

alcohol

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ALERT



**At a time of crisis
for the NHS,
alcohol-related
disease 'to rise
markedly'**

Contents

2. Licensing Act 'shambles' slated by MPs
3. Government still rejects lower drink drive limit
4. Supermarket promotions and discounts on alcohol increase sales by 25%
5. Violence rates higher where alcohol cheaper, say Cardiff researchers
6. Campaign on consensual sex
8. Alcohol and liver disease
9. Alcohol makes cancer tumours 'grow faster'
10. Drunkenness, intoxication and criminal liability
13. Diageo launches two 'responsible drinking' TV advertisements
14. How Alcoholics Anonymous is changing
16. Alcohol related disease to 'rise markedly'
18. Self-medication with alcohol
19. Website to tackle student drinking
20. Interventions to tackle harmful alcohol consumption
22. International study questions health benefits of moderate drinking

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Licensing Act 'shambles' slated by MPs

The House of Commons committee which reviews the work of the Office of the Deputy Prime Minister has strongly criticised the Government's introduction of the new Licensing Act. The cross party committee looked at the process of re-licensing which local authorities, the new licensing authorities, had to carry out over a six month period, and identified a catalogue of errors and failings on the part of the Department of Culture (DCMS), the government department responsible. The committee says that these errors caused 'unnecessary stress on all parties involved'.

A particular cause of criticism was that, although the Licensing Act was passed in 2003, the Statutory Guidance issued by the Secretary of State Tessa Jowell, designed to tell the licensing authorities how they should interpret and apply the new Act, was not produced by DCMS until two years later. The committee also complain that when the Guidance

finally appeared it was in places vague and inconsistent, and not altogether compatible with the Act itself.

The committee's chairman, Dr Phyllis Starkey MP, said: "*The last details were only produced three weeks before the process (of re-licensing) had to begin and local authorities of course were then in difficulty in setting up their councillors' licensing panels, in training the councillors and in training their staff to deal with it.*"

"*There was a six month period when pubs and clubs could apply for a licence, once they'd applied the licences had to be determined within two months by local authorities,*" she explained.

"*Another criticism we've made is that there should have been a financial incentive to encourage pubs and clubs to apply early so that the burden of work of the licensing panels would have been more spread out.*"

"*And the consequence of all those things was that councils often had to determine applications within the two months period without being able to give them sufficiently detailed examination and either refused licences when they might not have done or approved them without being able to look at*



Tessa Jowell

shambles'

them carefully enough.

"Also the whole thing put enormous strain on local authorities and local authority members, particularly those local authorities like Westminster which have a very large number of pubs and clubs within their area."



Dr Phyllis Starkey

Conservative Shadow Secretary of State for Culture, Media and Sport, Hugo Swire, said: "Clearly the Government's handling of the new licensing laws has been a shambles, and it is local authorities, village halls and community centres who are left to deal with the mess and the bill. Ultimately, council taxpayers will be left paying for the Government's mistakes.

"At times, the Department has seemed gripped by inertia and has refused to see the scale of the chaos before them. Most worrying is the admission that some licence applications were granted without being examined, even though the Government promised that residents would have a greater say in opposing rowdy pubs."

Confirming its status as the Act that failed to satisfy anyone, Nick Bish of The Association of Licensed Multiple Retailers, one of the main alcohol industry groups, agreed that errors made by the DCMS 'severely let down' licensees.

Mr. Bish said: "We whole-heartedly support and endorse the Committee's analysis of the problems faced by all sides in managing the introduction of the new Licensing Act. This was a complex piece of legislation and the Government let us all down by failing to provide clear, timely advice. We warned DCMS at the time that problems would emerge, but I'm afraid our advice was ignored."

A DCMS spokesman said: "Of course, as with any major transition process, there are lessons to be learned and we will consider the committee's report carefully.

"It is important to remember that the Licensing Act was the biggest overhaul of licensing laws in a generation. It is now delivering a better deal for the public, industry and enforcement authorities." ■

Government still rejects lower drink drive limit

The Government is still strongly opposed to lowering the legal alcohol limit for drivers, as it was 'minded' to do when elected to office, but this may not be the case forever.

Appearing before the House of Commons Transport Committee in March, Transport Minister Stephen Ladyman appeared to hold out the prospect that the Government might lower the limit at some point in the future but only when it had made much more progress in tackling drinking and driving above the present legal limit. Dr. Ladyman said:

"Clearly, if everybody obeyed the law and we reduced the blood alcohol level to 50 micrograms, yes, we would save more lives but we think about 500 deaths a year are attributable to people over the 80 micrograms limit and I think the figure is about 50 to 70 lives a year would be saved by reducing it, involving people between 50 and 80. It seems to me obvious that the target for our enforcement, our priority, has to be catching all of the people who are over the 80 micrograms limit and saving the 500 lives before we start diverting police resources to try to catch the 70 or so that are between the 50 and 80 limit. I do not rule out the possibility, once we have strict enforcement at 80, once we have the situation under good control with 80, of the government of the day wishing to move down to 50. Let us focus where the big gain is to be made first."

Asked whether reducing the legal limit would not help to reduce the number of drink drivers, Dr Ladyman denied that there was 'the slightest bit of evidence' to support that suggestion.

These comments are likely to cause dismay in the road safety community, not least because they clearly suggest that the Government is still flatly refusing even to acknowledge the existence of a substantial body of evidence from around the world showing that lowering the legal limit prevents drink driving and saves lives. In fact, and contrary to Dr Ladyman's assertion, the evidence of the benefits of lowering drink drive limits is strong enough for a recent authoritative review to have rated lowered limits as one of the most effective drink drive policies available, far more effective than the designated driver programmes that the alcohol industry and the Government encourage.

Supermarket promotions and discounts on alcohol increase sales by 25%

An investigation conducted by Alcohol Focus Scotland has revealed that promotional offers on alcohol by the major retailers dramatically increase both sales and frequency of customer return.



Jack Law, Chief Executive of Alcohol Focus Scotland

Alcohol Focus Scotland approached a number of the major supermarket and off-sales chains to request information on customer spending patterns when alcohol products are sold at reduced prices or through special offers such as '3 for 2'.

Very few provided information, but of those who did, the findings show a clear link between off-sales promotions and how much alcohol people buy and therefore consume:

- Sales increase by 20-25% when promotions are run
- Customers who buy on promotions tend to be heavier spenders than average
- 83% of customers who purchase alcohol on promotion will return for a second purchase
- Largest uptake is among those doing their weekly shop between Friday pm and Saturday am
- Wine is the most popular promoted alcohol product

Jack Law, Chief Executive of Alcohol Focus Scotland said:

"We are not a nation which is known for storing or 'laying down' drink. It is not unreasonable to assume from this exercise that alcohol promotions, as is the case in the on-trade, will contribute to excessive and dangerous drinking at home.

For too long the major retailers have been putting profits before their social responsibilities by selling alcohol at ridiculously low prices and encouraging customers to purchase more than they intended via clever promotions. Alcohol is a very different product from any other - a special offer on bread or milk is not going to cause harm to individuals and communities the way a special offer on alcohol can. These irresponsible practices must be curbed when Scotland's new licensing legislation comes into force, otherwise the health and social problems relating to excessive drinking will continue to escalate."

AFS has begun discussions with some retailers who appear to be

beginning to recognise this problem, but the blank denial of many is disappointing. AFS is asking for the sector to acknowledge that it too contributes to Scotland's drinking problems and to work alongside us to establish what they can contribute to resolving them."

Dr Peter Rice, Consultant Psychiatrist with Tayside Alcohol Problems Service said: *"In my work helping people overcome alcohol problems, the issue of people avoiding high risk situations is a crucial one. In general, our clients don't expect the world to change to suit them, but one issue which is frequently raised is that of display policies in supermarkets. People plan carefully to avoid the 'drink aisle' but the display of alcohol outside these areas can catch people unawares and create problems. Alcohol is not an ordinary commodity; it is a drug which causes considerable and increasing harm to our communities. It has to be treated with respect and with appropriate safeguards, and the needs of those tackling alcohol problems should be given due consideration."* ■

Violence rates higher where alcohol cheaper, say Cardiff researchers

Cardiff team uncovers the true price of a pint

Gordon Brown's recent tax hike of a penny on a pint of beer is good news for hospital casualty departments, according to Cardiff University researchers.

Their analysis of more than 350,000 assault-related accident and emergency cases found that violence rates were highest in those regions where alcohol was cheapest.

The study is the first to make a direct link between violence and the cost of alcohol. It suggests that a 1% increase in the price of beer could mean 2,200 fewer assault victims in casualty every month in England and Wales.

The research was carried out Professor Kent Matthews of Cardiff Business School and Professor Jonathan Shepherd and Dr Vaseekaran Sivarajasingham, both in the Violence Research Group at the University's School of Dentistry. Professor Shepherd is a long-standing campaigner



for non-glass bottles and glasses to be used in pubs and clubs.

The team analysed assault figures over five years from 58 major accident and emergency departments, linking them to regional beer price data from the Campaign for Real Ale (CAMRA).

They found violence was more closely linked to alcohol prices than a range of other

factors, including house prices, youth unemployment and ethnic population density.

The study, published in the *International Journal of the Care of the Injured*, also found assaults were common in the summer months and during major sporting events. Men were three times more likely to be attacked than women.

Dr Sivarajasingham said: "The study shows that violence-related harm in England and Wales relates closely to alcohol prices.

"In practical terms raising alcohol prices, for example through taxation, may have a beneficial effect in reducing violence-related harm throughout England and Wales." ■

Campaign on con

The Government has launched a campaign warning men to ensure that a woman has consented to sex in order to avoid being accused of rape.

The £0.5 million campaign, consisting of magazine and radio adverts and posters, is designed

primarily to reduce the number of sexual assaults taking place when a woman is drunk. The

adverts will feature in 'lads magazines', on radio stations and in pub washrooms. Aside from its obvious coarseness and vulgarity, the campaign also raises questions about how far, if at all, individuals can be held responsible for their actions while intoxicated.

It is well known that alcohol is implicated in a high proportion of cases of sexual violence, and a recent study by the Metropolitan Police found that more than a third of women who reported being raped had consumed alcohol immediately before the alleged attack.

However, the Government is concerned that many cases of alleged sexual assault fail to reach the courts because the victim cannot remember all the details due to having been drunk, or judges have stopped trials on the grounds of the unreliability of the accuser's evidence because of her being intoxicated at the relevant time.

The Government has also issued a consultation paper – 'Convicting Rapists and Protecting Victims – Justice for Victims of Rape' – which seeks views on the problem of capacity or incapacity to give consent to sex due to alcohol intoxication and on means of overcoming the problem.

Launching the advertising campaign, Home Office Minister Fiona Mactaggart said: "For a long time, work to raise awareness of sexual violence has focused on the need for women to take responsibility for their personal safety. That is still important, but I



HAVE SEX WITH SOMEONE WHO HASN'T SAID YES TO IT, AND THE NEXT PLACE YOU ENTER COULD BE PRISON.

/// If you have sex without consent you could end up going to prison, for rape. If you don't get a yes don't have sex.

Home Office
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nsensual sex

believe that we need to start putting the onus onto men and make them aware of their responsibilities.

“I want young men to see these adverts and realise that they should not be having sex unless they have secured the consent of the other person. Our campaign is not saying ‘don’t have sex’; it is about ensuring that sex is mutually agreed. Victims of crime often feel they are to blame for the offence, they are not - perpetrators are. But I want to make sure that men, who are most often the perpetrators of this appalling crime, are fully aware of their responsibility to seek consent before having sex. I hope that greater awareness of the law and a clearer sense of everybody’s responsibilities will lead to a reduction in the number of rapes committed.”

The Sexual Offences Act 2003 set down for the first time that a defendant in a rape case would need to show that he had reasonable grounds to believe that the other person had given her consent. The Act also introduced a definition of consent – that a person consents if s/he ‘agrees by choice, and has the freedom and capacity to make that choice.’

Ministers insist that in sexual matters, at least, giving consent is an active not a passive process, and that the onus is on the man to take positive steps to ensure that the woman in question is actively consenting to sexual activity.

The problem arises, however, when modern sexual mores permitting or encouraging casual sexual relationships coexist with the

binge drinking culture. Does drunken consent count as consent? Clearly, if a woman is so drunk as to be unconscious, the question of her consenting to sex does not arise. However, speaking on BBC TV’s Breakfast programme, Ms Mactaggart said it was important *“that men were aware of the risk in having sex with a woman who was too drunk to really know what she was saying.”* This clearly implies that even if the man does actively seek consent and obtains it, he could still be accused of rape if, subsequently, the woman’s consent is ruled not to count as a result of being given while under the influence of alcohol.

Ms Mactaggart’s comment appears, on the face of it, to conflict with the Home Secretary’s commitment in a 2002 White Paper ‘Protecting the Public’ that drunkenness would not be deemed to invalidate consent: *“I have rejected the suggestion that someone who is inebriated could claim they were unable to give consent – as opposed to someone who is unconscious for whatever reason, including because of alcohol – on the ground that we do not want mischievous accusations.”*

However, the Solicitor General, Mike O’Brien, suggested that the law may need ‘clarification’ to allow a jury to decide whether the woman was too drunk to be capable of consenting. If drunken consent is ruled invalid, it seems to follow that whenever sexual intercourse takes place with a drunk woman, then the man is a

rapist by definition.

Given contemporary acceptance of both drinking to intoxication and free and easy sexual mores, it also seems to follow that high proportions, if not most, young people have either been raped or are rapists. A survey commissioned for Channel 4 TV found that 20% of males and 13% of females aged 15–19 cited alcohol as the main reason for first intercourse, and the younger the woman the more likely it was that alcohol was involved. The incidence of drunken sex is likely to be substantially higher in some older age groups.

Mr. O’Brien did not comment on cases in which the man is also drunk, and on any need to clarify whether, if drunkenness in a woman is held to render her incapable of giving consent, drunkenness in a man should be regarded as rendering him incapable of seeking it.

A Psychiatrist’s Perspective – Dr Jonathan Chick

There is another law which depends on an assessment by an individual of whether another person is ‘drunk’, namely the law that alcohol should not be served to an intoxicated person. There have never been more than a handful of prosecutions in recent times under this law, and one reason has been the difficulty in establishing the definition of intoxication. Most people coming up to the bar for a third or later drink would have some degrees of psychomotor



deficit, except the markedly dependent ('alcoholic') drinker who might not manifest that till the 6th or 7th drink.

The drink-driving legislation did away with the difficulty of definition, by specifying a maximum blood, and then a breath, alcohol concentration, above which a driver is, by definition, too 'drunk' to drive. For the government's plans on protecting women from rape to be effective, perhaps it will specify a breath alcohol level above which consent cannot be deemed to be given and males advised to have a breathalyser to hand and to request an apparently consenting woman to provide a specimen.

Another approach would be to increase the price and

diminish the availability of alcohol, which research shows, would reduce the amount consumed per drinking session, and so reduce the number of women putting themselves at risk. While there may still be difficulties implementing the law in such cases, it is good to draw wise attention to this important matter, and we can hope that there will be men who will take note. ■

Dr. Chick is a Consultant Psychiatrist at the University of Edinburgh

Alcohol and liver disease

Doctors at the University of Southampton have found that most patients with severe alcohol-induced liver disease do not have a dependence on alcohol, as generally previously believed. These findings are at odds with current strategies to combat the increase in alcohol related deaths which are targeted at those with alcohol dependency.

In a study of thirty four patients with severe ALD (Alcohol-Induced Liver Disease), the team found that only 9 per cent showed evidence of severe alcohol dependence. They were more likely to be employed, married or in a stable relationship, and to drink with family, friends or work colleagues – a pattern which often escalated into heavy drinking.

This compared with the control group of thirty four patients known to have alcohol dependence, who were more likely to drink alone, to be unemployed and unattached. The trigger for heavy drinking was likely to be a traumatic event and/or depression.

“The majority of patients

presenting with alcoholic liver disease appear to be heavy controlled or social drinkers, leading relatively controlled lives, perhaps not feeling that their drinking is a major health issue until they are diagnosed with end-stage liver disease, at which point the liver has been damaged to the extent that only 30 per cent will be long term survivors. Alternatively, if drinking spirals out of control as a result of dependence, subjects are more likely to seek treatment at an earlier stage, and therefore survive for longer." said Dr Nick Sheron, consultant hepatologist and senior lecturer at the University of Southampton.

"The high mortality from severe ALD at first presentation means that there are limited options for reducing deaths. The current government focus on binge drinking and on alcohol dependency will miss many patients who will later die from ALD. The documented rise in liver deaths so far is very worrying but does not include the impact of more recent changes in drinking patterns, particularly in women. Unless something is done fairly urgently, we predict a continued rise in deaths from ALD over the next 10 years, most particularly in young and middle aged women," concludes Dr Sheron.

Professor Ian Gilmore, Chairman of the Royal College of Physicians' Alcohol Committee said: "The Royal College of Physicians welcomes this important piece of research which dispels the myth that all patients with alcoholic liver disease are alcoholics or dependent drinkers. Because alcoholic cirrhosis is such a silent killer, the first signs may come when it is already too late. This emphasises the importance of early detection of problem drinkers in the NHS and the availability of advice and support to help people cut down on their drinking." ■

Alcohol makes cancer tumours 'grow faster'

Having just two alcoholic drinks a day can cause cancer tumours to grow more rapidly and make them bigger, a new US study has claimed.

University of Mississippi research shows that alcohol seems to increase the body's production of vascular endothelial growth factor (VEGF) which can aid the growth of tumours by helping them develop a system of blood vessels which they would otherwise die without.

The researchers, led by the study's author Professor Wei Tan, looked at the effect of alcohol on tumours in mice.

Instead of giving the mice large amounts of alcohol, they gave them only the equivalent of two to four glasses a day.

Six mice were given drinking water with one per cent alcohol for eight hours each night during the month-long experiment. In the second week the mice were injected with mouse melanoma.

Professor Tan found that the mice who had the alcohol, compared to the group who were given plain drinking water were almost twice as heavy, showed a dramatic increase in blood capillaries and had more VEGF in their system.

Co-researcher Professor Jian-Wei Gu said the study showed that people with cancer should not drink at all. He also said that usually the body's immune system can fight off small

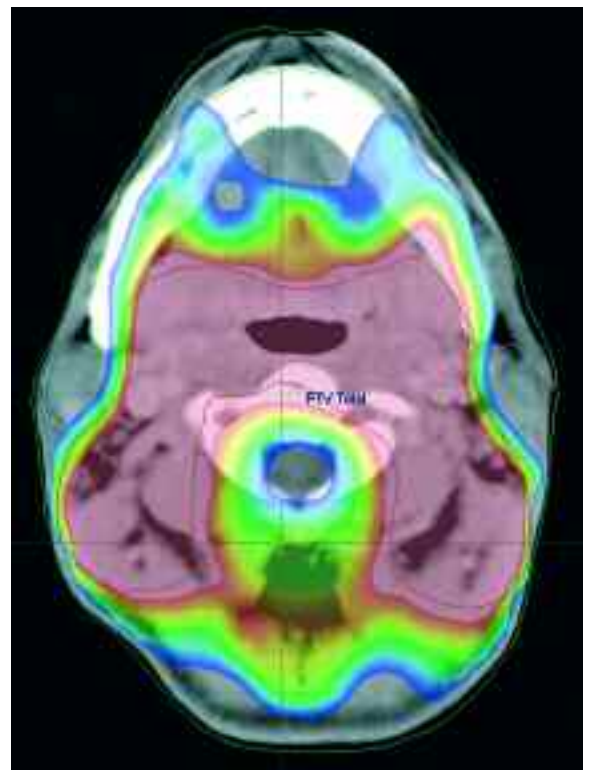
tumours, but that alcohol could make them grow so big that the immune system could not cope.

Professor Tan concluded: "It's very important to have a model of how to prevent cancer, and this study provides that model."

Epidemiologists have recognised alcohol as a risk factor for cancer for 100 years, but this study examines how that happens."

The findings were presented at the Experimental Biology Conference 2006 in San Francisco at the beginning of April. ■

Image of brain tumour



Drunkenness, int criminal liability

By Gavin Dingwall*
Reader in Law,
De Montfort University, Leicester

The statistics make grim reading. Research has consistently shown that a high proportion of offenders drink prior to offending (Dingwall, 2006, chapter 2). To take but one example, the 2000 British Crime Survey found that the offender was 'under the influence of drink' in 40% of violent incidents (Budd, 2003: 2). On a daily basis, therefore, criminal courts have to deal with individuals who had been drunk at the time that the incident took place. A suitable response has to be found.

This has not proved easy. Usually the criminal law does not just penalise harmful

conduct. In most cases, particularly with more serious offences, there is an additional requirement that the individual has to intend to commit that harm or is at least reckless that the harm would materialise. If an individual causes the prohibited harm but without the necessary mental state then he is entitled to an acquittal. Drunkenness in itself is not problematic. The law is quite clear that 'drunken intent is nevertheless an intent' and the jury are directed on this basis (Sheehan and Moore [1975] 2 All ER 960). The defendant will, therefore, not be entitled to an acquittal if he tries to argue that he would not have committed the offence if he had been sober if he still had the required mental state (Kingston [1994] 3 All ER 353).

The situation becomes more problematic where an individual is so intoxicated that he can form no intent whatsoever. Ordinarily, if someone does not form the required mental state, standard criminal law principle would suggest that he is entitled to an acquittal. However, many people would argue that intoxication should be treated as an exception because the individual is (almost invariably) responsible for his condition. This, though, does not get round the fact that he was incapable of satisfying a standard requirement of criminal liability. A number of different responses have emerged internationally. In Scotland, for example, intoxication is always irrelevant in determining criminal liability. Even in a murder case, the jury have to disregard the fact that the defendant was intoxicated at the time. Conversely, some jurisdictions (e.g. New Zealand) allow juries to consider evidence of intoxication in order to decide whether or not the defendant had the necessary mental state for all offences which specify a particular state of mind.

The position in England and Wales

In this jurisdiction the position is something of a half-way house. Evidence of intoxication can be considered for some offences but not for others (the



Intoxication and

case which is usually cited for authority for this is *DPP v Majewski* [1976] 2 All ER 142 although the roots of the doctrine go back far further: *Singh*, 1933). Offences are divided into two categories – those requiring a ‘specific’ intent and those requiring a ‘basic’ intent. If the offence requires a ‘specific’ intent, e.g. murder, then the jury may consider evidence relating to intoxication in order to decide whether or not the defendant possessed the required mental state. It should be emphasised that this does not mean that every defendant who is being tried for a ‘specific’ intent offence is going to be acquitted if he was drunk at the time of the offence. The evidence will be considered and only if he did not form the required mental state will he be acquitted (*Sheehan and Moore* [1975] 2 All ER 960).

If the offence is one of ‘basic’ intent, evidence of voluntary intoxication cannot be considered. However grave the charge, the evidence is deemed irrelevant. Given this structure, it is obvious that the definitions of ‘specific’ intent and ‘basic’ intent are of paramount importance. In *Majewski* [1976] 2 All ER 142, the judges considered this issue carefully but came up with different definitions. It is certainly true that some of the current categorisations are, therefore,

problematic in terms of criminal law theory (*Dingwall*, 2006: 107-109) but, in practical terms, there is no real confusion as the courts have determined on a case-by-case basis which offences fall into each category.

Can the English position be defended? It could be argued that the English model represents a pragmatic compromise. An individual who killed whilst in a very intoxicated state might be acquitted on a murder charge but would be convicted of manslaughter. It could be argued that this better reflects the culpability of a severely intoxicated individual who kills unintentionally. There is also the added benefit that manslaughter does not carry a mandatory life sentence; the judge has discretion, therefore, to arrive at an appropriate sentence.

This defence, though, is not without flaws. Not all ‘specific’ intent offences are underwritten with a corresponding ‘basic’ intent offence. An obvious example of this is theft. Secondly, the approach rests on a fiction. For certain offences, where a particular state of mind (e.g. recklessness) has to be proved, the prosecution do not have to prove it if the defendant was intoxicated. Some have argued that intoxication equates to recklessness and that this is not problematic. However, this uses the term recklessness in a

far wider sense than is usual in the criminal law. Ordinarily the recklessness has to be about a particular result occurring, here the recklessness would appear to be about getting intoxicated.

I have argued elsewhere (*Dingwall*, 2006: 118-125) that a better response would be to allow evidence of intoxication to go before a jury in all cases where a particular state of mind has to be proved by the prosecution (as say in New Zealand). The current distinction between offences of ‘specific’ intent and ‘basic’ intent in England and Wales rests on a fiction and has little to commend it. Under this alternative model, if the jury decide that the defendant did have the required state of mind then he should be convicted of that offence. However, I would propose creating a specific criminal offence of causing harm whilst intoxicated to deal with those who are acquitted of the primary offence. I am not the first to suggest such an option (the Law Society did in 1993 but backtracked in 1995). It also operates in some other jurisdictions (e.g. the offence of total intoxication in s.323a(1) of the German Criminal Code). The attraction of this approach is that the offence targets what is culpable in such a scenario – the defendant intentionally or recklessly getting intoxicated.



A note on rape

The Government have recently launched a campaign highlighting the possibility that men who have sex with intoxicated women will be guilty of rape. In light of this, the position with regards to rape deserves separate comment. For the purposes of s.1 of the Sexual Offences Act 2003 a person (A) commits rape if –

- (a) he intentionally penetrates the vagina, anus or mouth of another person (B) with his penis,
- (b) B does not consent to the penetration, and
- (c) A does not reasonably believe that B consents.

There are two issues regarding consent: firstly, whether B does in fact consent to the penetration and, secondly, whether or not A reasonably believes that B consents. The Act expands on both of these issues (Tempkin and Ashworth, 2004). With regards to whether there is consent present, there is a general definition of ‘consent’, which is a notoriously difficult philosophical concept (Dingwall, 2002; Schulhofer, 1998). Section 74 states that ‘a person consents if he agrees by choice, and has the freedom and capacity to make that choice’. There are further sections which provide scenarios where there will definitely be no consent (s.76) or where there will be an

‘evidential presumption’ that consent was lacking (s.75). In what circumstances will it be relevant that B had been drinking? With regards to s.74 the jury will have to determine whether or not B ‘agrees by choice’ and had ‘the freedom and capacity to make that choice’. This does not mean that every time B has been drinking she loses the freedom and capacity to decide whether to have sexual intercourse. It is suggested that the freedom and capacity to make such a choice is only lost when she is incapacitated by the alcohol.

This is a question of fact for the jury to make. There are also two ‘evidential presumptions’ which could be relevant. If the complainant was asleep or ‘otherwise unconscious at the time of the relevant act’ (s.75(2)(d)) or if ‘any person had administered to or caused to be taken by the complainant, without the complainant’s consent, a substance which...was capable of causing or enabling the complainant to be stupefied or overpowered at the time of the relevant act’ (s.75(2)(f)) then there will be no consent unless sufficient evidence is adduced to raise an issue that there was consent (Finch and Munro, 2004). It is suggested that in these situations it would be exceptionally difficult to raise an argument that B was consenting.

If B does not consent to the penetration, it has to be shown that A does not reasonably believe that B consents. Rape traditionally has been regarded as a crime of ‘basic’ intent (Fotheringham (1988) 88 Cr.App.R. 206) and it seems logical that the defendant’s intoxication cannot be taken

into consideration in determining whether his belief that B was consenting was reasonable. The campaign is to be welcomed in that it publicises how intoxicated men cannot rely on evidence of intoxication to show that they believed that the complainant was consenting. At the same time, it has to be recognised that drunkenness and incapacitation are not synonymous, and that only the incapacitated cannot consent to sexual intercourse. ■

I wish to thank my colleague Alisdair A. Gillespie for his comments on a draft of this article. All errors remain my responsibility.

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Diageo launches two 'responsible drinking' TV advertisements

Drinks company Diageo spearheaded the alcohol industry's campaign to be seen as responsible by launching a TV advertising campaign warning of the dangers of excessive drinking. The advertisements, titled 'Many Me' and 'Mirror', were shown in the London, Manchester and Nottingham regions.

They joined a range of other initiatives such as supposedly new codes of practice on cheap alcohol promotions, increased unit labelling on alcohol containers and the creation of the 'Drinkaware' web site taken as a response to the Government's National Alcohol Harm Reduction Strategy and its proposed social responsibility charter for alcohol producers and retailers.

The Diageo advertisements, which ran for a two-month period, were set in the different drinking environments of a night out in a bar and at a house party and illustrated how excessive drinking for both men and women could ruin a good evening.

Kate Blakeley, Head of Social Responsibility at Diageo GB commented: "As a leading alcohol producer we recognise we have a role to play in encouraging people to enjoy our drinks responsibly. We hope the campaign shows that no matter where you mix socially, alcohol should be enjoyed in moderation."

Andy Fennell, Diageo Europe Marketing and Innovation Director said: "This

campaign shows the negative impact that irresponsible drinking can have on you and the way others perceive you. It also shows the positive impact of being in control and at your social best. It is an empowering message, demonstrating that how you drink comes down to personal choice. We want people to enjoy alcohol in moderation and hope this campaign, alongside other initiatives from the drinks industry, Government and others, helps to make positive changes to our drinking culture."

The campaign was based on the notion that drinking too much impairs 'social currency', by spoiling the good time that the drinkers and their friends are having. Drinkers were told that pacing themselves and staying in control helped them to avoid this pitfall.

The 'Many Me' advertisement showed a man considering the route a typical night out at a bar could go. He saw himself enjoying the company of friends; however, he also saw himself having too much to drink and becoming unruly and messy. The barman's question to the man at the end, "So, what'll it be?",

had an obvious double meaning and emphasised the message that everyone has a choice about how much they drink. The end line was "Don't see a Great Night Wasted".

The 'Mirror' advertisement followed a woman at a house party. At the start of the evening, she was enjoying herself and chatting to friends. Later she became aware that, reflected in the mirror and other surfaces, she was seeing someone who looked like herself also at the party. The difference was this woman's behaviour – she was losing control and her friends were no longer as warm or welcoming as before. The woman realised that this was her drunk self and the ad closed with the strapline "Make sure you like what you see".

The introduction of these advertisements follows the successful evaluation of a similar campaign that ran in the Republic of Ireland. The evaluation showed that responsible drinking advertising was an effective way of reminding the customer about issues of individual responsibility and choice in relation to alcohol consumption with:

- 80% of consumers saying they remembered that the ad is for sensible drinking
- 76% saying they would be more likely to consider drinking sensibly having seen the advertisement.

Another initiative taken by Diageo GB was a student unit awareness programme entitled 'What's In It?' reaching 750,000 students across 55 universities, in partnership with NUS Services Ltd. Diageo GB has also funded theatre company CragRats to deliver workshops to 44,000 secondary school pupils, to raise awareness of alcohol issues. ■



How Alcoholics Anonymous is changing

By an AA member

My own experience

I first came into contact with Alcoholics Anonymous 20 years ago. I had just been discharged from mental hospital after a suicide attempt and after losing two jobs within a few weeks. AA was the main thing which kept me going over the following months, although I also got help from family, friends, my doctor and my therapist. I have not had an alcoholic drink since my first AA meeting.

I have had many problems getting my life together since then, not least with depression. With the benefit of hindsight depression was probably one of the reasons why I drank, but the drinking was more a cause than an effect of my problems.

I still attend AA meetings regularly. I do not want to drink again and I still value the support I get in maintaining sobriety, among other things by listening to people who have had a harder time than I have, have only just stopped drinking or are still trying to stop. AA is also part of my social life.

Carrying the AA message

The 12th step of the AA programme¹ encourages its

members to carry the AA message to other alcoholics. The proposition that helping others helps you to stay sober has support in peer-reviewed scientific literature² as well as in the practical experience of AA groups. In London, where I live, current initiatives include AA members speaking to school children about their experiences, giving presentations at magistrates courts, working with the probation service and supporting AA meetings at prisons. A seminar about the work of AA was held at the Houses of Parliament in March 2005 and a repeat of this is due in May 2006.

AA has been particularly successful in working with some

leading hospitals which provide treatment for alcohol dependence. AA meetings are held in the hospitals and AA members give separate talks to the patients to help them to think about becoming members too.

In other hospitals AA meetings may be held in the premises without such a close working relationship. There may be a clash of cultures. There are sometimes strong contrasts in general approach and language between AA members and those who work professionally in the field of addiction, although both sides are usually trying to achieve what is essentially the same thing.

Working with AA

A doctor in charge of an alcohol treatment unit once told me that I was the first AA member he had met. Others may strongly encourage their clients to try AA without having any direct contact with the fellowship themselves.

Professionals who want to make optimal use of AA as a resource may sometimes need to make a greater effort to understand its programme, meet with members involved in

outreach activities and attend a few “open” meetings (which should usually be done far enough away from where you work to ensure that you do not meet your own clients). This is surely not a disproportionate time commitment. It can enable the professional, for instance, to tell his or her patients or clients at first hand what they should expect. You do not have to become an alcoholic yourself (or apply the ‘Minnesota Model’, which involves integrating the AA programme within treatment³) to get to this point.

Why should you make the effort? Partly because there is now a sound body of scientific evidence suggesting that AA does work for a significant number of people with drink problems⁴. It operates at no cost to the taxpayer and is paid for entirely by voluntary contributions from those members who can afford to make them. It is also most active outside normal working hours and thus complements the help that can be provided at a professional level.

The need for AA to adjust

AA members actively involved in its public relations activities may need to make an equivalent effort to understand other people’s points of view and find common ground. Involvement in AA outreach activities helps to achieve this up to a point as does, for instance, reading some scientific literature, contact with professionals, attending conferences focusing on alcohol problems and involvement in working groups at a local level. One of the co-founders of AA, William Wilson, acknowledged⁵ that some AA members ‘decry

every attempt at therapy except our own’ but the majority ‘don’t care too much whether new and valuable knowledge issues from a test tube, a psychiatrist’s couch or revealing social studies’.

AA has changed considerably over the 20 years I have been a member. There are, for instance, more people under 30 and more women. There are meetings focused on the needs of young people, women, gays and lesbians and some provision in Central London (although still not nearly enough) for child care. It was rare in the 1980s to see anyone from racial minorities at meetings. Now it is rare not to see them. The fellowship is making every effort to provide help to people whose first language is not English or who may have other communication problems or disabilities.

The Internet and email has also helped to spread the AA message. For instance the basic ‘Alcoholics Anonymous’ textbook is now available online⁶ in full text in English, French and Spanish as well as being available in hard copy in many other languages.

The anonymity tradition

There is sometimes a tendency to over-interpret the AA anonymity tradition. It only requires members to maintain anonymity at the level of press, radio, film etc. The second co-founder of AA, Dr Robert Smith, argued⁷ that maintaining anonymity at any other level and in particular “being so anonymous you can’t be reached by other drunks” was itself a breach of the anonymity tradition. He also considered that AA members should let themselves be known as such in the community.

This may be feasible in North America, but in Europe it is perhaps more an ideal to be strived for. I am a professional myself, although I do not practise in the field of addictions. I do not tell my colleagues at work (whom I have only known for about 18 months) about my past drinking problems and my membership of AA. When I get to know them better, and if it were to serve a useful purpose, I might perhaps do so. ■

(This article represents the views of the author which are not necessarily shared by other AA members or by the AA fellowship as a whole)

References

- 1 www.alcoholics-anonymous.org.uk/geninfo/05steps.shtml
- 2 See Zemore SE, Kaskutas, LE and Ammon LN (2004) ‘*In 12-step groups, helping helps the helper*’, *Addiction* 99, 1015.
- 3 See www.hazelden.org/servlet/hazelden/go/INFO_MNMODEL
- 4 See, for instance: Vaillant, GE (2003) ‘*A 60-year follow-up of alcoholic men*’ *Addiction*, 98, 1043–1051. Gossop M, Harris, R, Best D, Man L-H et al, ‘*Is attendance at Alcoholics Anonymous meetings after inpatient treatment related to improved outcomes? A 6 month follow-up study*’ *Alcohol and Alcoholism*, Vol 38 No 5 421–426. Project MATCH Research Group (1997) ‘*Matching alcoholism treatments to client heterogeneity: Project MATCH post treatment outcomes*’. *Journal of Studies on Alcohol* 58, 7–29.
- 5 ‘*Let’s be friendly with our friends*’, *AA Grapevine* March 1958.
- 6 www.aa.org/bigbookonline/
- 7 ‘*Doctor Bob and the Good Oldtimers*’, page 264, 1980 AA World Services inc

Alcohol related disease to 'rise markedly'



The burden of alcohol related gastrointestinal disease, alcoholic liver disease and pancreatitis, will increase markedly over the coming decade or more, according to the British Society of Gastroenterology. Managing the health consequences of the rising tide of alcohol misuse in the United Kingdom will be one of the key challenges of the future, and much of it will fall to the gastroenterology and Hepatology services in acute hospitals, the Society concludes.

The Society, in a report putting forward a strategy for improving the care of patients with gastrointestinal disorders, says that the care of patients with alcohol-related diseases causes particular difficulties to gastroenterologists. The liver and GI tract are the most common focus for alcohol related damage and in most inner-city hospitals, the management of in-patients with alcoholic liver disease and its complications is the largest single workload that GI physicians face. Furthermore, when around 20% of unselected emergency admissions are alcohol-related, many of them gravitate to GI physicians under triage systems even when there are no specific liver or GI problems, for instance, patients suffering from alcohol withdrawal or the social consequences of alcohol dependence.

The Society says that it is important to anticipate that the burden from alcohol is going to increase markedly over the coming decade or more.

“As a nation, we are drinking more than for 90 years and there is a lag time between consumption and cirrhosis. Already, we have seen a 350% increase in cirrhosis between 1970 and 1998, and this figure is 900% for those under 45 years of age. Patients with alcoholic cirrhosis and alcoholic pancreatitis and related complications are heavy users of expensive hospital resources, particularly length of stay, intensive care, blood and interventional procedures, and they are often regarded by other specialties and departments as of lower priority because of the perceived self-afflicted nature of the condition.”

The Society says that GI physicians accept their key role in the management of patients with alcohol-related disease but

realise that they cannot take on this load without explicit consideration of the implications. The Society endorses the evidence-based blueprint for managing alcohol-related diseases produced in 2001 and reaffirmed at a recent joint Royal College of Physicians/British Society of Gastroenterology conference in early 2005 entitled ‘Alcohol-related harm – a growing crisis, time for action!’

The blueprint included recommendations for local care by acute hospitals receiving unselected medical admissions:

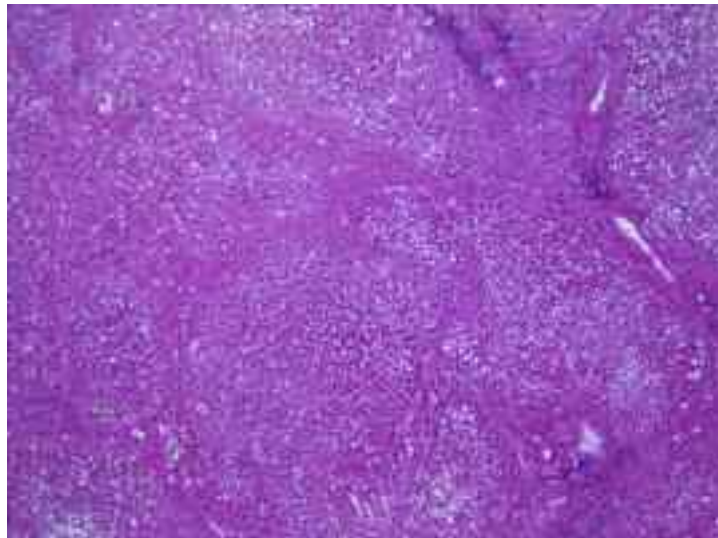
- Screening strategy for early detection of harmful/coincidental hazardous drinkers. Early assessment of dependence severity by appropriately trained staff.
- Widely available protocols for the pharmacotherapy of detoxification.

isease

- Readily available “acute response” from liaison or specialised alcohol psychiatry services for the management of patients undergoing “complicated” alcohol withdrawal.
- Assessment of the need for referral to on-going support services by appropriately trained staff with knowledge of local services.
- Provision of brief interventions for coincidental hazardous drinkers.
- Provision of general staff education.
- Occupational policies for alcohol for all hospital health care workers, for examples with respect to drinking at work.
- Close liaison with General Practitioners on discharge.

The blueprint also recommended that Health Trusts’ strategy should include the identification of:

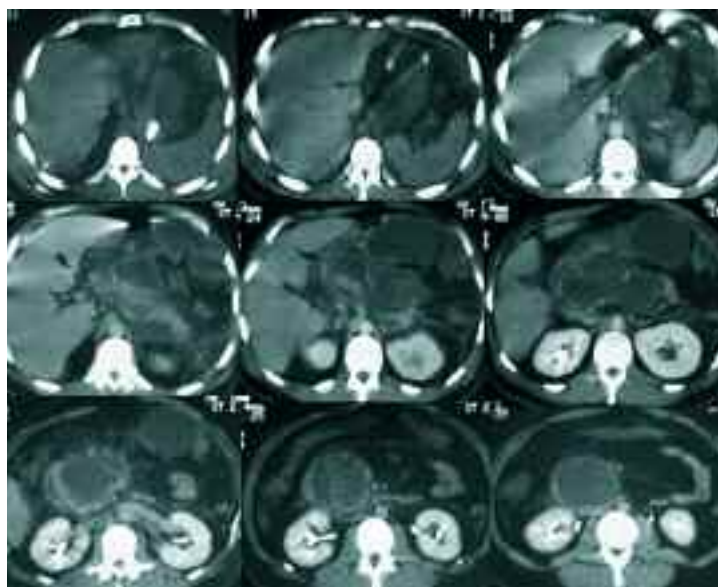
1. A senior member of medical staff and a senior member of nursing staff to act as a focus for alcohol strategy and to support more junior members of staff.
2. Senior psychiatric colleagues with an interest in the management of alcohol problems to act as the primary link between the acute hospital trust and local mental health services. This



Alcoholic liver disease with cirrhosis and steatosis.

- individual may or may not be employed by the acute trust.
3. One or more dedicated alcohol health workers employed by and answerable to the acute Trust. The roles will include:
 - a. Implementation of screening strategies.
 - b. Detoxification of dependent drinkers
 - c. Brief interventions in hazardous drinkers.
 - d. Referral of patients for on-going support/with access/knowledge about locally available non-statutory/voluntary agencies.
 - e. To provide links with liaison/specialist alcohol psychiatry.
 - f. An education resource and support focus for other health care workers in the Trust. ■

Care of Patients with Gastrointestinal Disorders in the United Kingdom: A Strategy for the Future. British Society of Gastroenterology, March 2006



MRI images of the abdomen

Self-medication with alcohol

Many adults in the UK are using alcohol to deal with feelings of stress, anxiety and depression, according to a new report from the Mental Health Foundation. The report, ‘Cheers?’ – outlines the relationship between alcohol and mental health and describes how excessive drinking increases vulnerability to a range of mental health problems.



National opinion poll research carried out to identify reasons for drinking found that people reported that alcohol made them feel:

- relaxed (77 per cent)
- happy (63 per cent)
- more able to fit in socially (44 per cent)
- more confident (41 per cent).

The results also revealed that drinking alcohol made people:

- feel less anxious (40 per cent)
- less depressed (26 per cent)
- more able to forget their problems (30 per cent).

This is consistent with the theory that people use alcohol to cope with feelings of stress, anxiety and depression

Evidence outlined in the ‘Cheers?’ report also shows that people who drink high volumes of alcohol are vulnerable to mental ill health. Over the last 50 years, alcohol consumption has doubled in the UK, mirroring an increase in the number of people experiencing mental illness.

Regular drinking changes the chemistry of the brain and depletes the neurotransmitters the brain needs to prevent anxiety and depression naturally.

According to the World Health Organisation, enough evidence exists to show alcohol can contribute to depression.

According to the Mental Health Foundation, physical health concerns related to increasing alcohol consumption are being reflected in Government policy developments, yet very little attention has been given to the links between alcohol and mental health, with little debate about why people drink alcohol.

Dr Andrew McCulloch, Chief Executive of the Mental Health Foundation, said: *“The research confirms our worries that people are drinking to cope with emotions and situations they can’t otherwise manage, to deal with feelings of anxiety and depression.*

“Drinking alcohol is a very common and accepted way of coping - our culture allows us to use alcohol for ‘medicinal purposes’ or ‘dutch courage’ from an early age. But using alcohol to deal with anxiety and depression doesn’t work as alcohol can weaken the neurotransmitters that the brain needs to reduce anxiety and depressive thoughts. This is why lots of people feel low when they have a hangover.”

The Mental Health Foundation believes that the public has a right to information about the hazardous effects that alcohol misuse can have on their mental as well as physical health. The report makes a number of Government policy recommendations.

Cheers? Understanding the relationship between alcohol and mental health. Mental Health Foundation. April 2006

Website to tackle student drinking

An innovative way to tackle the growing problem of excessive drinking amongst students, a population whose drinking habits are traditionally highlighted as indicative of a carefree and transient lifestyle, has been launched by the University of Leeds.



As part of its e-UNICAL Project, funded by a grant from the European Advisory Research Board, the University has developed the country's first interactive website designed specifically for UK students, which aims to help them reduce their consumption of alcohol. If it proves to be successful, then it could be implemented across the UK to other universities, and populations within the same age range.

The project will use tailored online feedback based on reported alcohol consumption in order to raise awareness amongst students, and help them make informed decisions about their drinking. It aims to reduce consumption by 10% in two years, following feedback from the UNIQOLL student experience survey which the

University has been running for six years. The findings showed that, in common with all young adults, a proportion of students had a high alcohol intake.

The first phase of the project, now close to completion, involves three hundred student volunteers providing information on their drinking habits via the website; they will then receive tailored feedback in relation to the 'sensible drinking' guidelines, but will also receive information on their drinking in relation to fellow students. Indeed, principal investigator and project manager Bridgette Bewick from the Psychological Therapies Research Centre suggests that "students tend to overestimate how much their peers are drinking, and giving students personalised feedback that they're in a high-risk category

can act as a wake-up call."

Feedback will be given on students' perceptions of how drinking is impacting on their health, their studies, and – a top priority for students – their finances.

The project has received an overwhelming uptake from the students, and over 1000 students have volunteered to participate, hugely exceeding the original sample of 300. "The fact that the students are willing to engage and participate in such a project shows that they find it relevant, and that they are thinking about their drinking", says Bridgette.

The website, built by the University's information systems services department, is currently only available to the volunteers. "If the trial is successful in reducing alcohol consumption and binge drinking it will provide an effective and low-cost tool that could be used not only by the University of Leeds but also by student populations across the UK and Europe," said Bridgette.

Evidence shows that online surveys can be an effective method of data collection amongst certain populations, and there is an increasing use of the Internet as a tool for social research. "There is a growing interest in the health professions in using online resources to change the way people behave, and the widespread availability of low-cost IT makes the internet a great potential source for instigating change", claims Bridgette. ■

Interventions to alcohol consumption

Guidance providing practical steps to improve screening and brief interventions for problem drinkers or people drinking to hazardous levels has been published by the Department of Health.¹



Caroline Flint, Public Health Minister

‘The guidance’, explained Caroline Flint, Public Health Minister, “*supports organisations thinking about developing the alcohol misuse interventions that will help improve health, reduce inequalities, reduce demand and improve access for the NHS*”.

The document provides further detail on the policy context and evidence of harm to the NHS, to individuals, families and communities. It presents powerful economic arguments for action, identifies practical steps for those implementing this guidance locally and introduces new, nationally developed tools that can be used by local organisations.

Findings from ANARP

The 2005 ‘Alcohol Needs Assessment Research Project (ANARP)’ report had already provided the first detailed national picture of the need for treatment and the availability of provision. The evidence presented suggests that the prevalence of Alcohol Use Disorders (AUD’s) and access to treatment varies considerably across England. Indeed, there are important discrepancies in

terms of levels of hazardous and harmful drinking, and the provisions of treatment. Some areas present high levels of hazardous drinking, which manifests itself in terms of alcohol-related crime and disorder and is typically associated with a younger population. On the other hand, some regions present high levels of harmful drinking, more often associated with dependent drinkers, who are usually older and are more likely to experience a range of health harms.

There are also wide regional disparities in terms of the provision of alcohol treatment services, which aim to benefit an older, dependent drinking population. It is also noted that people with alcohol dependence are heavy consumers of health services, but are not often identified as having alcohol dependence.

Alcohol misuse is now costing around £20 billion a year in England, it is suggested, including alcohol-related health disorders and diseases. This figure encompasses the costs of crime and antisocial behaviour,

loss of productivity in the workplace, and problems for those who misuse alcohol and their families, including domestic violence. Evidence based alcohol treatment in the UK could result in net savings in the ratio of £5 saved for every £1 spent.

Making it happen locally, regionally and nationally

The new guidance outlines practical steps that Primary Care Trusts (PCT’s) can take. These include assessing local need, current provision and levels of investment for screening, brief interventions and services for dependent drinkers across the local health and social care economy. As part of an assessment of local need for the entire pathway, greatest impact may be made if screening and brief interventions are offered to hazardous and harmful drinkers.

The regional support to deliver local programmes includes a series of conferences, held from January 2006 in partnership with the DH Regional Directors of Public Health to discuss the emerging evidence and practice.

The sum of £15 million per annum will be included within the PCT’s general allocation from 2007/2008 onwards to help PCT’s improve their local arrangements for commissioning and delivering alcohol interventions.

tackle harmful tion

A number of 'Trailblazer Projects' are to be implemented with the aim of strengthening the evidence base, in assessing and determining the impact of targeted screening and brief intervention within key settings: primary care, hospital and criminal justice systems. These projects are to begin in Spring 2006, with a final report released by the Summer 2008.

The Guidance summarises the economic justification for interventions into harmful and dependent drinking:

Potential benefits of interventions

Recent studies suggest that alcohol treatment has both short and long-term savings, and analysis from the UKATT Study suggests that for every £1 spent on treatment, the public sector saves £5.

The provision of alcohol treatment to the 10% of the dependent drinking population within the United Kingdom would reduce public sector resource costs by between £109m and £156 m each year.

The direct cost of brief intervention delivered to hazardous harmful drinkers was calculated to be only £20 in 1993.

A recent trial found that brief intervention trials can reduce weekly drinking by between 13% and 34%, resulting in 2.9 to 7.8 fewer mean drinks

per week, with a significant effect on recommended or safe alcohol use.

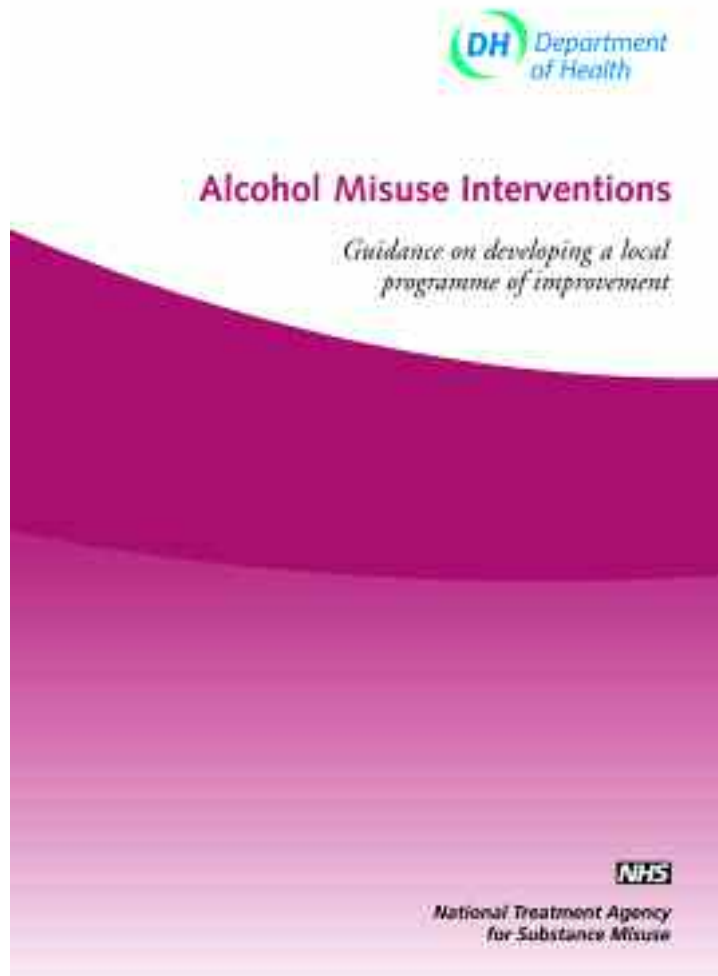
Evidence suggested that hazardous and harmful drinkers receiving brief interventions were twice as likely to moderate their drinking 6 to 12 months after an intervention, when compared to drinkers receiving no intervention.

If consistently implemented, GP based interventions would reduce levels of drinking from hazardous or harmful to low risk

levels for 250,000 men and 67,500 women each year. ■

Reference

- i *Alcohol Misuse Interventions – Guidance on developing a local programme of improvement*. NHS National Treatment Agency for Substance Misuse. Department of Health 2005



International study questions health benefits of moderate drinking

The majority of studies suggesting that ‘moderate’ drinking helps prevent heart disease may be flawed, according to an international research group.

In a new report, researchers from the U.S., Canada, and Australia analyse 54 studies that linked how much people drink with risk of premature death from all causes, including heart disease.

‘Sick quitters’

The researchers investigated a suggestion put forth by scientific skeptics of the ‘alcohol protects against heart attacks’ theory, that many of the studies conducted so far on drinking and premature death made a consistent and serious error by including as ‘abstainers’ people who had actually cut down or quit drinking due to declining health, frailty, medication use or disability. When such studies show a higher death rate for abstainers than for moderate drinkers, this result may reflect the poor health of some abstainers who recently quit drinking rather than indicating a protective effect for alcohol.

The authors credit British researcher Professor Gerry Shaper of the Royal Free and University College Medical School in London, for first proposing the possibility of an ‘abstainer error’ in the design of prospective studies of the

association between alcohol use and heart disease risks. The new study supports Professor Shaper’s conclusion that while the known biological effects of alcohol on risk factors for coronary heart disease are of scientific interest, they have limited significance for public health.

The team found just seven studies that included only long-term non-drinkers in the ‘abstainers’ group. The results of these seven studies showed no reduction in risk of death among the moderate drinkers compared with abstainers. When the researchers combined the data from these studies, they showed that it was possible to perform new analyses that appeared to show a protective effect of moderate drinking – but only when they deliberately included the error of combining long-term abstainers with people who had cut down or quit drinking more recently.

The authors caution that their report has not disproved the notion that light drinking is good for health, as too few error-free studies have been performed. They suggest, however, that the extent to which these benefits actually translate into longer life may have been exaggerated.

“The widely-held belief that light or moderate drinking protects against coronary heart disease has had great influence on alcohol policy and clinical advice of doctors to their patients throughout the world,” said Tim Stockwell, PhD, of the Centre for Addictions Research at the University of Victoria. *“These findings suggest that caution should be exerted in recommending light drinking to abstainers because of the possibility that this result may be more apparent than real.*

“We know that older people who are light drinkers are usually healthier than their non-drinking peers,” said Dr Kaye Fillmore of the UCSF School of Nursing. *“Our research suggests light drinking is a sign of good health, not necessarily its cause. Many people reduce their drinking as they get older for a variety of health reasons.”*

The authors emphasize that there is a need for more well-designed research in the future that assesses people’s alcohol intake and abstinence more precisely as their drinking patterns change with age. ■

Moderate alcohol use and reduced mortality risk: Systematic error in prospective studies. Kaye Middleton Fillmore, William C. Kerr, Tim Stockwell, Tanya Chikritzhs, & Alan Bostrom. *Addiction Research and Theory* 2006. Published online.



Further publications available from the Institute of Alcohol Studies

Counterbalancing the Drinks Industry

Counterbalancing the Drinks Industry: A Report to the European Union on Alcohol Policy

A response to a report published by the European drinks industry and a defence of the WHO Alcohol Action Plan for Europe.

Alcohol Policy and The Public Good

Alcohol Policy and the Public Good: A Guide for Action

An easy-to-read summary of the book written by an international team of researchers to present the scientific evidence underpinning the WHO Alcohol Action Plan for Europe

Medical Education

Medical Education in Alcohol and Alcohol Problems: A European Perspective

A review of educational programmes on alcohol and alcohol problems in European medical schools, identifying gaps in provision and proposing guidelines for a minimal educational level within the normal curriculum of under- and post-graduate medical students.

Alcohol Problems in the Family

Alcohol Problems in the Family: A Report to the European Union

A report produced with the financial support of the European Commission describing the nature and extent of family alcohol problems in the Member Countries, giving examples of good practice in policy and service provision, and making recommendations to the European Union and Member Governments.



Marketing Alcohol to Young People

Children are growing up in an environment where they are bombarded with positive images of alcohol. The youth sector is a key target of the marketing practices of the alcohol industry. The booklet depicts the marketing strategies of the industry and shows how advertising codes of practice are being breached.

alcohol



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