Action Plan to Reduce Alcohol-related Harm in Hong Kong

Department of Health
Hong Kong Special Administrative Region of China

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Contents

Abbreviations

Abbreviation	Full name
ABV	Alcohol By Volume
BAC	Blood Alcohol Concentration
BRFS	Behavioural Risk Factor Survey
BRFSS	Behavioural Risk Factor Surveillance System
CHS	Child Health Survey
DALYs	Disability-Adjusted Life Years
DH	Department of Health
HA	Hospital Authority
HKPF	Hong Kong Police Force
NCD	Non-communicable Diseases
ND	Narcotics Division of the Security Bureau
NGOs	Non-governmental Organisations
NHS	National Health Service
PHS	Population Health Survey
SACs	Substance Abuse Clinics
SC	Steering Committee on Prevention and Control of Non-communicable Diseases
SWD	Social Welfare Department
TD	Transport Department
TWGHs	Tung Wah Group of Hospitals
UK	United Kingdom
US	United States
WGAH	Working Group on Alcohol and Health
WHA	World Health Assembly
WHO	World Health Organization

Preface

In many parts of the world, drinking alcohol beverages is a common behaviour which carries different socio-cultural implications. Nevertheless, the World Health Organization (WHO) has identified alcohol use as the third leading risk factor for global burden of disease, causing an estimated 2.5 million deaths worldwide each year. As such, reducing alcohol-related harm has been accorded as one of the priority areas for action in the prevention and control of non-communicable diseases.

Along with rapid urbanisation and economic growth, drinking alcohol is gaining popularity in Hong Kong. Local surveys have reflected a rising trend of alcohol consumption among the adult population, in particular among women and the younger age group, in recent years. As a result, the disease burden attributed by alcohol use is expected to increase. Apart from physical and mental diseases, social consequences such as work-related problems, domestic violence, financial problems and interpersonal violence will increase and pose significant costs to our society.

To prevent this from happening, we must work in a coordinated manner with an ultimate goal to reduce alcohol-related harm in Hong Kong from all sides and at all levels: the individual, family, organisation and the community, and actively respond to the call made in the Government's strategic framework document *"Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases"* published in 2008.

As Chairman of the Working Group on Alcohol and Health, I would like to thank all who helped in drawing up this Action Plan. It is built on detailed examination of the local situation on alcohol use, while drawing references from overseas evidence as well as recommendations of the WHO. Its purpose is to outline the framework of actions that will take place in the coming years to support, and help to set the directions for, effective prevention and control of alcohol-related harm in Hong Kong.

This document marks an important step forward to reduce alcohol-related harm in Hong Kong. It is a product of concerted efforts and wisdom among stakeholders from different sectors of our society. Every individual and organisation has a role to play. With dedication, partnership, and coordinated effort in working towards the objectives of this Action Plan, I am confident that we would be better placed to empower individuals to take responsibility for their own health as well as the health of others, and to create a healthier, safer and more pleasant community, in which we live, learn, work, play and love.

Patrick MA Ching-hang, BBS, JP
Chairman
Working Group on Alcohol and Health

1 Introduction

1. Introduction

Developing a local strategy to reduce alcohol-related harm in Hong Kong

1.1 The Department of Health (DH) published a strategic framework document entitled "*Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases*" in October 2008 with a view to curbing non-communicable diseases (NCD). Reducing alcohol-related harm has been identified as one of the public health priority areas.

1.2 In order to deliberate on and oversee the overall roadmap of the strategic framework, a high-level Steering Committee on Prevention and Control of NCD (SC) was established in late 2008. The SC is chaired by the Secretary for Food and Health, with representatives from the Government, public and private sectors, academia and professional bodies, industry and other key partners. Under the SC, a Working Group on Alcohol and Health (WGAH) was established in June 2009 to advise on the priority areas for action and to draw up targets and action plans related to alcohol-related harm for the SC's consideration. The WGAH is chaired by Mr. Patrick MA Ching-hang and comprises key stakeholders in the public and private sectors, representatives from the academia, District Councils, education sector, healthcare professions, social services sector and relevant government departments. The membership and the terms of reference of the WGAH are listed in Annexes 1 and 2 respectively.

1.3 Since its establishment in June 2009, the WGAH has met five times to discuss:

(i) the effects of alcohol use on population health,

(ii) the global situation of alcohol-related harm,

(iii) national strategies of overseas countries to reduce alcohol-related harm,

(iv) overseas interventions in reducing alcohol-related harm and evidence on their effectiveness, and

(v) the current Hong Kong situation in relation to alcohol-related harm and its interventions.

The above issues will be summarised in the following paragraphs and Section 2 of this document. The details of the topics discussed in the meetings are listed in Annex 3.

1.4 After careful consideration of the available evidence and the local situation, the WGAH produced a "*Report on Recommendations to Reduce Harmful Use of Alcohol in Hong Kong*", highlighting five priority areas and 10 recommendations to reduce alcohol-related harm in Hong Kong. The Report was endorsed by the SC in February 2010. To implement the 10 recommendations therein, the WGAH drew up 17 specific actions which are set out in details in Section 3 of this document.

Effects of alcohol use on population health

1.5 Alcohol plays an important social and cultural role in society. Alcohol is consumed on different occasions to serve different socio-cultural functions, such as relaxation, socialisation and celebration. Some studies have suggested that consuming a low to moderate amount of alcohol could have a protective effect on certain heart diseases in specific populations[1,2,3,4]. Notwithstanding these findings, according to the WHO, alcohol use is a major factor contributing to premature deaths and avoidable disease burden worldwide. Alcohol use also has a major impact on public health, even when protective effects of low and moderate alcohol consumption on morbidity and mortality have been taken into consideration[5]. Alcohol was estimated to cause about 2.25 million deaths (3.8% of total) worldwide and to be responsible for 69.38 million (4.5% of total) of Disability-Adjusted Life Years (DALYs) in 2004[6].

1.6 Several factors contribute to alcohol-related harm. One is the volume of alcohol drunk over time. The strongest drinking-related predictor of many chronic illnesses is the cumulated amount of alcohol consumed over a period of years. Other factors include the pattern of drinking, in particular occasional or regular drinking to intoxication; the drinking context, which may increase the risks of intentional and unintentional injuries, as well as the transmission of certain infectious diseases[5].

1.7 Alcohol has both acute and cumulative chronic effects. Excessive amounts of alcohol consumed on a single occasion increases the immediate risk of alcoholic intoxication, accidental injury and poisoning, suicide, interpersonal violence, and the likelihood of adopting risk-taking behaviours such as unprotected sex[7]. Each additional drink further increases the risk as cognitive performance decreases progressively with alcohol intake. Not only are those who drink affected, innocent bystanders may become victims of alcohol-related aggression or road traffic accidents due to drink-driving.

1 Corrao G et al. (2000). Alcohol and coronary heart disease: a meta-analysis. *Addiction*, 95(10):1505-23.
2 Baer DJ et al. (2002). Moderate alcohol consumption lowers risk factors for cardiovascular disease in postmenopausal women fed a controlled diet. *Am J Clin Nutr*, 75:593-599.
3 Mukamal KJ et al. (2006). Alcohol consumption and risk of coronary heart disease in older adults: The Cardiovascular Health Study. *J Am Geriatr Soc*, 54:30-37.
4 Arriola L et al. (2010). Alcohol intake and the risk of coronary heart disease in the Spanish EPIC cohort study. *Heart*, 96:124-130.
5 World Health Organization (2008). *Report by Secretariat to the Sixty-First World Health Assembly "Strategies to reduce the harmful use of alcohol"* (A61/13). Available at: http://apps.who.int/gb/ebwha/pdf_files/A61/A61_13-en.pdf
6 World Health Organization (2011). *Global status report on alcohol and health*. Geneva: World Health Organization.
7 WHO Expert Committee on Problems Related to Alcohol Consumption (2007). *Second report / WHO Expert Committee on Problems Related to Alcohol Consumption*. WHO technical report series; no. 944. Geneva: World Health Organization.

1.8 Alcohol affects nearly every organ in the human body. Alcohol has been linked to more than 60 disease conditions in a series of meta-analyses[8, 9,10,11], e.g. alcoholic hepatitis, cirrhosis, fatty liver, stroke, hypertension, coronary heart disease and heart failure, and alcohol dependence. Alcohol worsens pre-existing liver diseases and medical conditions associated with diabetes, and also affects sleep and sexual performance[12]. It also interacts with the metabolism of many drugs.

1.9 Alcohol is classified as a group 1 carcinogen by the International Agency for Research on Cancer. It increases the risk of a wide range of cancers, including cancers of the mouth, pharynx, larynx, oesophagus, colon and rectum, liver and breast[13]. Worldwide, alcohol has been estimated to cause about 20-30% of oesophageal cancer, liver cancer and a range of other health effects[14].

1.10 Developing fetuses and babies on breastfeeding are particularly at risk of the adverse effects of alcohol. Alcohol consumption during pregnancy increases the risk of a range of birth defects and growth and developmental problems of the unborn babies, which may persist into adulthood[15]. Alcohol enters breast milk. Alcohol consumption during lactation adversely affects lactational performance of the nursing mother, and psychomotor development and behaviour of the breastfed baby[16, 17].

8 English DR et al. (1995). *The Quantification of Drug Caused Morbidity and Mortality in Australia, 1992*. Canberra: Commonwealth Department of Human Services and Health.
9 Gutjahr E, Gmel G & Rehm J (2001). Relation between average alcohol consumption and disease: an overview. *European Addiction Research*, 7(3):117-127.
10 Ridolfo B & Stevenson CE (2001). *The Quantification of Drug-Caused Mortality and Morbidity in Australia 1998*. Canberra: Australian Institute of Health and Welfare.
11 Single E et al. (1999). Morbidity and mortality attributable to alcohol, tobacco, and illicit drug use in Canada. *American Journal of Public Health*, 89(3):385-390.
12 National Health and Medical Research Council (2009). *Australian guidelines to reduce health risks from drinking alcohol.* Canberra: National Health and Medical Research Council.
13 International Agency for Research on Cancer (2010). Alcohol Consumption and Ethyl Carbamate. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans*. Vol. 96. Lyon, France: International Agency for Research on Cancer.
14 World Health Organization (2010). Alcohol. Available at: http://www.who.int/substance_abuse/facts/alcohol/en/index.html
15 Jacobson JL and Jocobson SW (2002). Effects of prenatal alcohol exposure on child development. *Alcohol Research & Health*, 26(4): 282-286.
16 Ho E, Collantes A, Kapur BM et al. (2001). Alcohol and breast feeding: calculation of time to zero level in milk. *Biol Neonate*, 80:219–22.
17 Giglia RC & Binns CW (2006). Alcohol and lactation: a systematic review. *Nutrition & Dietetics*, 63: 103–16.

1.11 Apart from physical health, alcohol is intertwined with many mental health conditions. Alcohol use is associated with a high prevalence of mental illnesses such as anxiety disorder, depression, bipolar disorder and schizophrenia[18, 19, 20, 21].

1.12 In addition, the adverse effects of alcohol consumption extend far beyond physical and mental diseases, accidents and injuries. Social consequences such as workplace-related problems, family and domestic problems, and interpersonal violence pose significant cost to the whole community[22]. Reduced productivity and sickness absence associated with alcohol use and alcohol dependence entail a substantial cost to employers and social security systems[22]. In industrialised countries, a substantial proportion of the annual Gross Domestic Product loss is on account of the adverse effects of alcohol[23].

18 Kranzler HR, Del Boca FK, Rounsaville BJ (1996). Comorbid psychiatric diagnosis predicts three-year outcomes in alcoholics: a post treatment natural history study. *J Stud Alcohol*, 57:619–26.

19 Merikangas KR, Angst J, Eaton W et al. (1996). Comorbidity and boundaries of affective disorders with anxiety disorders and substance misuse: results of an International Task Force. *Br J Psych*, 168 (June Supp):58–67.

20 Hodgins DC, el-Guebaly N, Armstrong S et al. (1999). Implications of depression on outcome from alcohol dependence: A 3-year prospective follow-up. *Alcohol Clin Exp Res*, 23:151–57.

21 Burns L & Teesson M (2002). Alcohol use disorders comorbid with anxiety, depression and drug use disorders: findings from the Australian National Survey of Mental Health and Well Being. *Drug Alcohol Depend*, 68(3):299–307.

22 Klingemann H, Gmel G, eds (2001). *Mapping the Social Consequences of Alcohol Consumption*. Dordrecht, Kluwer Academic Publishers.

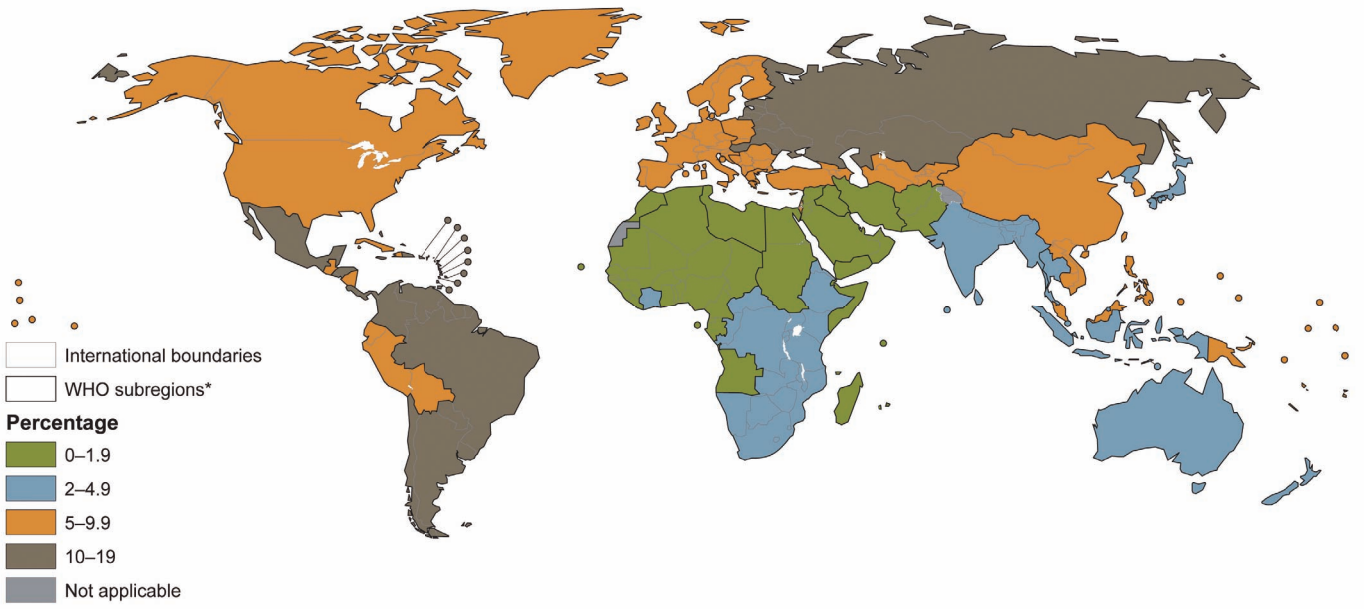
23 Rehm J, Mathers C, Popova S et al. (2009). Alcohol and global health 1. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders, *Lancet*, 373(9682):2223-33.

Global situation of alcohol-related harm

Global burden of disease attributable to alcohol and WHO's global strategies to reduce alcohol-related harm

1.13 Alcohol is the third leading global risk for burden of disease, only preceded by childhood underweight and unsafe sex[24]. In 2000, about 4% of the global disease burden was attributable to alcohol, which was about the same magnitude as tobacco. The alcohol-related disease burden is especially detrimental in developed countries[25]. When only developed countries are considered, 9.2% of the entire disease burden is attributable to alcohol, only exceeded by tobacco and blood pressure (Table 1)[25]. The WHO estimated the social and economic costs of alcohol use (including costs of treatment, prevention, law enforcement and lost productivity plus some measures of the quality of life years lost) to be accountable for 1 - 6% of Gross Domestic Product in high income countries (e.g. Canada, France and Australia)[25].

Figure 1: Distribution of global burden of disease attributable to alcohol (percentage of total DALYs by WHO subregion), 2004



Source: WHO Global Status Report on Alcohol and Health 2011

[24] World Health Organization (2009). *Global health risks: mortality and burden of disease attributable to selected major risks*. Geneva: World Health Organization.
[25] World Health Organization (2004). *Global status report on alcohol* 2004. Geneva: World Health Organization.

Table 1: Global burden of disease in 2000 attributable to tobacco, alcohol and drugs by developing status of countries and sex

	High mortality developing countries			Low mortality developing countries			Developed countries		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Total DALYs (000s)	420 711	412 052	832 763	223 181	185 316	408 497	117 670	96 543	214 213
Smoking and oral tobacco (%)	3.4	0.6	2.0	6.2	1.3	4.0	17.1	6.2	12.2
Alcohol (%)	2.6	0.5	1.6	9.8	2.0	6.2	14.0	3.3	9.2
Illicit drugs (%)	0.8	0.2	0.5	1.2	0.3	0.8	2.3	1.2	1.8

Source: WHO Global Status Report on Alcohol 2004

1.14 Recognising that the rapid rise of alcohol consumption would become one of the major health challenges in the coming century, the WHO developed the global alcohol database in 1996 to document the global patterns of alcoholic beverages use, health consequences, and national policy responses, by country. "*The Global Status Report: Alcohol Policy*" published by the WHO in 2004 serves as an advocacy tool for identifying existing gaps and raising awareness about the need for alcohol policies[26]. At the 61st World Health Assembly (WHA) held in May 2008, Member States considered the Secretariat's report on the "*Strategies to Reduce Harmful Use of Alcohol*". At the 63rd WHA held in 2010, the global strategy to reduce the harmful use of alcohol was endorsed. The WHO urged Member States to adopt and implement the global strategy as appropriate in order to complement and support public health policies, to mobilise political will and financial resources for the purpose of reducing the alcohol-related harm[27].

National strategies in overseas countries to reduce alcohol-related harm

1.15 The public health problems caused by alcohol use are multidimensional and complex. With significant differences in consumption levels, drinking patterns and drinking contexts between countries, public health problems and needs of individual countries vary[28]. Therefore, different countries have developed and adopted different national strategies to reduce alcohol-related harm.

[26] World Health Organization (2004). *Global status report: Alcohol policy. 2004*. Geneva: World Health Organization. Available at: http://www.who.int/substance_abuse/publications/alcohol/en/

[27] World Health Organization (2010). *Sixty-third World Health Assembly: Notes from day 4: Thursday, 20 May 2010*. Available at: http://www.who.int/mediacentre/events/2010/wha63/journal4/en/index.html

[28] World Health Organization (2008). *Report by Secretariat to the Sixty-First World Health Assembly "Strategies to reduce the harmful use of alcohol" (A61/13)*. Available at: http://apps.who.int/gb/ebwha/pdf_files/A61/A61_13-en.pdf

1.16 In the United Kingdom (UK), the authorities issued an "*Alcohol Harm Reduction Strategy for England*" in March 2004, which mainly focused on (i) education and communication; (ii) identification and treatment; (iii) alcohol-related crime and disorders; and (iv) supply and industry responsibility[29]. Based on the foundations laid and the lessons learnt since 2004, a new strategy namely "*Safe. Sensible. Social. The next steps in the National Alcohol Strategy*" was published in 2007, which called on a clear and focused programme of action for the following[30]:

(a) Sharpened criminal justice for drunken behaviour;
(b) A review of NHS alcohol spending;
(c) More help for people who want to drink less;
(d) Toughened enforcement of underage sales;
(e) Trusted guidance for parents and young people;
(f) Public information campaigns to promote a new sensible drinking culture;
(g) Public consultation on alcohol pricing and promotion; and
(h) Local alcohol strategies.

1.17 In the United States (US), Federal, State and local governments have established alcohol policies, which aim at reducing alcohol problems through environmental prevention, including[31]:

(a) Raising alcohol excise taxes;
(b) Keg tagging;
(c) Responsible beverage service training;
(d) Product labelling;
(e) Limiting alcohol sales licenses;
(f) Enforcement of underage drinking laws;
(g) Restrictions on alcohol advertisements;
(h) Holding adults responsible for teen parties;
(i) Land use policies;
(j) Concurrent sales of alcohol; and
(k) Dram shop liability and legislation.

[29] Prime Minister's Strategy Unit, Cabinet Office (2004). *Alcohol Harm Reduction Strategy for England*. London, UK: Cabinet Office.
[30] Department of Health, Home Office, Department for Education and Skills and Department for Culture, Media and Sport (2007). *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*. HM Government.
[31] The Marine Institute. *Alcohol Policy*. Available at: http://www.marininstitute.org/alcohol_policy/index.htm (accessed on 8 June 2010)

1.18 In Australia, the *"National Alcohol Strategy 2006 – 2009"* with an extension of terms until 2011 focuses on four priorities, namely (i) intoxication; (ii) public safety and amenity; (iii) health impacts; and (iv) cultural place and availability through employing the following strategies[32]:

(a) Integrated and coordinated responses;
(b) Building the research agenda;
(c) Data collection;
(d) Monitoring and evaluation;
(e) Developing the workforce;
(f) Developing partnerships and links; and
(g) Shaping the future – providing strong leadership.

Overseas interventions in reducing alcohol-related harm and evidence on their effectiveness

1.19 Public health actions should be based on the best available evidence. To date, there is a substantial evidence base from overseas studies on the effectiveness and cost-effectiveness of different strategies and interventions to reduce alcohol-related harm[33, 34, 35], a summary of which is listed in Table 2. The analyses of the effectiveness of different interventions are grouped under 9 target areas according to the ultimate goal of the strategies and interventions. Such assessment of effectiveness provides invaluable insights into developing local interventions to reduce alcohol-related harm in Hong Kong.

[32] Ministerial Council on Drug Strategy (2006). *National Alcohol Strategy 2006-2009, Australia*.
[33] Anderson P, Chisholm D, Fuhr DC (2009). Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet*, 373(9682):2234-2246.
[34] WHO Regional Office for Europe (2009b). *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. Copenhagen: WHO Regional Office for Europe.
[35] Babor TF and Caetano R (2005). Evidence-based alcohol policy in the Americas: strengths, weaknesses and future challenges. *Rev Panam Salud Publica/ Pan Am J Public Health*, 18(4/5):327-37.

Table 2: Evidence on effectiveness of the various interventions to reduce alcohol-related harm

Action areas	Intervention components	Evidence of effect		Comments/implications
		Anderson et al, 2009[i,ii]	Babor et al, 2005[iii]	
1) Raising public awareness	Setting drinking guidelines	?	--	No scientifically published assessment
	Public information campaign/ Public service announcements	↓↓	↓	Not an effective antidote to the high quality pro-drinking messages and not effective in behavioural change
	Consumer labelling and health warnings	↓↓	↓	Raise awareness, but do not change behaviour
	Counter-advertising	?	--	Little evidence; inconclusive results
	School-based education	↓↓↓	↓	May increase knowledge and change attitude but has no sustained effect on drinking
	Parenting programme	↑	--	Effective in reducing alcohol use in preteens and adolescents
	Social marketing interventions	↑	--	Short term effect on reducing alcohol use
2) Health-sector response	Screening and Brief Intervention	↑↑↑	↑↑	Effective for people with inappropriate alcohol drinking behaviour but who are not severely dependent
	Treatment programme for alcohol dependent individuals	↑↑↑	↑	Effective, but population reach may be low because of limited treatment facilities
3) Community and workplace action	Multi-component community-based interventions with engagement of different stakeholders	↑	↑↑	Evidence of effectiveness of systematic approaches to coordinate community resources to implement effective policies, when backed up by enforcement measures
	Media advocacy	?	--	Little evidence, but advocacy in media aimed at uptake of specific policies can lead to increased attention to alcohol on political and public agenda
	Workplace-based interventions	↑	--	Little evidence of effect in changing drinking norms and reducing alcohol use
4) Drink-driving policies and countermeasures	Introduction or reduction of Blood Alcohol Concentration (BAC) levels for driving	↑↑↑	↑↑↑	Effective in reducing drink-driving causalities, but may not reduce alcohol use
	Restrictions on target groups of drivers (e.g. lower BAC levels for road traffic offenders, young, inexperienced or commercial drivers)	↑↑	↑↑	Some effect in reducing fatal crashes
	Sobriety checkpoints and Random Breath Test	↑↑↑	↑↑	Effective in reducing alcohol-related traffic accidents
	Penalty - Suspension of driving licences	↑	↑↑	Effective as a deterrent to driving while intoxicated
	Ignition interlock device	↑	--	Some evidence of effect but does not extend once the interlock is removed
	Designated driver programmes	↓↓	↓	May increase awareness but no impact on traffic accidents

Action areas	Intervention components	Evidence of effect		Comments/implications
		Anderson et al, 2009[i,ii]	Babor et al, 2005[iii]	
5) Addressing the accessibility and availability of alcohol	Minimum legal purchase age or drinking age	↑↑↑	↑↑↑	Does not eliminate drinking, but effective in reducing alcohol consumption and alcohol-related harm
	Restrictions on outlet density (licensing)	↑↑↑	↑↑	Effective in minimising violence, harm to others and drink-driving fatalities
	Restrictions on days and hours of sale	↑↑↑	↑↑	Effective in reducing consumption and harm
6) Addressing the marketing and promotion of alcoholic beverages	Control or partial ban on volume, placement and content of alcohol advertising	↑↑	↑	Evidence noted a positive effect of advertising on youth initiation and heavier drinking among current users
	Self-regulation of alcohol marketing	↓↓↓	--	No evidence of effectiveness
7) Pricing policies	Alcohol taxes (price elasticity)	↑↑↑	↑↑↑	Effective; increasing taxes can reduce acute and chronic alcohol-related harm
	A minimum price per unit of alcohol	↑↑	--	Effective, setting minimum price can reduce acute and chronic harm
8) Harm reduction	Intervention targeting the drinking environment	↓↓	--	Little effectiveness unless backed up by police enforcement and license inspectors
	Training programme for alcohol servers	↓↓	↑	Little effectiveness
9) Reducing the public health effect of illegally and informally produced alcohol	Informal and surrogate alcohol	↑	--	Some experience in reducing alcohol-related harm by, for example, not allowing methanol to be used as denaturing agent
	Strict tax labelling	↑	--	Some evidence of effectiveness drawn from other psychoactive substances (tobacco)

Notes:

[i] Rating adapted from WHO Regional Office for Europe (2009b). *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. Copenhagen: WHO Regional Office for Europe.

[ii] Evidence of effect: ↑↑↑ = convincing effective; ↑↑ = probable effective; ↑ = limited-suggestive effective; ↓ = limited-suggestive ineffective; ↓↓ = probable ineffective; ↓↓↓ = convincing ineffective; ? = no rigorous assessment/little evidence/inconclusive results

[iii] Level of effectiveness: ↑↑↑ = high degree of effectiveness; ↑↑ = moderate effectiveness; ↑ = limited effectiveness; ↓ = lack of effectiveness

2 Alcohol and health: Hong Kong situation

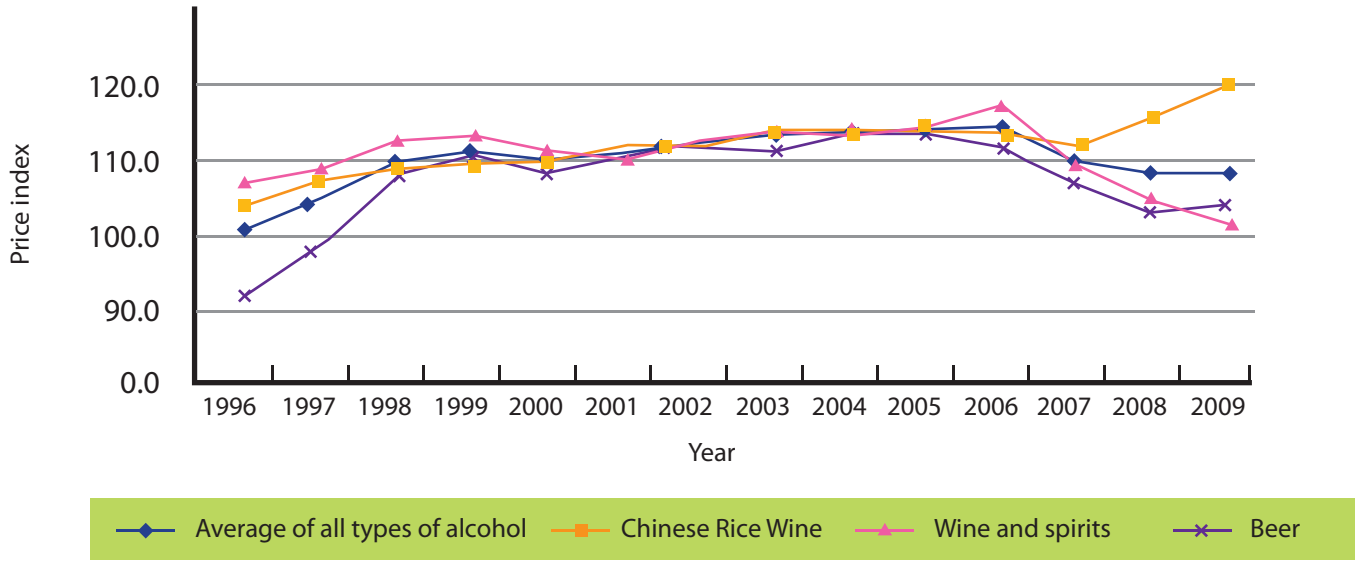
2. Alcohol and health: Hong Kong situation

Availability and price of alcohol in Hong Kong

2.1 Alcoholic beverages are readily accessible in Hong Kong. They are available for sale in retail shops such as supermarkets and convenience stores, and in premises granted with liquor licence including some restaurants and bars. There are also a variety of alcoholic beverages on the market, such as beer, wine, spirits, Chinese rice wine and sake. A brief summary on the common types of drinks available in Hong Kong and their alcohol content measured in "standard drink" units is listed in Table 5 in Annex 4[36].

2.2 In 2008, there was a sharp drop in average price for wine and beer following a decrease in the duty of wine and liquor with a low alcoholic strength (Figure 2).

Figure 2 : Price index of alcohol in Hong Kong, by type of alcohol, 1996-2009



Source: Consumer Price Index Section, Census and Statistics Department

[36] A "standard drink" is equivalent to 10g of pure alcohol and is the measure of alcohol used to work out consumption. To calculate alcohol units in a drink, the following formula is used:
No. of standard drink = Drink volume (ml) x alcohol content (% by volume) x 0.789 / 1 000

Alcohol consumption per capita in Hong Kong

2.3 Alcohol consumption per capita is closely related to the prevalence of alcohol-related harm and alcohol dependence *at the population level*. Alcohol consumption per capita in Hong Kong is estimated by the following formula:

$$\text{Alcohol consumption per capita (litres of pure alcohol)} = \frac{\text{Total alcohol consumption (A + B)}}{\text{Population aged 15 years or above}}$$

where (A) = local consumption of locally produced alcohol beverages
= local production – export of locally produced alcohol
(B) = net import
= import – re-export

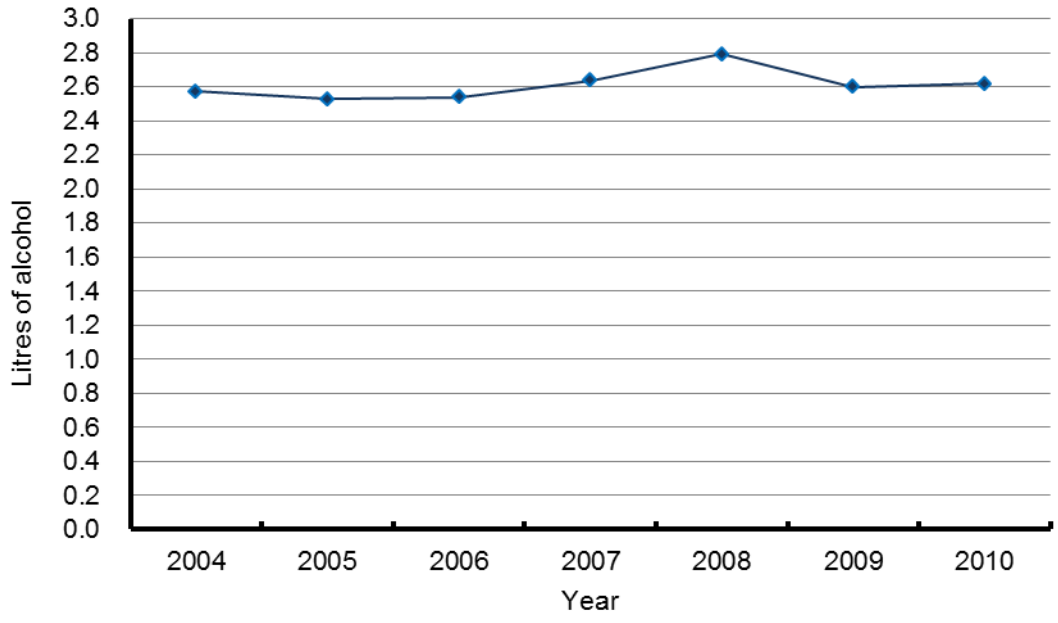
2.4 As the duty for wine and liquor with an alcoholic strength of not more than 30% has been waived since February 2008 and the related licensing/permit arrangement on zero-rated goods was revoked, data for the estimation on local consumption of locally produced alcohol beverages (i.e. (A) in the formula) was not available after February 2008. Estimation of the total and per capita alcohol consumption in Hong Kong from 2004 to 2010, as shown in Table 3 and Figure 3, is based on the assumption that local consumption of locally produced wine and spirits of an alcoholic strength of not more than 30% in year 2008, 2009 and 2010 was the same as that in 2007, while local consumption of locally produced beer was estimated from the relevant company reports of local beer manufacturers.

Table 3: Estimated total and per capita alcohol consumption in Hong Kong (in litres), 2004-2010#

	Pure alcohol consumption from local production (A)			Pure alcohol consumption from net import (B)			Total pure alcohol consumption = (A) + (B)			Population aged	Alcohol consumption
Year	Beer	Wine	Spirits	Beer	Wine	Spirits	Beer	Wine	Spirits	≥15 years	per capita
2004	1 438 465	0	144 581	6 161 356	1 588 901	5 525 970	7 599 821	1 588 901	5 670 551	5 778 300	2.57
2005	1 328 790	0	172 328	6 283 786	1 770 057	5 204 485	7 612 576	1 770 057	5 376 813	5 844 300	2.53
2006	1 126 110	0	154 951	6 320 893	1 995 111	5 431 296	7 447 003	1 995 111	5 586 247	5 917 900	2.54
2007	1 359 455	0	164 088	6 139 077	2 379 850	5 763 158	7 498 532	2 379 850	5 927 246	5 997 800	2.64
2008	*16 260	0	*146 734	7 786 343	3 164 107	5 799 900	*7 802 603	3 164 107	*5 946 634	6 061 600	*2.79
2009	*1 025 967	0	*107 837	7 057 842	3 556 149	4 136 418	*8 038 809	3 556 149	*4 244 254	6 109 000	*2.60
2010	*1 128 954	0	*90 343	6 157 894	3 735 296	5 066 524	*7 286 848	3 735 296	*5 156 867	6 180 000	*2.62

Note: # the volume of pure alcohol consumed was estimated from the total volume of alcoholic beverages consumed by assuming that beer is 5% by volume, wine is 13.5% by volume, and spirits ≤ 30% and spirits > 30% are 30% and 40% by volume respectively.
*figures estimated by assuming that local consumption of locally produced wine and spirits with an alcoholic strength of not more than 30% in year 2008, 2009 and 2010 was the same as that in 2007, while local consumption of locally produced beer was estimated from the relevant company reports of local beer manufacturers.

Figure 3: Estimated per capita alcohol consumption among Hong Kong adults, 2004-2010



Source: Census and Statistics Department, and Customs and Excise Department

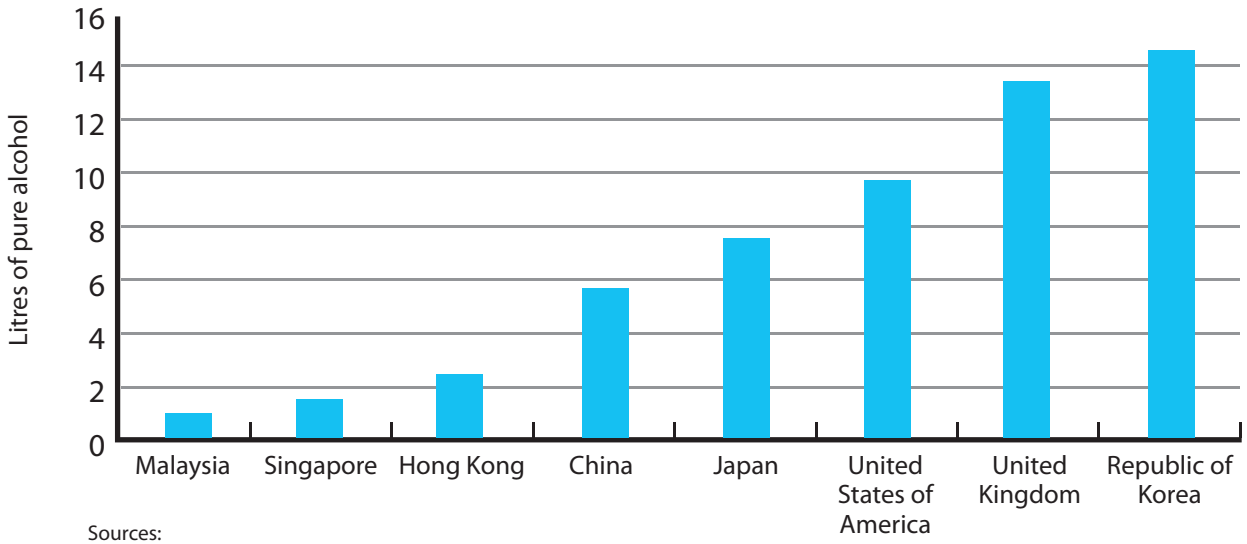
2.5 When all types of alcohol are considered as a whole, the alcohol consumption per capita of Hong Kong has been stable from 2004 to 2010, except for a surge in 2008 due to the increase in alcohol consumption from beer and wine, as shown in Figure 3. This observation is consistent with the evidence from overseas studies and experience that alcohol consumption was inversely proportional to its price[37]. In 2009 and 2010, although the increase in wine consumption persisted, such increase was offset by a significant reduction in spirits consumption due to an increase in price. The alcohol consumption per capita in Hong Kong was estimated to be 2.62 litres in 2010 (1.18 litres of beer; 0.60 litres of wine and 0.83 litres of spirits), which has slightly dropped from 2.79 litres in 2008.

2.6 Due to cultural, religious and economic differences, alcohol consumption per capita varies greatly among countries. According to the WHO, Republic of Moldova had the highest alcohol consumption per capita amounting 23.01 litres in 2008, whereas those in the Middle East region were generally minimal due to religious reasons. In Asia, the Republic of Korea consumed 14.81 litres per capita; Japan consumed 7.79 litres per capita; China consumed 5.56 litres per capita; Singapore consumed 1.54 litres per capita and Malaysia consumed 0.87 litres per capita in 2008 (Figure 4)[38].

[37] World Health Organization (2009). *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm*. Copenhagen: WHO Regional Office for Europe. Available at: http://www.euro.who.int/document/E92823.pdf

[38] World Health Organization (2011). *Global status report on noncommunicable diseases 2010*. Geneva: World Health Organization.

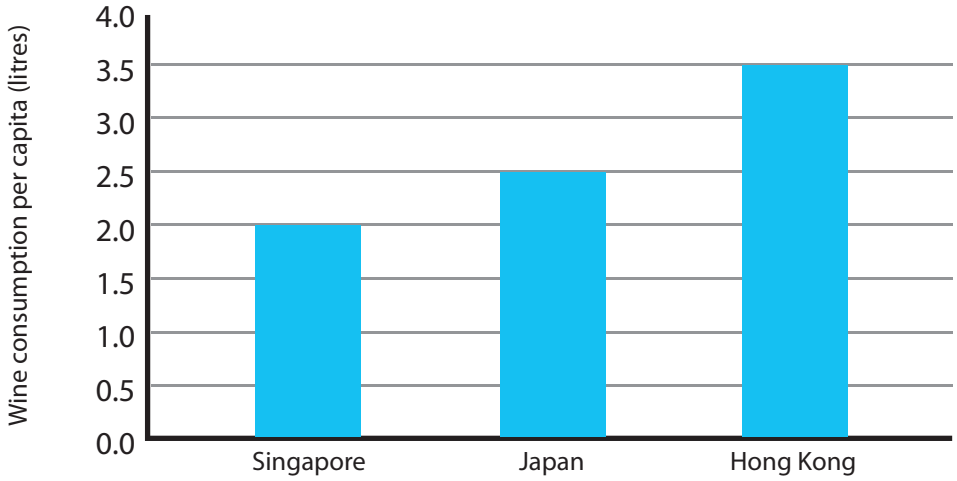
Figure 4: Per capita alcohol consumption among adults (>=15 years) in Hong Kong in year 2010 and other regions/countries in year 2008



Sources:
Regions other than Hong Kong: World Health Organization
Hong Kong: Census and Statistics Department, and Customs and Excise Department

2.7 However, according to the International Wine and Spirits Report 2010 study conducted by the trade, Hong Kong consumed 3.5 litres of wine per capita in 2008 (= 0.47 litres of pure alcohol, assuming that wine has 13.5% alcohol by volume), which was the highest and significantly ahead of other neighbouring countries in Asia such as Japan and Singapore (Figure 5)[39].

Figure 5: Wine consumption per capita among selected Asian countries/cities in 2008



Source: International Wine and Spirits Report 2010 Study

[39] International Wine and Spirits Report 2010 (http://www.vinexpo.com/dyn/press/le-marche-hong-kong-2010---anglais.pdf)

2.8 Although per capita consumption provides an overall estimate of alcohol consumed in Hong Kong, survey data are needed to link the consumption data with factors such as socio-demographic variables and alcohol-related harm *at the individual level*, which will be presented in the following paragraphs.

Local epidemiology of alcohol consumption behaviour and risk perception

Data sources for surveillance of alcohol consumption behaviour and risk perception

2.9 The DH, in collaboration with the Department of Community Medicine of the University of Hong Kong, conducted a population-based health survey (Population Health Survey, PHS) in 2003/2004 to report the patterns of health status and health-related issues of the general population in Hong Kong, including alcohol use. Around 7 000 land-based non-institutionalised population of Hong Kong (excluding foreign domestic helpers) aged 15 years and over were interviewed.

2.10 Following the initial assessment through the PHS in 2003/2004, the DH has continuously monitored the alcohol consumption behaviour of the local adult population, among other behavioural risk factors, through the Behavioural Risk Factor Surveillance System (BRFSS) since 2004. The BRFSS comprises a series of surveys conducted regularly enumerating about 2 000 people aged 18 - 64 years.

2.11 As for the surveillance among children and youth, the DH conducted the first population-based Child Health Survey (CHS) in 2005/2006 to collect health information of local children aged 14 years and below, including alcohol use. Separately, the Narcotics Division of the Security Bureau (ND) has been conducting a series of surveys of around 100 000 adolescent students every 4 years since 1992 about their use of alcohol (among other drug uses), the majority of whom were studying in secondary schools or equivalent. In the survey conducted in 2008, students in primary 4 to 6 and university were also included.

2.12 Apart from surveys, some local researchers also conducted ad-hoc qualitative and quantitative studies to investigate risk perception and patterns of alcohol consumption in different populations.

Alcohol consumption behaviour in the adult general population

2.13 The PHS in 2003/2004 revealed that 23.7% of the respondents (persons aged 15 years and above in Hong Kong) drank alcohol occasionally (drink 3 days or less a month); 9.4% were regular alcohol consumers drinking at least once a week; 61.6% were non-drinkers; and 4.7% were ex-drinkers. Among the drinkers, the majority (66.5%) reported that they usually drank beer, 19.6% drank table wine, whereas 10.6% drank Chinese rice wine and 6.9% drank spirits[40].

2.14 According to the PHS in 2003/2004, the prevalence of drinking was different between males and females. The male to female ratio among current drinkers was about 2:1. The proportions of current drinkers among males and females were 45.3% and 23.2% respectively. In addition, a higher proportion of men (11.3%) than women (3.7%) drank alcohol everyday. On the contrary, a higher proportion of females (84.0%) than males (63.6%) among current drinkers drank alcohol occasionally (drink 3 days or less a month).

2.15 Results of the BRFSS showed that there was an increase of 4.0 percentage points of the drinking prevalence among adult population in Hong Kong (i.e. proportion of people reported to have consumed at least one alcoholic drink during the 30 days prior to the survey), from 30.9% in 2005 to 34.9% in 2010. In particular, the rise in the drinking prevalence in females was steeper (5.1 percentage points), from 19.5% in 2005 to 24.6% in 2010[41]. This finding warrants concern for several reasons. Firstly, women are more vulnerable to the effects of alcohol because of their smaller physical build compared to men. Secondly, addiction to alcohol can be particularly hazardous for existing or subsequent pregnancies. Thirdly, women play a primary role in managing households and children in Asia. This primary responsibility can be seriously affected if women are habituated to alcohol[42].

2.16 Also, according to the Behavioural Risk Factor Survey (BRFS) of 2010, 16.9% reported drinking beyond the recommended daily limit (exceeding 2 standard drinks for men and 1 standard drink for women on average on any drinking day), and 5.8% reported drinking so much that they exhibited signs of drunkenness (such as flushed face or reddened eyes, slurred or incoherent speech, unsteady or staggering gait, vomiting and hangover on the next day) during the month prior to the study.

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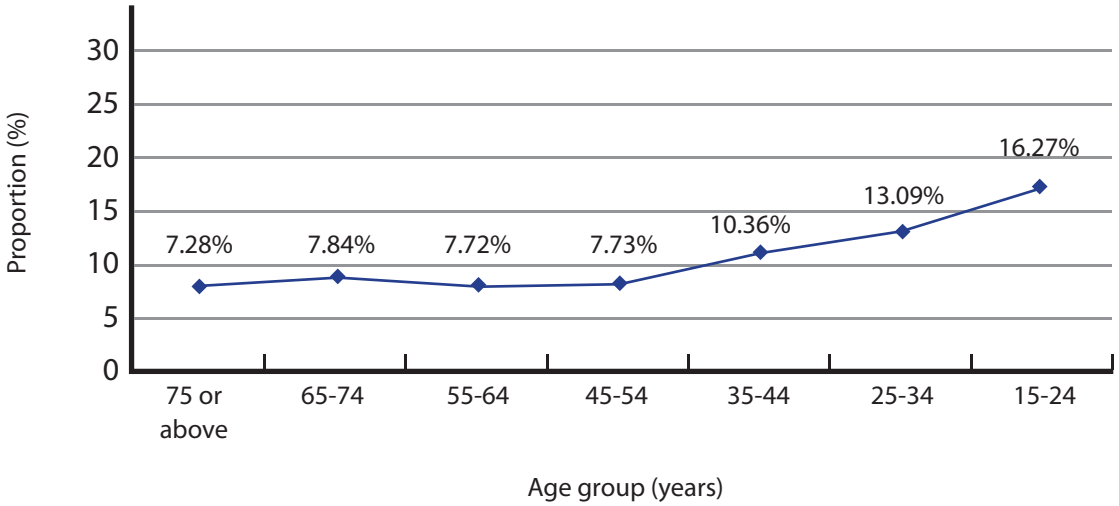
[40] Population Health Survey 2003/2004. Hong Kong SAR: Department of Health and Department of Community Medicine, University of Hong Kong.
[41] Behavioral Risk Factor Surveillance System. Hong Kong SAR: Department of Health.
[42] WHO Regional Office for South-East Asia (2003). *Need for a Regional Alcohol Action Plan: 21st Meeting of Ministers of Health New Delhi, India, 8-9 September 2003*. Available at: http://www.searo.who.int/en/Section1174/Section1199/Section2278.htm

Alcohol consumption behaviour in the younger population

2.17 The CHS of 2005/2006 showed that 5.0% of children aged 11 to 14 years were ever alcohol users and 0.3% were current binge drinkers (who had five or more drinks of alcohol in a row within a couple of hours in the past month). Furthermore, the PHS in 2003/2004 showed that the prevalence of underage drinking (reported to have started drinking before 18 years of age) was higher among the younger cohorts[43] (Figure 6).

Figure 6: Proportion of respondents started drinking below age of 18 by age group



Source: Population Health Survey, 2003/2004

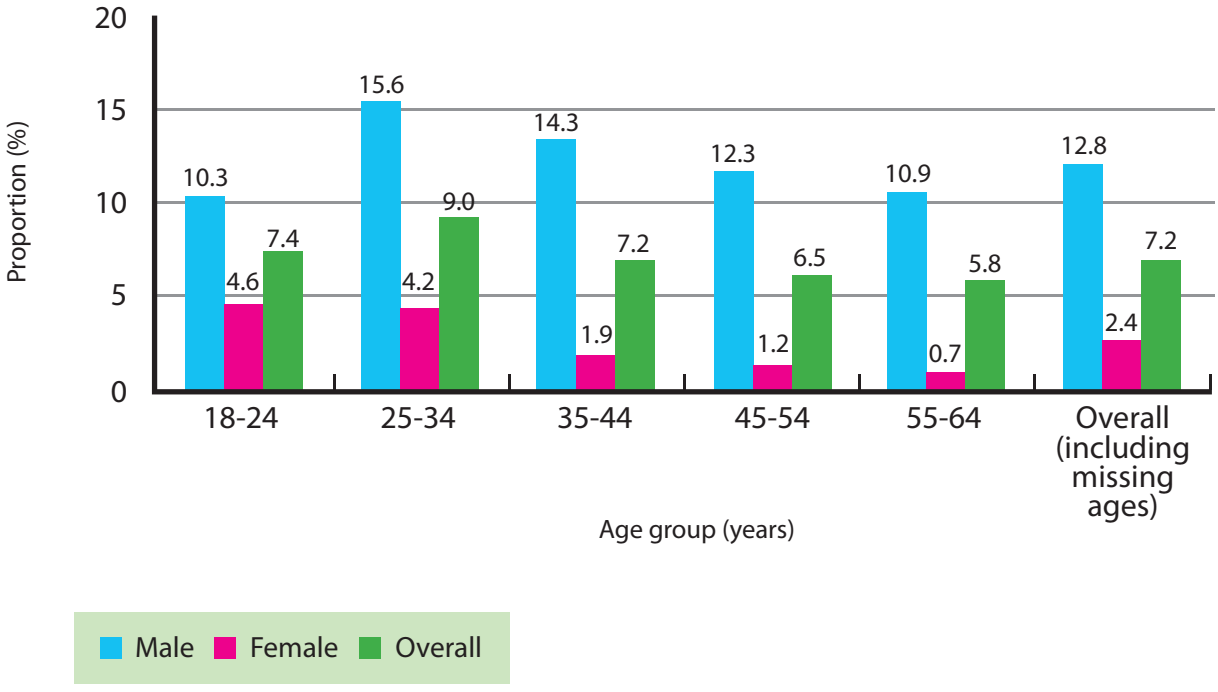
2.18 According to the most recent survey (2008) conducted by the ND, 64.9% of students studying in secondary schools had ever consumed alcohol. Furthermore, 24.2% of the secondary students reported that they had consumed alcohol in the preceding month[44].

[43] Child Health Survey 2005/2006. Hong Kong SAR: Department of Health.
[44] The 2008/2009 Survey of Drug Use among Students. Hong Kong SAR: Narcotics Division of Security Bureau. Available at: http://www.nd.gov.hk/pdf/survey_drug_use/2008-2009/Report.pdf

Binge drinking

2.19 Apart from drinking frequency and the total amount consumed, alcohol consumption pattern, e.g. binge drinking, was another important aspect leading to alcohol-related harm. The BRFSS defines binge drinking as reported drinking of at least 5 cans/glasses of alcohol beverages on one occasion during the month prior to the survey, which is equivalent to an average of 62.5 grams (50 to 75 grams) of pure alcohol consumed in both men and women. In 2010, the BRFS revealed that about 7.2% of the respondents were binge drinkers. It is worth noting that there was a higher proportion of binge drinkers among young adults. Among the various age groups, the highest proportion of binge drinkers was found in age group 25 – 34 in males (15.6%) and age group 18 – 24 in females (4.6%) (Figure 7).

Figure 7: Prevalence of binge drinking by sex and age group, 2010, Hong Kong



Source: Behavioural Risk Factor Survey (2010)

2.20 A local random telephone survey conducted among about 10 000 Chinese adults in Hong Kong in 2006 showed that the age-adjusted prevalence of binge drinking among adult men and women were 14.4% and 3.6% respectively. The prevalence of binge drinking was higher in younger age groups. An age distribution of binge drinkers similar to that in the BRFS was observed. The prevalence of binge drinking were 23.3% and 12.3% in 21-30 year-old and 18-20 year-old men respectively; whereas the prevalence were 8.7% and 6.3% in 21-30 year-old and 18-20 year-old women respectively[45]. These findings were consistent with those in the BRFS and showed that binge drinking is a relatively common phenomenon among the younger age groups in Hong Kong.

2.21 In another local survey of 3 000 university students in 2003, the prevalence of binge drinking was found to be 7% (12% among men, 3% among women)[46]. The study found that although the majority of first year university students in Hong Kong were not binge or regular drinkers in contrast with students in the West, there was a subgroup that drank more and used alcohol as a means of coping with stress.

Public awareness of harmful effects of alcohol and social/cultural meaning of drinking

2.22 It should be noted that despite its health effects, alcohol does play an important social and cultural role in society. In Chinese culture, alcohol may sometimes be treated as traditional health or medicinal products and may also be consumed during social events and collective celebrations, although drunkenness is usually frowned upon by the Chinese society[47].

2.23 Such cultural endorsement of drinking is also observed among Hong Kong people including youngsters and may affect their risk perception. A recent local study found that the perception of risk on alcohol use was low in a representative group of university students in Hong Kong[45]. In another exploratory study on local young people's views on both positive and negative consequences of alcohol use, female youngsters perceived that drinking made it easier for them to interact with others, and male youngsters considered that alcohol promoted relaxation and enhanced sleep onset[48]. For negative consequences, male youngsters' response was limited to physical effects such as flushing and drowsiness, whereas female respondents added strained relationships, irresponsible behaviour and accidents.

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45 Kim JH, Lee S, Chow J et al. (2008). Prevalence and the factors associated with binge drinking, alcohol abuse, and alcohol dependence: a population-based study of Chinese adults in Hong Kong. *Alcohol & Alcoholism*, 43(3):360-370.

46 Griffiths S, Lau JT, Chow JK et al. (2006). Alcohol use among entrants to a Hong Kong University. *Alcohol & Alcoholism*, 41(5):560-565.

47 郭萬軍 等 (2007)。社會經濟文化變遷對酒精消費及其相關健康問題的影響—世界衛生組織及社會經濟文化快速變遷地區和國家的研究。 *國際精神病學雜誌*，34(3): 168-171。

48 Lo CC, Globetti G (2000). Gender differences in drinking patterns among Hong Kong Chinese youth: a pilot study. *Subst Use Misuse*, 35(9):1297-1306.

Local epidemiology of alcohol-related harm

Data sources for surveillance of alcohol-related harm

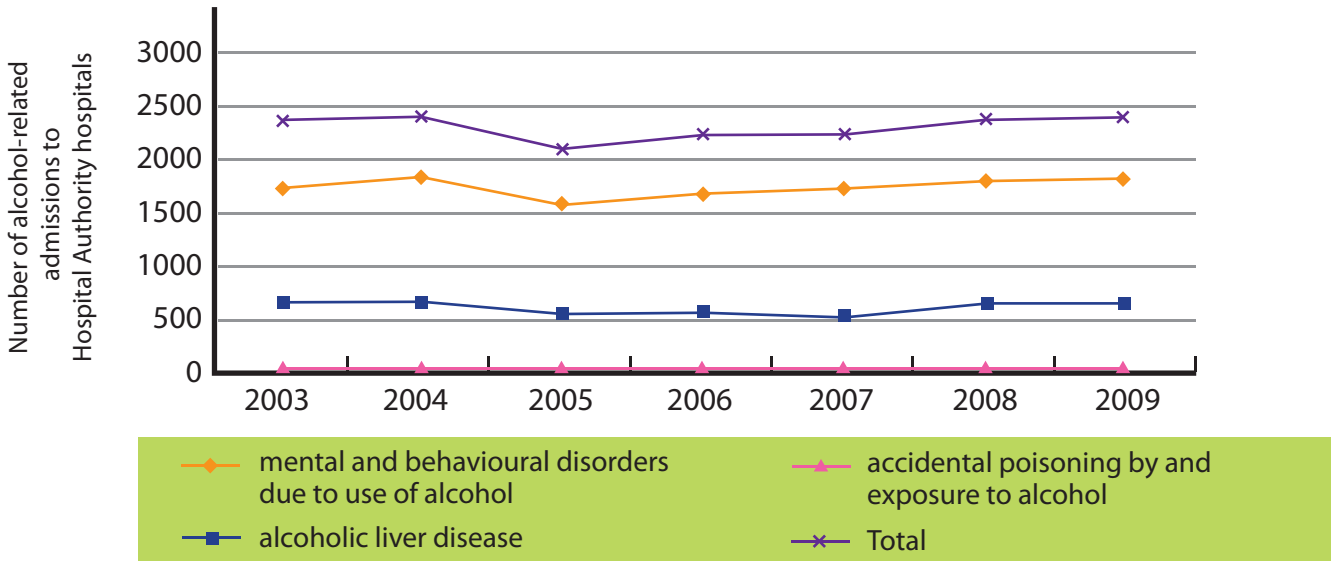
2.24 Statistics on alcohol-related hospital admissions and deaths are routinely collected by the Hospital Authority (HA). Statistics on traffic accidents associated with drink-driving are also regularly collected by the Transport Department (TD).

Alcohol-related hospital admissions

2.25 In 2009, alcohol-related illness or injuries (ICD-10: F10, K70 and X45) accounted for a total of 2 433 admissions into public/private hospitals in Hong Kong. More men than women were affected with a male to female ratio of about 5 to 1. Mental and behavioural disorders due to use of alcohol (73.6%) and alcoholic liver disease (26.4%) accounted for the majority of these admissions.

2.26 As shown in Figure 8, the number of alcohol-related admissions into public hospitals in 2009 was similar to those in the previous 6 years. The number of alcohol-related admissions into private hospitals was relatively small, amounting to fewer than 30 in 2009. However, it must be cautioned that only those admissions with alcohol-related disease marked as the principal diagnosis were counted and therefore it is expected that the figures have significantly under-estimated the disease burden related to alcohol.

Figure 8: Number of alcohol-related admissions in HA hospitals, by principal diagnosis and by year, 2003-2009

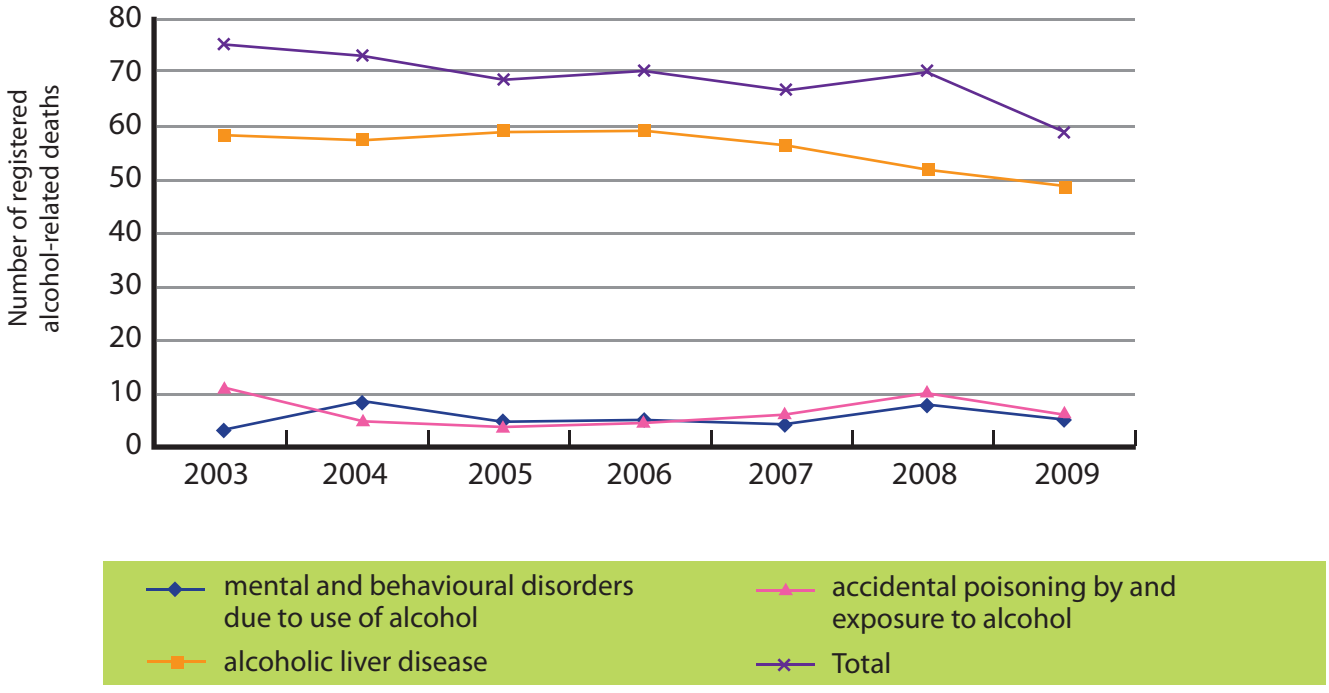


Sources: Census and Statistics Department, Department of Health & Hospital Authority

Alcohol-related deaths

2.27 In 2009, alcohol-related deaths (ICD-10: F10, K70 and X45) contributed to 0.14% of locally registered deaths in Hong Kong (58 out of 41 047). Of these, 48, 6 and 4 deaths (82.8%, 10.3% and 6.9% of the total number of alcohol-related deaths) were related to alcoholic liver disease, accidental poisoning by alcohol, and mental and behavioural disorders respectively. More men than women were affected with a ratio of about 9 to 1. Men aged 45 years or above accounted for 50 deaths (86.2% of the total number of alcohol-related deaths) in 2009. The trend was stable in the past 6 years (Figure 9). Nonetheless, taking similar limitations in hospital admissions statistics into account, significant under-estimation needs to be considered.

Figure 9: Number of alcohol-attributed registered deaths, by cause of deaths and by year, 2003-2009



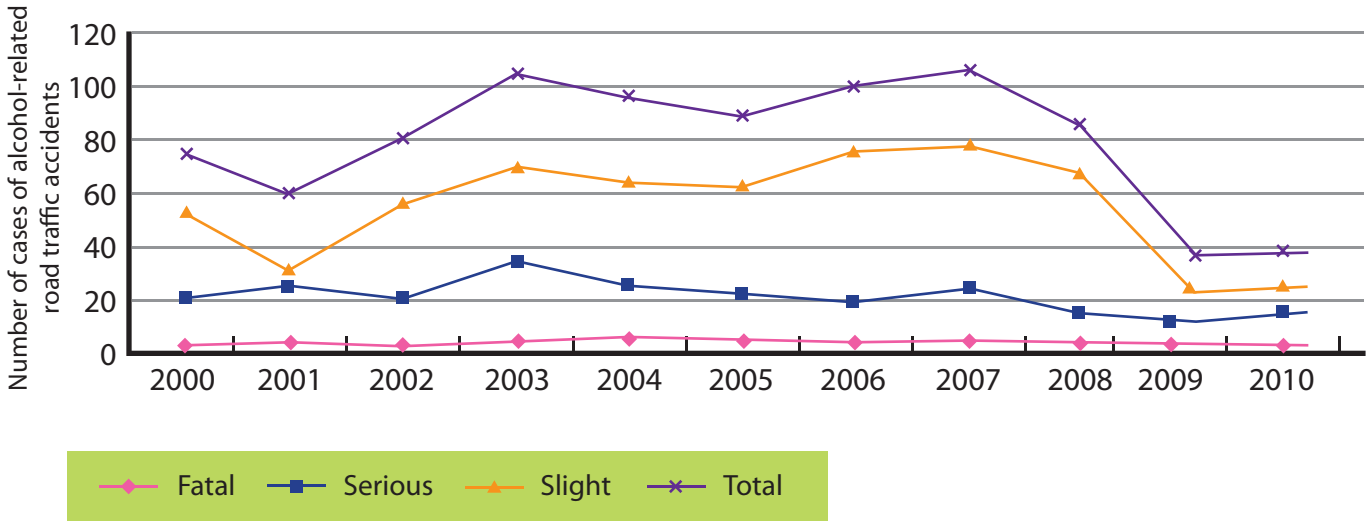
Sources: Census and Statistics Department, Department of Health & Hospital Authority

Drink-driving

2.28 A local random telephone survey conducted among 9 860 Chinese adults aged 18-70 years in Hong Kong in 2006 showed that the age-standardised past-year prevalence of driving within 2 hours of drinking among males and females were 5.2% and 0.8% respectively. The prevalence of drinking and driving across age showed an inverted U-shaped trend for males peaking at 8.2% between 36 and 45 years, while the prevalence was fairly stable between 26 and 55 years for females. The age-adjusted past-year prevalence of alcohol-related motor vehicle accidents was 0.15% among males and 0.02% among females, with the majority being in the 26-35 age group[49].

2.29 Drink-driving increases the risk of road traffic accidents. A local epidemiological study in 2001 showed that about one in ten (10.3%) of all motor vehicle deaths were associated with alcohol[50]. According to the statistics from the TD, between 2000 and 2010, 874 vehicle accidents resulting in personal injury were related to alcohol use, including 24 fatal cases. An overall increasing trend was observed from year 2000 to 2008 (Figure 10), but then a sharp drop was seen in 2009 and 2010 following the implementation of random breath test from February 2009.

Figure 10: Number of drivers found to have consumed alcohol and involved in road traffic accidents by severity and by year, 2000-2010, Hong Kong



Source: Transport Department

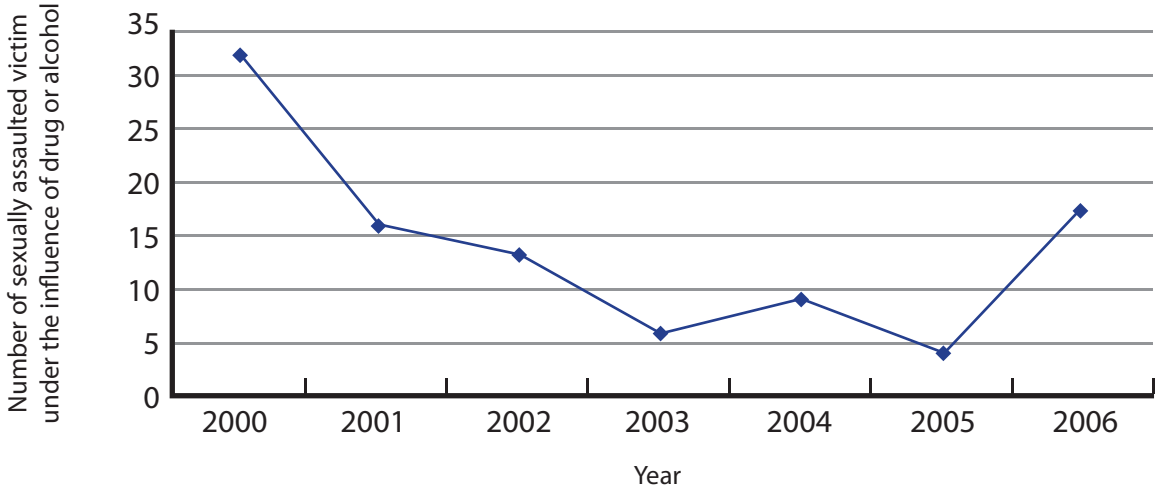
[49] Kim H et al. (2010). A population-based study on the prevalence and correlates of drinking and driving in Hong Kong. *Accident Analysis and Prevention*, 42: 944-1002.

[50] Cameron PA, Rainer TH, Mak P (2004). Motor vehicle deaths in Hong Kong: opportunities for improvement. *Journal of Trauma*, 56(4):890-893.

Domestic violence and sexual assault

2.30 Alcohol consumption triggers the occurrence and aggravates the severity of domestic violence and sexual assault. Currently, there is no up-to-date data on the local prevalence of domestic violence or sexual assault related to alcohol. Nonetheless, one local study found that alcohol abuse by the husband was a significant risk factor for domestic violence injuries among married women[51]. According to the statistics of the Family Planning Association of Hong Kong, the number of calls for help from victims sexually-assaulted under the influence of drug or alcohol ranged from 4 to 32 in the period from 2000 to 2006 (Figure 11).

Figure 11: Number of calls for help from victims sexually assaulted under the influence of drug or alcohol, 2000-2006



Source: Family Planning Association of Hong Kong

[51] Tsui KL, Chan AY, So FL, Kam CW (2006). Risk factors for injury to married women from domestic violence in Hong Kong. *Hong Kong Medical Journal*, 12(4):289-293.

Local interventions to reduce alcohol-related harm

Raising public awareness to prevent alcohol-related harm

2.31 Currently, various government departments and local organisations actively participate in the prevention of alcohol-related harm. For example, the DH provides printed materials, 24-hour education hotline, website (Men's Health Programme) and electronic publications *("NCD Watch")* to educate the public on the prevention of alcohol-related harm. The Tung Wah Group of Hospitals (TWGHs) and Tuen Mun Alcohol Problems Clinic of HA provide pamphlets and website for public education. The Education Bureau promotes healthy lifestyles, including prevention of alcohol use, to students through a holistic school curriculum which comprises knowledge, skills and attitudes. To support the delivery of the curriculum in schools, professional development programmes and resource materials are available for principals and teachers. Moreover, all schools are encouraged to implement the school-based Healthy School Policy starting from the 2010/11 school year. The TD, Road Safety Council, and the Hong Kong Police Force (HKPF) have produced Announcements in the Public Interest about drink-driving prevention for broadcast on TV and radio. Anti-drink-driving slogans are displayed on banners and advertisement boards to remind the public not to drive if they drink.

Health sector response on alcohol-related harm

2.32 In the public sector, the Tuen Mun Alcohol Problems Clinic of the HA provides various services including (a) comprehensive assessment; (b) alcohol detoxification; (c) treatment of co-existing psychiatric and psychological problems; (d) marital counselling, family therapy and social work service; (e) organisation of self-help group; and (f) referral to other treatment services. The other six substance abuse clinics of the HA also provide treatment services on alcohol-related problems upon referrals.

2.33 The NGOs contribute significantly to health services for people with alcohol-related problems. A special project known as "Stay Sober, Stay Free" run by the TWGHs provides comprehensive assessment, treatment and counselling services through a multi-disciplinary team including doctors, nurses, clinical psychologists, social workers and occupational therapists. Clients would be appropriately referred to in-patient treatment services, and would be offered family support service, hotline service and voluntary service as well as activities on well-balanced living by the project. Alcoholics Anonymous, a worldwide organisation, also provides local alcohol users with volunteer-conducted support group and alcohol abstinence services.

Drink-driving legislation and relevant alcohol-related harm reduction measures

2.34 According to the Road Traffic Ordinance (Cap. 374, Reg 39A), it is illegal for a person to drive or attempt to drive a motor vehicle, or be in possession of a motor vehicle, on any road with the proportion of alcohol in his breath, blood or urine exceeding the prescribed limit. Since 1 October 1999, the prescribed limit for drink-driving has been set as follows:

- 50 milligrams of alcohol per 100ml of blood; or
- 22 micrograms of alcohol per 100ml of breath; or
- 67 milligrams of alcohol per 100ml of urine.

2.35 With effect from 9 February 2009, uniformed police officers can require a person who is driving or attempting to drive a vehicle on a road to perform an alcohol breath test without the need for reasonable suspicion (Cap. 374, Reg 39B). The maximum fine for a person breaching the prescribed limit is HK$25,000 and imprisonment for up to 3 years. With effect from 17 December 2010, 3-tier penalty system with a sliding scale was also introduced. The more a driver exceeds the prescribed limit for alcohol, the longer will be the driving disqualification period. The minimum disqualification period for drink drivers on first conviction is 6 months to 2 years; and on subsequent conviction is 2 to 5 years.

2.36 Some NGOs such as the Hong Kong Automobile Association have also started some designated driver services, which provide designated sober drivers to drive those who have consumed alcohol to return home.

Measures to control the availability of alcohol

2.37 It is an offence under the Dutiable Commodities (Liquor) Regulations (Cap. 109B) to sell liquor except on the authority of a liquor licence or a temporary liquor licence at any premises for consumption on those premises; or at a place of public entertainment or a public occasion for consumption at the place or occasion. It also stated that "no licensee shall permit any person under the age of 18 years to drink any intoxicating liquor on any licensed premises".

2.38 However, there is currently no restriction on the minimum age for off-premise sales of alcohol in Hong Kong. Some organisations have adopted a voluntary code of conduct to restrict the sale of alcohol to young people. For example, the Hong Kong Retail Management Association, which is the major retail association in Hong Kong with more than 5 000 retail outlets, states in their code of conduct that its members should not sell any alcoholic beverages to people aged under 18 years.

Measures to control the marketing of alcohol beverages

2.39 Under the Broadcasting Ordinance (Cap. 562) and the Broadcasting Authority Ordinance (Cap. 391), all television programme service licensees have to comply with the Codes of Practice issued by the Broadcasting Authority. Under the Codes of Practice, there are restrictions on advertising alcoholic beverages to young people, some examples of which include:

- such advertising should only target the adult audience;
- such matters should not be advertised in proximity to children's programmes; or programmes which target young persons under the age of 18;
- the licensee should not broadcast any such advertisement between the hours of 4:00 p.m. and 8:30 p.m.;
- such advertisements must not feature any personality whose example children or young persons are likely to follow or who has a particular appeal to children or young persons under the age of 18; and
- advertising must not encourage, challenge or dare non-drinkers or young persons under the age of 18 to drink.

Pricing Policies

2.40 The duty on beer and wine has been exempted since February 2008. For spirits with 30% alcohol by volume (ABV), the duty is 100%.

Knowledge gaps identification and situation analysis

Knowledge gaps in alcohol use and alcohol-related harm in Hong Kong

2.41 A good surveillance system is essential to the accurate determination of the size and nature of alcohol use and alcohol-related harm in Hong Kong. Although a number of information sources are available, they are uncoordinated and there is still inadequate research to identify and examine the risk factors and protective factors of alcohol use in Hong Kong. Moreover, surveillance on alcohol consumption and its related harm is incomplete. There is a lack of information on violence or alcohol-related assault in particular.

Size and nature of alcohol use and alcohol-related harm

2.42 The BRFSS showed that a significant proportion (15.3%) of adults drank beyond the recommended daily limit and there was a rise in the proportion of drinkers from 2005 to 2010 in Hong Kong adult population. It is worth noting that the proportion of female drinkers was increasing from 2005 to 2010 although fewer females drank than males in general[52]. Different local studies consistently showed that binge drinking was prevalent in younger age groups (18-30 years old)[53]. Furthermore, an increasing prevalence of underage drinking in the younger cohorts was noted from the PHS in 2003/2004[54]. As for alcohol-related harm, various sources of information have demonstrated that alcohol use contributed to significant loss of lives and disease burden in Hong Kong[55,56].

Public awareness and current health education of alcohol-related harm

2.43 While the perceived benefits of drinking (proven and unproven) such as prevention of heart disease, improving sleep onset and maintenance of general health are better known in Hong Kong[57], public awareness of the harmful effects of alcohol needs to be strengthened.

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[52] Behavioral Risk Factor Surveillance System. Hong Kong SAR: Department of Health.
[53] Kim JH, S Lee, J Chow, et al. (2008). Prevalence and the factors associated with binge drinking, alcohol abuse, and alcohol dependence: a population-based study of Chinese adults in Hong Kong. *Alcohol & Alcoholism*, 43(3):360-370.
[54] Population Health Survey 2003/2004. Hong Kong SAR: Department of Health and Department of Community Medicine, University of Hong Kong.
[55] Census and Statistics Department, Department of Health, Hospital Authority and Transport Department, Hong Kong SAR Government.
[56] Cameron Pa, TH Rainer, P Mak (2004). Motor vehicle deaths in Hong Kong: opportunities for improvement. *Journal of Trauma*, 56(4):890-893.
[57] Lo CC, Globetti G (2000). Gender differences in drinking patterns among Hong Kong Chinese youth: a pilot study. *Subst Use Misuse*, 35(9):1297-1306.

Health sector response and community action

2.44 At present, there are some treatment and support services for people with alcohol-related problems provided by the public sector and the NGOs. Nonetheless, there is room for improvement in terms of active early identification and treatment.

2.45 Reducing alcohol-related harm has not been a popular agenda in community health actions and can be accorded a higher priority in policy agenda through enhanced preventive and control measures involving more government bureaux/departments.

Drink-driving policies and relevant harm-reduction measures

2.46 With the recent legislation of random alcohol breath tests that can be performed by uniformed police officers and the related education and publicity measures, it is worthwhile to study its effect on drink-driving.

Measures to control the availability of alcohol

2.47 Currently, there is no restriction on the minimum age for off-premise sales of alcohol in Hong Kong. Only some organisations have adopted a voluntary code of conduct to restrict the sale of alcohol to young people.

Measures to control the marketing of alcohol beverages

2.48 Restrictions on advertising alcoholic beverages to young people are only applicable to television programme service licensees. To date, there is no restriction on other forms of marketing and promotion of alcoholic beverages which are commonly accessible to children and young people.

Pricing Policies

2.49 In Hong Kong, duty on beer and wine has been waived since February 2008, while the duty is 100% for spirit of more than 30% alcohol by volume. This has made beer and wine more affordable, which may increase alcohol consumption in the population. However, alcohol pricing and its effect on consumption in the local setting warrants further study.

3 Actions to reduce alcohol-related harm

3. Actions to reduce alcohol-related harm

Preamble

3.1 It is envisioned that with the successful implementation of the Strategic Framework for NCD Prevention and Control, Hong Kong will have a well-informed population that is able to take responsibility for their own health, a caring community that integrates public and private sectors to ensure healthy choices for the public, a competent healthcare profession that views health promotion and preventive medicine as priorities, and a sustainable healthcare system that incorporates strong elements of health promotion, disease prevention and curative care for our people, thereby significantly reducing the toll of disease burden related to NCD.

3.2 To achieve the above vision, the WGAH recognises the importance of concerted efforts of the Government and different sectors in the community in order to create a sustainable environment to reduce alcohol-related harm. It is of equal importance that individual citizens take responsibility for their own health, as well as the health of their families and the communities, by making informed and healthier choices with regard to alcohol consumption.

3.3 Although the WGAH is mainly tasked to recommend actions to reduce alcohol-related harm in Hong Kong, the WGAH also recognises the synergistic health benefits that can be brought by working on other major behavioural risk factors including healthy diet, physical activity and smoking cessation. Therefore, the WGAH calls for continuing actions in tobacco control, adoption of healthy diet and active living, in addition to reducing alcohol-related harm.

Goals

3.4 After careful review and critical appraisal of overseas evidence and a detailed examination of the local situation on alcohol use, the WGAH has drawn up the "*Action Plan to Reduce alcohol-related harm in Hong Kong*" (Action Plan). With the implementation of the Action Plan, it is hoped that:

- a sustainable environment to reduce alcohol-related harm will be created;
- the general public will be able to make informed choices about alcohol consumption; and
- the burden of alcohol-related harm can be reduced.

Details of 17 specific actions

3.5 In order to address the levels and patterns of drinking in different populations and the different context of alcohol consumption, a combination of measures are proposed to target (i) particular populations e.g. the population at large, vulnerable groups such as young people and pregnant women, and affected individuals; and (ii) particular alcohol-related public health problems e.g. drink-driving and alcohol-related violence. Priority areas for action are based on the best available evidence as highlighted in Table 2 in Section 2 of this document.

3.6 A total of 17 specific actions are set out in this Action Plan. In accordance with the "*Promoting Health in Hong Kong: A Strategic Framework for Prevention and Control of Non-communicable Diseases*", the 17 actions are grouped under five priority areas and 10 recommendations. The list of specific actions are summarised in Table 4.

Priority area 1: Generate an effective information system to understand the epidemiology of alcohol-related harm and to provide advice and support on prevention and control of alcohol-related harm

(Recommendation 1A) Strengthen surveillance on alcohol consumption and psychosocial/ demographic profile of local drinkers

3.7 Research and surveillance of alcohol consumption, alcohol-related harm and the related risk factors help inform evidence-based intervention, prioritise actions and steer the direction of future policy on prevention and control of alcohol-related harm. To date, there is little understanding on psychosocial and demographic profile of local drinkers, as well as risk factors and protective factors of alcohol use in Hong Kong.

3.8 The WGAH recognises that there is insufficient information on the psychosocial and demographic profile of drinkers. In this connection, the WGAH recommends strengthening surveillance of alcohol consumption and the psychosocial/demographic profile of drinkers. The existing population-based health surveys, such as the BRFS and the PHS, should be reinforced by including measurement of psychosocial risk factors.

Action 1: Strengthen surveillance on alcohol consumption among adults aged 18-64 years on alcohol drinking behaviour through the BRFSS

3.9 Since October 2004, the BRFSS of the DH has continuously monitored the trend of health-related behaviours for adults aged 18-64 years through a series of telephone surveys conducted systematically and periodically. Information on alcohol consumption was monitored as part of the surveillance system. The DH will continue to conduct the BRFS regularly, where surveillance items on alcohol consumption will be reviewed, adjusted and strengthened as necessary.

Action 2: Make use of the second PHS for persons aged 15 years and above to strengthen the knowledge on epidemiology of alcohol consumption

3.10 In 2003/2004, the DH conducted a PHS to study the patterns of health status and health-related issues, including information on alcohol consumption, of the general population in Hong Kong for persons aged 15 years and above. The DH plans to conduct the second round of PHS in 2013/2014. By making use of the second PHS, more useful epidemiological information on alcohol consumption can be obtained. Updated epidemiology on alcohol consumption will be available by 2015.

Action 3: Make use of appropriate research means to monitor the pattern of alcohol consumption among youth

3.11 Regular and ad-hoc surveys, such as the CHS conducted by the DH, can provide useful information on the pattern of alcohol consumption among youths. In addition, the ND has been conducting regular surveys (once every 4 years) among local adolescent students to examine their use of alcohol (among other drugs) since 1992. Such survey data could be used to continue to monitor the pattern of alcohol use among local youths.

(Recommendation 1B) Strengthen surveillance of alcohol-related harm

3.12 Alcohol can lead to a range of disease, injury, violence and sometimes fatal outcomes. To date, information on alcohol-related violence and injury that do not require hospital treatment often goes unreported. The WGAH recognises that there is insufficient information on the association of alcohol use with domestic violence, sexual assault and other alcohol-related offences. In this connection, the WGAH recommends strengthening surveillance of alcohol-related harm so that the burden of alcohol-related harm can be estimated and monitored more closely and accurately.

Action 4: Continue to monitor disease burden of alcohol

3.13 Mortality and hospital admission data are presently reported to the DH by Deaths Registry, and public and private hospitals respectively. The DH will continue to partner with the HA to regularly monitor the statistics of alcohol-related registered deaths and hospital admissions coded as related to alcohol. The DH will work with the HA to explore the feasibility of enhancing sensitivity in monitoring alcohol-related hospitalisation, mortality and disease burden on an ongoing basis.

Action 5: Consider the feasibility of including questions related to alcohol use in the data input form of reporting communal violence cases

3.14 The HKPF operates a Communal Information System (CIS) for its day-to-day operations. The CIS captures, maintains and processes details of cases reported, assists in prosecution, generates management reports for crime prevention, and supports traffic operations. Currently, there is limited alcohol-related information in the CIS. The HKPF will consider the feasibility of including questions related to alcohol use in the data input of reporting communal violence. As such, the HKPF will conduct a feasibility study at the system analysis and design stage of the new CIS by 2011. In addition, the HKPF will continue to closely monitor the statistics of traffic accidents and their trends, analyse the causes, and introduce corresponding improvement measures with a view to improving road safety. The HKPF will maintain daily returns of Random Breath Test enforcement results, monthly returns on traffic accidents involving drink-driving and monthly returns on drink-driving enforcement/ prosecution.

Action 6: Consider the feasibility of including questions related to alcohol use in the data input form of reporting battered spouse, sexual violence and child abuse cases

3.15 The Social Welfare Department (SWD) administers a "Central Information System on Battered Spouse Cases and Sexual Violence Cases" and the "Child Protection Registry" to collect essential data on battered spouse cases, sexual violence cases and child abuse cases handled by different organisations and departments to gauge the size of the problem. However, the systems do not capture alcohol-related data. In view of the possible association of alcohol consumption, it is considered appropriate to include questions related to alcohol use in the data input forms for these systems. The SWD will explore the feasibility to include this item in the review of the "Central Information System on Battered Spouse Cases and Sexual Violence Cases" and "Child Protection Registry" targeted to commence tentatively in 2012.

(Recommendation 1C) Promote research in areas related to feasibility, efficiency, and cost-effectiveness of interventions to reduce alcohol-related harm

3.16 A substantial amount of studies on the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm have been conducted in overseas countries. On the other hand, local studies are limited and it is important to investigate the possible effect and feasibility of new measures to reduce alcohol-related harm, such as imposing age restriction on off-premise sales and change of alcohol taxes or pricing. As such, the WGAH recognises the information gap and recommends promoting research in areas related to feasibility, efficiency, and cost-effectiveness of interventions to reduce alcohol-related harm. The research results will be valuable for guiding future evidence-based interventions in reducing alcohol-related harm.

Action 7: Organise forums and workshops to encourage academia and NGOs to conduct studies on related subjects and enhance their understanding on various funding sources

3.17 In order to encourage relevant parties, including academia and NGOs, to conduct research on alcohol and health, the DH will commence by 2011 the organisation of forum(s)/workshop(s) to introduce the local situation of alcohol consumption and overseas evidence on effective alcohol harm reduction. During the forum(s)/workshop(s), the DH will also introduce the various funding sources available for various research/project themes, and provide support for the academia and the NGOs if they apply for the funding.

Priority area 2: Strengthen partnership and foster engagement of all relevant stakeholders

(Recommendation 2A) Government bureaux/ departments, other health promotion partners, NGOs, schools, employees and employers of different industries to work together to develop and implement measures that are sensitive to the needs of the public in achieving prevention and control of alcohol-related harm

3.18 Health promotion and disease prevention require the involvement of not only the health sector but the whole community. Working in partnership with all relevant stakeholders at community level is crucial for the success of health promotion. Given the complexity and challenges in relation to prevention of alcohol-related harm, the WGAH recognises that health authorities, healthcare professionals, government departments, education sector, business sector, NGOs and other community groups have to work closely together in a coordinated approach. As such, the WGAH recommends that government bureaux/ departments, other health promotion partners, NGOs, schools, employees and employers work together to develop and implement measures that are sensitive to the needs of the public in achieving prevention and control of alcohol-related harm.

Action 8: Organise information sharing session(s) or seminar(s) for different stakeholders and target audience to raise awareness on alcohol-related harm

3.19 In order to raise the awareness and seek support from different stakeholders and health promotion partners, including government bureaux/ departments, District Councils, healthy cities, NGOs, schools and universities, on prevention of alcohol-related harm, the DH will commence by 2011 the organisation of information sharing session to highlight the importance of alcohol-related harm in Hong Kong from the public health perspective, in particular, local surveillance and epidemiology information like increasing trend of alcohol consumption in males and females and underage drinking. Local and overseas experience in reducing alcohol-related harm will also be shared.

Action 9: Organise a conference on NCD prevention emphasising prevention and control of alcohol-related harm

3.20 The DH plans to host a conference in 2012 to raise the public awareness of NCD prevention and control and bring about the synergistic health benefits of modifying major behavioural risk factors. Alcohol use is one of the main shared modifiable risk factors for NCD and identified priority area in the NCD strategic framework of Hong Kong. As such, prevention and control of alcohol-related harm will be one of the focuses in the conference. Through this event, we aim to bring together major local as well as international health promotion partners to share their experience on successful health promotion approaches and best practices on prevention and control of alcohol-related harm.

Priority area 3: Build the capacity and capability to prevent and control alcohol-related harm

(Recommendation 3A) Developing evidence-based advice to empower and enable the general public to make informed choices about the use of alcohol

3.21 Effective risk communication is a fundamental tool to assist the public to make informed choice about their health and lives. Currently, information on the risk of alcohol use in causing disease, injury, violence and even deaths is not comprehensive. Thus, the WGAH recommends developing evidence-based advice to empower and enable the general public to make informed choices about alcohol use.

Action 10: Develop drinking advice to strengthen the risk communication on alcohol-related harm

3.22 Many countries have adopted "drinking guidelines" as a measure to moderate the drinking behaviour of the public, particularly those countries having high level of alcohol consumption, such as the UK, Australia, the US and Canada. However, overseas studies showed that there has been little scientific assessment evaluating the effectiveness of "drinking guidelines" on influencing drinking behaviour or reducing alcohol-related harm[58, 59]. Furthermore, there has been some discussion internationally about the disadvantages of using "drinking guidelines" for prevention of alcohol problems. For example, some quarters of the community have expressed concern that "drinking guidelines" may be interpreted as recommendations for a minimum intake for good health, or used to rationalise continued destructive drinking[60]. Instead, communicating the risk of alcohol-related harm is more fundamental and important to assist the public to make informed choice about alcohol use. Therefore, the DH will take into consideration local drinking habits and collaborate with relevant parties to develop evidence-based drinking advice, to strengthen the risk communication on alcohol-related harm for different target groups after studying their different characteristics by 2012.

58 Babor TF and Caetano R (2005). Evidence-based alcohol policy in the Americas: strengths, weaknesses and future challenges. *Rev Panam Salud Publica/ Pan Am J Public Health*, 18(4/5):327-37.

59 Anderson P, Chisholm D, Fuhr DC (2009). Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet*, 27;373(9682):2234-46.

60 Walsh GW, Bondy SJ, Rehm J (1998). Review of Canadian low-risk drinking guidelines and their effectiveness. *Canadian Journal of Public Health*, 89(4):241-247.

Action 11: Develop educational materials targeting against drink-driving

3.23 The HKPF will collaborate with the Hong Kong Medical Association and the Law Society of Hong Kong, to develop leaflets from medical and legal perspectives warning against drink-driving. It is an important component in the public education campaign on drink-driving which was launched in April 2009. The aim of the campaign is to raise public awareness on the risks of drink-driving, dispel misconceptions towards drinking, and to emphasise the criminal consequences of drink-driving. Produced leaflets will be disseminated by 2011/2012.

(Recommendation 3B) Strengthen community awareness and actions to reduce alcohol-related harm

3.24 Community awareness of a public health issue is an indicator of the community action and resources taken on such issue. the WGAH considers that it is important to empower the general public with the knowledge and skills in communicating and addressing the alcohol-related harm, in particular, the rising trend of underage drinking and accidents due to drink-driving. In this connection, the WGAH recommends strengthening community awareness and actions to reduce alcohol use.

Action 12: Develop age-specific education materials to facilitate parents, teachers and other parties to appropriately communicate with children to prevent underage drinking

3.25 Overseas experience showed that many parents lack the ability to positively communicate with their children on alcohol-related harm. Evidence showed that parenting programmes were effective in significantly reducing the use of alcohol in preteen and early adolescent children[61]. Some overseas countries have developed parenting education materials to help parents talk to their children about alcohol. For example, in the US, the National Institute on Alcohol Abuse and Alcoholism developed the guide "*Make a Difference: Talk to Your Child about Alcohol*", targeted at parents or guardians of young people aged 10-14 years. In view of the rising trend of underage drinking, the DH will take reference to overseas parenting guides and develop age-specific education materials to facilitate parents, teachers and other parties to appropriately communicate with children to prevent underage drinking. Education materials will be developed by 2012.

[61] Petrie J, Bunn F, Byrne G (2007). Parenting programmes for preventing tobacco, alcohol and drug misuse in children <18 years: a systematic review. *Health Educ Res*, 22: 177–91.

Action 13: Continue publicity to the public targeting against drink-driving at strategic locations

3.26 Raising road safety awareness among motorists and road users is an effective means to enhance road safety. On this front, publicity and education are very important. All along, the HKPF has been carrying out publicity and education activities. The HKPF will continue to disseminate messages against drink-driving at billboards, TV walls, video systems inside bars, restaurants and other strategic locations.

3.27 In addition, the HKPF has also adopted a multi-agency approach to engage other government departments, District Councils, Road Safety Patrols and other road safety partners to participate in various road safety publicity campaigns. One of those was the "3C Responsible Drivers" Campaign in September 2009 to encourage all drivers to drive with "Care"; to "Concern" for the safety of other road-users; and the "Commitment" not to drink and drive. The HKPF will continue to launch annual multi-agency anti-drink-driving campaign before and during festive occasions.

3.28 To promote the revised drink-driving legislation, stickers with anti-drink-driving messages have been mounted on thousands of the TD parking meters all over the territory since November 2008. Parking meter stickers will continue to be produced and mounted on parking meters across Hong Kong.

Priority area 4: Ensure a health sector that is responsive to the NCD challenges and to improve the healthcare system

(Recommendation 4A) Involve healthcare professionals in reducing alcohol-related harm

3.29 Primary care is an important means to promote health to the public including at-risk drinkers, as family doctors and other primary care providers are often the first point of contact for patients at the community level. Contact during consultation allows primary care providers to offer advice on alcohol-related harm such as screening, providing health education/self-help materials, brief intervention/counselling and referral to specific services as appropriate. The WGAH recommends involving health professionals in reducing alcohol-related harm.

Action 14: Develop health education materials to facilitate healthcare professional to reduce alcohol-related harm

3.30 To support primary care professionals in their role as health promoters, the DH will develop health education materials by 2012 to facilitate healthcare professionals' work in reducing alcohol-related harm, supporting them in advising people who choose to drink to do so sensibly. To better disseminate these health education materials and build healthcare professional capacity in reducing alcohol-related harm, the DH will explore the collaboration with various colleges of the Academy of Medicine and societies of other healthcare professionals, to incorporate the topic of "Alcohol and Health" in their training activities and continuous education programmes.

(Recommendation 4B) Encourage healthcare professionals to identify and manage at-risk drinkers

3.31 At present, many individuals who are at risk of or are suffering from inappropriate alcohol drinking behaviour are only identified after hospital admission due to related conditions. By that time, the drinking problem may be fairly well entrenched. It is found that brief advice is the most effective evidence-based treatment method for those who are at risk of or are suffering from inappropriate alcohol consumption. It includes feedback advice by using motivational interviewing style to support behavioural change[62, 63]. This approach has been shown to be effective in lowering alcohol consumption, mortality, morbidity, alcohol-related injuries, alcohol-related social consequences and health-care resource use[64]. In addition, extensive evidence from systematic reviews and meta-analyses from a range of healthcare settings in different countries has shown the effectiveness of early identification and brief advice for people with inappropriate alcohol drinking behaviour but who are not severely dependent.

3.32 As such, the WGAH encourages healthcare professionals to identify and manage at-risk drinkers. This includes addressing the risk factors of alcohol-related diseases, engaging in early intervention through counselling and health advice for drinkers, and supporting patients for self-management by using brief intervention and making appropriate referrals when necessary.

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62 Cheng CM (2009). Family doctors can help young drug abusers. *Hong Kong Medical Association Continuous Medical Education* Feb 2009. Available at: http://www.hkma.org/chinese/cme/onlinecme/cme200902set.htm

63 Coombes L, Allen D, Foxcroft D, Guydish J (2009). Motivational interviewing for the prevention of alcohol misuse in young people. *Cochrane Database Systematic Review*, 2: CD007025.

64 Kaner EF, Dickinson HO, Beyer FR et al. (2007). Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews*, 2: CD004148.

Action 15: Develop guidelines for proper screening and brief interventions to identify and manage at-risk drinkers

3.33 Individuals who wish to quit smoking, drinking or illicit drugs may consult their family doctor during consultation visits or health checks. They will be given advice accordingly and referred to appropriate agencies when indicated. In some countries, screening and brief intervention are being implemented in settings ranging from out-patient clinics to emergency rooms in hospitals for proper screening and interventions to identify and manage at-risk drinkers. Evidence also suggested that more intensive brief interventions are no more effective than less intensive interventions[65]. However, in Hong Kong, there are no standardised guidelines for proper screening and brief interventions to identify at-risk drinkers and appropriate interventions. Expert opinion from different sectors, e.g. clinical and academic, public and private is essential to the development of guidelines for proper screening and interventions for local use. Guidelines for screening and brief interventions will be produced by 2013/2014. To better disseminate the screening and brief interventions guidelines and build healthcare professional capacity in identifying and managing at-risk drinkers, collaboration with various colleges of the Academy of Medicine and societies of other healthcare professionals to provide relevant training activities and continuous education will also be explored.

(Recommendation 4C) Ensure provision of secondary and tertiary care services as well as mental health services for those with alcohol-related illnesses

3.34 Alcohol-related harm is often closely associated with mental health problem. People with mental health problems are at increased risk of alcohol-related problems and vice versa[66]. Moreover, people with alcohol-related problems also have other concurrent problems such as family and social problems. Provision of appropriate services for these people is necessary to meet their needs, including treatment, support, counselling and rehabilitation[67]. As such, the WGAH recommends ensuring the provision of secondary and tertiary care services as well as mental health services for those with alcohol-related illness.

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65 Anderson P, Chisholm D, Fuhr DC (2009). Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet*, 27;373(9682):2234-46.

66 Mental Health Foundation (2009). *Alcohol and mental health*. Available at: http://www.mentalhealth.org.uk/information/mental-health-a-z/alcohol/

67 WHO Regional Office for the Western Pacific (2009). *Meeting Report: Regional Technical Consultation on the Global Strategy to Reduce the Harmful Use of Alcohol, Auckland, New Zealand, 24-26 March 2009*. Manila, Philippines: WHO Regional Office for the Western Pacific.

Action 16: Review existing relevant services provided by public and private sectors

3.35 The Substance Abuse Clinics (SACs) are set up by the HA to provide specialist medical intervention for substance abusers who have developed psychiatric complications and/or co-morbidity. In order to enhance secondary and tertiary care services for people with alcohol-related illness, the HA will review the existing relevant services provided by public and private sectors in 2011-15. An ultimate goal is to incorporate alcohol abuse service into the SACs by 2015.

Priority area 5: Strengthen and develop supportive health promotion legislation

(Recommendation 5A) Advise the relevant authorities to review and consider the feasibility of imposing age restrictions for off-premise sales of alcohol

Action 17: Make recommendation to SC when local evidence is available

3.36 In Hong Kong, there is currently no age restriction on off-premise sales of alcohol. Overseas experience and studies have shown that setting a minimal age for legal sale of alcoholic beverages is an effective measure to reduce alcohol-related harm. A review of 132 overseas studies published between 1960 and 1999 found strong evidence that changes in minimum drinking-age laws could have substantial effects on drinking among young people and alcohol-related harm[68]. Studies also showed that even moderate increases in enforcement could reduce sales to minors by as much as 35% to 40%, especially when combined with media and other community activities[68].

3.37 Nonetheless, local studies are limited. It is therefore important to investigate locally the possible effect and feasibility on new measures, such as imposing age restriction on off-premise sales of alcohol and change of alcohol taxes or pricing, before implementation to avoid backlash, unforeseen costs and other considerations. Currently, a study on price elasticity of alcohol is being conducted by local academia. When such local evidence is available, the WGAH will advise the SC on whether to recommend relevant authorities to review and consider the feasibility of imposing age restrictions on off-premise sales of alcohol.

[68] Wagenaar AC, Toomey TL (2000). Alcohol policy: gaps between legislative action and current research. *Contemporary Drug Problems*, 27:681–733.

Table 4: List of detailed actions with target(s) and timeframe

Priority Areas	Recommendations	Actions	Lead action parties	Target(s) and Timeframe
1) Generate an effective information system to understand the epidemiology of alcohol- related harm and to provide advice and support on prevention and control of alcohol-related harm	• **(1A)** Strengthen surveillance on alcohol consumption and psychosocial/ demographic profile of local drinkers	• Strengthen surveillance on alcohol consumption among adults aged 18-64 years on alcohol drinking behaviour through the Behavioural Risk Factor Surveillance System (BRFSS) **[Action 1]**	• DH	• Continue to conduct the Behavioural Risk Factor Survey (BRFS) regularly, where surveillance items on alcohol consumption will be reviewed, adjusted and strengthened as necessary
		• Make use of the second Population Health Survey (PHS) for persons aged 15 years and above to strengthen the knowledge on epidemiology of alcohol consumption **[Action 2]**	• DH • Academia	• Provide epidemiology information on alcohol consumption of adults by 2015
		• Make use of appropriate research means to monitor the pattern of alcohol consumption among youth **[Action 3]**	• DH	• Continue to examine the pattern of alcohol consumption among youth in Hong Kong
	• **(1B)** Strengthen surveillance of alcohol-related harm	• Continue to monitor disease burden of alcohol **[Action 4]**	• DH • HA	• Continue to provide information on disease burden
		• Consider the feasibility of including questions related to alcohol use in the data input form of reporting communal violence cases **[Action 5]**	• HKPF	• Conduct a feasibility study at the system analysis and design stage of the new communal information system by 2011

Priority Areas	Recommendations	Actions	Lead action parties	Target(s) and Timeframe
		• Consider the feasibility of including questions related to alcohol use in the data input forms of reporting battered spouse, sexual violence and child abuse cases **[Action 6]**	• SWD	• Include the item in the review of the "Central Information System on Battered Spouse Cases and Sexual Violence Cases" and the "Child Protection Registry" in 2012 tentatively
	• **(1C)** Promote research in areas related to feasibility, efficiency, and cost-effectiveness of interventions to reduce alcohol-related harm	• Organise forum/ workshop to encourage academia and NGOs to conduct studies on related subjects and enhance their understanding on various funding sources **[Action 7]**	• DH • Academia • NGOs	• Commence by 2011
2) Strengthen partnership and foster engagement of all relevant stakeholders	• **(2A)** Government bureaux/ departments, other health promotion partners, NGOs, schools, employees and employers of different industries to work together to develop and implement measures that are sensitive to the needs of the public in achieving prevention and control of alcohol-related harm	• Organise information sharing session(s) or seminar(s) for different stakeholders and target audience to raise awareness on alcohol-related harm **[Action 8]**	• DH • Academia • NGOs • Community partners (e.g. District Councils and Healthy Cities)	• Commence by 2011
		• Organise a conference on NCD prevention emphasising, including promotion of prevention and control of alcohol-related harm **[Action 9]**	• DH • Community partners	• One conference conducted by 2012

Priority Areas	Recommendations	Actions	Lead action parties	Target(s) and Timeframe
3) Build the capacity and capability to prevent and control alcohol-related harm	• **(3A)** Develop evidence-based advice to empower and enable the general public to make informed choices about the use of alcohol	• Develop drinking advice to strengthen the risk communication on alcohol-related harm **[Action 10]**	• DH • Professional bodies • Academia	• Develop drinking advice by 2012
		• Develop educational materials targeting against drink-driving **[Action 11]**	• HKPF	• Develop leaflets by 2011/2012
	• **(3B)** Strengthen community awareness and actions to reduce alcohol-related harm	• Develop age-specific education materials to facilitate parents, teachers and other parties to appropriately communicate with children to prevent underage drinking **[Action 12]**	• DH • Other Government departments • NGOs	• Develop education materials by 2012
		• Continue publicity to the public targeting against drink-driving at strategic locations **[Action 13]**	• HKPF	• Dissemination of anti-drink-driving messages at billboards, TV walls, video systems inside bars, restaurants and other strategic locations • Produce and display parking meter stickers for promotion of the revised drink-driving legislation • Continue to launch annual multi-agency campaign against drink-driving before and during festive occasions

Priority Areas	Recommendations	Actions	Lead action parties	Target(s) and Timeframe
4) Ensure a health sector that is responsive to the NCD challenges and to improve the healthcare system	• **(4A)** Involve healthcare professionals in reducing alcohol-related harm	• Develop health education materials to facilitate healthcare professionals to reduce alcohol-related harm **[Action 14]**	• DH • Professional bodies • Academia	• Produce health education materials by 2012
	• **(4B)** Encourage healthcare professionals to identify and manage at-risk drinkers	• Develop guidelines for proper screening and brief interventions to identify and manage at-risk drinkers **[Action 15]**	• DH • HA • Private hospitals • Academia	• Produce guidelines for screening and brief interventions by 2013/2014
	• **(4C)** Ensure provision of secondary and tertiary care services as well as mental health services for those with alcohol-related illnesses	• Review existing relevant services provided by public and private sectors **[Action 16]**	• HA • NGOs • DH	• Ensure alcohol abuse service is incorporated into the services provided by substance abuse clinics of HA by 2015
5) Strengthen and develop supportive health promotion legislation	• **(5A)** Advise the relevant authorities to review and consider the feasibility of imposing age restrictions on off-premise sales of alcohol	• Make recommendation to SC when local evidence is available **[Action 17]**	• WGAH	• Inform relevant parties of the recommendation in due course

4 Making it happen

4. Making it happen

4.1 To take forward the Action Plan, the Administration will consult professionals, NGOs and other community stakeholders to seek their views on the proposed actions and their interests to participate. In order to ensure that people in all parts of the society will get involved and act together, the implementation of the Action Plan will be publicised through various means, such as publications, media and forums.

4.2 With a leadership role in combating the challenge of NCD, the Government will provide information on alcohol-related harm and work closely with stakeholders in both the public and private sectors to create a supportive environment for people to make the right choices for themselves and their families. The Government will also be responsible for reviewing licensing and enforcing regulations governing the sales and marketing of alcohol if necessary.

4.3 Partnership between all the relevant stakeholders is needed to increase social responsibility to promote health of the workforce. It is also high time for everyone in the community to act together. By working in partnership, Hong Kong will be a safer and healthier place to live.

Annexes

Annex 1

Membership of Working Group on Alcohol and Health

Chairman

Mr Patrick MA Ching-hang, BBS, JP

Vice Chairman

Dr LAM Ping-yan, JP

Members

Dr Charles CHAN Ching-hai
Dr Peter CHAN Hung-chiu
Dr CHOW Chun-bong, BBS, JP
Prof Sian GRIFFITHS, OBE, JP
Ms Angie LAI Fung-yee
Dr LEE Sing (June 2009 to July 2011)
Mr LIU Ah-chuen
Ms Carmen LO Ka-man (since September 2010)
Mrs Anna MAK CHOW Suk-har (June 2009 to May 2011)
Mr NG Sze-fuk, SBS, JP
Dr Kathleen SO Pik-han, BBS, JP
Dr Thomas TSANG Ho-fai, JP
Ms Caran WONG Ka-wing (since May 2011)
Mr Peter WONG (June 2009 to January 2010)
Mr Alan YU Mun-wah, PMSM (June 2009 to September 2010)

Secretary

Dr LEUNG Ting-hung, JP

Annex 2

Terms of reference of Working Group on Alcohol and Health

(a) to assess the epidemiology, risk factors and socioeconomic determinants of alcohol use among local population;

(b) to make recommendations on the health and health improvement needs of the local population in relation to prevention of alcohol-related harm;

(c) to review local and international good practices and intervention strategies to prevent alcohol-related harm; and

(d) to make recommendations on the development, implementation and evaluation of a plan of action for prevention of alcohol-related harm in Hong Kong.

Annex 3

Discussion topics of Working Group on Alcohol and Health meetings

	Date	Topics
First meeting	23 June 2009	• Highlights of the Strategic Framework for Prevention and Control of Non-Communicable Diseases and WHO global strategies to reduce harmful use of alcohol • Alcohol misuse: Hong Kong Situation (WGIAM Paper No. 01/2009) • Presentation on Health and Health Services Research Fund and Health Care and Promotion Fund
Second meeting	7 October 2009	• Local actions in prevention and control of alcohol misuse • Overseas interventions in reducing harmful use of alcohol (WGIAM Paper No. 02/2009) • Overseas and local interventions in reducing harmful use of alcohol: a comparison (WGIAM Paper No. 03/2009)
Third meeting	9 December 2009	• Draft Report on Recommendations to Reduce Harmful Use of Alcohol in Hong Kong (WGIAM Paper No. 04/2009)
Fourth meeting	8 July 2010	• Draft Action Plan to Reduce Harmful Use of Alcohol in Hong Kong (WGIAM Paper No. 01/2010)
Fifth meeting	20 December 2010	• Revised Draft Action Plan to Reduce Alcohol-related Harm in Hong Kong (WGAH Paper No. 01/2010)

Annex 4

Table 5: Some common types of alcoholic drinks and their alcohol content measured in "Standard drink" units in Hong Kong

Type	Alcohol content (% by volume)*	Volume per container or per usual serving	Number of standard drinks #*	
			Per container	Per 100ml
Shandy	0.5%	330ml (can)	0.1	0.04
Beer	5%	330ml (small can)	1	0.4
		500ml (king can)	2	
		330ml (small bottle)	1	
		640ml (large bottle)	3	
Cider	5%	275ml (small bottle)	1	
Red wine/ White wine	12% (11%-15%)	125 ml (small glass)	1 (1-2)	1 (1-2)
		750ml (bottle)	7 (7-9)	
Champagne/ Sparkling	12%	125 ml (small glass)	1	1
		750ml (bottle)	7	
Fortified Wine (Sherry/ Port)	15%-20%	125ml (small glass)	2	2
Spirits (Whisky/Vodka/Gin/ Rum/Tequila/Brandy)	40% (35%-57%)	30ml (pub measure)	1	3 (3-5)
Plum wine	15%	300ml (small bottle)	4	1
Sake	16%	300ml (small bottle)	4	1
Hua Diao	18%	approx. 50ml (1 tael)	1	1
		250ml (water glass)	4	
Glutinous Rice Wine	18%	approx. 50ml (1 tael)	1	1
		250ml (water glass)	4	
Sheung Jin Chiew	30%	approx. 50ml (1 tael)	1	2
		250ml (water glass)	6	
San Cheng Chiew	38%	approx. 50ml (1 tael)	2	3
		250ml (water glass)	8	
Chinese spirits (Baijiu)	52% (38%-67%)	approx. 50ml (1 tael)	2 (2-3)	4 (3-5)
		250ml (water glass)	10 (8-13)	

Remarks:

Number of standard drinks = Drink volume(ml) x $\frac{\text{alcohol content (\% by volume)}}{1000}$ x 0.789

One standard drink is approximately equivalent to 10g of pure alcohol in Hong Kong.

* These values are approximate and for reference only and that may vary depending on brand chosen.

Reduce

Alcohol-related Harm

Reduce

Alcohol-related Harm

Alcohol-related Harm

Reduce

Alcohol-related Harm

Reduce

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