WHO European Ministerial Conference on Mental Health

Facing the Challenges, Building Solutions

Helsinki, Finland 12–15 January 2005

Alcohol and mental health

"First the man takes a drink; then the drink takes a drink; then the drink takes the man."
(Proverb)

"Alcoholism isn't a spectator sport. Eventually the whole family gets to play."
(Joyce Rebeta-Burditt, author)

Facing the challenges

The European Region of the World Health Organization (WHO) is the region with the highest alcohol intake in the world. Alcohol is the third largest preventable risk factor in the Region and a major cause of mental disorders, accidents and injuries *(1)*. Alcohol consumption is an important mental health issue and a major factor for the global burden of disease.

Alcohol-use disorders are recognised and classified as mental disorders. Hazardous and harmful use of alcohol is associated with a wide range of mental and behavioural problems. It also has social consequences, affecting the lives and indeed the mental health of those people who live or work with an alcohol-dependent person.

Alcohol-use disorders are preventable and, although it is not realistic to expect to eradicate them completely, there is evidence of the effectiveness of a whole array of measures that can significantly reduce the harm done by alcohol.

Alcohol can interact with mental health disorders in several ways:

- people with mental ill health are at higher risk of experiencing alcohol-related problems;
- people with alcohol-use disorders are more likely to suffer from other mental health problems;
- alcohol use by a person with mental ill-health can:
  - lead to a poorer treatment outcome;
  - make the symptoms worse;
  - increase the risk of alcohol dependence;
  - have harmful interactions with prescribed medicine;
  - contribute to worse mood in the long run.

Management of alcohol-related problems should be incorporated into any public health response to mental health problems. Evidence-based preventive measures are available at both individual and population levels, with alcohol taxes, restrictions on alcohol availability and drink-driving countermeasures among the most effective policy options. Despite the scientific advances, alcohol problems continue to present a major challenge to medicine and public health.

The scale of the problem

Worldwide, alcohol use causes 1.8 million deaths and 4% of the total disease burden as measured by the global burden of disease study. Unintentional injuries alone account for about one third of the 1.8

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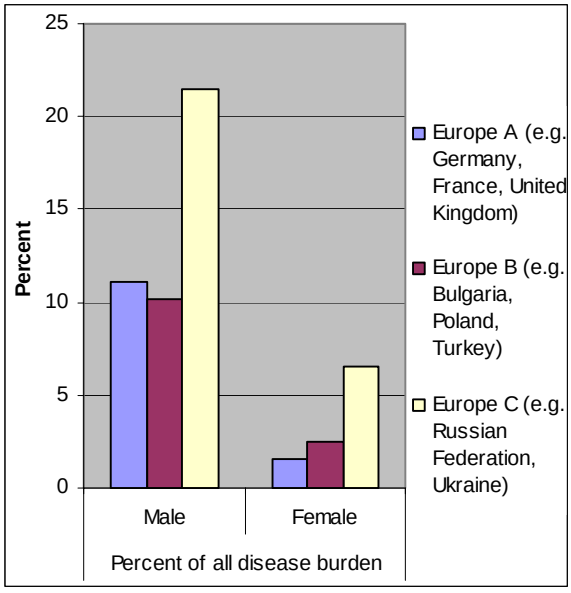
million deaths, while neuropsychiatric conditions account for close to 40% of the overall disease burden *(2)*.

In the European Region, there are 86.8 million people (99 per 1000) who have harmful levels of alcohol consumption, causing 15.4 million years lost to ill health and premature death each year. Of that figure, 5 million years (32%) are lost owing to neuropsychiatric conditions.

Men have a far greater alcohol-related disease burden than women, the ratio being 5:1. The health damage and social harm caused by alcohol fall not only on the drinker but also on others. Women bear a disproportionate share of the burden of harm from others' drinking *(3)*.

Policies which affect the rates of alcohol-related harm thus not only improve the health and save the lives of those who drink, but potentially have a broader impact on the health and well-being of families, communities and society at large.

Figure 1: Proportion of alcohol-attributable disease burden according to subregion and gender in 2000 in WHO European Region *(4)*.



Alcohol and depression

The evidence indicates a close relationship between alcohol consumption and depression. Heavy drinking can lead to depression, and depression can lead to hazardous and harmful drinking and alcohol-use disorder. Studies of people in treatment have shown that one of the effects of long-term high alcohol consumption is an increase in depressive symptoms, which tend to disappear when alcohol consumption is reduced or stopped. Policies that reduce alcohol consumption, especially among heavier drinkers, might be expected to reduce the burden of disease related to depression.

Alcohol and suicide

The relationship between alcohol consumption and suicide or attempted suicide is well established among heavier drinkers. The risk of suicidal behaviour in this group increases with psychiatric comorbidity. Suicide rates are also found to rise with increased per capita consumption. The suicide rate for younger age groups seems to be more significantly related to per capita consumption than that for older people. In addition, research suggests that suicide rates tend to be more responsive to changes in per capita alcohol consumption in drinking cultures characterized by irregular heavy drinking occasions. The association at population level between alcohol consumption and suicide is thus conditioned by cultural factors, and the strength of the overall relationship is greater in cultures where intoxication is a more prominent characteristic.

Alcohol and schizophrenia

An individual with alcohol dependence is more likely to have schizophrenia and a patient with schizophrenia is more likely to exhibit alcohol dependence, than is the general population. Most clinical studies, patient reports and anecdotal clinical observations suggest that excessive use of alcohol leads to a clear exacerbation of the symptoms of schizophrenia. Furthermore, it appears that approximately 30% of patients with comorbidity show a harmful use of alcohol before the first signs of schizophrenia emerge.

Alcohol, aggression and violence

Alcohol is strongly associated with violent crime, and research suggests that alcohol plays a contributing role in aggression. The strength of the relationship seems to be culturally dependent, and the pattern of drinking seems to play an important role in causing the violence. The effects of alcohol are thus influenced by both the environment and the characteristics of the drinker.

Building solutions

The consumption of alcoholic beverages is an accepted social custom in most parts of the world. Nevertheless, as alcohol use is closely associated with mental disorders and is one of the most important contributors to disease, injury, disability and premature death, a considerable amount of human misery could be avoided by greater attention to public health-oriented alcohol control policies, prevention, brief interventions and treatment.

To take an example, the anti-alcohol campaign from 1985 to 1988 in Russia and other parts of the Soviet Union produced a sharp decline in alcohol consumption. It was accompanied by a sudden sharp decline in mortality in that same period. For each litre reduction in pure alcohol consumption per capita in the latter half of the 1980s, the age-standardized mortality rate dropped by 2.7%. Alcohol consumption rose again in the early 1990s, also mirrored in a dramatic increase in mortality from 1990 to 1994. The situation improved in the period from 1994 to 1998, but mortality started to rise again from 1999. The change in life expectancy in the Russian Federation in the past 20 years is a consequence of a complex pattern of trends in different causes of death. Evidence suggests that alcohol has played an important part in this fluctuation.

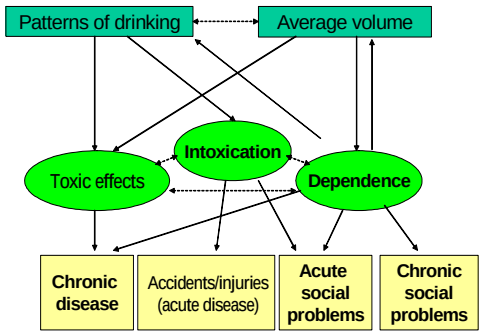
Even brief interventions can make a difference in reducing alcohol use. A meta-analysis of 43 brief interventions in primary care and related settings for non-treatment-seeking populations showed that brief advice was effective in reducing drinking-related outcomes, including intoxication, alcohol dependence symptoms and problems in multiple life areas by 12% more in the intervention group than the control group.

However, in spite of the importance alcohol plays in many mental health problems, there is little evidence that mental health promotion planning strategies have specifically targeted harmful and hazardous alcohol use.

Recent research has contributed substantially to our understanding of the relationship between alcohol consumption and the associated burden on society. There is thus a strong need for the health professions to step up their health advocacy for policies that reduce the harm done by alcohol, including in the case of comorbid mental and behavioural disorders.

Alcohol consumption as a risk factor has two dimensions: average volume and patterns of drinking. Research indicates a causal relationship between average volume of alcohol consumption and more than 60 types of disease and injury. Evidence is accumulating that patterns of drinking are an important factor in the link between alcohol and harm. It is also important to note that 40% of the disease burden caused by alcohol arises from acute conditions and is as such almost immediately preventable.

Figure 2: Model of alcohol consumption, intermediate outcomes, and long-term consequences *(5)*.



Average consumption figures hide wide variations in individual levels of alcohol consumption and drinking habits. For instance, in any population, there are people who abstain totally from drinking alcohol. The majority of the drinking population is composed of moderate or light drinkers. Heavy drinkers, even if a minority, consume quite a large part of the total alcohol intake.

However, the adverse effects of drinking alcohol are not confined to a minority of easily identified heavy or problem drinkers or people dependent on alcohol. Many moderate or occasional drinkers also suffer from alcohol-related problems, especially when alcoholic beverages are used as intoxicants. And no matter how drinking is measured, the risk of alcohol dependence begins at low levels of drinking and increases linearly with both the volume of alcohol consumption and a pattern of drinking larger amounts on occasion.

On the other hand, most alcohol consumers must see some benefits from drinking alcohol, since they

are willing to use their money to buy it. Just as alcohol consumption patterns and the culture of drinking vary greatly in different societies, the incidence and character of alcohol-related benefits and problems also vary.

In the longer term, there is a need for sustainable alcohol policies and programmes which aim to:

- reduce hazardous and harmful patterns of drinking;
- separate drinking from certain activities and situations like driving or operating machinery, when at work, and during pregnancy;
- reduce the overall volume of drinking;
- provide adequate help to people with alcohol problems, and especially to people with co-occurring mental and behavioural disorders.

Regional response

Alcohol problems arise in many different situations and affect a diversity of people. Appropriate policies will therefore be a mix of different measures.

Three major instruments adopted by WHO have provided a framework for action in the European Region.

Since 1992, the European Alcohol Action Plan (EAAP) has provided a basis for the development and implementation of alcohol policies and programmes in the Member States. The EAAP for the period 2000–2005 aims to prevent and reduce the harm that can be done by alcohol consumption throughout the European Region.

The European Charter on Alcohol, adopted by Member States in 1995, sets out the guiding principles and goals for promoting and protecting the health and well-being of all people in the Region. The Charter calls on all Member States to draw up comprehensive alcohol policies and implement programmes, as appropriate in their differing cultures and social, legal and economic environments.

The Declaration on young people and alcohol, adopted by Member States in Stockholm in 2001, aims to protect children and young people from the pressures to drink and reduce the harm done to them directly or indirectly by alcohol. The Declaration reaffirms the five principles of the European Charter on Alcohol and underlines the fact that public health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests.

The EAAP, the European Charter and the Stockholm Declaration have offered paths for the development and implementation of effective measures in the field of alcohol and therefore contributed to the general health policy in the Region.

European Alcohol Action Plan

The overall objectives of the EAAP for the period 2000–2005 are to:

- generate greater awareness of, provide education in, and build up support for public health policies that address the task of preventing the harm that can be done by alcohol;
- reduce the risk of alcohol-related problems that may occur in a variety of settings such as the home, workplace, community or drinking environment;
- reduce both the breadth and depth of alcohol-related harm such as fatalities, accidents, violence, child abuse and neglect, and family crises;
- provide accessible and effective treatment for people with hazardous and harmful alcohol consumption and those with alcohol dependence;
- provide greater protection from the pressures to drink for children, young people and those who choose not to drink alcohol.

European Charter on Alcohol

The Charter was adopted at the European Conference on Health, Society and Alcohol (Paris, 12–14 December 1995). The Charter establishes five ethical principles and goals, as laid out below, for work to reduce the negative consequences of alcohol consumption in Europe.

- All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
- All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
- All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption

and, to the extent possible, from the promotion of alcoholic beverages.

- All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.

- All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

Declaration on Young People and Alcohol

Young people are more vulnerable to the effects of the alcohol consumption and alcohol is the most important avoidable risk for the burden of disease in adolescents and young adults. The WHO European Ministerial Conference on Young People and Alcohol (Stockholm, 19–21 February 2001) adopted a special declaration containing the following main elements:

- identification of alcohol as an important issue in young people's health;

- opportunity to have young people themselves involved in the policy-making process;

- need to determine, at national and local levels, targets to reduce the impact of alcohol on young people's health;

- recognition that alcohol policies directed at young people should be part of a broader societal response, since drinking among young people to a large extent reflects the attitudes and practices of wider adult society.

References[1]

1. Rehm J. The global distribution of average volume of alcohol consumption and patterns of drinking. *European Addiction Research*, 2003, 9:147–156.

2. *The world health report 2002: Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002 (http://www.who.int/whr/2002/en/).

3. Room R. et al. Drinking and its burden in a global perspective: policy considerations and options. *European Addiction Research*, 2003, 9:165–175.

4. Rehm J. The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease - an overview. *Addiction*, 2003, 98:1209–1228.

5. Babor T et al. *Alcohol: no ordinary commodity: research and public policy*. Oxford, Oxford University Press, 2003.

Further reading[1]

Chisholm D et al. Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. *Journal of Studies in Alcohol*, 2004 [in press].

Declaration on young people and alcohol. Copenhagen, WHO Regional Office for Europe, 2001 (http://www.euro.who.int/AboutWHO/Policy/20030204_1).

European Alcohol Action Plan 2000-2005. Copenhagen, WHO Regional Office for Europe 2000 (http://www.euro.who.int/document/E67946.pdf).

European Charter on Alcohol. Copenhagen, WHO Regional Office for Europe, 1995 (http://www.euro.who.int/AboutWHO/Policy/20010927_7).

Klingemann H, Gmel G. *Mapping the social consequences of alcohol consumption*. Dordrecht, Kluwer Academic Publishers, 2001.

Maffli E. Problem drinking and relatives. In: Klingemann H, Gmel G, eds. *Mapping the social consequences of alcohol consumption*. Dordrecht, Kluwer Academic Publishers, 2001.

Neuroscience of psychoactive substance use and dependence. Geneva, World Health Organization, 2004 (http://www.who.int/substance_abuse/publications/en/Neuroscience.pdf).

Petrakis IL et al. Comorbidity of alcoholism and psychiatric disorders, *Alcohol Research and Health*, 2002, 26(2):81-89.

Rehm J. Alcohol. In: Ezzati M et al, eds. *Comparative quantification of health risks: global and regional burden of disease due to selected major risk factors*. Geneva, World Health Organization (in press).

Shkolnikov VM, Nemtsov A. The anti-alcohol campaign and variations in Russian mortality. In: Bobadilla JL, Costello CA, Mitchell F, eds. *Premature death in the new independent states*. Washington DC, National Academy Press, 1997.

Shkolnikov VM, McKee M, Leon DA. Changes in life expectancy in Russia in the mid-1990s. *The Lancet*, 2001, 357, 917-921.

Tikkanen, M. *The love story of the century*, San Bernardino CA, Borgo Press, 1984.

[1] All web sites accessed 24 November 2004

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