The Royal Australasian College of Physicians

This submission has been developed to provide detailed feedback in response to the National Alcohol Strategy 2016-2021 Development Discussion Paper.

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RACP Submission:
National Alcohol Strategy 2016-2021
October 2015

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to comment on the National Alcohol Strategy (NAS) 2016-2021 Discussion Paper. This submission answers the questions posed in the Discussion Paper in the sequence in which they were presented on a section by section basis.

Purpose

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. Fellows and trainees of the RACP know first-hand of the harms that alcohol can cause, from their professional experience across Australia's addiction clinics, emergency departments, orthopaedic wards, rehabilitation centres, liver clinics and cancer wards. It is on the basis of this experience, as well as a comprehensive review of the evidence, that we provide the following input to the development of the National Alcohol Strategy (NAS) 2016-2021.

Overarching goal

The NAS 2016-2021 Discussion Paper states that:

The overarching goal for the NAS will be to set a national policy and implementation framework that seeks to improve the health of all Australians by reducing the prevalence of risky alcohol consumption, preventing or delaying the uptake of alcohol use and improving treatment outcomes for people with alcohol dependence to minimise health, social and economic costs, and the inequalities it causes

Subject to one caveat we support the above as an appropriate goal for the NAS. The caveat is that in our view it is misleading to focus only on reducing the prevalence of 'risky' alcohol consumption as there are gains to be made in public health from reducing the average level of alcohol consumption in general and from better addressing the general 'pro-drinking' culture in Australia - any level of drinking increases the risk of ill-health and injury. Therefore we would propose amending the goal so that it refers to '*reducing alcohol consumption including but not limited to the prevalence of risky consumption*'.

We support the current five year timeframe as an appropriate period for formulating and implementing the NAS. A period longer than this would be too infrequent to keep up with developments in alcohol policy research while a period shorter than this may not be feasible given the time and resources that need to go into formulating an appropriate strategy.

Guiding principles

We agree with the proposed guiding principles for the NAS. However we suggest that an additional one be added to state that, 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.[1]

[1] Spanagel R, Noori HR, Heilig M. Stress and alcohol interactions: animal studies and clinical significance. Trends Neurosc. 2014 Apr;37(4):219–27. http://dx.doi.org/10.1016/j.tins.2014.02.006; Marmot MG et al. Health inequalities among British civil servants: the Whitehall II study. The Lancet 1991;337(8754):1387–1393.

Building on existing efforts and progress

The RACP agrees that among the key successes to build on in the NAS are the successful and effective implementation of trading hour restrictions of on and off licence outlets in Newcastle and Sydney, which have already resulted in reductions in alcohol-related hospitalisations[2] and alcohol-related assaults[3] [4]. Another key success has been some recent attempts at implementing community based alcohol restrictions – typically these are characterised by high community support and implementation in more isolated geographical locations where supply restrictions are easier to enforce[5].

A key challenge that must be addressed going forward is the need for better intergovernmental coordination and cooperation. To be effective, many key priorities for policy change require improved coordination of the different policy actions determined by the various levels of government, including:

- reducing the physical availability of alcohol; which requires actions on a state/territory-wide basis, as well as better empowering local governments to develop and implement supply reduction measures
- appropriate alcohol pricing policies, implemented at both the Commonwealth level through appropriate volumetric taxation policies and at the state level through implementation of a minimum price per standard drink
- better Fetal Alcohol Spectrum Disorder (FASD) prevention policies, which require coordination across all levels of government to ensure effective education campaigns and training of health professionals to improve FASD diagnosis
- more comprehensive collection of data related to alcohol policy, including a national approach to data on sales and alcohol-related hospitalisations that can be disaggregated and compared at the state and territory level
- greater and long-term funding by all levels of government in Australia dedicated to alcohol treatment services and workforce development.

Evidence based strategies

We agree with the areas of focus that the Discussion Paper has identified as targets of evidence-based strategy development; namely influencing community attitudes, ensuring appropriate controls on alcohol advertising and promotion, controlling access to and the availability of alcohol, reducing alcohol use during pregnancy, and reducing variability in access to treatment and support.

Other areas of focus that merit further emphasis include:

- the formulation of effective supply reduction measures at the local government/community level;

[2] Jones, C Kypri K, Moffatt S, Borzycki C, Price B. The impact of restricted alcohol availability on alcohol-related violence in Newcastle, NSW. Crime and Justice Bulletin. No. 137; 2009.
[3] Menéndez P, Weatherburn D, Kypri K, Fitzgerald J. Lockouts and last drinks: the impact of the January 2014 liquor licence reforms on assaults in NSW, Australia. Crime and Justice Bulletin. No. 83; April 2015. Note that the research does not distinguish between the impacts of earlier closing times and impacts of earlier lockout times and so does not necessarily contradict the findings of the Ballarat research on lockout times.
[4] Kypri K, McElduff P, Miller P. Restrictions in pub closing times and lockouts in Newcastle, Australia 5 years on. Drug Alcohol Rev 2014 May;33(3):323–326.
[5] For instance, the restrictions imposed on Groote Eylandt and Bickerton Islands in the Northern Territory – see Conigrave K et al. An evaluation of the Groote Eylandt and Milyakburra Island Alcohol Management System. A report produced for the Department of Justice, Northern Territory Government; 2007.

- setting appropriate rates of volumetric taxation, which can differentiate between the different levels of harm associated with different types of alcoholic drinks; and
- identifying opportunities for more targeted treatment services to meet the different needs of clients who are at different stages in addressing their alcohol consumption.

Working in partnership

Key partnerships that are needed to underpin implementation of the NAS are:

- Partnerships between all three levels of government - Commonwealth, state/territory and local government and associated organisations; due to the importance of policies that require coordination between these different levels;
- Partnerships between governments and healthcare professionals, including specialist physicians, because they are frequently at the coalface of addressing the health repercussions of alcohol consumption.

Priority population groups

Subject to one significant caveat, the College agrees that children and young people and Aboriginal and Torres Strait Islander people are two population groups that may merit more than a 'whole of population' approach for addressing alcohol-related harms. The caveat is that this priority focus does not lead to discriminatory policies unless they are specifically requested, developed and led by the community and community leaders.

In the case of Aboriginal and Torres Islander peoples, we recognise that:

- The considerable inequities and disadvantage experienced by Aboriginal and Torres Strait Islander peoples have contributed significantly to their harmful use of alcohol.
- There is cumulative evidence of deficiencies in treatments available for Aboriginal and Torres Strait Islander people.

In the case of young people, there are a number of reasons why they should be a priority focus:

- 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.[6]
- Early initiation into drinking is associated with significantly increased risk of suffering from an alcohol use disorder.[7]
- 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.[8]
- Finally, an early drinking age is also associated with increased risk-taking behaviour among the young, for example culminating in increased drink driving, traffic accidents, emergency department presentations and prosecution for disorder offences[9]

[6] Brown S, Tapert S. Adolescence and the trajectory of alcohol use: basic to clinical studies. *Ann N Y Acad Sci*. 2004 Jun;1021: 234–244.

[7] Norberg K, Bierut LJ, Crucza RA. Long term effects of minimum drinking age laws on past-year alcohol and drug use disorders. Alcohol Clin Exp Res. 2009 Dec;33(12):2180–2190; Plunk AD, Cavazos-Rehg P, Bierut LJ, Crucza RA. The persistent effects of minimum legal drinking age laws on drinking patterns later in life. Alcohol Clin Exp Res. 2013 Mar;37(3):463–469.

[8] Hermens DF et al. Pathways to alcohol-induced brain impairment in young people: a review. Cortex 2013;49(1):3–17.

Another priority population group should be pregnant women. There is evidence that women are less likely to use specialised alcohol and drug treatment services and are more likely to use primary healthcare than their male counterparts.[10] This can be a barrier to identifying and treating pregnant women who are problem drinkers, with one study estimating that between only 10 per cent and 50 per cent of substance-using pregnant women will access treatment services.[11] 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.[12]

Priority areas and actions

The priority areas and actions identified in the NAS Discussion Paper are:

1. Change the current drinking culture in Australia to reduce harmful drinking
2. Prevent and reduce alcohol-related injury and violence
3. Prevent and reduce alcohol use during pregnancy
4. Protect young people from alcohol-related harm
5. Improve outcomes for Aboriginal and Torres Strait Islander people and their communities.
6. Provide an effective framework for advertising, promotion and sponsorship
7. Enhance effective enforcement and controls on availability
8. Improve treatment capacity, particularly within primary, acute and other health care settings
9. Guide practice through appropriate data collection and evaluation, and be responsive to emerging issues
10. Improve responses for emergency services
11. Improve criminal justice responses for alcohol-related offenders
12. Reduce chronic harms and disease related to alcohol use

This is a comprehensive list of priority areas, which the RACP supports.

We note that there is some overlap between some of these priorities. For instance, the evidence shows that price based measures and trading hour restrictions (which reduce physical and financial availability) are the best means of reducing consumption, which in turn can effectively influence drinking culture. Hence policies that address priority 7 (enhance effective enforcement and controls on availability) are also the best ones for addressing priority 1.

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[9] Kypri K et al. Minimum purchasing age for alcohol and traffic crash injuries among 15- to 19-year-olds in New Zealand. Am J Public Health 2006 Jan:96(1):126–131; Huckle T, Pledger M, Casswell S. Trends in alcohol-related harms and offences in a liberalized alcohol environment. Addiction 2006;101(2):232–240; and Everitt R, Jones P. Changing the minimum legal drinking age – its effect on a central city emergency department. NZMJ 2002;115(1146):9.

[10] Greenfield S, et al. Gender differences in alcohol treatment: an analysis of outcome from the COMBINE study. Alcohol Clin Exp Res. 2010;34(10):1803–1812.

[11] Hankin J, McCaul ME, Heussner J. Pregnant, alcohol-abusing women. Alcohol Clin Exp Res. 2000;24(8):1276–1286.

[12] Messer K, Clark K, Martin S. Characteristics associated with pregnant women's utilization of substance use treatment services. Am J Drug Alcohol Abuse 1996;22(403–421); Small J, Curran GM, Booth B. Barriers and facilitators for alcohol treatment for women: Are there more or less for rural women? Journal of Substance Abuse Treatment 2010;39(1):1–13.

We also note that the best means of addressing priorities such as priority 2, 3, 4 and 5, which relate to the 'spillover' effects of alcohol consumption, is by addressing the drinking culture and reducing overall levels of alcohol consumption which is the objective of priorities 1 and 7.

Similarly priorities 4 and 6 also share evidence based policies in common as policies that address alcohol advertising can be a powerful means of reducing underage drinking and levels of drinking among young people given the significant loopholes that currently exist in prohibitions on advertising alcohol to young people.

Bearing the above in mind, we recommend the following evidence based policies which would address most of the relevant priority areas above.

- **Alcohol pricing and taxation**:
    - National, comprehensive alcohol pricing policies should be introduced comprising an underlying volumetric-based tax system for all alcoholic drinks, the ability to apply higher tax rates on alcoholic drinks with higher health risks and a minimum price per standard drink.
    - A proportion of revenue raised from alcohol taxation should be used to fund improved access to alcohol treatment and harm prevention programs.
- **Restricting the physical availability of alcohol**:
    - State and territory governments should further restrict trading hours for licensed establishments and off-licence liquor sales premises
    - Local governments 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
- **Stronger advertising and marketing restrictions on alcohol**
    - The current self-regulatory approach to alcohol advertising should be changed to include statutory restrictions, including the enforcement of costly sanctions for breaches of the advertising code.
    - Sponsorship of sporting events by the alcohol industry should be prohibited in Australia as a first step towards a model of alcohol advertising regulations which would phase out all alcohol promotions to young people
    - 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 should be put in place for its comprehensive implementation.
- **Raising the minimum purchase age for alcohol**
    - Measures should be introduced to increase the age for some types of access to alcohol, including raising the age at which takeaway alcohol can be purchased.
- **Further reducing the incidence of drink driving**
    - The permitted blood alcohol concentration (BAC) limit should be reduced to 0.02 for all non-learner drivers and zero for all learner drivers. This should be as a prelude to gradually reducing the BAC limit to zero for all drivers.
    - 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.

- **Improving the prevention of FASD**
    - Governments at all levels should work together to develop and implement policies to prevent FASD.
    - Governments at all levels should support education and training of health professionals to improve early diagnosis of FASD and appropriate intervention.
    - Governments at all levels should 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.
- **Providing more effective and accessible treatment services**
    - Greater funding by all levels of government dedicated to alcohol treatment services and workforce development (to address unmet demand for treatment).
    - Governments at all levels should 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.
    - Governments should invest in research to develop and implement treatment services using new technologies for interventions for alcohol disorders and related comorbidities
- **Strengthening data collection and evidence**
    - Nationally consistent data collection that is timely and complete on alcohol sales should be implemented which can be disaggregated and compared at the State and Territory level
    - Liquor Acts in each Australian jurisdiction should 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.
    - Infrastructure and data collection systems should be put in place for alcohol-related medical consultations, emergency department presentations and hospital admissions, and for other key issues such as family violence.
    - A system for ongoing monitoring of alcohol-related harm, including harm to others should be introduced, especially within the hospital sector
- More generally, comprehensive policies should be introduced 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.

Monitoring implementation and progress

As emphasised in our recommendations above, on strengthening data collection and evidence, it is vital that we improve our ability to monitor and measure progress and the outcomes of policy changes.

The RACP recommend that, in addition to collecting alcohol sales data that can be disaggregated on a state by state basis, there is a focus on strategies and systems to systematically collect data from alcohol licensees on occupancy, trading hours and compliance; data on alcohol related hospitalisations; and, data to support the monitoring of other alcohol-related harms.

Conclusion

The many harms of alcohol and their costs to both individuals and society are both undisputed and substantial, with alcohol consumption being a causal factor in more than 200 disease and injury conditions.[13] The RACP is therefore supportive of the overarching goals of the NAS 2016-2021 and of the priority areas for development which it has identified. A key challenge that must be addressed going forward is the need for better intergovernmental coordination and cooperation because so many of the most effective areas for policy reform will required improved coordination between all three levels of government.

A consultative approach which encourages a strong working partnership between the government and major stakeholders, particularly healthcare professionals who know first-hand of the harms that alcohol can cause, from their professional experience, is needed. Finally, words must be backed up by action, in terms of a strong funding commitment and the willingness to address implementation challenges associated with whatever policy responses are developed as a result of the NAS consultation process.

[13] World Health Organization. Alcohol. Fact sheet; 2015, http://www.who.int/mediacentre/factsheets/fs349/en/.