treatment services. Another very effective strategy is to systematically administer alcohol screening and intervention services in general healthcare settings. Peer health educators can be trained to deliver the service, making it quite inexpensive. Research shows that these services reduce healthcare utilization, alcohol-related car crashes, criminal justice system involvement, and related expenditures, with substantial cost savings generated within 12 months. In partnership with 20 clinics, the Wisconsin Initiative to Promote Healthy Lifestyles has delivered over 45,000 screens and over 7,000 interventions. We could help others implement similar programs.

Full text contributions

WHO Member States

080 Cuba: La Misión Permanente de la República de Cuba en Ginebra
102 Thailand: Office of Alcoholic beverage control committee, Department of Disease Control, Ministry of public Health
120 Argentina: Ministerio de Salud de la Nación
156 Suisse: Office Fédéral de la Santé Publique en Suisse
178 Costa Rica: Instituto sobre Alcoholismo y Farmacodependencia - Ministerio de Salud,
199 Belgique
330 Finland: The Finnish Ministry of Social Affairs and Health

Intergovernmental organizations

224 Secretariat of the Pacific Community

Government institutions

037 Child Protection Special Service of Budapest
071 U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA)
103 National Supervisory Authority for Welfare and Health (Valvira) (Former Nationnal Product Control Agency for Welfare and Health)
121 Centro Alcologico Regionale Toscana
130 New Mexico Prevention Network
165 Canadian Association of Liquor Jurisdictions
177 Komenda Wojewódzka Policji w Poznaniu
188 New Mexico State Attorney General's Office
261 Marin County Mental Health Board
274 Programa de Salud Mental Barrial del Hospital Pirovano, Bueno Aires
296 Bureau of Substance Abuse Services, Massachusetts Department of Public Health
299 South Shore Health; South West Health; Annapolis Valley Health
312 Public Health Institute and Directorate of Health
321 Centers for Disease Control and Prevention, Nat Cntr for Chronic Disease Prevention, Alcohol Program
329 Taipei City Hospital, Taipei
335 ФГУ ""Центральный Научно-Исследовательский Институт Организации и Информатизации Здравоохранения Минздравсоцразвития России"", Научно-исследовательская организация "

Academia Research

039 Second University of Naples
066 Institute on Lifestyle & Health, Boston University School of Medicine, Boston, MA, USA
073 International Health Policy Program
090 Western Michigan University
129 Canadian Foundation on Fetal Alcohol Research
137 National Drug Research Institute
147 Royal College of Nursing
168 Faculty of Public Health Medicine, Royal College of Physicians of Ireland
220 Strengthening Families Center at University of Utah
223 International Network of Brief Interventions on Alcohol Problems
230 The Australian Wine Research Institute
249 Centre for Social and Health Outcomes Research and Evaluation (SHORE), Massey University, Auckland, New Zealand
301 Centre for Addiction and Mental Health

Full text contributions from WHO Member States

080 Cuba: La Misión Permanente de la República de Cuba en Ginebra
102 Thailand: Office of Alcoholic beverage control committee, Department of Disease Control, Ministry of public Health
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178 Costa Rica: Instituto sobre Alcoholismo y Farmacodependencia - Ministerio de Salud,
199 Belgique
330 Finland: The Finnish Ministry of Social Affairs and Health

REPÚBLICA DE CUBA
MISIÓN PERMANENTE ANTE LA OFICINA
DE LAS NACIONES UNIDAS EN GINEBRA Y LOS
ORGANISMOS INTERNACIONALES CON SEDE EN SUIZA

Nota Nro. 759/08

La Misión Permanente de la República de Cuba ante la Oficina de las Naciones Unidas en Ginebra y los Organismos Internacionales con sede en Suiza saluda muy atentamente a la Organización Mundial de la Salud, Departamento de Salud Mental y Abuso de Sustancias, y en relación a la audiencia pública sobre reducción del uso nocivo del alcohol tiene a bien adjuntar la contribución inicial de Cuba al proceso de consultas para la elaboración por parte de la Secretaría de la OMS de un proyecto de Estrategia Mundial para reducir el uso nocivo del alcohol.

La Misión Permanente de la República de Cuba ante la Oficina de las Naciones Unidas en Ginebra y los Organismos Internacionales con sede en Suiza aprovecha la ocasión para reiterar a la Organización Mundial de la Salud, Departamento de Salud Mental y Abuso de Sustancias el testimonio de su más alta y distinguida consideración.

Ginebra, 29 de octubre de 2008

A la Organización Mundial de la Salud (OMS)
Departamento de Salud Mental y Abuso de Sustancias
Ginebra

REPUBLICA DE CUBA

Misión Permanente ante la Oficina de las Naciones Unidas
en Ginebra y los Organismos Internacionales con sede en Suiza

Contribución inicial de Cuba al proceso de consultas para la elaboración por parte de la Secretaría de la OMS de un proyecto de Estrategia Mundial para reducir el uso nocivo del alcohol.

Consulta on-line dirigida a todos los actores interesados. 3 al 31 de octubre de 2008.

1. Elementos de carácter general sobre la visión cubana de una Estrategia Mundial para reducir el uso nocivo del alcohol.

- En el lenguaje del párrafo 2.2 de la Resolución WHA 61.4 quedó claro el carácter no vinculante del proyecto de estrategia que se pidió elaborar, al solicitar a la Directora General de la OMS que *"vele porque el proyecto de estrategia contemple un conjunto de posibles medidas recomendadas, que los Estados habrían de aplicar a escala nacional, teniendo en cuenta las circunstancias nacionales de cada país*". Cuba participará de forma constructiva en las negociaciones de este proyecto de Estrategia, sobre la base de esta naturaleza no vinculante ya aprobada por todos los Estados miembros en la 61 Asamblea Mundial de la Salud.

- Cuba considera que la elaboración de una estrategia para reducir el uso nocivo del alcohol por parte de la OMS deberá partir de la premisa de que el problema no es el alcohol en sí mismo, sino el abuso en su consumo.

- Por tanto, la OMS deberá abordar el proceso de elaboración de la estrategia en este tema con una proyección centrada en políticas preventivas en materia de salud pública, teniendo en cuenta los daños a la salud de los individuos que implica el consumo abusivo de bebidas alcohólicas. En este sentido, los esfuerzos en curso se deberán centrar en los aspectos técnicos relacionados con la prevención y la atención a las adicciones, pues otros aspectos como las regulaciones de la

comercialización no son de la competencia de la OMS y cualquier incursión en tales asuntos tendría efectos contraproducentes.

- Las medidas a adoptar deben dirigirse fundamentalmente a los grupos de riesgos, incluidos los menores, los adolescentes y las mujeres embarazadas, y no a la inmensa mayoría de personas que consumen el alcohol de manera responsable.

- El informe sobre el estado de la salud en el mundo del año 2002 indicó que las regiones donde se reporta el volumen medio más alto de consumo de alcohol son Europa y Norteamérica, donde se concentran los países desarrollados. Por lo que es posible concluir que el alcoholismo es un problema de salud fundamentalmente de países desarrollados o en desarrollo con una baja tasa de mortalidad.

- Aunque existe una relación causal entre el volumen medio de alcohol consumido y más de 60 tipos de enfermedades y de traumatismos, en muchos casos perjudiciales, también está reconocido que en otros, como cardiopatías y diabetes múltiple puede ser beneficioso, con la condición de que el volumen consumido esté entre moderado y bajo, y el bebedor no termine borracho. Se estima además que los accidentes de isquemia cerebral vascular serían 17% más frecuentes en las subregiones de América, de Europa y del Pacífico occidental, si nadie consumiera alcohol. Es válido concluir entonces que los problemas de salud que provoca el alcohol se deben a su uso o abuso excesivo, y no al simple consumo de este producto.

- En los países en vías de desarrollo con tarifas de mortalidad más altas, en donde viven las 2/5 partes de la población mundial, el alcohol no está entre los 10 factores de riesgo principales. Las causas principales de muerte en estos países son: las enfermedades transmisibles, la mortalidad materna e infantil, la falta de acceso al agua potable, la falta de acceso a una atención médica adecuada, el SIDA y el hambre, asociadas principalmente a la pobreza y al subdesarrollo.

- Aunque el abuso en el consumo del alcohol, del tabaco y del azúcar sea la base de importantes problemas de salud, no es la prioridad para millones de personas pobres y desnutridas en el mundo, ni para los millones que mueran debido a la carencia de inmunización contra enfermedades que pueden ser prevenidas con una vacuna, o para los millones que mueren por la carencia de asistencia médica adecuada o por la escasez o falta de acceso a los medicamentos.

- Los principales problemas de salud de los pobres y de los países en vías de desarrollo se deben fundamentalmente al subdesarrollo y a la pobreza,

como consecuencia de su pasado colonial y el actual orden económico y comercial internacional impuesto por los países desarrollados para su ventaja, así como por la falta de acceso a las medicinas debido al monopolio de patentes por las trasnacionales de los productos farmacéuticos de los países desarrollados o de los altos precios que le imponen a las medicinas.

- Llega a ser contradictoria la prioridad a estos temas dentro de la OMS en los últimos años, en detrimento a la atención exigida para otros problemas de salud que afectan a las grandes mayorías en los países del Sur, muchos de los cuales se encuentran dentro de los Objetivos de Desarrollo del Milenio cuya meta de cumplimiento señala el 2015.

- Por otro lado, no estamos totalmente de acuerdo con lo expuesto en algunos informes de la Secretaría de la OMS sobre el tema (ejemplo: A60/14) cuando afirman que la regulación o limitación de la venta de alcohol y las medidas relacionadas con los impuestos y los precios son dos de las más eficaces medidas. Las estrategias de la OMS para hacerle frente a este problema, cuyo origen es en primer lugar social, debe darle prioridad a las acciones en la esfera social y a nivel nacional. Está probado que la conducta de adolescentes y bebedores que abusan del consumo del alcohol se adapta a estos cambios y políticas comerciales sin obtener resultados positivos para evitar que sigan consumiendo.

- La Organización Mundial de la Salud no tiene el mandato, ni la competencia, ni la especialización necesaria para incursionar en medidas o acciones dirigidas al comercio y el mercado de bebidas alcohólicas. Estas cuestiones son reguladas por disciplinas de otras organizaciones e instituciones internacionales.

- Las acciones encaminadas a la prevención, promoción y tratamiento, propias de la esfera de la salud son precisamente las principales herramientas para enfrentar el uso excesivo o abuso en el consumo del alcohol por parte de la OMS. La promoción de estilos de vida saludable y la educación sanitaria con la participación comunitaria y multisectorial son las medidas más costo-eficaces que la OMS y otras organizaciones internacionales han recomendado siempre para contener las epidemias de enfermedades crónicas no transmisibles, como el alcoholismo.

- La inclusión de referencias de cualquier tipo a los aspectos de la comercialización del alcohol podría interferir con las regulaciones de la Organización Mundial del Comercio.

- El Acuerdo General sobre Aranceles Aduaneros y Comercio (GATT 1947) proporciona las excepciones generales (artículo XX) que permite aplicar

las medidas necesarias para proteger la salud y la vida de las personas, pero estas medidas no pueden constituir un medio de discriminación arbitrario o injustificable, o una restricción encubierta al comercio internacional.

- Cualquier medida que sea adoptada en el área del comercio, por ejemplo reglamentos técnicos para proteger la salud de las personas no deberán restringir el comercio más de lo necesario para alcanzar tal objetivo (artículo 2 del Acuerdo sobre Obstáculos Técnicos al Comercio). Si estos objetivos legítimos (salud humana) pueden atenderse con medidas menos restrictivas al comercio estas deben ser usadas.

- En este sentido, es válido recordar que existen en la historia de muchos países ejemplos de políticas prohibitivas o restrictivas del alcohol que han causado efectos contrarios a la reducción del consumo de alcohol. En muchos casos, las medidas de este tipo tienden a generar más contrabando o actividades criminales, como la producción subterránea o ilegal de bebidas alcohólicas, sin cumplir con los estándares sanitarios y técnicos establecidos provocando con esto un mayor riesgo para la salud humana.

- El impuesto y las políticas de precio deben ser controlados y utilizados por cada país según sus condiciones, por lo tanto no es recomendable incluir la afirmación de que las medidas relacionadas con los impuestos y los precios son dos de las estrategias más eficaces y económicas que los países y las comunidades pueden aplicar para reducir o prevenir los daños ocasionados por el alcohol.

- La introducción de estos temas en los trabajos de la OMS significa una amenaza para la regulación sobre el consumo del alcohol en el mundo y puede tener un impacto comercial. En este sentido, lo que parecería ser un esfuerzo loable, puede traer un impacto negativo para muchos países del sur productores de bebidas alcohólicas con un alto componente etílico, tal como el ron. Una eventual intromisión en el comercio y el mercado de bebidas alcohólicas podría significar para muchos de esos países una pérdida importante de sus ingresos económicos, con los cuales pudiera sufragar importantes gastos de salud y planificar y ejecutar políticas de salud pública.

- Es necesario que el proyecto de Estrategia Mundial tenga en cuenta los diferentes modos de consumos, fuertemente ligados a elementos culturales, económicos y sociales así como las diferencias entre países desarrollados y en desarrollo.

- Por tanto, el proyecto de Estrategia Mundial que preparará la OMS deberá dejar un margen para que cada país pueda decidir el tipo de medidas de prevención en el área de salud pública a adoptar para reducir el abuso o el consumo excesivo del alcohol en su territorio. Sólo así se garantizará que las medidas que se adopten tengan en cuenta las realidades específicas de cada país, incluidas sus peculiaridades y especificidades culturales y sociales. Es importante también que la estrategia prevea ayudas económicas consecuentes en materia de prevención y educación para los países en desarrollo.

- Los esfuerzos de la OMS en este ámbito deben estar centrados en la promoción y la prevención de salud, privilegiando el desarrollo y el fortalecimiento de las capacidades nacionales, incluidos los servicios de salud primarios.

- Para la implementación de los planes de acciones nacionales e internacionales en materia de educación sanitaria y prevención de las enfermedades no transmisibles en los países en desarrollo, particularmente en los países más pobres, se requiere de la cooperación internacional, incluida la movilización de recursos financieros adicionales que permitan fortalecer las capacidades nacionales para que las acciones que se lleven a cabo alcancen a toda la población afectada. Por tanto, la Estrategia Global deberá también incluir medidas en este ámbito.

2. Experiencia cubana para la prevención del alcoholismo.

En Cuba para enfrentar un problema cuyo origen es social privilegiamos las acciones a realizarse en ese ámbito.

Preferimos privilegiar un enfoque basado en el trabajo de prevención y promoción de estilos de vida saludables y la educación para la salud, con participación comunitaria e intersectorial, así como el abordaje integral de las enfermedades crónicas no transmisibles en la Atención Primaria de Salud, lo que ha permitido obtener resultados positivos.

Contamos con un programa de prevención y control del alcoholismo de alcance nacional, que presenta algunos resultados de impacto, como es la reducción del consumo de alcohol calculado per cápita de 4.4 litros en los finales de los años 80 a 2.00 en fecha reciente. Este programa se perfecciona de forma continua en su aplicación de acuerdo a las experiencias y resultados obtenidos. A este programa se vinculan**,** como parte del programa de salud y calidad de vida**,** representantes del Ministerio de Educación, del Ministerio de Cultura, de las instituciones responsables en materia de deporte cultura física y recreación, del Ministerio del Comercio Interior, del Centro de promoción de la Salud del MINSAP, de la Sociedad cubana de psiquiatría y especialistas en la materia,

entre otros.

Entre las acciones de prevención contempladas, especial énfasis se le presta a las siguientes:

- La creación de Grupos de Ayuda Mutua (GAM). Estos grupos llegan a 370 en todo el país con preferencia en las regiones identificadas como de mayor riesgo e incidencia de dependencia alcohólica.

- La creación de una red asistencial, cuyo primer nivel de atención se basa en la cobertura con el modelo del médico de la familia y la enfermera de la familia, y la participación activa de los Centros Comunitarios de Salud Mental, lo que ha posibilitado abarcar a un mayor número de personas**,** y con intervenciones más breves se ha logrado alejarlas del consumo del alcohol y además convertirlas en promotores de salud y salud mental. Se eleva la capacitación del personal sanitario y se llega a la especialización en la prevención del uso nocivo del alcohol de parte de este personal. También se capacitan a personas provenientes de las organizaciones locales.

- La creación de una línea de ayuda telefónica confidencial, de cobertura nacional, se convierte en la puerta al sistema de atención y también deviene en factor de importancia en la prevención y la incorporación asistencial de bebedores sociales y en riesgo.

- En un segundo nivel de atención se contemplan los servicios de psiquiatría en hospitales generales. Las unidades de intervención en crisis se responsabilizan con la atención de aquellas situaciones de urgencia por intoxicación aguda, abstinencia, lesiones u otro tipo de violencia, que requieren ser abordadas fuera del contexto social. La rehabilitación psicosocial de esas personas se dirige a su reinserción en el medio de procedencia, evitando la institucionalización prolongada.

En este sentido, recalcamos una vez más que las acciones encaminadas a la prevención, promoción y tratamiento propias de terreno de la salud, son precisamente las principales herramientas para contrarrestar el consumo excesivo y nocivo del alcohol, sobre todo las acciones dirigidas a los adolescentes y mujeres embarazadas, con la participación comunitaria y un enfoque intersectorial.

Cuba considera que estas experiencias en el plano nacional pueden servir de utilidad en la elaboración de posibles medidas a incluir por la OMS en el proyecto de Estrategia Mundial que deberá poner a la consideración de los Estados miembros.

Question 1: What are your views on effective strategies to reduce alcohol-related harm?

The effectiveness of the strategy to reduce alcohol-related harms relies on few characteristics. These are being knowledge-based approach, having comprehensive policy framework and targets, prioritising on cost-effective policy interventions, and the accountability and transparency of key stakeholders.

In reality, the process on how alcohol policy is formulated and how it is implemented is a long way from being knowledge-based. Alcohol policy domain at all levels is influenced by many myths, delusions, and structured discourses, which are far away from existing knowledge. These policy discourses, particularly those intentionally set up by stakeholders with conflict of interest, are obstacles to the development of effective alcohol policy.

As the international technical health agency, WHO has an exclusive task in clarifying these misunderstandings. This must be done in urgency and in proactive manner, in order to promote evidence-based policy discourses to support the development of effective alcohol policy.

On the second aspect, alcohol policy framework must be comprehensive to cover three policy mechanisms; to reduce alcohol consumption per se, to reduce risk of alcohol consumption, and to control the extent of alcohol-related harms. These three mechanisms function at different levels and certainly not alternative to others. They are also different in effectiveness and cost-effectiveness. Just like controlling wild fire from its origin, the worthiest area is to control alcohol consumption volume. It is useless trying to modify drinking pattern and promote safer drinking without controlling alcohol consumption, particularly at the population level. Controlling alcohol consumption volume at aggregated level must consist of control of number drinker in each society including preventing new drinkers, control of drinking frequency, and control of drinking volume for each occasion.

Unfortunately, the appeal of controlling consumption at population level is increasingly faded away, partially by the so-called comfortable delusions, and the influence of the alcohol industry. Policy makers worldwide currently tend to focus on the narrowly targeted harm-reduction interventions including promotion of responsible drinking and alcohol education, and not those primary prevention interventions at population level. This fallacy relies on few misconceptions that if one is informed, if one has responsibility, and if one has controlling ability over his/her drinking practice, no harms would occur at all. Although they may sound good, these misconceptions could lead to neither effective nor cost-effective approach to tackle alcohol problems, and could even worsen the situation. This trend is the major warning signal, and WHO has the great task to bring technical knowledge to reverse it.

Alcohol policy interventions differ in their effectiveness and cost-effectiveness. Taking this into concern, we should avoid investing in such costly and ineffective interventions. Being acceptable by all stakeholders and having less resistance are not, by any mean, a justification for alcohol policy formulation.

Stakeholders come into alcohol policy domain with their own interests. The approach of the alcohol industry to this sphere, at all policy levels and in both developed and developing world, is increasingly sophisticated. The ultimate and only concern for the alcohol industry and industry-supported entities including social aspect organizations, technocrats, scholars, related businesses, is particularly clear. This is to protect industry profit, by discarding any effort to have effective alcohol policy interventions, and by undermining key stakeholders. The industry always calls for being partners and participants in all policy forums and through all entities. This is a effective approach where industry can buy partnership, dependency, support and quiet, as well as their public image. Partnership, particularly public-private partnership, is good but for only sectors without conflict of interest, and definitely not as the mean for private sector to protect and promote its income, like alcohol industry to alcohol policy domain. At the end of the day, partnership with conflict of interest could only do harm to public benefit.

Public and all stakeholders must be informed and well aware of the cost of having alcohol industry as partnership. Dealing with alcohol and tobacco industry differently is a critical error, not have to say about letting alcohol industry and its supported sector sitting in the navigator seat. If the process to develop and implement the Global Strategy, and the way forwards do not have adequate transparency and integrity, including under direct and indirect influence of alcohol industry, it would be hopeless.

Sometime facts are bitter. The way WHO has dealt with alcohol issue, which is one of the world leading health risk factors, is unbelievable and hardly acceptable. If WHO continues neglecting alcohol issue, like it has been done for over two decades, who else will protect global health, the alcohol industry? And only if WHO were sincere enough to this issue and being independent to industry's direct and indirect influence, perhaps global population won't have to suffer much from alcohol-related burden, like today. This global burden is much bitterer than the fact mentioned above.

Question 2: From a global perspective, what are the best ways to reduce problems related to harmful use of alcohol?

Thailand would like to specifically respond to this question on what should be the function of the Global Strategy and the appropriate role of WHO, rather than in general.

First of all, the Strategy should be an innovative, yet effective, approach to create global awareness and promote commitment among all stakeholders, at all levels. The Strategy should guide those stakeholders on their potential and

appropriate role in reducing alcohol-related harms. Commitment and responsibility of stakeholders, particularly those international agencies, are critical to the success of this Strategy.

Thailand would like to request WHO should take a leading role in advocating for health in the non-health arena, especially in economic and trade sectors. The recognition that alcohol is a non-ordinary commodity; being an obstacle to human achievement and social development, and creating net loss to any society, should be acknowledged worldwide.

Apart from creating global climate toward problem reduction, the Strategy should elaborate the appropriate role of stakeholders with conflict of interest, including the appropriate relationship of those stakeholders to other stakeholders; officials, academics, civil society and NGOs. This does not mean that economic operators have no place in the alcohol policy process. The appropriate role of alcohol industry is to ensure that their practices comply with formulated policy at the implementation phase. Public Health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests. The independency of stakeholders, from the influence of the alcohol industry and related entities, should be addressed in this Strategy.

The Strategy must address the existing limitations, as well as current and future threats to alcohol policy. These constraints include the decrease in popularity of effective alcohol policy interventions particularly at population level, and the capacity limitation of key stakeholders. The Strategy should raise policy momentum for those population-based interventions aim to control consumption and marketing. In this Strategy and in the long run, WHO should have critical responsibility to support Member States to make the most out of the effectiveness-proven interventions. This task for WHO includes protecting any threat to the alcohol policy development, at all levels.

One of major threats is the economic agreements, which evidence worldwide indicates that they have negative impact on alcohol problems. Most important, its practice has undermined the strength of national alcohol policy. The appropriate mechanism to mitigate these impacts must be addressed in this Strategy.

Particularly when taking the effect of international trade agreement into concern, alcohol policy that is confined within national boundary is unlikely to effectively tackle this globalised problem. This means that there is the important gap between policy setting and characteristics of problem. To close this gap, alcohol policy at international level is urgently needed. The concerted efforts in the public health interest are urgently required to create awareness at the national and international levels that alcohol and tobacco should be considered as special goods which cause widespread damage to the whole of society. And countries should be free to reduce alcohol-related harms with health-oriented interventions within their own boundaries.

Furthermore, an international policy framework, or other international health initiatives, can be used to counterbalance the negative impacts of economic agreement and treaties on alcohol problems. This could be along the lines of the Framework Convention for Tobacco Control (FCTC). Many have critiqued that WHO always keeps trade agreement off its agenda, please acknowledge the importance of this and take urgent action.

Question 3: In what ways can you or your organization contribute to reduce harmful use of alcohol?

By, mandate, the Ministry of Public Health (MoPH) has major responsibility to protect, prevent and mitigate any harm to the health of Thais. MoPH has involved in the lively development of alcohol policy in recent years. It mainly deals with alcohol problems through the newly set up entity, the Tobacco and Alcohol Consumption Control Unit (TACCU) under the Department of Disease Control. Since established, TACCU has participated in all stages of the alcohol policy process, including creating social climate, conducting public campaign, formulating alcohol policy, implementing and regulating the regulations, and monitoring and evaluating policy performance. Therefore, having such specialize body for alcohol issue has been a success factor for the effort to reduce alcohol-related harms, and could be a model to other countries. Other MoPH facets dealing with alcohol include the Department of Mental Health and Department of Medical Service for the screening and treatment interventions, the Food and Drug Administration for advertising control and warning label interventions, and Office of Permanent Secretariat for the general management.

Alcohol issue goes far beyond Health Ministry. The effective way to deal with it, therefore, requires commitment from related sectors. MoPH has been an active participant of the multidisciplinary mechanisms. These are where public agencies and private sectors, including representative from civil society, NGOs and technocrats, have worked together to tackle alcohol-related problems. MoPH has carried the secretariat work for the National Alcohol Consumption Control Committee. This forum is where many alcohol policies originate from and many implementing strategy has been developed. Other MoPH-related mechanisms include through the Board of the Health System Research Institute who established the Center for Alcohol Studies (CAS), the Board of Thai Health Promotion Foundation- who has conducted many campaigns and supported many civil societies, and the Road Safety Management Committee.

Going beyond national boundary, the representatives from Thai MoPH have proactively involved in many international forums in recent years. These include WHO-related forums, such as the meeting of WHO Executive Board, the World Health Assembly, and many SEAR regional activities. Our primary objectives is clearly to promote the effective alcohol policy development and implementation at all levels. The independency of the process from any commercial interest is our major and most concern.

Summary (500 words)

From our perspective, the effective approach to reduce alcohol-related harms must obtain few characteristics. First of all it must rely on existing knowledge, which can help stakeholders better structure the problems. The technical knowledge is also important to clarify myths and delusions, which are obstacles to the development of alcohol policy. These include those policy discourses that are created by stakeholders with conflict of interest with intention to protect their profit. Therefore, the effective approach should create global climate and better understanding to support the development and better implementation of alcohol policy at all levels.

Secondly, it should have comprehensive policy framework and focus on all policy targets. The appropriate alcohol policy framework must cover three policy mechanisms; consumption control, harms deterrence, and harms recovery. These three mechanisms function differently, therefore cannot replace each others.

Alcohol policy interventions differ in their effectiveness and cost-effectiveness. Evidences suggest that interventions to control consumption and those aim at general population are more effective and cost-effective. Despite their value, these interventions have increasingly lost their popularity. And this vicious trend must be addressed and curbed urgently. The effective approach must address and alleviate the existing limitations and threats, and to raise policy momentum for those population-based interventions aim to control consumption and marketing.

The transparency and integrity of the process and stakeholder participation are as of paramount importance. The stance and interest of those stakeholders with conflict of interest to alcohol policy should be recognized. Other stakeholders must well concern on the cost and potential consequences of letting those economic operators to involve in alcohol policy development process, as well as direct and indirect relationship with the alcohol industry and its nominee. The independency of stakeholders, from the influence of the alcohol industry and related entities, should be addressed. Further, the Global Strategy should clarify the appropriate role of stakeholders with conflict of interest, including the appropriate relationship of those stakeholders to others.

Taking these points into concern, WHO must have a leading role in creating ownership and commitment of stakeholders with no conflict of interest to concertedly tackle alcohol problems, supporting knowledge generation and utilization, creating that alcohol is a non-ordinary that should be treated differently from other commodities, supporting and guiding stakeholders to develop effective alcohol policy, protecting any threat to the alcohol policy development, and promoting the development of supra-national alcohol policy. But first of all, WHO must show it commitment to this issue, keeping alcohol off priority list is no more acceptable.

The Ministry of Public Health, Thailand, has the mandate to protect the health of Thais from alcohol-related problems. Taking the success in alcohol policy development in recent years into concern, Thai experience is worth sharing to other countries, particularly those with the rise of alcohol-related burden. The Thai MoPH commits itself to any development of supra-national alcohol policy, if they are to protect the health of the public, not the health of the alcohol industry.

El uso nocivo de alcohol, en la población de la República Argentina, es consecuencia de una cantidad de factores que tienen que ver con la vulnerabilidad social, la tolerancia y la disponibilidad de los productos que contienen en mayor o menor medida alcohol etílico.

El Ministerio de Salud de la Nación hace hincapié en la decisión política de atender las problemáticas de los usuarios abusivos de alcohol en el Sistema Público de Salud, tanto desde la calidad asistencial como desde la accesibilidad y desde conceptos como universalidad, equidad e integralidad de la Salud Comunitaria basados en la Atención Primaria de la Salud

Nuestro desafío es superar el aspecto biomédico y reconocer el carácter socio cultural del uso nocivo de alcohol por parte de creciente de la población, en su gran mayoría jóvenes.
Además, superar el enfoque de que el alcohol aparece como fenómeno exterior a nuestra sociedad, algo que viene de afuera; y reconocer como comprender la complejidad de esta realidad.

Salud es responsable del desarrollo de políticas sanitarias eficientes y eficaces de atención, pero estas se deben insertar dentro de políticas socio sanitarias públicas junto a los Ministerios de Educación, Trabajo, Justicia y desarrollo Social.

Este Ministerio encara las acciones desde el marco que el uso nocivo de alcohol, es una patología social, que debe ser prevenida y asistida integralmente por el sistema sanitario en Red referencial, con estrategias de promoción e inclusión desde los sistemas sociales y las comunidades locales.

Diseña estrategias de acceso a la atención con calidad, como puerta de entrada a un Modelo de Contención a la población afectada.

El CeNaReSo, Hospital Monovalente dependiente de este Ministerio, atiende la temática desde hace 35 años, con criterio sanitario, con sus Consultorios Externos, Centro de día y los Servicios de Internación de Crisis, Comunidad Terapéutica, Reinserción, sus 104 camas y casi 200 RR.HH.

Además se están conformando Mesas de Trabajo en las provincias donde se está fortaleciendo las Redes Sanitarias Locales, aumentando la cobertura y visibilidad de las mismas.
Se están conformando Equipos Móviles de abordaje complejos, que incluyen crisis en salud mental y frente al uso de alcohol y otras sustancias.
Se está iniciando la Capacitación, protocolización y apoyo técnico a los Servicios y Equipos Sanitarios de los Hospitales más importantes de cada provincia y de los Centros de 1er Nivel de Atención de las Grandes Urbes.

Se entregan reactivos de alcohol en orina para que los Equipos Interdisciplinarios de las Guardias Hospitalarias puedan llegar al diagnóstico rápido frente al uso nocivo de alcohol.

Se están generando dentro de los Hospitales, ampliación de los Servicios de Atención en Crisis, con internaciones breves, como también el aumento de los GIA (Grupos Institucionales de Alcoholismo).
Se desarrollan Consultorios Externos especializados en la temática, dentro de los Centros de 1er Nivel de Atención (CAPS), para los usuarios como también para sus familiares y allegados.

El desafío implementado desde los Sistemas de Salud Locales, es invertir la desintegración social vinculada al uso nocivo del alcohol, sumándolos a estrategias comunitarias inclusivas con proyectos de vida, por medio de la participación, de las acciones culturales, deportivas y políticas, con las Organizaciones Sociales Locales.

Además se trabaja en estrategias Interministeriales junto a:

- Ministerio de Desarrollo Social y su Programa preventivo a las adicciones “Abriendo Caminos” y su Programa Asistencial en infancia y juventud “Paida”.
- Ministerio de Educación y el Programa conjunto “Salud Escolar”
- Ministerio de Trabajo y el Programa de Prevención de las adicciones en el Ámbito Laboral.
- Ministerio del Interior – Agencia Nacional de Seguridad Vial con el asesoramiento sobre estrategias de Alcoholemia y Métodos de Testeo
- SeDroNar con la participación conjunta en los Consejos Nacionales de Salud y Adicciones.
- Ministerio de Justicia con el Programa Salud en las Cárceles.

Finalmente este Ministerio Reglamenta la Ley 24788 de Lucha contra el Alcoholismo con implementación actual.

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

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Audition publique sur les moyens de réduire l'usage nocif de l'alcool

Monsieur le Directeur,

Nous avons le plaisir de vous transmettre la contribution suivante du gouvernement suisse à l'audition publique susmentionnée. Nous avons également téléchargé cette contribution directement sur la page web de l'OMS créée à cet effet.

Nous tenons tout d'abord à vous remercier pour le travail qui a été effectué dans le cadre de l'élaboration du rapport de l'OMS sur les stratégies visant à réduire l'usage nocif de l'alcool. Nous soutenons beaucoup l'idée d'élaborer une stratégie mondiale qui tienne compte de la diversité des contextes nationaux, religieux et culturels.

A. Stratégies efficaces pour réduire l'usage nocif de l'alcool

Selon les expériences faites en Suisse, des stratégies efficaces pour réduire l'usage nocif de l'alcool devrait être fondée sur les postulats suivants:

- Il convient d'aménager la politique en matière d'alcool selon le principe de l'*evidence based policy*; les méthodes d'intervention efficaces réalisées dans le passé sont encouragées et développées avec détermination dans le sens de *best practices* (bonnes pratiques).
- La politique en matière d'alcool met prioritairement l'accent sur la réduction de la consommation problématique.
- La priorité revient à l'application des dispositions de protection de la jeunesse existantes et à la prévention.

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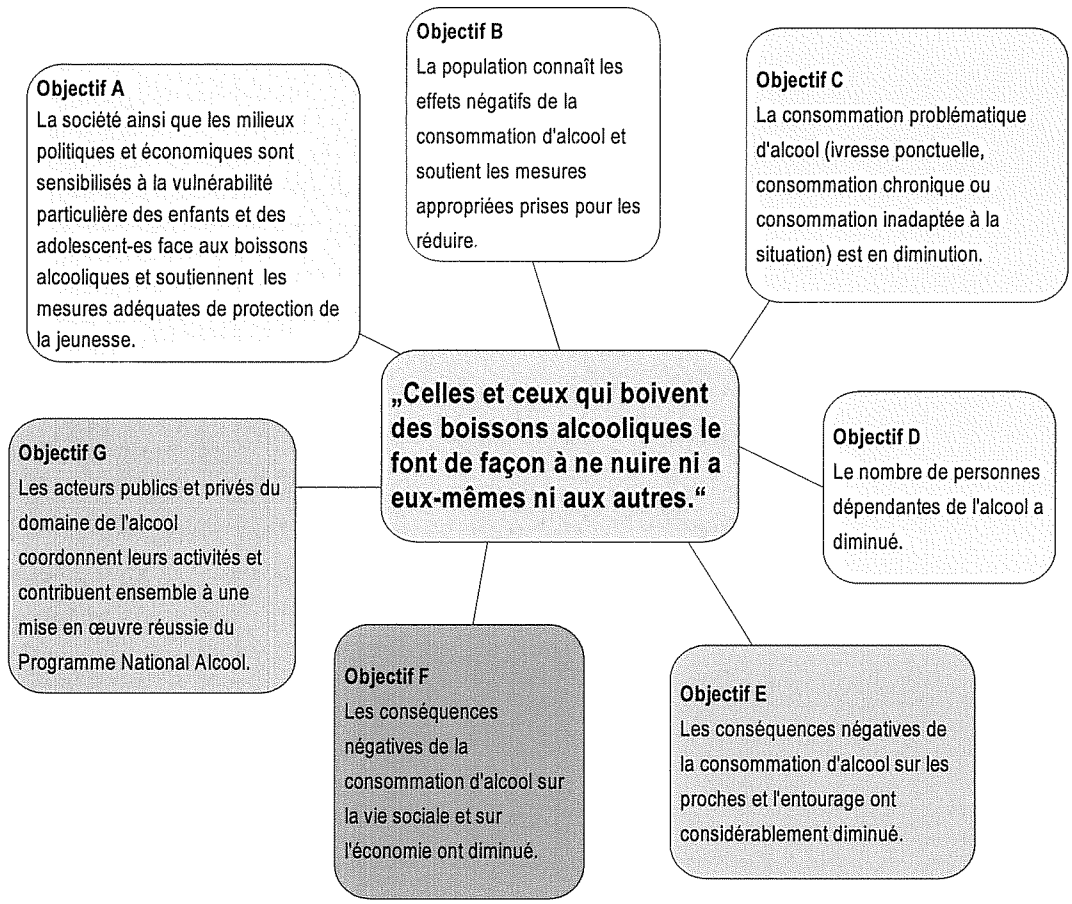
- La politique en matière d'alcool vise davantage la réduction des conséquences négatives de la consommation pour les proches et pour la société. La violence, les accidents et le sport sont considérés comme des cibles majeures à cet égard.
- Afin d'obtenir un impact préventif suffisant et durable, la prévention comportementale et la prévention structurelle doivent être prises en considération.
- La mise en œuvre d'une stratégie mondiale doit être organisée en un processus ouvert et transparent pour toutes les parties prenantes, processus permettant d'apporter des corrections et des compléments au cheminement prévu.
- Dans le cadre de la mise en œuvre de la stratégie, il faudra assurer l'information et l'acquisition de données ainsi que l'évaluation et la formulation de recommandations sur les actions à entreprendre (bonnes pratiques).
- L'efficacité de la stratégie doit être évaluée (système de surveillance, rapports annuels). En vue du contrôle de l'efficacité prévu dans le cadre de l'évaluation, les objectifs d'efficacité concrets (*outcomes*) devraient être définis.

B. Activités en Suisse: Programme national alcool 2008–2012 (PNA)

La Confédération suisse est active depuis plusieurs années dans le domaine de la prévention de l'alcool. Elle renforce actuellement son engagement dans le cadre d'un programme national.
Le Programme national alcool est fondé sur la vision suivante : **«Celles et ceux qui boivent de l'alcool le font de façon à ne nuire ni à eux-mêmes ni aux autres.»** Pour préciser cette vision, le programme retient 7 objectifs principaux pour la politique en matière d'alcool dans les années à venir:



C. Champs d'action et orientations stratégiques

Pour chacun des objectifs (mentionnés sous lettre B), le Programme national suisse définit 10 champs d'action avec des mesures spécifiques. Ces propositions de mesures nous semblent également applicables à un niveau global:

1. Protection de la santé, promotion de la santé et dépistage précoce
Le dépistage précoce de situations à risque liées à l'alcool dans divers lieux de vie (école, travail, etc.) est à promouvoir. Les personnes de référence sont formées pour s'occuper de personnes ayant une consommation d'alcool préoccupante. La prévention en matière d'alcool est à mettre en lien avec la promotion de la santé et la prévention des dépendances.

2. Thérapie et intégration sociale
Les personnes ayant une consommation d'alcool dangereuse et les personnes alcoolodépendantes devraient bénéficier d'un traitement adéquat. Il convient de renforcer l'intégration sociale des personnes qui ont des problèmes liés à l'alcool. On s'efforce de faire en sorte que la couverture du traitement et du suivi adaptés par les assurances sociales soit garantie.

3. Réduction individuelle et sociale des risques
Les conséquences nuisibles de la consommation d'alcool (p. ex. accidents, propension accrue à la violence) sont limitées autant que possible : il s'agit de protéger aussi bien les personnes touchées que la population contre les effets secondaires non souhaités. La jeunesse, la violence, les accidents et le sport sont les domaines visés en priorité.

4. Réglementation du marché et protection de la jeunesse
Une réglementation différenciée du marché vise avant tout à permettre de réduire les ivresses ponctuelles largement répandues et d'endiguer efficacement la consommation d'alcool par les enfants et les adolescents. Il s'agit en outre de promouvoir les boissons sans alcool de façon ciblée, en favorisant leur image et un prix attractif.

5. Information et relations publiques
La population est sensibilisée à une consommation d'alcool raisonnable et peu problématique; il s'agit d'accroître l'acceptation de la société, de la politique et de l'économie pour développer une prévention cohérente et des mesures correspondantes.

6. Collaboration institutionnelle
Il convient de renforcer la collaboration entre les acteurs de la prévention des problèmes liés à l'alcool, d'exploiter les synergies existantes de façon optimale et d'assurer le transfert de savoir-faire.

7. Recherche et statistique
Le point central consiste dans les efforts, sur la base d'une stratégie de recherche, pour récolter régulièrement les données nécessaires, les évaluer et en communiquer les résultats aux acteurs concernés. Les connaissances issues de la recherche sont intégrées à la mise en oeuvre des mesures du PNA.

8. Application du droit, directives internationales
Dans le cadre de ce champ d'action, le PNA met l'accent sur une application plus stricte des dispositions en vigueur concernant la protection de la jeunesse. De plus, la Suisse continue à participer activement au développement et à la mise en œuvre des normes internationales.

9. Ressources, financement
Il est souhaitable que les instances publiques (Confédération, cantons, communes) mettent à disposition les moyens suffisants pour une prévention efficace des problèmes liés à l'alcool, garantissent une

utilisation efficace de ces moyens et accordent la place appropriée aux objectifs du PNA dans l'attribution des moyens disponibles.

10. Assurance qualité, formation de base et continue
Font partie de ce champ d'action tous les efforts visant à assurer une professionnalisation et une efficience de haut niveau dans le domaine de la prévention des problèmes liés à l'alcool, à évaluer les méthodes d'intervention à intervalles réguliers et à les adapter en permanence aux situations nouvelles.

Pour des informations plus amples concernant le Programme national alcool 2008–2012, nous vous prions de consulter le site: http://www.bag.admin.ch/themen/drogen/00039/00596/index.html?lang=fr

Nous restons à votre disposition pour toute question éventuelle relative à cette contribution ou soutien que nous pourrions apporter dans le cadre du processus d'élaboration de la stratégie.

Je vous prie de croire, Monsieur le Directeur, à l'expression de ma considération distinguée.

Le directeur

Prof. Thomas Zeltner

Copie : Dr Vladimir Poznyak, Coordonnateur, Département Santé mentale et abus de substances psychoactives, OMS, Genève

República de Costa Rica
Ministerio de Salud de Costa Rica
Instituto sobre Alcoholismo y Farmacodependencia

Contribución a las Audiencias Públicas sobre
Reducción del Uso Nocivo del Alcohol.

1. **Opiniones sobre estrategias eficaces para reducir los daños relacionados con el alcohol.**

Es trascendental que el tema de los problemas de salud pública provocados por el consumo de alcohol se introduzca en la agenda pública de los Gobiernos y a partir de ello, se manifieste un compromiso político claro, decido y concreto, reflejado en políticas públicas que se formulan para dar respuesta a esta necesidad.

En esta tarea las entidades encargadas de velar por la salud pública de los países, tienen un rol prioritario dirigido a garantizar el apoyo de los Gobiernos y el respaldo del público, pero también, en su papel de rectores de las actividades que competen al Sector Salud, al introducir estrategias eficaces y rentables para prevenir y reducir el consumo de alcohol y los daños asociados a éste.

En el marco de una estrategia amplia de prevención una actividad prioritaria a realizar desde el Sector Salud, al menos para la mayoría de los países del continente americano, es la introducción de pruebas y de intervenciones breves.

De igual forma, en el marco de un sistema nacional de tratamiento y desde el Sector Salud, se debe propiciar, orientar u ordenar la participación de las redes de organismos comunitarios y organizaciones no gubernamentales (no afiliados a la industria del alcohol), en su doble rol: en la prevención y la prestación de asistencia y apoyo a los afectados y sus familiares y como grupos de presión para influir, condicionar, bloquear o activar las decisiones públicas.

Sin lugar a dudas la mayor disponibilidad y accesibilidad a las bebidas alcohólicas y los cambios en las conductas de consumo, justifican una intervención gubernamental urgente y prioritaria.

Se hace necesario favorecer los enfoques basados en la población, que afectan el contexto social de consumo y la disponibilidad de bebidas alcohólicas, en otras palabras, implementar medidas que controlen el suministro de alcohol y afecten la amplia demanda de bebidas alcohólicas de la población.

Las políticas deben afectar los patrones de consumo al limitar el acceso y disuadir el consumo, prioritariamente en los jóvenes, al establecer una edad legal mínima para beber y adquirir alcohol. Además es vital controlar el acceso al alcohol, no solo por edad, sino también, con la restricción de horas y días de venta, además de lo relacionado con la densidad y cantidad de establecimientos de venta.

Por otra parte, existe una clara asociación entre precio, disponibilidad y consumo. Este aspecto es importante de considerar al estar los problemas del alcohol correlacionados con el consumo individual, la reducción del uso puede disminuir los problemas del alcohol, lo cual se puede lograr al incrementar los precios (influenciados por los impuestos) e impactando las ventas de bebidas alcohólicas, esta claro que si los precios aumentan, baja la demanda y viceversa. Se recaudan impuestos que afecten los precios de las bebidas alcohólicas, lo que se constituye en un y pago por los problemas que causa el consumo.

No se trata solo de restringir la provisión y uso de alcohol, sino también los patrocinios y la publicidad de bebidas alcohólicas, ya sea mediante la prohibición o al menos, ampliándose las restricciones existentes en lo que respecta al volumen, la ubicación y contenido de las comunicaciones comerciales.

En este sentido, se considera prioritario intensificar aquellas medidas dirigidas a proteger a los menores de edad y jóvenes de la exposición a la promoción, patrocinios y publicidad del alcohol y de las presiones ejercidas para que comiencen a beber. Así como también se debe propiciar la búsqueda de mecanismos que permitan potenciar la participación de los medios de comunicación social en la prevención de los problemas asociados al alcohol.

Es necesario que los países apliquen un paquete de medidas que afectan la accesibilidad, suministro, distribución, venta y la publicidad y promoción de bebidas alcohólicas.

Además es necesario contar estrategias para reducir el daño y limitar los problemas relacionados con el alcohol, en particular los relacionados con la conducción bajo los efectos del alcohol y la violencia intrafamiliar.

Son vitales medidas preventivas eficaces contra la conducción bajo la influencia del alcohol, como las regulaciones que permitan reducir la tasa legal de alcoholemia o establecer límites bajos de concentración de alcohol en la sangre permitidos para los conductores (más baja aún para los jóvenes conductores).

Pero estas medidas deben estar complementadas con la aplicación activa de las medidas de seguridad de tránsito, control aleatorio de alcoholemia e intervenciones legales y médicas para conductores intoxicados reincidentes y suspensión del permiso

de conducir. Estas acciones deben estar apoyadas con campañas recurrentes de publicidad y sensibilización.

2. **Opiniones sobre el mejor modo de reducir los problemas relacionados con el uso nocivo del alcohol desde una perspectiva mundial.**

Es necesario promover la consideración de un convenio marco para el control del alcohol, similar al Convenio Marco de la OMS para el Control del Tabaco, con el fin de que se ejecute en forma sostenida de un paquete de políticas y programas eficaces, cuya combinación genere un mayor beneficio para la sociedad en cuanto a la salud pública y el bienestar social se refiere.

Prioritariamente hay que abocarse a cambiar la situación imperante de falta de apoyo institucional y político para la formulación y ejecución de forma consistente y sostenida de políticas públicas sobre el consumo de alcohol.

Estamos convencidos, como se señala en las Estrategias para Reducir el Uso Nocivo del Alcohol, que las políticas y planes de acción nacionales que se formulen, requieren de desarrollo de campañas regionales y mundiales de sensibilización, actividades de promoción, investigación y fortalecimiento de la capacidad.

Las estrategias para reducir el suministro, la demanda y los daños generados por el alcohol deben ser considerados como componentes esenciales de toda estrategia de salud pública. Compartimos la idea de brindar prioridad a la prevención del consumo nocivo para reducir los daños ligados al alcohol, medidas de protección que no pueden ser aisladas, sino que deben enmarcarse en una política comprensiva, coordinada y multisectorial, en la cual las actividades de prevención y promoción de la salud tienen un papel importante.

Nos inclínanos por una conceptualización, promulgación, ejecución y evaluación de las políticas públicas hacia el alcohol que en forma integrada contemple, por una parte, las políticas públicas para el control y la reducción de los problemas relacionados con el alcohol y por otra parte, las políticas relacionadas con la reducción de la demanda de drogas: el tratamiento de los problemas generados por el consumo del alcohol y las encaminadas hacia programas preventivos y las campañas en medios de comunicación, que permitan preparar el terreno para intervenciones específicas y cambios en las políticas adoptadas.

Esta claro que los programas de prevención, por si solos, han sido incapaces de conseguir modificaciones sustanciales en las prevalencias de consumo de alcohol, por eso se necesitan políticas que propicien una acción protectora sobre el contexto social y cultural, que hoy permite, tolera y banaliza el impacto que tienen el uso de alcohol.

Esta situación puede variar con la adopción de un paquete de medidas reguladoras de la accesibilidad, disponibilidad y comercialización de las bebidas alcohólicas y el compromiso efectivo de garantizar el cumplimiento de estas restricciones, con el fin de reducir significativamente la oferta de estas sustancias y la tolerancia social con que cuenta su consumo y la aceptación de la ebriedad pública.

En resumen, abogamos por que se incorpore a las estrategias para reducir el suministro, la demanda y los daños generados por el alcohol, un componente de "Otras Políticas Públicas", en donde se pueda considerar las estrategias de educación y persuasión, el desarrollo de campañas de publicidad e informativas y el fomento de la investigación, para generar opinión publica e incrementar la sensibilización sobre el tema del uso de alcohol y los problemas que ocasiona.

Con el fin de apoyar las políticas nacionales de gran extensión que se lleguen a formular para reducir los problemas relacionados con el uso nocivo del alcohol, es necesario, promover y reforzar la concienciación pública sobre dichas políticas y preparar el terreno para intervenciones específicas, usando todas las herramientas de comunicación disponibles, logrando también potenciar la participación de instituciones públicas y privadas, organismos de la comunidad, así como de organizaciones no gubernamentales (no afiliadas a la industria comercial del alcohol), para desarrollar y aplicar programas intersectoriales y estrategias sobre el alcohol.

3. **Modos en que se puede contribuir a reducir el uso nocivo del alcohol.**

Costa Rica se ha propuesto mejorar la atención en los servicios de programas de tratamiento y rehabilitación, públicos y privados, implícito esta el hecho de fortalecer y consolidar las redes sociales y comunitarias de atención, además de diversificar la oferta existente para adecuarla a los requerimientos de las personas afectadas y al nivel de complejidad del problema de las drogas en el país.

Para tal fin, se formula una "Política del Sector Salud para la Atención de los Problemas derivados del Consumo de Alcohol, Tabaco y Otras Drogas", cuya conducción estará a cargo del Ministerio de la Salud y el Instituto sobre Alcoholismo y Farmacodependencia.

El propósito de esta política es posibilitar el acceso a la atención integral en materia de consumo de alcohol, tabaco y otras drogas, ya sea de manera ambulatoria o bajo internamiento, en condiciones de seguridad y habitabilidad, en especial para aquellas personas que están en mayor situación de vulnerabilidad y exclusión social.

Un eje central de la política es la mejora en el diagnóstico, la detección e intervención temprana, que asegure mejores resultados para las personas con problemas derivados del consumo de drogas.

La intención actual es poder articular estas políticas públicas, con las estrategias para reducir el uso nocivo del alcohol, y lograr una ejecución de forma consistente y sostenida de políticas públicas sobre el uso del alcohol.

En Costa Rica y las medidas asumidas hasta el día de hoy se agrupan en:

Disponibilidad del alcohol en general

- Edad mínima legal para beber y comprar alcohol
- Restricciones de horarios y días de venta
- Restricciones sobre la densidad de los establecimientos
- Precios e Impuestos
- Monopolio del gobierno

Las razones del monopolio estatal de la producción de bebidas alcohólicas destiladas no se reducen al arbitrio rentístico y la hacienda pública, la validez del monopolio estatal abarca fines económicos, sociales y en todo caso de conveniencia pública, como lo es el controlar el consumo.

Medidas dirigidas a la conducción bajo la influencia del alcohol

- Tasa legal de alcoholemia
- Control aleatorio de alcoholemias
- Suspensión de licencia

Restricción a las comunicaciones comerciales

- Regulación de la publicidad de las bebidas alcohólicas
- Leyendas de advertencia

Intervenciones educativas - persuasivas.

- Programas preventivos en el ámbito escolar
- Desarrollo de campañas mediáticas.

SPF SANTE PUBLIQUE, SECURITE DE LA CHAINE ALIMENTAIRE ET ENVIRONNEMENT

FOD VOLKSGEZONDHEID, VEILIGHEID VAN DE VOEDSELKETEN EN LEEFMILIEU

Conférence Interministérielle Santé Publique

Interministeriële Conferentie Volksgezondheid

A

7.3. Déclaration Conjointe sur la politique future en matière d'alcool

Cellule Politique de Santé Drogues

7.3. Gemeenschappelijke Verklaring betreffende het toekomstige alcoholbeleid

Cel Gezondheidsbeleid Drugs

Réunion
17 juin 2008

Vergadering
17 juni 2008

Déclaration Conjointe sur la politique future en matière d'alcool

Gemeenschappelijke Verklaring betreffende het toekomstige alcoholbeleid

17 juin 2008 - Déclaration conjointe des Ministres, qui ont la Santé publique dans leurs attributions, sur la politique future en matière d'alcool

Vu les compétences respectives des Communautés, des Régions et de l'Etat fédéral en matière d'alcool;

Considérant que la Cellule Politique Santé Drogues, créée par le Protocole d'accord du 31 mai 2001 relatif à la création d'une politique de santé intégrée en matière de drogues, a élaboré et approuvé un projet de Plan d'Action National d'Alcool et ce en collaboration avec des experts;

Considérant que les Ministres de la Santé ont souhaité dégager des mesures prioritaires en matière de lutte contre la consommation problématique d'Alcool ;

Considérant que, néanmoins, le travail d'opérationnalisation du plan Alcool doit se poursuivre au sein de la Cellule Politique Générale Drogues ;

Sur la base des considérations précitées, la Conférence Interministérielle de Santé publique a convenu de faire la Déclaration suivante :

1. LE BESOIN D'UNE POLITIQUE INTEGREE EN MATIERE D'ALCOOL

Les instances tant nationales qu'internationales prennent toujours davantage conscience des méfaits d'une consommation d'alcool. Certains organismes internationaux ont, dès lors, consacré

17 juni 2008 - Gemeenschappelijke Verklaring van de Ministers, die de Volksgezondheid onder hun bevoegdheden hebben, betreffende het toekomstige alcoholbeleid

Gelet op de respectievelijke bevoegdheden van de Gemeenschappen, de Gewesten en de federale Staat inzake alcohol;

Overwegende dat de Cel Gezondheidsbeleid Drugs, opgericht door het Protocolakkoord van 31 mei 2001 inzake de totstandkoming van een geïntegreerd gezondheidsbeleid inzake drugs, een Nationaal Alcohol Actie Plan uitwerkte en goedkeurde en dit in samenwerking met experts;

Overwegende dat de Ministers van Volksgezondheid prioritaire maatregelen wensten te formuleren in de strijd tegen het problematische gebruik van alcohol;

Overwegende dat het werk voor het operationeel maken van het alcoholplan niettemin binnen de Algemene Cel Drugs moet worden voortgezet;

Op basis van voorgaande overwegingen, is de Interministeriële Conferentie Volksgezondheid overeengekomen om volgende Verklaring af te leggen:

1. DE NOOD AAN EEN GEÏNTEGREERD BELEID INZAKE ALCOHOL

Zowel de nationale als de internationale instanties worden zich steeds meer bewust van de kwalijke gevolgen van alcoholgebruik.

différents études et projets en matière de lutte contre la consommation problématique d'Alcool.

Bepaalde internationale organismen hebben derhalve verschillende studies en projecten gewijd aan de strijd tegen het problematische gebruik van alcohol.

La 58e Conférence Mondiale de la santé, qui s'est tenue le 25 mai 2005, demande dans la résolution WHA 58.26 aux Etats membres d'élaborer et de mettre en œuvre des stratégies et programmes efficaces afin de réduire les conséquences négatives d'une consommation nocive d'alcool.

De 58ste Wereldgezondheidsconferentie van 25 mei 2005, vraagt in de resolutie WHA 58.26, aan de lidstaten om strategieën en efficiënte programma's uit te werken en in werking te brengen om de negatieve gevolgen van aan alcoholgebruik gerelateerde schade te verminderen.

La 'Charte Européenne sur la consommation d'alcool' de l'OMS, Région Européenne, énonce 5 principes éthiques concernant une politique relative à la consommation d'alcool, et formule 10 stratégies pour les poursuivre. Sur cette base le 'European Alcohol Action Plan 2000-2005', la 'Déclaration sur les jeunes et l'alcool' et le 'Cadre de la politique en matière d'alcool dans la Région européenne de l'OMS' ont été développés.

Het 'Europees Handvest inzake gebruik van alcohol' van de WGO, Regio Europa, formuleert 5 ethische principes betreffende een beleid inzake het gebruik van alcohol en formuleert 10 strategieën om dat beleid verder te zetten. Op deze basis werden het 'European Alcohol Action Plan 2000-2005', de 'Verklaring inzake jonge mensen en alcohol' en het 'Kader van het beleid inzake alcohol in de Europese Regio van de WGO' ontwikkeld.

L'Union Européenne a également fait de nombreux efforts en vue de mettre en place une politique intégrée en matière d'alcool. De même, les 'Conclusions du Conseil du 5 juin 2001 relatives à une stratégie communautaire visant à réduire les dommages liés à l'alcool' soulignent la nécessité d'élaborer une stratégie commune.

De Europese Unie heeft eveneens talrijke inspanningen geleverd met het oog op het instellen van een geïntegreerd beleid inzake alcohol. Ook de 'Conclusies van de Raad van 5 juni 2001 inzake een strategie van de Gemeenschap ter beperking van aan alcohol gerelateerde schade' onderstrepen de noodzaak van het uitwerken van een gemeenschappelijke strategie.

La mise en place d'une politique intégrée, efficace et coordonnée en matière de lutte contre la consommation problématique d'alcool en Belgique est donc primordiale.

Het instellen van een geïntegreerd, efficiënt en gecoördineerd beleid inzake de strijd tegen het problematische gebruik van alcohol in België is dus primordiaal.

2. QUELQUES CHIFFRES

2. ENKELE CIJFERS

Dans la gamme des substances psychoactives, l'alcool est la plus consommé en Belgique. Dans la dernière enquête de santé de 2004, 84% des Belges de 15 ans et plus ont déclaré avoir consommé des boissons alcoolisées au cours de l'année écoulée (1). D'une façon générale, cette consommation est, de surcroît, plus importante chez les hommes que chez les femmes. En 2003, le Belge a bu en moyenne 8,8 litres d'alcool pur (2). En matière de consommation d'alcool, la Belgique se situe dans la moyenne européenne (3).

In het gamma van de psychoactieve stoffen, wordt alcohol in België het meest gebruikt. In de laatste gezondheidsenquête van 2004 verklaarden 84% van de Belgen van 15 jaar en ouder dat ze in de loop van het afgelopen jaar alcohol gebruikten (1). Meer algemeen ligt dit gebruik bovendien hoger bij mannen dan bij vrouwen. In 2003 dronk de Belg gemiddeld 8,8 liter zuivere alcohol (2). Inzake alcoholgebruik plaatst België zich binnen het Europees gemiddelde (3).

Dans la même enquête de santé de 2004, 18% des Belges ont déclaré avoir abusé de l'alcool de

In dezelfde gezondheidsenquête van 2004 hebben 18% van de Belgen verklaard dat ze

façon régulière (plus de 6 verres sur une même journée au moins 1 fois par mois). Ce pourcentage n'a pas changé de manière significative depuis 1997. Ce sont surtout les jeunes (15-24 ans) qui consomment régulièrement une quantité excessive d'alcool ainsi que les hommes qui abusent trois fois plus que les femmes de l'alcool. Les Belges consommeraient plus régulièrement de l'alcool de manière excessive que la moyenne européenne.

regelmatig alcohol misbruikten (meer dan 6 glazen op dezelfde dag, minstens 1 keer per maand). Dit percentage veranderde niet significant tegenover 1997. Het zijn vooral de jongeren (15-24 jaar) die regelmatig te veel alcohol gebruiken, evenals de mannen, die drie keer meer dan de vrouwen misbruik van alcohol maken. De Belgen zouden regelmatiger overmatig alcohol gebruiken dan het Europees gemiddelde.

Selon l'enquête de santé, 8% des Belges avaient un problème d'alcool en 2004.

Volgens de gezondheidsenquête had 8% van de Belgen in 2004 een alcoholprobleem.

Les jeunes commencent déjà très tôt à consommer de l'alcool. Trois quarts des élèves flamands de 13 ans ont déjà consommé de l'alcool et cette proportion grimpe à 85% à l'âge de 14 ans (ou encore : 63% des jeunes de 12 ans). 15% des 15-16 ans indiquent avoir déjà pris une cuite avant leur 13e anniversaire (11% des filles et 20% des garçons) (4). 5% des jeunes bruxellois et 8% des jeunes Wallons de 15 à 24 ans s'estiment dépendants à l'alcool (5).

Jongeren beginnen reeds zeer vroeg alcohol te gebruiken. Drievierden van de Vlaamse leerlingen van 13 jaar hebben reeds alcohol gebruikt en deze verhouding gaat naar 85% bij de leeftijd van 14 jaar (of nog: 63% van de jongeren van 12 jaar). 15% van de 15 tot 16-jarigen vermelden dat ze voor hun 13de verjaardag al eens dronken waren (11% van de meisjes en 20% van de jongens) (4). 5% van de jonge Brusselaars en 8% van de jonge Walen van 15 tot 24 jaar zijn van mening dat ze van alcohol afhankelijk zijn (5).

Les jeunes Belges de 15-16 ans sont, avec les jeunes Néerlandais, Autrichiens et Maltais du même âge, les Européens qui consomment le plus fréquemment de l'alcool (10 fois ou plus au cours du mois écoulé) (6). On observe également un certain nombre de phénomènes caractéristiques chez les jeunes en matière de consommation nocive d'alcool, tels que le 'binge-drinking'.

De jonge Belgen van 15-16 jaar zijn, samen met de jonge Nederlanders, Oostenrijkers en Maltezers van dezelfde leeftijd de Europeanen die het vaakst alcohol gebruiken (10 maal of meer tijdens de afgelopen maand) (6). Men stelt ook een bepaald aantal karakteristieke fenomenen bij de jongeren vast inzake het schadelijk gebruik van alcohol, zoals het 'binge-drinking'.

Les données chiffrées sont essentielles afin de cerner la problématique et de pouvoir y répondre le plus adéquatement possible.

Cijfergegevens zijn essentieel om de problematiek af te bakenen en om er zo adequaat mogelijk op te kunnen antwoorden.

Des études sont en cours et devraient permettre l'obtention de nouveaux chiffres.

Er zijn studies bezig en die zouden het mogelijk moeten maken dat men nieuwe cijfers verkrijgt.

Il s'agit notamment de l'enquête santé qui a été lancée le 19 mai dernier et dont il convient de souligner le caractère récurrent. Il en est de même pour l'enquête HBSC réalisée par les Communautés.

Het betreft onder meer de gezondheidsenquête die op 19 mei jongstleden werd gelanceerd en de HBSC-studie, gesteund door de Gemeenschappen, waarvan het weerkerende karakter moet worden onderstreept.

Des chiffres relatifs aux dépenses publiques Santé en matière de drogues font cependant défaut. Dès lors, les Ministres de la Santé estiment qu'il est nécessaire qu'une étude collectant de telles données soit réalisée.

Cijfers in verband met de publieke uitgaven voor Gezondheid inzake drugs ontbreken echter. De ministers van Gezondheid zijn het eens over de noodzaak van een studie die dergelijke gegevens verzamelt.

De même, les évolutions sociales quant à la consommation d'alcool devront également être étudiées de manière permanente. Il faudra, en

De sociale evoluties betreffende het gebruik van alcohol zullen echter ook permanent moeten bestudeerd worden. Men zal bovendien de

outre, étudier l'efficacité des programmes de prévention et de traitements existants.

efficiëntie moeten bestuderen van de bestaande preventie- en behandelingsprogramma's.

3. VISION ET OBJECTIFS GENERAUX DE LA POLITIQUE EN MATIERE D'ALCOOL

Les objectifs généraux qui doivent être poursuivis sont les suivants :

- Prévenir et réduire les dommages liés à l'alcool.
- Combattre la consommation inadaptée, excessive, problématique et risquée d'alcool et non pas seulement la dépendance
- Avoir une politique orientée vers des groupes cibles à risques et des situations à risques.

3. VISIE EN ALGEMENE DOELSTELLINGEN VAN HET BELEID INZAKE ALCOHOL

De na te streven algemene doelstellingen luiden als volgt:

- De aan alcohol gerelateerde schade voorkomen en verminderen.
- Het onaangepaste, buitensporige, problematische en risicovolle gebruik van alcohol bestrijden en niet alleen de afhankelijkheid ervan.
- Een beleid voeren dat gericht is op risicogroepen en op risicosituaties.

4. MESURES

L'ensemble des mesures proposées infra doivent être mises en œuvre en tenant compte des particularités de certains groupes cibles dits à risques et objectivées eu égard à certaines situations dites à risques.

A cet égard, les jeunes constituent un groupe-cible de premier plan, sachant que l'alcool nuit au développement cérébral. L'âge des premières consommations peut avoir un impact sur la consommation à l'âge adulte. En effet, les personnes qui ont débuté une consommation lors de leur adolescence seraient plus exposées au risque de dépendance à l'alcool.

De même, les femmes enceintes représentent également un groupe cible important. Boire de l'alcool pendant la grossesse peut nuire à l'enfant en gestation. Par précaution, la recommandation la plus indiquée est de s'abstenir de tout produit contenant de l'alcool et ce, durant toute la période de la grossesse.

4. MAATREGELEN

Bij de aanwending van de hierna voorgestelde maatregelen zal men rekening moeten houden met de bijzondere kenmerken van bepaalde zogenaamde risicogroepen en ze zullen geobjectiveerd moeten zijn ten aanzien van bepaalde zogenaamde risicosituaties.

In dit opzicht staan de jongeren als doelgroep vooraan, want men weet dat alcohol schadelijk is voor de ontwikkeling van de hersenen. De leeftijd waarop men voor het eerst gebruikt, kan een impact hebben op het gebruik op volwassen leeftijd. Personen die tijdens hun adolescentie zijn beginnen gebruiken, zouden inderdaad veel sneller blootgesteld zijn aan latere afhankelijkheid van alcohol.

Ook zwangere vrouwen zijn een belangrijke doelgroep. Tijdens de zwangerschap alcohol drinken kan schadelijk zijn voor het kind in wording. Uit voorzorg is de beste aanbeveling geen enkel product dat alcohol bevat te gebruiken en dit gedurende de hele zwangerschapsperiode.

4.1. Mesures relatives à la disponibilité

4.1.1. Les Ministres de la Santé recommandent l'interdiction de la vente d'alcool dans certains lieux déterminés, à savoir :
- dans les stations services le long des autoroutes
- dans les distributeurs automatiques

4.1.Maatregelen betreffende de beschikbaarheid

4.1.1. De ministers van Gezondheid bevelen aan om de verkoop van alcohol te verbieden op enkele bepaalde plaatsen, te weten:
- in de tankstations langs de snelwegen;
- in de automaten.

4.1.2. Il faut mettre fin à la confusion existant entre certains boissons contenant de l'alcool et les autres (eaux, softs, ..) dans les commerces. Pour ce faire, tous les boissons contenant de l'alcool doivent se trouver dans un rayon bien distinct.

4.1.2. Er moet een einde komen aan de bestaande verwarring tussen bepaalde dranken met alcohol en de andere (waters, softdrinks,...) in de handel. Hiertoe moeten alle dranken die alcohol bevatten zich in een duidelijk apart rek bevinden.

4.1.3. De même, il est nécessaire de mettre fin à la pratique qui consiste à exposer uniquement de l'alcool dans les vitrines des « night shops ».

4.1.3. Het is ook nodig om een einde te maken aan de praktijk die eruit bestaat dat men uitsluitend alcohol laat zien in de vitrines van de "night shops".

4.2. Mesures relatives à la législation

4.2. Maatregelen betreffende de wetgeving

4.2.1 Il y a lieu de clarifier l'application de la législation actuelle en matière de vente (distribution et horeca) de boissons contenant de l'alcool aux jeunes.

4.2.1. De toepassing van de huidige wetgeving inzake de verkoop (distributie en horeca) van alcoholische dranken aan jongeren moet verduidelijkt worden.

En effet, la réglementation actuelle manque cruellement de clarté. Sa complexité est telle qu'il est extrêmement difficile de la traduire en messages de prévention efficace. La réglementation doit donc être simplifiée et harmonisée afin de rendre son respect plus aisé et les contrôles plus efficients ; une campagne d'information à destination de professionnels concernés par la vente et la distribution devra être réalisée.

De huidige reglementering blinkt immers uit door de onduidelijkheid ervan. Ze is zodanig complex dat het uiterst moeilijk is om ze te vertalen in efficiënte preventieve boodschappen. De reglementering moet dus vereenvoudigd en geharmoniseerd worden, zodat men ze makkelijker kan respecteren en de controles erop efficiënter kunnen zijn. Er zou een informatiecampagne moeten komen ten behoeve van de professionelen die betrokken zijn bij de verkoop en de distributie.

4.2.2. Les ministres de la santé rappellent que la législation applicable en matière de vente et de distribution des boissons contentant de l'alcool est la suivante :

1. L'arrêté-loi du 14 novembre 1939 relatif à la répression de l'ivresse
2. La loi du 15 juillet 1960 sur la préservation de la jeunesse
3. La loi du 28 décembre 1983 sur la patente pour les débits de boissons spiritueuses

4.2.2. De ministers van Volksgezondheid herinneren dat de wetgeving, die van toepassing is op de verkoop en de distributie van alcoholhoudende dranken, de volgende is:

1. De Besluitwet van 14 november 1939 betreffende de beteugeling van de dronkenschap.
2. De wet van 15 juli 1960 tot zedelijke bescherming van de jeugd.
3. De wet van 28 december 1983 betreffende de vergunning voor het verstrekken van sterke drank.

Les Ministres de la santé rappellent donc que la vente des vins et bières dans l'horeca est interdit aux moins de 16 ans et que la vente des spiritueux dans l'horeca et les commerces est interdite aux moins de 18 ans.

De ministers van Volksgezondheid herinneren er dus aan dat de verkoop van wijnen en bieren in de horeca verboden is aan min-16-jarigen en dat de verkoop van geestrijke dranken aan min-18-jarigen verboden is in de horeca en in alle handelszaken.

4.2.3. Les ministres estiment par conséquent qu'il y a lieu d'étendre l'interdiction de la vente des vins et bières aux moins de 16 ans dans tous les commerces.

4.2.3 Bijgevolg vinden de Ministers van Volksgezondheid de uitbreiding van het verkoopsverbod van bieren en wijnen aan min-16-jarigen in alle handelszaken nodig.

4.2.4. Les Ministres de la Santé souhaitent également évaluer la législation en matière de vente et de distribution sur les boissons mixtes dites « alcopops ».

4.2.4 De Ministers van Volksgezondheid wensen eveneens de wetgeving op de verkoop en de distributie van gemengde dranken, 'alcopops' genoemd, te onderzoeken.

4.3. Mesures relatives au marketing et publicité

4.3. Maatregelen betreffende marketing en reclame

Les stratégies marketing et publicitaires en faveur de l'alcool doivent être limitées autant que possible sur le plan quantitatif. De préférence, on doit les interdire lorsqu'elles s'adressent à certains groupes cibles, tels que les jeunes (mineurs).

De marketing- en reclamestrategieën voor alcohol moeten zoveel mogelijk kwantitatief beperkt worden. Men moet ze bij voorkeur verbieden wanneer ze zich tot bepaalde doelgroepen, zoals de jongeren (minderjarigen), richten.

Les stratégies marketing et publicitaires en faveur de l'alcool peuvent uniquement fournir des informations sur le produit et diffuser des messages et des images renvoyant exclusivement à l'origine, à la composition, aux procédés de fabrication du produit.

De marketing- en reclamestrategieën voor alcohol mogen alleen informatie geven over het product, en boodschappen en beelden verspreiden die exclusief verwijzen naar de oorsprong, de samenstelling, het fabricageprocédé van het product.

Les Ministres de la Santé recommandent :

De ministers van Gezondheid bevelen aan:

4.3.1 D'institutionnaliser la convention signée en matière de publicité entre le secteur, les consommateurs et le Ministre de la santé publique en 2005 et qui confie au Jury d'éthique publicitaire le soin de contrôler le respect de l'application de cette convention.

4.3.1. Het convenant inzake reclame dat in 2005 tussen de sector, de gebruikers en de minister van Volksgezondheid afgesloten werd en dat het aan de Jury voor Ethische Praktijken overlaat om het respecteren van de toepassing van dit convenant te controleren, te institutionaliseren.

4.3.2 D'interdire la mise à disposition gratuite de produits alcoolisés lors d'événements culturels et sportifs.

4.3.2. Het gratis aanbieden van alcoholische producten tijdens culturele en sportieve evenementen te verbieden.

Ce sont évidemment surtout les jeunes qu'il conviendra de protéger contre l'influence des techniques marketings et de la publicité, entre autres en leur apprenant à faire preuve de sens critique vis-à-vis des pratiques de marketing.

Het zijn uiteraard vooral de jongeren die men moet beschermen tegen de invloed van de marketing- en reclametechnieken, onder meer door hen te leren om kritisch te staan tegenover de marketingpraktijken.

4.4. Mesures relatives à l'alcool au volant

4.4. Maatregelen betreffende alcohol in het verkeer

La consommation d'alcool est une cause très importante d'accidents de la route. Il faut donc être particulièrement vigilant à cette problématique.

Alcoholgebruik is een zeer belangrijke oorzaak van verkeersongevallen. Men moet dus bijzonder waakzaam zijn voor deze problematiek.

Une politique sans équivoque, qui s'articule autour d'un taux d'alcoolémie légalement autorisé, de contrôles et de mesures répressives doit réduire le nombre d'accidents de la route dus à l'alcool. L'application et le contrôle du respect de la

Een ondubbelzinnig beleid, toegespitst rond een wettelijk toegelaten alcoholgehalte, controles en repressieve maatregelen, moet het aantal verkeersongevallen dat te wijten is aan alcohol verminderen. In dit opzicht zijn de toepassing en

législation existante sont les axes prioritaires à cet égard.

Pour ce faire, il faut :

4.4.1. Intensifier les contrôles.

4.4.2. Mener une politique plus sévère au niveau des amendes et/ou des interdictions prononcées à l'égard des récidivistes. A cet égard, une attention particulière doit être portée aux 'professionnels du volant' (taxis, conducteurs de poids lourds, ...).

de controle op het respecteren van de bestaande wetgeving prioritaire beleidslijnen.

Hiertoe moet men:

4.4.1. De controles opvoeren.

4.4.2. Een strenger beleid voeren op het niveau van de boetes en/of het rijverbod dat uitgesproken wordt ten aanzien van recidivisten. Hierbij moet bijzondere aandacht besteed worden aan de 'beroepschauffeurs' (taxi's, vrachtwagenbestuurders,...).

4.5.Mesures relatives à la politique des prix

4.5.1 Une analyse des prix moyens pratiqués en Europe et, tout particulièrement, une comparaison des prix belges avec ceux pratiqués dans nos pays limitrophes doit être effectuée et ce dans la perspective d'aligner les prix à la hausse si le différentiel constaté est trop important.

4.5. Maatregelen betreffende het prijsbeleid

4.5.1. Er moet een analyse uitgevoerd worden van de gemiddelde toegepaste prijzen in Europa en, meer in het bijzonder, moeten de Belgische prijzen vergeleken worden met die welke toegepast worden in onze buurlanden. Dit met het oog op het aanpassen van de prijzen naar boven toe, indien het vastgestelde verschil te groot is.

4.6. Mesures relatives à certains groupes cibles

4.6.1. Comme évoqué supra, les jeunes (qui feront l'objet d'une clarification législative) et les femmes enceintes constituent des groupes cibles auxquels une attention particulière doit être réservée.

C'est pourquoi, en sus de la récente initiative parlementaire visant à apposer un logo 'interdiction pour les femmes enceintes de boire de l'alcool' sur toutes les bouteilles d'alcool (propositions 4-530/1 et 4-607/1), il serait cohérent de sensibiliser les professionnels de la santé (médecins généralistes, gynécologues, accoucheuses,...) en ce sens.

4.6. Maatregelen betreffende bepaalde doelgroepen

4.6.1. Zoals hierboven vermeld, vormen de jongeren (die het voorwerp zullen zijn van een verduidelijking van de wetgeving) en de zwangere vrouwen de doelgroepen waaraan men bijzondere aandacht moet besteden. Daarom zou het, naast het recente parlementaire initiatief dat ertoe strekt om een logo 'verboden voor zwangere vrouwen om alcohol te drinken' op alle flessen met alcohol (voorstellen 4-530/1 en 4-607/1), coherent zijn om de gezondheidswerkers (huisartsen, gynaecologen, vroedvrouwen,...) in die zin te sensibiliseren.

4.7. Mesures dont il faut examiner la faisabilité

4.7.1. Installation systématique d'un système 'alcolocks' dans les voitures des récidivistes et des professionnels de la route. Cette mesure, qui existe au Canada, devra être analysée plus avant afin d'en déterminer l'efficacité, la faisabilité technique mais également la charge financière.

4.7.2. Limiter le taux d'alcoolémie au volant pour les conducteurs inexpérimentés. Une telle mesure devra être mise en perspective afin d'éviter la complication et l'illisibilité du système.

4.7. Maatregelen waarvan men de haalbaarheid moet onderzoeken

4.7.1. Systematische installatie van een systeem van 'alcolocks' in voertuigen van recidivisten en beroepschauffeurs. Deze maatregel, die in Canada bestaat, zal verder moeten geanalyseerd worden, teneinde de technische haalbaarheid en de efficiëntie, maar ook de financiële last ervan te bepalen.

4.7.2. Het alcoholgehalte in het bloed in het verkeer beperken voor onervaren chauffeurs. Een dergelijke maatregel zal in het vooruitzicht moeten gesteld worden, teneinde de complexiteit en de onleesbaarheid van het systeem te vermijden.

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Les différents Ministres de la Santé adresseront à leurs collègues compétents (Ministre des Finances, de l'Economie, de la Mobilité, ...) les recommandations énumérées dans la présente Déclaration afin que ces derniers étudient la faisabilité de prendre de telles mesures et le cas échéant prennent les initiatives nécessaires.

De verschillende ministers van Volksgezondheid zullen aan hun bevoegde collega's (minister van Financiën, Economie, Mobiliteit,...) de in deze Verklaring opgenoemde aanbevelingen sturen, zodat die de haalbaarheid kunnen bestuderen van het nemen van dergelijke maatregelen en ze in voorkomend geval de nodige initiatieven kunnen nemen.

Références

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(3) De Donder, E. (2006), *Alcohol: cijfers in perspectief (1994-2004)*, Antwerpen: Garant

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Referenties

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(4) Ibidem

(5) Health Behaviour in School-aged Children, a WHO Collaborative Cross-national study, 2006

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17 -06- 2008

Voor de Federale Staat:
Pour l'Etat Fédéral:

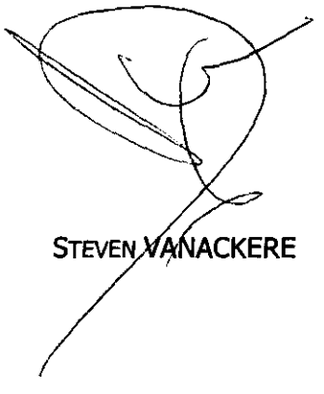
17 -06- 2008

De Minister van Sociale Zaken en Volksgezondheid
La Ministre des Affaires Sociales et de la Santé Publique

LAURETTE ONKELINX

Voor de Vlaamse Gemeenschap en het Vlaams Gewest:
Pour la Communauté Flamande et la Région Flamande:

De Vlaamse Minister van Welzijn, Gezondheid en Gezin
Le Ministre Flamande de Bien-être, de la Santé et de la Famille



STEVEN VANACKERE

Voor de Franse Gemeenschap:
Pour la Communauté Française:

De Minister van Gezondheid, Kinderen en Jeugdhulp
La Ministre de la Santé, de L'Enfance et de l'Aide à la Jeunesse

CATHERINE FONCK

Voor de Duitstalige Gemeenschap:
Pour la Communauté Germanophone:

De Gemeenschapsminister van Vorming en Werk, Sociale Zaken en Toerisme
Le Ministre Communautaire de la Formation et de l'Emploi, des Affaires Sociales et du Tourisme

BERNARD GENTGES

Voor de Franse Gemeenschapscommissie:
Pour la Commission Communautaire Française:

Het lid van het College van de Franse Gemeenschapscommissie bevoegd voor het Gezondheidsbeleid
Le membre du Collège de la Commission Communautaire Française compétent pour la Politique de la Santé

BENOÎT CEREXHE

Voor de Gemeenschappelijke Gemeenschapscommissie:
Pour la Commission Communautaire Commune:

De leden van het Verenigd College bevoegd voor het Gezondheidsbeleid
Les membres du Collège réuni compétents pour la Politique de la Santé

GUY VANHENGEL

BENOÎT CEREXHE

Voor het Waals Gewest:
Pour la Région Wallonne:

De Minister van Gezondheid, Sociale Zaken en Gelijkheid van Kansen
Le Ministre de la Santé, de l'Action sociale et de l'Egalité des Chances

DIDIER DONFUT

15.09.2008

Referring to the request of the WHO for consultation with Member States, as well as with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators, on ways they could contribute to reducing harmful use of alcohol,

The Finnish Ministry of Social Affairs and Health wishes to contribute to public hearing on ways of reducing alcohol-related harm with the following submission:

1. Effective strategies to reduce alcohol-related harm

In general effective strategies should recognize and acknowledge three main facts:

- *Evidence shows that alcoholic beverages are no ordinary commodities*

Alcohol consumption causes a wide range of harm to the individual as well as to public health. Alcoholic beverages cause substantial medical, psychological and social harm by means of physical toxicity, intoxication and dependence.

Hence alcoholic beverages should not be considered as ordinary consumer commodities. If international trade policy agreements are implemented on alcohol as they are implemented on ordinary commodities, they have the potential to undermine national efforts to reduce alcohol related harm. For example Finland has experienced difficulties in maintaining high level public health alcohol policies due to cross border activity, like exposure to cross border private imports and cross-border advertising of alcohol.

From the point of view of international trade agreements different national regulations concerning trade on alcoholic beverages as well as tobacco products may jeopardise free trade and give rise to distortions in competition. When tobacco and alcohol are concerned there are, however, substantial reasons for national authorities to regulate the trade of these harmful commodities in different ways.

The primary aim of all alcohol-related policies – including national and international trade policies - should be to reduce alcohol-related harm in a transparent way and without discriminating foreign products.

- *Evidence shows the extraordinary nature of alcohol-related harm not only to the drinker but also in particular to others*

Alcoholic beverages have not only negative impact on the drinker but also on people other than the drinker in particular in relation to foetal damage, family member suffering, violence, third party deaths and injuries in traffic accidents, and lost productivity at work. The most vulnerable group in this respect are children, others include people with learning disabilities, mental health problems, and those addicted to alcohol and other drugs.

In economic terms there are externalities involved: the costs of selling or using alcohol spill over onto other parties. In this respect, the market fails. Public policies can and should correct this fail-

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ure, the same way as for example when considering regulating the activities of the financial institutions.

- *Evidence shows what strategies work*

The definition of alcohol-related harm should not be reduced to definitions such as “harmful use of alcohol” and “misuse of alcohol”. It has been considered reasonably safe to suggest that the focus on strategies should be on heavy and extreme drinking patterns, as well as underage drinking. However, the evidence shows that alcohol related harm results from a range of drinking patterns. For example, alcohol related road accidents might result from drivers drinking relatively small amounts of alcohol. The same applies to the risks of foetal alcohol syndrome and cancer.

Education and information have often been referred to as effective measure to reduce alcohol related harm. However, the research evidence shows that education and information have a low rate of effectiveness in reducing alcohol related harm.

Two of the most effective evidence –based strategies already applied by many countries in tackling alcohol related harm, namely pricing policy through high excise duties on alcohol and regulating alcohol distribution and marketing through legislation, should be recommended.

2. Global perspective on reducing alcohol-related harm

It is for the national institutions to define national alcohol policies taking into account different social, religious and cultural contexts, including national public health problems, needs and priorities, and differences in resources, capacities and capabilities when addressing alcohol-related harm.

However, it has become more and more difficult to maintain effective national and local alcohol policy measures with the growth of globalisation and international trade. This gives rise to a serious concern with regard to public health and social considerations.

In the opinion of the Ministry of Social Affairs and Health there should be an legitimate sphere of action for national alcohol policies. At the same time there is a pressing need for more international co-operation aimed at reducing the negative consequences of alcohol.

Hence we would very much like to support the WHO efforts to reduce alcohol related harm globally. For this we would need, inter alia, a global convention.

Secretariat of the Pacific Community
Submission to the World Health Organization's *'Public hearing on ways of reducing harmful use of alcohol'*

Background

Established in 1947, the Secretariat of the Pacific Community (SPC) is an international organization that provides technical and policy advice and assistance, training and research services to its Pacific Island members. It works in a wide range of sectors, including Public Health, natural resources (agriculture, fisheries and forestry), and Human Development.
SPC has 26 member countries and territories and its working languages are English and French. SPC's headquarters is in Noumea, New Caledonia. It also has regional offices in Suva, Fiji Islands, and in Pohnpei, Federated States of Micronesia. SPC's Public Health Programme (PHP) supports the development of healthier Pacific Island communities through two broad objectives:

1. Prevention, control and management of communicable and non-communicable diseases; and
2. Enhancement of public health systems, including their management and infrastructure.

A key component of the public health programme is the prevention and control non-communicable diseases. SPC and WHO have jointly developed and agreed the 'Pacific Framework for the Prevention and Control of Noncommunicable diseases (NCD)' which outlines the burden of NCD in the pacific, its causation, and the best practice components of NCD prevention and control to guide the 22 Pacific island country and territories (PICTs) in their efforts. Aligned to this, WHO and SPC have developed a programme of support for the 22 PICTs with its *'joint implementation plan'* with guaranteed funding from AusAID and NZAID for an initial 4 year period, 2008 – 2011. The programme has been titled ***'2-1-22 Pacific NCD Programme'*** signifying 2 organizations, 1 team serving 22 countries and territories for NCD Prevention and Control. The programme focuses on four key risk factors for NCD Prevention, one of which is the control and prevention of harm from alcohol.

In addition to working with 22 PICTs works with a range of other international and national agencies, both government and non government, and is a member of Asia Pacific Alcohol Policy Alliance (APAPA) which actively works to disseminate information on effective alcohol policy and interventions.

SPC welcomes the opportunity to participate in this public hearing and provides comments on the 3 questions below.

Question 1: What are your views on effective strategies to reduce alcohol-related harm?

There is a comprehensive literature on effective evidence based policies as well as a number of key strategies, most notably WHO's Western Pacific Region Regional Strategy to Reduce Alcohol-related Harm (2006), which identify the most effective strategies to reduce alcohol

related harm.
The key strategies which we believe to be the most effective include;

1. Real and Regular Price Increases through taxation.

Young people are particularly sensitive to price increase, and benefits to governments in terms of revenue from taxes and tariffs are an important income source, particularly for countries in the Pacific.

2. Trade restrictions.

The Pacific provides an example through PICTA where alcohol and tobacco has been excluded from trade agreements.

3. Regulation of production.

Regulation and controlling Illegal production and production of home brew are all key issues for consideration in the Pacific context.

4. Legislation and regulation affecting supply.

This includes restrictions on the number and type of outlets, restricted trading and legislation and enforcement of laws on sales to minors.

5. Restrictions on Alcohol Marketing.

Including all forms of marketing, advertising and promotion, web based promotions and sales, and banning sports and arts and cultural festivities sponsorship

6. Effective drink driving legislation.

Including legislation on blood alcohol limits, public education campaigns and random breath testing.

We believe the response requires comprehensive, integrated approaches, tailored to meet the needs of individual countries. For many countries in the Pacific region limited funds to tackle alcohol harm makes it imperative that best practices approaches that are cost effective are implemented.

Question 2: From a global perspective, what are the best ways to reduce problems related to harmful use of alcohol?

SPC in collaboration with WHO in the region sees an opportunity to assist PICTs develop strategies to reduce alcohol related harm, ensure appropriately enforced legislative and regulatory frameworks and provide technical assistance with policy development and programme implementation.

There are global requirements for adequate data collection and surveillance and for evaluation where interventions have been undertaken in specific countries. But often such data collection is not seen as apriority when resources and capacity is very limited.

SPC is part of a wider network of interested parties working towards reduction of alcohol harms and as such supports opportunities for regional networking and meetings. In the Pacific region such regional meetings are essential and provide key evidence on best practice and sharing from across the region as to cost effective approaches. Such meetings and networks however require considerable financial support, which is often difficult to secure.

To be truly effective in responding to what is a global issue, any response needs to address cross border issues, specifically trade issues. In the Pacific we have ensured the continued exclusion by Pacific Trade Ministers of tobacco and alcohol from the Pacific Islands Countries Trade Agreement (PICTA), but the exclusion (in relation to alcohol) is due for reconsideration in 2009.

A model that effectively tackles such issues is provided by the Framework Convention on Tobacco control (FCTC), and whilst we recognise the considerable infrastructure requirements that are required to support the FCTC we see an equivalent process, with a global alcohol treaty as an opportunity to provide a much needed regulatory framework to control demand and supply of alcohol.

Question 3: In what ways can you or your organization contribute to reduce harmful use of alcohol?

SPC contributes to a reduction in alcohol-related harm through the development of the '2-1-22 Pacific NCD Programme' which includes prevention and control of alcohol.

SPC and WHO work with all 22 PICTS to assist them in the development of the Noncommunicable disease prevention and control plans, which includes an alcohol component. In conjunction with this over the next four years SPC is working with PICTs to establish NCD Coordinators who will be focal points for NCD issues and provide funding for implementation of NCD Plan activities. The prevention and control of harmful use of alcohol is one of four key components of this initiative.

This year as part of this programme (funded by AusAID) and with additional funding from NZAID, SPC and Massey University (SHORE), New Zealand brought together key representatives from the Pacific to discuss alcohol action for the region. We view such networks and meetings as an essential activity which assist in keeping alcohol issues high on the agenda, shore up political will and allow sharing of experiences from the Region to maximize efficiencies in delivering effective programmes. SPC is hoping to continue this work and add to it with specific country visits to assist PICTs to develop key components of their alcohol strategy, during 2009.

SPC also plans to work with the Pacific Islands Forum Secretariat to ensure the continued exclusion of alcohol (and tobacco) from the Pacific Islands Countries Trade Agreement (PICTA).

We thank you for the opportunity to add our response to this important hearing on ways to reduce the harmful effects of alcohol.

Jeanie McKenzie, NCD Adviser, Tobacco and Alcohol, Public Health Division, SPC, Noumea. 7th November 2008

Full texts submissions from government institutions

037 Child Protection Special Service of Budapest
071 U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA)
103 National Supervisory Authority for Welfare and Health (Valvira) (Former Nationnal Product Control Agency for Welfare and Health)
121 Centro Alcologico Regionale Toscana
130 New Mexico Prevention Network
165 Canadian Association of Liquor Jurisdictions
177 Komenda Wojewódzka Policji w Poznaniu
188 New Mexico State Attorney General's Office
261 Marin County Mental Health Board
274 Programa de Salud Mental Barrial del Hospital Pirovano, Bueno Aires
296 Bureau of Substance Abuse Services, Massachusetts Department of Public Health
299 South Shore Health; South West Health; Annapolis Valley Health
312 Public Health Institute and Directorate of Health
321 Centers for Disease Control and Prevention, Nat Cntr for Chronic Disease Prevention, Alcohol Program
329 Taipei City Hospital, Taipei
335 ФГУ ""Центральный Научно-Исследовательский Институт Организации и Информатизации Здравоохранения Минздравсоцразвития России"", Научно-исследовательская организация "

1. An effective strategy against the excessive and improper alcohol drinking can not be based upon on the overall prohibition. The European approach must be professionally and methodologically well-thought out, which development reaches beyond the health-related aspects. Alcoholism in terms of its effects and consequences is an extremely complex problem. This must be mirrored in the "complexity" of the participants and strategy-creators, thus in their entire representation. Targets and the most important problems, i.e. milestones can be globally and preliminarily defined. Strategy must be built down to actions seriously and the results of the singe sections must be measured. Participation-based strategy is to be set up, which must be broadly agreed by the producers, commerce, public health and the civil organizations of the affected. This is not simply a question of public health care, every affected party's opinion must be taken into account, and their high-levelled motivation should be reached in the whole process of developing and executing the strategy. The WHO has been giving frame to this debate for long, I am pleased to see these frames moving towards other professions by these public debates.
2. There is no one, beatific solution for the European countries against the excessive consumption of alcohol. A joint platform can be developed in terms of methodological approach and of defining common basic principles, goals and priorities. Prevention of the teenagers' alcoholism and mitigating the deviancies ruining families are pivotal problems for every European country. Determining these and such priorities can bring real results. Priorities are needed to be examined in a complex way, thus making the actions complex as well in order to realize them smartly. Problems in connection with the improper consumption of alcohol are problems not only for the public health care but at the same time they are issues of the national economy, education, public safety and the list goes on.
3. My personal experience is that elaborating and realizing complex programs with the involvement of the mostly endangered teenagers is an important aspiration of the social workers, psychologists and educators working in the Hungarian child care. Complexity is extremely significant because for instance we can take measures against teenagers' excessive alcohol drinking if we are able to affect their social and economic environment. Therefore, they need to meet not only prohibitions but also realistic get-outs and alternatives offered and reachable at their social and maturity level. Entire prohibition doesn't surely serve the purpose of convincing the teenagers, it rather provokes resentment. The viable way is rather to offer other sources of pleasure instead of alcohol and to teach them how to treat problematic situations efficiently. I consider it important that young people in the course of their socialization acquire attitude towards the various "materials", learn how to say no in order to have positive self-esteem and to become confident, independent personalities able to make decisions alone. In my opinion, it is worth integrating the child care projects' experiences into the practical realization of the strategy. In the realization of such projects we are working as well in our institution in Hungary.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the U.S. National Institute's of Health is pleased to contribute to this important public hearing. NIAAA provides leadership in the United States' and global efforts to reduce alcohol-related problems by conducting and supporting research in a wide range of scientific areas including genetics, neuroscience, epidemiology, health risks and benefits of alcohol consumption, prevention, and treatment ;coordinating and collaborating with other research institutes and U.S. and other nation federal programs on alcohol-related issues; collaborating with international, national, state, and local institutions, organizations, agencies, and programs engaged in alcohol-related work ; and translating and disseminating research findings to health care providers, researchers, policymakers, and the public.

Numerous factors influence the onset and continuation of alcohol use by an individual. These factors include the individual's genetic makeup, the environments to which he or she is exposed and complex ways that genes interact with one another and with the environment. These same factors determine an individual's pattern of alcohol consumption and the risks for developing alcohol related harm, including alcohol dependence (alcoholism). Scientists now recognize that human biology and behavior continues to change throughout life – the emergence and progression of drinking behavior is influenced by changes in biology, psychology and in exposure to social and environmental inputs over a person's lifetime, and vice versa. Therefore, successful strategies for identifying, treating and preventing alcohol-related harm will benefit from considering this "lifespan" perspective.

NIAAA would like to offer the following strategies and related research on prevention and treatment for consideration to the WHO plan to reduce the harmful use of alcohol:

1) The earliest stages of life are periods of great vulnerability to the adverse effects of alcohol, and alcohol is now the leading known environmental teratogen. Alcohol-induced birth defects are known as fetal alcohol spectrum disorders (FASD) and include physical defects as well as neurological damage. Prevention efforts need to focus on identifying and eliminating drinking by the mother during pregnancy.

2) While parental history contributes to the risk for developing alcoholism, early initiation of alcohol use has come to the forefront as an important predictor of risk for alcoholism. This makes the issue of underage drinking a significant target for prevention. NIAAA has worked together with the U.S. Department of Health and Human Services to produce the *Surgeon General's Call to Action to Prevent and Reduce Underage Drinking 2007.* This publication is available at http://www.surgeongeneral.gov

3) NIAAA recently commissioned a scientific review of interventions that address underage drinking, "Preventive Interventions Addressing

Underage Drinking: State of the Evidence and Steps towards Public Health Impact by Spoth, Greenberg, and Turrisi. This article has been published, along with other research on underage drinking in a special supplement to the journal *Pediatrics* and is available at http://www.pediatrics.org/cgi/content/full/121/Supplement_4/S311.

4) College-age drinking, especially binge drinking (drinking enough alcohol in a two hour period to raise an individual's blood alcohol concentration to .08), is associated with numerous harms, especially traffic injury/death and violence. NIAAA has recently updated its review of both environmental and individual focused drinking prevention strategies in this age group. Toomey et al, *J. Stud. Alcohol and Drugs* 68:208-219, 2007; and Larimer and Cronce, *Addictive Behaviors* 32: 2439-2468, 2006 can be found on http://www.collegedrinkingprevention.gov/

5) Scientific research has identified a number of alcohol-related policies that have significant effects on public health outcomes, notably traffic fatalities (raising the minimum drinking age to 21, enforcing stricter drinking and driving penalties), a reduction in child abuse and sexually transmitted diseases (raising taxes on alcoholic beverages), and enhancement of access to alcohol treatment programs (State –mandated provision in health care financing). A study supported by NIAAA concluded that community interventions to reduce alcohol availability and increase treatment can reduce alcohol-related fatal traffic crashes, Hingson, et al *Injury Prevention* 11:84-90, 2005.

6) Rigorous systematic reviews of the literature have continued to validate the efficacy of systematic screening and brief intervention for risky/harmful use of alcohol in adults by practitioners in primary care clinic settings to reduce alcohol-related harms. See Solberg et al, *Am J Prev Med* 34(2) :143-152, 2008, http://www.ajpm-online.net Also Kaner et al, *Cochrane Database of Systematic Reviews,* 3, 2008, http://mrw.interscience.wiley.com/cochrane/clsyrev/articles/CD004148 And Whitlock et al, *Ann Intern Med.*2004;140:558-569 http://www.preventiveservices.ahrq.gov

7) NIAAA has developed screening and brief intervention guidelines for clinicians, utilizing the WHO screening instrument (AUDIT), which can be found at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

8) Treatments for alcohol dependence are continuing to be improved through research on medications and behavioral interventions. See Anton et al, *JAMA* 295 (17): 2003-2017, 2006, http://www.jama.com and Johnson et al *JAMA* 298(14):1641-1651, 2007.

October 29th, 2008 dnro 679/22/08

WORLD HEALTH ORGANIZATION, WHO

to whom it may concern,

WHA61.4 STRATEGIES TO REDUCE THE HARMFUL USE OF ALCOHOL

Alcohol is definitely a major global health problem. The National Product Control Agency for Welfare and Health (later the Product Control Agency) is pleased to notice that WHO has responded to the epidemic of alcohol problems that is increasing with growing alcohol consumption. Further, the Product Control Agency welcomes the opportunity to give a statement for this important question.

The Product Control Agency is the national control authority in Finland, who is, amongst others, in charge of supervising the advertising as well as the other sales promotion of alcoholic beverages. The agency is supervised by the Ministry of Social Affairs and Health.

Alcohol is not an ordinary commodity. Like smoking, the harmful effects of alcohol sadly hardly ever affect only to the actual user itself, but also his/her relatives. These harms to the others are not certainly considered enough. In this statement the Product Control Agency focuses on the harmful effects on children.

In advertising the alcohol is linked to wealth, success, beauty, fashion and happiness. Alcohol marketing is often aggressive, in addition to the traditional advertising, it also covers for example huge events (sport, parties) sponsored by alcohol industry. Children may be not the target group number one of marketing, but there is, however, no doubt that advertising reach them also. Children who can not read or/and who are not able to understand the multi-level information given in advertisements live their every day life in environment, where alcohol industry gives a message of the luxury-life associated with alcohol. This is certainly against the educational goal, which most of the parents have. Society must support parent in their challenging duty. Restriction the content of alcohol advertising to the information of product without images, would definitely decrease the seductive character of alcohol.

Drinking alcohol during pregnancy can cause physical and mental birth defects. Consuming alcohol during pregnancy also increases the risk of miscarriage, low birth weight and stillbirth. Although, many women are aware that heavy drinking during pregnancy can cause birth defects, many do not realize that moderate, or even light, drinking also may harm the fetus. And each year too many babies are born with some degree of alcohol-related damage. In fact, there is no level of

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alcohol use during pregnancy proven to be safe. Therefore, in order to prevent women to drink during pregnancy, it should be taken under consideration that health warnings would be included in alcohol advertisements and alcohol packages.

As summary, the Product Control Agency concludes, that alcohol markets and marketing are increasingly internationalized. Thereby, national regulations and restrictions are not enough, but we need international regulation about the advertising of alcohol and health education. The Product Control Agency would very much like to see in future WHO alcohol strategies global restrictions the alcohol marketing only to product information without images as well as health warnings in all alcohol packages and advertisings.

Sincerely yours,

Director General Ilkka Suojasalmi

Senior Officer Satu Räsänen

Sosiaali- ja terveydenhuollon tuotevalvontakeskus
Social- och hälsovårdens produktkontrollcentral
STV

Copy the Ministry of Social Affairs and Health (Finland)

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1.Inclusion of the alcoholics' relatives and children in the treatment process

Actually, in Italy there are no national policy concerning the involvement of the alcoholics' relatives in the treatment process. In our country we don't know any other experience to support children of alcoholics inside the health system services. Since last year there is a National Network of Alcohol Health Services that works with an ecological approach and the Alcohol Regional Centre of Tuscany Region is a partner. Alcohol Centres involved in this network consider alcohol related problems as problems regarding the families and the whole community. It is meaning that the alcohol services moving from this background consider the family and self help groups or Club of Alcoholics Treatment as a fundamental parts of the treatment process.
This network is working on developing a reorganization of the health services for the treatment of alcohol related problems.
We believe that the development of policies regarding the involvement of the children of alcoholics should be considered, by the establishment of networks with school, mental health services, social public services, volunteers association, self help groups, Club of Alcoholics Treatment and the whole community, considering the treatment process linked with the prevention of alcohol related problems.
The involvement of the relatives of an alcoholic person in a support activities should be one of the aims of an Alcohol Treatment Centre.
These activities aimed both to young adults and children of alcoholics should be considered also as an health promotion activities, allowing to the young individual to fight the negative feelings coming from the distress. Thus, appropriate goals for primary prevention for children of alcoholics would include the reduction of stress and the development of self-esteem, social competence, and a strong social support system.
The fact that children are likely to be affected by the problems arising from alcohol consumption was recognised by the *WHO European Alcohol Charter* signed by all member states of the European Union in Paris 1995.
It is also important that an effective European Community Policy aim to contrast the sale of non-alcoholic beverages that are often marketed and presented for call to mind alcoholic beverages, with the promotion of an alcoholic lifestyle in consequence.

2.Strengthen community actions

Community development draws on existing human and material resources in the community to enhance self help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters, as alcohol related problems. This requires full and continuous access to information, learning opportunities for health, as well as funding support, to include alcohol related problems as a primary care concern, at each level of a community: from

prevention to treatment. We believe that alcohol problems should be considered as an issue linked much more to the primary care services than substance user services; it is important to remark that alcohol related problems involve more people than alcohol dependents.
Focal points for an Alcohol Service linked with the local community:

- Networking with other health services and volunteer associations
- To be a reference point for the alcohol related problems at the community level
- To promote advocacy practices with politicians to calling for alcohol policies

3.Training and networking with paediatricians and practitioners at the workplaces and sport setting

The main goal is to structure, organize and coordinate a specific network with the different services involved to allow an effective delivery of care, in the view of health promotion.
The focus on paediatricians is linked to two issues: the first is to have an opportunity to intercept alcohol problems in the family by taking care of the children; the second is the opportunity to manage brief intervention addressed to the young people that started to drink and have an “at risk” alcohol use, for eg. binge drinking.
The focus on practitioners at the workplaces or in sport setting is linked to the importance to contrast alcohol related problems in the everyday life setting, as the workplaces or sport activities are.
The opportunity for the practitioners is to screen alcohol consumption and contrast alcohol related problems by managing brief intervention or referral to the alcohol services. For this reason we think that the training of these practitioners in screening alcohol problems and managing brief intervention is one of the most important issues that should be considered.

CANADIAN ASSOCIATION OF LIQUOR JURISDICTIONS

ASSOCIATION CANADIENNE DES SOCIÉTÉS DES ALCOOLS

Each of Canada's 13 provinces and territories has a liquor board or commission that oversees the control, distribution and sale of beverage alcohol in its jurisdiction. While each of these bodies is unique, they are all committed to working together through CALJ on liquor-related issues of common interest.

The heads of each of Canada's liquor boards and commissions meet at CALJ to discuss topics ranging from operations and trade to alcohol policy and social responsibility.

Created in 1942, CALJ's mandate is to:

• promote and encourage frank, open and ethical practices concerning the control, purchase and/or sale of alcoholic beverages;
• co-operate with all provincial, territorial and federal agencies concerned with the control, sale and taxation of alcoholic beverages;
• improve the provinces' and territories' systems of control and distribution of alcoholic beverages by co-operation and free flow of information among the members of the Association and by regular meetings or conferences of the members of the Association and comparable jurisdictions outside Canada.

The 13 Canadian liquor commissions and boards are:

• Alberta Gaming and Liquor Commission
• British Columbia Liquor Distribution Branch
• Liquor Control Board of Ontario
• Manitoba Liquor Control Commission
• Northwest Territories Liquor Commission
• Newfoundland and Labrador Liquor Corporation
• New Brunswick Liquor Corporation
• Nova Scotia Liquor Corporation
• Nunavut Liquor Commission
• Prince Edward Island Liquor Control Commission
• Saskatchewan Liquor and Gaming Authority

• Société des alcools du Québec
• Yukon Liquor Corporation

With regard to social responsibility and moderate drinking initiatives, CALJ mandated the jurisdictions to meet and review various programs and to determine the feasibility of implementing an annual national programme. Representatives of all jurisdictions meet to discuss the issues and plan national programmes on a yearly basis.

Since 2000, the committee implemented national programmes aimed at under age drinking, on issues related to responsible hosting and the responsible use of off-road vehicles (Personal watercraft, Snowmobiles and ATV's).

Moreover the different Liquor Jurisdictions believe that they have a responsibility to sell alcohol in the most rigorous manner and according to the highest moral standard. No sales to minors, no sale to intoxicated people are only but the least we can do as Alcohol Monopolies. But CALJ's members also consider they must do their share as collaborators in the field of public health. Of course, we are liquor jurisdictions and we don't have to be preachy and give "orders" to our customers. But we certainly can give them advice on how to best enjoy the products that we put on the market and sell. We are making sure that people enjoy the products we sell and do not harm themselves and the others. This is what we convey to our customers.

Therefore, in the last ten years all CALJ members not only believe in the effect of prevention and education as an efficient tool to protect people from the harmful effects of alcohol abuse and misuse but also have implemented many programmes for that purpose. All jurisdictions have Alcohol and pregnancy awareness programmes, Don't drink and drive initiatives, Training for servers in licensed establishments, Anti-binge drinking campaigns, Responsible hosts programmes and many others.

To illustrate this broad array of interventions, in 2008 only, these programmes have been implemented in the following jurisdictions:

Newfoundland & Labrador:
Check 25 (No selling to underage customers)
Clean Air Zone
Its OK To Protect Your Communities

Prince Edward Island:
Responsible Beverage Server Program
ID Training

Women's Expo

Nova Scotia:
Lots of Ways not to drink and drive
Don't Buy For Minors
Anti-Binge Drinking

New Brunswick:
Safe Graduation
Paul's Story: drinking and driving

Québec:
Alcohol & Health Publications
Evening Planner
Youth Programs In Schools, Colleges & Universities

Ontario:
Responsibility Starts Here
Anti Drinking & Driving Campaign
Safe Prom

Manitoba:
With Child, Without Alcohol
Be UnDrunk
Be The Influence

Saskatchewan:
FASD awareness and education
Check 25
Community Liaison Education Programs

Alberta:
Alberta Alcohol Strategy
Alberta Safer Bars Council
Protect Security

British Columbia:
Dry Grad
Drinking Driving Counter Attack
You Got All Dressed Up For This? (Graduation and Prom)

Yukon:
Ride Safe, Ride Sober

Safe Grad Pack
Delaying First Use

Northwest Territories:
Warning messages on bottles and bags
Drinking While Pregnant

CALJ members strongly believe that *alcohol is no ordinary commodity* and therefore have a responsibility to support and promote public health. We see our educational and awareness initiatives as part of the solution to moderate, responsible drinking and to avoid/reduce the harmful effects of alcohol abuse.

Last fall the US Surgeon General spoke in New Mexico to unveil his 2007 Report, “Surgeon General’s Call to Action to Prevent and Reduce Underage Drinking”. Among other findings, the Surgeon General noted that:

- 38% of alcohol-related traffic deaths involve underage drinkers; and
- 32% of youth homicides involve alcohol

On top of this, the Journal of the Study of Alcohol and Drugs recently reported that 20% of all alcohol is consumed by underage drinkers.

As a result, one of my legislative priorities in 2009 will be to address this crisis in underage drinking. Numerous research reviews have determined that increasing excise taxes, along with other pricing policies that increase the cost of alcohol, is one of the most effective strategies for curbing abuse of alcohol. With this in mind, I plan on seeking enactment of the following tax legislation to curb the harmful use of alcohol by underage drinkers:

- **Increase the Tax on “Flavored Malt Beverages” (aka “Alcopops”)**
- **Give Every County the Option For Taxing Alcohol at a higher rate to generate revenue for substance abuse programs**

In addition, I am proposing:

- **A Ban on Alcohol with Caffeine and other stimulants (aka Alcohol “energy” drinks)**
- **A Prohibition on Alcohol Consumption By Minors**
- **Regulation of alcohol advertising to youth**

From a global perspective, the best ways to reduce alcohol-related harm are:

- Globally, public health interests must be represented in global trade negotiations, and trade agreements need to make exceptions for commodities like alcohol that pose a serious threat to public health and safety.[8, 9]
- Global public health leadership is needed, in the form of WHO identifying and training governments and NGOs in how to implement best practices in monitoring *and* controlling alcohol-related harm.
- Leadership from WHO and governments in the developed world in providing support and resources to developing nations to insure effective alcohol policies that are based on public health and safety principles and to offset the influence of the global alcohol industry.
- Global networks are needed among NGOs to strengthen coordination, share lessons learned and peer support, and provide a civil society alternative to the globally well-organized and coordinated alcohol industry

The Needs and Services Committee of The Marin County Mental Health Board is reviewing the county mental health program to find pluses and problems therein. In our review process, one re-occurring theme is lack of or cuts in funding for persons suffering from the effects of alcohol related illness.

The Marin Mental Health Board is investigating the opportunity to charge those businesses in Marin County licensed to sell alcoholic beverages a per serving fee, including servings available in products sold at off site retail establishments. We are recommending these fees should be restricted for the costs of emergency services and treatment of alcoholism and mental health co-occurring disorders. We believe this fee may be an opportunity to free up current available funds for other mental health issues.

Buena Ventura, CA adopted a municipal code in 2005 to recover costs of municipal emergency services by assessing a fee on businesses who are licensed to sell alcoholic beverages. While municipalities currently may have more authority than counties to assess fees, we believe it important that these per alcohol fees be assessed at the county level and restricted for use to recover costs occurred for treatment of alcoholism and co-occurring disorders.

I have included a spreadsheet showing potential revenues at varying fee levels. The frequency data was provided by Marin Institute.

I believe this or a similar approach may be useful for all governments as alcoholism is a major problem affecting the quality of life for millions of people. Failure to address this treatment funding crisis will result in higher health, crime, related prison costs and an increase in homelessness, domestic abuse, sexual abuse and dysfunctional families..

Gary G Scheppke Sr
Secretary, Marin County Mental Health Board
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Marin Census Data

People QuickFacts From US Census 2006	Marin County	Population totals	Drinking Age persons	
Population, 2006 estimate	248742			
Persons under 5 years old, percent, 2006	5.60%	13929.55	0	
Persons under 18 years old, percent, 2006	19.80%	49250.92	0	
Persons 65 years old and over, percent, 2006	14.90%	37062.56	37063	
Persons 18 to 64 years old, percent 2006	59.70%	148498.97	148499	
Persons 18 to 24 years old who reported binge drinking in the past month, Percent 2006	40.00%			
Marin adult survey respondents who reported binge drinking in the past month, Percent 2006	23.00%			
Totals Rows 4-8	**100.00%**	**248742**	**185562**	

Marin Institute Frequency of Alcohol Consumption Marin County Adults 2001

Frequency	Percentage	Drinking Age Population	Estimated Servings Per Month	Estimated Servings Per Year	Cost Recovery Fee per Serving
Abstainers	22.00%	40,824	0	0	
Once per month	10.00%	18,556	12	222,674	
2_3 times a month	12.00%	22,267	24	534,419	
Once a week	12.00%	22,267	52	1,157,907	
2-3 times a week	20.00%	37,112	104	3,859,690	
4-5 times a week	10.00%	18,556	208	3,859,690	
Almost every day	15.00%	27,834	312	8,684,302	
Totals	**101.00%**	**187,418**	**712**	**18,318,681**	

Cost Recovery Fee per Serving	Revenue by Fee total	
0.05	**$915,934**	**5 cents**
0.10	**$1,831,868**	**10 cents**
0.15	**$2,747,802**	**15 cents**
0.20	**$3,663,736**	**20 cents**
0.25	$4,579,670	**25 cents**

Note 1: Totals may not add up to 100% due to rounding.
Note 2: Number used for servings per incident was one (1).
Note 3: Data for frequency provided by Marin Institute.

In providing your contribution you may wish to focus on the following issues:

Question 1: What are your views on effective strategies to reduce alcohol-related harm?

Las estrategias más adecuadas son las que apuntan a promover valores y experiencias significativas de intercambio humano entre jóvenes en edad adolescente, sin que el alcohol sea tema central. Focalizar en el alcohol adjudica una importancia excesiva a la sustancia, generando un efecto paradojal ya que no aborda el corazón de la problemática que aqueja a muchos jóvenes y adultos que abusan de alcohol. El problema no es el alcohol sino lo que pasa en el espíritu de las personas que abusan de él.

Se requiere de una lectura de las condiciones sociales, económicas, culturales y espirituales, y no solo circunscribir la estrategia a la implementación automática de planes que pretendan suprimir síntomas de problemas más abarcativos.

Mejor que luchar contra los males, es generar bienes, en este caso, bienes ligados al sentido de la vida y al encuentro de valores de vida. Esto se logra generando experiencias emocionalmente significativas, no solo didácticas meramente informativas sobre los daños y perjuicios que ocasionan los abusos.

En este sentido es más válido apuntar a charlas o comunicaciones con los jóvenes, que apunten a generar una vida personal y comunitaria significativa, con elementos emocionales en el intercambio y ESCUCHANDO lo que los jóvenes dicen, no tan solo pretendiendo introducir en sus mentes determinadas ideas carentes de significación emocional.

Question 2: From a global perspective, what are the best ways to reduce problems related to harmful use of alcohol?

Apuntar al control de la publicidad en su conjunto, favoreciendo el prestigio de los intercambios humanos por sobre los intercaqmbios mediatizados por los bienes de consumo.

Esto aplica no solo a la publicidad ligada al alcohol sino a todo el sistema de valores consumistas que lleva, justamente, a que los jóvenes tengan la idea de que “consumiendo” (lo que sea) serán felices. Ese control a la publicidad debe regirse por leyes de protección a los menores y los mayores. También se debe decidir que la publicidad se rija por valores de vida genuinos, con respeto a los menores de edad, con énfasis en elementos que desprestigien el descontrol y el exceso emocional como sinónimo de felicidad.

A su vez, la generación de espacios de intercambio emocional con los estudiantes desde su adolescencia temprana o incluso antes, para intercambiar respecto de sus ideales, sus emociones y los valores que rigen su vida, ayuda a que los jóvenes tengan dentro de sí elementos que los ayuden a conducir sus impulsos y favorecer el cuidado recíproco entre ellos, además del que deben tener por parte del mundo adulto.

Question 3: In what ways can you or your organization contribute to reduce harmful use of alcohol?

El Programa de Salud Mental Barrial del Hospital Pirovano (www.talleresdelpirovano.com.ar)es una institución cultural y sanitaria de Salud Mental que ofrece una red gratuita de grupos de ayuda mutual ligada a un hospital público de la Ciudad de Buenos Aires con 3000 prestaciones semanales. La red de grupos genera un respaldo emocional y un marco de referencia en los cudadanos que los fortalece significativamente frente a la alternativa de abusar de sustancias.

A la vez, es importante que el alcohol no se convierta en “chivo emisario” de un sistema de valores centrado en el consumo como única fuente de felicidad. En ese sentido, las condiciones de infelicidad que generan muchos problemas, entre ellos, la ingesta abusiva de alcohol, seguirían vigentes y la tarea de protección sería solamente cosmética.

WHO Submission
November 14, 2008

Samantha Cukier, BSc, MBA, MA
Social Marketing Coordinator, Alcohol Strategy
Addiction Services
South Shore, South West and Annapolis Valley Health

Effective strategies to reduce alcohol-related harm need to address the contexts, the culture and the environments in which alcohol is consumed. We must be a part of fostering the environments most conducive to the healthiest possible behaviours, thereby reducing the likelihood of harm. As per best practice approaches to reducing alcohol-related harm, we are looking at helping shape environments with public policy so that the healthier choices will be the easier choices. Before public policy is addressed, however, a readiness in our communities must exist. In order to prime and ready our audiences, we must start from the grassroots. At this level, we are encouraging community capacity building by supporting a network of concerned citizens. The following describes the early stages of our communities' attempts at increasing readiness for change, as the network grows.

At Addiction Services in the South Shore, South West and Annapolis Valley Health Districts in Nova Scotia, Canada, alcohol strategy staff are working on population-based approaches to reduce alcohol-related harm within the framework of the Provincial Alcohol Strategy. The five key directions identified in the Strategy are as follows: Community capacity and partnership building; Communication and social marketing; Strengthening prevention, early intervention and treatment; Healthy public policy; Research and evaluation.

The approaches outlined in the Strategy include ways in which to address and challenge common notions about alcohol and its uses. Canadian culture and more specifically, Nova-Scotian culture has normalized over-drinking, and has come to see it used as a coping mechanism, an escape, and even a way in which to increase social prestige. We need to look no further than one of the country's favourite television programs to watch medical doctors using alcohol as a common activity and coping mechanism when all else in life is failing. It is these types of messages that we see in the media that appear harmless and help shape the culture of alcohol use. It is these messages that we are asking our friends, colleagues and neighbours to pay closer attention to and to question the subtle cultural influences that these messages convey.

One way in which to promote healthier environments and healthier choices within these environments is through the de-normalization of harmful patterns of drinking, including underage drinking and drinking to intoxication. In our region of Nova Scotia, we have been looking at foundational ways to address the normalization of over-drinking. One of the strategies has been to look at alcohol and the role it plays in our everyday lives. At a grassroots level, we are engaging with community members, asking them to look at the environments in which they live and encouraging a closer look at daily alcohol influences and influencers within their neighbourhoods. Some issues that have arisen include: the growing ease of access to alcohol including increased hours and days of operation of alcohol outlets, the alcohol industry within schools and alcohol proliferation in the media.

The following is a first example of our community members' investigations into the alcohol-environments in which they live: In 2006, when there was question as to whether or not 52 new "agency" stores (smaller alcohol retail outlets in rural areas) should be

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allowed to open across rural sections of Nova Scotia, information on best practice approaches to alcohol policy was gathered by experts at Addiction Services. The information taken from international research clearly pointed out that increased access to alcohol leads to increased consumption which then leads to increased harm. This collection of research was disseminated to the public, identifying the fact that there was opposition to the alcohol outlet expansion for reasons of health and well-being, and then submitted to the appropriate decision-makers.

The following is a second example, similar in nature: In 2007, a little less than one year later, there was question as to whether or not alcohol outlets should be open on Sundays, when at the time they remained closed on this one day in the week. Community members looked to the experts at Addiction Services who gathered the evidence from other countries. Once again, the research indicating that increasing access to alcohol would increase alcohol consumption and related harm was presented to the appropriate decision-makers.

Although the outcomes of these two examples did not garner the intended results, the process was a successful one. The beginning of this advocacy work linked to alcohol-related harms had begun and was now growing roots within the communities. No longer was alcohol legislation simply being put out to the public without question; instead, the beginnings of an alcohol-policy network were forming, where Addiction Services experts were communicating with community members and fostering healthy reciprocal relationships. We see this ongoing community capacity building as one of the first steps in helping to set the stage for change.

The following is a third example of our community members' continuing investigation of the influence of alcohol in their environments; this time with the network starting to take shape:

Mid-year, in 2008, community members were concerned about their children's exposure to the alcohol industry with a "responsible drinking" program in elementary and junior high schools in Nova Scotia. Addiction Services staff members were consulted and agreed that for children as young as 10, exposure to the alcohol industry and this *normalization* of alcohol use was not appropriate and could actually be incurring harm. Key messages were gathered by Addiction Services experts from the body of international research on this topic and shared with community members. These messages included items such as the inappropriateness of the normalization of alcohol use for those who are underage as well as the notion that at 10 years old, children are not developmentally ready to understand issues that go outside the simplistic notions of good or bad, i.e. they can only understand that drinking is good or drinking is bad, nothing in between. Therefore, to expect children to comprehend that for those who are of legal drinking age and choose to consume alcohol, there are ways to engage in this activity while minimizing the harms, is not palpable. These key messages were passed from community members and Addiction Services staff to School Board officials, Provincial Health Authorities, hospital organizations and Government Departments. In the end it was agreed that this program was inappropriate for school-aged children and the program

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that existed around the province for 10 years, was discontinued. This time, advocating for change was successful. This networking and advocacy helped increase awareness of the cultural subtleties that exists all around us. It also demonstrated to our community members that they have the power to create change.

The continued fostering of this advocacy network is key in supporting long term and sustainable change. In looking at the overall goal of Nova Scotia's Alcohol Strategy, i.e., to change the culture of alcohol use in the province, it is imperative that there is a level of readiness for this change among community members. Supporting the growth of this network as one of the key pieces of the Strategy will help create the contextual, cultural and environmental readiness for the appropriate kinds of changes that will reduce the types and patterns of drinking that are most harmful. We are encouraging and supporting a community network made up of individuals who are experts in their own right, and asking them to voice their concerns as we share best practice. By increasing the community's capacity to ask for change, we are increasing awareness, knowledge and opportunities for advocacy towards policy change. The initial discussions surrounding this type of shared experience and new learnings are helping to raise awareness of the issues and allowing those who are most affected to create the change they want to see.

Comments to the World Health Organization on the Development of a Global Alcohol Strategy

What are your views on effective strategies to reduce alcohol-related harm? From a global perspective, what are the best ways to reduce problems related to harmful use of alcohol?

As noted in the WHO's *Strategies to Reduce the Harmful use of Alcohol,* harmful alcohol use causes 2.3 million premature deaths worldwide each year (3.7% of global mortality), and is responsible for 4.4% of the global burden of disease. Recognizing this huge public health impact, WHO has appropriately emphasized that the harmful use of alcohol is one of the leading modifiable risk factors for non-communicable diseases.

In the United States, the harmful use of alcohol – that is, excessive alcohol use − is responsible for an average of 79,000 deaths per year and 2.3 million years of potential life lost (30 years of life lost per death)[1], making it the third leading preventable cause of death in this country[2]. Binge drinking, usually defined as the consumption on a single occasion of 5 or more drinks for a man or 4 or more drinks for a woman[3], typically leads to acute impairment and accounts for over half of these deaths and two-thirds of the years of potential life lost. In fact, approximately 15% of all U.S. adults (or almost 30% of adult current drinkers) report binge drinking in the past 30 days[4] and half of all alcohol consumed by U.S. adults[5] and 90% of the alcohol consumed by underage youth[6] occurs on days when they have 5 or more drinks. However, less than 20% of binge drinkers in the U.S. are alcohol dependent[7,8].

Similar to tobacco, alcohol consumption is strongly influenced by the environment within which people make their drinking decisions. In fact, systematic reviews of the scientific literature[9, 10] have found that the most impactful strategies for preventing excessive alcohol consumption and related harms that influence the social context within which people make their drinking decisions. Specific evidence-based strategies for preventing excessive alcohol consumption and related harms include enforcing an age 21 minimum legal drinking age, limiting alcohol outlet density, and increasing alcohol excise taxes[9, 10]. These can and should be combined with effective strategies to reduce alcohol-impaired driving, including an age 21 minimum legal drinking age, 0.08 laws, and sobriety checkpoints[11]. Various studies have also emphasized the importance of adopting a comprehensive, community-based approach for preventing excessive alcohol consumption and related harms, using a combination of mutually reinforcing intervention strategies[12].

It is also important to engage health care providers in the prevention of excessive drinking. Screening and brief counseling has been shown to be effective in reducing excessive alcohol consumption, and is recommended by the U.S. Preventive Services Task Force for reducing excessive drinking among adults[13].

In addition, it is important to improve public health surveillance on excessive alcohol use and build public health capacity within member states to address this key health risk

behavior. The U.S. Surgeon General has specifically emphasized the importance of collecting more detailed data on the quantity and frequency of adolescent alcohol consumption; conducting ongoing public health surveillance on the type of alcohol and the quantity and frequency with which they are used by age; the ongoing, independent monitoring of alcohol marketing to youth; and the building of state and federal capacity in alcohol epidemiology to assure the timely analysis and dissemination of data on underage drinking to support public health practice[14].

In what ways can you or your organization contribute to reduce harmful use of alcohol?

The Alcohol Team in the CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) is involved in strengthening the scientific foundation for the prevention of excessive alcohol consumption. To accomplish this mission, the Alcohol Team conducts public health surveillance on excessive alcohol use, particularly underage and binge drinking, and related health outcomes; leads applied public health research on alcohol-related health impacts and population-based strategies to prevent excessive alcohol consumption; builds state public health capacity in alcohol epidemiology; provides public health leadership and collaborates in national initiatives to prevent underage and binge drinking.

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Стратегия и меры по снижению вреда, связанного со злоупотреблением алкоголя, основанные на фактических данных.

Проблема чрезмерного употреблением алкоголя и степени причиняемого вреда является чрезвычайно актуальной для России. О масштабах реальных потерь, связанных с избыточным потреблением алкоголя, можно судить по итогам «естественного эксперимента» - проведенной в СССР антиалкогольной кампании 1985-1987 гг. Ее крайне важным результатом, согласованным после многих лет дебатов, включая участие международных экспертов, явилось увеличение средней продолжительности жизни российских мужчин на 3,1 года и женщин – на 1,3 года. К сожалению, эффект снижения потребления алкоголя в короткие сроки исчерпал свое позитивное влияние и период реформ в Российской Федерации, начавшийся в 1990-е годы, охарактеризовался невиданной ранее по интенсивности алкоголизацией населения.

Важным фактором развития этого негативного явления стало резкое и устойчивое обнищание широких слоев населения, произошедшее в результате кризиса социально-политического уклада гигантской страны и в ходе социально-экономических реформ рыночной ориентации. Социологические исследования показали существенное пополнение группы риска алкоголизации, подтвердив при этом склонность к стрессовым реакциям, а также выявленную расположенность и распространенность девиантного поведения и повышенного риска приобретения вредных привычек, в бедных слоях населения. В этой связи для России равно актуальными являются и вопрос о социальных последствиях алкоголизма: совершение преступлений, и актов вандализма, умышленного и неумышленного травматизма, в том числе вызванного дорожно-транспортными происшествиями.

Как показывает статистика в плане потери здоровья, последствия алкоголизации населения в России выразились резким ростом смертности, как от внешних причин, так и от соматической патологии (алкогольные психозы, цирроз печени, алкогольные кардиопатии и болезни системы кровообращения в целом). Так смертность в трудоспособном возрасте от травм и отравлений в 1992-2005 гг. выросла на 18%, от случайных отравлений алкоголем – в 1,5 раза, от алкогольных психозов – в 6 раз, от болезней системы кровообращения в трудоспособных возрастах – в 1,5 раза и в 2 раза в более молодом (20-39 лет) возрасте. Беспрецедентно высокими, в 25 раз, оказались показатели роста смертности от алкогольных циррозов. Эти крайне тревожные тенденции на фоне выраженных изменений социального профиля общества не могут не вызвать вопросы, на которые необходимо ответить для формирования эффективной политики и контрмер. Считаем исключительно важным то, что ВОЗ выстраивает стратегию противостояния развитию вредных последствий чрезмерного употребления алкоголя с учетом всей сложности взаимоотношения индивидуума и общества; здоровья лиц злоупотребляющих алкоголем и социальных последствий их поведения в обществе. Это вопрос ориентации политики на все население, на группы риска и наиболее уязвимые слои населения. Важным для выбора правильной тактики также является выявление различий пристрастий к видам алкоголя в различных слоях общества и в различных возрастно-половых группах. Обоснованность вопросов очевидна в условиях массовой нисходящей социальной мобильности, сформировавшейся в период реформ, а также изменившейся структуры и уровня потребления алкоголя, наиболее выраженных в подростковых и молодых возрастах: впервые в России структура потребления существенно изменилась в пользу большего потребления легких алкогольных напитков. Эта тенденция во всем мире воспринимается как позитивная, однако российские эксперты отмечают формирование «пивного алкоголизма» среди молодежи, и только будущее покажет, каковы будут эпидемиологические последствия этих сдвигов.

Еще один аспект проблемы злоупотребления алкоголем в России связан с утратой в значительной степени официальной статистики смертности, происшедшей в период реформ: наиболее высокими темпами «растет» смертность от размытых, «неуточненных», «других»,

«прочих», «неточно обозначенных» и т.п. причин смерти. Массовый источник недоучета алкогольной смертности в России – это, по мнению экспертов, класс «Симптомы, признаки и неточно обозначенные состояния», темпы роста смертности от которого среди трудоспособного населения были максимальными (3,3-кратными и у мужчин, и у женщин), а о масштабах потерь свидетельствует то обстоятельство, что в 2005 г. от этих неизвестных причин в России погибло на 7,5 тыс. лиц трудоспособного возраста больше, нежели в дорожно-транспортных происшествиях.

Вопрос о мерах, направленных на улучшение ситуации, в России, должен основываться, помимо их реальной необходимости и действенности, еще и на их культурной и социальной приемлемости. Опросы населения и экспертов указывают, что российское население достаточно единодушно осознает необходимость комплекса антиалкогольных мероприятий.

Таким образом, антиалкогольная политика в России должна формироваться на базе

- улучшения качества статистики смертности и оценки масштаба реальных потерь, которые несет страна вследствие алкоголизации;
- мониторинга эпидемиологических последствий новой картины потребления алкоголя в молодых возрастах;
- специального исследования, направленного на изучение алкогольной ситуации в разных социальных слоях российского общества.

Только ответ на эти вопросы позволит сформировать адекватную алкогольную политику в России, включая систему конкретных мер, направленных на снижение алкоголизации в стране, а также позволит понять, насколько общими или адресными должны быть эти меры.

Эксперты России готовы принять участие в международном сотрудничестве под эгидой ВОЗ в разработке проекта глобальной стратегии противодействию вредного употребления алкоголя на основе фактических данных и передового опыта стран, включая системы мониторинга потребления алкоголя и укрепления мер в помощь общественному здоровью в странах.

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137 National Drug Research Institute
147 Royal College of Nursing
168 Faculty of Public Health Medicine, Royal College of Physicians of Ireland
220 Strengthening Families Center at University of Utah
223 International Network of Brief Interventions on Alcohol Problems
230 The Australian Wine Research Institute
249 Centre for Social and Health Outcomes Research and Evaluation (SHORE), Massey University, Auckland, New Zealand
301 Centre for Addiction and Mental Health

WHO conducts public hearing on ways of reducing harmful use of alcohol

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Abstract

The relationships occurring among alcohol abuse and diseases/disability/mortality are well known. Similarly, the misuse f alcohol by young people across Europe is well known. Little known are, on the contrary, the concepts about the potential toxicity of ethanol also at low daily doses, as a "cofactor" of a large series of diseases. In fact, the duration of alcohol use, more than its amounts, is related to the occurrence of diseases of the liver, of diabetes, of hypertension, etc..
Alcohol enhances the toxicity of drugs, of smoke, of various foods, such as those containing fructose or polyunsatured fats, etc.. The actual main characteristics of young people from industrialized countries are: the spontaneous indiscriminate use of various drugs, frequently as herbal products, that, in the majority of cases, are uncontrolled by institutions, the use of "fast foods", rich in fructose, in satured and polyunsatured fats, the use of alcohol, moderate or not. Liver steatosis, metabolic syndrome and obesity, are all pathologies of young European people.
An European strategy of interventation on the problem "alcohol", could necessarily involve a more large discussion about the total life style of our young people. We suggest to discuss about alcohol, not only as a substance dangerous for the nervous system and for the dependence, but also as a substance that, particularly in young subjects, may induce or facilitate the occurrence of a large series of diseases, from the liver to the cardiovascular system.

Text

The relationships occurring among alcohol abuse and diseases/disability/mortality are well known. Similarly, the misuse f alcohol by young people across Europe is well known. However, the concept of "alcohol misuse", other than the modalities of use and the quantity of pure ethanol, must also include the duration of the use, as well as the characteristics of the user. This is particularly relevant for young people. In fact, the appearance of some diseases that are typical of adult generation, such as diabetes, metabolic syndrome, hypertension, cirrhosis,
Is strongly related to the duration of alcohol use, other than, as obviously, to its daily amounts.
Another important consideration is necessary about the concept of "moderate" alcohol use. The "dose" of ethanol considered dangerous for various organs is dependent on its concentration, that, in turn, is related to its distribution in the total body (water, adipose tissue, liver, etc,..). Therefore, 20-40/ day of pure ethanol, that corresponds, in the global agreement in the world, to the "moderate" use, may be effectively "moderate" in a subject of about 70 Kg b.w., but they may result in excess for a subject of 40 Kg b.w., as example. In addition, the absorbtion of ethanol is dependent on the integrity of gastrointestinal mucosa, of the concentration of the alcoholic beverages, on the contemporaneous presence of foods in the stomach, on the motility of gastrointestinal tract, etc…Therefore, not all the 20-40 g of ethanol are similar for all subjects.
Finally, in keeping with a large series of literature data, at the moment alcohol is considered an important "cofactor" of various disease, also at low doses. Alcohol, for example, enhances the toxicity of drugs, of smoke, of various foods, such as those containing fructose or polyunsatured fats, etc.. The actual main characteristics of young people from industrialized countries are: the spontaneous indiscriminate use of various drugs, frequently as herbal products, that, in the majority

of cases, are uncontrolled by institutions, the use of “fast foods”, rich in fructose, in satured and polyunsatured fats, the use of alcohol, moderate or not. Liver steatosis, metabolic syndrome and obesity, are all pathologies of young European people. Liver steatosis is mainly due to two factors: the metabolic syndrome (Non Alcoholic Fatty Liver Disease, NAFLD) and alcohol use (Alcoholic Fatty Liver Disease, AFLD). The global prevalence of fatty liver in the general population increases from normal to obese subjects, and it is also related to alcohol use : global prevalence 58,2 %; in lean teotaller subjects:16%; in obese subjects: 76%; in alcohol users >50 g/die: 46%; in obese alcohol users: 95% . The importance of a precocious diagnosis of fatty liver is due to the knowledge that this condition may evolve to steatohepatitis (NASH) until cirrhosis and hepatocellular carcinoma. Predictive independent factors of NASH are the age, the presence of metabolic syndrome and diabetes. It is well known that the metabolic syndrome is characterized by the presence of almost two of the following alterations: obesity, diabetes, dyslipidemia, hypertension, all factors that, also individually, are risk factor for cardiovascular diseases. In patients with overweight and/or metabolic syndrome, fatty liver is present in the majority of cases and this condition is actually considered the hepatic expression of the metabolic syndrome.The prevalence of NAFLD in Italy is actually considered in a range of 16- 22,5% of the global people, and the globality of the studies performed on NAFLD indicate that the factors involved in the occurrence of the metabolic syndrome are also predictive factors of fatty liver.The role of alcohol as a factor or co-factor of fatty liver could be excluded only in teotaller subjects. In the others, alcohol use is a predictive factor of fatty liver also at low daily intake. The presence of overweight and of diabetes increases the risk of have alcoholic liver disease. A constant alcohol use >30g/day in both genders is associated to liver steatosis in 80% of cases. In Italy, the prevalence of alcoholic fatty liver in the general population that constantly use >30-40 g /day of ethanol is about 13% . However, studies performed to evaluate the incidence of fatty liver, both by ethanol and associate to the metabolic syndrome, indicate that AFLD and NAFLD are constantly increasing.The risk of have cirrhosis and hepatocellular carcinoma increases with the degree of obesity, the presence of diabetes and the continuous use of ethanol. More recently it has been documented that NAFLD patients have an enhanced risk of develop cardiovascular diseases.In fact, NAFLD patients develops metabolic problems and precocious alterations both at echocardiography and at eco-doppler evaluations. Liver cirrhosis is a step by step progressive damage that starts with fibrogenesis. This process in the liver is similar to that occurs in the vascular endothelium when affected by atherosclerosis. Central obesity, insulin resistance and dyslipidemia, enhanced production of pro-inflammatory cytokines, altered production of platelets and vascular-derived growth factors, imbalance in the nitric oxide production and exchange, oxidative stress,, are all findings present in both liver damage and in atherosclerosis.

On the basis of these data, it is obviously to consider that an European strategy of interventation on the problem “alcohol”, could necessarily involve a more large discussion about the total life style of our young people. We suggest to discuss about alcohol, not only as a substance dangerous for the nervous system and for the dependence, but also as a substance that, particularly in young subjects, may induce or facilitate the occurrence of a large series of diseases, from the liver to the cardiovascular system. Our young arel preparing to the onset of diabetes and metabolic syndrome, that, in turn, are the greater papubulum for the occurrence of tumors. Our young people should be all abstainers, but the European scientific expert should necessarily devoted to explain the motivations of these decisions, in the total respect of each individual well motivated choice.

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Question 1: What are your views on effective strategies to reduce alcohol-related harm?

Successful approaches to reduce alcohol-related problems should have at least four characteristics;

1. Clear policy direction

The policy to reduce alcohol-related problems is naturally complicated, controversial, and dominated by many interests and values. The chalk-and-cheese confrontation between health and commercial interests are evidence worldwide. While those policy led by public health values can improve the alcohol-related situations, commercial interest leads to another way. To control alcohol-related harms on one hand and promoting alcohol sales and consumption in the other is, therefore, incompatible, if not impossible and a useless effort.

Many perceptions on problem situations, related factors and mechanisms to tackle these problems are based on incomprehensive knowledge and influence of economic operators, whose only interest is to protect their profit. The attempts to deviate policy direction, narrow down policy extent and weaken policy content have been witnessed worldwide.

Policy commitment is, therefore, as of crucial importance. Strong leadership and clear policy direction can set up policy momentum, promote policy development, and strengthen policy enforcement.

As an international health agency, WHO has a vital role in promoting the health-protecting policy value for other national and international stakeholders. Providing evidence to reduce controversies in alcohol policy and convince others is an effective approach. WHO has to have clear and firm stance on alcohol policy. Here at WHO, the similarity between tobacco and alcohol must be addressed, including their epidemics, underlying factors, impacts and characteristics of economic operators.

2. Effective policy content

Like never before, the advance in knowledge on alcohol policy, particularly on policy effectiveness and cost-effectiveness, allows us to separate effective interventions from those ineffective interventions. Stakeholders should not allocate their limit resource to ineffective interventions, just because they sound plausible. Policy makers, in particular, should well aware of the attempt of alcohol industry to advocate for those ineffective interventions such as education and self regulation as alternatives to other effective and cost-effective interventions.

In general, an alcohol policy framework should cover, and strike a balance between, individual and environmental level strategies. However, it becomes

clear that interventions directed at general population, particularly consumption control measures, average higher effectiveness than those targeted at high-risk groups and harmful drinkers. Therefore, WHO should take this fact into concern.

Interventions aim to delay onset and discourage of alcohol use among young people, particularly advertising control, provide long term benefits. Moreover, the by-product or spill-over effects of alcohol policy should be taken into account. Some measures may have a synergistic effect on the effectiveness of other measures; such as impact of advertising bans on the social climate around alcohol.

WHO should trigger and support the development of alcohol policy at local and supra-national levels, which can augment the effectiveness of national and sub-national alcohol policy. Alcohol problems are global epidemic where country cannot tackle alone. Having supra-national alcohol policy, at global and regional scales, in the line of FCTC is an effective mechanism to collaboratively deal with this global problem.

3. Effective implementation

Perhaps the most important limitation is the weakness in alcohol policy implementation. WHO should address this limitation seriously. Without implementation, alcohol policy is nothing. Shortages in financial, human, equipment and technical resources have been simply declared as the main cause. However, strong and clear commitment from policy makers and administrators can trigger those implementers and regulators. Meanwhile, NGOs and civil society can enhance the implementation, by playing the watch dog role.

4. Strong policy support

Another important task for WHO is to create alcohol policy supports. These supports include knowledge management, commercial interest-free collaboration and partnership, and social awareness and support.

Strengthening research in alcohol policy arena is an urgent must for alcohol policy formulation. An effective communication is crucial. Knowledge must be appropriately packaged for policy makers. The dissemination of information to civil society and public can create a favourable social climate and support for policy decisions and implementation.

The collaboration among stakeholders increases social asset and resolves possible conflicts. Partnerships between the public sector, professionals, academics, the community and NGOs at all levels can be productive, but must be constructed independent of commercial interests.

Question 2: From a global perspective, what are the best ways to

reduce problems related to harmful use of alcohol?

From our point of view, the global strategy should be based on three principles, consist of five plans, and prioritize two policy areas.

Principles

Although the principles here are synthesized from our national experience, we see no problem in scaling our lesson learned up to global scale. These principles are based on the concept Triangle that Moves the Mountain. This concept emphasizes in strengthening of and collaboration among three policy sectors; 1) knowledge, 2) politic and officials, and 3) civil movement. As alcohol policy is a complicated domain, employing power in each of three sectors alone can bring only flawed outcome. Knowledge without political leadership is meaningless, while social concern without knowledge only goes nowhere. Political commitment without technical evidence and social support is even more dangerous.

The first principle is to strengthen up capacity of each sector, including setting up the network among stakeholders within, setting up intra-sectoral coordinator and facilitator. The second principle then is to connect and synergize movements of each sector. Policy makers and civil society must be equipped with knowledge, social mobilization can turn to be an informal check and balance mechanism to monitor the officials and enhance the performance of alcohol policy.

The third principle is on the transparency of the process, more specific, on to deal with stakeholders with conflict of interest. Partnership is good, but only for public benefit-oriented partnership, not for partnership manipulated by commercial interest. Do not and never let those stakeholders with commercial interest take the navigator seat. Other stakeholder should understand, and be informed and conscious on the status and interest of players that are setup, funded and influenced by economic operators.

Plans

The Global Strategy should cover these missions.

- Setting up policy direction

Very important, the global strategy should guide the policy direction at national, regional and global levels. Alcohol issue is neglected from the priority list of many official and philanthropic agencies, including within UN system. WHO and the Strategy, therefore, should persuade those relevant agencies to change their position on alcohol and alcohol policy. The perception on alcohol as an obstacle for health, well-being, human achievement, and social development should be propagated to all relevant agencies. First thing first, alcohol should gain priority in WHO system. Raising

it to the Cabinet level, like tobacco, would reflect the sincerity and commitment of the Director-General.

- Identifying and minimizing policy gaps

The Strategy should address and mitigate the weaknesses of alcohol policy process at national and global levels. It should aims to solve limitations in three sectors; political, knowledge, civil society. WHO and the Strategy should rate policy areas with poor development, and/or being orphanage and ambiguous, rather than areas that are already strong and well taken care of. For example, the Strategy and WHO should not allocate much resource on the drinking driving programs, although important, because they already gain attention, have many specialized agencies/programs to deal with, and are relatively progressive. Instead, the Strategy should highlight consumption control measures, where no other international agencies/programs have mandate on and/or are serious in.

- Strengthening knowledge management

Knowledge management, consisting of knowledge generation and utilization, is fundamental to the whole policy process. First of all, the Global Strategy should map the knowledge needed, particularly in the developing world, and set up and support competent technical community, without conflict of interest, to be responsible for the knowledge generation. Few urgent research topics include effectiveness and cost-effectiveness of alcohol policy, and the impact of alcohol marketing in the 'emerging market' developing world. WHO should support Member States and technical community in monitoring and evaluating alcohol policy. Further, the Strategy should aim to set up the effective communication between research sphere and national and international authorities.

- Setting up and promoting the use of connection mechanism

According to the principles stated above, the Strategy should enhance and synergize movements within and among three sectors. Regular communication and meeting among technical researchers, civil society and NGO, and official authorities is key to promote knowledge and experience sharing. Forums for across-section stakeholders, free from conflict of interest, should also be organized occasionally. Unfortunately, such mechanisms gain very little attention from official and charitable agency. Hence WHO should address these mechanisms seriously, including allocating more resources.

- Identify the appropriate role of stakeholders with conflict of interest

We strongly believe that public Health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests. Economic interests are barriers to public health initiatives. The beverage industry has been involved in the alcohol policy process, through

many avenues, including shaping the perspectives of legislators on policy issues, funding industry-friendly interventions and research. Such participation comes with cost to public, for example the opportunity to have effective alcohol policy. We hope that WHO, the process to develop the Strategy and the movements afterward will be well aware off this fact. However, this does not mean that industry has no place in the process. The appropriate role of alcohol industry is to ensure that their practices comply with formulated policy at the implementation phase.

Policy areas

From our view, we would like the Global Strategy to prioritize two policy areas, where these are hardly addressed by other programs/agencies.

The first area of priority is to control alcohol consumption at aggregate level. It would be unwise to tackle alcohol-related problems without consumption control. Consumption control at collective level should employ three intermediates; the reduction and control of drinking frequency, drinking volume per occasion, and drinker prevalence particularly among youth and young people. The Strategy should focus on effectiveness-approved interventions, including taxation, physical availability control and marketing control. Most important, the process to avoid unproductive industry-friendly alternatives, such as interventions focusing on unrecorded beverages, and promoting responsible drinking and self regulation.

The second area of priority for this Strategy is to promote global climate to support effective alcohol policy. This includes clarifying myths and eradicating comfortable delusions of relevant agencies and stakeholders on alcohol-related problems and policy. Better problem structuring can reduce limitation for the process to reduce this serious problem.

Question 3: In what ways can you or your organization contribute to reduce harmful use of alcohol?

In response to this question, we would like to focus on the contribution at supra-national level, particularly on the implementation of the Global Strategy.

As a research centre, Alcohol Policy Research Program (APR), under the International Health Policy Program (IHPP) and the support from Center for Alcohol Studies (CAS), has mandate to strengthen technical knowledge on alcohol consumption, consequences and policy. Such an alcohol-specialized organization is rather uncommon in developing countries. Furthermore, participating with other technical agencies and NGOs abroad, including conducting joint project, is our priority.

Therefore, we believe that APR and IHPP are competent and prompt to contribute to the supra-national alcohol policy development and strengthening;

by

1. being an active member to technical community, including in knowledge sharing and conducting joint research
2. being a technical outlet to broadcast Thai experience to other countries, as well as to import and synthesize international experience to Thailand
3. Together with CAS, being a technical focal point for the Southeast Asia region and other neighboring countries, for WHO and other international agencies, in any project and program relevant to alcohol policy
4. being an active member of the of international technical and NGO networks, free from conflict of interest, to strengthen alcohol policy at national and sub-national levels

As integrated to the Ministry of Public Health (MOPH) of Thailand, furthermore, APR and IHPP can strengthen and support the role of MOPH in the international level.

Models for Developing an Alcohol Prevention Program on a College Campus

Strategies and Approaches:

Important things to consider in the process of planning and developing this program are the key issues and strategies that will be utilized in its approach. The program can focus on the following areas:

Education and Leadership: Specific training, analysis and social norms organizing can be done to provide students and staff with the support, guidance and information they need to understand the drinking culture on campus, how they can make safe and responsible choices and what they can do as peers and leaders to set an example and support their friends. This could involve 1) providing trainings to student leaders and staff on campus among the various programs, 2) developing a social norms campaign to report on the drinking behaviors on campus (using positive data and potentially negative for more of a social marketing approach) to dispel some of the myths students may have about drinking based on stereotypes and assumed social pressures 3) Working with existing student leaders and groups to talk to them about ways they can advocate for change and make specific efforts to address some of the problems on campus 4) Do work to advocate for and ensure alcohol education is incorporated into curricula so that all students will have the opportunity to learn and discuss this issue within their time as an undergraduate. This could involve providing support to RA's and Res Life Staff, and SALP staff and student leaders to address this issue in their programming as well.

Campus and Community Policies: Look at the existing policies on campus related to alcohol and how they are enforced among the residence halls, Greeks, and overall campus property and activities. Identify any potential loop holes and connect with key individuals who are enforcing and implementing these policies, to talk about ways they can be made more effective, as well as discuss and collaborate to develop a plan for addressing some of these issues.

This can also involve working with the community to address some of the problems related to this issue and look at the level of enforcement that is taking place on campus and in the community, with the potential of advocating for increased or more targeted enforcement efforts. Community policies directly related to the campus can look at price and marketing specifically with drink specials and other promotions at local bars and restaurants and their ability to advertise on campus. Policies regarding promotion of alcohol on campus, and alcohol sponsorship will be important to address as well.

Developing Specific goals: It is crucial to develop goals in the short and long term to identify priorities and set specific targets for creating change on this issue, and a stronger presence of alcohol prevention and intervention on this campus over a particular time frame. These should also include measurable outcomes. Examples of specific goals are:

- ***Reducing underage and binge drinking among students by a certain percentage over a particular time frame-*** this can be addressed in many ways depending on the priority and time frame for this goal. It's important to assess the current underage and binge drinking rates and assure that specific methods are being used to assess this on an ongoing basis. It is also important to focus on implementing specific efforts to prevent repeat offenders and address alcohol related issues on campus and in the community through education and intervention, and appropriate enforcement.

- ***Reducing access to alcohol among underage students by a certain percentage over a certain time frame-*** This can also be done through a number of ways that focus on access to alcohol, both on campus and in the community. Examples of this can be working with alcohol vendors and law enforcement to reduce alcohol sales to minors, working with Greeks to require wrist bands or ID's and other policies at parties, making sure students are aware of the laws and consequences related to purchasing alcohol for a minor and contributing to the delinquency of a minor, analyze, advocate for and improve campus and community policy to reduce underage access to alcohol.
- ***Increasing awareness as it relates to underage and binge drinking and its negative impacts among students by a certain percentage over a certain time frame-*** engaging in a social norms campaign on campus, supporting student groups focused on alcohol and substance abuse issues to increase visibility and effectiveness on campus, advocating for curricula and other educational opportunities for all students related to alcohol and substance abuse.
- ***Reducing on and off campus violations of alcohol policies and liquor laws among students by a certain percentage over a certain time frame-*** Many of the tactics mentioned above can be used, however this would involve a specific effort to analyze campus policies and their effectiveness with the potential of proposing changes, additions or new policies. Also efforts to assure that first time offenders are dealt with in a way that can be most effective in preventing repeat offenses i.e. graduated fines for each offense, required participation in an educational program, and other methods. Additionally coordinated efforts to work with campus and community police, res life, student and judicial affairs to make sure this is a priority issue and it is being addressed appropriately and consistently is important.

The structure of the program under the guise of evidence base practices may depend largely on the specific priority areas that are identified by campus leadership and the conclusions from analysis of existing data. If it is a priority to focus more attention on students identified as at higher risk due to regular binge or problem drinking, the BASICS model may be a more effective approach. However, if the goal of utilizing a wider outreach method for implementing a risk assessment tool is a priority, and campus departments are willing to invest time as partners in gaining student participation in an initial program like the online risk assessment tool, utilizing evidence based models such as Challenging College Alcohol Abuse may be more effective.

Overall the goal would be to develop a comprehensive program that impacts all of the areas mentioned above. However, these factors may determine what will be the central focus for utilizing evidence based strategies that will be tailored to this campus. It is possible to use pieces from both of the models mentioned, however to maintain fidelity and effectively use the models it will be important to decide on which model will be used for the core aspects of this program. This will allow for adequate and effective program evaluation and sustainability.

Effective responses to alcohol-related problems:

The harms associated with alcohol

Alcohol use in Australia is associated with a range of symbolic, economic and social benefits. However, alcohol use also contributes to a range of acute adverse consequences, such as injury (e.g. violence, accidents on the road and at work; self-harm) and chronic harms, (e.g. problems such as cirrhosis, breast cancer, cardio-vascular disease and depression).

In Australia, the main causes of alcohol-related deaths are cancer, alcoholic liver cirrhosis and road trauma. Among people aged 15 to 34 years, alcohol is responsible for the majority of drug-related deaths and hospital episodes, causing more deaths and hospitalisations in this age group than all illicit drugs combined.

More than 40 different conditions have been identified as being either partly or entirely attributable to alcohol consumption. The alcohol-related degenerative diseases, typified by chronic conditions such as organ failure (eg liver cirrhosis) and the development of cancer (eg liver cancer) tend to occur as a result of many years of alcohol use.

Short bouts of drinking to intoxification tend to be associated with acute conditions such as violent assaults, road injuries and drowning. Chronic conditions accounted for most (42%) of the 3290 estimated alcohol caused deaths in Australia in 1997 (Chikritzhs et al, 2001). Acute conditions accounted for 28% and mixed (stroke and suicide) for 30%. Of the 62,914 estimated potential life years lost in that year, acute conditions were responsible for 46%, chronic for 33% and mixed for 31%. The average number of years of life lost due to premature death from acute conditions was more than twice that from chronic conditions, because the former mostly involved younger people. The most prevalent alcohol-caused deaths can be attributed to:

*Acute**	*Chronic*
Road injuries (418)	Alcoholic liver cirrhosis (683)
Assault (124)	Alcohol dependence (257)
Drowning (73)	Alcoholic cardiomyopathy (109)
Alcoholic psychosis (51)	Liver cancer (65)
Falls (41)	Oropharyngeal cancer (55)
Aspiration (57)	Oesophageal cancer (54)
Acute pancreatitis (38)	Hypertension (38)
Ethanol toxicity (37)	Laryngeal cancer (31)
Fire injuries (35)	Epilepsy (31)

Source: Chikritzhs et al, 2001

Drinking alcohol during pregnancy can also cause harm to the unborn child and may cause Fetal Alcohol Syndrome, alcohol is a causal factor for colorectal cancer, and Australian and international studies have established that alcohol is significantly associated with crime, particularly violent crime.

Alcohol is a major public health concern in Australia. Research published by the National Drug Research Institute as part of the National Alcohol Indicators Project (www.ndri.curtin.edu.au/publications/naip.html) shows that:

- 44% of alcohol is consumed at levels that pose risk in the long-term, and 62% is drunk at levels that pose risk in the short-term;
- 24% of males and 17% of females are at risk of short-term harm at least once a month;
- Every year, about 50 teenagers (14-17 year olds) die from alcohol-attributable injury and disease and another 3,500 are hospitalised;
- Over 80% of all alcohol consumed by 14-17 year olds is drunk at risky/high risk levels for acute harm;
- Between 1993/94 and 2000/01 over half a million Australians were hospitalised due to risky/high-risk drinking. These admissions are costly - in a single year in this period, alcohol problems demanded 400,000 hospital-bed days.
- An estimated 10,592 Australians aged over 65 died from causes directly attribute to alcohol between 1994 and 2003, and the trend is towards increasing numbers in many Australian States and Territories;
- Over a five-year period between 2000-2004, an estimated 1145 Indigenous Australians died from alcohol-attributable injury and disease; and
- In Australia 4381 years of life were lost prematurely due to alcohol-caused violence in 1997.
- In 1998/99, an estimated 8,661 people were admitted to hospital from alcohol-caused assaults in Australia (4.6 per 10,000 persons). Many more serious alcohol-related assaults were reported to police (62,534) and still more were unreported.

(For further details on alcohol related harm in Australia, see the Bulletins from the National Alcohol Indicator Project: www.ndri.curtin.edu.au/publications/naip.html.)

Responding to alcohol-related harm

The National Drug Research Institute, which is a WHO Collaborating Centre for the Prevention of Alcohol and Drug Abuse, supports evidence based practice.

The evidence shows that isolated initiatives have limited effectiveness in addressing the harmful use of alcohol in Australia. The introduction of a package of integrated measures is likely to be most effective.

According to Loxley et al 2004, ‘whole of population’ or universal strategies are of particular importance in reducing the more prevalent harms associated with alcohol use.

Regulation of the supply of alcohol products is strongly supported in the research literature. There is evidence for the effectiveness of measures that control the price of alcoholic drinks. Young people and heavy drinkers are influenced by price. The current Australian approach to alcohol taxation, and therefore pricing systems, are not entirely consistent with good public health approaches to minimising alcohol-related problems.

There is evidence and a sound rationale for the enforcement of laws prohibiting sale of alcohol to persons under legal purchasing age and enforcing laws regarding not serving alcohol to intoxicated patrons.
Physical availability of alcohol in terms of numbers of outlets and hours of sale has increased in Australia over the past decade and Australian and overseas evidence identifies late night trading for hotels and nightclubs as contributing to alcohol-related violence and road trauma.
The development and enforcement of laws to detect and deter drink-driving in Australia have been major successes for public health and safety with generally uniform laws in place across Australia.
Public education campaigns may contribute to reducing risky alcohol use, but usually when they support other policy measures such as tax increases and law enforcement.
Babor et al 2003 and Loxley et al 2004 presented the strategies research consistently tells us are the most effective in addressing alcohol-related problems. In addition to the work of Babor et al, NDRI is particularly involved in facilitating responses to Indigenous Australians. Indigenous communities have taken two main approaches to reducing alcohol supply: declaring 'dry' areas and extending controls on availability (supply), through liquor licensing legislation. These approaches can be effective but communities need support to enforce them, and underlying policy must promote Indigenous control. There is strong evidence for the effectiveness of local licensing restrictions in communities with high Indigenous populations, e.g. restrictions on the days and hours of sale and on the type and quantity of liquor that can be purchased (Chikritzhs et al 2007).
(See www.ndri.curtin.edu.au/pdfs/publications/M68.pdf for more information on alcohol restrictions.)

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WHO Reducing Alcohol Harm Response

The Royal College of Nursing (RCN) is the UK's largest professional association and trade union for nurses, with over 390,000 members. The RCN works locally, nationally and internationally to promote high standards of care and the interests of patients and nurses, and of nursing as a profession. We welcome this opportunity to respond to the above document.

Nurses work in diverse areas and are faced with the consequences of excessive alcohol consumption on a daily basis. This ranges from having to deal with violent and aggressive patients in A&E, to caring for people and their families suffering from long term conditions as a direct result of drinking alcohol.

In England, hospital admissions directly attributable to alcohol are rising by 80,000 people a year. The cost of alcohol consumption to the NHS is estimated to be £2.7 billion (€3.4 billion) a year, this does not take into account the social costs that could be attributed to excess alcohol consumption such as crime and disorder, lost days at work and the detrimental effects it can have on family life.

People living in deprived areas suffer the highest levels of disease and hospital admissions due to alcohol abuse[1]. This contributes to the inequalities in health suffered by those living in deprived circumstances.

We hope, through this response to contribute to a global reduction in the harm caused by alcohol by providing a summary of some of the successes and failures of a number of approaches that have been used in England and a number of measures suggested by the RCN to further reduce this harm.

[1] ~~Review of the national harm r~~eduction strategy for England. Health Impact assessment. DOH 2007.

Alcohol treatment, education and the role of nurses

Different sections of the community exhibit markedly different attitudes towards alcohol, its consumption and the problems it can cause. It is essential to engage with communities at a local level to help identify root causes and effective and suitable methods for education and harm prevention. Amongst some groups of young people excessive alcohol consumption may be seen as normal and linked to 'street cred' or bravado whereas in other factions of society there may be some stigma attached to it and an element of shame. There is evidence to support the benefit of brief interventions on alcohol consumption designed specifically for target groups. There is a strong case for targeted interventions that reflect the different patterns of alcohol use, e.g. Young Women and 'pre-loading'.

An insurmountable amount of evidence linking smoking to a number of diseases has seen it become a public health priority to educate the public about the harm it can cause. Alcohol is a widely consumed substance that can have equally harmful consequences if consumed to excess and deserves a priority status on the public health agenda. The RCN favours a multi-faceted approach to providing help and education to those who are at risk or who wish to cut down on their drinking that includes engagement with communities at a local level.

Nurses are well placed to work in partnership with other agencies to intervene in many settings in their work with families, schools and GP practices as well as the more traditional hospital settings. For this to be effective, alcohol related harm must be recognised as a public health priority and adequately resourced.

Nurses often have direct experience caring for individuals who have suffered injury as a result of excessive alcohol consumption, either as a consequence of harm caused by the effects of alcohol on the body or through injuries incurred as a result of intoxication.

Statistics show that underage drinking is a substantial problem in the UK and is a significant cause of morbidity and mortality. School nurses are ideally situated to educate younger people on the effects of alcohol. Any scheme seeking to use school nurses as educators in a school setting will be limited by the current shortage of school nurses. The RCN advocates the doubling of school nurses to combat this problem. It is vital that young people are not overlooked in a strategy to educate the public. Nurses are also attached to the Youth Offending Service or working with children 'looked after' by Local Authorities. Such vulnerable children and young people are at greater risk of alcohol misuse.

Pilot studies in two Glasgow hospitals in partnership with the Strathclyde Police have Emergency Room nurses trained in alcohol counselling to provide brief interventions on alcohol intake to patients presenting with knife wounds. Patients are encouraged to think about the way drinking may be affecting their lives and the links between alcohol and violence. A preliminary evaluation suggests that these types of interventions have a positive effect on curtailing harmful drinking behaviours.

The RCN recognises the benefit of brief interventions and has produced a resource for nurses and healthcare assistants to identify and assist individuals who have problems with alcohol. In Merseyside two PCTs have invested in nurse led primary care

services that provide rapid access to assessment and treatment of patients identified as having harmful or hazardous patterns of alcohol use. Whilst this approach is to be applauded it also highlights the dearth of such services in the rest of the country as alcohol treatment has not received the level of investment that drug misuse has received in recent years.

Clear labelling on all alcoholic beverages

There has been some success in implementing a voluntary labelling agreement between the UK government and the alcohol industry. According to an initial report approximately 57% of products contain information on alcohol unit content.[2] It is disappointing to note that only 3% contained the full agreed label in its entirety and agreed format which includes:

a) One of three pre-determined health messages:
    a. "Know your limits"
    b. "Enjoy responsibly"
    c. "Drink responsibly"
b) UK Unit information.
c) Maximum intake recommendations for men and women and a specific warning for women who are pregnant or trying to conceive.
d) The address of the Drink Aware website.

It is very difficult to evaluate the impact of labelling on harm reduction in a public health context without some form of standardisation. The fact that only 3% of products fully comply with the labelling agreement represents a lost opportunity to study the efficacy of such a labelling measure in reducing alcohol related harm in the UK. This is a strong incentive for a mandatory labelling requirement.

At the request of the alcohol industry, in return for providing this type of information on labels, the government launched its own 'Units Awareness' campaign to help consumers understand the information included on bottles. The RCN were pleased to be one of the organisations who were publicly named and signed up supporters of this campaign.

A study conducted in Australia before the introduction of mandatory unit labelling on all alcoholic products indicated that most consumers did not know the number of units contained in their standard drinks and when asked often underestimated the number of units. To make consumers aware of the amount they can drink safely is of limited use if they are unaware of the amount they are actually drinking. There have been no controlled studies to determine the effect of the introduction of mandatory unit labelling in Australia but there has been a reduction in consumption and alcohol related deaths since its introduction.

There has been discussion about introducing a EU wide labelling requirement. The RCN recognises that there are number of difficulties in implementing an EU wide requirement. Different member states have different standard units and there are also

[2] *Monitoring Implementation of Alcoholic Labelling Regime,* Department of Health, Campden & Chorleywood Food Research Association Group, June 2008.

issues with creating barriers to trade. This is not something that can be done quickly but there is certainly merit in pursuing a consolidated European standard so that people in any European state can accurately and easily determine the amount of alcohol they are consuming.

Labelling is an efficient way of giving individuals clear and unambiguous information about how much they are drinking while they are drinking. A public that are better informed about the amount they are drinking and aware of the consequences of unsafe drinking are more likely to drink responsibly. We believe that a culture of increased awareness will result in a cultural shift towards safer drinking practices in much the same way that attitudes about smoking have changed as society has become more aware of its negative effect on health.

The RCN believes that people everywhere have a right to know the amount they are drinking and to make informed choices about how much they drink. Women who are pregnant or trying to conceive have a right to know that drinking has the potential to damage their baby.

For this reason the RCN strongly advocates that all alcoholic beverages contain at the very least unit information and a warning to pregnant women.

Labelling should also apply to boxes of wine and similar containers for other drinks. There is also the issue of helping people to know the number of units they are drinking in pubs, clubs etc where it can be more difficult to determine the number of units in a beverage. For example, in the UK there is an increasing trend to serve wine in large glasses however given the varying alcohol content of wine an individual will have difficulty in accurately assessing the number of units they are drinking.

Regulation of the retail industry

In an attempt to curb irresponsible and excessive drinking many countries have introduced rules that affect the way alcohol is sold to the public. Whether this be through prohibiting the sale of alcohol to intoxicated customers or by requiring that alcoholic drinks be displayed separately from other goods, there is a growing recognition that the harm caused by alcohol can be reduced by regulating alcohol retailing practises.

The Government has a history of working closely with the alcohol industry - Both On-Licenses(Places where alcohol is purchased and consumed, Bars, Clubs etc) and Off-Licenses (Places where alcohol is purchased but not consumed, Supermarkets etc) are subject to a voluntary code of practise concerning alcohol retailing practices. There is a developing consensus that the effectiveness of an essentially voluntary approach is limited and that self regulation alone is not sufficient to protect society and individuals from the harms of unsafe and unscrupulous retailing practices.[3] This is echoed in a Home Office commissioned KPMG review of industry compliance.[4]

[3] *Safe, Sensible Social, Consultation on Further Action*, Department of Health, 2008.
[4] *Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks*, Home Office, KPMG, April 2008.

In its response the Department of Health consultation on Alcohol, *Safe, Sensible, Social* The RCN recommended to the Department of Health mandatory code be introduced in England and urges the global community to consider the weakness of a voluntary approach to regulation in the context of its own national policy.

Underage drinking is a particular concern in the UK. A study conducted in 2003 found that UK teenagers have some of the highest levels of lifetime drunkenness in Europe.[5] The average amount of alcohol consumed per week by 11-15 year olds who drink regularly has doubled from 5.3 units in 1990 to 11.4 units in 2006[6]. Unhealthy patterns of drinking in adolescence may lead to an increased level of addiction and dependence on alcohol in adulthood [7]

Alcohol is also a significant cause of mortality in England. 3.1% of all mortalities can be attributed wholly or in part to alcohol consumption. Young people are at particular risk, with 26.6% of male deaths attributed wholly or in part to alcohol occurring within the 16-24 age group. The same figure for females is slightly lower at 14.7%.[8] These figures show that younger people and particularly males are disproportionately susceptible to alcohol related mortality.

Young people are thought to be particularly susceptible to advertising and branding, therefore it should be clear within any new code that targeting young people either directly or indirectly in marketing or advertising campaigns is unacceptable. There are a number of possible measures to ensure that this is enforced, each requiring careful consideration and examination. The RCN advocates a strict approach to the regulation of alcohol advertising that directly or indirectly targets young people.

Young people often drink in unsupervised areas as they are unable to gain access to pubs and clubs to buy alcohol. This can lead to risk taking behaviour such as unprotected sex, fights and accidents. Depending on various factors unique to each country there may be merit in increasing the minimum age at which alcohol can be purchased.

There is evidence to suggest that alcohol is used as a loss leader in UK supermarkets.[9] £38.6 million (€48.5 million) of alcohol was sold below trade price in the 2006 World Cup from supermarkets. Within the limits of EU and local competition law the RCN has recommended that a new code should include measures to prohibit or curtail deep discounting.

Staff working in retail premises selling alcohol should have training to enable them to identify both underage and intoxicated drinkers and deal with them appropriately.

North West Trading Standards surveyed over 10,000 young people in the region regarding under aged drinking. (2006) The survey's findings were analysed by the

[5] *Alcohol Concern. Unequal Partners.* http://www.alcoholconcern.org.uk.
[6] *Parklife: Alcohol and Young People at risk.* Addaction.
[7] *Alcohol misuse* BMA 2008.
[8] *Alcohol-Attributable Fractions for England, Alcohol-Attributable Mortality and Hospital Admissions,*. Centre for Public Health, Faculty of Health and Apllied Social Sciences, Liverpool John Moores Univeristy North West Public Health Observatory, June 2008, p13,14.
[9] *Alcohol as a Loss Leader*, Institute of Alcohol Studies, Russell Bennetts, 2008.

North West Public Health Observatory and highlighted the protective effects of parents educating their children about alcohol. Such education included controlled access to alcohol in a similar fashion to many European countries. The RCN has recommended that the Government's strategy should assist parents to educate their children by providing educational materials that they can use.

There are examples of good practice that have been developed to target young people who have been found to be involved in street drinking. Police in Lancashire have been accompanied by a nurse on their evening patrols of areas used by young people. The nurse has been able to provide health advice to young drinkers and access to on going support. In Merseyside the police and community wardens in the borough of Sefton have be issued with 'litmus strips' in order to test whether young people have concealed alcohol in soft drinks such as Coke. The parents of any young person found to be drinking alcohol will receive a letter from the local Council's Anti Social Behaviour Prevention Team. Initial evaluation suggest that this approach has reduced the number of young people involved in street drinking and has enabled persistent 'Offenders' to be identified and followed up for further assistance or treatment from the borough's specialist Young People's Substance Misuse Team. (This team is nurse led.)

Public health

Government figures show that in England the harm to health from alcohol is increasing whilst crime levels are dropping. It is estimated that 38% of males and 16% of females have an alcohol use disorder, equating to 8.2 million people. Areas of deprivation have the highest levels of disease and hospital admissions due to alcohol. We are concerned that alcohol is further exacerbating health inequalities in poorer areas and amongst underprivileged groups.

In 2006/2007, 6% of all hospital admissions were directly attributable to the use of alcohol. This constitutes a significant threat to public health. Failing to make public health concerns part of licensing objectives is inconsistent with wider health and wellbeing policies and must be urgently addressed. Scotland and Northern Ireland already include the protection and improvement of public health in their licensing objectives.

The Department of Health's evaluation of the cost of alcohol use in 2008 highlighted that 35% of all ambulance journeys and A/E visits were as a result of alcohol use. As this equates to over 1.2 million ambulance visits and over 6.6 A/E attendances in 2006/07, the case for highlighting the adverse health effects is at least as strong as the crime and disorder case.

Submission on Ways of Reducing Harmful Use of Alcohol

Introduction

The mission of The Royal College of Physicians of Ireland is to develop and maintain high professional standards in specialist medical practice in order to achieve optimum patient care and to promote health nationally and internationally. The Faculty of Public Health Medicine is one of the faculties of the College. The role of the Faculty is to advance the science, art and practice of Public Health Medicine in Ireland and to promote education, study and research in Public Health Medicine for the public benefit. The training of doctors in public health medicine in Ireland is the responsibility of the Faculty.

Alcohol and Harm

Alcohol consumption is linked to more than 60 diseases and conditions affecting nearly every organ in the human body and is the third highest risk factor for premature death and ill-health in the European Union. Alcohol-related harm include such problems as accidents, injuries, chronic ill-health, premature death, public safety, violence, child neglect, marital problems and lost productivity due to absenteeism or poor performance at work.

Alcohol-related Harm in Ireland

There is extensive harm caused by alcohol in Ireland. Examples of alcohol related harm include:

- 34% of those seeking legal advice due to marital breakdown cite alcohol as the main cause
- 31% of road deaths are alcohol related
- 11% of pedestrians killed have blood alcohol levels of greater than 240mg/100ml.

- Alcohol related admissions to hospitals increased by 95% between 1995 and 2002.
- Every 8th new patient attending A/E is there because of alcohol related injury
- 45% of men aged 18-45 in a national survey indicated that drinking alcohol has contributed to them having sex without contraception.
- Intoxication in a public place increased by 470% from 1996 to 2002
- Cost to the economy in 2003 was €2.65 billion.

- Alcohol related mortality Ireland 1992-2002
  - Mortality from alcohol acute conditions + 90%
  - Mortality from alcoholic specific chronic + 61%
  - Whilst overall mortality fell by - 14%

The toll of alcohol-related harm includes harms experienced by the drinker and also harms experienced by people other than the drinker. A national survey in Ireland showed that 44% had been injured, harassed by someone's use of alcohol.

The large increase in alcohol consumption in Ireland in the late 1990's has resulted in a huge and corresponding increase in alcohol related harm as outlined above. The alcohol morbidity and mortality in Ireland presents a huge burden on individuals, the health services, industries, local communities and the state.

Repeated ESPAD studies show Ireland's young people to be amongst the very highest for consumption and for binge drinking. This bodes very badly for the future. Young people are particularly susceptible to advertisements and the promotion of alcohol and most likely to be harmed by drinking. It is therefore vital to delay the age of onset of drinking by young people, as recommended by the WHO.

Effective Strategies to reduce alcohol related harm

There is clear evidence that the more a population consumes the greater the degree of alcohol related harm. Strategies therefore should concentrate on reducing our overall

consumption. The most effective have been outlined in The Strategic Task Force on Alcohol reports in Ireland where the reports made recommendations for reducing alcohol-related harm in Ireland based on the scientific evidence. The following strategies are required to reduce consumption and alcohol related harm:

1. An increase in price through taxation
2. A minimum price on alcohol in particular for off sales
3. A decrease in the physical availability of alcohol through restrictions on hours of sale and the number of premises available to sell alcohol
4. A ban on advertising of alcohol
5. A ban on the sponsorship of sporting events by alcohol companies
6. Targeted action in respect of road safety with the reduction of the legal limit for driving to 50mgs% for drivers and to 20mg% for learner and professional drivers. These need to be accompanied by highly visible and sustained enforcement.

As alcohol related harm effects every sector of the population there is a need for a strong leadership and a coordinated approach at government level across all departments. There is a need for one government body or agency to coordinate the required actions.

For strategies to be effective there has to be an acceptance by governments that alcohol is no ordinary commodity and that alcohol is a legitimate health concern and not just an industry. The need for alcohol companies to increase profits for their shareholders is a barrier to reducing consumption, yet alcohol industry representatives have a greater influence on governments' alcohol strategy than those advocating for healthy public policy.

Emphasis should be placed on collective and shared responsibility in tackling alcohol related harm in each country rather than seeing the issue as something that pertains only to individuals who develop drinking problems.

There is a need for a framework convention on alcohol to be developed as is the case for

tobacco. This framework could lead on:

- Restrictions on alcohol marketing to include sponsorship by alcoholic beverage brands and companies.
- Warning labels and controls on alcohol packaging.
- Other specific actions to reduce of cross-border sales.

What Faculty of Public Health Medicine can do?

The Faculty of Public Health Medicine as part of the Royal College of Physicians can contribute by identifying evidence based policies, advocating at all levels for their implementation and by training doctors to be aware of the harm caused by alcohol to their patients and the wider communities and keeping them abreast of evidence based treatments and practices.

September 2008 version.
Kumpfer, K.L., & Brooks, J. (in press), Family Nurturing Programs. *Encyclopedia of Victimology and Crime Prevention, Sage Publications.*

Family Nurturing Programs

Rates of family violence, conflict, and child maltreatment are unacceptably high nationally and internationally with high costs to society. Family violence and child maltreatment are associated with multiple negative consequences for all family members, and include physical injury, child neglect, separation and divorce, incarceration, psychological problems, child removal from the home, multi-generational substance, youth delinquency, perpetration of violence, and death. This entry will discuss the incidence and prevalence of child maltreatment and relationship to parental substance abuse, the need for prevention services focusing on family interventions, called nurturing and family strengthening interventions, the definition of different types of family preventive interventions, and the most effective family interventions. The entry ends for research on the critical core components of child abuse prevention programs with a family focus, theories behind the evidence-based programs (EBPs), and need for widespread dissemination.

According to the Child Welfare League of America, nationally, substance abuse is a factor in around 40 to 80 percent of substantiated cases of child maltreatment. Over 80% of state child protection agencies report that parental alcohol and drug abuse and poverty are the two major factors associated with child maltreatment. Parental substance abuse increases child abuse by about 300% and child neglect by about 400%. Additionally, youth who have ever been in foster care had higher rates of illicit drug use than youths who have never been in foster care (33.6 vs. 21.7 percent). A greater percentage of youth who have ever been in foster care are in need of treatment for both alcohol and drug abuse (17%) than are youth who have never been in

foster care (9%).

Need for Prevention

Despite significant need, many families and children involved in child welfare are not getting the prevention and treatment services needed. In 1997, the Child Welfare League of America (CWLA) estimated that 43 percent of children and adolescents in care needed substance abuse services while agencies obtained treatment for only around a third of these youth. For parents, it was estimated that 67 percent needed services while agencies had capacity to serve around 31 percent. Beyond basic substance abuse treatment, it is unknown how many families learn skills and receive support to raise healthy children. A study by Ostler and associates of children involved with child protective services due to parental methamphetamine abuse found few social resources for coping with emotions, problem solving or talking about the experience.

Further, a multitude of developmental theories support the critical role of families in child raising. The ADD-Health longitudinal adolescent research published by Resnick and associates in 1997 suggests that parents have a larger impact on their children's development and health than previously thought. Although peer influence is the major reason adolescents initiate negative behaviors, a positive family environment (e.g., family bonding, parental supervision, and communication of pro-social family values) is the major reason youth do not engage in unhealthy behaviors, such as substance abuse, delinquency, and early or unprotected sex. These protective family factors have been found to exert an even a stronger influence on girls.

The intergenerational cycle of family violence and child maltreatment needs to be broken. These negative statistics support the need for development and research surrounding evidence based programs (EBP) for child welfare, substance abuse, and community setting implementation. Unfortunately, research in this area is scarce due to a lack of funding until this

year for child abuse prevention research testing evidence-based family nurturing programs. Additionally, family intervention researchers lacked access to cross systems service delivery databases to clearly prove their interventions worked to reduce child abuse reports. New grants to states and tribes by the Administration for Children and Families (ACF) should show that family strengthening interventions that improve parenting skills, family communication, problem solving, and stress management will result in reductions in family violence and child abuse.

Family Nurturing Solutions: Definitions of Types

A number of family interventions have been found through national expert reviews of research to be effective in strengthening family systems and reducing family violence. Due to the emergent nature of the intervention, there is not yet agreement among researchers about definitions and components of the different types of family-focused approaches. The Center for Substance Abuse (CSAP) reviewed family strengthening approaches in 1997 and defined about eight approaches; however, at that time only four approaches had sufficient research evidence to be considered an evidence-based approach in improving parenting skills and family relations: (1) *behavioral parent training* (primarily cognitive/behavioral parent training); (2) *family skills training* (parent training, children's skills training, and family practice); (3) *family therapy (*structural, functional, or behavioral) and 4) *in-home family support.* Since the CSAP review in 1998, two promising low cost approaches have emerged: Bauman and associates in 2001 found positive results when involving parents in mailed-out parenting homework assignments with 12-14 year old [Caucasian] children. Several effective family interventions utilized CD-ROM technology or learning videos.

The last national review of family strengthening approaches by Kumpfer and Alvarado in 2003 found about 35 evidence-based practices. However, only 14 of these have been tested in

randomized control trials and seven independently replicated, thus meeting the criteria for the highest level of evidence of effectiveness or Exemplary I Programs. The Exemplary I family programs for 0-5 year old children include: *Helping the Noncompliant Child* and *The Incredible Years*. The only Exemplary I rated program for families with 6 -12 year old children is the *Strengthening Families Program*. The pre-teen and adolescent programs are: *Functional Family Therapy, Multisystemic Family Therapy, Preparing for the Drug Free Years* (now called *Guiding Good Choices),* and *Treatment Foster Care*. According to a meta-analysis of all school based universal alcohol prevention program by Foxcroft and associates in 2003 for the Cochrane Collaboration Reviews in Medicine and Public Health at Oxford University, the *Strengthening Families Program for 10-14 Year Olds* is the most effective program and twice as effective as the next best program, *Preparing for the Drug-Free Years.* For additional reviews of these effective family strengthening approaches see Kumpfer and Alvarado (2003) and the OJJDP Strengthening America's Families web site developed at the University of Utah,. www.strengtheningfamilies.org.

Another systematic review in 2008 by the author for the United Nations of all the most effective parenting and family programs in the world identified several additional EBP parenting programs, including *Triple-P* from Australia that has suggestive evidence of reducing child maltreatment in families in a CDC-funded randomized control trial in South Carolina. However, this program has not been tested with high risk families yet; a study now under way. Adapting EBPs to the local families has been found by the author of this entry in 2002 to improve recruitment and retention by 40%. A useful compendium for the UN project is a manual on how to locally or culturally adapt EBP family interventions to maximize family recruitment, retention and outcomes. A summary of these steps to cultural adaptation of family programs was

recently published in 2008 by Kumpfer and associates.

Core Components Child Maltreatment Prevention Programs

Kaminski and associates in 2008 analyzed the *critical core components* of EBP family strengthening interventions from 77 studies of programs for child maltreatment prevention in 0-7 year olds. These *core components* include:

1. Format should include practice time for parents (with both children and group leaders in the sessions).
2. During family session, parents should be taught to interact positively with children (e.g. showing enthusiasm and attention for good behavior, letting the child take the lead in play activities).
3. Parenting content should include increasing attention and praise for positive children's behaviors, understanding normal development, positive family communication skills and effective discipline.
4. Children's content should include teaching children social skills.
5. Generalizion of new behaviors should be facilitated through assignments involving practice in home or other social settings.

Intervention Theories

Attention to mechanisms of change has been identified a crucial component for advancing theory in family-based treatment and ultimately for developing more effective prevention programs. The underlying psychological theories of most family EBPs are cognitive-behavioral psychology, social learning and/or family systems theory according to

Liddle and associates. A key concept incorporated into many of the evidence-based programs (EBPs) is to reduce coercive parent-child interactions that give rise to child abuse and family violence --a process well documented by Gerald Patterson at the Oregon Social Learning Center. The family systems approach uses reframing and cognitive restructuring methods to foster behavior change. Evidence-based family prevention interventions involve the whole family (rather than just the parents or children) in interactive change processes, rather than involving them in didactic educational lessons. These EBPs stress the importance of the engagement process and reducing barriers to attendance often through relationship building services-such as personal invitations, meals, childcare and transportation, and other incentives. Most begin with sessions designed to improve positive feelings through positive reframing or skills exercises stressing family strengths.

Dissemination

Web-site lists by state and national organizations as well as regional clearinghouses have helped local practitioners to locate EBPs in parenting and family interventions. However, learning how to effectively disseminate EBPs has only come with experience for the university researchers who were not adept 20 years ago in marketing and dissemination. Today, evidence-based family interventions are highly structured programs with rigorous training programs to assure adherence or fidelity to the model. Most EBP family interventions require initial training workshops with some type of ongoing quality assurance system via outcome evaluations including standardized measures.

Conclusions

Increased research, dissemination, and training in effective parenting and family intervention approaches will be important tools in helping societies address the problems

associated with family violence and child maltreatment. Practitioners in the field should seek training in identifying effective parenting programs, as well as addressing how to adapt these models to localized culture, gender and situation appropriate interventions.

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Useful web resource:

NIJ/OJJDP Strengthening America's Families website: www.strengtheningffamilies.org.

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INEBRIA is the international network on brief interventions for alcohol problems, with the secretariat based on the Health Department of the Government of Catalonia http://www.inebria.net/Du14/html/en/Du14/index.html, and with a South American regional section http://www.inebrialatina.org/.

The ***aim*** of INEBRIA is to promote wide implementation of brief interventions in a variety of settings for hazardous and harmful alcohol consumption at local, national and international levels.

The ***objectives*** of INEBRIA are:

1. To share information, experiences, research findings and expertise in the area of alcohol brief interventions.
2. To facilitate training on brief interventions and provide assistance to countries and institutions to adapt and implement brief interventions, particularly with regard to the transfer of knowledge and technology from high income to low income countries
3. To promote best practice and develop guidelines for the wide dissemination and implementation of brief interventions.
4. To identify gaps and needs for research in the field of alcohol brief interventions, promote international research co-operation and set standards for research in this field.
5. To integrate the study of brief interventions with the wider context of measures to prevent and reduce alcohol-related harm.
6. To pay particular attention to the needs of young people in relation to alcohol brief interventions.

THE HARM DONE BY ALCOHOL

INEBRIA notes that Alcohol is an intoxicant affecting a wide range of structures and processes in the central nervous system, which, interacting with personality characteristics, associated behaviours and socio-cultural expectations, is a casual factor for intentional and unintentional injuries and harm to people other than the drinker, including interpersonal violence, suicide, homicide, crime, and drink driving fatalities, and a contributory factor for risky sexual behaviour , sexually transmitted diseases and HIV infection. Alcohol is a potent teratogen with a range of negative outcomes to the foetus, including low birth weight, cognitive deficiencies and foetal alcohol disorders. Alcohol is neurotoxic to brain development, leading, in adolescence, to structural hippocampal changes, and, in middle age, to reduced brain volume. Alcohol is a dependence producing drug through its reinforcing properties, and neuroadaptation in the brain. Alcohol is an immunosuppressant, increasing the risk of communicable diseases. Alcohol is classified as a carcinogen by the International Agency for Research on Cancer, increasing the risk of cancers of the oral cavity and pharynx, oesophagus, stomach, colon, rectum and breast in a linear dose-response relationship. Alcohol has a bivariate relation with coronary heart disease. In low, and apparently regular doses (as little as 10g every other day), alcohol is cardio-protective, but, at high doses, particularly when consumed in an irregular fashion, is cardio-toxic. At the individual level, the risk of a lifetime attributable death from a chronic alcohol-related condition increases linearly from zero consumption in a dose-response manner with the volume of alcohol consumed, and from an acute alcohol-related condition increases from zero consumption in a dose response manner with frequency of drinking and exponentially with the amount drunk on an occasion.

Given the widespread harms done by alcohol INEBRIA recognizes the importance of implementing early identification and brief advice programmes for individuals with hazardous and harmful alcohol consumption in a wide variety of primary care settings.

THE EVIDENCE FOR EFFECTIVENESS

Brief advice heads the list of effective evidence-based treatment methods for alcohol use disorders. There is extensive evidence from a variety of health-care settings in different countries for the effectiveness of early identification and brief advice offered in primary care for persons with hazardous and harmful alcohol use in the absence of severe dependence, with evidence that more intensive brief interventions are no more effective than less intensive interventions. Such evidence-based technologies are being implemented and evaluated in both high-and low-income countries, with an increasing evidence base for effective implementation strategies. The cost-effectiveness of such interventions are in the range of I$ 2,000-4,000 per DALY saved. Although this is not as favourable as population-level policy instruments (such as tax increases and controls on availability and marketing), because brief interventions require direct contact with health care providers, brief interventions for hazardous and harmful alcohol consumption are highly cost effective when compared to other health-care based interventions.

TOWARDS A GLOBAL STRATEGY

INEBRIA strongly supports the development of a global strategy to reduce the harmful use of alcohol, that is based on the implementation of evidence based environmental policies, such as price and regulations on the availability and marketing of alcohol products, since such environmental policies are likely to augment the impact of brief advice programmes delivered in primary care. INEBRIA notes that as the main providers of health care, the many millions of health workers worldwide can contribute substantially to reducing and preventing harmful use of alcohol.

INEBRIA recommends that health care systems should ensure that early identification and brief advice programmes for hazardous and harmful alcohol consumption are widely available for all alcohol users. In particular, individuals with co-morbid conditions, for example hypertension, and those attending STD and HIV/AIDS clinics, should be offered screening for hazardous and harmful alcohol use, and advice and treatment as appropriate to reduce their alcohol consumption. INEBRIA agrees that identification and brief advice programmes are most effective when supported by sound policies and health systems and integrated within a broader preventive strategy. INEBRIA also agrees that health-care providers should concentrate on clients' health improvement and satisfaction through evidence-based and cost-effective interventions, and governments, in improving health systems, should take into consideration services for alcohol-use disorders and interventions for hazardous and harmful use of alcohol.

INEBRIA SUPPORT TO A GLOBAL STRATEGY

Through its website and the linked website to the PHEPA project managed by the Health Department of the Government of Catalonia, http://www.gencat.net/salut/phepa/units/phepa/html/en/Du9/index.html INEBRIA will continue to make the best evidence for identification and advice programmes readily available. Based on the PHEPA assessment tool, INEBRIA will develop a tool that can be used worldwide to assess the delivery of early identification and brief advice programmes at the country level. INEBRIA will prepare two simple guidance notes. One, for practitioners on how to undertake early identification and deliver brief advice, and one for health service providers on how to set up and manage early identification and brief advice programmes.

230 The Australian Wine Research Institute

Dr Vladimir Poznyak
Coordinator, Management of Substance Abuse
Department of Mental Health and Substance Abuse

Posted on WHO Website: *http://www.who.int/substance_abuse/activities/submit_form/en/index.html*

10 November 2008

Dear Dr Poznyak

Submission to public hearing on ways of reducing the harmful use of alcohol

Thank you for the opportunity to comment on, and address issues with, reducing the harmful use of alcohol.

Price as a measure of reducing harmful alcohol consumption

Over the past two decades, numerous studies have been published which have analysed whether price is a determinant of alcohol consumption (Cook 1982; Maynard 1988; Progue *et al.* 1989; Collins *et al.* 1991; Richardson *et al.* 1994). Some of these studies have built on the Kreitman Theory, whereby increased taxation based on alcohol content and hence increased selling price of an alcohol beverage, decreases the total alcohol consumption of a population and, therefore, decreases alcohol abuse in a population (Kreitman 1986). This also equates to a reduction in alcohol-related costs (Richardson 1989; Crowley *et al.* 1991). Implementation of the theory is problematic (Richardson *et al.* 1994) and studies to date have been methodologically imperfect.

For example, many of the studies consider the individual alcoholic beverages, that is, beer, wine and spirits, separately and do not examine the possibilities for beverage substitution in response to selective tax increases (Maynard 1988). Alcohol is a complex good composed of different types and qualities. While certain consumers respond to price increases by altering their total consumption, others vary their choice of type or quality. Indeed significant reductions in sales have been observed in response to price increases but these reductions were mitigated by significant substitutions between beverages types of qualities (Gruenewald et al. 2006).

While it can be demonstrated that the mean consumption of alcohol correlates with the prevalence of excessive alcohol consumption in a population (Rose *et al.* 1990), a reduction in total alcohol consumption results from some and not necessarily all individuals in a population consuming less. Unless the effect of the policy on the consumption by alcohol abusers is known specifically, such a policy can be regarded as a social experiment rather than a scientific

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prescription (Duffy 1977). Indeed when studies have evaluated whether prices have a differential effect on light, moderate and heavy alcohol consumption, the results suggest that both light and heavy alcohol consumption are much less price elastic than moderate consumption (Manning et al. 1995).

Indeed, as Skog remarked in 1980 and which was reiterated by Duffy in 1980, the necessity is to obtain direct evidence of the effect of specific control policies on the consumption habits of heavy drinkers. Hypothetical examples illustrating the 'effects' of hypothetical policies capable of halving or doubling the *per capita* consumption are of little value, particularly when they are also based on untenable statistical assumptions (Duffy 1980; Skog 1980).

Furthermore, econometric analysis of aggregate alcohol consumption shows that income, rather than price, is a main source of variation over time in consumption. The decline in alcohol consumption in Ireland in the mid 1970s and in the early 1980s was due to recession and high unemployment rather than to tax-induced price increases (Walsh 1987).

Alternative measures to reduce harmful alcohol consumption

Research suggests that telling an individual that a behaviour is harmful or providing information about the risk associated with a behaviour is insufficient to affect an individual's actions. In addition, increasing an individual's knowledge about a health risk does not necessarily cause that individual to change or modify negative or risky behaviour (Engs 1989).

It is considered that product warnings cannot readily and reliably be targeted to 'high risk' groups and individuals, such as excessive consumers of alcohol, whether regular consumer or 'binge drinkers'. The personal experiences affecting judgements of personal risk, motivations for high risk behaviour and the individual pharmacological and physiological properties of, and responses to, alcohol, all make the design of warnings that are effective with these individuals difficult. Young people, for example, who are considered to be an 'at risk' group, may have difficulty in judging or perceiving risks associated with alcohol consumption. This is because if an event has not occurred to an individual, and he/she cannot associate an event with a certain risk, then the individual may perceive that the risk may not occur in the future—that is, the risk is not related or relevant to them personally (Patterson *et al.* 1992). Also, 'at risk' individuals apparently give greater weight to uneventful experiences with alcohol interpreted to indicate that it carries low risk (Cvetkovich and Earle 1994, 1995). Indeed, the possibility that there are different reasons and motivations for high-risk behaviour makes it difficult to target messages to these individuals. Heavy alcohol consumers also perceive the risk of alcohol-related harm as low and less believable (Andrews et al. 1991, Andrews 1995) than do light alcohol consumers.

Personal susceptibility or relevance is also affected by a range of social and psychological factors, which act to establish the context of the judgement regarding credibility and hence the eventual effectiveness of the warning label (Cvetkovich and Earle 1995). Indeed, for a health warning label to be effective, it should involve the individual consumer, such that the individual will read the warning and process the information contained in the warning. It should also be relevant to the individual, as well as believable and credible.

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Interestingly, a study of alcohol consumption in 34,001 students in Cyprus, France, Hungary, Iceland, Ireland, Lithuania, Malta, the Slovak Republic, Slovenia, Sweden and the United Kingdom participating in the 1999 European School Survey Project on Alcohol and Other Drugs Study (Bjarnason et al. 2003) suggests that adolescent or underage drinking is more common in all types of non-intact families; this was observed in all 11 countries. The adverse effect of living in non-intact families is greater in societies where alcohol availability is greater and where adolescents drink more heavily. A combination of school-based approaches, involving curricula targeted at preventing alcohol, tobacco, or marijuana use and extracurricular approaches, offering activities outside of school in the form of social or life skills training or alternative activities, may be effective in reducing underage drinking (Komro and Toomey 2002).

Overall, however, the usefulness of international data in Australia is limited as the observations are not consistent. For example, a study by Engels and Knibbe (2000) suggests that the drinking patterns of young people in Mediterranean countries can be characterized as ‘innovative’ while those of young people in Northern countries as ‘rebellious’. The main health risk associated with the innovative pattern is the volume of consumption and associated chronic consequences, where the main health risk associated with the rebellious drinking is intoxication and the associated risks concerning violence, traffic accidents and acute health consequences.

The School Health and Alcohol Harm Reduction Project (SHAHRP) aimed to reduce alcohol-related harm by enhancing students' abilities to identify and deal with high-risk drinking situations and issues. The SHAHRP study involved a quasi-experimental research design, incorporating intervention and control groups and measuring change over a 32-month period. The study occurred in metropolitan, government secondary schools (13 to 17-year-olds) in Perth, Western Australia. The 14 intervention and control schools involved in the SHAHRP study represent approximately 23% of government secondary schools in the Perth metropolitan area. The sample was selected using cluster sampling, with stratification by socio-economic area, and involved over 2,300 intervention and control students from junior secondary schools. The retention rate of the study was 75.9% over 32 months. The intervention incorporated evidence-based approaches to enhance potential for behaviour change in the target population. The intervention was a classroom-based program, with an explicit harm minimization goal, and was conducted in two phases over a 2-year period. The results were analysed by baseline context of alcohol use to assess the impact of the program on students with varying experience with alcohol. Knowledge and attitudes were modified simultaneously after the first phase of the intervention in all baseline context of use groups. The program had little behavioural impact on baseline supervised drinkers; however, baseline non-drinkers and unsupervised drinkers were less likely to consume alcohol in a risky manner, compared to their corresponding control groups. In line with program goals, early unsupervised drinkers from the intervention group were also significantly less likely to experience harm associated with their own use of alcohol compared to the corresponding control group. Unsupervised drinkers experienced 18.4% less alcohol-related harm after participating in both phases of the program and this difference was maintained (19.4% difference) 17 months after the completion of the program. This study indicates that a school drug education program needs to be offered in several phases, that program components may need to be included to cater for the differing baseline context of use groups, and that early unsupervised drinkers experience less alcohol-related harm after participating in a harm reduction program

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(McBride et al. 2003).

In summary, to change the behaviour of an individual is complex, and price and labelling are simplistic interventions. Interventions to reduce risky alcohol drinking must make an individual:

- feel personally susceptible to a health (or other) risk;
- believe that the risk can cause a significant harm; and
- know what actions can be taken to avoid the harm, and also know the cost or benefit of the actions; if the costs outweigh the benefits, the action to avoid the harm is unlikely to be taken.

Yours sincerely,

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Centre for Social and Health Outcomes Research and Evaluation
(SHORE)

Submission to the
World Health Organization's

Public hearing on ways of reducing harmful use of alcohol

The SHORE Centre was designated a WHO Collaborating Centre for Research and Training in Alcohol and Drug Abuse in 2004. SHORE is a multi disciplinary research group with a strong strategic focus. Its research teams have considerable expertise in alcohol research, alcohol policy and alcohol workforce development, as well as other health related areas. The Centre is part of the Research School of Public Health, Massey University, Auckland, New Zealand. SHORE works in partnership with Te Ropu Whariki, a Maori research group.

Question 1: What are your views on effective strategies to reduce alcohol-related harm?

A large body of research is now available that provides evidence on the most effective and cost effective policies for reducing alcohol-related harm (Babor et al. 2003; Room et al. 2002; World Health Organization 2002). As a research group with considerable experience in the alcohol field, the SHORE Centre strongly supports the recommendations of WHO's Expert Committee on Problems Related to Alcohol Consumption. The Committee recommended that WHO:

"…support and assist governments, upon request:

- to regulate the availability of alcohol, including minimum ages for purchasing alcohol, hours of sale and density of outlets;
- to implement appropriate drink-driving policies based on low legal limits of blood alcohol concentrations that are strongly enforced;
- to reduce the demand for alcohol through taxation and pricing mechanisms;
- to raise awareness and support for effective policies"

The committee noted that commonly used classroom based alcohol education programmes, used in isolation rather than to support an integrated package of control policies, showed little evidence of effectiveness.

The SHORE Centre also supports the Expert Committee's recommendations in regard to alcohol marketing, which the committee defines widely, focusing on policies to limit the amount of alcohol promotion to which young people are exposed. A large body of research shows that alcohol advertising and other marketing influences children and young people's beliefs and

attitudes to alcohol, and their patterns of drinking (Hill and Casswell 2004). Starting to drink regularly at a young age has been linked to problem drinking at a later age (Hingson et al. 2006; Pitkänen et al. 2005), and young people experience greater harm from their drinking than older people consuming the same amounts (Wyllie et al. 1996). Highly sophisticated marketing methods developed in Europe and the USA are now being used to promote global and local brands and a drinking lifestyle in developing countries (Hill and Casswell 2006a).

The Expert Committee recommended that WHO support and assist governments:

- to effectively regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and of sponsorship of cultural and sports events, in particular those that have an impact on younger people;
- to designate statutory agencies to be responsible for monitoring and enforcement of marketing regulations;
- to work together to explore establishing a mechanism to regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and sponsorship, at the global level.

In addition, the SHORE Centre recommends that the global alcohol policy strategy address the public health implications of increased trade in alcohol. The SHORE Centre's work in the Western Pacific Region has pointed to the importance of communication and knowledge sharing between different sectors and government agencies with different areas of responsibility. This is particularly the case in regard to the growing number of trade agreements which can impact on alcohol consumption and effective national alcohol policies. The public health implications of trade liberalisation in alcohol are often not fully considered by trade policy makers and negotiators, and current exceptions processes have proved inadequate in addressing public health concerns (Grieshaber-Otto et al. 2006; Hill and Casswell 2006b). The inclusion of trade issues in the global alcohol policy strategy, as in the WPRO Regional Strategy, can help ensure that member governments' public health goals are paramount, not overridden by trade principles as at present.

Question 2: From a global perspective, what are the best ways to reduce problems related to harmful use of alcohol?

The SHORE Centre believes the time is right for WHO to take a much stronger leadership role. Alcohol is now a global marketing-driven industry (Room et al. 2002). In emerging markets, industry organisations such as the International Center for Alcohol Policy are offering information and policy advice that best suits their interests. A global response is needed, independent of commercial interests and led authoritatively by the World Health Organization and working collaboratively with NGOs.

Alcohol policies are set by member governments and different national situations will require some variations in how policies are implemented. Nevertheless, a global alcohol policy strategy, setting out the most effective strategies and supported with detailed information for implementation, monitoring and enforcement, will assist governments to make rapid and effective progress on this issue. At the regional level, WHO-WPRO's Regional Strategy to Reduce Alcohol Related Harm and SEARO's Alcohol Policy Options are already playing their part.

On the issue of public health implications of liberalised trade in alcohol, mentioned above, we support the Expert Committee's recommendation that WHO should work more closely with

WTO and other relevant UN agencies to raise this issue as part of its work towards a global alcohol policy strategy.

To fulfill this global leadership role, we recommend the creation of a WHO Cabinet Office focused on alcohol. Working with the network of WHO Collaborating Centres, including the SHORE Centre, this Office can develop new materials and an internet communications strategy to support policy development and implementation in line with the new global alcohol strategy.

More than a global alcohol policy strategy will be needed, however. The SHORE Centre believes strongly that achieving full political commitment by all member governments will require the same status as WHO policy on tobacco. The evidence supports the development of a Framework Convention on Alcohol Control.

Question 3: In what ways can you or your organization contribute to reduce harmful use of alcohol?

The SHORE Centre has been a WHO Collaborating Centre since 2004. Its Director Professor Sally Casswell is a member of the WHO Expert Committee on Problems Related to Alcohol Consumption. In 2005 and 2006 SHORE contributed to background papers and a Resource Book for the WHO WPRO Regional Strategy to Reduce Alcohol-related Harm in the Western Pacific Region.

The SHORE Centre's current programme includes technical contributions to the work of the WHO Secretariat at both the global and regional level related to the reduction of alcohol related harm. Assistance can be provided in relation to the needs and methods of data collection, strengthening capacity and effective alcohol policy in the context of the development of the global alcohol strategy.

In its work within New Zealand, the SHORE Centre and its research teams have contributed research and policy advice to New Zealand policy-makers, government agencies, local government and community projects on a wide range of alcohol policy issues. Our researchers contribute to alcohol research and policy publications in New Zealand and internationally.

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Strategies to Reduce the Harmful use of Alcohol

Thank you for the opportunity to provide input to the World Health Organization (WHO) public hearing on strategies to reduce the harmful use of alcohol.

The Centre for Addiction and Mental Health (CAMH), in addition to being a hospital, is an organization with a provincial mandate to conduct research, engage in public education health promotion, and participate in the development of healthy public policy in the area of addictions and mental health. CAMH has access to the most current evidence on: alcohol availability and its effects on consumption, drinking and driving, reducing aggression and injury in bars, harm reduction, alcohol management policies for municipalities, and the effects of measures designed to reduce health and social problems.

CAMH supports and endorses the National Alcohol Strategy (NAS) – a collaboration of different sectors of the alcohol stakeholder community that provides direction and recommendations about reducing alcohol-related harm in Canada. The NAS endorses four strategic areas of action. These include health promotion, prevention and education; health impacts and treatment; availability of alcohol; and safer communities. CAMH is currently working in all four strategic areas, whether through providing support to other organizations or taking an organizational lead where research and policy development is required.

1. What are your views on effective strategies to reduce alcohol-related harm?

Drinking Driving Policies and Countermeasures

CAMH believes that the reduction of deaths and injuries from drunk driving is a public health priority. Currently, in Canada it is a criminal offence to drive with a Blood Alcohol Content (BAC) over 80 mg%. In Ontario, alone this BAC level has been associated with an on-going reduction of 18% in drinking and driving fatalities. Evidence shows that driving skills are significantly impaired at levels of 50 mg% and below, and that collision risks are significantly elevated at BAC levels of 50 mg% [i] CAMH supports lowering the legal BAC limit from 80 mg% to 50 mg% in an effort to educate the public about the hazards of driving or operating motorized vehicles of any kind after excessive alcohol consumption.

CAMH also recommends random breath testing (RBT). RBT allows police to request a breath sample without probable cause. RBT operates as a general deterrent, as it increases the average driver's perception of being processed by the police if he/she drives while impaired. Evaluations and reviews, including a World Health Organization study, of RBT have supported its effectiveness in reducing alcohol related collisions and fatalities.

Addressing the Availability, Pricing and Marketing of Alcohol

Alcohol monopolies with a strong regulatory agenda play a key role in preventing alcohol related harm. Evidence demonstrates that a privatized system with little government regulation and open competition among private retailers typically leads to an increased number of outlets, longer opening hours, and increased consumption[ii]. And, higher consumption rates are strongly related to an increase in drinking related problems. CAMH recommends implementing alcohol monopolies with policies on alcohol that control sales, promote public health, curtail risk and reduce drinking related harm. Density restrictions that outline the maximum number of licensed outlets and number of occupants per region is an excellent example of a policy proven to control alcohol sales. CAMH urges the inclusion of public health objectives in government mandates and policies on alcohol.

Pricing is an important determinant of alcohol consumption. CAMH recommends adopting a minimum retail social reference price for alcohol and indexed to the Consumer Price Index. A

move towards alcohol volumetric pricing based on the volume of ethyl alcohol in alcohol products is also recommended. Volumetric pricing should be priced within each beverage class.

The marketing of alcoholic beverages, especially to young people, is of concern to CAMH. In order to reduce drinking related harm, it is essential that promotional, marketing and alcohol management strategies be assessed from a public health perspective and controls on volume, placement and content of alcohol advertising be implemented. CAMH, however, strongly encourages a social marketing campaign that focuses on a culture of moderation, such as the National Drinking Guidelines[iii] supported by the Centre for Addiction and Mental Health and partner organizations, as a health promotion and prevention tool.

Harm Reduction and Health Promotion

CAMH strongly endorses harm reduction interventions and health promotion strategies to reduce the harms of alcohol. A range of interventions to reduce alcohol related harm in and around licensed premises has been developed and evaluated. Requiring bars to develop prevention polices to reduce alcohol related problems due to over-service/over-consumption is strongly recommended. These policies should be based on evaluated safety measures. CAMH's 'Safer Bars Program'[iv] has been fully evaluated and has demonstrated effectiveness in reducing alcohol related violence in licensed establishments. Other interventions include implementing penalties for illegal services, (such as overcrowding, serving to people who are underage or intoxicated), and implementing server training programs as a pre-condition for receiving and/or renewing licenses for serving alcohol.

Excessive alcohol use leads to long-term health consequences. The harms to physical health is well documented and includes cirrhosis of the liver, cancer, a range of diseases affecting the heart, including stroke and hypertension, fetal harm and mental health problems. Despite the growing body of evidence concerning the role of alcohol in chronic disease it has received little attention from government bodies and non-government organizations. CAMH strongly encourages alcohol to be consistently included in policies and programs focused on chronic disease. In addition, collaboration with other national organizations in the area of chronic disease to improve the prevention of alcohol related chronic disease is strongly recommended.

Increasing public knowledge about alcohol and chronic illness should be a health priority. A public awareness campaign, which promotes consistent and clear messaging on alcohol related health and safety issues, emphasizing the strong link to chronic disease is recommended. A start would be to promote the National Drinking Guidelines through a social marketing campaign encouraging a culture of moderation. Although CAMH supports a culture of moderation, we also recognize that abstinence is a legitimate option, especially for underage youth, alcoholics, and those who abstain from alcohol for health or religious reasons.

Research shows that providing information through media campaigns and educational programs, as stand-alone interventions, will not reduce harm from alcohol, and should not be considered in isolation. CAMH is in favour of a greater emphasis on alcohol policy and regulatory measures with education/information as a supplement.

Health Sector Response

A health sector response is critical in reducing alcohol related harms. CAMH supports the development of integrated and culturally sensitive screening, brief intervention and referral tools and strategies for persons experiencing issues with alcohol. Making use of other health professionals, such as nurses and social workers to screen for problems with alcohol and begin brief intervention programs is recommended. Screening, brief intervention and referral tools, however, must be culturally and linguistically sensitive. A focus on marginalized and high-risk populations, such as Aboriginals, concurrent disorders, etc. is recommended.

2. **From a global perspective, what are the best ways to reduce problems related to harmful use of alcohol?**

a) Pressure governments to implement drinking and driving polices to reduce alcohol related fatalities.

Two proven effective strategies include lowering the legal BAC content and implementing random breath testing. However, research shows that laws can be unsuccessful in achieving reductions in collisions and fatalities if they are not enforced or if resources are not available to support their implementation and enforcement.[v]

b) Encourage governments to implement alcohol monopolies and reject the privatization of alcohol sales.

A review of both international and Canadian evidence indicates that retail alcohol monopolies with strong public health agendas combined with regulations governing alcohol have the potential to contribute significantly to the prevention of alcohol related problems. [vi]

CAMH suggests:

i) Governments should consider density restrictions on the availability of alcohol.
ii) Develop incentives to encourage healthier consumer choices whether through tax or price adjustments on reduced-alcohol beer, wines and spirits.

c) Promote governments to consistently include alcohol in policies and programs focused on chronic disease.

CAMH suggests:

i) Collaborate with other national organizations in the area of chronic disease to improve the prevention of alcohol related chronic disease.

d) *Develop a framework convention on alcohol control.*

Develop a framework convention on alcohol control similar to the 2005 framework on tobacco control. A framework convention would place restraint on international trade in alcohol, encourage a call to action by all governments and society, and aid legislators and government to develop effective policies on alcohol control.

3. **In what ways can you or your organization contribute to reduce harmful use of alcohol?**

CAMH is positioned to reduce the harmful use of alcohol in several ways:

1. Develop integrated and culturally sensitive screening, brief intervention and referral tools and strategies.

CAMH is exploring the opportunity to partner with other organizations in developing integrated and culturally sensitive screening, brief intervention and referral tools. CAMH has a long history in researching and disseminating screening, brief interventions and referral tools and partnering with other organizations on a variety of projects.

2. Ensure that alcohol is consistently included in policies and programs to chronic disease.

CAMH has a strong proven track record in conducting research, providing advice and working with others to advocate that greater attention be drawn to alcohol-related chronic disease. CAMH will develop:

-A synthesis [secondary analysis] report in partnership with experts in other centres, drawing from recent studies and data focusing on Canada that highlights the dimensions of alcohol-related chronic disease and links with drinking patterns and overall consumption.

-A summary document outlining the types of population-level policies considered to be most effective in controlling alcohol-related chronic disease.

CAMH will:

-Collaborate with the Chronic Disease Prevention Alliance of Canada and others to improve the prevention of alcohol related chronic disease including implementation of a public awareness campaign.

3. Maintain current systems of control over alcohol sales (Provincial/Territorial government).

CAMH will partner with non-government organizations and government to:

a) Require liquor control boards to maintain a social responsibility frame of reference for all matters pertaining to their operations and governance, and to maintain or increase their spending an programming in this area;

b) Enhance staff training at outlets and implement ongoing enforcement compliance programs to ensure that alcohol is consistently sold in a socially responsible way and in accordance with the law; and,

CAMH will:

- Work to monitor the social responsibility mandate, programming and spending of provincial/territorial jurisdictions across Canada.

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