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Science and Technology Committee

Alcohol guidelines

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Additional written evidence

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Science and Technology Committee

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Contacts

All correspondence should be addressed to the Clerk of the Science and Technology Committee, Committee Office, 7 Millbank, London SW1P 3JA. The telephone number for general inquiries is: 020 7219 2793; the Committee's e-mail address is: scitechcom@parliament.uk

List of additional written evidence

(published in Volume II on the Committee's website www.parliament.uk/science)

Written evidence

Written evidence submitted by Dr Anthony Ernest Hanwell (AG 01)

ALCOHOL GUIDELINES

1. I am a retired member of the general public. My interest arises because I was a founder director and shareholder of a company supplying medical equipment to the NHS and other medical institutions. I had a lifetime of opportunity to observe from outside the way in which medical research is conducted.

2. The link between high levels of morbidity/mortality and excessive alcohol consumption is well established. The BMA has suggested safe consumption levels for the general public. How are such levels arrived at?

3. The only source of such data is from the patients who present themselves with symptoms of diseases recognisably linked to excess alcohol consumption. As a preliminary to treatment, the patient's medical history is taken during which he/she will be questioned about his/her level of alcohol consumption.

4. It is my submission that there exists in our society a strong disapproval of consuming alcohol to excess. This disapproval leads to a tendency to claim a lower level of consumption than is actually the case. Most members of the public will own to being slightly discomfited when asked by their GP "How much alcohol do you consume?" and sometimes GPs will decorously collude in recording a lower level than the patient knows to be true.

5. A patient presenting at hospital with a disease caused by the abuse of alcohol is likely to be ashamed or embarrassed by this avoidable situation and when questioned about his/her alcohol consumption will inevitably down play his/her indulgence.

6. This bias towards understating alcohol consumption leads to a false correlation between the incidence of alcohol related diseases and the associated levels of alcohol consumption. It is this false correlation which has lead to incorrectly low levels recommended by the BMA. It may also account for the paradox that although there is widespread consumption in excess of the recommendations, longevity grows at an accelerating rate!

7. It is difficult to speak of immigration without the risk of being branded racist. Similarly, suggesting that the BMA recommendations are too low, runs the risk of being accused of encouraging alcohol abuse. Such considerations may have delayed a closer look at just how accurate and useful are the BMA guidelines.

Anthony Ernest Hanwell, MA PhD (Cantab), Hon DEng (Sheffield)

July 2011

Written evidence submitted by David Gill (AG 02)

1. I write in a personal capacity but one who has 30 years experience in the wine and spirit industry. I declare my interests as being currently employed by a leading Wine Merchant, Importer & Agent and also as Master of Wine.

2. It is clear that alcohol consumption has actually been falling in recent years, but that the incidence of alcohol-related health issues and also the apparent numbers of binge-drinking events/issues have both risen. Whether this is due to increased reporting and awareness or whether there is a direct line to previous alcohol consumption is moot. However, I do have a view about the cause of many of these problems.

3. Some 25 years ago I personally railed against the infantilisation of alcohol and refused to buy (as a retail buyer) the then new category of RTDs. I felt that these were cheap alcoholic drinks which were sweetened up and "fruitified" to target an increasingly young youth market. I forecast at the time that it would lead to problems with many young people starting to drink far too much and far too early. I believe my prediction has been all too accurate.

4. Prior to that, those "starting" on alcohol had to overcome such barriers of the bitterness of ale, the high cost and acquired taste of spirits or the gas and liquid volume versus effective alcohol content of lager and cider (ie they would often throw up much volume before overdosing on the alcohol). With RTDs, the entry cost was low, the liquid far too "easy" to drink (alcoholic fruit juice) and the liquid volume-to-effective alcohol content ratio was low.

5. The effect, over a very short time, is that very young people were becoming alcohol dependent at an ever-earlier stage. Many of those same people have grown up to have the associated problems at which we all now despair, often having moved on to other drinks. Many will have been permanently damaged by their early exposure and, in some instances, harmed the next generation through drinking through pregnancy.

6. Sadly, over the same period, successive governments has used tax as their weapon of choice to raise revenue and to appear top "control" this. They have failed. The higher excise duties on all alcohol have served only to kill traditional pubs and also the small independent quality wine merchant/food and wine emporia. They have favoured supermarkets who now dominate sales. They have further driven down the base cost of all alcohol with their immense buying power. This has also increased the number of RTDs as they are cheap

and easy to make and can sustain a large profit for the manufacturer and retailer alike. It has also, incidentally, led to big brands of wine and beer becoming sweeter to hide their low base quality in order to retain producer profit. Ergo, the problem, in my view, has not been alcohol per se but the co-incidence of alcohol with retained sugar.

7. We cannot turn the clock back (and we will have to deal with those already afflicted), but you can stop the next generation becoming young alcoholics. If you were to reduce excise duty on most alcohol categories but massively increase it on "made" products which have both alcohol and high retained/added sugar you would undoubtedly kill off many of the worst offenders and also make it harder for young people to get into alcohol from the outset.

8. In doing so you will also stop the demonization of all alcohol which often makes it MORE attractive to youngsters. It may also help to revitalise the village pub and also the small independent and quality-minded food/drink outlets which are being brutalised by the high cost of entry imposed by the current taxation system.

I look forward to the report and would welcome the chance to elaborate further on my personal observations (which will make me very unpopular in certain quarters!).

David Gill
Director
Bottle Green Ltd

July 2011

Written evidence submitted by Richard Williams (AG 03)

1. Having read that the BMA Guidance for alcoholic intake is being reviewed, to seek evidence for their current advice and to compare this with other countries' advice is perhaps long overdue. To suggest that as a result their advice to increase duty on alcohol however is not.

2. Conflicting evidence as to the harmfulness or otherwise of moderate drinking ie three to four pints per day for men, appears to be recommended elsewhere. Be that as it may, obviously those with addiction will endeavour to source their supply whatever the price, as will some teenagers with high disposable income. However if this is designed to stop anti social behaviour amongst the group known as binge drinkers it will have, if anything, a negative effect on their behaviour.

3. Although largely an urban problem, we already have sufficient law (some would argue too much) to "police" this problem, but magistrates differ in punishing the offenders. Similarly we have many feral gangs developing who feel they are immune from prosecution, behave how they wish, and escape any serious clampdown on their behaviour. These, mainly youngsters, are sometimes drunk and often have been using drugs.

4. The net effect of increasing duty on alcohol will be threefold at the supermarket level: a) If it is a significant increase, there will be a proportional increase in crime to fund the difference; b) An increase in White Van man selling cheap alcohol; and c) A much higher level of drug taking as it becomes increasingly cheaper than lager etc.

5. The smoking ban has significantly increased pub closures—which was the UK's clever and traditional way of alcohol control. That it is now impinging dramatically on the rural environment is undoubted, and patently at its current rate will alter our heritage and cause social unrest.

6. There might be an argument for two tier taxation whereby cheap lager etc. would be taxed at supermarkets, but if applied to brewer's the effect will be catastrophic for publican's already reeling from punitive duty, business rates etc. Such a structure would cost more to introduce than it would net the exchequer, but if a Reduction in duty on pub alcohol could have a better outcome.

7. It would be criminal to penalise the whole country by increasing taxes when everyone is feeling the effects of a serious economic downturn, when it is highly dubious that anyone would live significantly longer. If they did the cost to the Health Service would only increase accordingly as our population ages, and costs more to keep healthy. One could argue we should not view this as reasonable but we are talking about very dubious marginal returns, and in France this would be discredited and not even discussed. Remember that in most European countries alcohol is vastly cheaper already compared to the UK but they have far less problems.

8. Far from recommending that parents should stop children drinking until they are 15 the BMA should suggest that children drink "small beer" or watered down wine with their meals as they grow up. As in France this instils responsible drinking, an appreciation of the merits of social behaviour, and patently stands them in good stead into adulthood. In Britain girls become pregnant sometimes when drinking through limited appreciation of alcohol's effects, and we have semi riots in town centres at weekends.

I have no vested business interest or otherwise in any pub, club or sale of alcohol. I am just concerned like thousands of others by increased taxation, a willingness to listen to "experts" and subsequent actions which in fact do much more harm than good.

July 2011

Written evidence submitted by James Watson (AG 04)

1. I wish to make a submission to the Committee. I am an ordinary citizen. I have no connections with the alcohol industry, the health industry or any other. I believe that my submission is admissible under three in the terms of reference, in particular, the phrase: "... the risks of alcohol intake to the public".

2. I have today watched the Panorama programme "Dying for a Drink" which was broadcast just recently. I am not here to complain about the one-sided nature of this unrepresentative, scaremongering propaganda—I am merely using it to highlight the lack of consideration which the health industry grants to the general public.

3. I would recommend that the Committee watch that programme. I would suggest that the members pay attention to the following points:

(a) The lack of any reference to the pleasures of alcohol.

(b) The movement from *the particular* to *the general* when solutions to the difficulties of a very few people were aired.

(c) The general assumption that all human beings are standard. That is, that all humans have the same genetic susceptibilities.

(d) The claim that "intervention" would save thousands of lives.

4. With particular reference to d), may I draw the committee's attention to the Statistics taken from the ONS statistics on "Causes of Death in England and Wales 2009".

Deaths from liver disease.

Up to age 25	27
Age 25 to 64	4,960
Age 65 to 85+	2,339

5. We are looking for the thousands of lives which could be saved. The programme claimed that on fifth of all liver disease deaths implicate alcohol. Now let us look at the above figures. One fifth of 27 is c.5. So, the horrendous effect of alcohol on the young amounted to five deaths in 2009. In the age range 25 to 64, the figure is about 1,000. In the range 65 +, the figure is about 500. I would contend that "lives to be saved" should not include over 65s since any alcohol which they had already consumed has clearly not yet killed them, in which case, we can limit "lives to be saved" to about 1,005, of which only five are "young people". (May I draw the attention of the Committee that almost 500 000 people died in England and Wales in 2009. May I also draw attention to the fact that 3,600 people died as a result of falls.) So where are the thousands of lives which could be saved by intervention? The figure is fictitious.

6. In the programme, several health professionals said that the solution to the problems of the few individuals who become serious alcoholics is for the whole population to pay more for alcohol and for various draconian regulations to be enacted. This leap from the particular to the general is not justified.

7. Human beings are not standard copies of an original. We are all different genetically. It is not possible to recommend any specific number of units for either men or women. Individuals learn for themselves what their limit is.

August 2011

Written evidence submitted by the Association of Small Direct Wine Merchants (AG 05)

1. Executive Summary

1.1 Alcohol Units (Units) have been confusing since their creation and widely misunderstood or ignored.

1.2 The definition of Units themselves was unnecessary as they amount to the same as centilitres (cl) of alcohol. This information is already legally required on wine labels.

1.3 By having defined specific Units for the UK market, legislation is discriminating against small UK businesses as the cost of labelling UK specific labels in small quantities is far higher per label than the cost of labelling large volumes.

1.4 The requirement to have UK specific labelling will also lead to unwillingness by small producers to supply the UK market resulting in a lack of choice for UK consumers.

1.5 Alcohol consumption guidance should be presented in a simple, easily understood manner without spurious accuracy.

1.6 Standard weekly alcohol consumption in cl of alcohol guidelines should be suggested, the same for men and women based on the number of bottles of wine or pints of beer. Daily limits should be abandoned as they will be ignored as they are currently ignored.

2. Introduction to the Submitter

2.1 Warren EDWARDES was the founder Chairman of the Association of Small Direct Wine Merchants and is also the current 2011 Chairman of The ASDW. Edwardes is also CEO of his wine business Hyde Park Wines Limited and is CEO of Delphi Risk Management Limited, the financial product innovation and risk management consulting, training and expert-witness firm.

2.2 The Association of Small Direct Wine-Merchants (ASDW) was formed in 2005, as the name implies, by a group of British independent small wine merchants directly selling to the general public via mail order and the internet.

There are currently around 26 members each of which is passionate and knowledgeable about wine. The ASDW's members offer customers a specifically selected, interesting and often exclusive range of wines at very reasonable prices.

The British public are well served by supermarkets at the lower end (sub £5) of the price range but it is becoming increasingly more difficult to find quality wines as big brand names dominate high street shops and supermarkets.

2.3 In view of 2.1 and 2.2 this submission requires a declaration of interests and these interests are herein fully declared.

3. Submission

3.1 The UK system of Units of Alcohol or Alcohol Units (Units) is unnecessarily complicated and confusing and these and should never have been adopted.

3.2 Every country has different Units definitions and varying recommended alcohol intake maximums.

3.3 Vaguely suggesting 2–3 units of alcohol a day for women or 3–4 alcohol units a day for men without reference to body size is both spurious accuracy and vagueness and is akin to having driving speed limits of 20 to 30 MPH for women or 30–40 MPH for men.

3.3 UK Units limits should be replaced with guidelines on the consumption of centilitres of alcohol (cl). A UK unit just happens to be the same as 1 cl of alcohol. So replace units by cl of alcohol. This is much easier to grasp.

3.4 For example a 75 cl bottle of 12% ABV wine contains 9 cl of alcohol (units):

This is simply 12% x 75 = 9.

It is hereby suggested that the Science and Technology Committee has serious education and training issues to consider if British adults cannot handle calculations such as 12% of 75 to make 9. The UK economy is going to be in a very sorry state unless something is done very quickly about basic arithmetic skills.

Now a third of a bottle of a 75 cl wine (25cl) at 12% ABV contains 3 cl or units.

And a 25 cl bottle of beer at 4% ABV has 1 cl of alcohol. And that is about half a pint. Again no need for spurious accuracy.

And a 40% ABV 70 cl bottle of whisky or vodka or rum comes out at 28 cl. Calculating 40 % of 70 at 28 should not be deemed to be really that difficult. That is just basic primary school mathematics. And arguably not even maths. Four Sevens are Twenty-Eight is straight out of the traditional Seven Times Table, something every Korean, or Singaporean child is capable of.

3.5 Centilitres (cl) are the same in every country. But units are not. So that means every boutique small family wine maker has to label their wines with the Units in dozens of countries when all the information is already legally there. ie 75 cl and 12% which makes 9 cl (or Units). Country specific Units, as opposed to internationally recognised cl, favour refinery quantity low quality wine producers and the monopolistic supermarkets that ship such wines to the UK in tankers or containers. Units have perhaps an unintended consequence of being prohibitively expensive for small producers who have short run printing. A specially printed back label for the UK for a pallet of 100 six bottle cases would cost about €0.35 each compared with less than €0.01 each label for a print run of a million plus bottles. Moreover, some wine allocations from small family grower-winemakers amount to only a half case of six bottles or even less and the cost would be for hand printing and be charged at €2.00 for the inconvenience and time. More likely, the winemaker would simply stop selling wine to the UK. Such legislation requiring UK specific wine labelling represents unfair competition against small businesses in favour of large supermarkets. Such measures restrict choice forcing

British consumers to consume industrial refinery quality wines produced by multinationals rather than naturally produced wines made by small family owned and run grower-winemakers.

3.6 We suggest streamlining by scrapping the ranges, daily limits and differences for men and women. Introduce a flat recommended limit of 18 cl per week that can be remembered, (ie the legal age permitting drinking of alcohol) which is understood and remembered.

3.7 So two bottles of wine a week should be the guideline. In beer terms that is four and a half litres of beer a week or about eight pints. Perhaps a bit more allowable for the bigger framed and younger and a bit less for the smaller or older.

3.8 People are going to overshoot anyway. Few in practice drive precisely at 70 mph on motorways—more like 75 mph which is a bit above the speed limit even if they are risk averse.

3.9 These proposals are finger in the air but there is no spurious accuracy and it provides some sort of reasonable and memorable intake control. Strictly speaking alcohol intake limits should be personal and based on the individual's Body Mass Index (BMI). But there is enough evidence that some alcohol is good but "too much" is bad. So why waste money on expensive research that is probably going to be ignored?

4. Recommendations for Action

4.1 Abolish units and discuss centilitres (cl) of alcohol. This is internationally recognised.

4.2 Establish whether the calculation of cl of alcohol is too difficult for British adults of legal alcohol drinking age from the information legally established as per EU legislation. i.e. the volume of liquid and Alcohol by Volume % as stated on labels. If this is the case (ie British adults are incapable of calculating 12% of 75 or 4% of 25 or 40% of 70) it is more important for The Science and Technology Committee to encourage the teaching of remedial mathematics to the nation.

4.3 As a rule of thumb one bottle of wine has 9 cl of alcohol. Whilst it is true that many wines, perhaps most wines, have more than 12% ABV, the difference in terms of cl of alcohol is minimal when set against the added complexity which results in the issue being ignored. And also as a rule of thumb a small 25 cl bottle of beer has 1 cl of alcohol.

4.4 It is proposed that the weekly limit for everyone, males and females be set at 18 cl of alcohol. This is memorable and understood as it is the legal drinking age in the UK.

4.5 The proposed simple weekly guideline limit of 18 cl of alcohol represents a combination of two bottles of wine or 4.5 litres (eight pints) of beer a week. And binge-drinking of this weekly limit on one or two days is discouraged but it is suspected that this advice will be ignored. Larger than average and younger adults could consume 25% more, ie up to 23 cl of alcohol a week.

4.6 A personalised weekly and daily alcohol consumption guideline similar to the calculations and charts of Body Mass Index (BMI) could be produced for greater accuracy. But it is suggested that complexity reduces the likelihood of a system being accepted and adhered to.

Warren Edwardes
Chairman
Association of Small Direct Wine Merchants (ASDW)

August 2011

Written evidence submitted by 2020health (AG 07)

1. *Introduction*

1.1 At 2020health we have recently conducted research into "risky drinking" to be published in our forthcoming report "*From One too many: The risks of frequent excessive drinking"*. In this report we have drawn on both our internal and external expertise. Our Consultant Director, Gail Beer, was a renal nurse in her early work within the NHS, before becoming an NHS Trust COO, and we conducted interviews and conversations with experts in the field. The area of patient education and information is a central theme at 2020health and we have identified alcohol consumption as an area where there is not enough knowledge in the general population for people to be able to make informed choices about their lives.

1.2 In our report we identified the confusion regarding recommended safe limits. DH guidelines state that men should drink no more than 3–4 units per day and women 2–3. However historically weekly guidelines have been given that men should drink no more than 21 units per week and women 14 units, and these weekly guidelines are often still used. These two figures are clearly at odds with each other and cause some confusion. In addition there is misunderstanding of the term unit. A unit is taken as 8g of alcohol but many drinks contain more than 8g and drinkers are often unaware they are drinking more than 1 unit.

1.3 The current use of daily guidelines suggest that it's acceptable to drink every day and that this causes no harm; this may be the case if only 1 unit is consumed. Where the guidelines fail is when consumers believe

that the maximum recommended limit is the amount they can safely consume every day. We believe that education about the risks of drinking at different levels would be more beneficial than the setting of limits.

2. *What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed?*

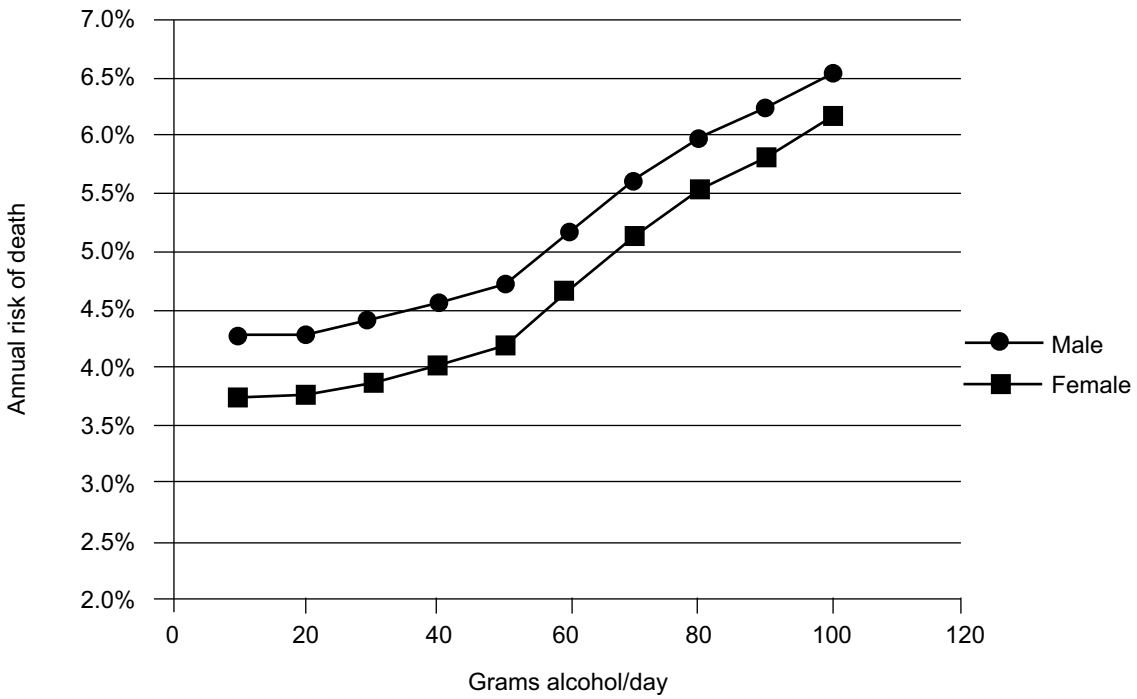
2.1 The evidence base for the government's current guidelines is unclear. Research has shown that for many alcohol-related conditions there is a continuing increase in risk with the amount of alcohol drunk and no clear cut-off between "safe" consumption and "risky" consumption. Whilst much is known about the risks of different levels of alcohol consumption over a period of time, and the risks of binge drinking, there is no clear reason for the current daily limit on alcohol consumption.

3. *Could the evidence base and sources of scientific advice to Government on alcohol be improved?*

3.1 There is extensive medical evidence around the relationship between alcohol consumption and the risk of many different diseases, including liver disease, many types of cancer, hypertension, stroke, pancreatitis and mental illness. Graphs showing the relationship between level of alcohol consumption and increasing risk of each condition show that there is no cut-off limit beneath which alcohol consumption is "safe". Any level of consumption will increase the risk of developing these conditions. For this reason the government should not attempt to define a "sensible limit" for drinking, but instead should educate the population of the risks associated with different levels of drinking. Drinking alcohol should be treated In a similar manner to smoking, where the focus is on public education of the risks associated with the behaviour.

Figure 1

ABSOLUTE ANNUAL RISK OF DEATH FROM DRINKING DIFFERENT AVERAGE AMOUNTS OF ALCOHOL PER DAY, FROM 10 G (1.25 UNITS) ALCOHOL/DAY TO 100 G (12.5 UNITS)/DAY. TAKEN FROM REHM ET AL. 2011[1]



3.2 As we have described in our forthcoming report "From one to many: The risks of frequent excessive drinking" there are three main types of drinkers. These are:

— binge drinkers;
— dependent drinkers; and
— risky drinkers.

The risks for these different groups are different. Whereas binge drinkers are more likely to subject themselves to acute damage, risky drinkers, who drink but do not get drunk, increase their risk of chronic conditions such as cancer and liver disease.

3.3 Separate guidelines should be issued by the government to target risky drinkers and binge drinkers. These types of drinking carry different risk. Education about the risk of chronic conditions are needed for risky

[1] Rehm J, Zatonksi W, Taylor B, Anderson P (2011): Epidemiology and alcohol policy in Europe. *Addiction*, 106 (Suppl. 1), 11–19

drinkers, whereas warning about the risks of binge drinking is also needed. Targeting these two populations should in turn help to avoid the development of alcohol dependence.

4. *How well does the Government communicate its guidelines and the risks of alcohol intake to the public?*

4.1 The current guidelines on the risks of alcohol intake are confusing and this has resulted in poor understanding of the recommendations around alcohol consumption in the population. Both daily limits of 3–4 units per day for men and 2–3 units per day for women and weekly limits of 21 units per week for men and 14 units per week for women are used. These guidelines are not compatible and result in confusion.

4.2 A YouGov poll conducted in January 2010 showed that 55% of English adults believe that alcohol only damages your health if you binge drink or get drunk. The poll showed that 83% of those who regularly drink more than the recommended limits don't think their drinking is putting their long-term health at risk. In another survey from 2008, 46% of the population did not know the sensible drinking guidelines.[2] There is a widespread ignorance of the harms associated with heavy drinking. While 86% of drinkers surveyed knew that drinking alcohol is related to liver disease, many were unaware of the links with cancer, stroke or heart disease. One of the difficulties in making sound behavioural choices is the time gap between the drinking behaviour and the health consequences. Chronic diseases such as liver disease and cancers may not manifest until the damaging drinking behaviour has continued for many years. This makes education about the risks and future consequences of this behaviour essential.

4.3 As explained above any guidelines issued by the government need to target risky drinkers and binge drinkers separately. Targeting these two populations should in turn help to avoid the development of alcohol dependence.

4.4 *Risky drinkers* are those who drink regularly, but do not binge drink or get drunk. They may be drinking several drinks every day, and are increasing the risk of developing long-term health conditions. Given the time lag between alcohol consumption and the development of conditions such as liver disease or cancer, the harm caused by drinking is often not seen for up to 10 or 20 years. This makes the need for education about the risks more pressing.

4.5 Rather than an arbitrary choice of limits for alcohol consumption, education of the public is needed about the different conditions related to alcohol consumption and the relationship between level of consumption and risk. Guidance should state that it is inadvisable to drink every day, and a public education campaign is needed to convey the risks of drinking at different levels. Information such as that shown in Table 1 should be more widely known and understood.

	Increased risk associated with drinking:	
Condition	*3 units of alcohol per day (1.5 pints of beer, 250ml of wine)*	*6 units of alcohol per day (3 pints of beer, 500ml of wine)*
Liver disease	3 times	7 times
Mouth cancer	2.5 times	5 times
Throat cancer	1.8 times	3 times
Breast cancer	1.3 times	2 times
Hypertension (high blood pressure)	1.7 times	3 times
Ischaemic stroke	No change	2 times
Haemorrhagic stroke	1.8 times	3 times
Pancreatitis	1.3 times	2 times

Table 1: The increased risk associated with drinking 3 or 6 units of alcohol per day. Data taken from the Australian Guidelines to Reduce Health Risks from Drinking Alcohol[3] and Corrao et al. (2004).[4]

4.6 *Binge drinkers* are those who drink eight or more units in a single session for men and six or more for women. In addition to the messages about risky drinking, it needs to be understood that binge drinking is not recommended. The harms of binge drinking are better understood than risky drinking as the effects of alcohol are usually seen immediately. Binge drinking can result in acute health problems, violence, crime, as well as a cost to employers due to time off or decreased productivity at work.

4.7 In order for the public to regulate their alcohol intake efficiently, they need to be aware of not only the risks associated with the consumption of a given number of units of alcohol, but they also need to be aware of how many units are contained in their drink. For this reason it is very important that beverages are labelled with information giving the units of alcohol contained both on the bottle/can itself and on drinks menus in restaurants/pubs.

[2] Wilkins D, Payne S, Granville G, Branney P (2008): The Gender and Access to Health Services Study. Department of Health. London.

[3] National Health and Medical Research Council (2009): Australian Guidelines to reduce health risks from Drinking Alcohol. NHMRC. Canberra.

[4] Corrao G, Bagnardi V, Zambon A, La Vecchia C. (2004): A meta-analysis of alcohol consumption and the risk of 15 diseases. Prev Med. 38(5):613–9.

5. *How do the UK Government's guidelines compare to those provided in other countries?*

5.1 In most respects the UK Government guidelines are comparable to those given in other European countries. However the UK guidelines around drinking in pregnancy are less clear than in the rest of Western Europe, North America and Australasia. Whilst the UK CMOs advise that "pregnant women or women trying to conceive should avoid drinking alcohol" this conflicts with NICE guidance which only advises women to avoid alcohol in the first trimester of pregnancy. CMO and DH guidance to drink no alcohol throughout pregnancy should be made more explicit.

5.2 One area where there is a disparity between the UK and other European countries is the marketing and advertising of alcohol. Alcohol advertising encourages positive attitudes to alcohol and increases levels of drinking. The UK operates a voluntary, self-regulatory code with no legal limitations in force and compared to many European countries is seen to be lax on alcohol advertising. Whilst the UK has voluntary codes of practice detailing how, where and when alcoholic drinks can be advertised, France has a legal ban on advertising of all alcoholic drinks over 1.2% abv on TV and in cinemas and also prohibits sponsorship of sport or cultural events by alcohol companies. In Italy there is a ban on TV and radio advertising of alcohol between 4pm and 9pm and alcohol advertisements are prohibited within 15 minutes of the start or end of children's programmes. Meanwhile, in Sweden there is a complete ban on advertising of all drinks above 2.25%abv, except at the point of sale and in trade journals.[5]

5.3 The ELSA (Enforcement of National Laws and Self-regulation in Advertising and Marketing of Alcohol) project which was funded by the European Commission and concluded in 2007, made specific recommendations for the protection of young people and vulnerable groups which should be taken into account during further development of UK alcohol policy. Statutory regulation on advertising in the UK should be brought in line with other European countries and WHO recommendations.

6. *2020health Key Recommendations*

6.1 The clear display of units on bottles or cans of all alcoholic drinks should be made compulsory. Units should be displayed on the front of the bottle and a minimum font size should be specified.

6.2 Statutory regulation on advertising should be brought in line with other Northern European countries, following WHO recommendations.

6.3 A national public health education campaign is needed to ensure that the population is made aware of the harms related to risky drinking. The campaign needs to advise people of the risks of different conditions associated with drinking and the harms of drinking every day. In particular the campaign should highlight risks such as the risk of specific cancers, of which many are not aware.

7. *Further Information*

7.1 For further information on the harm and cost of risky drinking please see our forthcoming report, due to be published mid-October "From one to many: The risks of frequent excessive drinking."

8. *Declaration of Interests*

8.1 2020health is an independent health and technology think tank with no connection to the alcohol industry. Our forthcoming report on alcohol "From one to many" has been sponsored by an unrestricted educational grant from Lundbeck, a pharmaceutical company with a specialist focus on psychiatry and neurology. This submission draws on the research undertaken for this report, but is an independent submission by 2020health.

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Written evidence submitted by the International Scientific Forum on Alcohol Research and AIM, Alcohol in Moderation (AG 09)

Introduction

Each year our understanding of the biological, physiological, psychological and social effects of drinking alcohol at different doses grows. In general, national guidelines reflect the medical findings of the j shape curve, that is, that approximately 20g a day consumption for women and 30g consumption a day for men is considered as "safe" or "low risk" for most healthy adults. Therefore we believe the current UK guidelines to be in accordance with the science base.

The science base for the health consequences of both alcohol misuse and moderate consumption, although important should not be the only factor considered by governments when producing guidelines as the purpose of recommendations is to encourage adults to drink within the responsible drinking guidelines. Hence, it is important to continue to promote a simple public health message that is likely to respected and regarded as realistic by consumers.

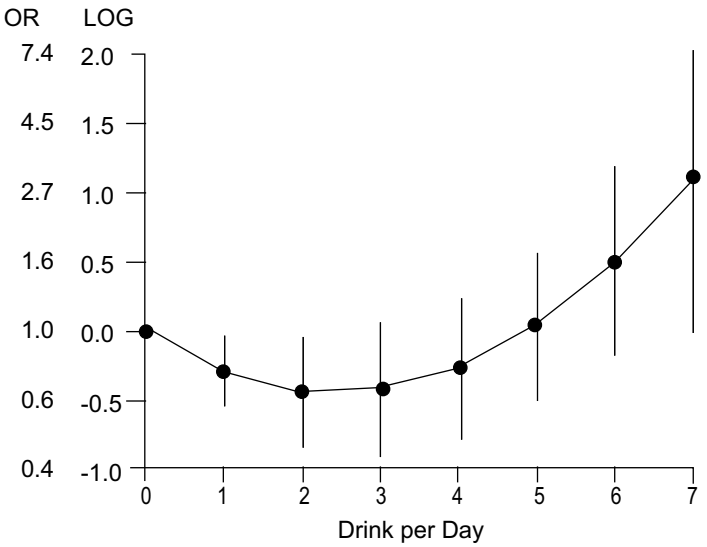
[5] Institute of Alcohol Studies (2010): Alcohol & Advertising IAS Factsheet.

1. *What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed*?

1.1 AIM, Alcohol in Moderation was one of many organisations that submitted a paper in 1995 to the sensible drinking guidelines review, drawing on evidence from eminent epidemiologists such as Sir Richard Doll, Professor Eric Rimm (USDA committee) and Professor R Curtis Ellison as well as cardiologists such as Professor Art Klatsky. In particular, the evidence base in the early 1990's showed the importance of a daily "little and often" guideline versus "saving up" units and drinking on one or two nights a week.

1.2 We are able to have "low risk" guidelines, rather than a message of "don't drink" due to the medical evidence base, which began with the publication by Professor Klatsky in 1974 of one of the first studies to suggest an inverse association between moderate alcohol consumption and coronary heart disease, This was followed in 1979 with St Leger in The Lancet finding that wine appeared to be protective against heart disease, independent of other risk factors. Since then, many hundreds of studies from 25 countries have confirmed and strengthened the association, with the protective effect, or what has become known as the J shaped curve for moderate alcohol consumption, applying predominantly to post menopausal women and men over 40.

Figure 3 Alcohol and Stroke risk



Relationship between daily alcohol and ischemic stroke. This was fully adjusted for the usual stroke factors. OR = odds ratio. Reporduced with permission from Sacco et al. (12).

Figure 1 Alcohol and All-Cause Mortality

The relationship of daily alcohol consumption to the relative risk of all-cause mortality in men and women. Reproduced with permisiion from DICastelnuovo et al. (2)

1.3 The j shaped curve shows that light and moderate drinkers of any form of alcohol live longer than those who abstain or drink heavily. The relative risk of mortality is lowest among moderate consumers (at the lowest point of the J), greater among abstainers (on the left-hand side of the J), and much greater still among heavy drinkers (on the right-hand side of the J). In addition to longevity in general, the J-shaped relationship also exists for cardiovascular deaths, specifically for coronary heart disease and ischemic stroke.

1.4 Many factors influence the definition of safe alcohol consumption and include age, gender, body mass index, ethnicity, family history, genetic differences, mental and physical health, and concomitant medications. Consequently, it has not been possible to determine the exact inflection point in dose where a potentially beneficial, or harmless dose changes to a potentially harmful one, hence definitions of a drink and responsible drinking guidelines vary from country to country and governments usually use simple messages and recommendations that apply to the majority general population.

1.5 Moderate drinking is generally medically defined, however, as approximately 20g a day (one or two standard drinks) for women and 30g a day for men. Further, epidemiological studies have assessed the importance of drinking patterns including frequency and quantity. "Saving up" units for drinking on one or two occasions a week is not considered moderate drinking.

How Can Moderate and Regular Doses of Alcohol be Protective?

1.6 Evidence from these studies suggests that beneficial changes in High Density Lipoprotein cholesterol levels, clotting factors, insulin sensitivity, and markers of inflammation provide biological plausibility to the association. Coronary heart disease (CHD) is the leading cause of death throughout the developed world, accounting for 25–50% of all deaths. Studies consistently show that regularly consuming moderate amounts of alcohol reduces mortality from CHD and ischemic stroke by 25 -30%, mainly in men aged over 40 years and in postmenopausal women, when the risk factors for CHD and stroke significantly increase.

1.7 It is thought that alcohol itself accounts for 75% of the cardio-protective effects of alcoholic beverages. It favourably alters the balance of fats or lipids in the blood, by stimulating the liver to produce the "good" high-density lipoprotein cholesterol (HDL). HDL removes the "bad" low-density lipoprotein cholesterol (LDL) from arteries and veins for disposal via the bile, which is referred to as reverse cholesterol transport.Alcohol decreases blood clotting and/or the "stickiness" of blood platelets, which if untreated could form a clot to block blood flow in an artery to cause a heart attack or stroke. The message is little and often as the blood thinning effect of alcohol lasts for approximately 24 hours and one drink confers the benefit.

1.8 Drinking alcohol is not recommended if suffering from uncontrolled, high blood pressure. If someone has an existing heart condition, alcohol can generally be drunk in moderation, but only if alcohol use does not affect the medication, a doctor's advice should be sought. Binge drinking is seen to significantly increase systolic blood pressure, which increases the risk of a heart attack or stroke.

1.9 The many epidemiological studies that have shown an inverse relation between alcohol and cardiovascular disease have come from a great variety of nations and cultures. Despite great diversity in the populations, study size, diet and lifestyle factors and length of follow-up the consistency and similarity of outcomes provide further support to the robustness of the findings. Inverse associations have been documented in France, Japan, Denmark, Germany, Finland, Korea, Great Britain Australia, China, Italy, Puerto Rico, the Netherlands, Sweden, Yugoslavia and the US (see references).

1.10 More recent studies of alcohol and CHD have focused on subgroups defined by age or health status. Although alcohol in moderation will likely provide greater benefit for older populations where rates of CHD are highest, the etiology of CHD is such that moderate consumption in middle age also is beneficial. Several important risk factors for CHD, such as obesity and the prevalence of type 2 diabetes, both of which have been increasing in younger adults around the world, are consistently reported to be inversely associated with moderate alcohol consumption.

Most Recent Evidence

1.11 An important meta-analysis of 4235 studies on the association of alcohol consumption with selected cardiovascular disease outcomes was published in the BMJ in 2011: This meta-analysis provides a summary of current knowledge regarding alcohol associations with six meaningful clinical end points—cardiovascular disease mortality, coronary heart disease incidence and mortality, stroke incidence and mortality, and all cause mortality. Reflecting previous meta-analysis by Maclure in 1993 and by Corrao et al in 2000, the results demonstrate risk reductions for alcohol drinkers relative to non-drinkers of 25% for cardiovascular disease mortality, 29% for incident coronary heart disease, 25% for CHD mortality and 13 % for all cause mortality. The lowest risk of CHD mortality occurred with 1–2 drinks (15–30 grams of alcohol) per day is also in line with previous knowledge. (Paul E Ronksley, Barbara J Turner, Kenneth J Mukamal et al BMJ 2011;342:d671 doi:10.1136/bmj.d671 Effect of alcohol consumption on biological markers associated with risk of coronary heart disease: systematic review and meta-analysis of interventional studies Susan E Brien, Paul E Ronksley, Barbara J Turner, Kenneth J Mukamal, William A Ghali Cite this as: BMJ 2011;342:d636 doi:10.1136/bmj.d636).

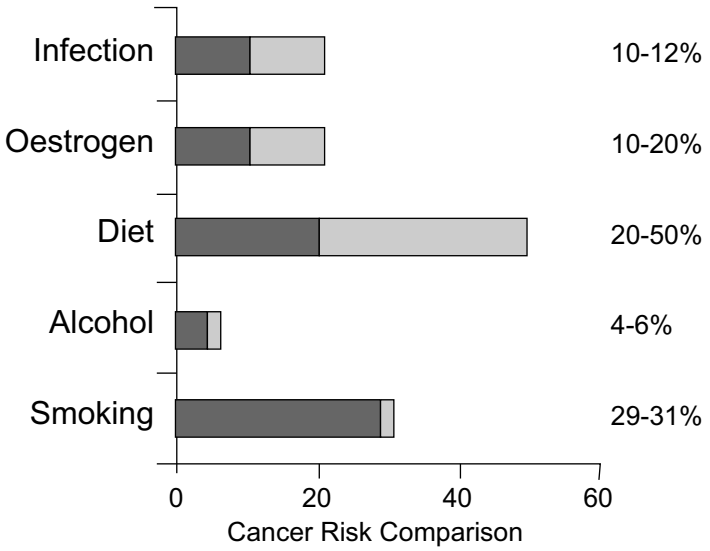
1.12 Another recent paper set out to determine the extent to which potential "errors" in many early epidemiologic studies led to erroneous conclusions about an inverse association between moderate drinking and coronary heart disease (CHD). Based on prospective data for more than 124,000 persons Fuller concludes that the so-called "errors" have not led to erroneous results, and that there is a strong protective effect of moderate drinking on CHD and all-cause mortality. (Fuller TD. Moderate alcohol consumption and the risk of mortality. Demography 2011. DOI 10.1007/s13524–011–0035–2).

Pattern of Drinking

1.13 Research is increasingly showing the importance of drinking at meal times, this is known as the "post prandial state". This not only decreases the effect of alcohol (drinking on an empty stomach), but helps us counter damaging free radicals. Rich foods increase the state of "oxidative stress" in the body. Research shows that drinking above 30g a day outside of meal times or abstinence increases the risk of blood pressure and all cause mortality significantly.

1.14 Research also emphasizes regular moderate versus episodic or binge drinking . An important prospective study shows that regular moderate drinking is associated with lower risk of MI, but episodic or binge drinking increases the risk. Lifetime abstinence has a similar adverse relation to CHD. Reference: Ruidavets J-B, Ducimetièere P et al Patterns of alcohol consumption and ischaemic heart disease in culturally divergent countries: the Prospective Epidemiological Study of Myocardial Infarction (PRIME). BMJ 2010;341:c6077 doi:10.1136/bmj.c6077.

Cancer Risk



1.15 There is no doubt that the prolonged excessive consumption of alcohol, especially when combined with smoking, leads to an increased incidence of many cancers (mouth, throat, larynx, oesophagus, breast and liver). A growing body of epidemiological studies show evidence for a positive association, even at moderate levels for breast cancer risk,(estimated lifetime increased risk of 6% per daily drink). Lifestyle factors such as diet and adequate folate intake may weaken the positive association, but this is an area still under study. The risk of breast cancer from alcohol consumption is additive with other risks such as: lifestyle; family history; medical history; nulliparity; endogenous/exogenous hormones (such as hormone replacement therapy); body mass index; and environmental exposure to carcinogens.

1.16 Cancer risk should not be considered in isolation from the risk of other factors for mortality, as regards responsible drinking guidelines. As regards all cause mortality, the current daily guidelines reflect the scientific findings well in recommending safe or low risk guidelines for alcohol consumption for healthy adults.

Potential Confounders

1.17 It has been suggested that the inverse association between alcohol and all cause mortality may not be causal but because moderate drinkers may be better off, more likely to eat better, exercise more, and live a healthier life. Most studies from the last decade account for potential con-founders of the effect of moderate drinking—such as education, occupation, social status, physical activity, diet, and changes in alcohol consumption during lifetime. Although most prospective studies of alcohol and cardiovascular risk are observational, trials have been conducted to study changes in markers of CHD such as HDL cholesterol, triglycerides, glycemic control, and clotting factors and support the conclusions of the observational studies.

1.18 Klatsky and Udaltsova (2007) reworked previously published data to address the purported confounding and potential over-estimation of a health benefit from moderate alcohol consumption claimed by Fillmore et al

(2006, 2007), and showed a shallower but still significant J-shaped relationship between alcohol consumption and all-cause mortality risk. The data was of 21,535 deaths and follow-up included 2,618,523 person-years of observation (average 20.6 years). Their re-analysis reconfirmed the relationship previously published with an increased risk for individuals consuming more than three (14 g) drinks per day and a reduced risk at three or less drinks per day, almost always due to a reduced risk of death from cardiovascular disease. Former consumers were observed to be at increased risk of death from non-cardiovascular disease and occasional consumers were observed to have a risk similar to lifelong abstainers.

1.19 Another study by *Mukamal et al* (2006) on older adults separated lifetime abstainers from former drinkers, and occasional drinkers from regular light drinkers It demonstrated reductions in the risk of a variety of cardiovascular outcomes from moderate consumption. Another study on older people by Tolvanen (2005) separating ex-drinkers were from lifetime abstainers, total mortality was highest in the ex-drinkers and labstainers, and 30–40% lower in current consumers.

Older populations

1.20 There have been suggestions that the elderly should reduce their alcohol consumption to below daily drinking guidelines. This is based on the fact that they have less body water than younger adults. However, moderate, regular consumption, within the guidelines helps protect against cardiovascular disease, cognitive decline and all cause mortality, especially among post menopausal women and men over 40, hence the US dietary guidelines 2010 cite:

> In most Western countries where chronic diseases such as CHD, cancer, stroke and diabetes are the primary causes of death, results from large epidemiological studies consistently show that alcohol has a favorable association with total mortality especially among middle age and older men and women ….

1.21 This message has been further strengthened this month by the findings of the nurses health study(Alcohol Consumption at Midlife and Successful Ageing in Women: A Prospective Cohort Analysis in the Nurses' Health Study) following 14,000 older women for 16 years. Those who consumed between 15g and 30g of alcohol regularly had a 28% better chance of "successful ageing versus abstainers or light occasional drinkers (http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1001090).

1.22 Another recent paper finds that after adjusting for former problem drinking status, health and social-behavioural factors, moderate drinking was associated with considerably lower risk of all-cause mortality. In comparison with "moderate drinkers" (subjects reporting up to 3 drinks/day), abstainers had 51 % higher mortality risk and heavy drinkers had 45% higher risk. *(Holahan CJ et al. Late-Life Alcohol Consumption and 20-Year Mortality. Alcoholism: Clinical and Experimental Research 2010;34).*

The Liver

1.23 There is no question that heavy alcohol consumption is a key factor in the development of Laennec's cirrhosis, and that almost all studies show that women may be at greater risk than men for a specified level of intake. The key question for public health officials is whether or not there is a threshold level of drinking associated with increased risk of cirrhosis.

A recent meta-analysis supports the theory that there is a threshold of drinking above which the risk is increased. The study reported that for morbidity from cirrhosis, both men and women consuming up to one drink per day had a lower risk than that of lifetime abstainers. Women had a significantly increased risk above 24 grams/day and men above 36 grams/day. This suggests that there may a threshold effect of alcohol on the risk of cirrhosis in line with current guidelines. (Rehm J, Alcohol as a risk factor for liver cirrhosis: A systematic review and meta-analysis. Drug and Alcohol Review 2010,29,437–445. DOI: 10.1111/ j.1465–3362.2009.00153.x).

Differences in Guidelines for Men and Women

1.24 There are physiological gender differences in body size and the distribution of fat and water, as well as in alcohol metabolism that determine that for a given amount of alcohol, the resultant BAC is greater in women than in men. The maximal BAC may be approximately 10–16% greater in women compared to men. In addition it should also be stated that women's organs and tissues are more susceptible to the toxic effects of alcohol and its metabolite such that harmful effects of regular heavy drinking are observed earlier in women. Hence the current lower guidelines for women are correct and balanced.

Pregnancy

1.25 Both NICE and The Royal College of Obstetricians and Gynaecologists have reviewed the extensive evidence base and the current guidelines are in line with their findings.

Parameters of Misuse

1.26 There are significant economic, medical and social consequences from irresponsible or high risk alcohol consumption. Heavy or hazardous drinking (more than twice the moderation guidelines), inappropriate drinking

(drinking to drunkenness), and binge drinking (more than five drinks in quick succession) have no health benefits and are associated with both acute and chronic harms to health, both short and long term.

Drinking at all in some circumstances is hazardous, such as when pregnant, on certain medications, when driving, suffering from some illnesses, working with machinery or at heights.

2. *Could the evidence base and sources of scientific advice to Government on alcohol be improved?*

2.1 You will find forwarded separately examples of how the Canadian and US Government's http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/DGAC/DGACpressrelease10–24–08.pdf conduct their responsible drinking guideline reviews, with an experienced panel of predominantly MEDICAL specialists and epidemiologists and nutrition lists reviewing the evidence collated reporting to a BALANCED panel of expertise.

2.2 The US guidelines are reviewed every five years. Australia and Canada more sporadically. You will find a recent review of common themes in country guidelines under separate cover.

2.3 It is very important that the evidence base is not based on a few individual papers but on a comprehensive database of studies and meta- analyses from different disciplines, please see the bibliography for the US and Canadian reviews.

2.4 There is a feeling among the 40 scientists and medical doctors that contribute comment to The International Scientific Forum on Alcohol Research http://www.bu.edu/alcohol-forum/members/ (unpaid) and AIM http://www.aim-digest.com/digest/index.htm who are directly involved in alcohol and health research that there is an unhealthy reliance on non medically qualified public health statisticians and use of mathematical modelling—such as the use of alcohol attributable fractions for example rather than analysing the hard science.

2.5 Evidence needs to take account of cardiology, hepatology, oncology, all cause mortality, epidemiology, pattern of drinking and put alcohol in context with other lifestyle factors such as BMI, smoking, exercise and diet. NICE may be the best body to bring together such a panel.

4. *How do the UK Government's guidelines compare to those provided in other countries?*

4.1 The UK definition of a unit is the smallest at 8g. Unit definition varies from 10g (Australia, France, Austria, Ireland, The Netherlands, New Zealand) 12g (Denmark, Italy), 13.6–14g (Canada and US) and 19.75 (Japan).

4.2 In spite of this, daily drinking guidelines where they exist , are broadly in line—suggesting an average intake of 20g a day for women and 30g for men.

4.3 The lowest guidelines for women are Poland at 10g and 14g a day from the US, with an average of 20g (WHO guidelines, France, Australia, New Zealand, Sweden, Switzerland). Some of the highest are from Canada (27.2g). the UK sits comfortably in the evidence zone of suggesting 16–24g as a daily guide.

4.4 The lowest guidelines for men are 20g in Poland, Sweden and Australia (up to 40g on occasions), rising to 28g in the US, 30g in France, New Zealand and WHO, and 40g in Spain, hence the UK guide of 24–32g is in balance.

4.5 For the many countries where there are no official Government guidelines, such as Belgium, China, Germany, Hungary, India or Russia, it is recommended that the WHO low risk responsible drinking guidelines are followed. Which are:

(2) Women should not drink more than two drinks (10g) a day on average.

(3) For men, not more than three drinks (10g) a day on average.

(4) Try not to exceed four drinks on any one occasion:

(0) Don't drink alcohol in some situations, such as when driving, if pregnant or in certain work situations and abstain from drinking at least once a week.

Men or women who consistently drink more than these recommended levels may increase risks to their health.

Increasing Moves to Stating a Maximum Number of Drinks a Day

4.6 Reflecting an acknowledgement that people celebrate and party, several guidelines now have an "upper limit":

— US guidelines: No more than three drinks in any single day for women (42g) and for men no more than four drinks (56g) in any single day for men.

— WHO—no more than 4 drinks on one occasion (40g).

— Australia's 2008 guidelines: up to 40 g of ethanol on occasional days for men and women.

4.7 Protection for older populations

Canadian guidelines: "men and women consuming up to 14 and 9 standard drinks (13.6g) per week respectively, have a lower risk of early death than abstainers."

UK guidance: "The health benefits are more evident from regular daily drinking." Specifically, men over age 40 and postmenopausal women are emphasized as recipients of a "significant health benefit in terms of reduced coronary heart disease mortality and morbidity." Middle aged or elderly non-drinkers or infrequent drinkers and especially those at risk for heart disease "may wish to consider the possibility that light drinking may be of benefit to their overall health and life expectancy."

US revised guidelines 2010: "In most Western countries where chronic diseases such as CHD, cancer, stroke and diabetes are the primary causes of death, results from large epidemiological studies consistently show that alcohol has a favourable association with total mortality especially among middle age and older men and women".

4.8 Balance between harms and benefits

These are reflected well in the US guideline conclusions:

> "The hazards of heavy alcohol (ethanol) intake have been known for centuries. Heavy drinking increases the risk of liver cirrhosis, hypertension, cancers of the upper gastrointestinal tract, injury, and violence. An average daily intake of one to two alcoholic beverages is associated with the lowest all-cause mortality and a low risk of diabetes and CHD among middle-aged and older adults. Despite this overall benefit of moderate alcohol consumption, the evidence for a positive association between alcohol consumption and risk of unintentional injuries and breast and colon cancer should be taken into consideration. The DGAC recommends that if alcohol is consumed, it should be consumed in moderation, and only by adults. "Reference: www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/PolicyDoc/Chapter3.pdf".

So, to conclude, The International Scientific Forum on Alcohol Research and the social Scientific and Medical Council of Alcohol in Moderation believe the current guidelines reflect the current scientific evidence base regarding alcohol and health and definitions of safe or low risk drinking well. It may be wise, as is the case with the USDA guidelines, to review the evidence base every 5 years to ensure that emerging research is accounted for.

Forum Directors

R Curtis Ellison, MD, Section of Preventive Medicine/Epidemiology, Boston University School of Medicine, Boston, MA, USA (Co-Director)

Helena Conibear, Alcohol in Moderation, Bath, UK (Co-Director)

Forum Members

Alan Crozier, PhD, Plant Biochemistry and Human Nutrition, University of Glasgow, Scotland, UK

Alun Evans, MD, Centre for Public Health, The Queen's University of Belfast, Belfast, UK

David Vauzour, PhD, Senior Research Associate, Department of Nutrition, Norwich Medical School, University of East Anglia, Norwich, UK

Oliver James, MD, Head of Medicine, University of Newcastle, UK

Jeremy P E Spencer, PhD, Reader in Biochemistry, The University of Reading, UK

Alberto Bertelli, MD, PhD, Institute of Human Anatomy, University of Milan, Italy

Dee Blackhurst, PhD, Lipid Laboratory, University of Cape Town, Cape Town, South Africa

Giorgio Calabrese, MD, Docente di Dietetica e Nutrizione, Umana Università Cattolica del S. Cuore, Piacenza, Italy

Maria Isabel Covas, DPharm, PhD, Cardiovascular Risk and Nutrition Research Group, Institut Municipal dÍnvestigació Mèdica, Barcelona, Spain

Giovanni de Gaetano, MD, PhD, Research Laboratories, Catholic University, Campobasso, Italy

Luc Djoussé, MD, DSc, Dept. of Medicine, Division of Aging, Brigham & Women's Hospital and Harvard Medical School, Boston, MA, USA

Harvey Finkel, MD, Hematology/Oncology, Boston University Medical Center, Boston, MA, USA

Tedd Goldfinger, DO, FACC, Desert Cardiology of Tucson Heart Center, University of Arizona School of Medicine, Tucson, AZ, USA

Lynn Gretkowski, MD, Obstetrics/Gynecology, Mountainview, CA, Stanford University, Stanford, CA, USA

Dwight Heath, PhD, Dept. of Anthropology, Brown University, Providence, RI, USA

Ulrich Keil, MD, Institute of Epidemiology & Social Medicine, University of Muenster, Germany

Arthur Klatsky, MD, Dept. of Cardiology, Kaiser Permanente Medical Center, Oakland, CA, USA

Maritha J Kotze, PhD, Human Genetics, Dept of Pathology, University of Stellenbosch, Tygerberg, South Africa.

Dominique Lanzmann-Petithory,MD, PhD, Nutrition/Cardiology, Praticien Hospitalier Hôpital Emile Roux, Paris, France

Federico Leighton, MD, Laboratorio de Nutricion Molecular, Facultad de Ciencias Biologicas, Universidad Catolica de Chile, Santiago, Chile

Ross McCormick, PhD, MSc, MBChB, Associate Dean, Faculty of Medical and Health Sciences, The University of Auckland, Auckland, New Zealand

Francesco Orlandi, MD, Dept. of Gastroenterology, Università degli Studi di Ancona. Italy

Lynda H Powell, MEd, PhD, Chair, Dept. of Preventive Medicine, Rush University Medical School, Chicago, IL, USA

Ian Puddey, MD, Dean, Faculty of Medicine, Dentistry & Health Sciences, University of Western Australia, Nedlands, Australia

Erik Skovenborg, MD, specialized in family medicine, member of the Scandinavian Medical Alcohol Board, Aarhus, Denmark

Jan Snel, PhD, Social and Behavioral Sciences, University of Amsterdam, Amsterdam, Holland

Arne Svilaas, MD, PhD, general practice and lipidology, Oslo University Hospital, Oslo, Norway

Pierre-Louis Teissedre, PhD, Faculty of Oenology–ISVV, University Victor Segalen Bordeaux 2, Bordeaux, France

Gordon Troup, MSc, DSc, School of Physics, Monash University, Victoria, Australia

Fulvio Ursini, MD, Dept. of Biological Chemistry, University of Padova, Padova, Italy

David Van Velden, MD, Dept. of Pathology, Stellenbosch University, Stellenbosch, South Africa

Andrew L Waterhouse, PhD, Marvin Sands Professor, Department of Viticulture and Enology, University of California, Davis.

Yuqing Zhang, MD, DSc, Clinical Epidemiology, Boston University School of Medicine, Boston, MA, USA

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September 2011

Supplementary written evidence submitted by the International Scientific Forum on Alcohol Research and AIM, Alcohol in Moderation (AG 09a)

We followed the first evidence meeting at the Commons last week with interest. Two very important things were not brought up:

(1) The Australian and Canadian responsible drinking reviews were brought up, but no mention of the US reviews were made. The US is the only country in the world to have carried out systematic reviews of the evidence base for guidelines every five years—it is a process that takes over a year as you will see and involves an impartial panel of specialists.[6,7]

(2) A lot of time was spent on "specifics" of particular diseases, especially heart disease and cancer. No mention was made of epidemiology and alcohol and all cause mortality—this is the key on which low risk guidelines are made. Ie you risk of dying if you drink a specific amount of alcohol daily/regularly. This approach balances out the "protective" effect of alcohol on heart disease in older populations and the negative effect of alcohol and cancer at higher doses for example. The "tipping point", as laid out

[6] http://www.cnpp.usda.gov/Publications/DietaryGuidelines/2010/DGAC/Report/D-7-Alcohol.pdf

[7] http://www.usda.gov/wps/portal/usda/!ut/p/c5/04_SB8K8xLLM9MSSzPy8xBz9CP0os_gAC9-wMJ8QY0MDpxBDA09nXw9DFxcXQ-cAA_1wkA5kFaGuQBXeASbmnu4uBgbe5hB5AxzA0UDfzyM_N1W_IDs7zdFRUREAZXAypA!!/dl3/d3/L2dJQSEvUUt3QS9ZQnZ3LzZfUDhNVlZMVDMxMEJUMTBJQ01IMURERDFTODU!/?printable=true&contentidonly=true&contentid=2008%2f10%2f0275.xml

in our submission is approximately 20g a day for women and 30g a day for men; importantly the evidence base points to little and often and preferably with food as the least risky pattern of drinking—rather than abstinence and binge.

October 2011

Written evidence submitted by the Population Health Sciences Research Network (AG 10)

BACKGROUND

1. The Population Health Sciences Research Network (PHSRN) is a network of Medical Research Council research units and centres which aims to bring together and add value to MRC's existing investments in public health, health services and epidemiology research by:

- galvanising MRC's research effort with a focus on methodological approaches to population health sciences research;
- adding value and strengthening research expertise intramurally by pooling and sharing resources to create a more effective critical mass in population health sciences, especially in underrepresented disciplines; and
- providing a coordinated voice on research and policy issues in population health sciences.

2. The PHSRN includes the following organisations, chaired by Professor Cyrus Cooper at the MRC Lifecourse Epidemiology Unit:

MRC BIOSTATISTICS UNIT

- MRC Centre for Causal Analyses in Translational Epidemiology.
- MRC Centre for Cognitive Ageing and Cognitive Epidemiology.
- MRC Centre of Epidemiology for Child Health.
- MRC Centre for Nutritional Epidemiology in Cancer Prevention and Survival.
- MRC Clinical Trials Service Unit and Epidemiological Studies Unit.
- MRC Clinical Trials Unit.
- MRC Lifecourse Epidemiology Unit.
- MRC Epidemiology Unit.
- MRC General Practice Research Framework.
- MRC Human Nutrition Research.
- MRC/CSO Social and Public Health Sciences Unit.
- MRC Unit for Lifelong Health and Ageing.

CONSULTATION ISSUES

1. What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed?

2. Could the evidence base and sources of scientific advice to Government on alcohol be improved?

3. How well does the Government communicate its guidelines and the risks of alcohol intake to the public?

4. How do the UK Government's guidelines compare to those provided in other countries?

PHSRN RESPONSE

PHSRN is in a position to address inquiry question 2 "Could the evidence base and sources of scientific advice to Government on alcohol be improved?"

1. Several members of the MRC Population Health Sciences Research Network undertake research into the effects of alcohol consumption. MRC research consists of several broad themes including: predictors and long-term consequences of alcohol use, intervention studies including community and pharmacological interventions, biological and physiological effects of alcohol consumption, and alcohol misuse and violence.

2. In addition to this, the NICE antenatal care guideline summarises recommendations and evidence for alcohol use in pregnancy:
http://guidance.nice.org.uk/CG62/NICEGuidance/pdf/English

There is also a Foresight report on addiction which includes alcohol as well as other drugs and psychoactive substances:
http://www.bis.gov.uk/foresight/our-work/projects/published-projects/brain-science

3. The 2009–14 MRC Strategic Plan, "*Research Changes Lives"*, emphasises the impact that world-class research has on improving the health and wellbeing of society. This involves delivering better health and wellbeing through developing prevention interventions, new treatments for diseases, producing well-founded policy guidance for research governance and ethics, and maintaining excellence in the basic research that underpins these activities.

The current MRC strategy clearly identifies the importance of research into alcohol consumption. The MRC is leading a strategy for addiction and substance misuse research, which is funding cross-discipline research addressing the biological, medical, social and economic aspects of addiction and substance misuse. The strategy is led by the MRC in partnership with the Economic and Social Research Council (ESRC) on behalf of the Office for Strategic Coordination of Health Research (OSCHR).

The aims of the strategy are to:

- Make better use of existing resources (expertise and infrastructure).
- Build research capacity in the UK within the addiction field.
- Increase coordination and connectivity.
- Carry out innovative, cross-disciplinary studies that will lead to improved public health.
- Take a frontline position in the cross-Government drive to reduce the harm caused by illicit drugs, alcohol, tobacco (nicotine) and problem gambling.

The four thematic categories for research clusters in addiction research include *cause*, *harm*, *treatment* and *alcohol*. Whilst alcohol may feature within all categories, it has been singled out as a theme as it is considered a special case in relation to Government strategies and public health problems. The focus will investigate the effects of hazardous drinking and support interventions to reduce heavy alcohol consumption.

September 2011

Written evidence submitted by the Sheffield Addiction Research Group at the University of Sheffield (AG 11)

1. *What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed*?

1.1 The evidence base for alcohol intake guidelines is primarily epidemiological studies relating alcohol consumption at different levels to the risk of various harms which have been shown to result from drinking. Such studies can be used to identify at what level of alcohol consumption the risk of harm begins to increase. The evidence base addresses both individual harms and "all cause mortality" (the total risk of premature death from any harm).

1.2 Different measures of risk

1.2.1 There are different ways of reporting the risk associated with levels of alcohol consumption. Amongst the most common ways are the use of absolute risk and relative risk measures. The absolute risk of experiencing harm is the simple probability that harm will be experienced at a given level of consumption. The relative risk is the probability of experiencing harm as a proportion of the risk associated with a reference category (usually abstention).

1.2.2 Both approaches have advantages and drawbacks. The absolute risk approach gives a clear indication of the level of risk associated with a particular behaviour (eg drinking *x* units a day is associated with a *y*% risk of premature mortality). However, it gives no comparison of how much greater this risk is than that experienced by non-drinkers. This can produce counterintuitive results whereby an individual belonging to a low risk group may perceive their high levels of consumption to be less harmful than if they were in a high risk group with lower consumption. Moreover, when setting a level of consumption which should not be exceeded, the threshold is typically based on a choice of absolute risk level which is essentially arbitrary (eg although the threshold could be set at a 1% risk of premature mortality, it could just as easily be 2%, 5% or 10%).

1.2.3 In contrast, the relative risk approach provides a measure of how much greater the risk of drinking at a particular level is compared to abstinence (eg drinking *x* units a day is associated with a *y* times greater risk of premature mortality than abstinence). Therefore, it focuses more clearly on the increase in risk which is actually associated with consumption. However, relative risk measures do not indicate whether the risk of higher levels of consumption is large in absolute terms or just large relative to abstinence.

1.2.4 As noted above, when using absolute risk measures guidelines for alcohol consumption can be derived by selecting a threshold level of risk and recommending not drinking at levels above those associated with that risk. When using relative risk measures there are two possible ways of deriving guidelines. Firstly, the threshold can be set at the consumption level above which the increase in risk of harm, relative to abstinence, becomes statistically significant. Secondly, and noting the protective effects of moderate consumption (see below), the

threshold can be set at the consumption level above which the increase in risk of harm is statistically significantly higher than the greatest protective effect.

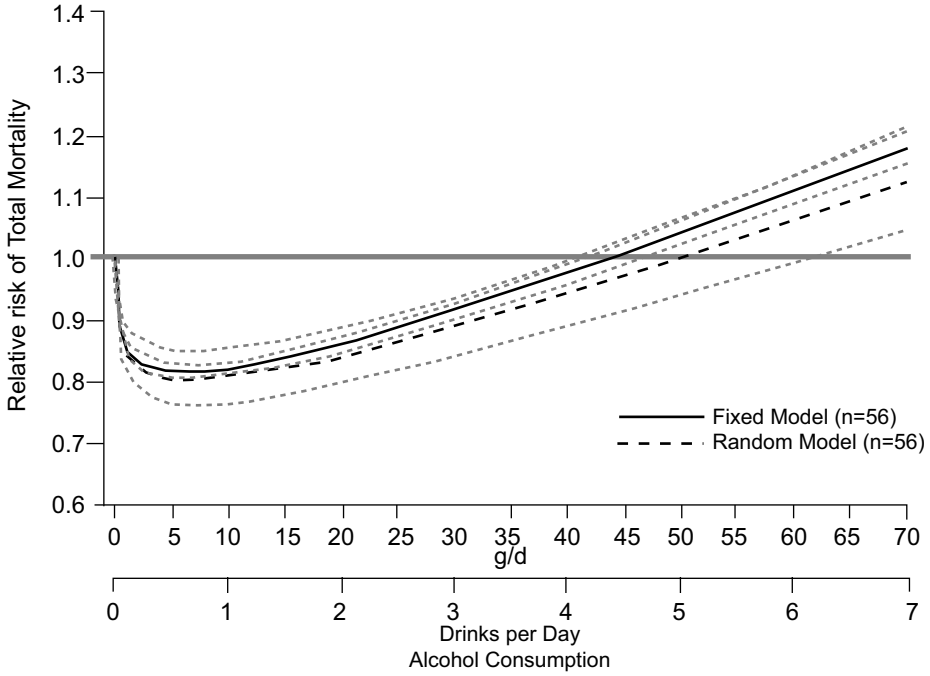
1.3 How up to date is the evidence base?

1.3.1 Studies of the relationship between alcohol and harm are frequently subjected to systematic reviews in order to identify those studies of the highest quality and to aggregate the effects into a more robust overall estimate of the relationship. Systematic reviews are carried out on a regular basis for individual harms[8,9,10] and for all-cause mortality.[11,12] This evidence is also compiled in the WHO's work on the burden of total disease which is due to alcohol.[13] Therefore, the evidence on which guidelines are based can be considered as of the highest quality available and is reviewed and updated on a regular basis.

1.3.2 Recent examples of relative and absolute risk estimates for different levels of consumption taken from systematic reviews are provided in figures 1 and 2 below.

Figure 1

RELATIVE RISK FUNCTION FOR TOTAL MORTALITY BY AVERAGE ALCOHOL CONSUMPTION. SOURCE: DI CASTELNUOVO ET AL., 2006[13]



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[12] Di Castelnuovo, A, Costanzo, S, Bagnardi, V et al (2006). "Alcohol Dosing and Total Mortality in Men and Women: An Updated Meta-analysis of 34 Prospective Studies", *Archives of Internal Medicine*, 166 pp.2437–45

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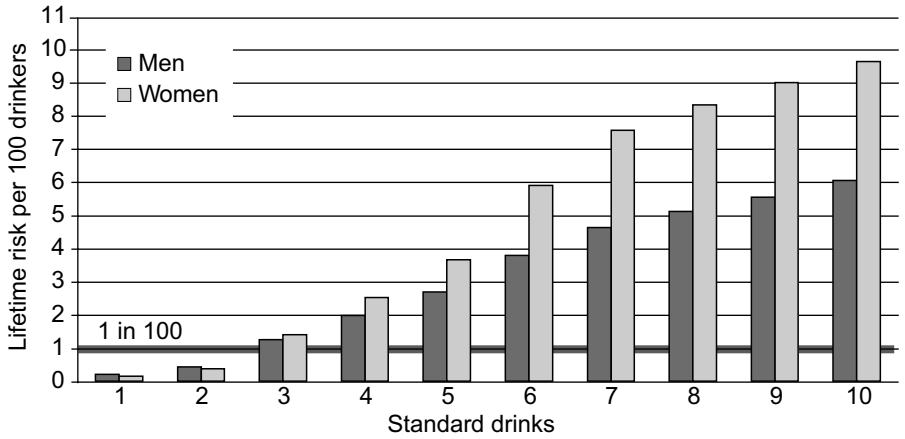
Figure 2

ABSOLUTE RISK OF MORTALITY BY AVERAGE ALCOHOL CONSUMPTION. SOURCE: NHMRC., 2008[14]



2. *Could the evidence base and sources of scientific advice to Government on alcohol be improved*?

2.1 We identify several weaknesses in the current evidence base which should be taken into consideration when formulating drinking guidelines.

2.2 The type of harm experienced and its link to different types of drinking

2.2.1 Elevated levels of alcohol consumption are associated with increased risk of both *chronic* and *acute* health-related harms. Chronic harms are conditions such as liver cirrhosis, coronary heart disease and cancers and the risk of having such conditions has been shown to be higher for individuals with higher levels of average alcohol consumption over a given time period. Acute harms include injuries and alcohol poisoning and these harms have been shown to be more closely associated with higher levels of recent alcohol consumption (ie the level of intoxication). The evidence base for individual harms is therefore divided between the risks of harm from an individual's average alcohol consumption and also their risk from individual episodes of alcohol consumption.

2.2.2 As drinkers are more likely to be interested in their risk of mortality from any cause, rather than from a particular harm, guidelines tend to be based on studies of all cause mortality. This presents a problem as harms associated with average and episodic consumption are aggregated. Average consumption is therefore serving as a less accurate proxy measure of the level of episodic consumption.

2.2.3 Evidence should recognise that different types of harm are the results of different types of drinking. Where possible, evidence should link acute harms to episodic drinking and chronic harms to average consumption although the limitations of data do not always permit this. Guidelines should also reflect this distinction and recommend upper limits for both typical and episodic consumption. Using the current guidelines as an example, this would give the recommendation that "men should not regularly drink more than 3–4 units of alcohol a day and not more than 8 units in any single drinking session".

2.3 The possible protective effects of moderate drinking

2.3.1 Drinking guidelines must take into account the evidence of a protective effect from moderate alcohol consumption.[15] This is seen in all cause mortality studies and largely stems from an apparent reduced risk of coronary heart disease for moderate drinkers compared to non-drinkers. This protective effect is not seen at higher levels of alcohol consumption and, importantly, there is also no protective effect seen in moderate drinkers who also have regular heavy drinking occasions.[16]

2.3.2 Recent work has questioned the validity of the protective effect after a review found studies which pooled "never drinkers" and "former drinkers" into a single "non-drinker" category saw larger protective effects

[14] NHMRC (National Health and Medical Research Council) (2006) "Australian Guidelines to Reduce Health Risks from Drinking Alcohol", available at http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf accessed 12 September 2011

[15] Ronksley, P E, Brien, S E, Turner, B J, Mukamal, K J & Ghali, W A (2011). "Association of alcohol consumption with selected cardiovascular disease outcomes: a systematic review and meta-analysis", *British Medical Journal*, 342, d671, DOI: 10.1136/bmj.d671

[16] Bagnardi, V, Zatonski, W, Scotti, L, La Vecchia, C & Corrao, G (2008). "Does drinking pattern modify the effect of alcohol on the risk of coronary heart disease? Evidence from a meta-analysis", *Journal of Epidemiology and Community Health*, 62 pp.615–9

than those which separated never and former drinkers.[17] This suggests a proportion of the mortality risk associated with abstinence may be due to the inclusion of abstainers who are in fact former heavy drinkers who now suffer from alcohol-related coronary heart disease. If ex-drinkers are excluded, a small cardio-protective effect of moderate consumption remains for older age groups. However, age-differentiated drinking guidelines would likely make the message very complex and should probably be avoided.

2.4 The reliability of survey data on consumption

2.4.1 Many studies of the risk of alcohol consumption are based on survey data which ask respondents to report their consumption. Such reports are known to substantially underestimate the amount of alcohol believed to be consumed based on sales data, by between 40% and 60%. Although efforts have been made to explain and address this problem,[18] many estimates of the risk from alcohol consumption may be biased upwards by under-reporting of heavy consumption.

2.4.2 Further efforts are therefore required to account for the under-reporting and under-estimation of alcohol consumption and to minimise the extent of bias on estimates of the risk from alcohol consumption.

2.5 The influence of factors other than drinking which are not included in analyses

2.5.1 Most studies make some attempt to take account of factors other than alcohol consumption which may lead to harms or premature mortality. For example, studies will typically account for the fact that men are often at greater risk than women and that risk of mortality increases with age. However, other important influences are less consistently taken account of, such as socioeconomic status, broader health status and a range of lifestyle factors (eg diet, physical activity and working environment). As many of these factors are also related to alcohol consumption (eg those who drink more tend to be less active and have a poorer diet) failure to account for them may mean their effects on mortality or harm are incorrectly attributed to alcohol consumption. In particular, these factors have been identified as potentially leading to overestimation of the protective effects of alcohol at moderate levels of consumption.[19]

2.5.2 Again, further work is required to establish the extent to which estimates of the level of risk due to alcohol consumption are biased by factors not included in analyses.

2.6 Protection of data

2.6.1 We also note that the NHS Information Centre recently withdrew its contribution to the funding of the General Lifestyle Survey (GLS). This has meant no further data will be collected on alcohol and other health issues. The GLS (and its predecessor the General Household Survey) provided a valuable source of in-depth data on alcohol consumption in the UK stretching back over four decades. They are recognised as the best source of data on UK consumption in the UK and are the basis for key government reports on consumption and many academic studies. Failing to protect such data sources greatly weakens the ability of the scientific community to advise the Government on alcohol.

2.6.2 The GLS also collected longitudinal data on the alcohol consumption of a panel comprising of the same individuals at several time points; however, due to funding shortages, this data is not being made available to researchers. This is a wasted opportunity as no other panel study in the UK has collected such rich data on alcohol consumption and other health-related variables. Again, failure to fund the release of valuable consumption data is a major hindrance to the scientific community's efforts to provide authoritative advice to the Government.

3. *How well does the Government communicate its guidelines and the risks of alcohol to the public*?

3.1 The NHS Information Centre reports on data collected in two surveys examining adults' awareness, recall and adherence to drinking guidelines.[20]

3.2 The findings show that awareness of units of alcohol is high with 90% of respondents in 2009 having heard of units and this has risen from 79% in 1997. Respondents were slightly less likely to have heard of drinking limits with 75% having done so, up from 54% in 1997. However, it is concerning that only 35% of men and 43% of women claimed to know what the recommendations which applied to them were. Furthermore, the NHS Information Centre report notes that those respondents who attempted to state the recommendations were more often wrong than right.

[17] Fillmore, K M, Kerr, W C, Stockwell, T, Chikritzhs, T & Bostrom, T (2006). "Moderate alcohol use and reduced mortality risk: Systematic error in prospective studies", *Addiction Research and Theory*, 17, (5 Supplement) S16–23

[18] Meier, P S, Meng, Y, Holmes, J, et al (2011). "Alcohol policy appraisals: The effect of adjusting survey and per capita consumption estimates for known biases", paper presented at *37th Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society*, Melbourne, Australia, 11–15 April 2011

[19] Chikritzhs, T, Fillmore, K & Stockwell, T (2009). "A healthy dose of scepticism: four good reasons to think again about protective effects of alcohol on coronary heart disease", *Drug and Alcohol Review*, 28 pp.441–4

[20] NHS The Information Centre (2011) "Statistics on Alcohol: England, 2011", available at http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Alcohol_2011/NHSIC_Statistics_on_Alcohol_England_2011.pdf accessed 2nd September 2011

3.3 In addition to being aware of the guidelines, adherence to guidelines require drinkers to also monitor their consumption which means being aware of the number of units in drinks they consume and, as necessary, keeping a check on their daily or weekly consumption. Although knowledge of the number of units in preferred drinks was relatively high at around 60%-70%, just 13% of drinkers kept a check on their consumption in 2009. This may many individual's belief that their consumption is at a moderate level, however it also suggests conscious adherence to drinking guidelines is rare.

3.4 Heavier drinkers were more likely to have heard of units and drinking limits and frequent drinkers were also more likely to be able to correctly identify the unit content of drinks. This suggests information campaigns have been successful in ensuring those drinkers at the greatest risk are more aware of that risk. It may also suggest that including the unit content on labels eventually leads to retention of this information. However, other information was less successfully communicated as heavy drinkers were no more likely to recall what the recommended drinking guidelines were. Heavier drinkers were also only slightly more likely to monitor their alcohol consumption.

3.5 Overall, these findings suggests the Government has been increasingly successful in communicating the idea of drinking guidelines and some of the concepts around it, such as units and unit content of drinks. Success has also been highest in the target group of heavier drinkers. However, it can claim less success in communicating recommended levels of consumption, knowledge of which was low for all groups.

3.6 The use of information campaigns has led to greater public awareness of the risks associated with drinking and how these relate to the consumption of different types and quantities of alcoholic drinks. However, there is little evidence this knowledge has impacted on behaviour. Whilst it is important that information campaigns continue to inform the public about the risks associated with drinking, information alone may have limited utility in motivating drinkers to reduce their consumption. To achieve reductions in consumption, further action may be required both by making explicit reference to the harms which may be incurred if drinking guidelines are exceeded and taking additional action beyond information campaigns.

4. *How do the UK Government's guidelines compare to those provided in other countries*?

4.1 The attached document produced by Alcohol in Moderation entitled "Sensible Drinking Guidelines" gives recommended drinking guidelines for a selection of developed nations.[21] As different nations define a unit of alcohol differently or base guidelines upon the notion of a "standard drink", it is easier to compare guidelines after converting recommended levels into pure alcohol consumption in grams. Some nations give guidelines as average daily thresholds whereas others use average weekly thresholds. For simplicity here, we only compare those with average daily thresholds.

4.2 The UK guidelines recommend not regularly drinking more than 24–32g of pure alcohol a day if you are a man and not more than 16–24g if you are a woman. These levels are similar to those used in many other nations such as Italy (24–36g and 12–24g), the USA (24g and 14g), France (30g and 20g), Germany (36g and 24g) and New Zealand (30g and 20g). Some nations do have slightly higher recommendations, particularly for men, such as The Netherlands and Spain (both 40g and 24g). Few nations have significantly lower guidelines and those that do include Denmark (21g and 14g), Poland (20g and 10g) and Slovenia (20g and 10g).

4.3 The UK drinking guidelines can be considered as in line with other developed nations and there appears no case to be made for altering them on the basis of international consensus.

5. *Acknowledgements*

5.1 The Sheffield Addiction Research Group would like to thank Tim Stockwell of the University of Victoria, Canada for his assistance in producing this document.

6. *Declaration of interests*

6.1 The Sheffield Addiction Research Group do not have any potential conflicts of interest and receive no funding from the alcohol industry.

September 2011

[21] Alcohol in Moderation (2011) "Sensible drinking guidelines" available at http://www.drinkingandyou.com/site/pdf/SENSIBLE%2520DRINKING.pdf accessed 2 September 2011

Written evidence submitted by the White Ribbon Association (AG 12)

1. *How well does the Government communicate its guidelines and risks of alcohol intake to the public?*

Government communication can be confusing and sometimes contradictory.

Media campaigns tend to highlight information about units, but in general the public are unaware of what a unit is. In addition, campaigns can be seasonal (usually around Christmas), when people are often out celebrating and not watching TV.

We use a units measuring activity during alcohol awareness sessions delivered by the *White Ribbon Association* in schools, colleges and other establishments.

The activity involves substituting water for alcohol, and asking participants to state what drink they would usually have at home and to then pour out the amount they would normally drink into the glass. Many participants are often genuinely shocked when they are shown how to work out the amount of units in the drink they have poured out and then calculate what the total units would be in an evening.

The message of drinking in the home and how measurements vary needs to be expressed more. I understand that the *"They all add up"* campaign did focus at least one of its adverts on a woman having a glass of wine at home; although the advert gave the units of a standard pub measurement, it was obvious that more wine had been poured into the glass than the standard measurement.

I think more could be done in the front line around unit guideline awareness, perhaps using a colour coded guide on drinks, (such as the traffic light system on foods), stating how high in units the drink was in view of the recommended daily allowance.

Manufactures should also highlight units more clearly on bottles and cans, in addition, the size of font used needs to be larger and standardised. The Government should make it statutory for pubs, off licence to advertise unit amounts, as they do in Australia. This could also be extended to restaurants and clubs.

As an organisation which communicates with the general public through our alcohol awareness sessions, I find the literature produced by *Drinkaware* can often be too bulky to carry around (such as the units calculator) or can be expensive to purchase. I also consider the Government is now focusing on issuing information via the internet, however not all members of society have access or the skills to use the internet, so other marketing methods remain essential.

The message of the "safe alcohol intake" guidelines are for the healthy adults of society, those with certain illnesses or conditions do pose a high risk with regard to alcohol causing damage, due to the way the body fails to process the alcohol. This information is not made clear enough in the messages conveyed by the Government.

Consideration should be given to new initiatives of how to publicise these factors, alongside the illnesses or conditions caused by alcohol, and to focus on international and national awareness days.

The guidelines of alcohol in pregnancy are misleading and there seems little information available within the public health sector for expectant mothers, to gain clarity. Although the UK recognises the *International Awareness Day of Foetal Alcohol Syndrome (FAS)*, there does not appear to be any Government advertising campaigns to raise awareness concerning alcohol consumption during pregnancy and the consequences of *FAS* (which is an incurable but preventable condition) to the child, family and the overall financial cost with regard to the health, education and social care of the individual, as a child and into adulthood. In addition, *FAS* is not an issue which is generally discussed in the sex education programmes in schools, even when teenage pregnancies and looking after a baby are discussed.

This is very concerning, especially when there are so many specialists and support networks in the field of *FAS* within the UK who would be able to advise the Government regarding a campaign.

The messages regarding the impact alcohol has on the body can vary. Some social groups are told it is bad for your health and others are told certain amounts are good for your health! These conflicting messages often cause further confusion to the general public.

Although the UK has a national *Alcohol Awareness Week*, it has been noted that media advertising to the general public about this is negligible. Although relevant websites, such as *Alcohol Concern*, carry information, this can be at very short notice for health promotion agencies, such as our organisation, to have time to develop sessions with schools and community projects. It is very different with *No Smoking Day* campaigns which seem to be more organised and offer at least eight months notice.

Alcohol awareness should also be a statutory subject in schools. Education and correct information needs to reach individuals *before* social behaviours take over, ideally at KS2, and before children move into secondary education, as well as KS3/4 level. How to say "no" and that this is acceptable, should also be conveyed within campaigns.

2. *How do the UK Government's guidelines compare to those provided in other countries?*

Firstly, the UK bases their safe levels on both daily and weekly allowances. However these units, if taken daily at the higher rate, will exceed the weekly allowance by seven units for men and women. *Daily* unit

amounts tend to give the impression that it is acceptable to drink every day. Alcohol free days and the benefits of these do not appear to be highlighted sufficiently.

The recommended alcohol guidelines for expectant mothers and breastfeeding mothers tend to be higher in the UK than other countries in Europe and the rest of the world. Most countries promote abstinence through the pregnancy and the breastfeeding stage, due to the harm alcohol causes the baby. These recommendations seem to be altered nearly every few years which causes confusion within this society group.

The guidelines for young people are not clear enough. In the UK it is recommended young people should not drink and live an alcohol free childhood, yet the law allows parents to give children aged from five years a drink at home, and within restaurants from the age of 16. In your guideline it states that those young people, who drink from the age of 15, should drink less than the daily recommended allowance; however there are no clear guidelines as to how much is less!

This area of the law can be confusing to young people, especially when trying to educate them of the dangers of alcohol.

The law needs to change regarding five year olds drinking at home, especially when parents are being encouraged to allow their children's childhood to be alcohol free.

Some countries categorise individual groups into a range of levels of risk, and adjust the alcohol intake accordingly. This method needs to be considered in the UK as, for instance, body proportions and medical conditions react to alcohol in different ways.

September 2011

Written evidence submitted by Dr William Haydock (AG 14)

Context and Summary

1. Government guidelines regarding alcohol consumption are primarily designed to inform people's alcohol consumption. Although they must be based on scientific analysis, they should not be set without reference to their aim in shaping drinking behaviour—and indeed the numerical figures have never been precise in terms of how they relate to harms resulting from alcohol use (Nicholls 2009, p.212). The guidelines and associated communication strategies must be chosen with an awareness of how people may respond to them. This submission therefore discusses potential responses of current drinkers to various Government social marketing campaigns.

2. It is not clear that recent strategies for communicating guidelines for consumption, exemplified by the *Units* and *Would You?* campaigns, have been effective in altering young people's drinking behaviour. Some young people actively seek out the unusual, and apparently undesirable—and yet not criminal—behaviour depicted in the *Would You?* advertisements, while others defend their drinking against quantitative consumption guidelines as communicated by the *Units* campaign by reference to the understanding lying behind *Would You?*: that behaviour while and after drinking is the measure by which problematic drinking should be defined, rather than quantity consumed.

3. Therefore, learning from previously successful campaigns to change norms and behaviour, I recommend that the setting and communication of alcohol guidelines be shaped by a focus on demonstrable crimes and harms to the individual drinker concerned and, perhaps more powerfully, to others around them.

Credentials

4. I will shortly be taking up a post as Information and Research Officer for Dorset County Council's Drug Action & Community Safety Team. However, I write here in a personal capacity and this submission is based on research and analysis conducted for my PhD, "Gender, Class and "Binge" Drinking", awarded by Bournemouth University, available from http://eprints.bournemouth.ac.uk/16236/. This included analysis of existing Government policy relating to alcohol, and interviews, observations and focus groups involving a range of relevant stakeholders: young drinkers themselves as well as various related professionals from youth workers to bar staff and managers, as well as local council staff. The names have been changed of all participants and venues referred to herein.

Declaration of Interests

5. I am not aware of any relevant interests. The research for my PhD was funded directly by Bournemouth University.

Recent Government Social Marketing Campaigns

6. The key attempt to communicate specific Government guidelines on drinking in recent years was the *Units* campaign of 2008. This showed the number of units in various drinks, such as glasses and bottles of

wine, pints of beer, and glasses of gin and tonic, followed by the phrase: "Units. They all add up." The targeted individual was considered to be 25 or over (see Home Office and NHS 2008).

7. In tandem with the *Units* campaign, the Government ran the *Would You?* campaign, which aimed to highlight the possible negative consequences of drinking "excessively", asking drinkers whether they would undertake a number of actions if they were sober. These actions ranged from the criminal through the dangerous to the antisocial or, arguably, simply immoral. The campaign was organised around the overarching theme "You wouldn't do this sober". Various posters, for example, advised drinkers not to smash up a shop, jump in rivers, or urinate in the street while another, implicitly aimed at young women, asked whether they would get into a car with a man they had just met if they were sober.

8. In some cases, the consequences of drinking that were portrayed as being undesirable in these two campaigns clearly relate to personal health and safety or committing crimes against other people. For example, to smash a glass in someone's face, as one of the *Would You?* posters envisages, is unquestionably a crime. Equally, there are undoubtedly alcohol-related health issues underlying the *Units* campaign, even if their precise relationship with the specific recommended consumption limits may be debatable.

9. However, not all the apparently negative consequences of drinking envisaged by the *Would You?* campaign are so clear cut, and can be seen as resembling something of a moral panic.[22] A number of actions depicted might be considered "anti-social", but it is difficult to see who is the direct "victim" of the transgression—apart from the perpetrator, who might have their pride or self-respect damaged. This is well illustrated by the television advertisements for the *Would You?* campaign. One shows a young man preparing to go out(NHS and Home Office 2008a), another shows a young woman(NHS and Home Office 2008b); as they get ready, the man urinates on his shoes, spills food on his t-shirt and rips his jacket, the woman gets her skirt wet, smudges her eye make-up and smears vomit in her hair. The adverts then ask: "You wouldn't start a night like this so why end it that way?"

10. The actions are symbolic of being excessive and irresponsible. They are not normal everyday (or daytime) behaviour. However, it is not immediately clear why the Government should be concerned with all the actions in the advertisements from a crime and health perspective. Even urinating on one's shoes or having a wet skirt are unlikely to cause a health problem, although the fact that one has vomited suggests that one has drunk more alcohol than one's body can cope with. This approach sprang from the conviction that alcohol-related problems originate in a wider culture surrounding drinking in the UK—a conviction that has been central to both the Labour and the Coalition Governments' approaches to drinking.

11. Therefore, it appears that there are two key assumptions behind this approach. First, if the activities shown are being engaged in, then there is a significant risk of genuine offences or mistakes occurring—also as a result of alcohol consumption. Second, a focus on these activities is a way to shape drinkers' behaviour, as they will be ashamed of them.

12. This rationale also lay behind Diageo's similar 2007 *Choices* campaign. However, Diageo understood that this tactic and campaign was only suitable for targeting those who do feel ashamed of their drunken behaviour—which is a particular group of young drinkers, referred to as "irresponsible shamefuls".[23] In my research I did not find quite the same groupings as Diageo, but the point remains that not all drinkers in the night-time economy have a sense of shame that can easily be mobilised to change their behaviour, as I discuss in the following section.

Young People's Attitudes to Drinking

13. Many young people drink to get drunk, which according to recent Government definitions would classify them as "binge" drinkers (see, for example, Szmigin et al. 2008). I refer to this approach as a "carnivalesque" drinking style, which one participant, Ollie, explained in very clear terms, telling me that in order for a night out to be considered "legendary" something "unusual" must happen, and this is only really possible if people drink and get drunk.

14. The most striking example of such a "legendary" story was told to me by Hannah, a first-year university student reminiscing about a day she had spent drinking when she was 17. She had gone to the toilet in the pub where she and her friend had spent the afternoon drinking shots, and was walking back to her table when her friend came over to her in the middle of the pub and stopped her. Hannah had walked out of the toilet with both her trousers and underwear still around her ankles because she was so drunk. She explained that initially such incidents can be embarrassing but they can soon become amusing: "You think "Oh God", and a few, maybe a few months later on you think "Oh that's really funny", you tell it to all your friends and they laugh and you laugh." She then laughed herself, remembering the incident, and, thinking about it, declared: "It was brilliant though". Importantly, the day was considered "brilliant" despite the fact that later in the evening she was sick and fell over a small wall—and still bears the scar from the fall.

[22] This is perhaps an overused term but is helpful in this context. See Cohen (2002) originally, and Borsay (2007) and Hobbs (2005) on drinking specifically.

[23] For an introduction to this campaign, see the "Brief for Meeting 3" of Responsibility Deal: Working with businesses to improve Public Health, pp.9–10. Available from http://www.publichealthcommission.co.uk/pdfs/PHCMeetings/NA-Pre-reading.pdf

15. These are precisely the sorts of actions that were condemned in the *Would You?* campaign, yet in Hannah's case are, if not celebrated at the time, considered perfect fodder for a funny, legendary story later. The incident is not shied away from or entirely veiled in shame, though the re-telling of the story may involve negotiating shameful associations. Such drinkers are deliberately trying to end the night in a different way from how they started it, in contrast with the *Would You?* slogans. Any instruction to avoid certain situations where the problem or harm is not evident to the drinker is therefore likely, I suggest, to be met with indifference or frustration.

16. As in the Diageo *Choices* campaign, however, such social marketing campaigns are not necessarily targeted at "carnivalesque" drinkers. In my research I found that some drinkers reject such celebrations of out-of-the-ordinary behaviour, and stress instead their difference from those they see as being mainstream "binge" drinkers. I understand their approach to drinking using the term "everyday".[24]

17. In terms of alcohol consumption directly, this everyday approach rejects the idea of drinking to get drunk. Simon expressed this neatly when he told me "I enjoy a drink, rather than drink to enjoy myself", and "I drink and have a laugh" contrasting this with those who drink *in order to* have a laugh. He explained that, for him, drink *is* involved, but for most other "people today" drink *has* to be part of their night out.

18. However, this approach does not imply drinking within Government unit guidelines. Another participant, Sam, defended his consumption by suggesting that unit-based definitions of "binge" drinking are "stupid". He explained that he and his friends had been drinking in the *Rose and Crown* since 12.30pm and it was now about 7.30pm, yet they were not about to "kick off" despite having "binged" according to, as he saw it, the Government definition. As far as he was concerned, quantity of alcohol consumed was irrelevant; what was important was people's behaviour, and he stated in his defence that he and his friends were probably the "sanest" people there, certainly more so than some "18-year-olds" who had had "a couple of pints of Stella".

19. This is not to say that such drinkers did not in fact engage in activities that Government might consider undesirable, quite apart from any potential health damage of drinking significant quantities of alcohol. Two young men were particularly vocal in stressing their "difference" from other mainstream, "binge" drinkers. Nevertheless, one explained with a laugh how the other had once set fire to public bins in a park on his way home from a night out. This was told as a funny story, and was not seen to compromise their position as different from "binge" drinkers.

20. It is therefore not clear that campaigns of either approach—*Units* or *Would You?*—will be effective in targeting those with a carnivalesque or an "everyday" approach to drinking, disregarding the possible group of "irresponsible shamefuls" who might be identified and relied upon to respond in the desired way. Those with a carnivalesque approach will tend to see many of the criticisms of the *Would You?* campaign as unhelpful, and will reject its model of ideal drinking behaviour. Conversely, those taking an "everyday" approach would be unlikely to recognise themselves in such campaigns focusing on apparently out-of-control drinking behaviour as this does not fit their conceptions of their own behaviour or motivations. At the same time, the *Units* campaign seems unlikely to resonate with these "everyday" drinkers as they choose to define their behaviour as responsible in terms of behaviour relative to other drinkers.

Implications for Communication of Alcohol Guidelines and Social Marketing Policy

21. These criticisms serve to make the point that where Government has used multiple definitions of concepts, such as "binge" or "responsible", it is not always the case that drinkers will take these and use them to understand and change their own behaviour in the desired way. The idea of drinking responsibly when considered in terms of behaviour or motivation is completely at odds with the carnivalesque drinking style, and cannot be employed to regulate people's behaviour within it. On the other hand, the definition in terms of behaviour and motivation allows those within the "everyday" drinking style to see "binge" drinking as the primary problematic form of consumption, and their practices as "responsible".

22. One possible response to these problems is therefore that the concepts should be more clearly fixed and defined. It could be argued that the Government already has very clear unit definitions and daily and weekly limits, which have been communicated through the *Units* social marketing campaign, and yet drinkers like Sam still duck the issue. However, Sam was able to sidestep the Government's unit-based definition of "sensible" or "responsible" drinking by virtue of invoking another: the behaviour-based one. Although he had drunk more than the recommended number of units, he was still drinking "responsibly" because he was not behaving like a binge drinker, and therefore he could feel he was referencing legitimate authority to support his claim.

23. To some extent, it is difficult to avoid tensions and alternative definitions of "binge" or irresponsible drinking, because there are different ways in which alcohol-related problems can be conceptualised. There are potential long-term health issues but also immediate harms more associated with "binge" drinking, as well as other policy issues in the areas of crime and economics, for example. Nevertheless, I would suggest that tighter and more consistent definitions and campaigns can serve to resolve some of these issues.

24. My criticisms so far might be seen as somewhat counterintuitive or back-to-front. To some extent they suggest that a campaign to address "binge" drinking should be shaped by precisely the attitudes that it is trying to change. However, this approach can be better understood if it is considered that there are two ways to

[24] I have discussed the everyday and carnivalesque drinking styles in more detail elsewhere (Haydock 2009).

approach the aims of alcohol-related social marketing: first, to work within existing norms to make people manage their desires and behaviour better; second, to change those overarching norms themselves. The evidence presented here suggests that recent Government campaigns are unlikely to have been successful in the first of these aims; I would also suggest that these campaigns are also unlikely to succeed in the second.

25. When considering previous attempts to change social norms from a public health perspective, the—successful—examples of drink driving or, more recently, the ban on smoking in workplaces, are sometimes cited(eg Stead et al. 2009). Although the cases differ, with Government in both cases prepared to criminalise the activities in themselves, the comparison does provide useful lessons for alcohol policy given that the campaigns, separate from criminal justice proceedings, have served to make the targeted practices socially unacceptable—an aspiration of Government with respect to "binge" drinking.

26. One key feature of both smoking in public places and drink driving is that although both practices place individuals' own health at risk, this is not the basis on which either initiative was justified. Rather, the central point was that drink driving or smoking in someone's workplace can harm other people, and therefore the state does not consider that individual drivers or smokers should be allowed to impose this risk on others. There is no doubt that this argument can be applied to alcohol-related crime—for some people at least, their drinking-related behaviour places others at risk. Identifying such a hard-hitting impact could be a successful way to defuse the implicit criticism of the *Would You?* campaign inherent in the carnivalesque drinking style.

27. Therefore, when communicating the downsides of certain forms of drinking, I suggest that Government should focus on those where either the individual themselves or, perhaps more powerfully, another person is demonstrably harmed—rather than concerning itself with the broader moral health of British young people, in terms eerily reminiscent of previous "moral panics". This will also ensure greater consistency across different definitions and campaigns, as none of the harms could be easily dismissed. I argue that by condemning a particular drinking culture the important messages regarding health and individual safety may become diluted and therefore ignored. If these implications for social marketing can be summarised in one sentence, it is that one must be very clear about what the problem is, and who the message regarding this is being targeted at.

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September 2011

Written evidence submitted by Grampian Alcohol and Drugs Partnerships (AG 15)

1. Introduction

The Scottish Picture

1.1 We welcome this opportunity to respond to the UK Government's new inquiry into the evidence base for alcohol guidelines. Scotland, like the rest of the UK, has seen a substantial increase in alcohol related mortality and morbidity over the past 20 years.[1] Alarmingly, Scottish mortality rates from chronic liver disease are amongst the highest in Western Europe and have risen steeply at a disproportionate rate to those seen in rest of the UK.[2]

1.2 Nonetheless there is promising evidence that indicates alcohol related mortality is beginning to stabilise in Scotland.[3] Furthermore, self reported data suggests that the average number of units consumed on the heaviest drinking day for both men and women has fallen slightly.[3] While this data is encouraging there is a great deal of progress still to be made. In 2010, 11.8L (22.8 units) of pure alcohol were sold per adult in Scotland which is 23% more than that sold per adult in England and Wales.[4] Therefore, we value the opportunity to work with both the Scottish and the UK Governments on policy and guidelines in this field.

1.3 We support the Scottish Government's alcohol framework for action which contains substantially progressive policy measures and is based on robust evidence.[5] While some aspects of alcohol control lie with devolved Scottish administration, for some measures such as guidelines it would be desirable to have a coordinated UK wide strategy in place.

About Us

1.4 Alcohol and Drug Partnerships (ADPs) are a focal point for local action on drug and alcohol misuse in Scotland. They were formed in 2009 following the publication of the Scottish Government / COSLA document, "A Framework For Local Partnerships On Alcohol And Drugs"[6] which highlighted the need and requirement for each local authority area to operate a dedicated partnership on alcohol and drugs which is firmly embedded within their Community Planning Partnership structure. ADPs commission and strategically coordinate partnership working in order to create a healthier and safer local area, free from harm due to alcohol and other drugs. Each ADP develops and implements a local alcohol and drugs strategy which identifies local need, identifies the role of relevant stakeholders and ensures investment is focused on agreed outcomes.

There are three ADPs in Grampian—Aberdeen City, Aberdeenshire and Moray. Each ADP consists of senior staff from relevant organisations such as a range of representatives from the local council, NHS Grampian, Grampian Police, Scottish Prison Service and representatives from voluntary organisations.

1.5 Our response is set out below. As ADPs we aim to deliver and promote safe, healthy and responsible attitudes to alcohol. It is from this point of view our response is formed. Therefore, the comments set out below primarily consider how alcohol guidelines are developed and communicated.

2. Key Recommendations

2.1 We recommend the following key principles are considered when reviewing "sensible drinking" guidelines:

- The guidelines are based on objective evidence and are untainted by other interests.
- There is a periodic review of the evidence and as a result a reassessment of the guidelines instigated if required.
- Guidelines are consistent within and between countries in the UK.
- Guidelines are mutually reinforcing and do not run contrary to other guidelines and legislation.
- There is transparency in the process if guidelines are to be altered.
- Guidelines have the potential to inform and raise awareness but are unlikely to have major effects on behaviour when implemented alone.
- Guidelines should be identifiable and relevant to their target audiences.
- Per capita increases in alcohol consumption will lead to net increases in alcohol related harm in the population.

3. Detailed Comments

3.1 *What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed?*

3.1.1 The guidelines were originally formulated by the Royal College of Physicians, Psychiatrists and General Practitioners in 1986–87 and the advice given was a maximum of 21 and 14 units of alcohol per week for men and women respectively.[7] This guidance was based on robust epidemiological research which compiled risk curves for various health outcomes against average levels of alcohol consumption.[8–10] From these studies

the group assessed the level of average alcohol consumption below which alcohol related harm was unlikely to occur. These were adopted by the Government and remained in place until 1995.[11–12]

3.1.2 In 1995 these guidelines were turned into daily "benchmarks" by a group of civil servants (2–3 units/day for women and 3–4 units/day for men).[12] These changes appeared to endorse daily drinking and an increase in weekly consumption (a 50% increase for women and a 33% increase for men). The reasoning and evidence driving this move remains unclear. Possibly the move was influenced by the increased recognition of the detrimental effects of binge drinking.[13] Others suggest that this move was driven by the putative benefits of low level daily drinking.[14] Certainly the most scientifically robust data available are based on studies of average consumption and have demonstrated that whilst binge drinking causes acute harm it is the average amount of alcohol consumed over long periods of time that is detrimental to long-term health.[13–15] Indeed the implication that daily drinking is less risky contradicts the evidence which shows that the frequency of consumption is a key risk factor.[14] The distortion of average consumption levels to daily limits have allowed the media to publicly deride the guidelines, and has increased public confusion and distrust of public health messages.[16,17]

3.1.3 The most up to date evidence should be scrutinised and synthesised regularly and a review of the guidelines instigated if required. The guidelines should be based on the most scientifically robust evidence rather than political expediency or commercial/economic interest. The review of the evidence and the formation of guidelines should be a transparent process.

3.2 *Could the evidence base and sources of scientific advice to Government on alcohol be improved?*

3.2.1 There should continue to be promotion of research into alcohol related health consequences and international collaboration between experts in the field.

3.2.2 The evidence base for alcohol related health consequences could be improved through standardisation of alcohol exposure measures taking into account both average consumption and drinking patterns. Prospective studies need to take better account of changes in alcohol consumption over time. Additionally some population groups have been underrepresented in studies to date eg younger people and people in deprived circumstances.[15]

3.2.3 Research should also reflect the changing patterns of disease. For example, the increased prevalence of obesity has lead to an increase in prevalence of diabetes and diabetic fatty liver. What may be low risk levels of consumption for a person with a normally functioning liver may not be for a diabetic or an obese person and may accelerate progression of liver disease.

3.3 *How well does the Government communicate its guidelines and the risks of alcohol intake to the public?*

3.3.1 Research to date suggests that sensible drinking guidelines have not been communicated as effectively as we would have hoped. Studies have evaluated the levels of knowledge of UK drinking guidelines. These show that while there are often high levels of awareness of units and daily alcohol limits, few people know what the actual guidelines are.[18,19] For example in the Scottish Health Survey (2008–09) while only 9% of adults had not heard of recommended daily limits only 18% of men and 14% women actually knew what the correct levels were.[19]

3.3.2 The survey also indicated that men who drank outwith daily limits were more likely to know the daily recommendations. Possible explanations for this include:

- Knowledge of the guidelines is insufficient to change behaviour alone.
- There is public distrust of the guidelines.
- Current guidelines are unrealistic and the public cannot identify with them.

3.3.3 Research has also indicated that more advantaged households were more likely to be aware of the guidelines.[19] Alcohol related harm disproportionately affects more disadvantaged communities. In 2009, alcohol related deaths were 6.3 times greater in the most deprived Scottish areas than the least deprived.[3] It is also known that health education messages are more likely to benefit those from more advantaged circumstances.[20] The guidelines therefore potentially polarise socioeconomic groups further and increase health inequalities. Legislative and regulatory controls are more likely to be effective in reducing inequalities in health than widespread information based campaigns.[20]

3.3.4 Additionally it should be borne in mind that these guidelines are not promulgated in isolation; the public view them alongside powerful commercial advertising and sponsorship.

3.3.5 Therefore there should not be the temptation to rely on this form of prevention of alcohol related harm alone. These guidelines should act synergistically within the wider alcohol policy context. Education is unlikely to be successful unless it accompanies and complements core public policies. Therefore the public health response should encompass a range of interventions which address the production, supply, marketing and consumption of alcohol.

Transparency

3.3.6 To date, there has been lack of transparency in the evidence used for the 1995 Government guidelines. Transparency when relaying the evidence and providing guidance to the general public may increase confidence in the advice given and may improve public understanding of alcohol related problems.

Realistic And Meaningful Messages

3.3.7 We would also contend the guidelines are rigid, overly concerned with counting units and are not relevant to ordinary people. The guidance needs to consider the style and pace of drinking and the motivation behind drinking. For example, drinking three large glasses of wine over a dinner party every other week is unlikely to have the same detrimental effects to health than going out and binging on nine vodkas in three hours or drinking four pints every evening. The underlying attitudes towards drinking are also likely to be different—the former probably drinks for enjoyment and perhaps a way of relaxing, the "binger" often drinks to get drunk and the "daily drinker" may have a number of psychosocial motivations behind his/her drinking.

3.3.8 What is required is a greater understanding of the different drinking patterns of our target audiences, less focus on unit counting and more focus on tailoring our message specifically so that the intended audience can identify with them.

The use of the word "benchmark" instead of limits/levels implies a degree of individual variance but this could be communicated more effectively.

3.3.9 We would like to see more longitudinal research which explores patterns of drinking. For example exploring the psychosocial processes and triggers that underlie the transition from an infrequent drinker who over consumes on occasion to someone who regularly over consumes.

Inaccuracies, Complexities, Contradictions and Missing Pieces of Information

3.3.10 As a rule of thumb it is said only one or two pieces of information should be conveyed to the general public at any one time to be effective.[16] However alcohol guidelines are unhelpfully and unavoidably complicated. There are often inaccuracies and vital pieces of information left out in official recommendations, perhaps in an attempt to keep messages simple. There are also inconsistencies between UK countries. This serves only to increase public confusion and incredulity, and allows the media and the commercial sector to undermine the message.[17,21] We would like to see consistent messages across and between countries in the UK.

3.3.11 The estimation of sensible drinking limits is complex—different countries measure units differently, strengths vary within types of drinks and drinks measures can vary.[22] Many people still think 3–4 units equal 3–4 drinks. A great deal of alcohol is consumed at home. In Scotland 67% of all alcohol bought in 2010 was through off-sales.[4] A misinterpretation of units risks people inadvertently drinking over their recommended levels when they pour their own measures. This aspect of risk communication could be improved greatly. In Grampian we provide information on how to calculate units of alcohol. We would encourage drink labels to provide contextual guidance. For example, "this bottle of wine contains 9.4 of your recommended weekly units (21 units for men/14 units for women). A standard glass (175ml) contains 2.1 units. Consistently drinking to excess adversely affects your health." Alternatively if it was a bottle of alcopop the risks of binge drinking could be stressed.

3.3.12 In Grampian daily benchmark information is accompanied by the original weekly limits.[23] In addition, in line with the original Government recommendations and to reinforce consistent daily drinking is harmful we advise that people should have two days of abstinence a week.[12] However this message does not appear in many official guidance documents probably driven by a need to keep messages simple.

Special Groups

3.3.13 In Scotland pregnant women are advised to abstain from alcohol and children should have an alcohol free childhood.[24] To avoid confusion we would advocate that there should be identical advice given throughout the UK which is evidence based.

3.3.14 Official recommendations and legislation need to be mutually reinforcing and not contradictory. For example, the law permits drinking in the home for children over five with parental consent. This runs counter to the advice of an alcohol free childhood (Scotland) or advising parents that children should not drink until they are 15 years old (England).

3.3.15 In Grampian we have a unique mix of ethnic minority groups attracted to the area by the oil, fishing and farming industries and we would support wider distribution of UK government alcohol guidelines in other languages such as Polish and other Eastern European languages.

3.4 *How do the UK Government's guidelines compare to those provided in other countries?*

3.4.1 The UK Government guidelines are largely similar to the majority of other countries that have set guidelines although there is wide variation. For example in Poland the advice for men is 2 units (20g) and for women 1 unit per day up to five times per week. At the other end of the spectrum in Basque parts of Spain

the advice there is not to exceed 70g/day for both men and women (ie 490g/week).[22] In contrast, Luxembourg promotes moderate alcohol consumption without issuing specific guidance.

3.4.2 While we support international collaboration of research and sharing of best practice it must be remembered that different countries have different attitudes and beliefs with regards to alcohol drinking. Guidelines that are suitable for one culture may not be for another.

4. Conclusion

4.1 We support measures that allow individuals to monitor and reflect on their own alcohol consumption although this should form only part of a multifaceted approach in preventing alcohol related harm. We advocate the use of up to date and robust evidence to inform guidelines. We would ask the Government to consider any changes carefully. It is pertinent that any changes do not provide stimulus for the media and allow the alcohol trade to promote their product.

We believe there are no grounds in terms of health benefit to increase the recommended alcohol limits and any increases may adversely affect health. Additionally we ask the Government to remember that increases in individual alcohol consumption would lead to a net increase in harm within the population.[25]

5. Declaration of Interests

5.1 None.

Emily Burt
Registrar in Public Health (Grampian)

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September 2011

Written evidence submitted by Lundbeck (AG 16)

Lundbeck welcomes the opportunity to respond to the Science and Technology Select Committee inquiry on the evidence base for alcohol guidelines. Lundbeck is an ethical research-based pharmaceutical company specialising in diseases of the central nervous system.

SUMMARY

- Evidence suggests that awareness of the Government's guidelines on alcohol consumption is increasing steadily amongst the public.
- 10 million adults in England continue drink above the recommended daily limits, with 2.6 million drinking twice over the recommended limits.
- Whilst significant harm to health and society is caused by alcohol misuse, awareness of the risks associated with alcohol is low.
- The Government should encourage greater use of screening for alcohol misuse and brief interventions to increase understanding of alcohol harm and help people reduce their alcohol consumption.
- The comparison of the UK Government's guidelines on alcohol consumption with that of other countries is difficult.
- The UK Government's approach to advertising contrasts with the strict laws in France.

How well does the Government communicate its guidelines and the risks of alcohol intake to the public?

1. Evidence suggests that awareness of the Government's guidelines relating to alcohol units is increasing steadily amongst the public. A survey in 2009 indicated that 90% of respondents had heard of measuring alcohol consumption in units, an increase from 79% in 1997. Additionally, there has been an increase from 54% in 1997 to 75% in 2009 in the percentage of people who had heard of daily drinking limits.[25]

2. However, despite increasing levels of awareness of recommended limits and public health education campaigns to promote better understanding of the risks of excessive alcohol, over 10 million adults in England drink above the recommended daily limits, with 2.6 million adults drinking more than twice the recommended limits. Those aged 65 and over were less likely to be aware of alcohol units: 80% compared with 96% of those aged 45 to 64 and 88% of the youngest age group (16 to 24).[25i]

3. Additionally, the health risks related to alcohol consumption have not been well communicated. A survey of women conducted in 2008, showed that 82% of women were not aware of the risk of breast cancer associated with alcohol consumption, compared with 95% who did link it to liver disease, and 71% who were aware it raised the risk of liver cancer.[26] Similarly a Stroke Association survey showed that 60% of respondents did not realise that stroke can be a consequence of binge drinking.[27]

[25] NHS Information Centre, *Statistics on Alcohol: England 2011,* 44

[26] BBC News, "Women unaware of alcohol threat", 17 October 2008 (http://news.bbc.co.uk/1/hi/7675843.stm)

[27] Stroke Association, *"New Survey is festive thought for binge drinkers"* press release, 3 December 2004 (http://www.stroke.org.uk/media_centre/press_releases/new_survey_is.html)

4. It is vital that the public gain a better understanding of the risks associated with alcohol misuse given the significant harm that can be caused to health by alcohol misuse. Excessive drinking causes accumulating harm in long-term ways, contributing to liver and kidney disease, acute and chronic pancreatitis, heart disease, high blood pressure, depression, strokes, and it can harm the developing foetus. Alcohol is the second biggest risk factor for cancer after smoking, contributing to cancers of the mouth and throat, liver, laryngeal, colon (in men) and breast cancer.[28] Alcohol misuse can also exacerbate and contribute to long term conditions, for instance recent evidence indicates that alcohol has become an important cause of death in patients with type 1diabetes.[29]

5. The burden of alcohol harm on the NHS and society is significant; hospital admissions related to alcohol have exceeded 1 million, alcohol costs the NHS £2.7 billion per year.[30] Additionally, alcohol contributes to 1.2 million incidents of violent crime and 40% of domestic violence.[30]

6. The Government must better communicate the health risks associated with alcohol to the public through increased screening for alcohol misuse and brief interventions for people who are drinking harmfully. Brief interventions have been shown to be both clinically and cost-effective, even when time spent providing advice is short.[30] A brief intervention enables people to better understand their alcohol consumption, the risks of harm to their health from harmful drinking and reduce their alcohol consumption. Unfortunately, brief advice is only sporadically provided by health workers and GPs tend to under-identify alcohol use disorders, finding and offering support to only one in 67 male and one in 82 female hazardous or harmful drinkers.[30]

7. Lundbeck proposes that the Government increases screening for alcohol misuse and the number of brief interventions offered to people who are drinking harmfully, as recommended in the NICE public health guidance on preventing alcohol harm,[31] by incentivising GPs and other healthcare professionals to take a more proactive approach to alcohol misuse. This can be achieved by including screening and brief interventions as indicators in the Quality and Outcomes Framework (QOF), as well as the forthcoming commissioning outcomes framework (COF) which will measure the health outcomes and quality of care achieved by clinical commissioning groups. Additionally, outcomes on alcohol misuse must be a determining factor of the quality premium that clinical commissioning groups may receive.

How do the UK Government's guidelines compare to those provided in other countries?

8. The comparison of the UK Government's guidelines on alcohol consumption with that of other countries is difficult for a number of reasons. Firstly, internationally the measurement of a standard drink or unit of alcohol varies country to country. The UK Government's unit size (or standard drink) is based on 8 grams of ethanol, whereas Australia, France, Hungary, Ireland, New Zealand, Poland, Spain unit size is 10 grams and Canada 13.6 grams. Secondly, guidelines may be set according to weekly or daily limits and countries vary on what is considered a "safe" limit of alcohol consumption, thus little consistency exists on an international level.[32]

9. However, what is clear is the difference in approach on advertising of alcohol. The UK is one of only two European countries that has no statutory regulation with regard to the advertising and marketing of alcohol, a system of co-regulation and non-statutory guidance being in place. This contrasts with a number of countries in Europe where self-regulation is supported by legislation. For example, France has particularly strict rules concerning alcohol advertising; the Loi Evin Law (1991) placed a ban on advertising alcohol on TV and in cinemas. The Loi Evin also enforces an absolute ban on the drinks industry being able to sponsor any sporting or cultural events.[33]

Andy Hockey
Public Affairs Manager
Lundbeck

September 2011

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Andy Hockey, Public Affairs Manager
Lundbeck
September 2011

Written evidence submitted by Cancer Research UK (AG 17)

CANCER RESEARCH UK RESPONSE TO THE SCIENCE AND TECHNOLOGY COMMITTEE INQUIRY INTO THE EVIDENCE BASE FOR ALCOHOL GUIDELINES

We welcome the opportunity to respond to the inquiry into the evidence base for alcohol guidelines. Cancer Research UK is the world's largest independent organisation dedicated to cancer research; in 2010–11 we spent £332 million on research. Our vision is that "Together we will beat cancer". We carry out world-class research to improve our understanding of cancer and to find out how to prevent, diagnose and treat different types of the disease. Around 300,000 people are diagnosed with cancer in the UK every year. And every year more than 150,000 people die from the disease.

The scale of the health risks posed by alcohol is extensive. Current estimates suggest more than 10 million people in the UK regularly exceed the recommended limits for alcohol consumption.[34] It is clear that the more alcohol someone drinks, the more their cancer risk increases. However, even very small amounts of alcohol, as little as one drink a day, can increase cancer risk,[35] and most people in Britain are not aware of the potential harmful effects of such low-level long-term drinking.[36]

There is a need for a comprehensive alcohol strategy to combat a problem of this size and to dispel some of the misinformation and clarify some of the mixed messages the public currently receives. A strategy is required to reduce overall consumption levels of alcohol in the UK, including measures to increase the cost of alcohol, further restrictions on marketing of alcohol and investment in public awareness campaigns which include messages about the link between alcohol consumption and risk.

Alcohol Consumption and Cancer Risk

After smoking, alcohol is one of the most important modifiable risk factors for cancer. Alcohol is estimated to account for around 6% of all cancer deaths[37] in the UK, about 9000 deaths per year. Research shows that the more alcohol an individual consumes, the more they increase their risk of seven types of cancer (mouth, pharyngeal, laryngeal, oesophageal, breast, bowel and liver). These conclusions are based on the results of hundreds of studies, including large cohorts such as the European Prospective Investigation into Cancer and Nutrition (EPIC), NIH-AARP and the Million Women Study.

Government recommendations state that adult men should drink no more than 3–4 units of alcohol a day and adult women no more than 2–3 units a day. However, the Million Women Study found that drinking just two units a day (less than a pint of premium lager) increases overall cancer risk by 15%. Although there is evidence that small amounts of alcohol can help prevent heart disease and are unlikely to have a significant effect on cancer risk, it should be noted that even these levels of alcohol consumption could raise cancer risk.

Alcohol intake is one of the main risk factors for liver cancer.[38] Heavy drinking can lead to cirrhosis, a condition in which scar tissue builds up in the liver as it is repeatedly damaged by alcohol abuse. Cirrhosis increases the risk of liver cancer.

Breast cancer risk is also particularly affected by alcohol intake. Even small amounts of alcohol can increase your risk of breast cancer. Several studies have shown that every alcohol unit drunk a day increases the risk of breast cancer by between 7 and 11%.[39,40,41,42] Alcohol accounts for around 6% of breast cancer cases in the UK, about 3,000 cases each year,[43] and there is unlikely to be a safe level of alcohol which doesn't increase the risk of breast cancer. Studies have found that even as little as one unit a day can increase a woman's chances of getting breast cancer.[44]

It is key that when the Government is setting guidelines it takes into account the long-term effects of consuming alcohol even in relatively small amounts as well as the better-publicised health and societal problems caused by binge drinking.

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GOVERNMENT COMMUNICATION OF GUIDELINES AND THE RISKS OF ALCOHOL INTAKE TO THE PUBLIC

Public awareness of the long-term risks of alcohol consumption is low. Great attention is paid to the problems caused and associated with binge drinking, and there is some evidence that drinking more drinks per day for less time increases cancer risk more than drinking fewer drinks for more time.[45] However we also know that there is a linear relationship between alcohol and risk, and that it is therefore the total amount of alcohol consumed that matters. Despite this, 55% of people questioned in a YouGov poll[46] believed alcohol is only harmful if a person regularly gets drunk or binge drinks. And although awareness of units is good,[47] awareness of the recommended daily limits is very patchy.

The Health Select Committee's report on alcohol which was published last year stated that despite evidence showing that greater education and information have not been effective in tackling alcohol related problems, they still form the cornerstone of Government strategy. The fact that the Government spent only £17.6 million on information and education in 2009–10[48] as compared to an estimated advertising spend from the drinks industry of £600–800 million makes clear the extent of the uphill struggle that the currently underfunded Government education programme will have if it is to make a clear impact.

However, education and information, including clear communication of Government guidelines should still be key parts of a more comprehensive strategy to tackle excessive alcohol consumption in the UK. We feel that such a strategy should include measures to increase the costs of alcohol, further restrictions on the marketing of alcohol and further investment in public information campaigns to raise awareness of the long-term health risks associated with drinking alcohol. We also feel that given the strength of the evidence linking alcohol consumption to cancer risk, cancer should be more consistently mentioned as a potential consequence of alcohol consumption—only 24% of respondents to Cancer Research UK's perception of risk survey mentioned alcohol when asked about how to reduce their risk of developing some types of cancer.[49]

We would be happy to provide any further information or detail as required. Please contact Emily Arkell in the Policy Team at the Cancer Research UK Policy and Public Affairs department at emily.arkell@cancer.org.uk.

Sarah Woolnough
Director of Policy
Cancer Research UK

September 2011

Written evidence submitted by the Royal College of Obstetricians and Gynaecologists (AG 19)

1. *What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed?*

1.1 The Government's guidelines for alcohol intake during pregnancy are based on guidance produced by a range of organisations including the RCOG and NICE (produced via the National Collaborating Centre for Women's and Children's Health).

1.2 The current NICE Clinical Guideline *Antenatal care. Routine care for the healthy pregnant woman* (first published in 2003, updated in 2008, next review date 2014) states that pregnant women and those planning a pregnancy should be advised to avoid drinking in the first three months of pregnancy because of the association with an increased risk of miscarriage. If women choose to drink, then they should limit their drinking to no more than one or two units once or twice a week. There is no evidence of harm to the unborn baby from this low-level consumption.

1.3 The RCOG's Statement No. 5 *Alcohol Consumption and Outcomes of Pregnancy* (first published in 1996, updated in 1999 and 2006, currently pending review). Briefly, the RCOG's position is similar to that of NICE. The safest option is for pregnant women is to abstain. However, if they wish to consume alcohol, one or two units once or twice a week has not yet be shown to be harmful to the woman or the baby. This amounts to no more than a pint of beer/lager or a small glass of wine a week.

The RCOG has been approached on several occasions by the media since the publication of Statement 5 for a view and the position has not changed.

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[49] CRUK's perception of risk survey, BMRB, 2009

Within the debate of the effects of alcohol consumption during pregnancy, the RCOG has voiced concern over issues around:

- Binge drinking in the general female population. There have been reports of an increase in the incidence among certain socio-demographic groups.
- Women who may have consumed large amounts of alcohol without knowing they were pregnant. This poses dangers to the baby.

There is also the need to ensure that women who suffer from alcohol abuse receive appropriate support to help them overcome this.

Other related issues include:

- Alcohol consumption as a public health issue.
- Alcohol consumption in the first trimester.
- The co-existing problems attached to women who have alcohol dependency, eg. domestic violence, substance misuse.
- The long-term social effects of fetal alcohol spectrum disorder.

1.4 The RCOG would like to draw to the attention of the Science and Technology Committee the National Collaborating Centre for Women's and Children's Health guideline *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors* (September 2010).

This provides guidance on service organisation, support for women and training for healthcare professionals. The recommendations on links with social services and referrals to the appropriate assistance programmes need to be implemented across the NHS. The recommendations for future research and the relevant chapters on health economics considerations will help inform future policy.

1.5 The RCOG regularly reviews international evidence and positioning statements, including those from countries which have medical professional bodies. The advice from the main specialist societies are summarised below:

American College of Obstetrics and Gynecology Committee Opinion *At-risk drinking and alcohol dependence: Obstetric and Gynecologic implications* (Aug 2011):

Agrees with the US Surgeon-General. Pregnant women and those considering pregnancy should NOT drink any alcohol.

Society of Obstetricians and Gynaecologists of Canada *Alcohol Use and Pregnancy Consensus Clinical Guidelines* (Aug 2010):

- Abstinence is the most prudence choice since there is insufficient evidence over the effects of low-level consumption of alcohol during pregnancy.
- Periodic universal screening of all pregnant women and women of child-bearing age is recommended.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists Statement *Alcohol in Pregnancy* (Jul 2011)

- No consensus on minimum threshold levels of alcohol in pregnancy and during breastfeeding.
- Recommends avoiding alcohol intake during pregnancy.

2. *Could the evidence base and sources of scientific advice to Government on alcohol be improved?*

The RCOG believes Alcohol Health Alliance (AHA), hosted by the Royal College of Physicians and under the chairmanship of Professor Sir Ian Gilmour, has been responsible for much good work to raise awareness about alcohol-related issues in the UK. The Government and Department of Health must seek the expert advice of the AHA.

National policies must take into account the social and economic costs of the effects of alcohol consumption within a public health context.

There is also a need to examine the classification system used in measuring units of alcohol. There is international variation and the lack of consistency causes confusion among the public.

3. *How well does the Government communicate its guidelines and the risks of alcohol intake to the public?*

3.1 Government communications on its guidelines on alcohol consumption in pregnancy has been poor. This is in part a result of a lack of international consensus over safe levels of drinking and the media's portrayal of the confusion and uncertainty within the scientific / medical community over this lack of consensus.

The Department of Health admitted that its call for abstinence during pregnancy in 2007 was not based on new evidence and did not align with evidence from other medical bodies, including the RCOG. This was not helped in part by the release of the BMA's report on Fetal Alcohol Syndrome soon after which stated that

women identified as having low-to-moderate consumption of alcohol should be offered pre-conception intervention counselling. A brief scan of the headlines that followed indicated scaremongering by certain sections of the media.

3.2 The majority of women adopt a sensible approach in their lifestyle choices once they know they are pregnant. Many women stop alcohol consumption altogether during pregnancy in much the same way as they prefer not to go on a course of drug treatment if they can help it when pregnant. They must be supported to have a healthy pregnancy and this includes a reduction in the levels of alcohol consumption if they are known to have dependency issues.

3.3 As noted in 1.3, it is women who binge drink regularly and are ignorant about their pregnancy who are of greatest concern. How these groups are targeted and engaged with will be a challenge for the Government and public health authorities. The ongoing Change4Life campaign by the Department of Health is an excellent case study of a successful public health awareness campaign and efforts should be made to transfer the knowledge from this campaign to a national campaign on alcohol consumption and responsible drinking.

Alcohol dependency is a complex problem as it may also indicate other social factors which health and social policy makers must consider. Government communications on alcohol consumption must be tailored to the specific needs of different groups of women. Pathways of care for women with alcohol problems must be developed and implemented. There may be the need for a separate algorithm in the NICE Pathways alcohol-use disorders overview for pregnant women.

3.4 More prospective research is needed into safe levels of drinking during pregnancy. Randomised controlled trials are not appropriate. Confounding factors such as the woman's age, overall health, nutrition and socio-demographics all have an effect and research needs to reflect these differences.

The affects of heavy drinking during pregnancy and adverse fetal outcomes are well documented.[1,2,3,4,5,6,7,8,9,10] However, lower levels of consumption presents us with a grey area since the current scientific evidence does not indicate harm, indeed some studies report a benefit,[11,12,13,14,15,16,17], including to the baby.[18,19]

3.5 There is a need for consistency in messages to the public and the government must ensure that a suite of materials for healthcare professionals are also developed as part of a larger awareness campaign on the harmful effects of un-moderated alcohol consumption during pregnancy. Communications activities targeted at professionals could be modelled on the successful awareness campaigns to increase uptake of the seasonal flu vaccinations.

Besides warning labels on packaging for alcoholic beverages, social media tools should be developed and used. Examples include mobile phone applications to help the individual measure their alcoholic intake at one sitting with a warning when they exceed the recommended amount.

4. *How do the UK Government's guidelines compare to those provided in other countries?*

4.1 A comparison has been provided in 1.5 above. The more conservative approach adopted by other medical bodies has been to impose the policy of no consumption of alcohol at any stage during pregnancy. The view is derived on the basis that alcohol is teratogenic and therefore with the long-term wellbeing of the baby in mind, abstinence should be observed.

Advice to pregnant women needs to be balanced. A ban on alcohol consumption during pregnancy affects the majority who drink responsibly and may instil feelings of guilt in normally sensible, rational people. It is accepted that a minority of individuals will be at risk of alcohol problems during pregnancy and it is these women who must be identified at their first antenatal appointment (or preconceptually) so that appropriate support can be provided to them.

The likelihood of the children of these women having fetal alcohol syndrome (FAS) or fetal alcohol spectrum disorder (FASD) is high and estimates by the National Organisation on Fetal Alcohol Syndrome suggest that around 7,000 babies each year are born with FASD.

Evidence shows that low to moderate alcohol consumption leads to a slight increase in the risk of miscarriage. The prevailing advice therefore is to avoid alcohol completely in the first trimester of pregnancy.

4.2 HES figures show a steady increase in the numbers of alcohol-related finished consultant episodes (FCE). Increasing numbers of women in the UK are binge drinking and the future needs of this group must be considered and planned. A recent news report showed the incidence of binge-drinking among women is on par with that in men.[20] This is clearly a public health issue that the Department of Health and NHS must tackle.

Evidence shows women who binge drink are more likely to indulge in risky behaviours when they are under the influence.[21] This includes having unprotected sex which may lead to sexually transmitted infections and / or an unwanted pregnancy. Individuals who binge drink are also more likely to becoming victims of assault or fall foul of the law, leading to added costs to the criminal justice system and health and social services.

4.3 Guidelines on alcohol consumption should examine the cost of binge drinking to public health and the NHS. Recommendations should include interventions to encourage individuals to moderate their drinking.

Individuals will continue to consume alcohol throughout their lives regardless of what governments or health authorities say. Furthermore, there is no way of policing how much individuals drink short of imposing a prohibition-style ban.

4.4 The present Government is keen to work with the private sector to produce guidance (eg. food labelling) and provide services (eg education) for consumers. There is a conflict of interest in engaging with business to promote products and the RCOG has voiced concern over the role of unchecked competition in the present Health and Social Care Bill. However, there are examples of responsible drinking programmes developed by the drinks industry, such as www.drinkware.co.uk, a website which provides open and clear information about safe and unsafe drinking levels.

Relationships between Government and industry in health matters are questionable and must therefore be conducted in a transparent manner, open to public scrutiny.

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Declaration of interest: The RCOG declares no conflicts of interest.

September 2011

Written evidence submitted by the Royal College of Psychiatrists (AG 20)

This response is submitted by Professor Colin Drummond, MD, FRCPsych, Professor of Addiction Psychiatry, National Addiction Centre, Institute of Psychiatry, King's College London on behalf of the Addictions Faculty of the Royal College of Psychiatrists.

The current guidance from the Royal College of Psychiatrists on "sensible drinking" is that adult males should drink no more than 21 Units of alcohol per week and women, no more than 14 Units per week. A Unit of alcohol in this context is 8g of ethanol. This guidance is based on a Royal College of Psychiatrists report published in 1986 (Royal College of Psychiatrists, 1986). This recommendation was based on the limited available evidence at the time, mostly from long term prospective studies of mortality in middle aged men which suggested a small beneficial effect of moderate alcohol consumption of less than 21/14 Units compared to complete abstinence. This effect was mostly related to risk of mortality through heart disease.

The Department of Health guidance adopted the Royal College of Psychiatrists' 21 and 14 Unit benchmarks until 1995 when new guidance was published based on daily alcohol consumption (DH, 1995). This change in emphasis was partly prompted by emerging evidence of the risks of acute consequences of alcohol consumption following single episodes of drinking (rather than the earlier emphasis on mortality from the more chronic consequences of excessive alcohol consumption). This new advice suggested a maximum of up to 2–3 Units per day for women, and 3–4 per day for men, with alcohol free days each week. Whilst this move to guidelines to daily rather than weekly Units cleared up some confusion about the way in which weekly Unit limits should be consumed over the course of a week, it was widely misinterpreted as an escalation in the weekly recommended limits: i.e. up to 21 units per week in women and 28 units per week in men.

The report also listed a large number of caveats to this advice including that the health benefit from drinking relates to men over 40 and post menopausal women, that the guidance may not be universally applicable, drinking within these benchmarks may be hazardous in certain situations eg in situations where cognitive ability and physical coordination should not be impaired. However, although the Group stated that "the recommendations……need to be presented as a whole, not in isolation, and guidance on benchmarks for regular drinking must be present in the context of the overall risks and benefits from drinking" this has rarely been the case in official public information.

Some of the conclusions of the report were not translated into public health messages by the Department of Health. For example the report stated that "all cause mortality is at its lowest at modest drinking levels (at about 1 unit a day for men and women) and does not exceed the mortality level of abstainers until consumption levels which are somewhat higher than the current recommended sensible drinking levels of 14 units per week for women and 21 units for men." So the Group identified from the evidence that a lower level of alcohol consumption than the then recommended sensible level of 21/14 units per week conferred the lowest risk of mortality: ie closer to 7 units per week for both men and women. It has subsequently been recognized that part of the explanation for abstainers having a higher mortality rate than moderate drinkers may be due to current abstainers containing a proportion who are former heavy drinkers, and therefore have potentially already increased their mortality risk through historical excessive drinking, and a proportion who are unable to consume alcohol because of pre-existing physical or psychiatric illness who may also be at higher risk of premature mortality.

Since these landmark reports on which current guidance is loosely based a number of factors suggest that a review of the guidance would be timely.

1. The typical size and strength of alcohol drinks has increased. Whereas at the time of the Royal College of Psychiatrists report beer and cider sold in licensed premises was typically 3–4% alcohol by volume (ABV), several popular beer brands are now 5% ABV or greater, and super strength cider is often closer to 8–9% ABV. Similarly there has been a trend towards marketing of higher ABV wines. The size of measures particularly of wine sold in licensed premises has also generally increased to 2–3 Units rather than 1 Unit in 1986. Spirits are often now sold in litre rather than 70 cl bottles in supermarkets. On license spirits are often promoted as double measures. Surveys have shown that public knowledge of the Unit content of alcohol drinks has always been limited. But what knowledge there is has been confounded by an escalation in alcoholic drink measures and strengths.
2. Research published since the Department of Health report (DH, 1995) on which current public guidance is largely based, has suggested that the health benefits of moderate alcohol consumption have been over-estimated. A recent World Health Organisation (2007) report noted that the wide inter-individual variation in susceptibility to the adverse effects of alcohol suggests that it is not possible to recommend a level of alcohol consumption at which alcohol is universally safe. The report also noted "Even in societies where heart disease is a very important cause of death, the overall number of lost years of life attributable to drinking outweighs the saved years attributable to protective effects." (p.9).
3. The harms caused by alcohol are not restricted to the individual drinker or to health. A wider perspective of the harms to third parties and society as a whole need to be considered in framing guidance (WHO, 2007).
4. Alcohol disproportionately harms the poorest and most vulnerable in society at a given level of alcohol consumption leading to significant health inequalities (Marmot et al., 2010).
5. Although the UK has had recommended sensible drinking limits promoted by the Department of Health since 1986, alcohol related harm in the UK has increased dramatically over that period. This calls into question the impact of sensible drinking guidelines alone as a public health strategy. The WHO (2007) and Babor et al. (2010) conclude that sensible drinking messages alone are ineffective in reducing alcohol consumption and alcohol related harm. More effective strategies include increasing the price and restricting availability of alcohol. If public health messages have an impact it is restricted to supporting other more effective strategies, rather then conferring benefits alone.

Specifically the House of Commons Science and Technology Committee should consider the following evidence in its enquiry:

1. The World Health Organisation (2007) expert committee report on problems related to alcohol consumption as discussed above.
2. Rehm et al. (2008) modeled risks of mortality and found that for "chronic disease death, lifetime risk increases by about 10% with each 10-gram (one drink) increase in daily alcohol consumption..." "… ..both men and women should not exceed a volume of two drinks a day for chronic disease mortality, and for occasional drinking three to four drinks seem tolerable."
3. Taylor et al. (2008) based on Canadian data found that "the probability of mortality was one in 100 for all levels of consumption above three drinks three times per week for men and above five drinks three times per week for women." They concluded that "No safe level of consumption is recommended based on the results, although risk is much lower consuming three standard drinks or less fewer than three times per week."
4. The Australian Government National Health and Medical Research Council (2009) published a review of the international literature of the health risks of alcohol as a basis for Australian national guidance. The report concluded, inter alia, that "the lifetime risk of harm from drinking alcohol increases with the amount consumed. For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol related disease or injury." As in the Department of Health (1995) report, this report contains a series of caveats about particular at risk groups and for whom these benchmarks will be too high, as well as specific situations in which this level of alcohol consumption may be harmful.
5. White et al (2002) found a direct dose response relationship between alcohol consumption and risk of death in women aged 16–54 and men aged 16–34. They concluded that "Substantially increased risks of all cause mortality can occur even in people drinking lower than recommended limits, and especially among younger people."
6. The Royal College of Psychiatrists (2011) has published a report on alcohol related harm in the elderly. The report concluded that "Because of physiological and metabolic changes associated with ageing, these [Department of Health] 'safe limits' are too high for older people; recent evidence suggests that the upper 'safe limit' for older people is 1.5 units per day or 11 units per week."
7. The WHO (2010) has published a monograph prepared by the International Agency for Research on Cancer on the carcinogenic risks of alcohol and ethyl carbimide. The report concluded that both alcoholic beverages and ethanol in alcoholic beverages are Group 1 carcinogens in humans. The IARC

recommends no exposure to Group 1 carcinogens. All alcohol related cancers have linear or near linear dose response relationships with alcohol, suggesting there is no universally safe level of alcohol consumption in relation to the risk of developing cancer.

In conclusion the Royal College of Psychiatrists recommends that the House of Commons Science and Technology Committee should take into account new evidence which calls into question the validity of the current Department of Health guidance on alcohol consumption. Such a review needs to take account of all consequences of alcohol consumption including morbidity, mortality and social harms and consequences rather than focusing on a specific aspect. Recent evidence on the carcinogenic effects of alcohol call into question guidance based primarily on risks of heart disease. Both daily and weekly levels of consumption as well as patterns need to be considered.

It should be noted, however, that the evidence shows that sensible drinking guidelines are in themselves an ineffective public health strategy to reduce alcohol related harm unless they are issued in support of more effective strategies such as increased price and restricted availability of alcohol.

It is further recommended that an appropriate scientific review of the evidence should be conducted by scientists who are independent of the alcohol industry and that any scientist engaged in such a review should provide a full disclosure of any competing interests.

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Professor Colin Drummond
On behalf of the Addictions Faculty
Royal College of Psychiatrists

September 2011

Written evidence submitted by Alcohol Focus Scotland and Scottish Health Action on Alcohol Problems (AG 21)

About Alcohol Focus Scotland

1. Alcohol Focus Scotland (AFS) was established in 1973 and is Scotland's national alcohol charity. Alcohol Focus Scotland's primary purpose is to reduce the health and social harm caused by alcohol.

2. Alcohol Focus Scotland plays a lead advocacy role in alcohol policy at a Scottish, UK and international level and is a member of the Alcohol Health Alliance (UK), Eurocare and the European Alcohol Policy Alliance.

About Scottish Health Action on Alcohol Problems

3. Scottish Health Action on Alcohol Problems (SHAAP) was set up in 2006 by the Scottish Medical Royal Colleges and Faculties to provide an authoritative medical voice on the impact of alcohol on the health of the people of Scotland.

4. SHAAP reviews established and emerging evidence and advocates for effective alcohol strategies and policies at a Scottish, UK and international level.

Introduction

5. In developed countries alcohol consumption is the 3rd most detrimental risk factor to health.

6. Alcohol consumption and harm today are at historically high levels in the UK. Alcohol consumption has doubled since the 1960s[50] and deaths from liver cirrhosis have increased by over 450% in the past 30 years.[51]

7. Research evidence clearly identifies alcohol control policies, particularly affordability and availability, as one of the most effective methods to reduce alcohol related harm.[52] However AFS and SHAAP believe that clear government advice on low, medium and high risk alcohol consumption is critical for the public and health practitioners.

8. Alcohol Focus Scotland and Scottish Health Action on Alcohol Problems welcome the opportunity to submit written evidence to the Science & Technology Select Committee on this important issue.

Summary of AFS and SHAAP Written Evidence

What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed?

- The original guidelines were based on a 1987 report from the Royal College of Physicians which considered epidemiological evidence and sought to give guidance on what the acceptable level of risk was in terms of alcohol consumption.
- In 1995 these guidelines were revised by the Department of Health following a report by an inter-departmental working group which changed the weekly limits to daily guidelines.

Could the evidence base and sources of scientific advice to Government on alcohol be improved?

- A substantial amount of new evidence has been accumulated in recent years quantifying the disease burden and mortality attributable to alcohol and identifying disease categories for which alcohol is a direct or contributory cause.
- It is appropriate that current UK drinking guidelines are reviewed in relation to this new evidence to ensure their continued validity.
- Any revision of the drinking guidelines needs to be based on a comprehensive, systematic review of the scientific evidence by individuals or organisations properly qualified for the task.

How well does the Government communicate its guidelines and the risks of alcohol intake to the public?

- Given the historically high levels of consumption and consequent alcohol-related harm the Government must set guidelines which encourage low risk drinking and a reduction in population level consumption.
- There is no "safe" amount of alcohol consumption. The government should avoid the use of words such as "sensible" and "safe" limits and use the terms low, medium and high risk drinking.
- Unit advice should be clear, for example, stating 3 units maximum in one day rather than 2–3 units.
- The provision of public health information about products such as alcohol, with known toxic, intoxicating and addictive effects, should be the job of public health agencies alone.

What evidence are government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed?

8. The original guidelines of no more than 21 units per week for a man and no more than 14 units per week for a woman, with two or three days per week without any alcohol, were based on a 1987 report from the Royal of Physicians, "The medical consequences of alcohol abuse: a great and growing evil".

9. This report considered a broad range of available evidence and sought to give guidance on what the "acceptable" level of risk was in terms of alcohol consumption. It concluded that it was difficult to advise on "safe" levels of consumption due to the effects of alcohol being dependant on the drinker and circumstances.

[50] Tighe A, Statistical handbook. London: Brewing Publications Ltd, 2007
[51] Calling Time: The Nation's drinking as a major health issue. Academy of Medical Sciences, 2004
[52] Babor T, et al (2010) Alcohol no ordinary commodity; research and public policy, 2nd Edition. Oxford University Press.

10. However it was recognised that, despite these difficulties, clear guidance was essential for both the public and for health practitioners and as such the report gave a recommendation based on expert advice from the leading doctors based on the available evidence.

11. In 1995 these guidelines were revised by the Department of Health following a report by an inter-departmental working group[53] which changed the weekly limits to daily guidelines.

12. This change raised concern within the medical and wider alcohol health community as drinking at the upper level of the daily limits each day would take people over previously set low risk weekly limits. Further this daily guideline implied that it was recommended or acceptable to drink on a daily, or near daily basis.

13. Since 1995 there has not been a similar review of the evidence base.

Could the evidence base and sources of scientific advice to Government on alcohol be improved?

14. Since the last review of the evidence that informed the recommendation for daily drinking limits, a substantial amount of new evidence has been amassed quantifying the disease burden and mortality attributable to alcohol and identifying disease categories for which alcohol is a direct or contributory cause.[54] A major international research project supported by the World Health Organization has been examining the relationship of different dimensions of alcohol consumption to chronic and infectious diseases and injuries.[55] Some new relationships have been identified and others have been clarified. In Scotland and England work has been done in the past five years to calculate alcohol population-attributable fractions for a range of diseases. In Scotland, for example, alcohol is estimated to account for 19 per cent of breast cancer in women.[56] More recently, a study has been undertaken examining the alcohol-attributable burden of incidence of cancer in eight European countries.[57] This study has found an important proportion of cases of cancer are attributable to alcohol consumption.

15. In light of the accumulation of new studies showing the impact of alcohol consumption on infectious and chronic disease it is appropriate to review guidance on recommended limits for daily and weekly alcohol consumption to ensure their validity. However, to be a meaningful exercise, any revision of the current drinking guidelines needs to be based not on popular opinion, or a consultation exercise, or on a simple comparison with guidelines in other countries, but on a thorough and systematic evaluation of the scientific evidence by individuals or organisations properly qualified for the task.

16. The Australian Guidelines to Reduce Health Risks from Drinking Alcohol could serve as a model for revising the current UK drinking guidelines.[58] The Australian guidelines were developed by the National Health and Medical Research Council and were based on a systematic assessment of the evidence of the risk of alcohol-related disease and injury based on single occasion drinking and alcohol consumption over a lifetime. The guidelines provide universal guidance on alcohol consumption for healthy adults aged 18 years and over, as well as guidance specific to children and young people and to pregnant and breastfeeding women.

How well does the Government communicate its guidelines and the risks of alcohol intake to the public?

19. Given the historically high levels of consumption and consequent alcohol-related harm the Government must set guidelines which encourage low risk drinking and a reduction in population level consumption.

20. Although official guidance from the Chief Medical Officer specifies recommended drinking limits, it is common for government communications, including those from the Department of Health, to use terms such as "sensible" drinking limits and even "safe" drinking limits. No amount of alcohol consumption is risk free. The government should avoid the use of words such as "recommended" and "sensible" limits and use the terms low, medium and high risk drinking.

21. The Government should be clear with unit advice, for example stating no more than 3 units maximum in one day rather than 2–3 units.

22. The provision of public health information about products such as alcohol with known toxic, intoxicating and addictive effects should be the job of public health agencies alone. Under the Public Health Responsibility Deal, the current UK government appears to have devolved responsibility for communicating important information on drinking guidelines to alcohol companies with detrimental consequences. A unit awareness poster recently produced by the British Beer and Pub Association already exposes the serious deficiencies of this approach. The poster, accessible at http://www.beerandpub.com/newsList_detail.aspx?newsId=427 purports

[53] Department of Health (1995) Sensible Drinking—the report of an inter-departmental working group

[54] White, I et al (2002) "Alcohol consumption and mortality: modelling risks for men and women at different ages", British Medical Journal Vol 325: 191

[55] Rehm, J et al (2010) "The relationship between different dimensions of alcohol consumption and burden of disease: an overview", *Addiction*, Vol 105 817–843.

[56] *Alcohol-attributable mortality and morbidity: alcohol population-attributable fractions for Scotland*, NHS Scotland Information Services Division, June 2009.

[57] Madlen Schütze, (2011), "Alcohol attributable burden of incidence of cancer in eight European countries based on results from prospective cohort study", BMJ 2011;342:d1584

[58] Australian Guidelines to Reduce Health Risks from Drinking Alcohol, Commonwealth of Australia 2009. http://www.nhmrc.gov.au

to offer consumers with information on alcohol units contained in typical drinks, but fails to provide any contextual information, such as recommended daily drinking limits, or the risks to health from drinking over recommended limits, that would make the unit information meaningful. As a piece of public health information it is exceptionally poor. Public health agencies are trained in communicating public health messages: alcohol companies are not.

September 2011

Written evidence submitted by Children in Scotland (AG 23)

1. Children in Scotland welcomes this opportunity to submit evidence to this Committee inquiry into the evidence base for alcohol guidelines. We recognise that health is an issue devolved to the Scottish Parliament, but believe that it is important that Chief Medical Officers and health professionals across the United Kingdom offer the same recommendations and provide the same advice in relation to alcohol as a public health concern of great importance.

2. The UK Chief Medical Officers (CMOs) currently recommend that men should not regularly drink more than 3–4 units of alcohol a day and women should not regularly drink more than 2–3 units a day. They also advise having at least two days a week where no alcohol is consumed or taking a break of 48 hours after consuming a lot of alcohol. While we will not comment on the scientific evidence base for the advised number of units, it should be noted that more guidance and explanation is needed—both on labeling and as part of public health campaigns on what actually constitutes a unit of alcohol—as many people underestimate how many units they are consuming.

3. These should be easy to understand—perhaps including pictoral as well as written information. Instead of measuring intake in these units perhaps recommended limits could be conveyed with examples—eg 3–4 units is the equivalent of a pint and a half of regular beer, and 2–3 units is equal to a 175ml glass of wine. The calorie content of alcohol would also be a useful measurement to communicate, as this is also commonly underestimated, and important to factor into planning a healthy lifestyle.

4. Pregnant women or women trying to (or likely to) conceive are advised to avoid drinking alcohol, or if they do choose to drink, not to drink more than 1–2 units of alcohol once or twice a week. We support messages that encourage these women to avoid alcohol as a certain way of preventing fetal alcohol harm. The message "avoid alcohol if pregnant or trying to conceive" or "consuming alcohol while pregnant or trying to conceive may damage your baby" or the "French logo" (pregnant women with a wine glass with a line through it) are recommended inclusions on alcohol labels. In addition to this, we would also support further messages encouraging consumers to seek support and advice—for example, a link to Drinkaware.

5. While a fair number of people are aware of the message that drinking should be reduced or avoided altogether during pregnancy, there is much less awareness of the reasons why—and of the risks involved for the health and long-term well-being of their child. This lack of public understanding about the potential consequences significantly reduces the impact of the warning itself. For example, it is not common knowledge that tens of *thousands* of children and adults in the UK already have been negatively affected (and have had their lives compromised) by Fetal Alcohol Syndrome (FAS)—or the wider Fetal Alcohol Spectrum Disorder. The brain damage and other problems caused by exposure to alcohol in utero are irreversible and can lead to serious lifelong health, educational and behaviour difficulties.

6. The evidence base supporting the public health message about not consuming alcohol if pregnant or trying/likely to conceive is robust. However, it is more extensive in North America and other OECD nations than in the UK. Several pathways into this evidence base are provided at the end of this consultation response. There is every reason to believe that this evidence fully applies throughout the UK, as the evidence (clinical and laboratory) demonstrating that alcohol is a teratogenic agent that can cause developmental abnormalities and serious brain damage *in utero* is not limited to particular people or places.

7. Having strong consistent messages delivered by public health professionals and other groups working with people of child-bearing age is one way of increasing awareness of, and altering attitudes toward, the risks of drinking in pregnancy. Labelling alcohol products is one (but only one) way of creating a greater societal awareness of these risks.

8. Messages delivered about the risks and realities of alcohol consumption need to be consistent across the UK, and kept up to date, with old information removed from publications and websites to reduce the current level of misinformation and confusion about what the best available international evidence indicates is true.

9. The Department of Health advises that children are not given any alcohol until they are at least 15 years old. Again, if this is the agreed message this needs to be widely and consistently delivered across the UK.

10. Much as labels on cigarettes and other tobacco products warn of the potential dangers to the self and to others; alcohol products and public health information should warn of the possible health risks, such as the increased risk of developing various cancers, posed by consuming these products, and why suggested daily unit guidance is in place. The increased possible damage done by both drinking and smoking also needs to be more widely publicised. Cancer Research UK has a wealth of evidence on the links between alcohol and cancer.

Children in Scotland is the national umbrella agency for organisations and professionals working with and for children, young people and their families. It exists to identify and promote the interests of children and their families and to ensure that policies and services and other provisions are of the highest possible quality and are able to meet the needs of a diverse society. Children in Scotland represents more than 400 members, including most of Scotland's local authorities, all major voluntary, statutory and private children's agencies, professional organisations, as well as many other smaller community groups and children's services. It is linked with similar agencies in other parts of the UK and Europe.

The work of Children in Scotland encompasses extensive information, policy, research and practice development programmes. The agency works closely with MSPs, the Scottish Government, local authorities and practitioners. It also services groups such as the Cross Party Parliamentary Group on Children and Young People (with YouthLink Scotland). In addition, Children in Scotland hosts Enquire—the national advice service for additional support for learning, and Resolve: ASL, Scotland's largest independent education mediation service.

September 2011

Written evidence submitted by the Campaign for Real Ale, CAMRA (AG 25)

A. Introduction

1. As a consumer organisation with 129,000 individual members, CAMRA supports the need for Government advice to educate and inform consumers on the adverse impacts of excessive alcohol consumption.

2. The current advice dates back to a 1995 Government Inter-Departmental Working Group[59] which reviewed all the available evidence at that time. This advice should be reviewed in light of the substantial volume of new research which has been conducted since 1995 showing the potential health benefits of moderate alcohol consumption.

3. These potential health benefits of moderate alcohol consumption can outweigh the negative consequences of alcohol consumption. There is now overwhelming evidence showing that light and moderate alcohol drinkers have a lower all-cause mortality rate than non drinkers. This scientific evidence needs to be reflected in revised Government guidelines.

B. Responses to Questions Posed

1. *What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed?*

1.1 In 1995, a Government Inter-Departmental Working Group reviewed the available scientific evidence and made recommendations on an appropriate evidence based sensible drinking message. The findings of the Working Group currently form the basis of the Government's guidelines on alcohol intake, and have not been subject to a substantive review since.

1.2 The Working Group considered the health benefits of moderate drinking, and stated that: "moderate consumption of alcohol has a beneficial effect on CHD" (coronary heart disease.) They also went as far to recommend that non-drinkers and very light drinkers in age groups at significant risk of CHD "may want to consider the health benefits of light drinking."[60] The evidence base to support this contention has increased substantially since 1995.

1.3 The Brewers of Europe have produced a summary of additional potential health benefits associated with beer which includes a reduced prevalence of diabetes mellitus, osteoporosis, gallstones, senile dementia and parkinson's disease. These potential benefits need further research and consideration.[61]

1.4 The health benefits of moderate drinking are constantly being examined, and new reports and results are regularly being published. This highlights the need for a regular review of guidelines to reflect scientific evidence on the subject, and to keep consumers informed on both the positive and negative impacts of alcohol.

2. *Could the evidence base and sources of scientific advice to Government on alcohol be improved?*

2.1 The base of contemporary evidence and sources of advice available to Government certainly extends beyond the 1995 Working Group. It is vital that the new evidence, alongside the 1995 findings, is used to inform the guidelines and that this is accurately communicated.

2.2 There have been repeated studies since 1995 providing new evidence of the positive health impacts of light and moderate alcohol consumption. For instance, a 2010 study based on 1,824 older adults over twenty years found that "even after adjusting for all covariates, abstainers and heavy drinkers continued to show

[59] Department of Health, "Sensible Drinking: The Report of an Inter-Departmental Working Group," December 2005. Available online at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084702.pdf

[60] Ibid p.28

[61] http://www.brewersofeurope.org/docs/publications/pdf-Mei04.pdf

increased mortality risks of 51% and 45%, respectively, compared to moderate drinkers."[62] A key new finding in this study is that within the older population non drinkers show a higher rate of mortality than heavy drinkers.

2.3 The hypothesis that a positive causal relationship exists between moderate alcohol consumption and health has been robustly tested by several studies including the following, which concludes:

> *"The study involves about 488,000 person-years. Controlling for a variety of covariates, this study finds that compared with non drinkers, those who consume a moderate amount of alcohol have lower all-cause and CHD mortality. The fact that the current study has taken care to avoid the pitfalls of some earlier studies and still finds that those who consume a moderate amount of alcohol have lower all-cause mortality and CHD mortality lends credence to the argument that the relationship is causal."*[63]

2.4 It is clear from available evidence that non drinkers have higher all cause mortality than light and moderate drinkers. At light and moderate consumption levels alcohol has a protective effect. This protective effect is eroded as alcohol consumption increases. The current sensible drinking guidelines are based on the level of alcohol consumption at which mortality rates are significantly lower than for both the non-drinking and heavy drinking population.

2.5 For the majority of the population it is possible to drink at above these levels and still suffer from a lower rate of mortality than the non drinking population. Consideration of contemporary scientific evidence could provide the basis for additional advice indicating to drinkers the point at which their consumption puts them at greater risk than a non drinker. This advice would be particularly useful in targeting those whose drinking causes them and society most harm.

2.6 An additional area which has not been sufficiently researched, but which could contribute to informing Government guidelines, is the potential personal wellbeing benefits that can be derived from consuming alcohol to relax and as a part of socialising and building relationships with friends and family.

2.7 Additional research into the ways in which alcohol impacts different people differently would also be very helpful as a means of making more tailored advice to people, age, gender, size and background.

3. *How well does the Government communicate its guidelines and the risks of alcohol intake to the public?*

3.1 CAMRA believes that the current sensible drinking advice is communicated in an overly prescriptive way that is not supported by the evidence. In formulating the current advice the Government Inter-Departmental Working Group intended the daily drinking levels guidance to act as "points of reference" to help people to monitor their drinking. The Group were very clear that the daily unit guidelines were intended as "only benchmarks and not rigid limits." In addition, the Group stated that "guidance on benchmarks for regular drinking must be presented in the context of the overall risks and benefits from drinking."[64]

3.2 The current sensible drinking message does not sufficiently highlight the benefits associated with moderate alcohol consumption despite the evidence based recommendation of the 1995 Interdepartmental Working Group and the growing body of evidence to support this recommendation. CAMRA would support a revision to the Government's alcohol advice to highlight that light to moderate alcohol consumption is likely to be beneficial to health.

3.3 There is a lack of clarity as to what is meant by "regular" in the Government's sensible drinking message. This is unhelpful for alcohol consumers. CAMRA believes that consideration of recent evidence is vital so that the Government can confidently communicate the health benefits of moderate drinking and the risks of heavy drinking. With consideration of current evidence, the Government could also stipulate exactly what is meant by "moderate" and "heavy". It would also be appropriate for Government to highlight the importance of alcohol free days.

3.4 In addition, the guidelines seem to portray the recommended allowance as an absolute upper limit, which is not the case. There is, in fact, a wide gap between the safe recommended limit, and the point where drinking will have a severe health impact. Other countries, such as Austria and Slovenia, issue recommended allowances but also specify the point at which drinking becomes hazardous, hence providing more information and comprehensive guidelines to consumers. In this respect, the current communication does not adequately specify the different risks associated with different intakes.

3.5 Finally, there is a lack of focus on the short term effects of heavy, or "binge" drinking in favour of focusing on the longer term impact. Including advice in the sensible drinking message on the short term impact of very heavy drinking may be of more relevance to some people than a focus on possible long term health impacts.

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[62] Charles J. Holahan et al—Late-Life Alcohol Consumption and 20-Year Mortality—Alcoholism: Clinical and Experimental Research,November 2010

[63] Theodore D. Fuller—Moderate Alcohol Consumption and the Risk of Mortality—Published online: 19 May 2011 Population Association of America 2011

[64] Department of Health, "Sensible Drinking: The Report of an Inter-Departmental Working Group", December 2005., p29

4. *How do the UK Government's guidelines compare to those provided in other countries?*

4.1 CAMRA has put together the following analysis of sensible drinking guidelines across the world. This cross-national comparison shows substantial variation in the level of alcohol consumption that is regarded as sensible. The UK guidelines are at neither extreme.

Table 1

RECOMMENDED WEEKLY GUIDELINES FOR ALCOHOL CONSUMPTION (IN PURE ALCOHOL) FOR VARIOUS COUNTRIES

Country	*Unit Size (g)*	*RDA Men (g)*	*RDA Women (g)*
Australia	10	20	20
Austria	10	24	16
Canada	13.6	27.2	27.2
Czech Republic	n/a	24	16
Denmark	12	36	24
Finland	11	23.6	15.7
France	10	30	20
Germany	12	36	24
Greece	10	30	20
Ireland	10	30	20
Italy	12	24 to 36	12 to 24
Japan	19.75	19.75 to 39.5	n/a
Netherlands	10	40	20
New Zealand	10	30	20
Poland	10	20	10
Portugal	14	28 to 42	14 and 28
Romania	n/a	32.5 beer/20.7 wine	32.5 beer/20.7 wine
Slovenia	n/a	20	10
Spain	10	40	24
Sweden	n/a	20	20
Switzerland	10 to 12	20 to 24	20 to 24
UK	8	24 to 32	16 to 24
USA	14	28	14

4.2 Italy, Portugal, Germany, Netherlands Spain, Denmark and Japan all have upper limits for men that are greater than in the UK. The wide variation indicates the subjective nature of determining a national sensible drinking message.

C. Conclusions

1. Given the near scientific consensus that light and moderate alcohol consumption can reduce mortality risk CAMRA believes the sensible drinking message should be amended to include reference to the potential health benefits of light and moderate alcohol consumption—particularly for older people.

2. The current guidelines make no distinction between the very limited harm of marginally exceeding the daily guidelines and someone who regularly exceeds the guidelines by a large amount. This could be rectified by providing additional advice indicating the likely level of consumption that will place a drinker at more harm than a non drinker. Additionally, a clearer definition of what is meant by regular should be introduced.

3. Communication of the guidelines should seek to avoid presenting them as absolute limits but instead seek to highlight that they are benchmarks.

4. Given the substantial number of new scientific studies published since 1995 providing additional data, CAMRA believes the current daily unit guidelines should be reviewed with a view to implementing a higher limit agreed following a thorough review of recent studies.

September 2011

Written evidence submitted by the Academy of Medical Sciences (AG 26)

I write on behalf of the Academy of Medical Sciences to draw your attention to our 2004 report *Calling time: the nation's drinking as a major health issue*.[65] The report was the result of a working group led by Professor Sir Michael Marmot FBA FMedSci. It sought to make an evidence-based contribution to proposals on how to ameliorate the damage done by alcohol. Although written some time ago, the report addressed issues pertinent to your inquiry, and the relevant sections of the report are highlighted in this letter.

Considering the evidence base for Government's guidelines

— There is a clear evidence base which supports policy aimed at reducing alcohol consumption. Our report highlighted the strong correlation between mean or median alcohol consumption and heavy or "problem" drinking. Data demonstrate that changes in *per capita* alcohol consumption are directly reflected in changes in harm. For instance, in Canada a one litre *per annum* rise in mean alcohol consumption was associated with a 30% increase in alcoholic cirrhosis of the liver.[66]

— Tax increases have been shown to impact on rates of cirrhosis mortality, drink-driving deaths, and violent crime and some have therefore questioned whether alcohol tax is high enough.[67,68] Our report suggested that increasing the tax on alcoholic beverages to restore the affordability level of 1970, and indexing the taxes to disposable income, would be a highly effective way of turning around not only the trend in alcohol consumption but also trends in alcohol-related harm.

— Our report highlighted areas where current policy may be considered out of line with scientific evidence. The third recommendation of our report was that the statutory blood alcohol concentration level for drivers should be lowered from 80mg to 50mg% and that there should be a zero statutory blood alcohol level as the limit for young drivers up to the age of 21 (see also below). It also drew attention to evidence from Finland which suggested that allowing the sale of alcohol in supermarkets led to an increase in its consumption.

Could the evidence base and sources of scientific advice to Government on alcohol be improved?

— The Academy recommends ensuring that all new public health policies are supported by evidence-based decision-making, robust piloting and rigorous evaluation throughout implementation. We have recently emphasised that public health challenges must become cross-Departmental priorities.[69] In our 2004 report, we recommended that an interdepartmental alcohol policy research programme should be funded to contribute to the evidence-base and further develop British alcohol policy. The committee may wish to investigate whether this recommendation was taken forward.

— At the time of our report, studies of the cost-effectiveness of different alcohol interventions were just becoming available.[70] For example, the study by Chisholm *et al.* (2003), estimated that implementation of full enforcement of drinking-driving legislation, including random breath testing, would reduce traffic deaths in Western Europe by 23% among men and 4% among women.[71] We hope that the results of such studies have, and continue to be, been taken into account when formulating policy.

— There is a need for greater investment in biomedical research to better understand the mechanisms of alcohol-induced harm, an area which at the time of our report was largely ignored by funding bodies. Other research priorities include understanding changing patterns of drinking, their social determinants and their contribution to increases in social problems, such as violence and other antisocial behaviour and health problems, such as liver cirrhosis.[72]

How do the UK government's guidelines compare to those provided in other countries?

— Although there are cultural differences between countries in relation to alcohol, in many aspects of alcohol research there are high-quality international studies that can contribute to the evidence base for the development of policy. The Government should take into account the wealth of international evidence, though it does not obviate the need for UK-specific studies.

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[65] Academy of Medical Sciences (2004). *Calling time: the nation's drinking as a major health issue.* http://www.acmedsci.ac.uk/p48prid16.html

[66] Ramstedt M (2003). *Alcohol consumption and liver cirrhosis mortality with and without mention of alcohol—the case of Canada. Addiction*, 98, 1267–1276.

[67] Cook P (1981). *The effect of liquor taxes on drinking, cirrhosis, and auto accidents.* In Moore MH and Gerstein DR (eds). Alcohol and Public Policy. National Academy Press, Washington DC, 255–285.

[68] Cook PJ and Moore M J (1993). *Violence reduction through restrictions on alcohol availability.* Alcohol Health and Research World, 17, 151–156.

[69] Academy of Medical Sciences (2010). *Reaping the rewards: a vision for UK medical science.* http://www.acmedsci.ac.uk/p99puid172.html

[70] Ludbrook A et al (2001). *Effective and Cost-Effective Measures to Reduce Alcohol Misuse in Scotland: A Literature Review* http://www.scotland.gov.uk.

[71] Chisholm D et al on behalf of WHO-CHOICE (2003). *Reducing the global burden of heavy alcohol use: a comparative cost-effectiveness analysis*. WHO (working paper), Geneva.

[72] Home Office (2000). *Report of Policy Action Team 8: Anti-Social Behaviour.* http://www.neighbourhood.gov.uk.

— At the time of our report, there had been cultural changes in countries such as Italy and France that had led to significant drops in mean alcohol consumption in those populations. Whereas in France and Italy *per capita* consumption of alcohol had more than halved since 1970, in the UK over the same period it had risen by 50%.

— Among the best-supported findings in alcohol policy research is the conclusion that increasing the minimum age for purchasing alcohol has an effect in reducing harms from drinking in the affected ages.[73,74] While much of this literature is from the United States, which has a relatively high minimum age of 21, studies from such countries as Canada and Denmark, with lower age limits, also show beneficial effects.[75]

— Britain, Ireland and Luxembourg have a higher Blood Alcohol Limit (BAL) for drivers (0.08%), than the general EU rule (0.05%). Another exception is Sweden which has a lower BAL (0.02%). An evaluation of the effects of lowering the BAL level to 0.02% in Sweden from the level of 0.05%, found that, in combination with other measures it had a significant effect on drink driving fatalities.[76] On this matter, the UK could be regarded as being out of step with much of the rest of Europe and with the research literature. Research findings suggest that reducing the British BAL could reduce rates of traffic casualties.

The Academy of Medical Sciences is the independent body in the UK representing the whole spectrum of medical science. Our mission is to ensure better healthcare through the rapid application of research to the practice of medicine. Our Fellowship includes leading medical scientists from hospitals, academia, industry and the public service. We look forward to the outcomes of the inquiry.

Dr Rachel Quinn, Director
Medical Science Policy
Academy of Medical Sciences

September 2011

Written evidence submitted by the Portman Group (AG 28)

1. The Portman Group is the responsibility body for drinks producers in the UK. Our role is:

— To **regulate** the promotion and packaging of alcoholic drinks sold or marketed in the UK.

— To **challenge** and encourage the industry to market its products responsibly.

— To show **leadership** on best practice in alcohol social responsibility through the actions of member companies.

Declaration of Interest

2. We are a not for profit for organisation funded by nine member companies[77] who represent every sector of drinks production and collectively account for more than half the UK alcohol market.

Summary

3. The Portman Group welcomes a timely review of the evidence base underpinning the Government's guidelines on sensible drinking.

4. We advocate strongly for the continued provision of clear and consistent information about the recommended daily unit guidelines for UK consumers, based on the best available evidence, so people can make informed decisions about sensible drinking.

5. As a result of this promotion by Government and industry, the guidelines are becoming more widely known and understood in the UK. Between 1997 and 2009, the proportion of people who had heard of alcohol units increased from 79% to 90%.[78] Over the same period, the proportion of people who could correctly identify the recommended daily limit for men increased from 35% to 44% and for women it increased from 39% to 52%.

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[73] Wagenaar A C and Toomey T L (2002). *Effects of minimum drinking age laws: Review and analyses of the literature from 1960 to 2000*. Journal of Studies on Alcohol, Supplement 14, 206–225.

[74] Shults R *et al* (2001). Reviews of evidence regarding interventions to reduce alcohol-impaired driving. *American Journal of Preventive Medicine,* 21, supplement 4, 66–88.

[75] Møller L (2002). *Legal restrictions resulted in a reduction of alcohol consumption among young people in Denmark.* In Room, R.(ed.) The Effects of Nordic Alcohol Policies: What happens to Drinking and Harm when Controls Change? Nordic Council for Alcohol and Drug Research: Helsinki. 155–166.

[76] Borschos B (2000). *Evaluation of the Swedish drunken driving legislation implemented on February 1, 1994.* Presented at the 15th International Conference on Alcohol, Drugs and Traffic Safety, Stockholm, Sweden: 22–26 September. http://www.vv.se.

[77] Current member companies are: AB InBev; Bacardi Brown-Forman Brands; Beverage Brands; Carlsberg; C&C Group; Diageo; Heineken; Molson Coors; and Pernod Ricard.

[78] Office of National Statistics, *Omnibus Survey Report: Drinking: Adults' Behaviour and Knowledge in 2009*, 2010, Table 4.1

6. We would therefore recommend caution in making any changes to the guidelines unless there is compelling and unequivocal scientific evidence to do so. The risk of undermining the progress made thus far in terms of people's understanding of sensible drinking guidelines should be considered very carefully.

Terms of Reference—Detailed Comments

What evidence are Government's guidelines on alcohol intake based on, and how regularly is the evidence base reviewed?

7. The existing guidelines are based largely on the recommendations contained in a report of an inter-departmental working group published in December 1995. The working group included medical experts and in devising its recommendations the working group took account of the most relevant and up-to-date research at that time. Further relevant research will, however, have been published since then and we therefore consider it is timely to undertake this inquiry into the evidence base.

Could the evidence base and sources of scientific advice to Government on alcohol be improved?

8. We do not propose to comment on this point.

How well does the Government communicate its guidelines and the risks of alcohol intake to the public?

9. Respective governments have made some efforts over the years to communicate the guidelines through ad hoc public health campaigns, such as the "Know your limits" campaign.

10. The industry, meanwhile, has increasingly sought to complement the Government's activity by communicating the guidelines to consumers. For example, Portman Group members were some of the first to include information on alcohol unit content on product labels. These days, the majority of drinks labels include such information. The alcohol industry as a whole has pledged to feature information on unit content, the Chief Medical Officers' guidance on responsible drinking and a warning against drinking during pregnancy on 80% of drinks' labels on UK shelves by the end of 2013 as part of the Government's Public Health Responsibility Deal[79] agreed in March 2011. The supporting labelling guidelines[80] drawn up by the Portman Group encourage companies additionally to feature a responsible drinking message and the Drinkaware website alongside these elements.

11. The alcohol industry also funds an independent charity, Drinkaware, which is the leading source of sensible drinking advice and has high level of awareness across the population. The Drinkaware website, which is promoted on billions of drinks containers and in millions of pounds worth of brand advertising annually, provides consumers with facts about alcohol and raises awareness of the Government's guidelines. The website receives over two million visitors a year.

12. As a result of this promotion by Government and industry, the guidelines are becoming more widely known and understood in the UK. Between 1997 and 2009, the proportion of people who had heard of alcohol units increased from 79% to 90%.[81] Over the same period, the proportion of people who could correctly identify the recommended daily limit for men increased from 35% to 44% and for women it increased from 39% to 52%.

13. It is not yet fully clear the extent to which all this activity has had a direct impact on drinking behaviour but it is noticeable that since 2004 there has been a noticeable decline in levels of alcohol misuse in the UK.[82]

14. Despite this progress, however, there is still much more work to be done to educate consumers about responsible drinking with many people still not knowing or understanding at what point their alcohol consumption may start presenting a significant risk to their health.

How do the UK Government's guidelines compare to those provided in other countries?

15. Direct comparisons are not easy, not least because the definition of an alcohol unit tends to vary between countries. Therefore, one has to convert any national advice on unit consumption into the equivalent grams of alcohol to make a comparison. Our understanding, however, is that the UK guidelines fall broadly mid-field being higher than some countries (eg the USA) but lower than others (eg Spain and Italy).

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[79] http://www.dh.gov.uk/en/Publichealth/Publichealthresponsibilitydeal/Pledges/index.htm
[80] http://www.portmangroup.org.uk/assets/documents/Alcohol%20labelling%20compliance%20and%20monitoring%20process%202011.pdf
[81] Office of National Statistics, *Omnibus Survey Report: Drinking: Adults' Behaviour and Knowledge in 2009*, 2010, Table 4.1
[82] http://www.portmangroup.org.uk/assets/documents/Fact%20Sheet%20-%20Summary%20of%20UK%20Alcohol%20Trends%20_2_xPDFApril2011.pdf