Preventing Alcohol-Related Harm in Australia
A submission to the National Preventative Health Taskforce

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Setting the Context

As noted in the "Australia: the Healthiest Country by 2020' discussion paper, alcohol use in Australia is associated with a range of symbolic, economic and social benefits. However, alcohol use also contributes to a range of acute adverse consequences, such as injury (e.g. violence, accidents on the road and at work; self-harm) and chronic harms (e.g. problems such as cirrhosis, breast cancer, cardio-vascular disease and depression).

In Australia, the main causes of alcohol-related deaths are cancer, alcoholic liver cirrhosis and road trauma. Among people aged 15 to 34 years, alcohol is responsible for the majority of drug-related deaths and hospital episodes, causing more deaths and hospitalisations in this age group than all illicit drugs combined.

More than 40 different conditions have been identified as being either partly or entirely attributable to alcohol consumption. The alcohol-related degenerative diseases, typified by chronic conditions such as organ failure (eg liver cirrhosis) and the development of cancer (eg liver cancer) tend to occur as a result of many years of alcohol use. Short bouts of drinking to intoxification tend to be associated with acute conditions such as violent assaults, road injuries and drowning.

Research published by the National Drug Research Institute as part of the National Alcohol Indicators Project (www.ndri.curtin.edu.au/publications/naip.html) shows that:

- 44% of alcohol is consumed at levels that pose risk in the long-term, and 62% is drunk at levels that pose risk in the short-term;
- 24% of males and 17% of females are at risk of short-term harm at least once a month;
- Every year, about 50 teenagers (14-17 year olds) die from alcohol-attributable injury and disease and another 3,500 are hospitalised;
- Over 80% of all alcohol consumed by 14-17 year olds is drunk at risky/high risk levels for acute harm;
- Between 1993/94 and 2000/01 over half a million Australians were hospitalised due to risky/high-risk drinking. In a single year in this period, alcohol problems demanded 400,000 hospital-bed days.
- An estimated 10,592 Australians aged over 65 died from causes directly attribute to alcohol between 1994 and 2003;
- Over a five-year period between 2000-2004, an estimated 1145 Indigenous Australians died from alcohol-attributable injury and disease; and
- In Australia 4381 years of life were lost prematurely due to alcohol-caused violence in 1997.

Prevention that works

The National Drug Research Institute's mission is to "conduct and disseminate high quality research that contributes to the primary prevention of harmful drug use and the reduction of drug related harm".

Therefore NDRI wholeheartedly supports the focus of the National Preventative Health Taskforce and efforts by the Australian Government to prevent health problems in Australia.

In particular, the Institute supports efforts to prevent alcohol-related harm, and in this submission, we will focus on the Taskforce's recommendations relating to alcohol.

More specifically, NDRI welcomes the acknowledgement in the discussion paper that Australia's prevention strategy must take a long-term and sustainable approach, and that recommendations to address alcohol-related harm make it clear that an integrated package of solutions is required.

NDRI supports evidence-based practice, and in the main the comprehensive Discussion Paper places emphasis correctly in terms of available evidence, which shows that isolated initiatives have limited effectiveness in addressing the harmful use of alcohol in Australia. The introduction of a package of integrated measures is likely to be most effective.

According to Loxley et al 2004, 'whole of population' or universal strategies are of particular importance in reducing the more prevalent harms associated with alcohol use.

Regulation of the supply of alcohol products is strongly supported in the research literature. There is evidence for the effectiveness of measures that control the price of alcoholic drinks. Young people and heavy drinkers are influenced by price. The current Australian approach to alcohol taxation, and therefore pricing systems, are not entirely consistent with good public health approaches to minimising alcohol-related problems.

There is evidence and a sound rationale for the enforcement of laws prohibiting sale of alcohol to persons under legal purchasing age and enforcing laws regarding not serving alcohol to intoxicated patrons.

Physical availability of alcohol in terms of numbers of outlets and hours of sale has increased in Australia over the past decade and Australian and overseas evidence identifies late night trading for hotels and nightclubs as contributing to alcohol-related violence and road trauma.

Public education campaigns may contribute to reducing risky alcohol use, but usually when they support other policy measures such as tax increases and law enforcement.

Babor et al 2003 and Loxley et al 2004 presented the strategies research consistently tells us are the most effective in addressing alcohol-related problems.

They are:

Price and tax

Alcohol taxation influences the price of alcohol over and above market forces. Changes in taxation and prices (even small changes) have an effect on alcohol consumption. The evidence consistently indicates that higher priced alcohol is associated with per capita declines in consumption. The evidence also indicates that particular subgroups, such as young people and heavy drinkers, are sensitive to price changes.

NDRI recommends the application of a 'tiered' volumetric tax, where the base tax is determined according to alcohol content and an additional 'harm index' is applied to beverages shown to be particularly problematic and/or associated with particularly high levels of harm. It is crucial that such a tax is re-assessed regularly to ensure it outpaces increases in disposable income. Such a tax would provide an incentive for production and consumption of lower alcoholic beverages, which the Discussion Paper lists as one of the major imperatives for Australia.

Physical availability

Consistent national and international evidence indicates that the physical availability of alcohol influences alcohol use and related problems. The ease or difficulty of accessing alcohol can affect alcohol consumption. Typically, as physical accessibility to alcohol within a community increases, overall alcohol consumption and related problems also increase. Alcohol may be totally banned (e.g. 'dry areas' or discrete 'dry community' declarations) or controls placed on the type of alcohol available at certain times or events (e.g., at some sporting events there are controls on the types of alcohol available and alcohol content as well as limitations on how many drinks an individual can purchase at one time). There are usually limitations on the days and hours of sale and, in some communities, there are restrictions on the nature of purchases (e.g. no bulk packaged liquor sales). Increases and decreases in the minimum purchase age have been associated with corresponding changes in levels of consumption and harm, as have increased trading hours and increased numbers of licensed premises.

Drinking context

Different drinking contexts are associated with different levels of risk. For example, overcrowded, late night venues with poor crowd control techniques have higher risk than venues with well-trained staff who comply with responsible server practices. Risk is significantly reduced when training in responsible service of alcohol (e.g. not serving drunk people; not engaging in promotions and other practices that encourage risky consumption; engaging skilled crowd controllers) is combined with enforcement strategies (e.g. through police and licensing authority activity).

Drink-driving

Random breath testing reduces drink-driving, if there is a perceived high probability of detection followed up by substantial consequences. There are some (such as those who record very high blood alcohol levels and who are alcohol dependent) who can be resistant to these strategies and additional approaches may be helpful (e.g., diversion to treatment; installation of devices that prevent car activation if a breath test is ‘positive’).

Alcohol promotions and advertising

The nature of alcohol promotions has become more diverse and sophisticated as electronic and other communications have developed. Greater exposure to alcohol promotions has been associated with increased product recognition, more positive attitudes to alcohol and drinking and, in some studies, heavy drinking. Unlike alcohol availability, promotions have largely been subject to voluntary as opposed to statutory regulation. The evidence is that self-regulation has been generally ineffective.

Education and persuasion

These include mass media communication, communicating guidelines on low risk drinking and school- and college-based programs (e.g. information about the risks of alcohol; resistance skills). The political acceptance and popularity of these programs appears high but their ability to influence the behaviour of individuals may be lower than many would hope or expect. While some well-resourced programs show modest effects, often these do not persist, particularly if the programs are conducted in isolation. As with other interventions, they might be more effective when combined with other approaches (e.g. mass media campaigns can build community support for drink-driving countermeasures).

Other specific measures

As indicated, the Discussion Paper is comprehensive and in large places emphasis correctly in terms of the available evidence.

However there are some key areas where, in NDRI's opinion, a greater emphasis will enhance the prevention of alcohol related harm in Australia.

These include:

Families and children

There should be a greater focus on preventing the impact of alcohol-related violence and other harms on families and children, in particular, on the impact of alcohol on chronic neglect of children.

A recent report, prepared by the National Drug Research Institute and the Centre for Social Research for the WA Child Death Review Committee (Frances et al 2008) showed that all but one of 22 cases of such neglect involved alcohol and other drug use (See http://www.ndri.curtin.edu.au/pdfs/publications/T187.pdf*).*

Social determinants

NDRI welcomes the focus on prevention and the recommendation that one action be to "commission research on effective strategies to address social determinants of alcohol consumption in Indigenous and low-income communities" (page 40, table 3). However, this focus must be expanded to adequately address prevention of the social determinants of substance misuse. That is, interventions in the early years (holistic early learning and care [including health and nutrition] focused on children and parents to assist transition to school), and at important life transitions (individual and family supports to assist transitions to school, university, employment, etc) which promote resilience in children and young people, and impact upon later alcohol use.

This is particularly the case with Indigenous people, those living in rural and remote communities, and those living with socioeconomic disadvantage.

Alcohol restrictions in Indigenous Communities

Indigenous communities have taken two main approaches to reducing alcohol supply: declaring 'dry' areas and extending controls on availability (supply), through liquor licensing legislation. These approaches can be effective but communities need support to enforce them, and underlying policy must promote Indigenous control. There is strong evidence for the effectiveness of local licensing restrictions in communities with high Indigenous populations, e.g. restrictions on the days and hours of sale and on the type and quantity of liquor that can be purchased (Chikritzhs et al 2007).

Furthermore, the Northern Territory Emergency Intervention alcohol measures can perhaps best be summarised as focusing on involuntary restrictions on availability, which have demonstrated effect (apart from local area bans which are less well supported), but the circumstances under which they've been introduced may have unintended negative consequences - such as people deliberately flouting what they see as racist laws.

As with all interventions, any alcohol restrictions introduced under the name of prevention must be implemented in accordance with the evidence of not only what works but in this case also with evidence of how it works. That is, the process of implementation itself significantly influences the effectiveness of the restriction.

(See www.ndri.curtin.edu.au/pdfs/publications/M68.pdf for more information on alcohol restrictions.)

Availability and Outlet Density

As indicated, availability of alcohol is a key predictor of alcohol consumption and alcohol-related harm. NDRI welcomes the recognition in the Discussion Paper of i) the preventative potential of addressing availability, and ii) the importance placed on the collection of data on alcohol sales by all State and Territory governments.

NDRI supports measures that lead to the reinstatement of this data being collected. NDRI researchers have developed a model that can predict the likely effect of granting a new liquor licence anywhere in Australia on alcohol-related assaults, hospitalisations, deaths and road crashes. However a national approach to gathering alcohol sales data (currently only collected in Western Australia and the Northern Territory) is the key to applying the liquor licensing model Australia-wide.

In this way, NDRI's research has demonstrated that the decisions of liquor licensing authorities can have a significant impact on the health and safety of communities, and therefore on the prevention of alcohol-related harm. The Outlet Density model could also play a key role in giving local communities a greater say in the availability and management of alcohol in their local area, as suggested in the Discussion Paper, and "an understanding of the impact of different types of alcohol outlets and their density on hospitalisation, violence and crime rates" (page 37).

(See http://www.ndlerf.gov.au/pub/Monograph_28.pdf for more information on the Outlet Density model.)

Key references

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