

Alcohol: Education

Background

Alcohol is a common commodity consumed in most countries around the world. Drinking is considered part of the culture in many European Member States, and, although rates and patterns vary across countries **the EU has the highest rate of alcohol consumption in the world** (WHO 2004).

Alcohol is a leading cause of death and disability in the EU with significant costs to society and to Europe's economy. The negative impact of alcohol consumption is seen across many sectors including health, social services, justice and education.

55 million
European adults
drink to
dangerous levels

Each year the EU and Member States spend millions of Euros to address the negative impacts of alcohol through policies and programmes aimed at reducing harmful alcohol consumption. Activities include regulation of sale and marketing and, initiatives aimed at the general population or specific groups such as young people, pregnant women or drivers using education and social marketing.

A number of countries have seen a decline in alcohol consumption in recent years. However, many have experienced a concerning rise, particularly among young people and in harmful and heavy episodic drinking ("binge drinking")¹. This behaviour is not confined to young people but is increasingly common among older age groups (Anderson 2007²). While 24% of people aged 15-24 years reported binge drinking at least once a week in 2006, the rate was 18% for those over 55 years (Eurobarometer 2007³).

Although much attention is paid to "alcopops" these are *not* the most popular drink in any country.

This rise in overall and problem drinking is accompanied by an increase in alcohol related harm (Anderson & Baumberg 2006). Alcohol related harm includes not only ill-health but also violence, accidents and injuries and social problems such as unemployment, crime and family problems.

Education activities undertaken in Member States to inform citizens of the consequences of alcohol consumption are implemented and funded within countries' own policy guidelines and programs. Education activities and dissemination of guidelines are often limited to healthcare settings and schools, although a number of countries undertake alcohol related public health campaigns using the mass media or through messages displayed at the point of sale.

Some educational activities are undertaken by the alcohol industry. However, the budgets allocated to these are dwarfed by the industry's spending on advertising and marketing alcoholic beverages. Similarly, the resources available to governments, public health bodies and other actors are minimal when compared to industry spending on advertising.

A number of EU countries have no definition of lower or higher risk levels of drinking

Definitions of lower and higher risk consumption differ across the region with a number of countries lacking any guidelines provided by government or a public health body on lower and higher risk levels of drinking; although it is generally accepted that women should not drink at all during pregnancy.

¹ Harmful drinking: Regular consumption of >20g day (♀) or 40g day (♂). Binge drinking: >60g on one occasion).

² Refers to EU15: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom.

³ Refers to EU25: Austria, Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, United Kingdom.

EU priorities

In 2006 the Commission adopted an EU strategy⁴ to support Member States in reducing alcohol-related harm.

The Commission identified five priority themes, which are relevant to all Member States and for which Community action as a complement to national policies has an added value:

- Protect young people, children and the unborn child;
- Reduce injuries and death from alcohol-related road accidents;
- Prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
- Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;
- Develop and maintain a common evidence base at EU level.

80 million Europeans aged over 15 years
reported binge drinking at least once a week in 2006
(almost double the population of Spain)

The Strategy outlines action at three levels: European Commission; national; and, local. At the EC level action is focused on supporting and working with Member States to monitor drinking patterns and develop strategies and action to tackle harmful drinking.

The Strategy states that *Citizens have the right to obtain relevant information on the health impact, and in particular on the risks and consequences related to harmful and hazardous consumption of alcohol, and to obtain more detailed information on added ingredients that may be harmful to the health of certain groups of consumers.*

The EC Treaty includes obligations to protect the health and safety of consumers and to promote their right to information. In support of consumers' rights to information EC level action within the alcohol strategy includes *exploring the usefulness of developing efficient common approaches throughout the community to provide adequate consumer information. This is reinforced by national action to improve consumer information, at point of sale or on products, on the impact of alcohol abuse on health and work performance. As part of consumer information, some Member States have introduced, or are considering introducing labelling to protect pregnant women and the unborn child. Other actions aim at providing easily understandable information on alcohol content and moderate drinking.*

⁴ Commission Of The European Communities, Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the committee of the regions, An EU strategy to support Member States in reducing alcohol related harm, 2006 Brussels

Key Facts

Alcohol is a leading cause of ill-health and death in the EU

- Alcohol is the 3rd leading risk factor for ill-health and death in the EU
- 7.4% of all ill-health and premature death in the EU is due to alcohol
- 55 million European adults drink to dangerous levels
- Some 23 million Europeans are dependent on alcohol in any year
- 25% of all male deaths and 11% of all female deaths between 15-29yrs are due to alcohol
- 80million Europeans aged 15 years plus reported binge drinking at least once a week in 2006

HARMFUL & BINGE DRINKING ARE RISING

Harmful: >4 drinks day (♂) >2 day (♀)

Binge: >6 drinks in one session (60g+)

Alcohol harms the EU economy

- Alcohol related disease, injury and violence cost the EU €125bn in 2003 (1.3% GDP)
- The costs of alcohol related harm impact health, welfare, employment, criminal justice
- Alcohol contributes to absenteeism, unemployment and accidents at work
- *Intangible costs* of criminal, social and health harms caused by alcohol were estimated at €270bn in 2003.

Health risks

Alcohol, cancer and vascular disease

- Alcohol is a carcinogen, causing cancer of the oral cavity and pharynx, oesophagus, stomach, colon, rectum and breast, with no safe level.
- Persistent use damages the liver and can lead to liver cirrhosis or cancer
- Alcohol increases the risk of stroke, and, in high doses, coronary disease and heart failure

Alcohol and pregnancy

- Alcohol is a teratogen, affecting the development of the baby.
- Drinking during pregnancy can damage the foetus and increase the risk of miscarriage
- Each year in the EU approx. 60 000 babies are born below normal birth weight due to alcohol

Alcohol and driving

- Over 1 in 3 deaths in traffic accidents are caused by drink-driving (approx 17 000 /year)
- Over 10 000 people killed as a result of drink-driving each year are not the driver

Alcohol and risk taking, violence, accidents and injury

- Alcohol intoxication increases the risk of unsafe sex therefore increasing transmission of sexually transmitted infections and unwanted pregnancies
- 4 of every 10 homicides in the EU (>2000) are attributable to alcohol
- 10 000 suicides a year (1 in 6) are attributable to alcohol

Alcohol and children/young people

- Brain development in young people and children is damaged by alcohol use
- Alcohol is estimated to be the cause of 16% of cases of child abuse
- Over 1 in 8 of 15-16 yr olds have been drunk more than 20 times in their life

Discussion

Education and campaigns

Different kinds of education and persuasion interventions are used to reduce the harm done by alcohol: these include education campaigns which may be school based or more general and social marketing using mass media.

As well as initiatives implemented by public health bodies there are also those implemented by the alcohol industry along the themes of corporate social responsibility and promoting “sensible drinking”.

Many of these programmes / interventions aim to affect behaviour by influencing attitudes.

Education programmes aim to change beliefs and attitudes about drinking and to provide the skills to refuse when encouraged to drink (or to drink excessively) by peers, social custom or industry marketing. This is most often targeted at young people and implemented in schools.

Social marketing is the application of commercial marketing technologies to programmes designed to influence behaviour in order to improve personal welfare or that of society. Social marketing uses techniques common to commercial marketing and applies them to social and health problems. Social marketing has four key features:

1. a focus on voluntary behaviour change;
2. the recognition that behaviour change must result in a benefit to the target audience;
3. use of marketing techniques such as “the marketing mix”; and,
4. an end goal of improving individual welfare and society. (Gordon et al. 2006).

It differs from traditional marketing in that the aim is not to benefit the organisation doing the marketing but the individual and society. Social marketing can also be used to change behaviour among professionals, organisations and policymakers. For example, to gain the support of policy makers for legislation, or to encourage retailers to comply with restrictions on the sale of products such as alcohol or tobacco to minors.

School-based education programmes

School-based education programmes are relatively easy to implement and are a visible activity which demonstrates publicly that action is being taken. However, the evidence suggests that these programmes are ineffective when used alone (Babor et al 2003).

The effectiveness of an intervention depends largely on how it is delivered as demonstrated by warning labels on cigarettes and alcohol where studies show that design, placement and frequently changing the labels all have a significant impact on recall and behaviour change while unchanging, plain, unappealing labels are ineffective (Hammond et al 2007, Borland 1997). Any intervention to reduce alcohol consumption and related harm is competing with the expertise and funding available to the alcohol industry for sophisticated advertising and marketing. School based programmes are often implemented with few resources (monetary and personnel) and are rarely followed up with “booster shots” (Rehm et al 2006).

Many systematic reviews have evaluated school-based education and concluded that classroom-based education is not an effective intervention to reduce alcohol-related harm (Foxcroft et al 2003, Jones et al 2007, Hall and Room 2006). Although there is evidence of increased knowledge about alcohol and on improved alcohol related attitudes, there is no evidence for a sustained effect on behaviour. Very few interventions show decreased drinking in either the short or the long-term (Jones et al 2007, Anderson 2007, Giesbrecht 2007). As school programmes are rarely followed up it is unknown whether sustained, ongoing programmes would result in better outcomes (Craplet 2006, Warner 2007).

Public education campaigns

In general, public information campaigns have been found to be ineffective in reducing alcohol related harm (Babor et al 2003). An exception to this are mass media campaigns to reduce drink-driving, which, when implemented in the presence of strong drinking and driving countermeasures, can have an impact (Elder 2004). Counter-advertising, a variant of public information campaigns which provides information about a product, its effects and the industry that promotes it, has inconclusive effects (Babor et al 2003).

Campaigns based on drinking guidelines

Whilst campaigns based on drinking guidelines have been used in a number of countries, there have been no rigorous evaluations of whether or not publicising drinking guidelines have any impact on alcohol-related harm.

Social marketing

Social marketing has been used in a range of public health areas including work safety, nutrition, physical exercise, drink driving, alcohol and substance use not only targeted at individual behaviour but also as a means to facilitate policy change. There is some evidence of effectiveness both with individual behaviour change and in effecting policy change (Gordon et al. 2006)

Consumer labelling and warning messages

Evaluation of the impact of alcohol labelling in raising awareness and changing behaviour. indicates that labels alone are unlikely to directly affect behaviour change however they can contribute to raising awareness and intention to change drinking patterns which is an important stage leading to behaviour change (Stockwell et al. 2006).

A number of factors appear to influence the effectiveness of labelling: design and location, rotating messages and integration with a broader public health strategy (Hammond et al 2006). Evidence from studies on the effectiveness of tobacco labelling indicate that static, unchanging messages are less effective than rotating messages. In Canada pictorial labels have had an impact in both reducing the amount smoked and in increasing cessation. The WHO Framework for Tobacco Control sets out clear standards for labels, requiring them to be: rotating, large, clear, visible and legible. In Australia, research found that smokers showed increased knowledge of the main constituents of tobacco smoke and identified significantly more disease groups following the introduction of warning labels (Borland 1997).

Alcohol industry funded campaigns

There is evidence that social responsibility messages, whether stand-alone or when added to product advertisements, benefit the reputation of the sponsor more than public health and create a sense of good-will toward the company and the product. For example, tobacco industry prevention campaigns consistently cause young people to become more favourably inclined towards the tobacco industry (Henriksen et al 2006; Wakefield et al 2005; Wakefield et al 2006). In alcohol, a study by Christie et al (2001), assessing the impact of adding drink-driving messages to bar advertisements, showed that including the message had positive effects on the perception of the advertiser in terms of concern about the safety of bar customers, but did not affect their attitudes or intentions. Alcohol advertising frequently places alcohol within a social, fun, glamorous context. Although the commercials may include a brief message regarding responsible drinking, alcohol is positioned as 'normal'. One study found the message in alcohol industry social responsibility spots to be ambiguous, especially for 16-18 year olds (Smith et al 2006), but that the source of the message (the alcohol company) was favourably perceived. Over two-thirds of the sample agreed that the spots suggested beer drinking was fun.

There is also evidence, that alcohol companies are more circumspect about their messaging than a public health source. They tend to avoid the negative consequences of irresponsible drinking (Lavack 1999) and set their messages within a 'drinking as normal' context (Dejong et al 1992). They also co-opt social responsibility messaging to serve product marketing objectives. Thus, seemingly pro-health messages can end up serving to subtly advance both industry sales and public relations interests, while having little impact on reducing harmful drinking.

Attitudes versus Behaviour

While education primarily aims to affect behaviour through influencing attitudes there is some evidence to suggest that in fact attitudes are influenced by behaviour. Thus raising the question of whether interventions should focus on attitudes or whether it would be more effective to focus on behaviour.

Research in adolescent smoking found that attitudes towards smoking were neither a consistent nor strong predictor of smoking behaviour over time (Leeuw et al 2008). The same study found that in fact, past smoking was related to attitudes indicating that adolescents adapted their attitudes to match their behaviour. It also suggests that other factors play important roles in beginning and continuing to smoke, such as favourable social images and smoking peers. With adolescents in particular there is evidence that their behaviour is more influenced by social goals than health related goals (Gibbons et al 2006)

Providing information and education is important to raise awareness and impart knowledge. However, in an environment in which there are many competing messages in the form of marketing and social norms supporting drinking, and in which alcohol is readily accessible, education programmes alone which focus on changing attitudes do not lead to sustained changes in alcohol-related behaviour.

Questions for Consideration by Policy Makers

? What are the priorities / goals of alcohol policy and interventions?

From a public health perspective alcohol policy should aim to reduce death and disability in the population related to alcohol. This includes both illness due to alcohol and alcohol related injuries. More broadly, alcohol policy should aim to reduce the negative socio-economic impact due to alcohol.

Alcohol policy should prioritise those policies/interventions which are likely to have the highest impact on reducing alcohol related harm.

? What is the current epidemiology of alcohol related harm? Are interventions / policies focusing on the most common and serious problems?

Policy makers must be aware of the most common and serious alcohol related harms and prioritise interventions / policies which address these. They should also be aware of those harms related to sectors other than health e.g. employment, justice, social welfare.

In terms of reducing harm the current EU Strategy focuses on:

protecting young people, children and the unborn child;

→ Young people and children are affected not only by their own drinking but are also directly harmed by alcohol related accidents and violence and by the socio-economic impact of alcohol use on the family/society (e.g., illness, employment, parenting, domestic violence and abuse). Unborn children are affected by maternal alcohol use, including increased risk of miscarriage and developmental problems.

reducing injuries and death from alcohol-related road accidents;

→ Alcohol related road accidents are a significant cause of death and disability in the EU.

→ A large portion of those killed as a result of drink-driving each year are not the driver.

preventing alcohol-related harm among adults and reducing the negative impact on the workplace.

→ Alcohol is a significant factor in road accidents, injuries, violence, homicides and suicide.

→ Alcohol is related to over 60 types of disease including cancers, cardiovascular conditions and liver damage.

→ Alcohol contributes to absenteeism, unemployment and accidents in the workplace.

? Who are the current audience of education and are they those most likely to produce significant impacts on alcohol related harm?

Many education programs focus on youth. Meanwhile, there is evidence that young adults and adults are often overlooked. These groups often serve both as drinking role models for youth and support easy access to alcohol which is associated with increased drinking in all age groups and are therefore an important target audience (Giesbrecht 2007).

It may be more effective to focus education / information activities on policy makers and the general public as a means to raise awareness of the burden of alcohol related harm and both the benefits of and effective measures to reduce this harm.

Interventions could be reframed to encourage and support consumer advocacy by providing information on how the public can influence alcohol policy.

? What is known to be effective in reducing alcohol related harm?

A number of approaches to reducing alcohol related harm are supported by strong evidence. It is also known that a coherent strategy combining a number of reinforcing elements is more effective than a single type of intervention alone.

Actions with strong evidence for effectiveness include:

- higher taxes for higher alcohol beverages;
- raising the minimum drinking age;
- reducing outlet density;
- reducing trading hours;
- enforcement of random breath testing;
- enforcement of licensing laws; and,
- penalties for serving intoxicated customers (Babor et al 2003).

When looking at education alone, the lack of evidence for effectiveness could lead to policy makers to consider withdrawing funds from education programmes altogether. This creates several risks including: losing an important means of gaining awareness of and support for other control measures and, leaving a gap which may be filled by better-funded industry-backed programmes.

? Is there a conflict of interest with industry involvement?

As discussed, the alcohol industry undertakes a number of “social responsibility” activities. These include education programmes, point-of-sale information, web sites and adding tag lines urging people to drink responsibly to print, radio and television advertising.

It is clear from a number of studies that education activities undertaken or funded by the alcohol industry are ineffective in reducing excessive consumption and alcohol related harm (Smith et al 2006). Taking lessons from tobacco control it is known that industry funded programmes are unlikely to reduce harm and may in fact improve the public’s perception of the industry while having no effect on drinking patterns or intention to change behaviour thereby undermining efforts to reduce alcohol related harm (Henriksen et al 2006; Wakefield et al 2005; Wakefield et al 2006).

As with any commercial industry the objective is to sell a product. By implementing education programmes which are cheap to run when compared to commercial advertising the alcohol industry gains positive public relations at little cost while causing no damage to sales and with no demonstrated impact on alcohol related harm (Smith et al 2006, Lavack 1999, Dejong et al 1992).

Options

- **Continue to fund education as is**

Alcohol policy should prioritise those policies/interventions which are likely to have the highest impact on reducing alcohol related harm. Policies/interventions which do not demonstrate a positive impact on alcohol related harm should be phased out or redesigned to enhance effectiveness. Supporting policies/interventions which are shown to be ineffective diverts resources from those activities more likely to reduce alcohol related harm.

There is a growing body of evidence that alcohol education programmes in their current form are not producing the desired results. There is also evidence that industry involvement in alcohol education programmes is counterproductive and unlikely to reduce alcohol related harm.

The health and socio-economic impacts of alcohol are broad and significant. Failure to implement effective action to reduce alcohol related harm would result in continuing and increasing negative impacts on the health and society the EU.

- **Abandon education**

While the lack of evidence to support education programmes may lead some policy makers to abandon education altogether this approach entails some risks. Education can be a tool for awareness and support raising and an important feature of a broader strategy. Removing support for education also leaves a gap which may be filled by industry sponsored education which has been demonstrated to be ineffective and in some cases counterproductive to the goals of reducing alcohol related harm.

- **Reorientation**

It is possible to reorient/refocus alcohol education to align programmes/activities to priority areas and audiences. This approach is likely to lead to achieving the maximum positive outcomes. Focusing efforts on the more common and serious problems and prioritising interventions known to be effective ensures that resources are spent wisely and the best cost-benefit ratio achieved. Targeting groups which influence behaviour and attitudes such as young adults can also be beneficial along with using education to raise awareness among policy makers and the public. Education can also be used to encourage and support advocacy. The conceptual shift from influencing attitudes to effect behaviour to looking at the influence of behaviour on attitudes is important to consider especially among young people.

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This fact sheet was prepared by Rebecca Gordon and Peter Anderson on behalf of the German Centre for Addiction Issues (DHS) as part of the Building Capacity project managed by the Institute of Public Health of the Republic of Slovenia, co-financed by the European Commission.

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With the support of



Generalitat de Catalunya
Departament de Salut

Co-financed by

