

4.3 Priority Area 3:

Health Impacts

Aim: Improve health outcomes among all individuals and communities affected by alcohol consumption.

4.3.1 What is the issue?

There are positive and negative health impacts from alcohol consumption. When consumed at low levels, there is evidence, albeit debated (Emberson et al. 2005; Fuchs et al. 2004), that alcohol can provide some health benefits for certain age and gender groups. The physical benefits include reducing the risk of cardiovascular disease from middle age onwards. The social benefits include assisting in relaxation, enhancing social interactions, and contributing to traditions and cultural festivities. When used to excess alcohol can produce profoundly negative health and social outcomes. The adverse health outcomes from alcohol consumption range from short-term problems, such as injuries from road accidents and violence, to long-term health problems, such as liver disease, cancers and alcohol dependence. One in ten Australians consume alcohol at levels that are risky or a high risk to health in the long-term. Those aged in their twenties are the most at risk – 14.4 percent of males and 15.1 percent of females in 20–29 year age group consume alcohol at levels that are risky or a high risk for harm in the long-term (Source: AIHW 2005).

Key findings of consultations

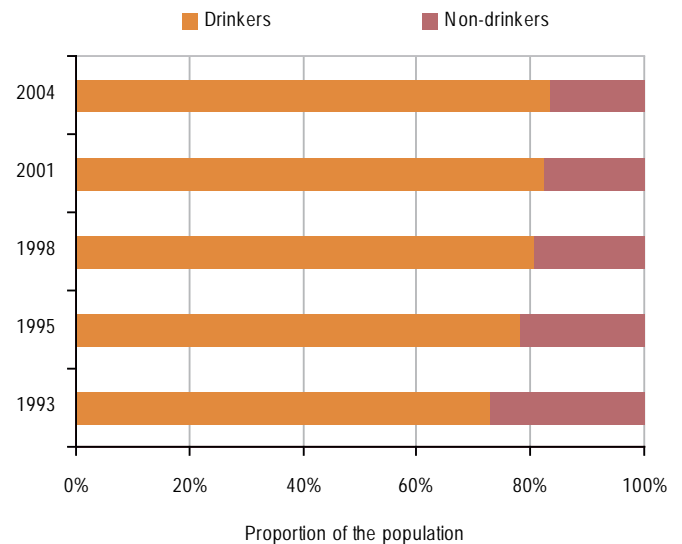
The health impacts of alcohol:

- are not all negative and include some health benefits for some individuals if consumed at low levels
- should be addressed within a whole-of-population approach, rather than only targeting specific high risk groups
- reflect broader socio-economic and structural issues in Australian society
- are both short-term and long-term and this is not fully understood by the general community
- could be reduced if the official Australian Alcohol Guidelines for low risk drinking were more easily comprehended
- are different but equally important for all life stages, including the young, women of childbearing age, and older people
- are most evident among Aboriginal and Torres Strait Islander peoples and people experiencing alcohol dependence
- are not adequately screened nor treated in the mainstream health system at present
- are often multiple and complex, and often include poly-drug use and other significant issues including mental illness

The scale of the problem

In Australia, it is not realistic or desirable to advocate for total abstinence from drinking for the whole population. Current trends show a decline in the number of people in Australia who do not drink and a decline in the number of people who are stopping drinking (see Figure 10).

Figure 10. Proportion of the population who are drinkers and non-drinkers, Australia, 2004 (Source: AIHW 2005).



A more sensible and sustainable goal is to cultivate cultures that embrace a harm minimisation approach. The starting point for such a strategy is to identify the healthy and unhealthy aspects of current drinking cultures, and the causes of harm, and to identify responses known to be effective in fostering and reducing these, respectively.

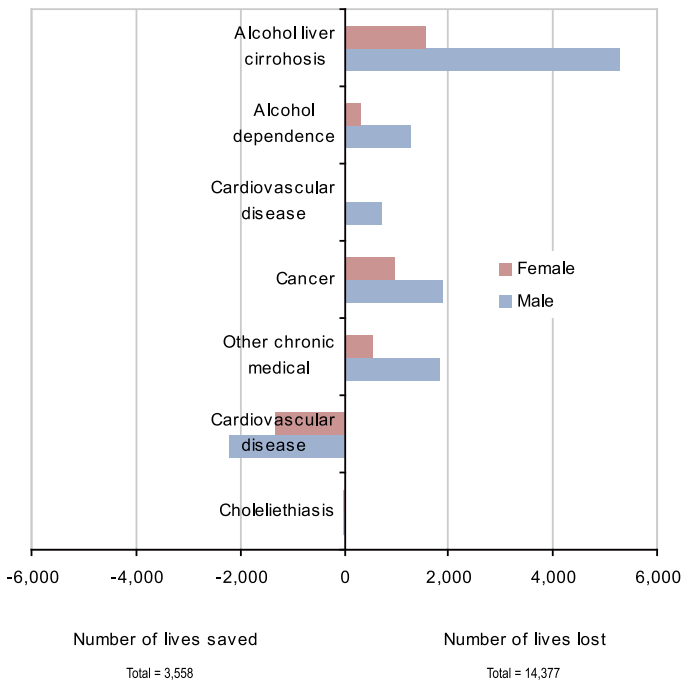
A global problem

- Four percent of the worldwide global burden of disease is attributable to alcohol, which accounts for almost as much death and disability globally as tobacco and hypertension (Room et al 2005).
- Alcohol has been shown to be causally related to more than 60 different medical conditions (Rehm 2003).
- In Australia, it is estimated that alcohol consumption accounts for 4.9 percent of the total burden of disease and injury (Mathers et al 1999).

Death and illness

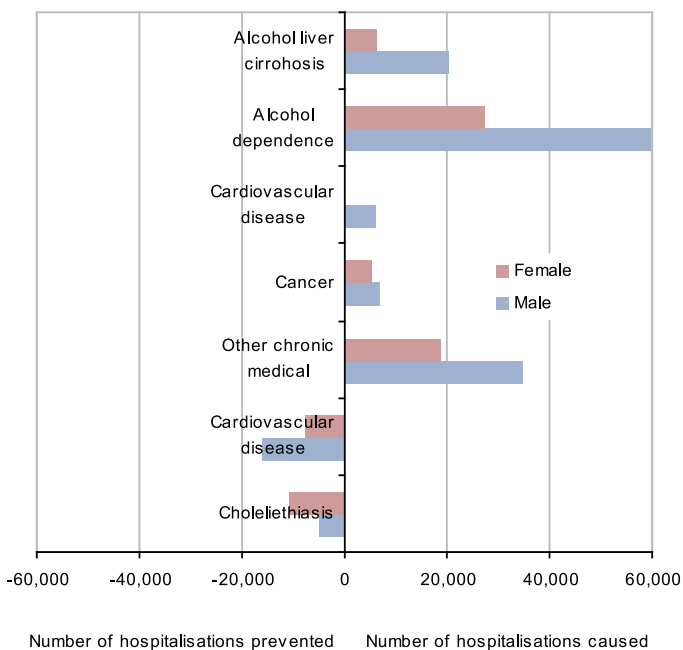
It is important to consider both the short-term and long-term health impacts of harmful consumption of alcohol as both result in significant morbidity (disease and injury) and mortality (death). In addition to the estimated 16,756 Australians who have died from acute conditions, between 1992 and 2001 there were an estimated 14,377 deaths in Australia from chronic conditions due to drinking at risky or high risk levels. Three quarters (76 percent) of these were males and around half (47 percent) of all deaths from risky or high risk drinking for long-term harm were due to alcoholic liver cirrhosis (see Figure 11).

Figure 11. Estimated number of lives lost and saved for chronic conditions due to drinking at levels risky or high risk to health, by sex, Australia, 1992-2001 (Source: Chikritzhs et al 2003).



Despite the significant loss of life from drinking at risky or high risk levels for long-term harm, it is estimated that some lives were saved as a consequence of long-term moderate drinking. A similar pattern exists in the number of hospitalisations for chronic conditions from drinking at risky or high risk levels for long-term harm, albeit much larger in scale (see Figure 12).

Figure 12. Estimated number of hospitalisations caused and prevented for chronic conditions due to drinking at levels risky or high risk to health, by sex, Australia, 1993/94-2000/01 (Source: Chikritzhs et al 2003).



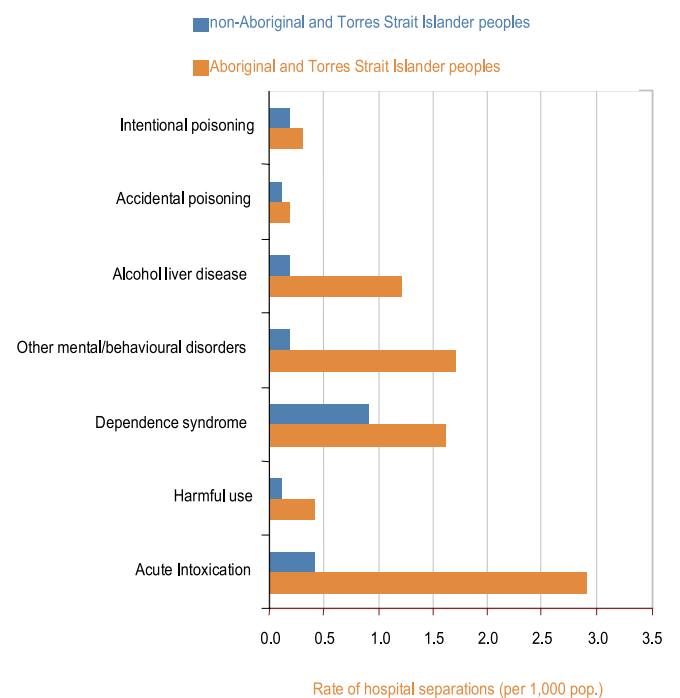
The most common alcohol-related chronic condition for hospitalisation was alcohol dependence. Between 1993-94 and 2000-01, there were 87,186 hospitalisations for alcohol dependence, two thirds of which were males.

A recent report **Overcoming Indigenous Disadvantage** (SCRGSP 2005) reported several key indicators of the health impacts of alcohol upon Aboriginal and Torres Strait Islander peoples:

- Regardless of sex and region, between 1990 and 1997, there were markedly higher rates of alcohol-related deaths among Aboriginal and Torres Strait Islander peoples, than the remainder of the Australian population.
- Between 1990 and 2002, young Aboriginal and Torres Strait Islanders were more than twice as likely as young people in the general population to die from alcohol-related causes.
- Death rates among young Aboriginal and Torres Strait Islanders have not improved in the past eight years.

While the leading causes of alcohol-related mortality and morbidity among Aboriginal and Torres Strait Islander peoples are similar to the remainder of the population, the rates at which these occur are considerably higher than those among the general population. For seven major alcohol-related conditions, Aboriginal and Torres Strait Islander peoples are significantly more likely to be hospitalised than the general population (see Figure 13).

Figure 13. Hospital separation rates related to alcohol use by Aboriginal and Torres Strait Islander status, Australia, 2002-03 (Source: SCRGSP 2005).



Particular health concerns

While the available evidence suggests that the birth prevalence of foetal alcohol syndrome (FAS) is relatively small in Australia, the condition is a particular issue of concern in Aboriginal and Torres Strait Islander communities (O'Leary 2004). In Western Australia, recent estimates of the prevalence of FAS are 2.76 per 1,000 births among Aboriginal and Torres Strait Islander children, compared to 0.02 per 1,000 births among children in the general population (Bower et al 2000). The prevalence of FAS in the Northern Territory was 0.68 per 1,000 live births in the general population and between 1.87 and 4.7 per 1,000 live births for Aboriginal and Torres Strait Islander peoples between 1990 and 2000 (Harris and Bucens 2003). Better and more consistent data and evidence are needed about the full range of alcohol-related birth defects, so that specific interventions can be well informed.

Long-term consumption of alcohol at harmful levels is a contributing factor in a number of mental health conditions, including alcoholic psychosis, alcohol dependence syndrome and alcohol-related dementia and Wernicke-Korsakoff syndrome. Recent research provides more evidence of the association between prior alcohol dependence and current depression (Caldwell et al 2002, Hasin & Grant 2002). Risky and high risk alcohol consumption also increases the risk of self-harm and suicide attempts (Borges et al 2004).

Good Practice

Prevention of Wernicke-Korsakoff syndrome

- The Wernicke-Korsakoff syndrome is seen in some long-term heavy drinkers and is caused by thiamine deficiency. The condition is characterised by neural atrophy and many affected individuals become permanently disabled and require long-term institutional care.
- In the early 1980s, research found the prevalence rate in Australia to be the highest recorded in the world.
- In an attempt to prevent cases of Wernicke-Korsakoff syndrome, thiamine supplementation of bread-making flour was introduced in 1990. Since this time, there has been a significant decrease in the incidence of Wernicke-Korsakoff syndrome (Harper et al 1998).

There are complex health issues arising from harmful consumption of alcohol and the use of other drugs, referred to as poly-drug use. In Australia, alcohol is often the primary drug among poly-drug users, whereas the community focus and principal concern is on illicit drugs, creating a complex cultural and political overlay. *The Alcohol and Other Drug Treatment Services National Minimum Data Set for 2002-03* found that in 42 percent of alcohol treatment cases, patients' use of other drugs was also a concern (AIHW 2004). The interactions between other drugs (tobacco, illicit and prescription) and alcohol are complex. Australian studies reveal a close association between heroin overdose and alcohol consumption at harmful levels at the time of overdose. Australian research has also found that among cannabis users, alcohol was almost universally used on a regular basis, with most users consuming alcohol at harmful levels.

The ageing of the Australian population is an important issue to consider in developing alcohol policy. It should not be a cause for alarm, but should signal the need for long-term research and planning. As the population ages, the number of older Australians at risk of alcohol-related problems increases. While only 3 percent of 20–29 year olds are daily drinkers, 17 percent of people aged 60+ years are (AIHW 2005).

There were over 110,000 hospitalisations of people over the age of 64 for alcohol-attributable injury or disease over a 9-year period (1993/94–2001/02). Falls precipitated the majority of these in both men and women for all sub-groups in the older years. Among those over 84 years, 63 percent of women's alcohol-attributable hospitalisations and 64 percent of men's were related to falls. (Chikritzhs & Pascal, 2005). Older people are more vulnerable to harms from alcohol due to lower tolerance, increased sensitivity and increased likelihood of interaction with other medications. In some circumstances, there may be a lack of awareness of the potential for interaction, particularly among older people who take prescription medications. This can contribute to a significant number of alcohol-related fall injuries. It is possible, in an elderly population, for consumption to remain steady while the ability to tolerate that level of consumption decreases, leading to alcohol-related problems without any increase in consumption.

Interventions and treatment

Good Practice

The Lifestyle Prescriptions initiative

- Aims to make it easier for GPs to provide healthy lifestyle advice to their patients, focusing on five risk factors: alcohol, tobacco, nutrition, physical activity and obesity.
- The Lifestyle Prescriptions Resource Kit contains consumer resources (posters, pamphlets, checklists), practitioner resources (script pads, assessment tools and evidence and guidelines for each of the five risk factors), and an educational CD-ROM on motivational interviewing. Australian Government: Department of Health and Ageing (2003)

During 2003–04, there were 136,869 closed treatment episodes in specialist alcohol and other drug treatment services reported in the *Alcohol and Other Drug Treatment Services National Minimum Data Set collection* (AIHW 2004b). In 38 percent of treatment episodes, alcohol was the principal drug of concern, the highest prevalence of all drugs. Despite these high numbers in treatment, figures suggest that there are potentially many more Australians in need of treatment for alcohol dependence than those who have received it.

Who is receiving treatment?

- It is estimated that 459,400 Australians consume alcohol at levels considered to be high risk to health in the long-term (AIHW 2005).
- However, each year only 41,000 Australians register for alcohol-related treatment at government-funded alcohol and other drug treatment agencies (AIHW 2005c).
- On average there are only 35,000 prescriptions each year for the two major pharmacotherapy treatment drugs for alcohol dependence, known as Acamprosate and Naltrexone (HIC 2005)
- New modes of delivering treatment, such as the *Initiating Controlled Drinking by Correspondence Program*, may help to reach those who don't have the time or financial resources to attend clinics, or are uncomfortable in seeking face-to-face treatment (Thiagarajan 2005).

The low uptake of some proven treatment options for alcohol dependence, such as early and brief interventions and pharmacotherapy for alcohol dependence, despite their proven effectiveness is an issue. Brief interventions are known to be effective in early detection and prevention of alcohol-related health problems. There are opportunities for such interventions in general practice settings and throughout the primary care system. An important factor in applying this approach is establishing effective links between different parts of the system, including general practice, hospital accident and emergency departments, alcohol and drug treatment services, and mental health services. Links outside the traditional health system are also important, including areas such as welfare, housing and other specialist support services.

Specialist services

In many states there is a commitment to ongoing quality accreditation of specialist alcohol and drug treatment services. These initiatives need to be supported nationally to ensure better client treatment outcomes. In Western Australia, the quality accreditation process of specialist alcohol and drug treatment services has been extended to incorporate measures of evidence based practice uptake.

Health professionals

Many health professionals currently lack the resources, support, and ongoing information and training, required to effectively assess and treat patients with alcohol issues. GPs are already a leading profession in responding to alcohol-related health issues in the community, and this should be built on. Eighty-five percent of the population attend a GP each year, and 90 percent every two years; although attendance of some groups, such as young males, is low. A recent survey of general practice activity in Australia found that 'at-risk' levels of alcohol intake were reported by 27 percent of the 32,000 adult patients surveyed, and that patient counselling and advice relating to alcohol is one of the 13 most common clinical treatments provided by GPs in Australia (Britt et al 2004). There are opportunities

for GPs to access support and resources for treating people with alcohol issues and mental illness, such as the Better Outcomes in Mental Health Care Initiative.

In the 1990's positions were funded in all medical schools to develop core alcohol and drug curriculum and support teaching efforts and other activities. This program - Coordinators for Alcohol and Drug Education in Medical Schools (CADEMS) contributed to the development of a text and companion work book. However, in the absence of on-going funding, few medical schools have retained a position for a dedicated individual to ensure that this element of education is delivered within the teaching program.

Good Practice

'The local men in this town typically don't come into the clinic until they're really sick. So, we do outreach to the local pubs to talk with the regulars about their health and do some basic health screening, blood pressure checks, diet, exercise. In our town, there are only six local shops, but three of them sell alcohol.'

Community health nurse in small town, regional Victoria

One professional group that warrants particular attention at this time are nurses and midwives. Nurses and midwives have extensive opportunities for patient contact and opportunities for imparting health information and advice. Along with GPs, nurses and midwives comprise the largest profession at the front line of alcohol and drug health issues in the community. They have key roles in brief interventions, routine screening, assessments, treatment support and referral. Nurses are present in accident and emergency departments, general and community health services and obstetric and gynaecology services, mental health services and other specialist areas, and they are increasingly present in general practice. Some undergraduate nursing courses include alcohol and drug subjects in their curricula, including Flinders, Adelaide, South Australia, Wollongong and some of the Australian Catholic Universities. However, many registered nurses and midwives have not had an opportunity to develop skills in alcohol and drug nursing and have not had exposure to alcohol and drug issues through undergraduate or postgraduate education.

4.3.2 What responses are recommended?

The following responses relate to the health system and therefore do not necessarily include other responses that can positively affect the health impacts of alcohol, many of which are recommended elsewhere in this Strategy.

3A Initiate a national effort to enhance the capacity and legitimacy of the nursing profession in addressing alcohol-related health problems.

- Support efforts to include alcohol and drug education in all undergraduate nursing and midwifery curricula.

- Mandatory policy to be developed to ensure that, in all health care settings nurses and midwives automatically assess all patients for levels of consumption of alcohol and define strategies for intervention and clinical management of intoxication and withdrawal, where appropriate.
- Provide nursing and midwifery staff with resources to support alcohol-related screening and early interventions in primary care settings, including hospital accident and emergency departments, general practice, and mental health services.
- Support further development of the Nurse Practitioner role in relation to alcohol and drugs.

3B Promote primary care settings as an accessible and non-stigmatising opportunity for health promotion, prevention and treatment of alcohol use problems.

- Increase the uptake of pharmacotherapy treatment for alcohol dependence, by GPs and specialist alcohol and drug treatment services, including attention to appropriate programs for use with alcohol dependent Aboriginal and Torres Strait Islander peoples.
- Provide a full range of approaches to Aboriginal and Torres Strait Islander peoples to address the impact of alcohol, tobacco and other drugs, and social and emotional wellbeing and issues related to co-morbidity.
- Develop and integrate an alcohol and drug component within the national Better Outcomes in Mental Health initiative to address alcohol dependence and co-morbidity issues in the community.

3C Improve capacity and encourage a system-wide health response to people at risk of short-term and longer-term alcohol-related health problems.

- Explore the potential effectiveness of the development of an assessment and treatment program for offenders where alcohol appears to significantly contribute to a criminal offence.
- Increase the feedback and referral for alcohol-related assessment and treatment from hospital accident and emergency departments to specialist alcohol and other drug services and to GPs.
- Support the ongoing implementation of quality accreditation systems in specialist alcohol and drug treatment services including review of the uptake of evidence based practice.
- Continue working with Aboriginal and Torres Strait Islander community leaders to identify programs that show promise in preventing and responding to alcohol-related health issues in their communities and support wider implementation and evaluation.
 - This could include building on programs such as the Indigenous Alcohol and other Drug National Train the Trainer Pilot Program.

- Establish a profile of the spread and treatment funding allocations to mainstream and targeted services and explore the relationship of funding to alcohol specific indicators such as those associated with alcohol use, indices of harm such as the burden of disease and demand for services.

3D Support whole-of-community initiatives to reduce alcohol-related health problems.

- As part of the cyclical review of the Australian Alcohol Guidelines:
 - consider any special needs for population sub-groups - pregnant women, young people, Aboriginal and Torres Strait Islander peoples, older people, and people who have experienced alcohol dependence;
 - continue to recognise non-drinking options; and,
 - consider the potential for distribution and use of these guidelines to other countries in our region that may request access to such specialist expertise (including consideration of consistency between Australia and New Zealand).
- Recognise the importance of thiamine fortification in preventing serious alcohol-related disease. Examine the potential for its inclusion in alcoholic beverages and the cost-effectiveness of such a measure, while ensuring ongoing provision of thiamine supplementation in flour used in baking.
- Support community-wide health promotion initiatives that have the potential to prevent and reduce alcohol-related harms, with emphasis on supporting local communities in developing and implementing such initiatives.
- Address the co-occurrence of depression and alcohol use and possible treatment responses with a view to multi-pronged prevention initiatives.
- Support consistent data collection on Foetal Alcohol Spectrum Disorders in the general population and in high risk groups.
- Monitor developments in Australia and overseas to address the problem of Foetal Alcohol Spectrum Disorders and identify best practice approaches to reduce its incidence, particularly in Aboriginal and Torres Strait Islander communities.

4.4 Priority Area 4:

Cultural Place and Availability

Aim: Facilitate safer and healthier drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability.

4.4.1 What is the issue?

In Australia today, alcohol retains deep-rooted cultural significance. Few question the cultural place of alcohol or its availability. This cultural acceptance of alcohol also appears to include its harmful impacts among some groups. Australians value the positive part that alcohol plays in their lives, but in general are largely unaware of many of the problems and costs associated with alcohol.

The nation's drinking cultures are driven by a mix of powerful, intangible social forces – such as habits, customs, images and norms, and other interlocking and equally powerful, tangible forces relating to the social, economic and physical availability of alcohol – such as promotion and marketing, age restrictions, price, outlets, hours of access and service practices.

Key findings of the consultations

The cultural place of alcohol:

- is driven by the normalisation of alcohol into everyday Australian consumer behaviour
- is not considered to be part of a 'drug' culture
- does make some positive contributions to Australian society being intrinsic to the cultural significance of socialisation, entertainment, celebration, and hospitality
- is influenced by the promotion of alcohol through advertising and other methods of product marketing
- will not change by telling young people they drink too much

The availability of alcohol:

- has proliferated, especially the number of licensed outlets, providing both on-premises and packaged liquor
- is increasingly driven by the National Competition Policy guidelines that are now reflected in liquor control laws
- is also driven by social forces such as the way alcohol is promoted, which is sometimes exploitive of women and young people
- should be restricted to encourage low risk drinking using price-related levers such as tax to partly achieve this
- should be more tightly regulated, especially for high risk and vulnerable groups in the community
- is most effectively regulated by enforcement of liquor licensing laws

The cultural place and availability of alcohol is a complex issue, but this need not be a reason for inaction. If it is acknowledged that culture change is a key strategy to reduce alcohol-related harm, it then follows that a starting point should be to identify what sort of drinking cultures are desirable.

There are lessons from successes in other fields, such as the cultural changes that have accompanied a reduction in smoking in Australia, the acceptance of compulsory seat belt wearing and support for random breath testing.

The key to these achievements has been a multifaceted approach involving efforts focusing on social values and norms, including community information and social marketing, as well as on regulation and enforcement. Perhaps the most critical factor in successful cultural change has been the clear definition of a long-term vision and a solid commitment from key stakeholders to work towards this vision.

Social availability

The wide-ranging ways in which alcohol is promoted is a major force behind Australia's drinking cultures. Advertising in mainstream media, especially print and television advertising is particularly influential, especially upon young and impressionable groups in the community. There is also evidence of significant peer pressure placed upon many Australian children in the uptake of drinking and equally strong peer pressure placed upon some parents to condone this. Research is required to more fully explain forces behind these social pressures and assess the risks of alcohol use for children and young people.

Social acceptance

The misuse of alcohol, and accordingly alcohol policy are complex areas. In many circumstances, especially Indigenous communities, the misuse of alcohol is a symptom of broader problems. Yet in other settings, especially around young people, it can often result from the simple social acceptance of drinking to excess.
(Winemaker's Federation of Australia 2005)

While there are general population guidelines for alcohol use (see NHMRC 2002), there has been a lack of attention to drinking patterns in adolescence. Efforts to identify safer alcohol use patterns among young people typically focus on short-term harms and major long-term harms. However, young people are unique in that they are also exposed to 'developmental harms' (Toumbourou 2005). Hence, there is still a need to develop a more substantial evidence base on the likely impacts of responses such as increasing the legal purchase age (for example, from 18 to 21 years) in Australia.

Raising the legal purchase age from 18 to 21 years

Arguments for:

- Current patterns of alcohol use in the adolescent and young adult age group have significant net social costs.
- Estimates are that it could have reduced the number of preventable deaths in the 15-24 age group between 1990 and 2002 by 320 (12 percent).
- It would add to benefits already enjoyed from other policies such as drink-drive law.
- It may reduce overall levels of adolescent alcohol use.
- Prior to the mid-20s, the human brain is still developing and emerging evidence associates the prevalent patterns of youth binge drinking with brain damage.
- Australian tolerance toward youth alcohol use is giving rise to historically high rates of binge drinking amongst young women.

Arguments against:

- It may foster intolerance to harm minimisation policies, and this would be counterproductive.
- It may lead to an increase in adolescent experimentation with illicit drug use. (Toumbourou 2005)

The most common means of obtaining alcohol by underage drinkers is from friends and family (Chikritzhs et al 2004). Of all 12-17 year old Australian school students surveyed in 2002, 11 percent of males and 8 percent of females bought their last alcoholic drink themselves. Parents were the most common source of alcohol, with 38 percent of males and females indicating their parents were the source of their last drink. Students indicated that the three main places they drank alcohol were the family home, a friend's home or a party (White and Hayman 2004).

Clearly, there is a need for a wide range of responses to underage and youth drinking, but the most important strategies to consider are those proven to work, including stricter enforcement of the existing purchase age restrictions and higher penalties for suppliers (licensed outlets, unsanctioned adults, others) of alcohol to underage persons in public and private venues. Other interventions may include information, support and awareness programs for parents, early interventions for at-risk young people, and harm reduction measures targeting underage drinking.

A role for all adults

Unless we change the culture of drinking in the adult community, we're only going to have a marginal impact on the way young people behave.

Dr Neal Blewett,
President of the Alcohol and Other Drugs Council of Australia,
(Quoted in Gooch 2005).

While alcohol prevention campaigns targeting young people can achieve positive results, it can be argued that as long as young people continue to be exposed to one-sided positive depictions of drinking through alcohol promotion, and continue to witness adults' intoxicated behaviour being modelled, and often celebrated by adult drinkers and in the media, these positive results will be only temporary. A more sustainable approach to achieving positive cultural change amongst Australian drinkers, thereby achieving an impact on youth drinking, would be to target intoxicated behaviour across society (Carroll 2005). This approach would seek to reduce the perceived acceptability of intoxicated behaviour and its concomitant alcohol-related harm amongst Australian drinkers.

As a parallel approach to reducing the acceptability of intoxicated behaviour and alcohol-related harm, there needs to be strong promotion of awareness of the Australian Alcohol Guidelines and education about standard drink measures amongst all Australian drinkers. At the same time, there is a key role for an ongoing information strategy to raise awareness of the extensive costs of harmful use of alcohol to individuals, families, communities and the Australian economy. It is important that national social marketing campaigns that aim to prevent alcohol-related harms are planned in conjunction with other information efforts, especially peer education and school-based drug education programs that engage parents as well as young people. Research evidence suggests that school-based drug education on its own will only have a modest impact but this can be enhanced with appropriately planned synergy with high profile media linked efforts.

Partnerships

The Re-Thinking Drinking program for students

- An example of long-standing stakeholder co-operation and multi-sectoral partnerships.
- In 1993, the Australian Associated Brewers Inc (AAB) identified the lack of harm minimisation teaching materials in schools as a resource gap and provided \$1.3 million towards research and development for a new program.
- The Youth Research Centre of the University of Melbourne undertook research and development work on the student kits and training.
- A number of state and independent education departments participated in trialling the teaching materials and the initial training of teachers.
- The Australian Government funded the revision of the materials to ensure they were culturally appropriate for Indigenous students and distributed these to all schools in October 2004.
- The Australian Council for Health, Physical Education and Recreation has maintained availability of the resource and revised the materials for the second edition.

(AAB 2005)

It is vital that alcohol promotions be regulated to ensure public health and safety interests are upheld. The alcohol beverage industry introduced its own self-regulatory alcohol advertising system in 1989 prior to the involvement of the MCDS in 2002, in what is now seen by the alcohol beverage industry as a 'co-regulatory' system. This involves guidelines for advertising that have been negotiated with government, and an emphasis on the independent handling of consumer complaints, with all costs being borne by the alcohol industry (ABAC 2004). In parallel with these changes, the MCDS has established some monitoring mechanisms. These regulatory measures will continue to play an important role in shaping safer and healthier drinking cultures in Australia. Under the Alcohol Beverages Advertising Code, advertisements, including those on the Internet, in a retail context, or related to promotion of alcohol at events, must:

- present a balanced, mature and responsible approach to the consumption of alcohol;
- not have a strong appeal to children or adolescents;
- not suggest that consumption can create change in mood or environment, or success of a personal, business, sporting or sexual kind;
- not depict association between consumption (other than low strength alcohol) and use of motor vehicle, boat or aircraft;
- not challenge or dare people to drink or offer inducements to drinking a product because of its higher alcohol content;
- comply with Australia's Advertiser Code of Ethics; and
- not encourage consumption that is inconsistent with the Australian Alcohol Guidelines.

Some ongoing monitoring of advertising and the implementation of the advertising code is necessary to continue to ensure improvement in compliance and timely action. There is also a need to promote the advertising guidelines while ensuring that community members who wish to object to specific alcohol advertisements are able to do so.

Changing the drinking culture

- There are many different cultures in Australia, especially in relation to alcohol, and different groups attach different values to alcohol and its role in their lives.
- Culture is about values, the social understandings or rules that connect us, and the importance and worth of various activities, objects and experiences.
- Lifestyle change, how people use alcohol, is not culture change per se.
- Effective cultural change must be driven by a fundamental shift in the cultural norms that underpin risky drinking patterns.
- The community needs to reassess what is 'socially acceptable' in relation to the consumption of alcohol.
- Cultural change is likely to be difficult, taking years, if not decades, to achieve.
- Cultural change will require a variety of co-ordinated approaches drawing together stakeholders across many different interrelated sectors.

Another shaper of our social attitudes to alcohol is the law. For instance, in Australia today, there can be legal ramifications of being intoxicated when engaged in criminal activity. The leading Australian court decision on criminal liability and self-induced intoxication is the decision of the High Court in *The Queen v. O'Connor* ("the O'Connor's case"), which requires that where evidence of self-induced intoxication raises any doubt as to whether a defendant has acted voluntarily or intentionally, he or she should be acquitted (PVLRC 1999). This principle has become the law in all Australian common law jurisdictions (Australian Capital Territory, New South Wales, South Australia, and Victoria) but is different in jurisdictions that have adopted legislative codes (Northern Territory, Queensland, Tasmania, and Western Australia). While there are some similarities between the jurisdictions' criminal codes, they are far from uniform (PVLRC 1999). With regards to Commonwealth criminal law, the *Criminal Code Amendment Act* was enacted in 1998 to significantly reduce the use of self-induced intoxication as a defence. Further consideration does need to be given to achieving national uniformity and community understanding.

Economic Availability

Research shows that using price-related levers, such as higher tax rates on alcohol, and hypothecating (assigning) the taxation revenue for alcohol specific government initiatives, is highly effective in preventing and reducing alcohol-related harm (Loxley et al 2005). It is generally expected that price-related levers have differential impacts upon some groups in the community, such as low and limited income groups, young people, older people and Aboriginal and Torres Strait Islander peoples. Nonetheless, these differentials are potentially beneficial from a public health perspective and they highlight the need for demand reduction and harm reduction responses for particular groups.

Good Practice

Northern Territory's Living with Alcohol Program

- The recently evaluated *Living with Alcohol Program* (1992-2002) was funded by a government levy on drinks containing 3%+ alcohol by volume.
- The levy was collected by the NT Government and funded community education campaigns, worker training and additional treatment services.
- Legislative changes reduced the drink driving limit and placed restrictions on serving people who were intoxicated.
- The result was a significant reduction in alcohol-attributable deaths and financial cost savings to government.
- The evaluation found that positive outcomes resulted from both the treatment programs and increases in real price through alcohol taxation. (Chikritzhs et al 2004)

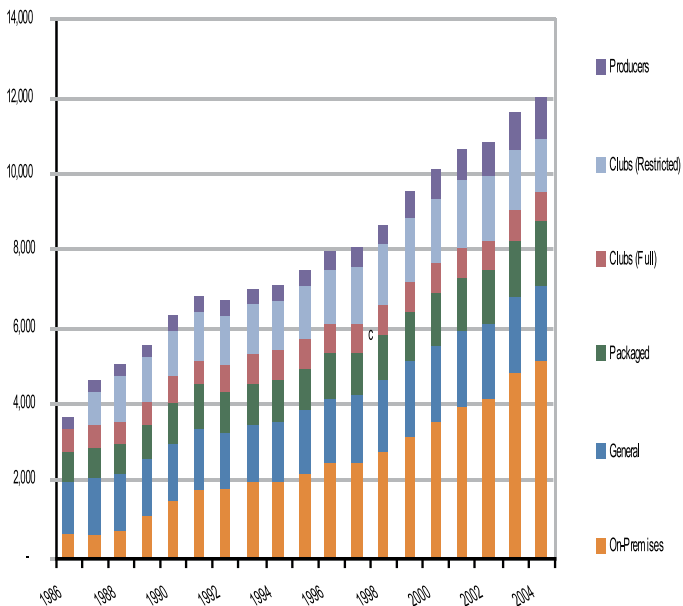
The impact of alcohol taxation on sustainability of the alcohol beverage and hospitality industries needs to be considered. Higher taxation may need to aim for neutral impacts on alcohol-related industries, in order to be accepted by industry and the community. This is a complex domain where historic arrangements are

difficult to change. Nevertheless, the logic of taxation on alcoholic beverages according to their alcohol content (the so-called volumetric approach to alcohol taxation) is difficult to refute. The current system can result in the same tax for a 3.5% alcohol volume drink as a 6% alcohol volume drink. A new tax structure that increases the affordability of low-strength alcoholic beverages is one potential way of achieving both public health and economic benefits.

Physical Availability

In many parts of Australia, the availability of alcohol has proliferated, due in part to relaxation of laws governing the issuing of liquor licences to reflect National Competition Policy principles. In Victoria, for example, the number of liquor licences has increased almost three-fold since 1986, climbing from around 4,000 to more than 12,000 (See Figure 14).

Figure 14. Growth in the number of liquor licences in Victoria, 1986 to 2004
(Source: Consumer Affairs Victoria 2005)



Some have suggested that more open availability of alcohol may foster a moderate, European-style drinking culture. A better understanding of so-called 'European drinking' might provide cause for some hesitation about this suggestion. Nevertheless, whether a culture consistent with moderate drinking would be achieved simply by making alcohol more available without other measures to change Australia's drinking cultures is highly questionable, particularly in light of evidence showing the continuing level of alcohol-related harm in communities where the physical availability has increased. Furthermore, there is now recognition that at the local level, such as individual suburbs, the level of outlet density is highly predictive of levels of alcohol-related harm (Loxley et al 2004; Stockwell & Gruenewald 2001). In any analysis of the impact of additional licences, it is important to consider the nature of the licence as the consequences for measures of harm are likely to be different when comparing, for example, an additional licensed restaurant with an extra extended hours night club. Further research is required rather than developing policy built only around the existing small evidence base.

Effective liquor licensing is good for everyone

Alcohol is one component of a product mix that includes entertainment, food, gaming and social interaction. For this reason, effective management of the consumption of alcohol has commercial as well as regulatory advantages. The AHA believes that unfettered access to alcohol products can undermine initiatives to promote the responsible service of alcohol. We suggest an effective licensing regime that controls access to, and places effective responsibility on, sellers of alcohol products.

Australia Hotels Association (2005)

All liquor control legislation in Australia now includes reference to one of the objects of liquor control, the reduction of alcohol-related harm. However, the extent to which implementation of these Acts has effectively addressed this object has not been reviewed. Police in most jurisdictions report resource and judicial issues as the major barriers to effective enforcement. The public also has concerns about the apparent limited opportunities for input into the decision-making processes when new liquor licences or changes to existing liquor licences are considered.

Achieving cultural change

A number of central points on changing Australia's drinking culture emerged from the Thinking Drinking 2020 conference held in 2005:

- The role of **social marketing strategies** in health promotion.
- The role of targeted **community mobilisation campaigns**, including in the workplace, in schools, licensed venues and other leisure settings.
- The need to consider **re-regulating alcohol promotions**.
- The ongoing development of coordinated, multi-sectoral **framework conventions** on alcohol policy.
- Whether governments should consider various **taxation reforms** including volumetric arrangements, as well as further restrictions on alcohol availability and supply.
- The need for an increase in **alcohol treatment** and withdrawal services.

(Source: Roche et al 2005)

The extent of alcohol-related problems among Aboriginal and Torres Strait Islander communities remains a major national concern. Patterns of drug use among Aboriginal and Torres Strait Islander peoples have been shaped by social, cultural, economic and historical factors.

While there are important differences between some of the problems facing Aboriginal and Torres Strait Islander peoples and the general population, the physical availability of alcohol is a major determinant that is common to both. Of course, responses targeting Aboriginal and Torres Strait Islander communities should consider the needs of people in all locations, not only in remote communities. It is acknowledged that alcohol issues among Aboriginal and Torres Strait Islander communities are also driven by broader issues such as poverty, dispossession and dislocation, and efforts to reduce alcohol-related harm would be enhanced by wider reaching strategies that address the housing, education and economic issues in these communities.

Aboriginal and Torres Strait Islander communities have a great depth of knowledge and experience in building efforts to change drinking cultures, and have potential to advise on and support efforts of this kind in the wider Australian community. It is to be remembered that when compared to the broader Australian community, a greater proportion of Aboriginal and Torres Strait Islander peoples are non-drinkers.

4.4.2 What responses are recommended?

4A Strengthen the regulation of alcohol availability including liquor licensing controls.

- Establish a working group to consider the impact of National Competition Policy on liquor licensing arrangements.
- Develop a nationally consistent approach and legislation regarding secondary supply of alcohol to minors.
- Increase community involvement in liquor licensing decision-making processes and in responding to related concerns, with emphasis on supporting Aboriginal and Torres Strait Islander communities to advocate for restrictions in the availability of bulk wine in areas affecting these communities.
- Review the mechanisms developed and implemented and the outcomes of the inclusion of the object of harm reduction in liquor control legislation in each jurisdiction.

4B Investigate price-related levers to reduce consumption of alcohol at harmful levels.

- Focus ongoing dialogue on price-related levers to reduce consumption of alcohol at harmful levels.

4C Monitor and review alcohol promotions.

- Implement monitoring and annual reporting on the advertising and promotion of alcohol.
- Maintain prohibition of alcohol promotion that encourages rapid and/or high levels of alcohol consumption.

4D Develop and implement social marketing campaigns to reduce alcohol-related harms.

- Develop a social marketing campaign with the aims of:
 - reducing the perceived acceptability of intoxicated behaviour;
 - promoting the Australian Alcohol Guidelines and standard drink labels and measures; and,
 - increasing awareness of the significant costs to individuals, families, communities and the Australian economy of harmful use of alcohol.
- Ensure that there is appropriate research and thorough consultation to inform the development of social marketing campaigns aimed at Aboriginal and Torres Strait Islander peoples, acknowledging differences in relevant communication messages.
- Ensure social marketing campaigns are comprehensive, targeted and well coordinated, and developed with thorough consultation mechanisms with key community partners and audiences, including the alcohol beverage and hospitality industry, the health sector, law enforcement, school-based drug education programs, young people and local communities.

4E Develop a shared vision for long-term culture change with the aim of reducing alcohol-related harm and developing safer and healthy drinking cultures in Australia.

- Develop an annual national alcohol action audit with an accompanying forum to promote implementation and to ensure accountability of all parties to the National Alcohol Strategy.

4F Examine the legal aspects of alcohol availability specifically in relation to:

- The realisation of stated objects in liquor licensing legislation in each jurisdiction.
- The use of alcohol consumption in the legal defence of diminished responsibility.
- The supply of alcohol to minors.