Preventing alcohol related harm

Issued *May 2016*

Alcohol related harm is pervasive throughout the Australia and accounts for 3.2 percent of the total national burden of disease (Preventative Health Taskforce 2009). There are a range of evidence informed policies and programs that can reduce the harm associated with this substance which are implemented in varying degrees. These include the need to reform liquor licencing, taxation and advertising, as well as resource the AOD treatment sector, and engage in a discourse which counters the harmful customs which encourage risky alcohol consumption.

Introduction

Alcohol consumption is largely ubiquitous throughout Australia with 86.2% of Australians having consumed alcohol at some stage during their lives (AIHW 2014). Melbourne has enjoyed a reputation for providing a vibrant nightlife, in part due to the significant increase of pubs, bars, cafes, restaurants and other entertainment venues which is the result of a trend towards the liberalisation of liquor licensing (Morgan and McAtamney 2009). Equally, there has been a significant expansion in takeaway liquor outlets including the expansion of larger outlets.

Greater availability of alcohol also has a downside. The harms associated with alcohol are global in nature, with alcohol being responsible for four per cent of all disability adjusted life years of health lost through premature death or disability (World Health Organisation 2009). In Victoria, alcohol related harms are prevalent throughout the community as evident from the data below:

- One in 12 emergency department presentations are alcohol related (ACEM 2015);
- During 2012/13, alcohol was the most common principle drug of concern for AOD drug treatment, evident in 21,460 AOD treatment episodes (Fare 2014);
- During 2013/14, 16,258 ambulance attendances were alcohol related (Lloyd et al 2015), creating a greater burden on ambulance services than any other pharmaceutical or illicit substance;
- During 2012/13, there were 7352 alcohol related assaults during hours of high alcohol consumption (Turning Point 2016);
- During 2012/13, 14,015 family incidents were alcohol related (Fare 2014)
- During 2012, 8422 alcohol related deaths were recorded (Turning Point 2016)

Harm associated with alcohol consumption nationally to both drinkers and others is estimated to amount to $36 billion per annum (Fare nd). This figure corresponds with the increasing harms associated with alcohol consumption, detailed in Figure 1 (Fare 2014) below:

Figure 1: trend analysis – measures of alcohol related harm[1]

	Trend	Trend per 100,000
Alcohol treatment episodes 2003-04 to 2012-13	28% ↑	10% ↑
Alcohol-related ambulance attendances 2003 to 2011	146% ↑	112% ↑
Alcohol-related hospital admissions 2001-02 to 2010-11	53% ↑	33% ↑
Alcohol-related assaults 2001-02 to 2010-11	30% ↑	13% ↑
Alcohol involvement in family incidents 2003-04 to 2012-13	85% ↑	59% ↑
Alcohol-related serious or fatal road injuries 2001-02 to 2010-11	36% ↓	45% ↓

It is evident that aside from alcohol related serious or fatal road injuries, the remaining measures detail an increase per capita despite government efforts detailed through a range of strategies and plans occurring at both a State and Commonwealth level.

There is a consensus in the evidence that outlines solutions to reducing alcohol related harm, including violence, which is canvassed throughout this policy paper. This research indicates that policies should be founded on the principles of addressing the systemic causes of alcohol harms, being alcohol availability, price and culture, as well as the various social determinants which may contribute to risky alcohol consumption.

> Recommendation 1: The Victorian Government resource evidence-informed research which identifies systemic social determinants that contribute to alcohol related harm and violence and that the findings be translated into effective policy.

Key Issues

Solutions to alcohol related violence can be summarised as follows:

i. Reducing availability;
ii. Targeting higher risk licenced venues;
iii. Alcohol tax reform;
iv. Local solutions and responses;
v. Access and provision of evidence-informed treatment;
vi. Advertising reform;
vii. Responding to alcohol related family violence; and
viii. Changing attitudes towards alcohol.

[1] It should be noted that there has been enduring and comprehensive state and national campaigns, legislative reform and resourcing directed toward reducing road trauma, which has likely contributed significantly to the reduction in alcohol related road trauma. .

Reducing availability

Research has indicated that localities with a high density of liquor outlets experience higher rates of violence (Livingston 2008), accidents, sexually transmitted diseases, morbidity, underage drinking, child abuse and local amenity issues (Livingston 2011). Further, areas which are closer to liquor outlets are more likely to experience alcohol related crime (Donnelly, Poynton, Weatherburn, Bamford and Nottage 2006). Packaged liquor outlets have been found to be associated with violence in Melbourne's suburbs while pubs and other licensed venues are associated with violence in the CBD and inner-suburbs (Livingston 2008). Also, a strong relationship between packaged liquor outlets and family violence has also been identified, with one additional packaged liquor outlet increasing the domestic violence rate by 1.36:1000 head of population (Livingston 2011). Suburbs in close proximity to areas with a high density of liquor outlets also experience higher levels of violence (Livingston, Chikritzhs and Room 2007).

Density of liquor outlets should be a primary consideration in the administration of liquor licences, as should other social determinants which are conducive to alcohol related violence and harm (some which are canvassed below). VAADA would caution against highly restrictive policies as this may engender unintended consequences and harm. For instance, denying people entry to local venues may shift some of the challenges and harms to another location and also heighten risks associated with travelling while intoxicated.

> Recommendation 2: Density of liquor outlets (packaged and licensed) be considered as a primary factor in the approval of further licenses.

Targeting high risk licensed venues

The prevalence of alcohol related violence within close proximity of liquor outlets varies depending on a number of risk factors evident in the design of the venue, staff behaviour and training, hours of operation, proximity of other liquor outlets and prevalence of other cluster points such as taxi ranks and queues. Venues which exhibit a high number of risk factors are more likely to experience alcohol related harms, including violence. Venues with extended trading hours are particularly prone to alcohol related harm, as it corresponds with those times which it is most likely to occur (between 9pm and 3am on Friday and Saturday nights). Broadly speaking, research indicates that higher levels of alcohol related assault occur between 6PM and 6AM on Friday and Saturday nights (Sweeney and Payne 2011). A large proportion of alcohol related violence occurs either when patrons are ejected from the venue or when the venue closes. Therefore, the external environment (which includes taxi ranks, access to public transport, lighting and security staff) is an important factor in determining the likelihood of violence (Morgan and McAtamney 2009).

VAADA believes that the licencing conditions of these venues must be regularly reviewed and modified if appropriate to reduce the likelihood of harm, with particular consideration to environmental conditions which may exacerbate alcohol related harm and violence.

VAADA recommends that venues that exhibit high levels of violence within or in the immediate surrounds of the venue be compelled to reduce risk factors which may contribute to violence, such as staff training, lighting and hours of operation. A more stringent approach to the service of alcohol

(including banning the service of certain high alcohol volume beverages after a certain time) should be considered.

> Recommendation 3: The licencing conditions be regularly reviewed and modified if appropriate to reduce the likelihood of harm, with particular consideration to environmental conditions which may exacerbate alcohol related harm.

> Recommendation 4: Venues that exhibit high levels of violence within or in the immediate surrounds of the venue be compelled to reduce risk factors which may contribute to violence, such as staff training, lighting and hours of operation. A more stringent approach to the service of alcohol (including banning the service of certain high alcohol volume beverages after a certain time) should be considered. Further, demarcations of responsibility for public areas within the immediate vicinity of the venue should be set with a view to mitigating factors which contribute to violence.

Alcohol tax reform

There is a strong body of evidence which indicates that price changes impact upon alcohol consumption (Vandenberg & Sharma 2015). Increasing the price of alcohol through taxation is an effective measure in reducing alcohol related harm. There are currently 16 different tax rates on alcoholic products in Australia increasing complexity in the taxation system (Vandenberg & Sharma 2015). There is a need for greater consistency in taxation practice and to this end, VAADA recommends that the current alcohol taxation system be reformed and a volumetric taxation regime with a minimum unit price be implemented. This approach creates a greater level of consistency through implementing a tax associated with the alcohol content of the beverage. Determining the specific details and taxation rates would require further work, however, if implemented in an evidence informed manner consistent with best practice this would encourage consumption of beverages with a lower alcohol volume or less consumption overall, which would have a mitigating effect on alcohol related harms. Modelling from Vandenberg and Sharma (2015) note that setting a minimum unit price at $1 for each standard drink would reduce consumption levels by up to 11.9 standard drinks per week.

Further, it is proposed that the revenue sourced from this tax could be allocated to alcohol related treatment programs, education and other harm minimisation endeavours. For further information, see VAADA's Position Paper on Alcohol Taxation at <http://www.vaada.org.au/resources/items/314239-upload-00001.pdf>.

VAADA reasserts the recommendations contained within the Position Paper on Alcohol Taxation.

Local solutions and responses

There is a growing body of evidence which supports the implementation of local solutions to alcohol related harm. This may involve community members working collaboratively with local businesses and government to reduce alcohol related harm through influencing drinking environments. Liquor accords are a good example of a local strategy to combat alcohol related violence. This involves local community groups, local government and business agreeing to a voluntary set of harm minimisation

practices as well as a code of conduct. This may result in practices such as more regular identification checks and the adoption of responsible service of alcohol practices (National Drug Research Institute 2007). Local initiatives may also rely on using local statistics to inform practice, as occurred with the Alcohol Linking Program in New South Wales (Wiggers 2007). It may involve responding to local trends, the needs of at risk cohorts, local environmental modifications and other endeavours. These types of laudable initiatives must be embedded in evidenced-based research and should involve local AOD agencies.

The Newcastle approach

In 2008, following a restriction imposed by the NSW liquor licensing authority, 14 pubs within Newcastle were require to close at 3AM with a 1.30AM lockout. Shots could not be served after 10PM and alcohol could not be sold within half an hour of closing. Licensees are now required to develop various plans, subject to audit and retain a *Responsible Service of Alcohol* officer from 11PM until close (Kypri et al, 2014).

In the following 18 months post the implementation of these interventions, the number of assaults within the CBD reduced by 34 percent (Kypri et al, 2014) and have now reduced to approximately half that of 2008 (Kypri 2016).

> Recommendation 5: VAADA recommends that evidence-informed local initiatives to reduce alcohol related harm are encouraged through provision of resources and support by all levels of government.
>
> Recommendation 6: VAADA recommends that strategic planning be undertaken to support local solutions to address alcohol related harms and where suitable, to replicate the Newcastle intervention in Victoria.

Access and provision of evidence-informed treatment

There is strong evidence that indicates that short term interventions and treatment approaches have a high level of efficacy in reducing alcohol related harm (O'Donnell et al, 2013). General practitioners (GP) can play a pivotal role in delivering brief interventions and should be provided with strong incentives to identify alcohol related health risks in patients presenting for separate health related matters and have capacity to conduct brief interventions where appropriate. Further, in diagnosing alcohol related harm, GPs should also provide their patients with sound nutritional and health advice on how to reduce the severity of alcohol related harm.

During 2013/14, in Victoria, 40 percent of AOD treatment service users presented with alcohol as the principle substance of concern (Australian Institute of Health and Welfare 2015). As noted above, alcohol also contributes to significant harms demonstrated through the high prevalence of ambulance and emergency department attendances with Cancer Council of Victoria citing long term consumption contributing to 3000 cases of cancer nationally (Choahan 2016). The provision of AOD treatment for alcohol issues is cost effective, with international evidence citing a $5 return on investment for each $1 spent on treatment through downstream savings in health, social care and justice systems (Raistrick, Heather and Godfrey 2006). Maximising on this benefit will require an expansion of the AOD treatment system to ensure that community members can access treatment services when and where they need them. Currently, there are significant wait times which often result in missed opportunities where individuals experiencing alcohol related dependency are unable

to access services at the time when they need them. This results in preventable harm occurring within the community.

There is a need for greater service integration, providing for individuals with multiple morbidities who require interventions from a number of service sectors. Evidence-informed local initiatives are encouraged through provision of resources and support by all levels of government.

Reducing exposure to alcohol advertising

Alcohol advertising has been associated with increased alcohol consumption and the commencement of alcohol consumption among young people (O'Brien et al 2014). A range of studies have highlighted a relationship between alcohol advertising and alcohol consumption which have been summarised in ANPHA's (2012) issues paper on alcohol advertising, noting the following:

- A meta analysis found a small but significant association between alcohol advertising (with regard to spirits) and consumption (Gallet 2007);
- Babor (2010) found a strong correlation between alcohol advertising and alcohol consumption among young people;
- Hurtz et al (2007) found a link between youth alcohol consumption and exposure to alcohol advertising in stores;
- Snyder et al (2006) found an association between alcohol advertising and increased youth alcohol consumption; and
- 94 percent of young people aged between 12 – 17 years have viewed televised alcohol advertising (MCAAY 2015).

The now defunded Australian National Preventative Health Agency (ANPHA 2012) noted that conservatively, $128 million was spent on alcohol advertising in 2007. They cite a view from industry that advertising aims to increase the market share of a specific product and shift current consumers to higher end products. Although this is likely correct, it portrays only part of the overall purpose, which is to derive the greatest profit which will be maximised through increasing sales of alcohol across the population. Despite the implicit intention not to expose young people to alcohol advertising, half of all televised alcohol advertising appears during children's popular viewing times often depicting alcohol consumption as something enjoyable (MCAAY 2015). Alcohol companies often sponsor events which are widely attended by young people and have a rapidly expanding presence on social media with over 2.5 million followers on their Facebook pages in 2012 (MCAAY 2015).

Significant reform limiting exposure of alcohol adverting should be progressed. As a starting point, in an effort to align rhetoric and practice, state and federal governments should show leadership in their efforts to reduce the harmful effects of alcohol by seeking the removal of all direct and indirect alcohol advertising from venues which are owned, leased, managed or run by state assisted entities.

Further discussion and recommendations regarding alcohol advertising and marketing can be found in VAADA's position paper entitled Alcohol Advertising, Marketing and Promotion, accessible from: http://www.vaada.org.au/resources/items/314236-upload-00001.pdf

> Recommendation 7: Local, State and federal governments should remove all direct and indirect alcohol advertising from venues which are owned, leased, managed or run by state

assisted or funded entities and should not provide any assistance or in kind support for these entities.

Responding to alcohol related family violence

There is a linkage between alcohol consumption and family violence, particularly in cases of heavy drinking; causation, however is a contested issue (Wilson et al 2014). Consuming alcohol has been found to be both a consequence of and precursor to relationship stress and violence (FARE 2015; Nicholas et al 2012) and is estimated to be involved in 50% of all violence between partners in Australia and 44% of all intimate partner homicides in Australia between 2000-2006 (Dearden & Payne 2009).

Alcohol use by a victim of family violence can make it more difficult for them to seek help from police, reduce their capacity to implement safety strategies and increase the likelihood they will be blamed for the violence and exclude them from support services such as women's crisis support accommodation or refuges (Nicholas et al 2012). Children are affected by exposure to family violence and can become victims of abuse, maltreatment or neglect themselves and intergenerational effects can occur where children exposed to violence may be more likely to develop AOD problems in later life and are at greater risk of using violence themselves (Battams & Roche 2011; Nicholas et al 2012).

Responding to this issue in an effective manner aligns with the range of recommendations detailed in this position paper, with a reduction in alcohol consumption potentially reducing family violence (Wilson et al 2014; WHO 2010). For instance, reducing alcohol outlet density, particularly packaged liquor licences, which Livingston (2011) notes has been positively associated with reducing rates of domestic violence in Melbourne.

VAADA's (2015) submission to the Victorian Royal Commission into Family Violence noted that the recent reforms on the AOD treatment sector had impeded agency capacity to undertake family inclusive programs. These programs result in positive outcomes for individuals, families and communities (VAADA 2010). Adequate and ongoing resourcing should be made available to allow for the continuation and further development of these programs within AOD services, with enhanced responses to family violence in AOD services being embedded within a broader framework of family inclusive practice. The sector should also be resourced to provide enhanced therapeutic responses to perpetrators of family violence experiencing AOD issues.

Recommendation 8: Adequate and ongoing resourcing be made available to allow for the continuation and further development of family inclusive programs within AOD services. This is in recognition that enhanced responses to family violence in AOD services should be embedded within a broader framework of family inclusive practice.

Recommendation 9: Emergency workers, GPs and the AOD treatment workforce be provided with the resources and capacity to identify, assess and engage with individuals impacted by alcohol related violence. There is a need to build the capacity across a range of sectors to support both victims and perpetrators of family violence to engage with AOD treatment services.

Changing public attitudes towards alcohol

VicHealth (2014) undertook broad based survey of Victorians on matters relating to alcohol consumption. This surveying confirms the ubiquity of alcohol consumption and the largely wide-spread acceptance of alcohol consumption as a regular activity in most social circumstances.

The research (VicHealth 2014) indicated that:

- the only events which should be alcohol free are church services, baby showers or study groups, with the view that alcohol should be consumed at other events, such as a child's birthday party or sporting event;
- One third of Victorians aged 16 – 29 years believe it is acceptable to drink with the intention of getting drunk with two thirds reporting that they drink at risky levels; and
- Over one quarter of Victorians feel the need to drink when others are drinking in a pub, club or bar.

This snapshot of data underpins the breath of alcohol consumption within Australia and its population-wide acceptance. Despite the wide spread messaging outlining alcohol related harms and the overall reduction in per capita alcohol consumption across the population (ABS 2015), many of the measures of harm continue to increase. There is a need for long term endeavours aiming to enact a cultural shift affecting the way alcohol is consumed in Victoria. This should accompany the evidence informed measures such as advertising, regulation and taxation reform.

> Recommendation 10: An ongoing, long term evidence informed campaign should be maintained with an overall goal of enacting a cultural shift with regard to alcohol consumption.

Powdered alcohol

Although powdered alcohol is not legally available in Australia, it should be noted that this product in a number of other international regions. This product poses a number of risks (Naimi and Mosher 2015) which should be noted in light of any future considerations regarding the availability of this product in Australia. Amongst a possible range of issues are implications which could arise in the administration and preparation for use which could lead to unpredictable alcohol volume with obvious dangers for consumption. Other issues may arise due to its portability and compact nature acting as a concentrated supplement with a variety of applications. Such a product should not be made freely available in Australia. As there is the risk it could generate considerable harms among certain cohorts.

VAADA's Recommendations

VAADA recommends that:

1. The Victorian Government resource evidence-informed research which identifies systemic social determinants that contribute to alcohol related harm and violence and that the findings be translated into effective policy.
2. Density of liquor outlets (packaged and licensed) be considered as a primary factor in the approval of further licenses.
3. The licencing conditions be regularly reviewed and modified if appropriate to reduce the likelihood of harm, with particular consideration to environmental conditions which may exacerbate alcohol related harm.
4. Venues that exhibit high levels of violence within or in the immediate surrounds of the venue be compelled to reduce risk factors which may contribute to violence, such as staff training, lighting and hours of operation. A more stringent approach to the service of alcohol (including banning the service of certain high alcohol volume beverages after a certain time) should be considered. Further, demarcations of responsibility for public areas within the immediate vicinity of the venue should be set with a view to mitigating factors which contribute to violence.
5. Evidence-informed local initiatives to reduce alcohol related harm are encouraged through provision of resources and support by all levels of government.
6. Strategic planning be undertaken to support local solutions to address alcohol related harms and where suitable, to replicate the Newcastle intervention in Victoria.
7. Local, State and federal governments should remove all direct and indirect alcohol advertising from venues which are owned, leased, managed or run by state assisted or funded entities and should not provide any assistance or in kind support for these entities.
8. Adequate and ongoing resourcing be made available to allow for the continuation and further development of family inclusive programs within AOD services. This is in recognition that enhanced responses to family violence in AOD services should be embedded within a broader framework of family inclusive practice.
9. Emergency workers, GPs and the AOD treatment workforce be provided with the resources and capacity to identify, assess and engage with individuals impacted by alcohol related violence. There is a need to build the capacity across a range of sectors to support both victims and perpetrators of family violence to engage with AOD treatment services.
10. An ongoing, long term evidence informed campaign should be maintained with an overall goal of enacting a cultural shift with regard to alcohol consumption.

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Disclaimer

While efforts have been made to incorporate and represent the views of our member agencies, the position and recommendations presented in this Paper are those of VAADA.

The Victorian Alcohol and Drug Association Inc. acknowledges the support of the Victorian Government.