ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

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16 December 2016

Dear Minister,

Review of the Liquor Control Reform Act 1998

Thank you for the opportunity to provide a submission to the review of the Liquor Control Reform Act 1998 (Victoria).

This Review provides a valuable opportunity for the Victorian Government to implement evidence-based reforms to reduce alcohol harm.

The Royal Australasian College of Surgeons submission to this review is attached.

If you would like to discuss anything in this submission further please feel free to contact the Victorian Regional Office.

Yours sincerely

Mr David Love, FRACS
Chair, Victorian Regional Committee
Royal Australasian College of Surgeons

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

RESPONSE TO THE VICTORIAN GOVERNMENT'S REVIEW OF THE LIQUOR CONTROL REFORM ACT 1998

DECEMBER 2016

About the Royal Australasian College of Surgeons

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in New Zealand and Australia. RACS is a not-for-profit organisation that represents more than 7000 surgeons and 1300 surgical trainees and international medical graduates across New Zealand and Australia. It also supports healthcare and surgical education in the Asia-Pacific region and is a substantial funder of surgical research. RACS provides training in nine surgical specialties, cardiothoracic surgery, general surgery, neurosurgery, orthopaedic surgery, otolaryngology head and neck surgery, paediatric surgery, plastic and reconstructive surgery, urology and vascular surgery. The College plays an active role in the setting of standards of surgical care, the training of surgeons and their participation in continuing medical education throughout their lifetime of surgical practice.

As part of our commitment to standards and professionalism RACS strives to take informed and principled positions on issues associated with the delivery of health services.

The Royal Australasian College of Surgeons is a member of the Alcohol Policy Coalition in Victoria.

Background

RACS has advocated against the harmful effects of alcohol for many years, not only for the increased risk of complication that it poses to surgical patients, but also for the broader ramifications it has on the sustainability of our public health system and society as a whole.

Surgeons are often confronted with the effects of alcohol misuse when treating patients with injuries resulting from road traffic trauma, interpersonal violence and personal accidents that are caused by excessive alcohol consumption. Alcohol misuse is also a significant contributor to the total burden of disease, including liver failure, GI bleeding, upper GI and oropharyngeal cancer and infections related to malnutrition.[1]

In the past year the RACS has released an updated position paper on alcohol related harm. This response reflects many of the themes outlined in previous submissions, and focuses on the key theme of harm minimisation.

Surgeons, alongside other health professionals, are first-hand witnesses to the damage that alcohol-related harm causes on a day to day basis. Whether it is through the extra strain on emergency departments and operating rooms, or the long-term suffering caused by non-communicable disease, the burden that alcohol-related harm places on Victoria is considerable. Therefore RACS is well placed to offer advice to the Victorian Government, and we thank you for allowing us the opportunity to be part of this process.

Alcohol takes a significant toll on our workload, the taxpayer and the health of Australians.

Facilitating a diverse industry and reducing red tape

The RACS is not in a position to make detailed comment on specific aspects of the licensing scheme but would like to make the following comments we consider should be key considerations of any liquor licensing scheme.

The RACS has significant concerns with the content and questions put forward in this section of the discussion paper. The terminology 'reducing red tape' appears to reflect a pre-determined conclusion that an overly burdensome regulatory structure currently exists. It implies that regulation is inherently undesirable, without providing an adequate analysis of why many of the regulations in question were initially established, and for what intended benefit.

RACS appreciates the complexities of establishing a comprehensive liquor licensing framework. We acknowledge the importance of having a streamlined regulatory process to ensure industry compliance, and to provide clarity for those that it affects. However, "red tape" should not simply be viewed as existing to place additional burden upon business. Comprehensive regulatory process can be a positive aspect to any system as they ensure a rigorous regulatory framework.

If it is determined that unnecessary regulation exists, then any proposed reconfiguration of the framework needs to be driven by the community and with the community's best interest at heart. This means developing a regulatory environment that supports the principles of harm minimisation and promotes responsible attitudes towards alcohol. It does not mean deregulating existing safeguards simply to appease industry concerns about the scrutiny liquor licensing applications receive.

It is also vital that any action to reduce regulatory burdens make the non-applicant (consumers, local residents, advocacy groups etc.) the primary focus. The current regulatory system is prohibitive to those wishing to lodge an objection and the burden of proof required for an objection to be considered acts as a deterrent to lodging that objection.

The policing and penalties associated with holding a licence should also be boosted. Without a properly resourced regulatory system that can proactively monitor licence holder's adherence to the Act there is no true deterrent in place to discourage poor behaviour amongst licence holders.

The holding of a liquor licence of any type is a serious responsibility, not a right based on the payment of a fee. In an industry notorious for its potential to cause harm if not regulated properly, the question needs to be asked; do we want the process of being granted a liquor license to be an easy one?

RACS recommends:

- **That the Act reduces the regulatory burden imposed on those wishing to make an objection to a licencing application.**
- **That licence fees are increased to ensure that they cover the cost of an effective and proactive regulatory system.**
- **That licence holders should be required to declare that there have been no breaches of the Act at each renewal. These declarations should be randomly audited each year.**
- **That the penalties associated with the demerit point system be increased to ensure they act as a true deterrent to poor behaviour by licensees.**

Harm Minimisation

Too many people are affected by alcohol harm through assault,[2,3] domestic violence,[4] road crashes,[5] and child maltreatment.[6,7,8] In 2012-13, there were 7,744 emergency department presentations in Victoria in which alcohol was identified as a contributing factor. The rate of such presentations has increased by 58.6 per cent since 2003-04, from 8.7 per 100,000 to 13.8 per 100,000.[9]

The RACS believes that any licencing scheme should, at a minimum, consider Australia's commitment to the WHO target of a 10 per cent relative reduction in the harmful use of alcohol by 2025.[10]

In line with the RACS Position Paper on Alcohol Related Harm (attached) the following should form key considerations of any licencing scheme.

Trading hours and outlet density

Research on the relationship between the trading hours and density of licensed premises and alcohol-related harm has consistently demonstrated that increased trading hours are associated with increased harms. This has been particularly predominant in areas with higher concentrations of licensed premises and has corresponded with higher levels of assault and domestic violence.

Alcohol-related assaults increase significantly after midnight. Time of night and proportion of younger patrons had a strong association with patron intoxication adding further support for the strong body of evidence that ceasing service of alcohol earlier in the evening will reduce intoxication levels.[11] An evaluation by the NSW Bureau of Crime Statistics and Research examined the relationship between alcohol and crime, and found that the percentage of alcohol-related assaults increased substantially between 6pm to 3am, with the highest rates of alcohol-related assaults occurring between midnight and 3am. This evaluation, published in April 2015, showed that that since the reduced trading hours were introduced in Sydney, assaults in Kings Cross have declined by 32%. Assaults in the Sydney CBD Entertainment Precinct dropped by 26%, and in the sub-section area of George Street South, by 40%. Reduced trading hours for pre-packaged liquor outlets across NSW have been matched by a 9% decrease across the state.[12] Since reduced trading hours have been shown to reduce assaults in NSW it is logical that other jurisdictions adopt the same measures.

RACS supports limiting the number of outlets where alcohol is sold. There is a positive relationship between alcohol outlets (general, on premise, and packaged) and increased rates of violence. The latest research suggests there is a sharp increase in domestic and non-domestic violence where there are more than two hotels and one bottle shop per 1,000 residents[13] with licenced premises being the third most common Australian setting for assault leading to hospitalization.[14] Research conducted in Sydney, Australia, finds that 44 % of all assaults (excluding domestic violence) and 60 % of alcohol-related violence occurs in and around drinking establishments.[15]

Studies also demonstrate that intentional and unintentional traumatic injuries occur more commonly in areas with greater concentrations of off-premise alcohol outlets, and that chain outlets contribute most substantially to trauma risk. These relationships may extend to areas adjacent to where the outlets are located. Importantly, chains also have cheaper alcohol available than independent outlets, and this relationships could not be explained by land and structure rents or other features of the alcohol market (for example, cheaper outlets are located in disadvantaged areas). [16]

Lockouts

The evidence is increasingly suggesting that lockouts do work. Since legislative reforms were introduced in Sydney NSW, assaults in Kings Cross have declined by 32%, in the Sydney CBD Entertainment Precinct by 26%, and in the sub-section area of George Street South by 40%. Across NSW there was a 9% decrease.[17] St Vincent Hospital in Darlinghurst reported a more than 50 per cent reduction in serious head injuries in the year after lockout laws were introduced compared with the year prior.[18]

It is disappointing that the NSW government has made the decision to relax laws which are showing a positive reduction in the level of alcohol related violence and harm. The RACS would encourage the Victorian Government to give due consideration to the evidence on the effectiveness of lockout laws in the Victorian context.

Family Violence

Alcohol is inextricable linked to family violence as a predictive, causal and contributing factor. Studies examining the relationship between drinking and violence at the daily or event level have found that alcohol use is more common in severely aggressive events and that perpetrator alcohol use in the preceding 4 hours predicts both verbal and physical aggressions.[19]

Around two thirds of family violence homicides involve alcohol and/or illicit drugs.[20] The use of alcohol may have an effect on the severity of the abuse or the ease with which the offender can justify their actions.[21]

The Hidden Harm: Alcohol's impact on children and families, which draws on 2011 statistics, reports there were 29,684 police-reported incidents of alcohol-related domestic violence in Australia for states and territories, where data is available.[22] The report found that that over a million children (22% of all Australian children) are affected in some way by the drinking of others, 142,582 children (3%) are substantially affected and 10,166 (0.2%) are already within the child protection system where a carer's problematic drinking has been identified as a factor.

The National Drug Law Enforcement Research Fund (NDLERF) final report into alcohol and drug involved family violence, released on 15 December 2016, further highlights the strong links between alcohol use and family and intimate partner violence. The Report found that alcohol was involved in 34 percent of Intimate Partner Violence (IPV) incidents, and 29 percent of Family Violence (FV) incidents and that alcohol-related IPV incidents were more likely to result in either a physical (34.4%) or psychological injury (20.6%) compared with those that did not involve alcohol. [23]

Statistics form Victorian Police showed that, 24 to 54 percent of Family Domestic Violence incidents reported to the police were classified as alcohol-related. Victorian Police attending FV and IPV incidents assessed and identified 22.6 percent of all offenders as having definitely used alcohol and 16.1 percent as having possibly used alcohol. Their statistics showed that alcohol use was more prevalent in intimate partner violence, with possible and definite alcohol use indicated in 14.9 percent and 16.2 percent of IPV victims respectively. [24]

Statistics collected by Victorian Police also found that 13.7 percent of all victims as having definitely used alcohol and 13.1 percent as having possibly used alcohol. Alcohol use was more prevalent in IPV, with possible and definite alcohol use indicated in 14.9 percent and 16.2 percent of IPV victims, and 9.7 percent and 8.8 percent of FV victims, respectively. [25]

These concerning statistics show that alcohol is a major contributing risk factor to domestic violence, increasing not just the risk of becoming a perpetrator but of becoming a victim. Given that the Royal Commission into Family Violence acknowledges the links between alcohol as a contributing factor to family violence it is important that the current review of the Liquor Act 1998 ensure that a key consideration of any changes to the Act be reducing the prevalence and burden of family violence.

Availability of alcohol in grocery settings

The RACS is concerned about the increasing integration of alcohol products into mixed business settings such as supermarkets and convenience stores. Allowing alcohol sales as part of the "weekly shop" has the potential to increase alcohol intake, increase sales to minors and can normalise the purchase and consumption of alcohol. This type of availability also increases outlet density.

Victoria currently has a mixture of models where these types of sales apply including those where alcohol is available in specific aisles of the supermarket, alongside other products or where there is a separate area in the store but sales are still put through a single check-out.

Although this model is common in international settings evidence shows that limiting this type of availability has a positive effect. A study undertaken in Germany where the sale of alcoholic beverages at gas-stations and supermarkets was banned between 10pm and 5 am reduced alcohol-related hospitalisations in adolescents (ages 15-19) and young adults (ages 20-24) by about seven percent.[26]

The NDLERF report, released on 15 December 2016, found that in addition to the strong links between alcohol and family and intimate partner violence risk more than half of the alcohol consumed during IPV incidents was purchased between 500 m and 10 km from the incident location. This report found that Supermarkets were the most frequent place of purchase. [27]

Given the strong links between alcohol availability and violence the RACS believes that a clear separation should be maintained between alcohol sales and grocery items. Alcohol should not be normalised as part of the regular grocery shop.

RACS recommends:

- **That trading hours and outlet density be reduced.**
- **That no new licenses be granted for sales of alcohol in supermarket/grocery settings.**
- **That the Review considers the growing evidence for the effectiveness of lockout laws.**
- **That reducing family violence is a key consideration of changes to the Act.**

Appendix 1: College Position Paper: Alcohol-related harm

[1] Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. The Lancet 373(9682): 2223-2233. 2009.
[2] Jochelson, R. (1997). *Crime and place: An analysis of assaults and robberies in Inner Sydney*. Sydney: New South Wales Bureau of Crime Statistics and Research.
[3] Briscoe, S. & Donnelly, N. (2001). Temporal and regional aspects of alcohol-related violence and disorder. *Alcohol Studies Bulletin.*
[4] Livingston, M. (2011). A longitudinal analysis of alcohol outlet density and domestic violence. *Addiction* 106: 919–25.
[5] Chikritzhs, T., Stockwell, T. (2006). The impact of later trading hours for hotels on levels of impaired driver road crashes and driver breath alcohol levels. *Addiction*, 101(9):1254-64.
[6] Laslett, A.M., Mugavin, J., Jiang, H., Manton, E., Callinan, S., MacLean, S. & Room, R. (2015) *The hidden harm: Alcohol's impact on children and families*. Canberra: Foundation for Alcohol Research and Education.
[7] Stockwell, T. & Chikritzhs, T. (2009). Do relaxed trading hours for bars and clubs mean more relaxed drinking? A review of international research on the impacts of changes to permitted hours of drinking. *Crime Prevention and Community Safety.* 2009,11, 153-170.
[8] Hobday, M., Chikritzhs, T., Liang, W. & Meulners, L. (2015). The effect of alcohol outlets, sales and trading hours on alcohol-related injuries presenting at emergency departments in Perth, Australia, from 2002 to 2010. *Addiction*, 110, 1901–1909.
[9] Turning Point. (2016). *AODstats*. Eastern Health. Retrieved from: http://aodstats.org.au/
[10] WHO. About 9 voluntary global targets. World Health Organization. World Health Organization; 2015. Accessed 18 November 2015. Available from: http://www.who.int/nmh/ncd-tools/definition-targets/en/.
[11] Coomber, K., Pennay, A., Droste, N., Mayshak, R., Martino, F., Bowe, S. J., & Miller, P. G. (2016). Observable characteristics associated with alcohol intoxication within licensed entertainment venues in Australia. *International Journal of Drug Policy*, *36*, 8-14.
[12] Menéndez P, Weatherburn D, Kypri K, and Fitzgerald J. Locjouts and Last Drinks. NSW Bureau of Crime Statistics and Research, 2015, School of Medicine & Public Health, University of Newcastle, Australia.
[13] Donnelly N, Menendez P, Mahoney N. The effect of liquor licence concentrations in local areas on rates of assault in New South Wales [Internet]. Sydney: NSW Bureau of Crime Statistics and Research; 2014 Dec. 2015. Available from: http://www.bocsar.nsw.gov.au/Documents/CJB/CJB181.pdf.
[14] McFadden, A.J., Young, M. & Markham, F. Int J Ment Health Addiction (2015) 13: 506
[15] McFadden, A.J., Young, M. & Markham, F. Int J Ment Health Addiction (2015) 13: 506
[16] Morrison, C., & Smith, K. (2015). *Disaggregating relationships between off-premise alcohol outlets and trauma.* Canberra: Foundation for Alcohol Research and Education
[17] Menéndez P,Weatherburn D, Kypri K, and Fitzgerald J. Locjouts and Last Drinks. NSW Bureau of Crime Statistics and Research, 2015, School of Medicine & Public Health, University of Newcastle, Australia.
[18] St Vincent's Health Australia. Submission to Senate Standing Committee on Economics Personal Choice and Community Impacts Inquiry. Bondi Junction, NSW; August 2015. Available from: https://svha.org.au/wps/wcm/connect/58e419ab-3049-479b-b350-

96d1b3b8acc1/Submission+to+Senate+Standing+Committee+on+Economics+Personal+Choice+and+Community+Impacts+inquiry+FINAL+210815.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=58e419ab-3049-479b- b350-96d1b3b8acc1

[19] Leonard, K. E., & Quigley, B. M. (2016). Thirty years of research show alcohol to be a cause of intimate partner violence: Future research needs to identify who to treat and how to treat them. *Drug and alcohol review*.

[20] Dearden J, Jones W. Homicide in Australia: 2006-07 National Homicide Monitoring Program annual report. Canberra: Australian Institute of Criminology, 2008.

[21] Wilson M. Domestic Violence and the intersection of alcohol from a front-line perspective. AMA Alcohol Summit, 28-29 October 2014, Canberra.

[22] Foundation for Alcohol Research & Education, Centre for Alcohol Policy Research. The Hidden Harm: Alcohol's impact on children and families. Canberra, 2015.

[23] Miller P., Cox E, Costa B., et al. Alcohol/Drug-Involved Family Violence in Australia (ADIVA) Final Report, *National Drug Law Enforcement Research Fund*

[24] Miller P., Cox E, Costa B., et al. Alcohol/Drug-Involved Family Violence in Australia (ADIVA) Final Report, *National Drug Law Enforcement Research Fund*

[25] Miller P., Cox E, Costa B., et al. Alcohol/Drug-Involved Family Violence in Australia (ADIVA) Final Report, *National Drug Law Enforcement Research Fund*

[26] Marcus, J., & Siedler, T. (2015). Reducing binge drinking? The effect of a ban on late-night off-premise alcohol sales on alcohol-related hospital stays in Germany. *Journal of Public Economics*, *123*, 55-77.

[27] Miller P., Cox E, Costa B., et al. Alcohol/Drug-Involved Family Violence in Australia (ADIVA) Final Report, *National Drug Law Enforcement Research Fund*

Subject:	Alcohol Related Harm	Ref. No.	REL-GOV-025

INTRODUCTION

The harmful use of alcohol is a significant contributor to the global burden of disease. The World Health Organisation (WHO) lists misuse of alcohol as the third leading risk factor for premature death and disability in the world. It is estimated that 2.5 million people worldwide died from alcohol-related causes in 2004, including 320,000 young people between 15 and 29 years of age.[1]

Alcohol misuse substantially contributes to social disruption, injury and death. In Australia about half the reported cases of interpersonal violence, domestic violence and sexual assault are related to excessive alcohol consumption.[2] Alcohol-fuelled incidents are also a factor in up to two thirds of police callouts and around half of homicides.

The College has developed its recommendations on reducing alcohol-related harm drawing on scientific evidence and the expertise of our Fellows in Australia and New Zealand, and other members of the medical profession.

CONTEXT

Surgeons are dramatically confronted with the effects of alcohol misuse when treating patients with injuries resulting from road traffic trauma, interpersonal violence and personal accidents that are related to excessive alcohol consumption. Alcohol misuse is also a significant contributor to the total burden of disease, including liver failure, GI bleeding, upper GI and oropharyngeal cancer and infections related to malnutrition.[3] Overall, hospitalisations relating to alcohol misuse continue to represent a significant and concerning proportion of the surgical workload.

Alcohol is legal but it is not an ordinary commodity. Public awareness of the extent of alcohol-related harm in Australia and New Zealand is limited. Alcohol has never been more affordable, available or heavily promoted than it is today,[4] and a major reason for this is the involvement of the alcohol industry in government decision making,[5] and lax advertising regulation.

HEALTH AND WELLBEING IMPACTS

Alcohol misuse is a causal factor in more than 200 diseases and injury conditions, including cirrhosis of the liver, inflammation of the gut and pancreas, heart and circulatory problems, sleep disorders, male impotency, and eye disease.[6] Excessive alcohol consumption also raises the overall risk of cancer, including cancer of the mouth, throat and oesophagus, liver cancer, breast cancer and bowel cancer.[7]

The Australian study 'The Range and Magnitude of Alcohol's Harm to Others' released in 2010 by Laslett et al, was the first of its type in the world to quantify alcohol harm on those directly affected by the drinker. The study has contributed to WHO methodology as part of that agency's global strategy to reduce the harmful use of alcohol.[8]

The study found that an estimated 367 Australians died and nearly 14,000 people were hospitalised because of the drinking of others, in the year studied. In 2005, interpersonal violence resulted in 182 deaths, of which 42% (77 deaths) were estimated to be attributable to another person's drinking. A total of 277 deaths of people aged 15 years and over were estimated to be due to another's drinking and driving, with 31 of these being pedestrian deaths.[9]

In New Zealand, the prevalence of self-reported harm from others' drinking was higher than harm from own drinking (18% vs. 12% in the past year) and was higher in women and young people.[10] The link between alcohol and family violence in New Zealand has also been recently highlighted in a report from The Glenn Inquiry, which identified alcohol as one of the overwhelming contributors to the severity of domestic abuse.[11]

The following statistics further demonstrate the pervasive effects of harmful alcohol use and the significant cost to health services and the community:

Australia

- Each week, on average, more than 100 Australians die and more than 3,000 are hospitalised as a result of excessive alcohol consumption.[12]
- Every year more than 70,000 Australians are the victims of alcohol-related assaults of which 24,000 are victims of domestic violence. In addition, almost 20,000 children across Australia experience substantiated alcohol-related child abuse.[13]
- The total cost to society of alcohol-related problems in 2010 was estimated to be $14.352b.[14] The estimated cost of alcohol's negative impacts on others was estimated at $6.807b.[15] The same year, the Australian Government received an estimated $7.075b in total alcohol tax revenue.[16]
- More than one third (38%) of people aged 14 or older consumed alcohol at least once in 2013 at a level placing them at risk of injury, and one quarter had done so as often as monthly (26%).[17]
- 3.5 million Australians drank at levels that placed them at lifetime risk of an alcohol-related disease or injury (down 250,000 from 3.7 million in 2010).
- Young people are more likely to drink at risky levels and their increased alcohol consumption is linked to an increase in alcohol-caused hospitalisations.[18]
- The rate of alcohol-attributable death among Indigenous Australians is about twice that of the non-Indigenous population, with a particularly strong association apparent between alcohol use and suicide[19]. From 2000-2006, 87% of intimate partner homicides among Indigenous populations were alcohol related.[20]

New Zealand

- Each week, on average, 20 New Zealanders die as a result of excessive alcohol consumption.[21]
- Around a third of injury-based emergency department presentations are alcohol-related.[22]
- The latest results from 2013/14 show that one in six adults has a hazardous drinking pattern - one in three of these are 18-24 year olds, and one in three identify as Mäori.[23]
- National drinking surveys consistently show around 25% of drinkers – the equivalent of 700,000 New Zealanders – typically drink large quantities when they drink.[24]
- In 2012, alcohol was a contributing factor in 73 fatal crashes, 331 serious injury crashes and 933 minor injury crashes. These crashes resulted in 93 deaths, 454 serious injuries and 1,331 minor injuries.[25]
- Harmful drug use in 2005/06 caused an estimated $6,525 million of social costs. This is equivalent to the GDP of New Zealand's agricultural industry ($6,701 million).[26]
- Overall, Mäori have four times the alcohol-related mortality of non-Mäori.[27]

WHAT CAN BE DONE?

The Royal Australasian College of Surgeons endorses preventative measures as the best way to reduce alcohol-related harm, as well as delivering substantial health, social and economic benefits. The College supports coordinated efforts between governments, health professionals, health services and community organisations to reduce alcohol related harm and injury by the production of evidence-based policy reform. Since the corporate responsibility of the alcohol industry is to its shareholders to

increase profit, governments should exercise considerable caution to ensure that harm minimisation remains at the core of legislative objectives, and that public health is prioritised over financial benefit.

Given that the tax revenue received by the Commonwealth Government is not even half of the total estimated cost of alcohol-related harm, an increased proportion of tax revenue could arguably be used to implement strategies aimed at further reducing the social costs associated with alcohol misuse.

RECOMMENDATIONS

The College encourages governments to give consideration to the following policy areas as a means to reduce alcohol-related harms.

Restricting the physical availability of alcohol (Hours and Outlets)

The Australian Government's Preventative Health Taskforce, citing evidence compiled by the National Drug Research Institute, concluded that, 'Most Australian studies have shown that increased trading hours have been accompanied by significantly increased levels of alcohol consumption and/or harms.'[28] The Taskforce highlighted consistent links between the availability of alcohol in a region and the alcohol-related problems experienced there. Many studies have also linked rates of violence to density of alcohol outlets.[29]

By regulating the physical availability of alcohol, through reduced trading hours and liquor outlet density restrictions, governments can make a significant contribution to reducing its negative impacts.

Restricting the economic availability of alcohol (Taxes)

International scientific evidence consistently shows that rates of alcohol consumption and resultant harm are influenced by price.[30] Alcohol taxation is one of the most effective policy interventions to reduce the level of alcohol consumption and related problems, including mortality rates, crime and traffic accidents. Even small increases in the price of alcohol can have a significant impact on consumption and harm.[31] However, despite its reported effectiveness, taxation as a strategy to reduce alcohol-related harm has been under-utilised in Australia and New Zealand.[32]

The Henry Review of Australia's taxation system described Australia's present alcohol tax system as 'incoherent', and recommended a new approach based on volumetric or alcohol content-based tax.
The Australian Government's Preventative Health Taskforce also called for taxes on alcohol to be overhauled. Economic modelling commissioned by the Foundation for Alcohol Research and Education has shown that replacing the Wine Equalisation Tax and rebate with a ten percent increase to all alcohol excise and a volumetric tax on wine and cider would deliver $2.9 billion revenue and reduce alcohol consumption by 9.4 per cent.[33]

The New Zealand Ministry of Justice has suggested that imposing a minimum price per standard drink of alcohol will reduce harmful alcohol consumption, particularly among young people, who consume the highest quantities of low cost, high alcohol volume products.[34] It estimated a $1-$1.20 minimum price per standard drink would result in net benefits to society ranging from $44 million to $86 million in the first year.

Reduce exposure

Analysis of national drinking survey data from New Zealand indicates young people's drinking patterns have changed in recent years towards increased consumption per occasion,[35] and the New Zealand Ministerial Forum on Alcohol Advertising and Sponsorship has made recommendations to the Government about restricting the exposure of minors to alcohol advertising and sponsorship.[36]

A 2013 survey commissioned by the Salvation Army found that nearly three-quarters of Australians believed that alcohol and sport were too closely related. Two thirds of the survey respondents believed that alcohol sponsorship should be phased out of sport, and 70 per cent said that the amount of alcohol advertising that people under 25 see encourages them to drink more.[37]

Australian studies have shown that exposure to alcohol advertisements among Australian adolescents is strongly associated with increased drinking patterns.[38] The National Health and Medical Research Council recommends that parents of adolescents delay the age of drinking initiation as long as possible to protect the health and wellbeing of young Australians.[39]

Given current high levels of drinking among Australian and New Zealand youth, the College supports efforts to reduce young people's exposure to alcohol advertising through policy reforms aimed at reducing the proliferation of alcohol advertising.

Data collection

Government agencies monitor and report incidents of alcohol-related harm and some of the costs associated with alcohol abuse, however, agencies do not monitor or report the total costs to the community through alcohol related trauma and law enforcement, meaning we do not have a complete picture of the harm caused by alcohol in terms of its costs and effects on society.

Despite the evidence supporting the effectiveness of Screening and Brief Intervention (SBI) programs very few patients are asked about their alcohol use in the past year. A structured SBI program is inexpensive, takes little time to implement (5-10 minutes), and can be undertaken by a wide range of health and welfare professionals.

The College supports further investigation of how a suitable SBI program could be implemented in Australia and New Zealand, in particular the mandatory collection of data on whether alcohol use is a factor in emergency department presentations, either by the patient or another individual. Since data is essential for good public policy, the College also supports the mandatory collection of alcohol sales data.[40]

RESOURCES

As below.

REFERENCES/ACKNOWLEDGEMENTS

As below.

Approver: Governance & Advocacy Committee
Authoriser: Council

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[1] World Health Organisation (2010) *Global strategy to reduce harmful use of alcohol*. Available from: http://www.who.int/substance_abuse/activities/gsrhua/en/

[2] Dearden J & Payne J 2009. Alcohol and homicide in Australia. *Trends & issues in crime and criminal justice* no. 372. Canberra: Australian Institute of Criminology. http://www.aic.gov.au/publications/current series/tandi/361-380/tandi372.aspx

Key issues in alcohol-related violence. Research in practice no. 4 Anthony Morgan and Amanda McAtamney ISSN 1836-9111, Canberra: Australian Institute of Criminology, December 2009

Briscoe S & Donnelly N, 2001. *Temporal and regional aspects of alcohol-related violence and disorder.* Alcohol studies bulletin no. 1. http://www.bocsar.nsw.gov.au/agdbasev7wr/bocsar/documents/pdf/ab01.pdf

Doherty SJ & Roche AM 2003. *Alcohol and licensed premises: best practice in policing. A monograph for police and policy makers*. Adelaide: Australasian Centre for Policing Research. http://nceta.flinders.edu.au/files/7312/5548/1448/EN34.pdf

Poynton S et al 2005. *The role of alcohol in injuries presenting to St Vincent's Hospital Emergency Department and the associated short-term costs*. Alcohol studies bulletin no. 6. http://www.bocsar.nsw.gov.au/agdbasev7wr/bocsar/documents/pdf/ab06.pdf

[3] *Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders.* The Lancet 373(9682): 2223-2233. 2009

[4] FARE (2013) *The Foundation for Alcohol Research and Education's 2013 Election Platform: 10 ways to reduce alcohol harms.* Available from: www.fare.org.au

[5] Saitz R. Alcohol: No ordinary health risk. Addiction. 2015 Jul 14;110(8):1228–9

[6] World Health Organisation (2015) Alcohol Fact Sheet. Available from: http://www.who.int/mediacentre/factsheets/fs349/en/

[7] IARC Working Group on the Evaluation of Carcinogenic Risks to Humans (2007: Lyon, France) *Alcohol consumption and ethyl carbamate*

[8] World Health Organisation (2010) *Global strategy to reduce harmful use of alcohol*. Available from: http://www.who.int/substance_abuse/activities/gsrhua/en/

[9] Laslett, A-M., Catalano, P., Chikritzhs, Y., Dale, C., Doran, C., Ferris, J., Jainullabudeen, T., Livingston, M, Matthews, S., Mugavin, J., Room, R., Schlotterlein, M. and Wilkinson, C. (2010) *The Range and Magnitude of Alcohol's Harm to Others.* Fitzroy, Victoria: AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health

[10] Connor, J., Casswell, S. (2012) *Alcohol-related harm to others in New Zealand: evidence of the burden and gaps in knowledge.* NZMJ Vol 125 No 1360; ISSN 1175 8716 p11 Available at: http://www.nzma.org.nz/journal/125-1360/5308/

[11] The Glenn Inquiry (2014) *The People's Blueprint: Transforming the way we deal with child abuse and domestic violence in New Zealand.* Available from: https://glenninquiry.org.nz/uploads/files/The_Peoples_Blueprint_Electronic_Final.pdf

[12] Gao, C.*, Ogeil, R.P.*, & Lloyd, B. (2014). *Alcohol's burden of disease in Australia.* Canberra: FARE and VicHealth in collaboration with Turning Point.

[13] Laslett, A-M., Catalano, P., Chikritzhs, Y., Dale, C., Doran, C., Ferris, J., Jainullabudeen, T., Livingston, M, Matthews, S., Mugavin, J., Room, R., Schlotterlein, M. and Wilkinson, C. (2010) *The Range and Magnitude of Alcohol's Harm to Others.* Fitzroy, Victoria: AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health.

[14] Manning, M., Smith, C. and Mazerolle, P. (2013) *Trends & issues in crime and criminal justice series: The societal costs of alcohol misuse in Australia* No. 454, Australian Institute of Criminology

[15] Laslett, A-M., Catalano, P., Chikritzhs, Y., Dale, C., Doran, C., Ferris, J., Jainullabudeen, T., Livingston, M, Matthews, S., Mugavin, J., Room, R., Schlotterlein, M. and Wilkinson, C. (2010) *The Range and Magnitude of Alcohol's Harm to Others.* Fitzroy, Victoria: AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health.

[16] Manning M, Smith C, Mazerolle P. Australian Institute of Criminology. Canberra: Australian Institute of Criminology. The societal costs of alcohol misuse in Australia; 2013 Apr 2. Available from: http://www.aic.gov.au/publications/current%20series/tandi/441-460/tandi454.html

[17] AIHW 2014. *National Drug Strategy Household Survey detailed report 2013*. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549848

[18] Chikritzhs, T., Catalano, P., Stockwell, T. et al. (2003). *Australian alcohol indicators 1990-2001: Patterns of alcohol use and related harms for Australian States and Territories*. National Drug Research Institute, Curtin University of Technology, Perth.

[19] National Health and Medical Research Council (2009) *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*

[20] Dearden J & Payne J 2009. Alcohol and homicide in Australia. *Trends & issues in crime and criminal justice* no. 372. Canberra: Australian Institute of Criminology.

[21] Connor, J., Broad, J., Jackson, R., Vander Hoorn, S., Rehm, J. (2004) *The burden of death, disease and disability due to alcohol in New Zealand*

[22] Humphrey, G., Casswell, S., and Yeo Han, D. *Alcohol and injury among attendees at a New Zealand emergency department*. NZMJ 24 January 2003, Vol 116 No 1168. Available at: http://www.nzma.org.nz/__data/assets/pdf_file/0005/17987/Vol-116-No-1168-24-January-2003.pdf

[23] Ministry of Health (2014) *Annual Update of Key Results 2013/14: New Zealand Health Survey.* Available from: http://www.health.govt.nz/publication/annual-update-key-results-2013-14-new-zealand-health-survey

[24] New Zealand Law Commission (2010) *Alcohol in our lives: Curbing the harm - A Report on the review of the Regulatory Framework for the sale and Supply of Liquor.* Available from: http://www.lawcom.govt.nz/project/review-regulatory-framework-sale-and-supply-liquor

[25] Health Promotion Agency. *Alcohol Facts*. Available from: http://www.alcohol.org.nz/research-resources/nz-statistics/alcohol-facts

[26] Business and Economic Research Limited (2009) *Costs of Harmful Alcohol and Other Drug Use.* Report to Ministry of Health and Accident Compensation Commission.

[27] Connor, J., Broad, J., Jackson, R., Vander Hoorn, S., Rehm, J. (2004) *The burden of death, disease and disability due to alcohol in New Zealand*

[28] Australian Government Department of Health. Technical Report No 3, *Preventing alcohol–related harm in Australia: a window of opportunity* (including addendum for October 2008 to June 2009). Available from: http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/09C94C0F1B9799F5CA2574DD0081E770/$File/alcohol-jul09.doc

[29] Donnelly N, Poynton S, Weatherburn D, Bamford E and Nottage J. *Liquor outlet concentrations and alcohol-related neighbourhood problems*. Alcohol Studies Bulletin. Sydney: NSW Bureau of Crime Statistics and Research, 2006. Available from: http://www.bocsar.nsw.gov.au/agdbasev7wr/bocsar/documents/pdf/ab08.pdf

Livingston M. *Alcohol outlet density and assault: a spatial analysis*. Addiction. 2008; 103:619−28. Available from: www3.interscience.wiley.com/journal/119411938/abstract

Chikritzhs T, Catalano P, Pascal R and Henrickson N. *Predicting alcohol-related harms from licensed outlet density: a feasibility study.* Monograph Series No. 28. Hobart: National Drug Law Enforcement Research Fund, 2007. Available from: www.ndlerf.gov.au/pub/Monograph_28.pdf

Livingston M. *A longitudinal analysis of alcohol outlet density and assault. Alcohol: Clinical and Experimental Research.* 2008; 32:1074−9. Available from: www3.interscience.wiley.com/journal/120084012/abstract

[30] Babor, T, et al. *Alcohol: No Ordinary Commodity*. Second Edition. New York: Oxford University Press. 2010. Available from: http://www.ndphs.org///documents/2253/Babor_alc%20no%20ordinary%20comm%20second%20edition.pdf

[31] Chikritzhs T, Stockwell T, Pascal R. *The impact of the Northern Territory's Living With Alcohol program, 1992-2002: revisiting the evaluation*. Addiction. 2005; 100(11):1625-36.

[32] Stockwell T. Australian alcohol policy and the public interest: a brief report card. Drug and Alcohol Review. 2004; 23:377–9. Available from: http://onlinelibrary.wiley.com/doi/10.1080/09595230412331324491/pdf

[33] The Allen Consulting Group (2011) *Alcohol taxation reform starting with the Wine Equalisation Tax.* Canberra: Foundation for Alcohol Research and Education (FARE).

[34] White, J., Lynn, R., Ong, S., Whittington, P. (2014) *The Effectiveness of Alcohol Pricing Policies: Reducing harmful alcohol consumption and alcohol-related harm.* Available from: http://www.justice.govt.nz/publications/global-publications/e/the-effectiveness-of-alcohol-pricing-policies

[35] New Zealand Law Commission (2010) *Alcohol in our lives: Curbing the harm - A Report on the review of the Regulatory Framework for the sale and Supply of Liquor,* p66. Available from: http://www.lawcom.govt.nz/project/review-regulatory-framework-sale-and-supply-liquor

[36] NZ Ministry of Health. Ministerial Forum on Alcohol Advertising and Sponsorship (2014) Ministerial Forum on Alcohol Advertising and Sponsorship: Recommendations on alcohol advertising and sponsorship. Available at: http://www.health.govt.nz/publication/ministerial-forum-alcohol-advertising

[37] Salvation Army media release (2013) *The Salvation Army releases national research highlighting the need for an urgent review of alcohol advertising and promotion*. Available at: http://salvos.org.au/blog/?p=80

[38] Jones, S. C. & Magee, C. A. (2011). *Exposure to alcohol advertising and alcohol consumption among Australian adolescents*. Alcohol and Alcoholism, 46 (5), 630-637. Available at: http://ro.uow.edu.au/cgi/viewcontent.cgi?article=2848&context=hbspapers

[39] Australian Government National Health and Medical Research Council (2009) *Australian Guidelines to reduce health risks from drinking alcohol.* Available from: https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf

[40] Hall W, Chikritzhs T, d'Abbs P and Room R. *Alcohol sales data are essential for good public policies towards alcohol.* MJA, 2008; 189:188−9. Available from: www.mja.com.au/public/issues/189_04_180808/hal10593_fm.html