



The Royal Australasian
College of Physicians



The Royal
Australian &
New Zealand
College of
Psychiatrists



The Royal Australasian College of Physicians
and
The Royal Australian and New Zealand College of
Psychiatrists

Alcohol Policy
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RACP

145 Macquarie Street, Sydney NSW 2000, Australia
+61 2 9256 5420 | racp@racp.edu.au

RANZCP

309 La Trobe Street, Melbourne VIC 3000, Australia
+61 3 9640 0646 | ranzcp@ranzcp.org

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The RACP and RANZCP would like to acknowledge and thank those who led this work:

Professor Paul Haber FRACP FChAM (Co-Chair RACP Alcohol Working Party)

Dr Steven Skov FAFPHM (Co-Chair RACP Alcohol Working Party)

Dr Nicolle Ait Khelifa FRANZCP

Dr Shalini Arunogiri FRANZCP

Associate Professor Simon Clarke FCP FRACP

Professor Katherine Conigrave FAFPHM FChAM

Dr Terence Donald PSM FRACP

Professor Elizabeth Elliott AM FRACP

Dr Nadine Ezard FChAM

Dr Bernard Hickey FRANZCP

Professor Dan Lubman FRANZCP

Dr Sam McBride FRANZCP

Associate Professor Kevin McNamara FRANZCP FChAM

Dr Leon Nixon FChAM

Professor Helen Slattery FRANZCP

Mr Jason Soon, RACP Senior Policy Officer

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Preface

The Royal Australasian College of Physicians (RACP) represents physicians across a diverse range of disciplines, including internal medicine, paediatrics, public health medicine, occupational and environmental medicine, rehabilitation medicine, addiction medicine and sexual health medicine.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for training, examining and awarding the qualification of Fellowship of the College (FRANZCP) to medical practitioners in psychiatry.

Together, these specialists manage patients, families and communities affected by alcohol on a daily basis, often in partnership with primary care providers. The RACP and RANZCP hold that the level of alcohol-related harm in Australia and New Zealand is unacceptable and much more could and should be done to reduce alcohol consumption and the harms arising from it. They also recognise that alcohol misuse affects our entire society and can only be addressed by a whole-of-community approach.

The RACP and RANZCP hold that, to comprehensively tackle the harms associated with alcohol in Australia and New Zealand, a national public health approach to reducing alcohol consumption is required. This will necessarily include consideration of the drinking culture in both countries. As well as addressing consumption, the RACP and RANZCP are calling for an increase in the availability and range of treatment services for those with problems associated with alcohol consumption.

This policy document provides a comprehensive overview of the significant and varied harms associated with alcohol, while making recommendations for addressing these harms. It highlights that a comprehensive, multifaceted approach to reducing alcohol-related harm is required, encompassing the following policy areas:

- Putting the right price on alcohol
- Further restricting the physical availability of alcohol
- Penalising breaches of advertising and marketing restrictions on alcohol
- Raising the minimum purchase age for alcohol
- Further reducing the incidence of drink driving
- Improving prevention of Fetal Alcohol Spectrum Disorders
- Providing more effective and accessible alcohol treatment services
- Strengthening data collection and evidence
- Bringing it all together: A comprehensive policy approach to reduce alcohol-related harms.

There is a clear and compelling need to have nationally coordinated and comprehensive alcohol policies, developed in collaboration with key stakeholders without the involvement of the alcohol industry which has strong competing interests. In light of these interests, the RACP and RANZCP call on political parties and governments at all levels to reconsider accepting financial donations from the alcohol industry.

The RACP and RANZCP urge governments in Australia and New Zealand to respond to the findings in this document and demonstrate leadership through developing and committing to long-term, resourced and sustained strategies to reduce the levels of alcohol-related harms in both countries.

1. Introduction

Alcohol is an undeniable part of the social fabric of Australian and New Zealand societies. Most adults consume some level of alcohol, and its sale contributes significantly to the Australian and New Zealand economies.

However, the many harms of alcohol and their costs to individuals and society are both undisputed and substantial, with alcohol consumption being a causal factor in more than 200 disease and injury conditions.¹ There is a clear link between the amount of alcohol consumed, either in the short or long term, and the level of harm that results both for individuals and societies.² The spectrum of harm is also related to the pattern of alcohol consumption. For example, single episodes of acute intoxication can lead to interpersonal violence and injuries and result in emotional trauma; chronic medium to high level consumption is associated with liver and cardiovascular disease, mental health disorders and domestic violence; and lower level consumption over long periods has been causally linked with a range of cancers.³ The evidence that modest alcohol consumption can lead to some health benefits is contested.⁴

In Australia, the two major guidelines of importance for the management of alcohol consumption and its associated problems are the National Health and Medical Research Council (NHMRC)'s *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* and the Australian Department of Health's *Guidelines for the Treatment of Alcohol Problems*. The former is targeted at the general population and contains the evidence base for alcohol policies and guidelines on what constitutes 'risky' levels of alcohol consumption. The latter provides evidence-based information to clinicians on the available treatments for people with alcohol problems. However, neither of these documents has been revised since 2009.

The Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists contend that the level of alcohol-related harm in Australia and New Zealand is unacceptable and that more should be done to reduce risky alcohol consumption and the harms that arise from it.

As this document will demonstrate, there is a wealth of evidence supporting the proposition that various well-targeted changes to existing policy settings can make a big difference in reducing the current level of alcohol-related harms. Yet there has been little movement by governments to make these changes and address one of the biggest public health challenges of our time. This lack of action must change and a whole-of-government approach must be taken, ensuring broad consultation across the health and social sectors and a firm commitment to funding and timely implementation, and excluding any involvement of the alcohol industry which clearly has competing interests.

1.1 Consumption patterns

Australia's apparent per capita consumption of alcohol in 2013–14 was 9.7 litres of pure alcohol per person over the age of 15 years.⁵ In New Zealand, for the same period, the figure was 9.1 litres per person aged 15 years and over.⁶

In the most recent (2013) Australian National Drug Strategy Household Survey, 21.8 per cent of Australians aged 14 years and older reported no alcohol consumption over the past 12 months. This is a statistically significant increase from 20.5 per cent in 2010 when fewer than 1 in 5 (18.2 per cent)

reported drinking at average daily levels that place them at risk of long-term harms based on National Health and Medical Research Council guidelines of more than 2 standard drinks. However, the same survey showed that 38 per cent of people over 14 years reported that on at least one occasion in the previous 12 months they had consumed alcohol at a level placing them at risk of injury and 26 per cent had done so as often as monthly. So, despite some positive developments in the drinking behaviour of younger Australians, there remains a clear need to bring down the numbers of lifetime risky drinkers and single occasion risky drinkers.

In New Zealand, the term 'hazardous drinking' is used. The 2012–13 New Zealand Health Survey showed a reduction in consumption of alcohol, as well as in drinking-related injuries, in people aged 15 years and over, when compared with the 2007–08 results.⁷ However, indicators of hazardous drinking by adults remain, with 15 per cent of adults reporting drinking at a level that was hazardous to their health, and half reporting having drunk to intoxication at least once in the preceding 12 months.⁸

The incidence of risky drinking among young people and vulnerable individuals (including those with mental illness), as well as in disadvantaged communities, deserves particular attention, as risky drinking may have disproportionate incidence and/or impacts on these groups.

For example, the most recent National Drug Strategy Household Survey found that the level of risky drinking among 18 to 24 year olds in Australia was 21.3 per cent in 2013,⁹ that is, more than 1 in 5 of that age group, while in New Zealand in 2013 the equivalent rate for people aged 15 to 24 was approximately 1 in 4.¹⁰ This is of particular concern given that there is emerging evidence that heavy drinking during adolescence is associated with poorer cognitive functioning and possible brain response abnormalities while performing challenging cognitive tasks.¹¹

In addition, although Aboriginal and Torres Strait Islander populations have a 28 per cent rate of alcohol abstinence, compared with 22 per cent abstinence in non-Indigenous people,¹² those who do drink are more likely to consume alcohol at risky levels, with episodic heavy drinking a common pattern.¹³

While there may be different strategies to reduce or address alcohol-related harms among different groups, there are many common principles. This policy integrates comments and recommendations into each chapter, which may apply differentially to particular population groups.

1.2 Health burdens of alcohol harms

Alcohol is the world's third largest risk factor for disease burden after childhood underweight and unsafe sex, accounting for 4.5 per cent of global Disability Adjusted Life Years (DALYs).¹⁴ Alcohol use is also the eighth largest risk factor for deaths, accounting for 3.8 per cent of global deaths.¹⁵ In high-income countries, it is the second largest risk factor after tobacco, accounting for 6.7 per cent of DALYs.¹⁶

In New Zealand, alcohol consumption is identified as one of the most significant risk factors for avoidable mortality and disease in early and middle adulthood, and contributes substantially to loss of good health across the life course. For example, it has been estimated that 5.4 per cent of deaths under 80 years of age were attributable to alcohol (802 deaths), with alcohol-related injuries

accounting for 43 per cent of these deaths, alcohol-attributable cancer for 30 per cent and other alcohol-attributable chronic disease for 27 per cent of these deaths.¹⁷

Alcohol was the sixth leading risk factor for health loss in New Zealand in 2006, after tobacco use, high body mass index, high blood pressure, high blood glucose and physical inactivity.¹⁸

In Australia, alcohol use is the sixth highest risk factor at an estimated 3.3 per cent of the total burden of disease.¹⁹ This estimate is based on 2003 data, as the more recent 2010 study does not provide an estimate of the percentage of total burden of disease attributable to alcohol. In New Zealand, alcohol use accounts for 5.6 per cent of the total burden of disease, or 3.9 per cent after taking account of its purported health benefits, making it the sixth highest risk factor.²⁰

These statistics may not, however, fully reflect the extent to which alcohol contributes to health burdens around the world. They may in fact be substantially underestimated as they only take into consideration the harm to the drinker and not harms to others, which can make up a sizeable proportion of the impact experienced in the community.²¹ These harms to others are discussed in more detail in Chapter 2.

Fetal Alcohol Spectrum Disorders (FASD), including Fetal Alcohol Syndrome (FAS), represent a group of preventable disorders caused by the consumption of alcohol during pregnancy. These disorders are characterised by a broad range of lifelong physical, neurodevelopmental and behavioural problems. Despite the paucity of accurate data on the prevalence of FASD in Australia and New Zealand, these conditions are considered a significant public health problem as discussed in more detail in Chapter 8.

The health impacts of alcohol are greater among younger people and other at-risk population groups. One in eight deaths of 25 year olds in Australia is due to alcohol consumption.²² In 2003, the burden of ill health due to alcohol dependence and harmful use in the Aboriginal and Torres Strait Islander population was 4.5 times greater than that experienced by non-Indigenous Australians.²³ In New Zealand, after adjusting for differences in age structure, the net burden of alcohol on the total burden of disease is almost three times greater for Māori²⁴ and accounts for 11 per cent of the total inequality in health between Māori and non-Māori.²⁵

In 2010, the most recent year for which statistics were available in Australia, there were 5,554 alcohol-attributable deaths, and 157,132 alcohol-attributable hospitalisations.²⁶ While there has generally been a decline in most Australian states and territories in the alcohol-attributable death rate since 1996, the hospitalisation rate as a result of alcohol has increased in all Australian jurisdictions.²⁷ A recent study has found that 1 in 7 emergency department (ED) presentations in Australia and New Zealand at 2 am local time were alcohol related, with some EDs reporting that more than 1 in 3 presentations were related to alcohol.²⁸

Beyond hospitalisation, treatment of alcohol abuse and dependence is conducted in specialised agencies. In Australia in 2013, alcohol was a drug of concern in 91,091 (59 per cent) of all treatment episodes in government-funded alcohol and other drug treatment agencies and was the most common principal drug of concern in 63,755 (41 per cent) of all episodes.²⁹

Table 1 shows that suicide is the third highest cause of alcohol-attributable deaths in males and the fifth highest cause of alcohol-attributable hospitalisations in females. This underscores the well-

documented relationship between alcohol abuse and mental health issues, with alcohol use increasing the risk of many mental health and social problems.³⁰ Alcohol can promote the development of mental health conditions including depression and/or anxiety,³¹ and people with pre-existing mental health conditions are also more likely to use alcohol.³² The combination of alcohol misuse and depression presents a tragically high-risk profile for suicidal behaviour and completed suicide.³³

Table 1: Top 5 causes of alcohol-attributable deaths and hospitalisations (per cent), males and females

| | Deaths | per cent | Hospitalisations | per cent |
|---|------------------------------|----------|----------------------------|----------|
| | Males | | Males | |
| 1 | Alcoholic liver cirrhosis | 25 | Alcohol dependence | 17 |
| 2 | Non-pedestrian road injury | 12 | Falls | 16 |
| 3 | Suicide | 7 | Assault | 10 |
| 4 | Haemorrhagic stroke | 6 | Alcohol abuse | 10 |
| 5 | Colon cancer | 6 | Non-pedestrian road injury | 8 |
| | Females | | Females | |
| 1 | Alcoholic liver cirrhosis | 22 | Alcohol dependence | 24 |
| 2 | Haemorrhagic stroke | 9 | Falls | 20 |
| 3 | Breast cancer | 7 | Alcohol abuse | 10 |
| 4 | Colon cancer | 7 | Assault | 7 |
| 5 | Non-pedestrian road injuries | 5 | Suicide | 6 |

Source: National Drug Research Institute 2009. Trends in estimated alcohol-attributable deaths and hospitalisations in Australia, 1996–2005.

The relationship between alcohol misuse, interpersonal violence and risk-taking behaviour is also well established. Australian research commissioned by the Foundation for Alcohol Research and Education (FARE) found that alcohol is implicated in a high percentage of physical assaults, with estimates varying between 40 per cent based on police data³⁴ and 70 per cent based on survey data.³⁵

Drink driving is estimated to be responsible for about 30 per cent of deaths in car crashes in Australia.³⁶ In 2008, an estimated 28 per cent of drivers and motorcyclists killed in Victoria had a blood alcohol content (BAC) level over the legal limit³⁷ and in the Northern Territory (2004 data) the number was 55 per cent.³⁸

1.3 Social costs

Alcohol is a substantial contributor to the economies of both Australia and New Zealand. In Australia, the value of liquor retailing turnover in the 2014-15 calendar year was approximately A\$10.4 billion.³⁹ In New Zealand, it is estimated that retail alcohol sales are worth NZ\$4–5 billion a year.⁴⁰

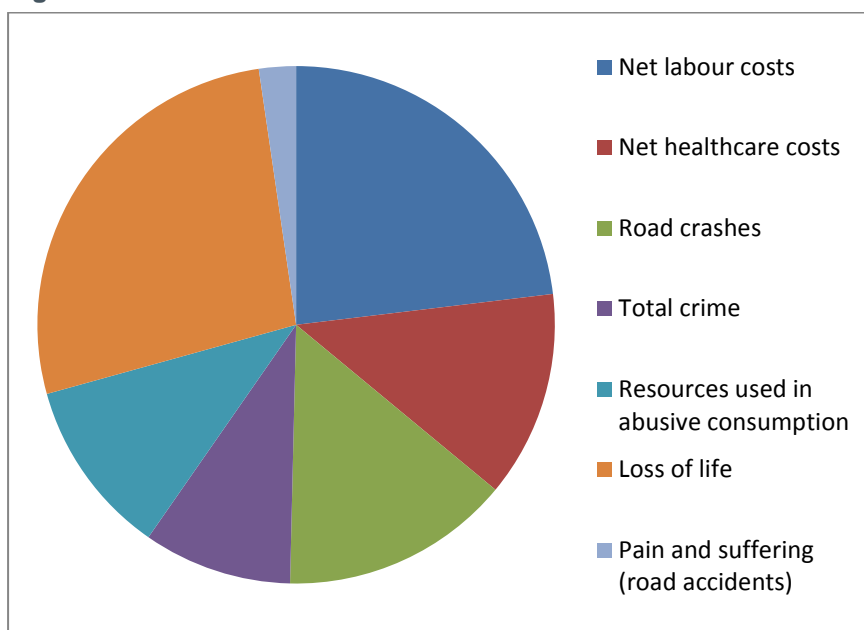
The social costs of harmful consumption of alcohol are also substantial. As discussed above and throughout this report, alcohol-related disease and injury are prevalent and result in direct medical costs as well as intangible costs of pain and suffering. Alcohol misuse leads to loss in the community in a range of forms, from reduced workforce productivity to the costs of road crashes and law enforcement. Alcohol intoxication is also a well-recognised and significant cause of violence, including domestic violence.

Studies estimate the social costs of alcohol misuse in Australia at between \$15 billion⁴¹ and \$36 billion.⁴² The higher estimates include the harm to those other than just the drinker. This cost significantly exceeds the almost \$6 billion in taxation revenue collected from the alcohol excise and the Wine Equalisation Tax (WET) in 2013–14 (net of WET rebates).⁴³ The need for more appropriate taxation of alcohol is considered in detail in Chapter 3 of this report.

Figure 1 shows the relative contribution of the social costs of alcohol misuse in Australia. They include:

- Lost productivity arising from sickness and premature death, and reductions in the workforce and absenteeism caused by alcohol
- Healthcare costs from medical, nursing, hospital, pharmaceutical and ambulance services
- Costs of crime associated with police, criminal courts and prisons, property damage, and insurance administration
- ‘Intangible’ costs which reflect an economic valuation of the pain and suffering and loss of life.

Figure 1: Estimated social costs of alcohol abuse in Australia



Source: Collins D, Lapsley H 2008. The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol.

The annual social costs of alcohol misuse in New Zealand were estimated in 2013 at approximately NZ\$4.76 billion.⁴⁴ This included premature death (34.2 per cent), net labour costs (33.3 per cent) and costs associated with crime (12.7 per cent).

1.4 Conclusions

To address the misuse of alcohol and the resulting harm in Australia and New Zealand, strong and unified political leadership is required. Mortality and morbidity statistics demonstrate that the ‘drinking culture’ in both countries is pervasive and damaging, and results in serious impacts on vulnerable populations and the broader community. This policy will examine the significant and varying harms of

alcohol misuse. It will discuss the wealth of evidence showing that various well-targeted changes to existing policy settings can make a big difference in reducing the current level of alcohol-related harms.

The RACP and the RANZCP call on governments to work in partnership with communities, health professionals and consumer groups to address these harms, ensure timely and equitable access to appropriate treatment, and develop and implement comprehensive and effective strategies both at a national and local level.

The obvious conflict of interest must preclude the alcohol industry having any place at the table in policy development. For similar reasons, political parties and governments should reconsider accepting financial contributions from the alcohol industry.

2. Harm to others from alcohol consumption

Alcohol consumption results in harm not only to drinkers, but also to others in the community. This includes people with a relationship with those drinking (such as their children, partners or other family members), as well as bystanders, co-tenants or people sharing public facilities with drinkers. The full span of harms to others ranges from inconveniences (e.g. having to work extra hours to cover for a colleague) to more serious harms (e.g. domestic violence, child maltreatment and suffering, fatal injuries due to road crashes caused by drunk drivers).

Of all drugs (legal and illegal), alcohol has been estimated as the most harmful to others – with more than half of the harms of alcohol borne by non-drinkers.⁴⁵

2.1 Costs associated with the drinking of others

A recent study in New Zealand has estimated that on average the magnitude of harm to others from alcohol consumption outweighs harm to the drinker.⁴⁶ Laslett et al have also examined this issue in Australia,⁴⁷ and the discussion that follows draws on the literature review they undertook and summarises their findings.

Studies measuring and quantifying the harms caused by the drinking of others typically include the following categories:⁴⁸

- Hospitalisation or health service costs
 - Specific resources expended on hospitalisation and other health services needed because of the harm caused by drinkers.
- Cost of time lost and lost output
 - Mortality or morbidity caused by drinkers' behaviour can give rise to time lost or spent, and lost output (e.g. due to individuals being incapacitated in hospital and therefore absent from the workplace).
- Out-of-pocket costs
 - Including damage to property (e.g. damaged cars in road crashes due to drunk driving) and other financial costs directly caused by the behaviour of drinkers.
- Intangible costs
 - The fear, pain, suffering or impact on quality of life due to alcohol. These costs are estimated based on survey respondents' self-reported reduction in quality of life, translated into Quality Adjusted Life Years (QALYs) lost.
- Child protection costs
 - The recurrent expenditure on child protection, out-of-home care services and intensive family support services needed due to child abuse, maltreatment and neglect by drinkers.

2.2 ‘Headline’ problems resulting from the drinking of others

Drinking can lead to various serious harms to others. Notable harms include those listed below (this list is not exhaustive):

- **Road crashes** – Alcohol consumption has a direct effect on the number of road crash incidents. It increases the response time of drinkers as well as the incidence of errors of judgement. Data collected in 2005 estimates that, in Australia, the drinking of others leads to 286 deaths and 4,184 hospitalisations a year due to road crashes,⁴⁹ while 14 per cent of road crash deaths involving children can be linked to drinking.⁵⁰ The total annual hospitalisation costs from road crashes due to the drinking of others was estimated to be \$33 million, with more than 10 per cent of this figure incurred by pedestrians.⁵¹
- **Violence in the community** – Alcohol is a disinhibitor and can facilitate aggressive behaviour, including violence.⁵² In Australia, between 3.3 per cent⁵³ and 4 per cent⁵⁴ of the community report being physically abused by someone affected by alcohol, while 24 per cent of people report being verbally abused, and 12 per cent report being ‘put in fear’ by someone affected by alcohol.⁵⁵ Between 40 per cent (according to police data) and 70 per cent (according to survey data) of physical assaults in Australia are alcohol related.⁵⁶ Based on 2005 data, the total annual costs of police-recorded assaults attributable to alcohol in Australia is more than \$117 million, excluding intangible costs and out-of-pocket costs.⁵⁷ Hospitalisation costs account for almost half this figure, whilst lost output and time account for the rest. New Zealand statistics from 2008 show that one-third of violent offenders had consumed alcohol before committing the offence.⁵⁸
- **Domestic violence** – Alcohol has been found to be a significant factor in 50 per cent of cases of domestic physical and sexual violence in Australia.⁵⁹ The annual costs of alcohol-attributable domestic violence are estimated to be more than \$46.4 million.⁶⁰ Of this figure, 50 per cent comprises hospitalisation costs, 49 per cent is due to costs of lost time and output, and the remaining 1 per cent is due to out-of-pocket costs.
- **Child abuse, maltreatment and neglect** – Most recent national research in Australia estimates that between 15 and 47 per cent of child protection cases involve alcohol.⁶¹ Annual child protection costs associated with alcohol-attributable child abuse, maltreatment and neglect equate to more than \$671 million.⁶²
- **Workplace-related costs** – Drinking has been shown to lead to a lack of productivity and increase in absenteeism, leading to knock-on additional work for colleagues and also an increase in workplace accidents. The annual lost output and time from these impacts in Australia has been estimated at \$801 million, with 43 per cent of this due to absenteeism created by others’ drinking.⁶³

2.3 Total costs of alcohol-related harms

Taking into account the overlap between some of the categories of costs discussed here, it is estimated that, in Australia, harm from the drinking of others results in a total of \$14.2 billion in tangible costs (relating to healthcare, child protection and out-of-pocket costs) and at least \$6.4 billion in intangible costs each year.⁶⁴ This includes the major ‘headline’ costs discussed in the previous

section as well as miscellaneous out-of-pocket, productivity and 'intangible' costs (which attempt to capture the impact of alcohol-related disturbances on individuals' quality of life).

Table 2 below provides a summary of both the costs of harm to others and the costs of harm to the drinkers themselves. It attempts to remove possible areas of double counting within the study by Laslett et al,⁶⁵ and any overlap between Laslett et al and Collins and Lapsley.⁶⁶ The resulting cost estimates total almost \$36 billion (in 2010 dollars), of which approximately \$18.7 billion is from harm to others.

Table 2: Estimated total social costs of alcohol in Australia (2010 \$)

| Social cost item | Tangible \$ m | Intangible \$ m | Total \$ m |
|---|---------------|-----------------|---------------|
| <i>Collins and Lapsley</i> | | | |
| Labour (i.e. lost productivity) costs | 3,975 | | 3,975 |
| Healthcare costs | 2,221 | | 2,221 |
| Road accident costs | 2,474 | 397 | 2,871 |
| Crimes not elsewhere included | 1,600 | | 1,600 |
| Resources used in abusive consumption ⁶⁷ | 1,897 | | 1,897 |
| Loss of life | | 4,646 | 4,646 |
| <i>Collins and Lapsley sub-total</i> | 12,167 | 5,043 | 17,210 |
| <i>Laslett et al</i> | | | |
| Child protection system | 672 | | 672 |
| Effects on household/family member or friend with most effect | 9,424 | 7,364 | 16,788 |
| Property damage by stranger's drinking | 1,133 | | 1,133 |
| Counselling advice, treatment expenses | 110 | | 110 |
| <i>Laslett et al sub-total</i> | 11,339 | 7,364 | 18,703 |
| Total | 23,506 | 12,407 | 35,913 |

Source: Doran C, Jainullabudeen T, Room R, Chikritzhs T, Laslett A, Livingston M, Ferris J, Hall W (unpublished). How much does alcohol really cost Australian drinkers and others affected by drinking? Extracted from Marsden Jacob Associates. Bingeing, collateral damage and the benefits and costs of taxing alcohol rationally. Report to the Foundation for Alcohol Research and Education; October 2012.

2.4 Harms over time

A 2011 update of the Laslett et al study, in which 1,106 respondents were surveyed a second time, found that personal experience of harm (or lack of harm) did not change for 70 per cent of respondents between 2008 and 2011. Past experience of harm was found to be a strong predictor of continued harm, with 65 per cent of respondents experiencing harm in 2008 reporting this again in 2011.

For each additional heavy drinker within a household, the risk of experiencing persistent harm increases almost six-fold.⁶⁸

2.5 Conclusions

The magnitude of harm to others caused by alcohol is insufficiently recognised in Australia and New Zealand. It is paramount that work on policies to reduce alcohol-related harm fully takes into account the harms to non-drinkers, given the estimates that these account for at least half the total harms.

3. Putting the right price on alcohol

Australia's current alcohol taxation system is illogical and complex. It has changed over time, with the changes seeming to reflect alcohol industry considerations rather than any response to the extent of alcohol-related harms.

The system sets up a range of perverse price signals and results:

- Beer tax is based on volume of alcohol; but while there are three broad categories of alcohol content (low, medium or full strength), there are eight different tax rates.
- All spirits are taxed at a single rate according to their volume of alcohol content, with the exception of brandy which has a concessional tax rate.
- Wine is taxed through the Wine Equalisation Tax (WET), which is based on wholesale price rather than volume of alcohol. This favours the consumption and production of cheaper wine. An annual rebate of up to a maximum of \$500,000 each financial year is also available via the WET, resulting in smaller wine producers paying very little tax or none at all.

The WET is the most distorted feature of the alcohol taxation system. Introduced alongside the Goods and Services Tax (GST), the WET applies to grape wine, grape wine products, cider and mead, and other alcoholic drinks made from fruit and vegetables with greater than 1.15 per cent alcohol by volume.

In New Zealand, products with an alcohol content below 14 per cent are taxed at a rate per litre of alcohol (i.e. on a volumetric basis), while products above 14 per cent are taxed at a higher rate per litre.

More appropriate alcohol pricing has the greatest potential to reduce consumption and alcohol-related harms. The direct relationship between alcohol price and its consumption and associated harms has been demonstrated over many decades and in different settings.⁶⁹ Low alcohol prices lead to higher consumption, including heavier drinking per occasion and more underage drinking.⁷⁰ Younger people and heavy drinkers are particularly sensitive to alcohol pricing,⁷¹ with changes to alcohol pricing yielding significant changes in total alcohol consumption in these groups.

The magnitude of the effect of pricing changes on alcohol consumption varies for different countries and different beverages. Beer consumption is usually less responsive to price changes than wine or spirits. The direction of the effect, however, is highly consistent across many studies, suggesting an elasticity of -0.44 .⁷² This equates to a 4.4 per cent reduction in alcohol consumption per 10 per cent increase in price.

A change to a standardised volumetric alcohol taxation policy would lead therefore to significant reduction in alcohol-related harms insofar as it increases the effective price of alcohol. This has been demonstrated in a number of cases.

- The 2009 increase in alcohol taxes in Illinois in the US was associated with a 26 per cent reduction in fatal alcohol-related motor vehicle crashes, with drivers younger than 30 showing larger declines.⁷³

- The reduction in alcohol tax in Finland in 2004 by approximately one-third, as well as the abolition of duty-free allowances for travellers from the European Union, led to a significant reduction in alcohol prices. During this period, the chronic (total) hospitalisation rate for Finnish men increased by 22 per cent among those aged 50–69 years, 11 per cent for 40–49 year olds and 16 per cent for 15–39 year olds.⁷⁴
- The ‘alcopops tax’ introduced in Australia in 2008, which increased the taxation rate on ready-to-drink spirit beverages (RTDs) by 70 per cent, led to a 30 per cent reduction in RTD consumption. Despite some evidence of drinkers switching to other alcoholic products, total sales of alcohol one year after its introduction fell by 1.5 per cent net.⁷⁵ Research also shows that the introduction of the tax was associated with a statistically significant decrease in ED presentations in NSW, particularly of younger people and more so for 18–24 year-old females.⁷⁶
- An Estonian study found a statistically significant negative relationship between the real average alcohol excise tax rate and alcohol-related traffic accidents.⁷⁷
- The *Living With Alcohol* program, implemented in the Northern Territory in 1992, introduced a levy of five cents per standard drink on all alcoholic drinks of greater than 3 per cent strength, with an extra levy of 35 cents per litre on cask wine. Though the effects of this levy were not disaggregated from the effects of other measures in the program, an evaluation to the end of 1996 found that it led to reductions in:
 - apparent per capita alcohol consumption of 22 per cent
 - alcohol-related road deaths (34.5 per cent) and hospitalisations (23.4 per cent)
 - deaths (19 per cent) and hospitalisations (2 per cent) from acute alcohol-related conditions other than road crashes (e.g. other injuries, alcohol withdrawal) and hospitalisations (66 per cent) for chronic alcohol-related conditions (e.g. dependence, cirrhosis, various cancers).⁷⁸

Given the evidence surrounding the impact of price on consumption and harm, addressing the distortion in the Australian alcohol taxation system should be a priority area for reform.

In New Zealand, alcohol is already taxed on a volumetric basis under the two-tier alcohol excise system and debate about how this system can be improved revolves more around the levels at which the tax should be set.

3.1 The aggregate health and fiscal benefits of alcohol tax reform

The evidence shows that the costs associated with alcohol-related harm outweighs the revenue generated by the tax on alcohol.

The taxation revenue generated from sales of alcohol in Australia is approximately \$6 billion a year (net of rebates provided to wine producers),⁷⁹ while the social costs from alcohol-related harm is estimated at \$15 to \$36 billion. In effect, the community is subsidising alcohol drinkers.

As a first step to reforming Australia's system of alcohol taxation, as recommended by nine separate government reviews,⁸⁰ the WET should be replaced with a volumetric tax on wine and the WET rebate abolished.

A recent study has estimated that subjecting wine to a volumetric excise rate equal to the current rate for low-strength beer sold off site would generate an additional \$1.3 billion in revenue, whilst also leading to net savings of \$820 million in lifetime healthcare costs for the population.⁸¹ This and the other evidence summarised here strongly suggests that moving to a fully volumetric-based alcohol tax system would generate additional revenue and reduce alcohol consumption, resulting in health benefits and cost savings from reduced healthcare and other expenditure.⁸² Ideally, this tax system should also incorporate differentiated rates contingent on the evidence of harm associated with particular beverage types.

Funds from increased alcohol tax revenues should be invested in alcohol treatment services and harm prevention programs. This approach is supported by the World Health Organization (WHO) which argues that hypothecation generates increased support for alcohol taxation measures, and increased accountability and transparency of the services being funded.⁸³

3.2 Minimum pricing policy

A further measure for addressing alcohol price is through government legislation which imposes a minimum retail price for a standard drink of alcohol. By reducing the availability of cheap alcoholic drinks and setting a 'floor price' on their affordability, minimum pricing policies can have significant impacts on alcohol consumption, particularly that of hazardous drinkers who tend to buy the cheapest alcohol.⁸⁴

Minimum prices also restrict the liquor industry from pricing promotions such as the 'buy-one-get-one-free' offers. While there is relatively little experience globally of minimum pricing policies and their impact, one example from British Columbia, Canada, showed a 10 per cent increase in average minimum price for all alcoholic beverages was associated with reduced consumption of all alcoholic drinks by 3.4 per cent⁸⁵ and a reduction in wholly alcohol-attributable deaths of almost a third.⁸⁶

Despite suggestions that this policy would impose hardships on low-income drinkers, a 2014 Lancet study found that its greatest impact would be on 'high risk' low-income drinkers who are in need of intervention.⁸⁷ Modelling of this policy option suggests it would have little effect on low-income moderate drinkers.⁸⁸

Recommendations

- 1. That national, comprehensive alcohol pricing policies be introduced in Australia and New Zealand comprising:**
 - a. An underlying volumetric-based tax system for all alcoholic drinks**
 - b. The ability to apply higher tax rates on alcoholic drinks with higher health risks**
 - c. A minimum price per standard drink, implemented nationally in New Zealand and at the state/territory level in Australia.**
- 2. That a proportion of revenue raised be used to fund improved access to alcohol treatment and harm prevention programs.**

4. Further restricting the physical availability of alcohol

There is strong evidence that policies restricting the physical availability of alcohol for sale can lead to significantly reduced levels of alcohol consumption and associated harms. These restrictions fall into two categories:

- Restrictions on the trading hours of both on-licence and off-licence outlets.
- Restrictions on the density of licensed alcohol-serving outlets.

Restrictions can be achieved via changes to liquor licensing laws. In Australia, this is a state and territory issue, and would require changes in each jurisdiction. This presents opportunities to compare the effects of the different state and territory licensing laws.

In New Zealand, the framework for Local Alcohol Policies (LAPs) allows for controls on location and density of alcohol outlets, empowered by the *Sale and Supply of Alcohol Act 2012*. Most LAPs notified to date have been subject to legal challenge by the alcohol and hospitality industries and have yet to be implemented, and thus the full potential of this framework is yet to be seen.

4.1 Restrictions on trading hours

Australian and international studies indicate that increased trading hours for licensed outlets are accompanied by substantially higher levels of alcohol consumption and associated harms such as drink-driver road crashes,⁸⁹ serious violent offences committed in the early hours of the morning,⁹⁰ and assaults per 100,000 inhabitants.⁹¹ Further studies provide indirect evidence of this relationship, showing that over 40 per cent of assaults at licensed premises occur after midnight.⁹² Regular heavy drinkers are especially likely to take advantage of longer trading hours.⁹³

A Norwegian study has found that every additional hour of trading in on-licence premises is associated with a 16 per cent increase in assaults.⁹⁴ The relationship also holds for off-licence outlets. For example, a study in New Zealand found that people purchasing alcohol in off-licences at later hours are more likely to drink in a hazardous fashion, both in quantity and frequency.⁹⁵

Reductions in outlet trading hours can have a significantly beneficial impact on reducing alcohol-related violence. Since 2008, pubs in Newcastle, NSW, have been required to close at 3.30 am. Three years after the introduction of these restrictions, non-domestic assaults requiring police attention had fallen by 35 per cent and street offences had fallen by 50 per cent.⁹⁶ The Newcastle trial has also led to reductions in the number of ambulance call-outs and emergency department presentations.⁹⁷ A more recent study of Newcastle five years after the trading-hour reductions were imposed found that a one-third reduction in recorded assaults had been sustained.⁹⁸ Research also suggests that larger modifications of trading hours can have disproportionately greater impacts than smaller changes.⁹⁹

Restrictions can also be implemented through the imposition of 'lockouts', which were also introduced in Newcastle. The implementation of lockouts means that new entrants to a licensed premises are not allowed after a certain time, but those already on the premises are allowed to continue drinking for some time, usually hours more. They have been a component of the NSW liquor reforms; however, there is no evidence of their effectiveness in reducing alcohol-related harms when their impacts are

considered separately from those of earlier closing times. Recent research into the effects of lockouts imposed in Ballarat, Victoria, found that they had no discernible long-term impact on alcohol-related emergency department attendances.¹⁰⁰

Research into earlier closing and lockout times for licensed establishments in the Kings Cross and Sydney CBD Entertainment precincts in Sydney found that, following the imposition of 3 am closing times on pubs in these precincts and a ban on takeaway alcohol sales after 10 pm across NSW, there had been substantial reductions in assaults in both Kings Cross (down 32 per cent) and Sydney CBD Entertainment precincts (down 40 per cent). A smaller but still significant reduction in assaults also occurred across the rest of NSW (9 per cent decrease).¹⁰¹

4.2 Restrictions on outlet density

Outlet density can be measured by examining the issuing of liquor licences. Between 1996 and 2010, the number of liquor licences issued in Victoria grew by 120 per cent.¹⁰² In South Australia, between 1996 and 2009, the number of licences grew by 60 per cent. These figures suggest there has been an increase in the density of licensed outlets in Australia.

A recent review of available studies concluded that ‘regulation of alcohol outlet density may be a useful public health tool for the reduction of excessive alcohol consumption and related harms’.¹⁰³ While there are limited studies directly assessing the effectiveness of controls on alcohol outlet density as a means of reducing excessive consumption and related harms, indirect evidence can be gleaned from studies examining the relationship between controls on alcohol outlet density and consumption.

Studies in Australia¹⁰⁴ and New Zealand¹⁰⁵ have found that outlet density is significantly related to high-risk drinking among the young, including illegal underage purchasing of alcohol¹⁰⁶ and secondary supply of alcohol to adolescents.¹⁰⁷ An Australian study found that people living closest to licensed premises reported the highest levels of drunkenness and property damage in their neighbourhoods. This relationship held even after adjusting for possible confounding factors.¹⁰⁸ A Western Australian study also found a relationship between outlet density and levels of assault and drink-driving offences.¹⁰⁹ This was strongest for off-licences such as bottle shops, and was more context dependent for on-premises licences.¹¹⁰ This is especially relevant as 78 per cent of all alcohol in Australia is bought as packaged liquor for off-premises consumption.¹¹¹ Outlet density also contributes to the level of alcohol-related harm by increasing competition between outlets, including the discounting of alcohol products,¹¹² with prices lower in areas with a higher density of liquor outlets.¹¹³ A Victorian study has estimated that a 10 per cent increase in general licence rates in one area increases assault rates by 0.6 per cent, while a 10 per cent increase in off-licence rates increases assault rates by 0.8 per cent.¹¹⁴

New Zealand research suggests that increases in outlet density can lead to increased rates of binge drinking even if there are no significant changes in average alcohol consumption.¹¹⁵

Two main approaches have been adopted internationally for regulating outlet density. In the UK, local authorities can designate ‘saturation zones’ within licensing policies, within which no new licensed premises are permitted.¹¹⁶ Alternatively, cluster controls can be established, which prohibit the granting of new liquor licences within a given distance of licensed premises of the same category. This approach has been adopted in the UK, Paris and New York.¹¹⁷

4.3 Community-based alcohol restriction plans

Various initiatives have been trialled to restrict the availability of alcohol at the local community level. For these measures to be successful they require strong community support and restrictions that cannot be easily bypassed. While some have been successful, others have led to residents sourcing their alcohol from neighbouring areas.

Alcohol Management Plans (AMPs), under which all or part of a community is declared a 'restricted area' or 'dry place' with alcohol banned, were adopted in Queensland in 2002. Twelve months after an AMP was applied in one Cape York community, the proportion of alcohol-related offences and number of assaults in the area covered by the plan remained unchanged, while property offences increased.¹¹⁸ While there was a reduction in the number of assaults and injury presentations to the Community Health Clinic, this downward trend had commenced six months prior to the introduction of the AMP. It was concluded that the continuation of 'sly-grogging' (that is, the illicit sale of alcohol) and the practice of storing and drinking alcohol outside the restricted area may have undermined the restrictions.

A more successful community-based alcohol restriction plan was put in place in October 2007 in Fitzroy Crossing in Western Australia. This prohibited the sale of packaged liquor exceeding a concentration of ethanol of 2.7 per cent. An evaluation of the restriction two years after it was introduced found some benefits, including reduced severity of domestic violence, a reduction in the severity of wounding from general public violence, reduced street drinking, and a reduction in the amount of alcohol being consumed by Fitzroy and Fitzroy Valley residents.¹¹⁹

A 12-month trial restricting alcohol sales in Mount Isa, Queensland, commenced in August 2002.¹²⁰ It was found that the total volume of alcohol purchased was 8.8 per cent lower after the restrictions were introduced. This was partially offset by increases in alcohol purchases in the nearby town of Cloncurry, with an overall decline in the two regions of only 0.9 per cent.

Effective supply reduction initiatives at the local level have typically been characterised by high community support and implementation in more isolated geographical locations where supply restrictions are easier to enforce.¹²¹ The results suggest that community-based initiatives may be less effective if they are not supported by legislative change to outlet density, pricing and marketing at higher levels of government.¹²²

As well as alcohol restrictions, AMPs can include other policy tools such as treatment programs. AMPs are discussed further in Chapter 11 as part of a comprehensive approach to alcohol policy.

4.4 Conclusions

Restricting the density of licensed alcohol-serving outlets and the trading hours of on- and off-licence liquor sales premises can lead to significantly reduced levels of alcohol consumption and associated harms. This is especially the case where restrictions in trading hours are significant. These interventions are essential to any overall package of liquor licensing reforms to address alcohol-related harm.

The evidence for community-based alcohol restriction plans is mixed. While they can lead to some reductions in consumption and alcohol-related harm, at least in the short term, their effectiveness is reduced if they can be easily circumvented.

Recommendations

- 1. That the Government of New Zealand and Australian state and territory governments should further restrict trading hours for licensed establishments and off-licence liquor sales premises.**
- 2. That local governments in Australia and New Zealand should be empowered to develop local supply reduction measures, such as challenging inappropriate liquor licences or implementing caps on the number of licensed premises allowed in a local community.**

5. Penalising breaches of advertising and marketing restrictions on alcohol

Advertising and marketing of alcohol is highly pervasive in Australia and New Zealand. As well as traditional media of television, print, radio and outdoor billboards, alcohol companies also utilise marketing techniques such as sponsorships and digital and social media strategies. Television remains the most common source of exposure to alcohol advertising for Australians, accounting for 59 per cent, sporting events are second at 45 per cent, and newspapers and magazines are third at 42 per cent.¹²³

In 2007, the estimated total annual alcohol advertising expenditure in Australia was \$128 million.¹²⁴ The true figure is likely to be significantly higher as this figure does not include expenditure on sponsorship, social media and point-of-sale promotions. Expenditure on alcohol sponsorship alone has been estimated at \$300 million per year.¹²⁵

Alcohol advertising expenditure on traditional media in Australia remains significant:

- **Television:** Alcohol advertising ranks in the top 10 by expenditure on free-to-air television, with a total of \$15.8 million spent on metropolitan television alcohol advertising over just two months in 2012.¹²⁶
- **Sponsorship:** Alcohol companies contribute \$50 million a year in sponsorship for major sporting events. Of this amount, 80 per cent is invested by three companies.¹²⁷ According to estimates, some sports may get around 25 per cent of their income from alcohol beverage sponsorship agreements or associated income.¹²⁸ Sponsorship of sporting events is a particularly potent tool for advertisers – 49 per cent of people surveyed recalled being exposed to alcohol advertising through sports.¹²⁹
- **Outdoor:** In 2012, outdoor alcohol advertising was the fifth largest outdoor advertiser category by expenditure at \$39.4 million.
- **Print:** Print accounts for a small proportion of alcohol advertising expenditure, but is a frequent and widespread method of advertising by the major alcohol retailers.¹³⁰
- **Social media:** Alcohol companies are increasingly utilising social media for promotion. The top 20 alcohol brands in Australia have more than 2.5 million followers and post four items of content per week.¹³¹ As at June 2013, official Facebook pages for Australian alcohol brands (beer, wine, cider and spirits combined) had attracted over 3.8 million followers. This is over a million more followers than for Australian non-alcoholic beverages (2.6 million) and automotive Facebook pages.¹³² Moreover, half of the available alcohol-related smartphone apps endorsed or encouraged alcohol consumption.¹³³

In New Zealand, expenditure on alcohol advertising in 2008 was estimated to be about NZ\$33 million, although this figure does not capture sponsorship activity.¹³⁴ It is estimated that alcohol promotions including sponsorship may be worth approximately \$73 million a year.¹³⁵

5.1 Impact of advertising and marketing on alcohol consumption

The significant expenditure on advertising in Australia and New Zealand demonstrates that alcohol companies clearly recognise its influence in driving sales. Research confirms that alcohol advertising leads to increased awareness of alcohol and more positive attitudes towards drinking.¹³⁶ Advertising also contributes to an increase in alcohol consumption among existing drinkers and encourages non-drinkers – particularly young people¹³⁷ – to become drinkers.¹³⁸

One US study found that each additional advertisement viewed by a young person resulted in 1 per cent more drinking. Another study estimated that each additional dollar per capita spent on alcohol advertising in a local market resulted in 3 per cent more drinking by young people.¹³⁹

Studies also show that alcohol marketing strategies lead to underage drinkers starting to drink, regular young drinkers becoming prone to binge-drinking patterns, and established young drinkers accruing a heavy level of consumption which can place them at risk of harms.¹⁴⁰

It is also clear that children are seeing a lot of alcohol advertisements when they watch sport on television. Alcohol advertising on Australian free-to-air television in the daytime is predominantly (87%) shown during televised sport, which has a higher number of average alcohol advertisements per hour than non-sport programs.¹⁴¹ Recent research has established that Australian children and adolescents are being exposed to as much alcohol advertising when viewing televised sport as young adults.¹⁴²

5.2 Self-regulation of alcohol advertising and marketing is insufficient

Despite regulations around the times alcohol can be advertised on television, young people, including adolescents, are exposed to almost the same level of alcohol advertising as the adult population.¹⁴³ The majority of Australians aged 12–17 have been exposed to alcohol advertising through a range of media channels, with television being the highest (94 per cent), followed by 75 per cent for magazines, 61 per cent for billboards or posters, 55 per cent on the internet, 53 per cent in newspapers and 51 per cent through promotional material.¹⁴⁴

A study of 2,810 alcohol advertisements aired on Australian television over 2 months found that 50 per cent appeared during viewing times when children were regularly watching; these were 7–9 am and 3.30–10.30 pm on weekdays and 7.30–10.30 am and 3.30–10.30 pm on weekends.¹⁴⁵

Other avenues for exposure to alcohol advertising include product placement in films, music videos and television programs, social media and in-store promotions.¹⁴⁶

Current regulations on alcohol advertising rely heavily on self-regulation in respect of both content and placement of advertising, and there is a lack of legally enforceable sanctions for instances when regulation breaches occur. In Australia, alcohol advertising content is predominantly regulated through the Alcohol Beverages Advertising (and Packaging) Code (ABAC). The scheme is administered by a Management Committee which includes industry, advertising and government representatives.

Regulation of placements of alcohol advertising (i.e. when and where such advertising is placed) on free to air television is done primarily through the Children's Television Standards of the Australian Communications and Media Authority (ACMA) and the Commercial Television Industry Code of

Practice (CTICP), a co-regulatory industry code registered by ACMA. The CTICP restricts the broadcasting of alcohol advertising to after 8.30 pm and before 5 am, and between 12 pm and 3 pm on school days.

New Zealand also operates a primarily self-regulatory framework for advertising. The Advertising Standards Authority (ASA), comprised of industry representatives, is the body responsible for self-regulation of advertising across all media. The ASA has developed Advertising Codes of Practice, including a Code for Advertising Liquor applicable to advertising agencies, magazine and newspaper publishers, television, cinema, outdoor advertising and radio. The ASA also funds a separate body called the Advertising Standards Complaints Board that adjudicates on complaints received about advertisements that may be in breach of the codes.

The studies quoted above clearly demonstrate that these placement regulations are not delivering on their intention; they are not preventing children from being exposed to alcohol advertising. One contributing factor is the exemption which permits alcohol advertising at any time during a live sport broadcast on weekends and public holidays.

Content self-regulation through ABAC does not extend to alcohol branded merchandise and sponsorships. Considering the strong and widespread encouragement for children and adolescents to engage in sports, support their teams and watch televised games, this 'loophole' is clearly a major issue.

5.3 More comprehensive restrictions on alcohol advertising and marketing are needed

In light of the inadequacies in the predominantly self-regulatory approach to alcohol advertising, as well as the documented impacts of advertising in increasing levels of underage and harmful drinking, more comprehensive restrictions on alcohol advertising and marketing are needed.

There is community support for greater restrictions on alcohol advertising and marketing, with a national survey in 2013 finding that 67 per cent of respondents supported a phase out of alcohol sponsorship of sport.¹⁴⁷

The French *Loi Évin* alcohol advertising legislation is a good model for stronger alcohol advertising and marketing restrictions. This legislation prohibits alcohol sponsorship of cultural and sporting events as well as alcohol advertisements on television and at the cinema. Alcohol advertising is restricted to billboards and some radio and print media for adults.¹⁴⁸ *Loi Évin* also prohibits the targeting of young people in alcohol advertising and imposes strict content regulations so that messages and images may refer only to the qualities of products such as degree, origin, composition, means of production and patterns of consumption. A health message must be included on each advertisement to the effect that 'alcohol abuse is dangerous for health'. Significant fines are imposed for infringements of the law.¹⁴⁹ Under this legislation, all drinks with over 1.2 per cent alcohol by volume are considered alcoholic beverages.

The RACP and RANZCP support a transition towards a *Loi Évin* model of alcohol advertising regulations across Australia and New Zealand. As a first step in Australia, the Commonwealth should adopt the recommendation of the National Preventative Health Taskforce to phase out alcohol

promotions from times and placements which have high exposure to young people aged up to 25 years.¹⁵⁰

The content of any alcohol advertising should also be subject to more rigorous and socially responsible standards. The Alcohol Advertising Review Board (AARB) Code sets criteria for acceptable alcohol advertising in Australia, and is an initiative of the McCusker Centre for Action on

Alcohol and Youth and Cancer Council WA to provide a system of alcohol advertising review which is independent of industry. However, it does not have any statutory authority. Statutory enforcement of a code similar to the AARB Code could provide a basis for revamping new standards for alcohol advertising content.

5.4 Alcohol labelling needs a stronger impetus

Alcohol health warning labels have an important role to play in reducing alcohol-related harms as they promote health messages at point of sale and at point of consumption. Alcohol labelling requirements in Australia and New Zealand are currently regulated by the *Food Standards Australia New Zealand Act 1991* (Cth) which is overseen and administered by Food Standards Australia New Zealand (FSANZ). In December 2011, the Australia and New Zealand Ministerial Forum on Food Regulation (FOFR), comprising food and health Ministers from New Zealand and Australian jurisdictions, agreed that warnings on alcohol products about the risks of consuming alcohol while pregnant should be pursued. To achieve this, they gave the alcohol industry two years to implement their own voluntary labelling scheme. In July 2014, the alcohol industry was given a further two years, until July 2016, to implement this scheme.

A 2014 evaluation of the effectiveness of the industry labels found that only 38 per cent of all products carried a pregnancy health warning (either text or pictogram), and only 6 per cent of women had seen any messages on alcohol products and only 4 per cent had seen any pregnancy warning labels.¹⁵¹

An immediate priority is requiring all alcohol products to be clearly labelled with warnings regarding the risks of alcohol consumption. Research shows that alcohol container warning labels have had some success in increasing awareness, reaching target audiences and, to a more limited extent, influencing individual behaviour.¹⁵² Possible labels may include the warning that alcohol 'may increase cancer risk' and 'can cause birth defects'.¹⁵³

Studies on the effectiveness of health warning labels in the US have shown that their implementation has resulted in increased awareness of the health messages used on the labels.¹⁵⁴ Awareness of the health warning labels was highest among groups deemed high risk, including young people and heavy drinkers. Recall was highest for the message regarding the risk of birth defects resulting from alcohol consumption during pregnancy.¹⁵⁵ Exposure to labels was also found to stimulate conversations about the risks of alcohol consumption.¹⁵⁶ Respondents also reported that they were less likely to have driven 'when they probably should not have'.¹⁵⁷ According to an analysis of current evidence-based research on alcohol product labelling, the use of specific warning messages is more effective than the use of generic warning messages.¹⁵⁸

Recommendations

- 1. That the current self-regulatory approach to alcohol advertising in Australia and New Zealand should be changed to include statutory restrictions, including the enforcement of costly sanctions for breaches of the advertising code.**
- 2. That the sponsorship of sporting events by the alcohol industry should be prohibited in Australia and New Zealand as a first step towards a model of alcohol advertising regulations which would phase out all alcohol promotions to young people.**
- 3. That the Australia New Zealand Food Standards Code should be amended to introduce mandatory warning label requirements for alcoholic beverages, with specific guidelines on the placement, size, colour and text of the label so they are visible and recognisable; and a strict timeframe put in place for its comprehensive implementation.**

6. Raising the minimum purchase age for alcohol

Adolescents and young adults are particularly vulnerable to the harmful effects of alcohol. Alcohol affects the development of the brain, which continues to form and mature throughout adolescence. Young people also have a propensity to combine high-risk drinking with other high-risk activities, increasing the potential for accidental injury both to themselves and to others.

The harmful effects of alcohol on young people raises questions about the adequacy of current policies in appropriately curbing access to and use of alcohol by youth. There is a need for a public conversation about whether the existing minimum purchase age for alcohol is appropriate or whether it should be raised, and consideration of other options to encourage a culture of responsible drinking amongst the young.

6.1 Drinking patterns of young people

In Australia, according to the most recent National Drug Strategy Household Survey, 3.4 per cent of 12–17 year olds and 32.7 per cent of 18–24 year olds drink weekly.¹⁵⁹ The level of risky drinking among 18–24 year olds was 21.3 per cent in 2013 compared with 31 per cent in 2010. This represents a statistically significant improvement and demonstrates that it is possible for the ‘drinking culture’ to shift. This should provide policy makers with increased motivation and momentum to explore policy reforms to reduce alcohol-related harms.

Problems do persist however, with aggregate improvements in drinking habits coupled with more problematic drinking patterns among some segments of young people. Normalisation of harmful alcohol behaviour among Australian youth remains a concern, with a questionnaire survey of 260 youth aged 17–19 years (recruited using intercept sampling during the end-of-school celebrations on the Queensland Gold Coast in December 2010) finding that most played drinking games (74.8 per cent) and consumed more than 10 drinks per night (64.1 per cent).¹⁶⁰

A 2012 study in New Zealand found that 1 in 4 people aged 15–24 engaged in ‘hazardous drinking’, with a roughly similar rate for people aged 25–34.¹⁶¹ Young people aged 18–29 in New Zealand suffer the greatest burden of alcohol-related mortality as a proportion of all-cause mortality. This age group also accounts for a large proportion of hospital presentations for alcohol-related injuries, alcohol-related offending and alcohol-use disorders.¹⁶²

The high rates of risky drinking of young people should be a policy priority given what is known about brain development not being fully complete in adolescence.¹⁶³ There is emerging evidence that heavy drinking during adolescence is associated with poorer cognitive functioning and possible brain response abnormalities while performing challenging cognitive tasks.¹⁶⁴ There is also evidence that short- and longer-term cognitive impairment during the post-pubertal and early adult years is associated with an earlier age-of-onset of harmful alcohol consumption.¹⁶⁵

Alongside education and early intervention programs, an effective means of addressing risky drinking in young people is to rethink the existing minimum age of 18 years for purchasing alcohol.

Over the last decade, there has been a substantial increase in public support in Australia for the minimum age to be raised. The most recent National Drug Strategy Household Survey showed a rise

in support for increasing it to 21 years, from 40.7 per cent in 2004 to 48 per cent in 2013,¹⁶⁶ though the 2013 figure represented a slight fall from 50 per cent public support in 2010.

Intermediate alternatives to raising the minimum purchase age for alcohol can also be considered, including raising the age at which takeaway alcohol is available from 18 to 20, as is currently the case in Sweden.

6.2 Minimum alcohol purchase age link to road traffic accidents

Evidence shows that changing the minimum purchase age for alcohol also changes various indicators of road safety, particularly the incidence of drink driving by young drivers.¹⁶⁷

A 2010 survey of the driving habits of young Australians found that one in five 23–24 year olds had driven when near or over the legal alcohol limit during the previous month, and over 40 per cent had friends who engaged in drink driving.¹⁶⁸

When New Zealand reduced its minimum purchase age for alcohol from 20 to 18 in 1997, there was a 12 per cent increase in the rate of traffic crashes and injuries for 18–19 year-old males, and a 14 per cent increase among 15–17 year-old males.¹⁶⁹ Accident rates among young female drivers rose 51 per cent for 18–19 year olds and 24 per cent for 15–17 year olds.¹⁷⁰ There was also a significant increase in hospital presentations of intoxicated people under 20.¹⁷¹

Another study into the impact of the reduced age in New Zealand found that the lower age was associated with an increase in drink-driving rates among 18–19 year olds and an increase in prosecution rates for disorder offences for 14–15 year olds.¹⁷² This demonstrates that the change impacted both the unsafe driving behaviour of people who fall within the drinking age and the behaviour of underage drinkers.

A possible reason for this is that a common source of alcohol for underage drinkers is from older friends.¹⁷³ Raising the minimum purchase age for alcohol may therefore also reduce opportunities for this source of supply for underage drinkers.

6.3 International experience of alcohol-related harms suffered by young people

Studies conducted around the world support the New Zealand experience outlined above regarding changes to the minimum purchase age for alcohol. A review of the empirical research from 1960 to 2000 shows that almost 60 per cent of high-quality studies undertaken concluded that a higher minimum purchase age for alcohol was associated with reduced road traffic accidents. None found the opposite.¹⁷⁴ This well-documented relationship strongly implies that increasing the minimum purchase age for alcohol can potentially save lives by reducing the incidence of road traffic accidents among young drivers, not to mention the long-term impact of serious injury.

Studies have also found an association between students' use of alcohol and higher rates of sexual behaviour. Students who consumed alcohol at risky levels were four times more likely to have sex that they later regretted compared to other students.¹⁷⁵ Statistics also show that the vast majority of alcohol-related injuries presenting to emergency departments are sustained by males under 30 years of age, while females under 30 are the group most likely to be the victims of alcohol-related violence.¹⁷⁶

6.4 Minimum purchase age for alcohol, alcohol culture and the prevention of alcohol use disorders

Changing the minimum purchase age for alcohol can have an impact on rates of long-term alcohol abuse and other psychological disorders relating to drug and alcohol consumption.¹⁷⁷ In the years following the lowering of the drinking age in New Zealand, there was a significant increase in the proportion of young men and women aged 15 to 17 years drinking enough to feel drunk at least once a month.¹⁷⁸ One US study found that a reduction in the drinking age from 21 to 18 was associated with an increased risk of binge drinking among young people, which persisted into adulthood.¹⁷⁹

This result is consistent with other studies which have found that a higher minimum purchase age for alcohol is associated with later initiation into drinking and reduced frequency of heavy drinking.¹⁸⁰

The effects of early initiation into drinking persist well past young adulthood, with one study finding that exposure to a younger legal purchase age is associated with a more than 30 per cent increase in the risk of a past-year alcohol use disorder, even among respondents evaluated in their 40s and 50s, and an elevated risk for a past-year drug use disorder in middle adulthood.¹⁸¹ A US study found that states with a lower minimum purchase age for alcohol had an 8 per cent higher suicide rate among persons aged 18-20 and a 6 per cent higher suicide rate among persons aged 21-24.¹⁸²

6.5 Minimum purchase age does not equate to minimum age of consumption

An important issue to note is that the minimum age for purchasing alcohol may provide little protection for the underaged if there is no equivalent culture change among parents and other adult guardians of children. Attempts to restrict supply to minors by adults can be difficult to enforce, so appropriate role-modelling is necessary.

Complementary measures may also be required to publicise the reduction in the minimum age of purchase to induce an effective reduction in the minimum age of consumption.

6.6 Conclusions

These findings strongly suggest that there is a need for a national debate in Australia and New Zealand on raising the minimum purchase age for alcohol. Public discussion should surround the ability of this measure to reduce the incidence of alcohol-related harms for young people, and the impact of this change on personal freedoms.

As the minimum purchase age for alcohol is currently determined at the state and territory level in Australia, more wholesale change would require the Commonwealth government brokering a coordinated agreement to amend all relevant regulations in all states and territories.

Recommendations

- 1. That broad public consultation should be initiated on raising the minimum purchase age for alcohol.**
- 2. That, as an intermediate step, measures should be introduced in Australia and New Zealand to increase the age for some types of access to alcohol, including raising the age at which takeaway alcohol can be purchased.**

7. Further reducing the incidence of drink driving

Drink driving is a major cause of morbidity and premature loss of life in Australia and New Zealand. Even low blood alcohol levels have been shown to impact cognitive functioning while driving. Alcohol consumption leads to slowed reaction times and dulled thinking processes, causing difficulties multitasking, reduced attention span, blurred vision and reduced hearing.¹⁸³

In Australia, alcohol remains the leading cause of deaths on the road, and is implicated in up to one-third of driver and pedestrian deaths.¹⁸⁴

In a 2013 study, 12.2 per cent of recent drinkers aged 14 years and over in Australia admitted to driving a vehicle while under the influence of alcohol.¹⁸⁵ In New Zealand, for the period 2007–08, 19.8 per cent of the surveyed population admitted driving a vehicle while feeling under the influence of alcohol.¹⁸⁶ According to Australian statistics, males are twice as likely as females to drive while under the influence (16.3 per cent compared with 7.9 per cent).¹⁸⁷ Young people aged 20–24 years were more likely than people in the other age groups to be charged with driving under the influence of alcohol and/or drugs.¹⁸⁸ A high proportion of repeat drink drivers have clinical alcohol dependence problems.¹⁸⁹

In 2010, 120 deaths on Australian roads and 2,285 hospitalisations due to motor vehicle accidents were attributable to alcohol.¹⁹⁰ The annual cost of alcohol-related crashes in Australia was estimated to be \$2.2 billion,¹⁹¹ while in New Zealand it was estimated at \$204.5 million.¹⁹²

Both Australia and New Zealand have laws on blood alcohol concentration (BAC) limits while driving, which are enforced through random breath testing (RBT). In Australia, it is an offence for any motorist to drive with a BAC of 0.05 or greater, and in most jurisdictions novice drivers (learners and P-plates) and professional drivers are required to have a BAC of zero. Victoria has a graduated licensing program with a zero BAC for all learner and P-plate drivers. P-plates are required for four years (P1 for a minimum of one year and a P2 licence for a minimum of three years), which means that drivers do not become fully licensed (and therefore no longer required to have a zero BAC) until at least 22 years of age, since the age at which Victorians are eligible for a P1 licence is 18.

Until recently, New Zealand's system required a zero alcohol limit for those under 20 but a higher 0.08 limit for those aged 20 and over. However, in November 2013, the Government announced that the limit for drivers over 20 would be reduced to 0.05 BAC, with instant fines and demerit points being imposed on those between 0.05 and 0.08. The zero alcohol requirement for younger drivers remains.

There is strong evidence that the adoption of limits on BAC while driving has led to significant reductions in road traffic accident rates and rates of unsafe driving:

- An analysis of the experience of 15 European countries found that the adoption of a 0.05 BAC driving limit reduced alcohol-related driving death rates by 11.5 per cent among young people aged 18–25, and reduced driving fatalities among men of all ages by 5.7 per cent.¹⁹³
- In Australia, reducing the BAC limit from 0.08 to 0.05 led to an 18 per cent reduction in Queensland and an 8 per cent reduction in NSW.¹⁹⁴

- Reducing the BAC limit from 0.08 to 0.05 in 1991 in the Australian Capital Territory led to a 34 per cent decrease in the proportion of random breath tested drivers with BACs between 0.15 and 0.19, and a 58 per cent decrease in the proportion testing above 0.2.¹⁹⁵

Lower BAC limits for younger drivers are particularly necessary as the risks of being involved in a casualty-resulting crash increases more rapidly with increasing BAC levels in the case of young drivers.¹⁹⁶ Lower limits for younger drivers have been shown to reduce the risk of road fatalities, especially if the BAC limit is set at zero.¹⁹⁷

7.1 Potential improvements from further reducing BAC limits

The rate of progress in safety improvements has slowed down in recent years in Australia.¹⁹⁸ The target of the last National Road Safety Strategy 2001–10 of no more than 5.6 deaths per 100,000 has not yet been met, and the road death rate for children aged 0 to 14 years is high by OECD standards.¹⁹⁹

The studies highlighted above indicate that one means of generating additional improvements in road safety is to further reduce BAC limits. Research suggests that drivers with a BAC of between 0.02 and 0.05 have at least a three times greater risk of dying in a vehicle crash than drivers who do not consume alcohol.²⁰⁰ Further reducing the legal BAC limit towards 0.02 or below could therefore lead to further reductions in road crash rates. International experience supports this claim:

- In Sweden there was a 10 per cent reduction in fatal crashes related to drink driving after the BAC limit was reduced to 0.02.²⁰¹
- In 2002, Japan reduced the BAC limit from 0.05 to 0.03 and increased the penalties for alcohol-impaired driving. The combined effect of these measures was a significant reduction in alcohol-impaired driving traffic fatalities, severe injuries and total injuries on the road.²⁰²
- Another Japanese study which focused on the impact of the reduction in BAC on teenage road traffic accident rates found statistically significant reductions in alcohol-related crashes, alcohol-related injuries and single-vehicle night-time crashes among young drivers aged 16–19.²⁰³

The European Transport Safety Council has recently recommended that all European Union (EU) member countries move to zero BAC limits (possibly with a small tolerance). Hungary, Czech Republic, Romania and Slovakia have already adopted zero BAC limits, while Sweden, Poland, Slovenia and Estonia have set a 0.02 limit.

Reducing the BAC limit to zero has an added advantage of not relying on drivers' perceptions of how much alcohol they can consume to stay under a legal limit. Having this clear prohibition in place would provide motorists with greater certainty while strongly reinforcing the message that drinking and driving should not occur.

The RACP and RANZCP recognise that this measure may need to be implemented in phases, in close consultation with the community. A possible phased approach may be to adopt a system similar to that in Victoria, requiring licensed drivers to maintain a blood alcohol concentration (BAC) of zero until at least the age of 21 years (preferably until 25 years).²⁰⁴

7.2 Other measures

A range of other measures have been implemented in Australia and other countries to reduce drink driving, with varying degrees of effectiveness. They include licence suspensions and increased penalties for drink driving, education and mandatory treatment of people convicted of drink-driving offences, and ignition interlock devices.

Licence suspensions have been found to have the most consistent impact, while other penalties such as increasing the severity of fines and imprisonment for drink driving have not been found to be as effective.²⁰⁵ However, there are limits to the effectiveness of a measure such as licence suspension, given the finding that up to 70 per cent of people who lose their licence continue to drive while unlicensed as the risk of apprehension is relatively low.²⁰⁶

Education and mandatory treatment interventions for drink drivers and the incapacitation of vehicles using ignition interlock devices have been found to be effective means of increasing compliance with licence suspension and reducing recidivism.²⁰⁷ Ignition interlock programs require people convicted of drink-driving offences to install an alcohol ignition interlock on their vehicle. This is a breath test device connected to the ignition of a vehicle to stop it from starting if the driver has been drinking alcohol. The intent of such programs is to enforce and specifically target a zero alcohol limit on people identified as high-risk drinkers. Installation of ignition interlocks may be court ordered or voluntarily installed in exchange for benefits such as reduced licence disqualification/suspension periods. Currently, the use of ignition interlocks in Australia has been limited compared with the United States and Canada.²⁰⁸

7.3 Conclusions

Drink driving persists as a major contributor to deaths and injuries on the road. Despite a range of measures to address this, the rate of harm caused by drink driving is still high. More must be done to reduce this in Australia and New Zealand.

Particular attention should be given to the evidence demonstrating that further reductions are achievable by tightening legal BAC limits and by the expansion of ignition interlock programs.

Recommendations

- 1. That the permitted blood alcohol concentration (BAC) limit in Australia and New Zealand should be reduced to 0.02 for all non-learner drivers and zero for all learner drivers.**
- 2. That the Governments of Australia and New Zealand should consider gradually reducing the BAC limit to zero for all drivers.**
- 3. That interlock-specific legislation mandating the installation of the device for recidivist and high-range drink-driving offenders should be considered for introduction in Australian states and territories and in New Zealand.**

8. Improving prevention of Fetal Alcohol Spectrum Disorders

Alcohol is a teratogen; that is, it can cause birth defects. Its use during pregnancy can harm prenatal development and may cause Fetal Alcohol Spectrum Disorders (FASD), which include a spectrum of conditions, including Fetal Alcohol Syndrome (FAS), Partial FAS (pFAS) and neurodevelopmental disorder associated with alcohol exposure (ND-AE).²⁰⁹ FASD encompass a broad range of physical and neurodevelopmental problems that are lifelong and range from severe intellectual impairment and major birth defects to subtle learning and developmental disorders.²¹⁰ Children with FASD may have low birth weight, distinctive facial features, heart and other birth defects, growth delay, hearing and visual impairment, behavioural problems and intellectual disability.²¹¹ A range of secondary disabilities has also been described in FASD. In one American study, 60 per cent of adults with FASD had been in trouble with the law and half had experienced confinement or admission to a psychiatric or alcohol and other drug facility.²¹² Of this cohort, fewer than 10 per cent were able to live and work independently at the age of 21.²¹³

In Australia, there has been increasing interest in FASD,²¹⁴ including publication of a monograph by the Intergovernmental Committee on Drugs;²¹⁵ a House of Representatives Inquiry into FASD in Australia;²¹⁶ and provision of targeted funding from the National Health and Medical Research Council of Australia (NHMRC) for FASD research. In 2014, the Commonwealth Department of Health committed \$9.2 million to advance a national strategy for FASD, 'Australian Government responding to Fetal Alcohol Spectrum Disorders in Australia: A Commonwealth action plan', including formation of a National FASD Technical Network. In 2014, the Department also funded resources to assist doctors and midwives to ask and advise about alcohol use in pregnancy – this was known as the 'Women Want to Know' campaign (www.alcohol.gov.au).

In 2010, the New Zealand Ministry of Health produced a guide for healthcare professionals engaging with clients on the topic of drinking during pregnancy and the associated risks: 'Alcohol and pregnancy: a practical guide for health professionals'. To support this guide, the Ministry of Health also funded the development of 'The pregnancy and alcohol cessation toolkit', an educational resource for health professionals, which was developed as a collaborative project between Alcohol Healthwatch (a non-government organisation) and the University of Otago. More recently, a Consensus Statement based on a FASD Symposium and FASD Policy and Research Roundtable, hosted by the University of Auckland's Centre for Addiction Research, was released in September 2014.

8.1 Alcohol use in pregnancy in Australia and New Zealand

No 'safe' low level of alcohol consumption during pregnancy has been established. The 2009 NHMRC guidelines on alcohol consumption²¹⁷ state that, for women who are pregnant or planning a pregnancy, not drinking is the safest option. Yet the most recent National Drug Strategy Household Survey²¹⁸ from 2013 reports that 47 per cent of Australian women drank during pregnancy. This represents a fall from the 2010 level (53 per cent). Over half (56 per cent) of all pregnant women drank before they were aware of their pregnancy. After they became aware they were pregnant, most ceased drinking but 26 per cent continued. The majority drank 1–2 standard drinks monthly or less; however, 17 per cent drank 2–4 times a month and 1.4 per cent consumed 6 or more standard drinks at least once during their pregnancy.²¹⁹ As nearly half of all pregnancies are unplanned,²²⁰ there is

potential for inadvertent fetal exposure in early pregnancy. Other Australian research backs up the finding that, despite a decline in the number of Australian women drinking during pregnancy, the proportion drinking at high levels remains unchanged.²²¹

In New Zealand, 55 per cent of women surveyed believe it is safe to drink during pregnancy, contrary to advice from the Ministry of Health.²²² A recent survey of midwives found that 36 per cent of pregnant clients, and 82 per cent of pregnant teenage clients, drank during their pregnancies.²²³ The risk to the fetus is greatest in women who drink at risky levels during pregnancy, but the outcomes vary according to the timing, frequency and duration of alcohol use.²²⁴

8.2 Epidemiology of FASD in Australia and New Zealand

There are conflicting studies regarding prevalence of FAS in Australia, and no reliable data for the full FASD spectrum.²²⁵ In short, no national estimates exist on the incidence or prevalence of FASD. This is because both Australia and New Zealand lack standardised data and recording of alcohol consumption during pregnancy and on the diagnosis and recording of people with FASD. However, data available in Australia suggests that there are disparities between the states and territories and between different populations. For instance, while one study based on Victorian data found a birth prevalence for FAS of 0.01 to 0.03 per 1,000 live births in the general population and identified no Indigenous cases of FAS,²²⁶ a study in the Top End of Australia's Northern Territory found a birth prevalence of FAS of 0.68 per 1,000 live births, with a higher rate in Aboriginal and Torres Strait Islander children (1.9 per 1,000 Indigenous live births).²²⁷ In Western Australia, FAS was identified in between 0.13 and 0.18 per 1,000 live births,²²⁸ while in Victoria a rate of 0.006 per 1,000 live births was found.²²⁹ Clinicians estimate that the prevalence of FAS may be as high as 15 per 1,000 children among Aboriginal and Torres Strait Islander communities in far north Queensland.²³⁰ A population-based study of FAS prevalence was recently completed in the remote Fitzroy Valley communities of WA, where over half of mothers of primary-aged children reported risky drinking during pregnancy.²³¹ In this high-risk population the prevalence was 120 per 1,000, amongst the highest in the world.²³² One study has attempted to estimate the national incidence of FAS rather than the full spectrum of FASD.²³³ The variation in incidence and prevalence rates likely reflects several factors, including small sample size; the use of different methods of case ascertainment; application of different diagnostic criteria; variations in health professionals' knowledge; access to diagnostic services; and regional differences in drinking patterns.

In New Zealand, the true extent of the incidence and prevalence of FASD is also unknown. There are no nationally consistent definitions or diagnostic criteria for FASD, and children are not routinely screened in infancy or early childhood.²³⁴ Based on overseas incidence rates of 3 per 1,000 live births, it is estimated that at least 173 babies are born with FASD every year in New Zealand.²³⁵ While the New Zealand Paediatric Surveillance Unit (NZPSU) collected data on the incidence and prevalence of FAS in New Zealand from July 1999 to December 2001 and reported that the incidence of FAS was low compared to other countries,²³⁶ this was possibly because only a small number of New Zealand paediatricians were diagnosing children with FAS.²³⁷

8.3 Barriers to the diagnosis of FASD

Most studies acknowledge the likely underestimation of the true frequency of FASD in Australia²³⁸ and New Zealand. It is very probable that there is substantial under-diagnosis of FASD because of the lack of awareness by clinicians²³⁹ and their fear of stigmatising children and families. In one WA

survey only 12 per cent of health professionals could identify the four diagnostic features of FAS, only 44 per cent who saw pregnant women routinely asked about alcohol use in pregnancy, and only 25 per cent routinely provided information on the consequences of alcohol use in pregnancy.²⁴⁰ In a similar survey paediatricians had limited knowledge about alcohol use during pregnancy and its effects, and felt poorly prepared to manage affected children.²⁴¹ The limited training and experience of health professionals in diagnosing FASD is of concern because delay in diagnosis and provision of appropriate health and educational interventions increase the risk of adverse secondary outcomes.²⁴² Other general barriers to the better diagnosis of FASD in the population are:

- The lack of standardised screening and diagnostic instruments for FASD, which results in health professionals using a combination of overseas diagnostic instruments with no standardisation
- The lack of awareness about FASD and alcohol harms during pregnancy within the general population
- Limited FASD diagnostic services. There are currently two FASD diagnostic clinics in Australia (one in Sydney and one in Gold Coast). This reflects the fact that FASD diagnosis is determined through a multidisciplinary team approach, with assessments needing to be undertaken by paediatricians, neuropsychologists, occupational therapists, speech and language therapists, physiotherapists and social workers.

8.4 Policy responses to FASD

As previous chapters demonstrate, the most effective strategies to reduce alcohol-related harms are policies aimed at reducing alcohol consumption overall, insofar as these measures are also likely to translate to a corresponding reduction in alcohol consumption before and during pregnancy. The rest of this chapter focuses on policy responses specifically for enhancing diagnosis/detection of FASD and consequent early intervention treatment services.

While there is no cure for FASD, early intervention treatment services can improve a child's development. However, prevention of FASD must be the priority.²⁴³ This will require a multifaceted approach that acknowledges the complex causal pathway to alcohol use during pregnancy and the existence of high-risk groups within our society.

Primary prevention strategies include community and individual education (e.g. mass media campaigns, education in schools, and warning labels on alcohol); provision of services and treatment for women with alcohol misuse and dependency; education of health professionals regarding the potential harms of alcohol use in pregnancy;²⁴⁴ and dissemination of NHMRC guidelines that recommend women who are pregnant or planning a pregnancy should avoid alcohol.²⁴⁵ Measures to reduce access to alcohol in the community, including restrictions on the number and opening hours of liquor outlets, minimum pricing of alcohol and volumetric taxation have been shown to decrease harms and should be considered. Akin to the campaign to reduce harm from tobacco, restriction on the advertising and promotion of alcohol should be introduced.²⁴⁶ It is crucial that Aboriginal community-led restrictions on access to alcohol should be supported.²⁴⁷

8.5 Role of clinicians in managing and diagnosing FASD

It is important that women be asked about alcohol use prior to and during pregnancy so that appropriate advice can be offered.²⁴⁸ A brief intervention or, where necessary, referral to drug and alcohol services may be indicated to prevent harms to both mother and developing child.

Women identify that health professionals are their preferred source of advice regarding alcohol use in pregnancy. One study found that education resulted in almost half of health professionals changing or intending to change their practice and the advice they offered.²⁴⁹ The target audience for resources such as 'Women Want to Know' (discussed previously) are all health professionals who see women who are pregnant or planning pregnancy, but particularly midwives, general practitioners, obstetricians and gynaecologists.

As discussed above, one of the many barriers to better diagnosis of FASD in the population is the limited number of specially trained health professionals and specialist diagnostic clinics for FASD. Assessment and diagnostic guidelines developed internationally for FASD recommend the use of multidisciplinary teams of specially trained professionals who also take responsibility for training other health professionals.²⁵⁰ Service models can be adapted depending on the circumstances, for example supplementing assessment services with telemedicine in rural and remote communities. Services should be underpinned by the use of standardised, nationally agreed diagnostic criteria for FASD and protocols for assessment. A diagnostic tool for Australia is in the piloting phase²⁵¹ and could help in expanding the number of such services.

8.6 Conclusions

Particularly because there is no cure for FASD, stronger measures must be taken across Australia and New Zealand to prevent it. In addition, policies must also adequately address the current barriers to its early diagnosis and improve access to early intervention services.

Recommendations

- 1. That governments at all levels in Australia and New Zealand work together to develop and implement policies to prevent FASD. This requires:**
 - **Educating communities, particularly high-risk communities, on the harms of alcohol use in pregnancy**
 - **Educating and supporting health professionals to provide primary care and specialised services for women and antenatal care**
 - **Establishing state- and territory-based specialist multidisciplinary clinics**
 - **Ensuring better dissemination of national NHMRC guidelines on alcohol use in pregnancy to health professionals and the general public**
 - **Providing routine screening and early interventions for women of reproductive age who misuse alcohol or have alcohol dependency.**

2. That governments at all levels in Australia and New Zealand support education and training of health professionals to improve early diagnosis of FASD and appropriate intervention by:

- Providing all health professionals with information and training about the potential harms of alcohol use in pregnancy and the diagnosis and management of FASD
- Investing in the establishment and training of multidisciplinary teams of health professionals to conduct assessment and diagnostic clinics for FASD (incorporating a train-the-trainer component and information about specialist services)
- Implementing a standardised national tool to assist health professionals in the assessment and diagnosis of FASD
- Investing in services for the diagnosis and management of FASD.

9. Providing more effective and accessible alcohol treatment services

There are over 1.6 million alcohol and other drug (AOD) treatment visits annually in Australia.²⁵² Alcohol is the principal drug of concern for most of these treatment sessions, accounting for 46 per cent of government-funded specialist agency episodes and 72 per cent of inpatient hospital episodes.²⁵³ Specific alcohol treatment services include helplines, detoxification, withdrawal management, and counselling delivered by government, non-government and private providers in a range of settings such as hospitals, general practices and residential programs.

In New Zealand, the Alcohol and Drug Helpline takes around 15,000 calls per year, and specialist treatment services reach around 40,000 people per year.²⁵⁴

However, these figures do not reveal the unmet need, with only about 1 in 10 Australians with alcohol dependence receiving any treatment within a given year.²⁵⁵ On average, there is a 20 year lag between the onset of an alcohol use related disorder and the first episode of treatment.²⁵⁶ Moreover, there is a low uptake of evidence-based treatment, as discussed later in this Chapter. Current approaches often include an emphasis on withdrawal management, which is largely ineffective in the absence of ongoing relapse prevention strategies and support.

9.1 Evidence on effectiveness of alcohol treatments

Without specific screening techniques, the majority of people who drink excessively will not be detected in general practice²⁵⁷ or hospital settings.²⁵⁸ Thus, systematic screening followed by brief intervention plays a critical role in identifying high-risk drinkers or those who have engaged in risky or potentially risky consumption and introducing treatment and management of their conditions. General practitioners (GPs) may be best placed to undertake this important first step given that they are the most frequent point of contact with the healthcare system.

The Australian evidence suggests that screening and brief interventions in primary care settings for alcohol use disorders can be cost effective²⁵⁹ as a means of reducing alcohol-related harm. Even for heavy drinkers, brief interventions can be as effective as more intensive interventions²⁶⁰ and an effective instigator of commitment to behaviour change.²⁶¹ It is worth noting that interventions can be as simple as a brief discussion of the Alcohol Use Disorder Identification Tool (AUDIT). The additional advantage of the AUDIT is that it can be used in a wide variety of primary and community care settings and so reach a larger number of patients.

For non-dependent but harmful drinkers, a brief intervention is usually more acceptable than referral to a specialist alcohol treatment service as there is less social stigma associated with it. Research suggests that brief interventions are capable of achieving reductions of up to 30 per cent in alcohol consumption.²⁶² New Zealand research suggests that brief interventions are being underutilised and could be used more in primary care, hospital emergency departments²⁶³ and inpatient wards.²⁶⁴

The effectiveness of brief interventions is limited in certain settings however. In emergency departments, this approach leads to reduced readmission for alcohol-related trauma but does not reduce long-term risky levels of alcohol consumption. Similarly, the evidence suggests that brief interventions do not result in improved health outcomes for hospital inpatients admitted for surgery.²⁶⁵

Their main benefits lie in earlier recognition, prevention of future harms, and treatment of alcohol withdrawal and alcohol-related medical toxicity.

Once alcohol dependence has developed, more extensive treatment may be required.²⁶⁶ Other recognised forms of treatment include alcohol withdrawal management, psychosocial intervention and pharmacotherapies. Psychological treatments such as motivational enhancement treatment and cognitive behaviour therapy remain the mainstay of non-residential approaches to relapse prevention. There is evidence of effectiveness for three types of pharmacotherapies – naltrexone, acamprostate and disulfiram – in reducing alcohol consumption in patients with alcohol dependence.²⁶⁷ However, it is worth noting that of these pharmacotherapies, disulfiram is still an unlisted medication in Australia. The evidence also suggests that effective treatments and strategies should be tailored to meet an individual's needs and goals, be available across a spectrum of service types and be integrated with primary care services to reduce social marginalisation,²⁶⁸ for example, to ensure a culturally safe and effective approach for Aboriginal and Torres Strait Islander people.

Other complementary elements of healthcare also need to be better recognised and coordinated. Notably, there are high rates of mental health comorbidity in individuals with alcohol dependence, with studies suggesting that over 20 per cent of people who drink nearly every day have a co-occurring mental health disorder.²⁶⁹ Identification and effective treatment of these co-occurring disorders or conditions are essential to recovery from alcohol dependence.

9.2 Availability and utilisation of effective treatments for alcohol use disorders

Although 14 per cent of the burden of disease in Australia is due to drug and alcohol problems, less than 1 per cent of our health budget is spent on drug and alcohol treatments.²⁷⁰ Clearly, the funding currently provided for alcohol and other drug treatment services is not commensurate with the needs of the population. For example in NSW, mental health treatments receive approximately 10 times the funding of alcohol and drug treatments, despite the fact that both these conditions account for similar amounts of the total burden of illness.²⁷¹ According to evidence submitted to the recent NSW Government Inquiry into Drug and Alcohol Treatment, there are current shortages of treatment services in NSW, such as youth detoxification, residential rehabilitation places and ancillary services, including support for families of individuals affected by drug and alcohol use.²⁷² There are also significant workforce issues such as insufficient numbers of trained addiction medicine physicians in NSW,²⁷³ and poor retention of qualified staff, including nurse practitioners, due to a lack of continuity of funding.²⁷⁴

Similarly in New Zealand it is estimated that only 15 to 20 per cent of people with alcohol problems are being identified and treated.²⁷⁵ Treatment capacity would need to double to treat just the 1 per cent of the population with the greatest need.²⁷⁶

Utilisation of health services is strongly related to availability.²⁷⁷ Existing rates of treatment utilisation can therefore be a useful indicator of availability in the case of health services. Given this, it is worth noting a past estimate that only about 30 per cent of people with AOD problems seek treatment,²⁷⁸ with utilisation rates of mental health treatment lower in rural than metropolitan areas.²⁷⁹ In particular, rates of utilisation of withdrawal management services were lowest in very remote (0.7 per cent) and remote areas (6 per cent) compared to those of major cities (17.7 per cent). These low utilisation rates may be reflective therefore of the current limited availability of AOD treatment services, especially of poor availability of withdrawal management in rural areas. The NSW government

committee set up to review alcohol and other drug treatment services has recognised this access problem and recommended that funding levels keep pace with the increasing demand for drug and alcohol treatment services.²⁸⁰

9.3 Poor uptake of most recent evidence-based treatments

A recent study of metropolitan hospitals in Sydney on the implementation of new evidence-based guidelines for nurses screening for alcohol treatment found no differences in screening rates three months after the guidelines had been implemented.²⁸¹

Moreover, while effective pharmacological treatments are available to assist in the symptoms associated with withdrawal from alcohol (e.g. benzodiazepines, valproate) and to maintain abstinence from alcohol (e.g. disulfiram, naltrexone and acamprosate), they are still underutilised.²⁸²

9.4 Improving access to services for the people who need it: Across the community and across the lifespan

Research suggests that difficulties in gaining access to treatment for alcohol use disorders are faced by many groups, including:

- People living in rural and remote locations – Research has identified a ‘distance decay’ effect whereby the number of consumers using healthcare services, including AOD services, decreases with increased distance from a service.²⁸³ The underuse of withdrawal management services in these areas, which was previously noted, may reflect this. In addition to problems with transportation, concerns about social stigma, a culture of self-reliance and stoicism, and financial problems due to unemployment or low income may also hold back use of alcohol treatment services in these areas.²⁸⁴ Studies suggest that AOD treatment services are scarce in rural Australia²⁸⁵ and staff of such services may not have appropriate training or support opportunities.²⁸⁶
- Aboriginal and Torres Strait Islander peoples – There is cumulative evidence of deficiencies in treatments available for Aboriginal and Torres Strait Islander people. For example, a recent survey of AOD centre staff found that 64 per cent of agency workers felt that Indigenous clients’ needs were only partially met, and 9 per cent reported that such needs were not met at all. Workers in remote locations were significantly more likely to report a strong need for AOD services for Indigenous Australians.²⁸⁷ Another study of a mainstream area health service found that outpatient treatment options for alcohol problems were rarely used by Indigenous individuals, who tended to use emergency and inpatient services for advanced complications from drinking or unplanned alcohol withdrawal instead.²⁸⁸ It is argued that a lack of treatment uptake among Indigenous people could be due to poor cultural appropriateness²⁸⁹ and a lack of community awareness of the range of treatment services available.²⁹⁰ Aboriginal and Torres Strait Islander people across Australia are not routinely receiving access to the full range of treatment services available to mainstream populations – this is true in urban as well as rural/remote areas.²⁹¹
- Pregnant women (see also Chapter 8 on Fetal Alcohol Spectrum Disorders) – Women are less likely to use specialised alcohol and drug treatment services and are more likely to use primary healthcare than their male counterparts.²⁹² This can be a barrier to identifying and

treating pregnant women who are problem drinkers, with one study estimating that between 10 per cent and 50 per cent of substance-using pregnant women will access treatment services.²⁹³ Pregnant women may also face barriers to seeking treatment because of fear of losing custody of their children, social stigma, lack of childcare, lack of transportation, and a lack of access or priority for pregnant women.²⁹⁴ On the other hand, women with a comorbid mental health disorder are more likely to seek treatment than men,²⁹⁵ though they are more likely to attribute their problems to mental health rather than alcohol use and hence are more likely to be seen in mental health or general practice settings rather than specialist substance treatment centres.²⁹⁶

- Young people – The peak age of onset for alcohol use disorders is 18 years.²⁹⁷ The reported lag between onset of an alcohol use disorder and the first episode of treatment is approximately 20 years.²⁹⁸ Strategies to engage young people in treatment in an age appropriate way are needed. Headspace is an Australian national mental health program that seeks to address this problem in a general sense and is an example of the type of programs that should be made more widely available, but with a focus on alcohol use disorders. Web-based and e-health interventions have also been shown to be effective, acceptable and accessible forms of treatment for young people.²⁹⁹
- Older people – Overall, substance use declines with age. However, the rates of alcohol problems commencing or progressing later in life are increasing. Engaging and treating older people has particular challenges in relation to mobility, communication and comorbidities. Effective strategies include integration of alcohol use disorder treatment with aged care services
- People in custody – Diversionary programs for people in custody that are focused on appropriate treatment for alcohol use disorders can improve not only their future health but other socioeconomic outcomes including reoffending rates. For instance, a recent study found that state and territory governments could save more than \$110,000 per year for every non-violent alcohol or drug-addicted Aboriginal and Torres Strait Islander offender if they were given rehabilitation instead of jail.³⁰⁰

It is important to ensure that alcohol treatment services are tailored to meet the needs of diverse populations, including people with disabilities, mental illness, and culturally and linguistically diverse backgrounds. Treatments must take into consideration accessibility, communication and other barriers people may face in obtaining treatment.

Recommendations

1. **That the Governments of Australia and New Zealand identify opportunities for more targeted treatment services to meet the different needs of clients who are at different stages in addressing their alcohol consumption including, but not limited to, screening for harmful drinking levels and brief intervention for high-risk drinkers.**
2. **That greater funding by all levels of government in Australia and New Zealand is dedicated to alcohol treatment services and workforce development to address unmet demand for treatment.**

3. That the Governments of Australia and New Zealand identify opportunities at a local health district level to ensure that all pregnant women receive screening for alcohol use, together with education, brief intervention and continued monitoring where appropriate.
4. That the Governments of Australia and New Zealand invest in research to develop and implement treatment services using new technologies for interventions for alcohol disorders and related comorbidities.

10. Strengthening data collection and evidence

Alcohol-related data should be sufficiently specific, reliable and valid to allow adequate judgement of the effectiveness of policy and population-level interventions.³⁰¹ There is a real lack of such data and a greater focus is needed to drive a systematic and consistent collection of alcohol-related data covering not only alcohol sales but also hospital presentations and admissions, and alcohol-related crime data. To achieve these objectives, improved infrastructure and data collection systems are needed.

As a start, detailed and localised data regarding the volume of alcohol sales is fundamental because of the strong relationship between per capita consumption and alcohol-related harms, such as traffic accidents, illnesses and assaults. Detailed alcohol sales data which allow policymakers to estimate how much alcohol is consumed per capita within a particular region or community is crucial for:

- Identifying emerging trends in use and harms to support intelligence-led policing and health service delivery
- Assisting authorities to identify 'hot-spot' communities and regions where alcohol consumption is associated with high levels of harm, which may require proactive intervention to address
- Gauging potential impacts of new liquor licences and changes to existing licences in local areas, thereby providing evidence to support licensing decision-making processes
- Assisting prosecutions against problematic or unlawful licensees and venue operators where necessary
- Facilitating the evaluation and monitoring of policy changes and interventions.

Regularly collected alcohol sales data provides for a more reliable, independent and objective measure of consumption than survey data or other administrative datasets employed for other purposes, such as hospital, police or survey data which may be affected by internal processes that differ by region or over time.

Current data on alcohol use in Australia comes from national estimates of per capita consumption by the Australian Bureau of Statistics (ABS) based primarily on data from the tax system and survey-derived estimates of alcohol consumption which have been periodically collected by the Australian Institute of Health and Welfare (AIHW). Similarly, data on alcohol use in New Zealand comes from a combination of sales data and periodic national surveys. As noted, alcohol consumption data based on sales is more reliable than data from surveys. There is a deficiency in the current data collection system in Australia, as the ABS only collects national data using tax information and does not break it down by state and territory or local government area. ABS estimates were complemented by state and territory alcohol sales data collected by liquor licensing authorities until 1996, when the High Court ruled that liquor licensing fees and levies were illegal under the terms of the Australian Constitution. While this ruling did not preclude the collection of wholesale alcohol purchase data, it removed the incentive for the continued collection of such data. Similarly, a breakdown of the New Zealand national-level alcohol use data into data at the local community level would further assist the formulation and assessment of evidence- and needs-based policy to reduce alcohol-related harms.

The federally funded National Alcohol Sales Data Project (NASDP) introduced recently in Australia aims to remedy this deficiency in alcohol sales data through an ongoing, regularly updated national database of standardised alcohol sales data. So far, however, only Queensland, Western Australia, the Northern Territory and the Australian Capital Territory have signed up to this project. Some recent progress has also been made in Victoria with the amendment of the liquor control legislation to require Victorian alcohol wholesalers to report their wholesale liquor supply information to government. Participation by all states and territories in the NASDP is needed to ensure we collect nationally consistent data on alcohol consumption, which can then be disaggregated and compared and made publicly available. This would put Australia on a par with other developed economies, for example Canada, which already mandate the collection of such data.

Further alcohol-related data could be collected by amending the liquor licensing legislation in each jurisdiction to mandate collection and public reporting not only of alcohol sales data (in local and regional areas) but also data on licensees' occupancy, trading hours and compliance with the liquor laws.

There are also major inconsistencies across jurisdictions in other areas of data collection, particularly regarding data to assess where alcohol has played a role in causing harm. For instance, alcohol-related violence data is collected and reported on quarterly by the New South Wales Bureau of Crime Statistics and Research (BOCSAR), while in Queensland this data is not reported on. However, the most compelling need in this area is for data on alcohol-related presentations to emergency departments and hospital admissions, and also on alcohol-related family violence. This could be facilitated by making the data collected by hospitals publicly available and making mandatory the collection of more alcohol-related items. New Zealand is slightly more advanced than Australia on this as the New Zealand Government is piloting the collection of alcohol-related presentation data at 10 emergency departments from July 2015, with the intent to introduce mandatory collection from 2016.

Recommendations

- 1. That nationally consistent data collection that is timely and complete on alcohol sales be implemented in Australia which can be disaggregated and compared at the state and territory level.**
- 2. That Liquor Acts in each Australian jurisdiction be amended to include mandatory collection and public reporting of alcohol sales data and data on liquor licensees' occupancy, trading hours and compliance with the liquor legislation.**
- 3. That infrastructure and data collection systems be put in place for alcohol-related medical consultations, emergency department presentations and hospital admissions, and for other key issues such as family violence.**
- 4. That a system for ongoing monitoring of alcohol-related harm, including harm to others, be introduced, especially within the hospital sector.**

11. Bringing it all together: A comprehensive policy approach to reduce alcohol-related harms

This document has covered the many different individual policies and interventions that can reduce alcohol-related harms. It is argued that the most effective of these are policies which address the drivers of alcohol consumption such as pricing and taxation and access and availability. It has also discussed the great variation in policy responses to alcohol across the different jurisdictions. Unfortunately, what characterises most of these approaches is that the policies or programs have largely been implemented in an ad-hoc manner in response to different issues or interests at different times. There are very few instances where a comprehensive suite of policies and programs have been implemented in a coordinated fashion and none at a national level. A nationally coordinated approach remains the best level at which to implement a comprehensive and effective policy.

The ideal features of a comprehensive policy to reducing alcohol-related harms are:

- A strategic and coordinated approach to reducing alcohol harm, through prevention, early intervention, treatment, monitoring and evaluation
- Clear governance structures
- Evidence-based and cost-effective strategies at the population, community and individual level, with social marketing and education campaigns reinforcing these activities
- Clear targets, resourced and accompanied by an implementation plan developed in conjunction with key stakeholders (excluding the alcohol industry which clearly has competing interests).

The National Strategy for Alcohol is a potential institutional framework for undertaking a comprehensive policy approach in Australia. However, the related elements need refreshing and governments must renew their commitment. For instance, as noted in the introduction, the two major guidelines of importance for the management of alcohol consumption, the National Health and Medical Research Council (NHMRC)'s Australian Guidelines to Reduce Health Risks from Drinking Alcohol and the Australian Department of Health's Guidelines for the Treatment of Alcohol Problems have not been updated since 2009.

There have been some attempts to take a comprehensive policy approach at lower levels of government. Bearing in mind their limitations which, as the discussion below illustrates, arise primarily because they are initiatives at the sub-national levels of government, the lessons learnt from these programs could nonetheless provide a basis for future comprehensive policies. The experience with the Northern Territory's *Living With Alcohol* program is particularly notable because, at least for part of the life of this program, the Northern Territory had access to the full suite of policy instruments needed to put in place a comprehensive policy before constitutional limitations were imposed.

11.1 The Northern Territory's Living With Alcohol (LWA) program

The LWA program ran between 1992 and 2002 in the Northern Territory and was a whole-of-government approach to a comprehensive package of reforms specifically aiming to reduce alcohol consumption and related harms. It included:

- Measures to increase the price and reduce availability of alcohol
- A broad range of health promotion, community development and education strategies
- A range of media strategies aiming to change attitudes towards alcohol
- A range of harm-reduction measures
- Increased access to alcohol treatment programs.

The program was funded by a levy of 5 cents per standard drink on all alcoholic drinks of greater than 3 per cent strength with an extra levy of 35 cents per litre on cask wine.³⁰² This created a price differential between full strength and light beer, and created an important price signal on cheap cask wines, which were highly problematic at the time. The funds were directly hypothecated to the program, which ensured its funding base and built public support for the increased alcohol prices. Prior to 1997, there were no limitations on the ability of states and territories to levy separate alcohol taxes, thus providing the Northern Territory with the full suite of policy instruments needed to adopt a comprehensive policy approach. The program lost its dedicated funding base following a 1997 High Court decision which removed the ability of states and territories to levy separate alcohol taxes.³⁰³ Subsequently the program lost momentum and ceased in 2002.

An evaluation to the end of 1996³⁰⁴ showed a saving to the NT economy of \$124.3 million and reductions in:

- Apparent per capita alcohol consumption of 22 per cent
- Alcohol-related road deaths (34.5 per cent) and hospitalisations (23.4 per cent)
- Deaths (19 per cent) and hospitalisations (2 per cent) from acute alcohol-related conditions other than road crashes (e.g. other injuries, alcohol withdrawal)
- Hospitalisations (66 per cent) for chronic alcohol-related conditions (e.g. dependence, cirrhosis, various cancers).

Benefits were apparent for both Aboriginal and Torres Strait Islander and non-Indigenous people. A subsequent evaluation to 2002 revealed a similar pattern of benefits sustained throughout the program.³⁰⁵ However, these impacts have not been sustained since the program ended. The Northern Territory currently has the highest per capita consumption of alcohol in Australia.

11.2 Alcohol Management Plans

Alcohol Management Plans (AMPs) in Australia were briefly discussed in Chapter 4 which focused on restricting the physical availability of alcohol as supply restriction is a key measure of AMPs. However, AMPs typically rely on policy tools in addition to restrictions on the sale of alcohol. The comprehensive nature of AMPs has been recently codified with the passing of the *Stronger Futures in the Northern Territory Act 2012* (Cth), which established for the first time a role for the Australian Minister of Indigenous Affairs in approving or rejecting AMPs in the Northern Territory. Following this, five minimum standards were established to help communities and local governments develop AMPs. These standards focus on the need for consultation and engagement, management and governance structures, monitoring, reporting and evaluation, and geographical boundaries. The standards also suggest strategies for supply, demand and harm reduction – in other words, all the elements of a comprehensive policy approach.

A recent review of studies of the effectiveness of AMPs concluded that, while the evidence was still limited, where AMPs were locally driven and owned, there were stronger and more sustainable outcomes. The weaknesses of AMPs were most evident where their coverage had been narrowed to cover primarily supply issues without complementary demand and harm-reduction measures and where there had been a lack of clarity in the roles and responsibilities of communities and governments, and lack of support in nurturing local community leadership.³⁰⁶

Effective AMPs are not programs that simply restrict the sale of alcohol. Successful AMPs have been observed in Aboriginal and Torres Strait Islander communities where they have been voluntarily introduced, driven and led by the communities and Aboriginal and Torres Strait Islander agencies, comprehensive (i.e. including a range of activities and resources to support individuals and communities in making changes and building community capacity), and fully implemented.

11.3 Aboriginal, Torres Strait Islander and Māori communities: Are additional considerations required?

The experience from the *Living With Alcohol* program clearly demonstrates that comprehensive alcohol policies are equally effective whether targeted towards Aboriginal and Torres Strait Islander people or non-Indigenous people. This reflects the findings from other studies.

As a general principle, alcohol policies should be non-discriminatory. Discriminatory approaches – unless they are specifically requested, developed and led by the community and community leaders – can exacerbate existing levels of disempowerment and stress, themselves risk factors for harmful drinking.³⁰⁷

Social and economic disadvantage has been found to increase the risk of dependence on substances such as alcohol.³⁰⁸ The considerable inequities and disadvantage experienced by Aboriginal and Torres Strait Islander and Māori peoples have been recognised as contributing significantly to their harmful use of alcohol.³⁰⁹

Because of this, and the significant evidence that addressing the social determinants of health can reduce vulnerability to substance abuse in later life,³¹⁰ there is a compelling need for these factors to be addressed when developing effective alcohol policies for Indigenous people.

11.4 Comprehensive alcohol policy trials in the US

A five-year community alcohol trauma prevention trial was conducted in the US from 1992 to 1996 involving three matched intervention communities – one in Northern California, one in Southern California and one in South Carolina. There were five prevention components at each intervention site:

- Mobilising the community to raise awareness of alcohol-related problems
- Encouraging responsible beverage service
- Reducing underage drinking by limiting young people's access to alcohol
- Increasing local enforcement of drink-driving laws
- Limiting access to alcohol by using zoning laws.

Population surveys in the intervention sites found that this comprehensive intervention strategy had significant impacts in reducing the incidence of harmful drinking and alcohol-related injuries caused by traffic accidents and assaults, relative to comparison communities lacking these interventions. In particular:

- The self-reported rate of 'having had too much to drink' fell by almost half.
- Self-reported driving when 'over the legal limit' was 51 per cent lower.
- Night-time road traffic accidents fell by 10 per cent and accidents in which the driver had been drinking fell by 6 per cent.
- Assault injuries observed in emergency departments fell by 43 per cent.

11.5 Conclusions

A comprehensive approach to developing and implementing policies and strategies for reducing alcohol-related harm in Australia and New Zealand should be adopted as this would enable the multiple elements of the situation to be addressed and also allow for important synergies of cost and effect.

The experience of the LWA program in the NT demonstrates the potential strengths of a comprehensive approach, as do the results of the comprehensive intervention trials conducted in the US in the 1990s.

The respective experiences of the LWA, AMPs and comprehensive alcohol policy trials in the US suggest that it is possible to achieve significant reductions in alcohol consumption and alcohol-related harms. They also indicate that a whole-of-government approach is most effective. The implications are, for instance, that measures at the community or local government level could be enhanced considerably by complementary state-wide licensing measures and federally implemented pricing measures.

Recommendations

- 1. That comprehensive policies be introduced in Australia and New Zealand that meaningfully address alcohol-related harms, taking a holistic approach to the issue including appropriately addressing alcohol pricing, marketing and promotion, supply, and access to a suitable range of treatment options. This would involve the inclusion of both federal and state/territory level initiatives within any National Strategy for Alcohol.**
- 2. That the Commonwealth Department of Health undertake a revision of the Australian Guidelines to Reduce Health Risks from Drinking Alcohol and the Guidelines for the Treatment of Alcohol Problems, both of which have not been revised since 2009.**
- 3. That further evaluation frameworks be formulated and implemented to measure and report on the effectiveness of plans and interventions, to ensure continuous quality improvement (CQI) in policy development in this area.**
- 4. That further evaluation frameworks be formulated and implemented to determine the effectiveness of plans and interventions to inform comprehensive approaches to reduce alcohol-related harms in Australia and New Zealand.**

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