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# RACP submission: Consultation on the Australian Draft National Alcohol Strategy 2018-2026

February 2018

## Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to comment on the Australian government's Consultation Draft National Alcohol Strategy 2018-2026 (the Consultation Draft). This is a long overdue initiative as the National Alcohol Strategy has not been updated since 2011. Physicians working in addiction clinics, emergency departments, orthopaedic wards, rehabilitation centres, liver clinics and cancer wards know first-hand the harm alcohol can cause. Therefore, the formulation of a focused, effective and properly supported National Alcohol Strategy is of great importance to the members of the RACP.

In March 2016, the RACP released its revised Alcohol Policy[1], co-developed with the Royal Australian and New Zealand College of Psychiatrists, which included a number of recommendations drawn from an in-depth review of the evidence on policies to reduce alcohol-related harms. It also was informed by the front-line clinical expertise and experience of our members. This submission draws on, and where relevant elaborates, the recommendations in our Alcohol Policy

The RACP considers that this Consultation Draft sets out a well-considered strategy for addressing alcohol-related harms with a sound logic. We particularly welcome the approach of identifying defined high-risk population groups where appropriate and the development of indicators of progress applied across different priorities. However, the Consultation Draft could be improved by:

- committing to stronger and clearer recommendations for action, including timeframes for action where appropriate.
- identifying more partnership and engagement opportunities for implementing the recommendations identified.
- a greater focus on the need to build the evidence base through research, with associated recommendations addressing this.

The RACP believes that the Consultation Draft could also be enhanced by adding the following recommendations:

- That the Commonwealth and State governments jointly initiate an inquiry into raising the minimum purchase age for alcohol.
- That State and Territory governments initiate measures to reduce the blood alcohol concentration (BAC) limit to zero for all drivers.
- That Commonwealth and State/Territory governments invest in better and more systematic data collection on alcohol sales and alcohol related harm.

We support (where relevant with caveats) the following sets of recommendations already in the Consultation Draft as key to addressing alcohol related harms:

- The introduction of volumetric taxation for all alcoholic beverages and the direction of revenue from such taxation towards preventative health activities
- The introduction of a minimum floor price for alcohol
- More restricted trading hours for both licensed establishments and off-license liquor sales premises.
- Including the density of existing alcohol trading outlets as a key consideration in the decision-making process by local governments for alcohol licensing.
- Changes to allow local governments the ability to more flexibly customise alcohol licensing conditions, including by declaring 'dry' areas where appropriate
- The introduction of a single national advertising code covering content and placement with statutory penalties for breach. Easily achievable first steps towards this goal would be to close the current loophole in the commercial television industry code which allows alcohol advertising to be broadcast during sports programs in children's viewing hours and to end all alcohol sponsorship of sporting events.

[1] https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-ranzcp-alcohol-policy.pdf

- Enhanced investments by governments in alcohol treatment services.
- Prioritised implementation of the National FASD Strategic Action Plan currently under development.
- Implementation and evaluation of new approaches to deter drinking and driving and other alcohol related anti-social behaviours particularly through use of ignition interlock systems
- Introduction of mandatory warning label requirements for alcoholic beverages.

## Introduction

This submission consists of four main parts.

In the first part of the submission we make some high level, broad overview comments on the Consultation Draft. In the second part of the submission we propose additional policy recommendations which in our view should be added to the Consultation Draft. In the third part, we identify the existing recommendations in the Consultation Draft which should be the priority for addressing alcohol related harm and which we largely support. Where there are caveats to this support, we propose amendments to improve on these recommendations. The final part of the submission provides a summary and conclusions.

For each of the recommendations either proposed or highlighted an overview of key and recent evidence is provided. This evidence review is not intended to be comprehensive but is targeted at the recommendations under consideration.

## A comprehensive basis which could benefit from clearer timeframes and a greater focus on partnerships and evaluation

Overall the RACP commends the Department of Health for this Consultation Draft which sets out a very comprehensive strategy for addressing alcohol-related harms developed with a sound logic. We particularly welcome the approach of identifying defined high-risk population groups where appropriate, including the section devoted to FAS and FASD. We also welcome the development of indicators of progress applied across different priorities.

Potential areas for improvement are as follows:

- The Consultation Draft should commit to stronger and clearer recommendations for action including timeframes for action where appropriate. Formulating relevant timeframes could include the division of recommended policies into 'initial actions' to be undertaken within a shorter time frame and 'future actions' which are longer term initiatives. Currently the document just reads as a wish-list of recommended but optional measures.
- The Consultation Draft should identify more partnership and engagement opportunities for implementing the recommendations identified. This should be allied with the identification of accountability mechanisms for the various levels of government to commit to undertaking meaningful action.
- There should be a greater focus on the need to build the evidence base through research.

On the need to identify appropriate partnerships and engagement strategies, we note that there are some existing recommendations in the Consultation Draft which already undertake this. For instance, the document highlights the need to support and build the capacity of local communities to declare themselves as dry communities where appropriate. Identifying strategic partnership with key stakeholders to implement appropriate policies to reduce alcohol-related harm (in this case by changing the drinking culture and reducing physical availability of alcohol) is good practice as, in most cases, the Commonwealth alone will be unable to achieve desired policy objectives without cooperation and commitment from these stakeholders. Identifying such partnerships is also the first step towards identifying accountability mechanisms because, as it stands, responsibility for achieving the various policy recommendations in the Consultation Draft can be amorphous given our

federated system of government. Thus, we note in our discussion below on specific recommendations that many policies require coordination between different levels of government (including both State and local governments). Local communities and the general public are perhaps the most important stakeholders of all, and it is vital that there is a focus on capturing community understanding, interest and involvement in reducing alcohol related harms.

On the second point - the need to build an evidence base through research - there should be more explicit acknowledgement throughout the Consultation Draft of the need for research and evaluation, and the means to facilitate this including through leveraging appropriate funding and more comprehensive and systematic data collection. to facilitate the development of meaningful accountability and outcomes measures.

## Additional recommendations which should be added to the Consultation Draft

1. **Initiate discussion and consultation on raising the minimum purchase age for alcohol**

Broad public consultation should be initiated on raising the minimum purchase age for alcohol. In particular, **the Commonwealth and State governments should jointly initiate an inquiry into raising the age at which takeaway alcohol can be purchased.** A recommendation or set of related recommendations around raising the minimum purchase age should be added to the recommendations already under **Priority 2, Objective 1: Strengthen controls on access and availability**

***The evidence***

Reducing rates of risky drinking by young people should be a priority given what is known about brain development not being complete in adolescence.[2] There is emerging evidence that heavy drinking during adolescence is associated with poorer cognitive functioning and possible brain response abnormalities while performing challenging cognitive tasks.[3] There is also evidence that short- and longer-term cognitive impairment during the post-pubertal and early adult years is associated with an earlier age-of-onset of harmful alcohol consumption.[4]

The effects of early initiation into drinking persist well past young adulthood, with one study finding that exposure to a younger legal purchase age is associated with a more than 30 per cent increase in the risk of a past-year alcohol use disorder, even among respondents evaluated in their 40s and 50s, and an elevated risk for a past-year drug use disorder in middle adulthood.[5] In the years following the reduction of the minimum purchase age in New Zealand, there was a significant increase in the proportion of young men and women aged 15 to 17 years drinking enough to feel drunk at least once a month.[6] One US study found that a reduction in the drinking age from 21 to 18 was associated with an increased risk of 'binge drinking' among young people, which persisted into adulthood.[7]

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[2] Gried J. Structural magnetic resonance imaging of the adolescent brain. *Ann N Y Acad Sci*. 2004 Jun;1021:77–85.
[3] Brown S, Tapert S. Adolescence and the trajectory of alcohol use: basic to clinical studies. *Ann N Y Acad Sci*. 2004 Jun;1021: 234–244.
[4] Hermens DF et al. Pathways to alcohol-induced brain impairment in young people: a review. Cortex 2013;49(1):3–17; Nguyen-Louie TT, Matt GE, Jacobus J, et al. Earlier Alcohol Use Onset Predicts Poorer Neuropsychological Functioning in Young Adults. Alcohol Clin Exp Res. 2017;41(12):2082-2092.
[5] Norberg K, Bierut LJ, Crucza RA. Long term effects of minimum drinking age laws on past-year alcohol and drug use disorders. Alcohol Clin Exp Res. 2009 Dec;33(12):2180–2190.
[6] Wilkins C et al. Drug use in New Zealand: National Surveys comparison 1998 and 2001.
Auckland: Alcohol and Public Health Research Unit; 2002.
[7] Plunk AD, Cavazos-Rehg P, Bierut LJ, Crucza RA. The persistent effects of minimum legal drinking age laws on drinking patterns later in life. Alcohol Clin Exp Res. 2013 Mar;37(3):463–469.

Evidence shows that changing the minimum purchase age for alcohol also changes various indicators of road safety, particularly the incidence of drink driving by young drivers.[8] New Zealand is a good indicator for the impacts of changing the minimum purchase age for alcohol since its reform in December 1999 when it lowered the alcohol minimum purchasing age from 20 to 18 years. The most recent study of the impact of this on traffic accidents among the young found that this was followed by long-term increases in the incidence of traffic injury attributable to male 15- to 19-year-old alcohol-impaired drivers.[9]

Studies conducted around the world on the impact of changes to the minimum purchase age reflect the New Zealand experience. A review of the empirical research from 1960 to 2000 shows that almost 60 per cent of high-quality studies undertaken concluded that a higher minimum purchase age for alcohol was associated with reduced road traffic accidents. None found the opposite.[10]

These results are also consistent with other studies which have found that a higher minimum purchase age for alcohol is associated with later initiation into drinking and reduced frequency of heavy drinking.[11] A possible reason for this is that a common source of alcohol for underage drinkers is from older friends. For instance, according to the latest National Household Drug Survey, 44% of drinkers aged 12-15 were supplied with their first glass of alcohol by a friend. Raising the minimum purchase age for alcohol may therefore also reduce opportunities for this source of supply for underage drinkers.

These strongly documented relationships suggest that raising the minimum age to above18 years for purchasing alcohol can reduce the future rate of alcohol use disorders among the younger generation as well as reducing drink driving rates among the young and associated traffic accidents, injuries and fatalities.

2. **Gradually reduce the blood alcohol concentration (BAC) limit to zero for all drivers**

The RACP supports gradually reducing the blood alcohol concentration (BAC) limit to zero for all drivers. As a first step, **the States and Territories could agree on a coordinated plan to reduce the BAC limit to 0.02 for all non-learner drivers**. A recommendation or recommendations of this nature should be added to the recommendations already under **Priority 1, Objective 1: Less injury and violence.**

***The evidence***

Drink driving is a major cause of morbidity and premature loss of life in Australia and New Zealand. Even low blood alcohol levels have been shown to impact cognitive functioning while driving. Alcohol consumption leads to slowed reaction times and dulled thinking processes, causing difficulties multitasking, reduced attention span, blurred vision and reduced hearing.[12] In 2016, 9.9 per cent of recent drinkers aged 14 years and over in Australia admitted to driving a vehicle while

[8] Kypri K et al. Minimum purchasing age for alcohol and traffic crash injuries among 15- to 19-year-olds in New Zealand. Am J Public Health 2006 Jan:96(1):126–131; Huckle T, Pledger M, Casswell S. Trends in alcohol-related harms and offences in a liberalized alcohol environment. Addiction 2006;101(2):232–240.
[9] Kypri K, Davie G, McElduff P, Langley J, Connor J. Long-term effects of lowering the alcohol minimum purchasing age on traffic crash injury rates in New Zealand. Drug Alcohol Rev 2017;36:178-185
[10] Wagenaar AC, Toomey TL. Effects of minimum drinking age laws: review and analyses of the literature from 1960 to 2000. J Stud Alcohol Suppl. 2002;14:206–225.
[11] Cook PJ, Moore MJ. Environment and persistence in youthful drinking patterns. In J Gruber (ed.). Risky behavior among youths: an economic analysis. Chicago: University of Chicago Press; 2001, pp. 375–437; Dee TS. State alcohol policies, teen drinking, and traffic fatalities. Journal of Political Economics 1999;72(2):289–315; O'Malley P, Wagenaar A. Effects of minimum drinking age laws on alcohol use, related behaviour and traffic crash involvement among American youth. J Stud Alcohol 1991;52:478–491.
[12] Centre for Accident Research and Road Safety. State of the road: Drink driving fact sheet; 2012.

under the influence of alcohol in the past 12 months.[13] A high proportion of repeat drink drivers have clinical alcohol dependence problems.[14]

It is currently an offence for any motorist to drive with a BAC of 0.05 or greater, and in most jurisdictions novice drivers (learners and P-platers) and professional drivers are now required to have a BAC of zero.

The risks of being involved in a casualty-resulting crash increases more rapidly with increasing BAC levels in the case of young drivers.[15] Lower limits for younger drivers have been shown to reduce the risk of road fatalities, especially if the BAC limit is set at zero.[16]

Indirect evidence of the benefits of reducing BAC limits to zero for all drivers is provided by a recent Cochrane review which identified 34 studies on graduated driver licensing (GDL) i.e. stricter requirements on new and inexperienced drivers. The review concluded that GDL is effective in reducing crash rates among young drivers, although the magnitude of the effect varies. Stronger GDL programs (i.e. more restrictions) appear to result in greater fatality reduction[17]

Research suggests that drivers with a BAC of between 0.02 and 0.05 have at least a three times greater risk of dying in a vehicle crash than drivers who do not consume alcohol.[18] Further reducing the legal BAC limit towards 0.02 or below could therefore lead to further reductions in road crash rates. International experience supports this claim:

- In Sweden, there was a 10 per cent reduction in fatal crashes related to drink driving after the BAC limit was reduced to 0.02.[19]
- In 2002, Japan reduced the BAC limit from 0.05 to 0.03 and increased the penalties for alcohol-impaired driving. The combined effect of these measures was a significant reduction in alcohol-impaired driving traffic fatalities, severe injuries and total injuries on the road.[20]
- Another Japanese study which focused on the impact of the reduction in BAC on teenage road traffic accident rates found statistically significant reductions in alcohol-related crashes, alcohol-related injuries and single-vehicle night-time crashes among young drivers aged 16–19.[21]

Reducing the BAC limit to zero has an added advantage of not relying on drivers' perceptions of how much alcohol they can consume to stay under a legal limit. Having this clear prohibition in place

[13] Australian Institute of Health and Welfare. National Drug Strategy Household Survey report 2016..
[14] Furr-Holden D et al. Toward national estimates of alcohol use disorders among drivers: results from the National Roadside Survey Pilot Program. Traffic Injury Prevention 2009;10(5):403–409.
[15] Keall MD, Frith WJ, Patterson TL. The influence of alcohol, age and the number of passengers on the night-time risk of driver injury in New Zealand. Accident Analysis and Prevention 2004;36(1):49–61; Organisation for Economic Co-operation and Development (OECD)/European Conference of Ministers of Transport. Young drivers: the road to safety. Paris: OECD; 2006.
[16] Loxley W et al. The prevention of substance use, risk and harm in Australia: a review of the evidence. Canberra: Australian Government Department of Health and Ageing; 2004. http://espace.lis.curtin.edu.au/archive/00000284/.
[17] Russell KF, Vandermeer B, Hartling L. Graduated driver licensing for reducing motor vehicle crashes among young drivers. Cochrane Database Syst Rev. 2011 Oct 5;(10):CD003300.
[18] Killoran A, Canning U, Doyle N, Sheppard L. Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths. Centre for Public Health Excellence. National Institute for Health and Care Excellence; 2010.
[19] Borschos B. An evaluation of the Swedish Drunken Driving Legislation implemented on 1 February 1994. In H Laurell, F Schlyter (eds). CD-ROM: Proceedings of the 15th International Conference on Alcohol, Drugs and Traffic Safety, Stockholm; 2000.
[20] Nagata T, Setoguchi S, Hemenway D, Perry MJ, Effectiveness of a law to reduce alcohol-impaired driving in Japan. Injury Prevention 2008;14(1):19–23.
[21] Desapriya E et al. Impact of lowering the legal blood alcohol concentration limit to 0.03 on male, female and teenage drivers involved in alcohol-related crashes in Japan. International Journal of Injury Control & Safety Promotion 2007;14(3):181–187.

would provide motorists with greater certainty while strongly reinforcing the message that drinking and driving should not occur.

3. **Invest in better and more systematic data collection on alcohol sales and alcohol related harms across all jurisdictions**

Investing in better and more systematic data collection on alcohol sales and alcohol related harms across all jurisdictions can aid in monitoring the progress of the National Alcohol Strategy and efforts by governments in all jurisdictions to assess the effectiveness of their policies to reduce alcohol related harm. While a start on this has been made by the federally funded National Alcohol Sales Data Project, more can be done to better link data and make it public, particularly data from licensing and hospitals and to allow the resulting data to be disaggregated at subnational levels.

Thus, the RACP supports:

- The implementation of **nationally consistent data collection** from all States and Territories that is timely and complete on alcohol sales which can be disaggregated and compared at sub-national levels, including local and regional levels
- amending the Liquor Acts in **each Australian jurisdiction to include mandatory collection and public reporting** of alcohol sales data and data on liquor licensees' occupancy, trading hours and compliance with the liquor legislation
- putting in place **infrastructure and data collection systems** for alcohol-related medical consultations, emergency department presentations and hospital admissions, and for other key issues such as family violence
- establishing a system for **ongoing monitoring of alcohol-related harm**, including harm to others within the hospital sector

We therefore advise that these specific recommendations be added to the discussion **on 'Monitoring progress'** in the Consultation Draft. **We note that implementation of these measures ideally requires the coordination and cooperation of the Commonwealth and State/Territory governments.**

## Key Recommendations from the Consultation Draft supported by the RACP

1. **Volumetric taxation and direction of revenue from taxation towards preventative health activities**

The RACP fully supports the following recommendations in the Consultation Draft:

- Taxation reform to include **volumetric taxation for all alcohol beverages** (as recommended by the Henry Tax Review) (Priority 2, Objective 2, 2nd point)
- **Direct revenue from alcohol taxation** towards preventative health activities (including a focus on alcohol-related harm) and alcohol and other drug treatment services (Priority 2, Objective 2, 3rd point)

***The evidence***

More appropriate alcohol pricing has the greatest potential to reduce consumption and alcohol-related harms. The direct relationship between alcohol price and its consumption and associated harms has been demonstrated over many decades and in different settings.[22] Low alcohol prices lead to higher consumption, including heavier drinking per occasion and more underage drinking.[23] Younger people and heavy drinkers are particularly sensitive to alcohol pricing,[24] with changes to alcohol pricing yielding significant changes in total alcohol consumption in these groups.

A recent Australian study using time series data between 1974 and 2012 on price and per-capita consumption for beer, wine and spirits and average weekly income estimated that a 10% increase in the alcohol price was associated with a 2% decrease in the population-level alcohol consumption in the following year, with further, diminishing, effects up to year 8, leading to an overall 6% reduction in total consumption. In contrast, when alcohol affordability increased, per-capita alcohol consumption increased over the following six years.[25]

The best means of raising taxes on alcohol is not through the current approach which essentially provides preferential treatment for cheap wine but through a standard tax on alcohol content (i.e. volumetric taxation). A recent mathematical modelling study which is one of the few to consider alternative tax mixes for increasing the price of alcohol concluded that volumetric taxation led to the largest reductions in health inequalities across income groups.[26] Studies based on Australian data have also concluded that moving to a fully volumetric-based alcohol tax system would generate additional revenue and reduce alcohol consumption, resulting in health benefits and cost savings from reduced healthcare and other expenditure.[27]

These benefits have also been proven from the experience of past attempts to increase alcohol taxation in Australia:

- The 'alcopops tax' introduced in Australia in 2008, which increased the taxation rate on ready-to-drink spirit beverages (RTDs) by 70 per cent, led to a 30 per cent reduction in RTD consumption. Despite some evidence of drinkers switching to other alcoholic products, total sales of alcohol one year after its introduction fell by 1.5 per cent net.[28] Research also shows that that the introduction of the tax was associated with a statistically significant decrease in

[22] Anderson P, Baumberg B 2006. Alcohol in Europe: a public health perspective. Report prepared for the European Commission. London: Institute for Alcohol Studies; Babor et al 2010. Alcohol: no ordinary commodity – Research and Public Policy, 2nd edn. Oxford: Oxford University Press;
Cook PJ, Ostermann J, Sloan FA 2005, Are alcohol excise taxes good for us? Short- and long-term effects on mortality rates. Working Paper No. 11138. Cambridge MA: National Bureau of Economic Research; Grossman M et al. Effects of alcohol price policy on youth: a summary of economic research. J. Res. Adolesc 1994;4(2):347–364; Wagenaar AC, Salois MJ, Komro KA. Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction 1994;104(2):179–190.

[23] Babor TF et al. Alcohol: no ordinary commodity – Research and Public Policy. 2nd edn. Oxford: Oxford University Press; 2010. For New Zealand evidence see Casswell S, Huckle T, Wall M, Yeh LC. International Alcohol Control Study: pricing data and hours of purchase predict heavier drinking. Alcohol. Clin. Exp. Res 2014 May;38(5):1425–1431. DOI: 10.1111/acer.12359.

[24] Chaloupka FJ, Grossman M, Saffer H. The effects of price on alcohol consumption and alcohol-related problems. Alcohol Research and Health 2002;26(1):22–34.

[25] Jiang H, Livingston M. The Dynamic Effects of Changes in Prices and Affordability on Alcohol Consumption: An Impulse Response Analysis. Alcohol Alcohol. 2015 ;50(6):631-8

[26] Meier PS, Holmes J, Angus C, et al. Estimated Effects of Different Alcohol Taxation and Price Policies on Health Inequalities: A Mathematical Modelling Study. PLoS Med. 2016 23;13(2):e1001963

[27] Byrnes JM et al. Cost-effectiveness of volumetric alcohol taxation in Australia. Med J Aust 2010;192 (8):439–443. See also Doran C et al. Estimated impacts of alternative Australian alcohol taxation structures on consumption, public health and government revenues. Med J Aust 2013;199(9):619–622, which evaluates the cost-effectiveness of four options for reforming alcohol taxation, one of which involves replacing the Wine Equalisation Tax (WET) with a volumetric tax and another which involves the introduction of a two-tiered volumetric tax.

[28] Skov S et al. Is the alcopops tax working? Probably yes but there is a bigger picture. *MJA* 2011 July;195(2):84–86.

ED presentations in NSW, particularly of younger people and more so for 18–24-year-old females.[29]

- The *Living With Alcohol* program, implemented in the Northern Territory in 1992, introduced a levy of five cents per standard drink on all alcoholic drinks of greater than 3 per cent strength, with an extra levy of 35 cents per litre on cask wine. Though the effects of this levy were not disaggregated from the effects of other measures in the program, an evaluation to the end of 1996 found that it led to reductions in:
    - apparent per capita alcohol consumption of 22 per cent
    - alcohol-related road deaths (34.5 per cent) and hospitalisations (23.4 per cent)
    - deaths (19 per cent) and hospitalisations (2 per cent) from acute alcohol-related conditions other than road crashes (e.g. other injuries, alcohol withdrawal) and hospitalisations (66 per cent) for chronic alcohol-related conditions (e.g. dependence, cirrhosis, various cancers).[30]

As a first step to reforming Australia's system of alcohol taxation, as recommended by numerous government reviews,[31] the WET should be replaced with a volumetric tax on wine and the WET rebate abolished. According to one major study published in the *Medical Journal of Australia*, subjecting wine to a volumetric excise rate equal to the current rate for low-strength beer sold off site would generate an additional $1.3 billion in revenue, whilst also leading to net savings of $820 million in lifetime healthcare costs for the population.[32]

Funds from increased alcohol tax revenues should be invested in alcohol treatment services and harm prevention programs. This approach is supported by the World Health Organization (WHO) which argues that hypothecation generates increased support for alcohol taxation measures, and increased accountability and transparency of the services being funded.[33]

## 2. Minimum floor price for alcohol

The RACP supports the following recommendations in the Consultation Draft:

- Introduction of a **minimum floor price for alcohol** (Priority 2, Objective 2, 1st point)
- Regulatory measures to **prevent promotion of discounted/low priced alcohol** including bulk buys, two-for-one offers, shop-a- dockets and other promotions based on price (Priority 2, Objective 3, point 3)

We note that implementation of these measures also involves State and Territory governments and urge that collaboration across the jurisdictions will enable a common minimum floor price to be coordinated across all Australia.

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[29] Gale M et al. Alcopops, taxation and harm: a segmented time series analysis of emergency department presentations. BMC Public Health 2015;15:468.

[30] Chikritzhs T et al. The public health, safety and economic benefits of the Northern Territory's Living With Alcohol Program 1992/2 to 1995/6. NDRI Monograph No. 2. Perth: National Drug Research Institute, Curtin University of Technology; 1999.

[31] These reviews are: 1995 Committee of Inquiry into the Wine Grape and Wine Industry; 2003 House of Representatives Standing Committee on Family and Community Affairs Inquiry into Substance Abuse; 2006 Victorian Inquiry into Strategies to Reduce Harmful Alcohol Consumption; 2009 Australia's Future Tax System (Henry Review); 2009 National Preventative Health Taskforce Report on Preventing Alcohol Related Harms; 2010 Victorian Inquiry into Strategies to Reduce Assaults in Public Places; 2011 WA Education and Health Standing Committee Inquiry Into Alcohol; 2012 Australian National Preventive Health Agency (ANPHA), Exploring the Public Interest Case for a Minimum (Floor) Price for Alcohol, Draft Report; and the 2012 ANPHA Exploring the Public Interest Case for a Minimum (Floor) Price for Alcohol, Final Report.

[32] Doran C. et al. Estimated impacts of alternative Australian alcohol taxation structures on consumption, public health and government revenues. Med J Aust 2013;199(9):619–622.

[33] Doetinchem O. Hypothecation of tax revenue for health. World Health Report. Background Paper No. 51. Geneva: World Health Organization; 2010.

***The evidence***

By reducing the availability of cheap alcoholic drinks and setting a floor price on their affordability, minimum pricing policies can have significant impacts on alcohol consumption, particularly that of hazardous drinkers who tend to buy the cheapest alcohol.[34] Minimum prices also restrict the liquor industry from pricing promotions such as the 'buy-one-get-one-free' promotions. So far there has been little experience globally of minimum pricing policies and their impact. The experience from British Columbia, Canada, showed a 10 per cent increase in average minimum price for all alcoholic beverages was associated with reduced consumption of all alcoholic drinks by 3.4 per cent[35] and a reduction in wholly alcohol-attributable deaths of almost a third.[36]

Compared to taxation, implementing a minimum alcohol price can lift the price of the cheapest alcohol while having limited effect on the price of other less harmful alcoholic products. Therefore, the degree to which cheap alcohol is consumed by harmful drinkers (relative to moderate drinkers) should guide an evaluation of how well targeted a minimum price can be. According to FARE[37], hazardous drinkers (men consuming 14 to 41 standard drinks and women consuming 14 to 34 standard drinks per week, inclusive) are more likely to purchase alcohol products that cost below $1.00 and $1.25 so this seems to be the 'sweet spot' for setting a minimum price.

Despite suggestions that this policy would impose hardships on low-income drinkers, a 2014 *Lancet* study found that its greatest impact would be on 'high risk' low-income drinkers who are in need of intervention.[38] Modelling of this policy option suggests it would have impose little hardship on low-income moderate drinkers.[39]

### 3. Increased restrictions on trading hours

The RACP supports more restricted trading hours for both licensed establishments and off-license liquor sales premises. We support these restrictions occurring through both **earlier closing hours** and **later opening hours**. Therefore, subject to these caveats, we express our support for the following recommendations in the Consultation Draft which either relate to or specifically endorse such policies:

- Implement policy and legislation around serving **restrictions after a set time** and the type of drinks which can be purchased and cessation of sales (Priority 1, Objective 1, point 1)
- **Licensing procedures** that consider outlet density, trading hours, impact on amenity, and related risks and harms, **drawing on local evidence and local community concerns** (Priority 2, Objective 1, point 2)

[34] Kerr W, Greenfield T. Distribution of alcohol consumption and expenditures and the impact of improved measurement on coverage of alcohol sales in the 2000 National Alcohol Survey. Alcohol Clin Exp Res 2007;31:1714–1722; Meir P, Purshouse R, Brennan A. Policy options for alcohol price regulation: the importance of modelling population heterogeneity. Addiction 2010;105:383–393; and Record C, Day C. Britain's alcohol market: how minimum alcohol prices could stop moderate drinkers subsidising those drinking at hazardous and harmful levels. Clinical Medicine 2009;9:5:421–425.
[35] Stockwell T, Auld MC, Zhao Z, Martin G. Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. Addiction 2012;107(5):912–920.
[36] Zhao J et al. The relationship between minimum alcohol prices, outlet densities and alcohol-attributable deaths in British Columbia, 2002–09. Addiction 2013 Jun;108(6):1059–1069. doi: 10.1111/add.12139. Epub 2013 Mar 21. Indirect evidence is also available from a study of Scotland's recent legislation which prohibits pricing promotions for alcoholic products. The legislation led to a 4 per cent decrease in wine sales and an 8.5 per cent drop in sales of pre-mixers compared to England and Wales where the legislation did not apply. See NHS Health Scotland 2013. Monitoring and evaluating Scotland's Alcohol Strategy: the impact of the Alcohol Act on off-trade alcohol sales in Scotland.
[37] FARE, The price is right: Setting a floor price for alcohol in the Northern Territory, August 2017.
[38] Holmes J et al. Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. Lancet; 10 February 2014. http://dx.doi.org/10.1016/S0140-6736(13)62417-4.
[39] Holmes J et al. Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. Lancet; 10 February 2014. http://dx.doi.org/10.1016/S0140-6736(13)62417-4

We note that implementation of these measures also involves State and Territory jurisdictions, with some opportunity for greater flexibility depending on specific characteristics at the local government level - for more on this, read the discussion on 'Building local community capacity to respond to alcohol-related harms'. We urge the Australian government to work towards establishing a common set of evidence based restrictions on trading hours across all Australian jurisdictions.

***The evidence***

There is robust international[40] and Australian evidence[41] that alcohol availability, through hotels and bottle shops, is strongly linked to alcohol-related harm and that reductions in alcohol availability results in decreased alcohol-related harm. Australian and international studies indicate that increased trading hours for licensed outlets are accompanied by substantially higher levels of alcohol consumption and associated harms such as drink-driver road crashes,[42] serious violent offences committed in the early hours of the morning,[43] and assaults per 100,000 inhabitants.[44] Further studies provide indirect evidence of this relationship, showing that over 40 per cent of assaults at licensed premises occur after midnight.[45] A recent study of Amsterdam trading hours found that a 1-hour extension of alcohol outlet closing times in some of Amsterdam's nightlife areas was associated with 34% more alcohol-related injuries.[46] Regular heavy drinkers are especially likely to take advantage of longer trading hours.[47]

The relationship also holds for off-licence outlets. For example, a New Zealand study found that people purchasing alcohol in off-licences at later hours are more likely to drink in a hazardous fashion, both in quantity and frequency.[48] Impacts from later trading hours for the two kinds of establishments can also interact through the phenomenon of 'preloading' where people drink before they head out to pubs and clubs.

Restrictions in alcohol trading in Newcastle introduced in 2008 has resulted in a successful, significant and sustained reduction in alcohol-related violence, demonstrated by academic publications from researchers at Newcastle University and elsewhere. The restriction in alcohol availability resulted in an immediate decrease of alcohol-related violence of 37 per cent[49] that has

[40] Babor T., Caetano R., Casswell S., Edwards G., Giesbrecht N., Graham K. *et al. (2010),* Alcohol: No Ordinary Commodity—Research and Public Policy*. Oxford, UK: Oxford University Press;* 2010

[41] Donnelley N et al.(2006), Liquor outlet concentrations and alcohol-related neighbourhood problems. Sydney: Bureau of Crime Statistics and Research, Sydney; 2006; Chikritzhs P, Catalano P, Pascal R, Henrickson N. (2007), Predicting alcohol-related harms from licensed density: a feasibility study. Hobart: National Drug Law Enforcement Research Fund: 2007, pp. x–xv; Livingston M. (2008), A longitudinal analysis of alcohol outlet density and assault. Alcoholism: Clinical & Experimental Research 2008;32(6):1074–1079.

[42] Chikritzhs T, Stockwell T. The impact of later trading hours for hotels on levels of impaired driver road crashes and driver breath alcohol levels. Addiction 2006;101(9):1254–1264.

[43] Australian Medical Association (NSW), NSW Nurses' Association, Health Services Union and Police Association of NSW. Last drinks: a coalition of concerned emergency services workers; 2010.

[44] Rossow I, Norström T. The impact of small changes in bar closing hours on violence: the Norwegian experience from 18 cities. Addiction 2011;107(3):530–537.

[45] Moffatt S, Weatherburn D. Trends in assaults after midnight. NSW Bureau of Crime Statistics and Research, Crime and Justice Statistics. Issue paper no. 59; 2011.

[46] de Goeij MC, Veldhuizen EM, Buster MC, et al. The impact of extended closing times of alcohol outlets on alcohol-related injuries in the nightlife areas of Amsterdam: a controlled before-and-after evaluation. Addiction. 2015;110(6):955-64

[47] Moffatt S, Weatherburn D. Trends in assaults after midnight. NSW Bureau of Crime Statistics and Research, Crime and Justice Statistics. Issue paper no. 59; 2011.

[48] Casswell S, Huckle T, Wall M, Yeh LC. International Alcohol Control Study: pricing data and hours of purchase predict heavier drinking. Alcohol Clin Exp Res. 2014 May;38(5):1425–1431.

[49] Kypri. K., Jones, C., McElduff, P., & Barker, D.J. (2010). Effects of restricting pub closing times on night-time assaults in an Australian city. *Addiction* 106 (2): 303-310.

been sustained with a decrease of alcohol-related assaults by 21 per cent five years after the introduction of the Newcastle conditions[50].

A recent systematic review of literature over 10 years which identified 21 relevant studies including 7 from Australia concluded that reducing the hours during which on-premise alcohol outlets can sell alcohol late at night can substantially reduce rates of violence.[51]

4. **Outlet density regulation**

The RACP supports the inclusion of **density of existing alcohol trading outlets as a key consideration** in the decision-making process for approving or denying an application for a new alcohol outlet. Therefore, we express our support for the following recommendations in the Consultation Draft which either relate to or specifically endorse policies to allow for consideration of existing outlet density in licensing applications:

- Supporting licensing decision making to achieve outcomes that **contribute to reducing or minimising alcohol-related harm and ill-health** (Priority 1, Objective 2, point 7)
- **Licensing procedures** that consider outlet density, trading hours, impact on amenity, and related risks and harms, **drawing on local evidence and local community concerns** (Priority 2, Objective 1, point 2)

We note that implementation of these measures involves State and Territory governments, which will need to enact changes to allow local governments within their jurisdiction the ability to take account of outlet density in their licensing decision making.

***The evidence***

There is a large body of evidence linking the density of licensed outlets with various alcohol related harms[52] and harmful behaviour including teenage binge drinking,[53] illegal underage purchasing of alcohol,[54] secondary supply of alcohol to adolescents;[55] and alcohol related violence[56]. Recent rigorous evidence from the UK based on 5 years of a record-linked database (covering 22 local authorities including hospital admissions data) confirms that hospital admissions and violent crime

[50] Kypri, K., McElduff, P. & Miller, P. (2014). Restrictions in pub closing times and lockouts in Newcastle, Australia five years on. *Drug and Alcohol Review* 33(3): 323–6.
[51] Wilkinson C, Livingston M, Room R. Impacts of changes to trading hours of liquor licences on alcohol-related harm: a systematic review 2005-2015. Public Health Res Pract. 2016 30;26(4).
[52] Donnelley N et al. Liquor outlet concentrations and alcohol-related neighbourhood problems. Sydney: Bureau of Crime Statistics and Research, Sydney; 2006; Chikritzhs P, Catalano P, Pascal R, Henrickson N. Predicting alcohol-related harms from licensed density: a feasibility study. Hobart: National Drug Law Enforcement Research Fund: 2007, pp. x–xv; Gruenewald P. Ecological models of alcohol outlets and violent assaults: crime potentials and geospatial analysis. Addiction 2006;101(5):666–677
[53] Livingston AM, Laslett AM, Dietze P. Individual and community correlates of young people's high-risk drinking in Victoria, Australia. Drug Alcohol Depend. 2008 Dec;98(3):241–248; McKetin R, Livingston M, Chalmers J, Bright D. The role of off-licence outlets in binge drinking: a survey of drinking practices last Saturday night among young adults in Australia. Drug and Alcohol Review 2014;33(1):51–58. http://dx.doi.org/10.1111/dar.12073; Rowland B et al. Associations between alcohol outlet densities and adolescent alcohol consumption: a study in Australian students. Addictive Behaviors 2014;39(1):282–288. http://dx.doi.org/10.1016/j.addbeh.2013.10.001; Huckle T et al. Density of alcohol outlets and teenage drinking: living in an alcogenic environment is associated with higher consumption in a metropolitan setting. Addiction 2008 Oct;103(10):1614–1621
[54] Rowland B, Toumbourou JW, Livingston M. The association of alcohol outlet density with illegal underage adolescent purchasing of alcohol. Journal of Adolescent Health 2015;56(2):146–152. http://dx.doi.org/10.1016/j.jadohealth.2014.08.005.
[55] Rowland B, Toumbourou JW, Satyen L, Livingston M, Williams J. The relationship between the density of alcohol outlets and parental supply of alcohol to adolescents. Addictive Behaviors 2014;39(12):1898–1903. http://dx.doi.org/10.1016/j.addbeh.2014.07.025.
[56]Gruenewald P. Ecological models of alcohol outlets and violent assaults: crime potentials and geospatial analysis. Addiction 2006;101(5):666–677; Livingston M. A longitudinal analysis of alcohol outlet density and assault. Alcoholism: Clinical & Experimental Research 2008;32(6):1074–1079.

track changes in outlet density.[57] Moreover, outlet density can reinforce the pricing impacts of alcohol and in particular, the consumption expanding impact of lower prices as studies have also found that higher outlet density is associated with increased pricing competition between outlets, including the discounting of alcohol products.[58]

Two main approaches for regulating outlet density have been adopted internationally. In the UK, local authorities can designate 'saturation zones' within licensing policies, meaning no new licensed premises are permitted in that area.[59] Alternatively, cluster controls can be established, which prohibit new liquor licences if they are within a given distance from licensed premises of the same category. This approach has been adopted in the UK, Paris and New York.[60]

## 5. Building local community capacity to respond to alcohol related harms

The RACP supports the following recommendations in the Consultation Draft which either relate to or specifically endorse policies to allow and encourage local communities to respond to alcohol related harms flexibly, including by declaring 'dry' communities as appropriate. At the same time policymakers should continue to monitor the emerging research on the effectiveness of these local approaches and note their limitations and their pre-requisites for success including strong community support and leadership.

- Build the **capacity of local community stakeholders** to identify and respond to prevent harm (Priority 1, Objective 1, point 2)
- Support communities to **declare themselves as 'dry' communities** (Priority 1, Objective 1, point 3).

We note that high level implementation of these measures involves State and Territory governments which would need to enact changes to allow local governments within their jurisdiction the ability to more flexibly customise alcohol licensing conditions. However, implementation of customised restrictions should then be at the discretion of respective local governments.

### *The evidence*

The research on Alcohol Management Plans (AMPs) in Queensland provides important lessons on the opportunities and limitations of more locally flexible approaches for addressing alcohol related harms. A review of studies on the effectiveness of AMPs concluded that, while the evidence was still limited, if the AMPs were locally driven and owned the outcomes were stronger and more sustainable. [61] The weaknesses of AMPs were most evident where their coverage had been narrowed to address primarily supply issues without complementary demand and harm-reduction

[57] Fone D, Morgan J, Fry R, et al. Change in alcohol outlet density and alcohol-related harm to population health (CHALICE): a comprehensive record-linked database study in Wales. 2016.
[58] Cameron M et al. The impacts of liquor outlets in Manukai City. Research Report No. 3. Wellington: Alcohol Advisory Council of New Zealand; Treno AJ, Ponicki WR, Stockwell T, et al. Alcohol outlet densities and alcohol price: the British Columbia experiment in the partial privatization of alcohol sales off-premise. Alcohol Clin Exp Res. 2013;37(5):854-9.
[59] Hadfield P, Measham F. A review of nightlife and crime in England and Wales. In P Hadfield (ed.). Nightlife and crime: social order and governance in international perspective. New York: Oxford University Press; 2009.
[60] Code de La Sante Publique Article L3335-1 and L3335-2.
[61] Smith K et al. Alcohol management plans and related alcohol reforms. Indigenous Justice Clearinghouse. Brief 16; October 2013.

measures; where there had been a lack of clarity in the roles and responsibilities of communities and governments; and where there was a lack of support in nurturing local community leadership.[62]

The most recent (2017) evaluation of AMPs in Queensland points to more mixed results:[63]

- Slim majorities agreed that: AMPs reduced violence, made the community a better place to live and made children safer.
- Larger majorities agreed that: school attendance improved and awareness of alcohol's harms increased.
- However community opinion was equivocal about improved personal safety and reduced violence against women.
- Negative assessments of AMPs which commanded majority support were that alcohol availability was not reduced, drinking was not reduced, cannabis use increased, there was more binge drinking, greater discrimination was experienced along with increased fines, convictions and criminal records for breaching restrictions.
- Participants were also equivocal that police could enforce restrictions effectively.
- Longer-term (≥ 6 years) residents more likely agreed that violence against women had reduced and that personal safety had improved but also that criminalization and binge drinking had increased. Younger people disagreed that their community was a better place to live and strongly agreed about increased discrimination resulting from AMPs.

### 6. Single national advertising code covering content and placement with statutory penalties for breach and an end to alcohol sponsorship of sporting events

Subject to some amendments including adding a recommendation for an explicit ban on all alcohol sponsorship of sporting events, the RACP supports the following recommendations in the Consultation Draft which aim to minimise the exposure of children and young people to alcohol advertising:

- Align a single **national advertising code** which covers placement and content across all media which provides consistent protection of exposure to minors regardless of programming (Priority 2, Objective 3, point 1)
- Implement regulatory measures to **reduce alcohol advertising exposure to young people** (including in sport and online) (Priority 2, Objective 3, point 2)
- Effective **controls on alcohol promotion** to protect at-risk groups including youth and dependent drinkers (Priority 2, Objective 3, point 4)

Our main caveat is that the recommendations should be more explicit in outlining the restrictions and penalties applicable to alcohol advertising. In particular the introduction of a single national advertising code covering placement and content across all media should be backed up by the introduction of statutory penalties for individuals and entities found to be in breach of this code. It needs to be made clearer that this national system should involve the dismantling of the current system of self-regulation and self-regulatory bodies which is clearly not working and that there should be no alcohol industry representation or participation in the regulatory body that determines whether there has been a breach of the new advertising code. In addition, we propose the recommendation should

[62] Smith K et al. Alcohol management plans and related alcohol reforms. Indigenous Justice Clearinghouse. Brief 16; October 2013.
[63] Clough AR, Margolis SA, Miller A, et al. Alcohol management plans in Aboriginal and Torres Strait Islander (Indigenous) Australian communities in Queensland: community residents have experienced favourable impacts but also suffered unfavourable ones. BMC Public Health. 2017 10;17(1):55

- state that sponsorship of sporting events by the alcohol industry should be prohibited and
- the loophole in the commercial television industry code registered by the Australian Communications and Media Authority (ACMA) currently allowing broadcast of alcohol advertising during sports programs in children's viewing hours at the weekends and public holidays should be closed.

These measures would be important first steps towards a model of alcohol advertising regulations which would phase out all alcohol promotions to young people.

### *The evidence*

The significant expenditure on advertising in Australia demonstrates that alcohol companies clearly recognise its influence in promoting consumption and driving sales. A recent systematic review has found conclusive evidence of positive associations between exposure to alcohol sports sponsorship and self-reported alcohol consumption[64], while a recent study which examined the association between alcohol advertising restrictions and the prevalence of hazardous drinking (defined based on a measure used by the World Health Organization) among people aged 50-64 in 16 European countries found that even after adjusting for confounding factors there was a positive association between less regulated alcohol advertising and hazardous drinking rates, even among this older age group.[65]

There is a particularly strong evidence base that exposure of young people to alcohol advertising encourages early initiation into alcohol use[66]. It also puts young people at greater risk of engaging in harmful and risky levels of alcohol consumption[67] and of developing long term alcohol use disorders.[68] The most recent estimate of the impact of alcohol advertising on increasing drinking using Australian data found that for every increase of 1000 Targeted Rating Points (a measure of television advertising exposure) the odds of an adolescent drinking in the past month increased by approximately 10%, while the odds of an adolescent engaging in past-week risky drinking increased by 16%.[69]

Current Australian regulations at the national level on alcohol advertising rely heavily on self-regulation in respect of both content and placement of advertising, and there is a lack of legally enforceable sanctions for instances when regulation breaches occur. At the national level, alcohol advertising content is predominantly regulated through the Alcohol Beverages Advertising (and Packaging) Code (ABAC). This code is operated by a management committee that comprises members of the alcohol industry, together with a government representative, but has no representation from the medical or public health sectors. As it is a voluntary scheme, it is not underpinned by legislation and therefore there are no statutory penalties for infringing the ABAC. Regulation of the placements of alcohol advertising (i.e. when and where such advertising is placed) on free to air television is done primarily through the Children's Television Standards of the

[64] Brown K. Association Between Alcohol Sports Sponsorship and Consumption: A Systematic Review. Alcohol Alcohol. 2016;51(6):747-755.
[65] Bosque-Prous M, Espelt A, Guitart AM, et al. Association between stricter alcohol advertising regulations and lower hazardous drinking across European countries. Addiction. 2014 Oct;109(10):1634-43.
[66] Wyllie A., Zhang J. F., Casswell S. Responses to televised alcohol advertisements associated with drinking behaviour of 10–17-year-olds. Addiction 1998; 93: 361–71; Jernigan, D., Noel, J., Landon, J., Thornton, N., and Lobstein, T. (2017) Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008. Addiction, 112: 7–20.
[67] Wyllie A., Zhang J. F., Casswell S. Responses to televised alcohol advertisements associated with drinking behaviour of 10–17-year-olds. Addiction 1998; 93: 361–71; Jernigan, D., Noel, J., Landon, J., Thornton, N., and Lobstein, T. (2017) Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008. Addiction, 112: 7–20.
[68] Grenard JL, Dent CW, Stacy AW. Exposure to Alcohol Advertisements and Teenage Alcohol-Related Problems. Pediatrics. 2013;131(2):e369-e379. doi:10.1542/peds.2012-1480.
[69] White, V., Azar, D., Faulkner, A., Coomber, K., Durkin, S., Livingston, M., Chikritzhs, T., Room, R., and Wakefield, M. (2017) Adolescents' exposure to paid alcohol advertising on television and their alcohol use: exploring associations during a 13-year period. Addiction, 112: 1742–1751.

Australian Communications and Media Authority (ACMA) and the Commercial Television Industry Code of Practice (CTICP), a co-regulatory industry code registered by ACMA. The broadcasting of alcohol advertising is restricted at certain times to ensure that children and adolescents are not exposed to alcohol advertising, however—incomprehensibly—there is a loophole that allows alcohol adverts to be broadcast during sports programs in children's viewing hours at the weekends and public holidays. It is a serious concern that the ACMA further relaxed these restrictions recently, widening their scope from sports broadcasts to sports programs.

Given the absence of a statutory 'bite' and despite CTICP having provisions around the timing of alcohol advertising on television, it is not surprising but very concerning that young people, including adolescents, are exposed to almost the same level of alcohol advertising as the rest of the population.[70] For instance, a study of 2,810 alcohol advertisements aired on Australian television over two months found that 50 per cent appeared during viewing times when children were regularly watching.[71] While a more recent study of Australian adolescents' exposure to television alcohol advertisements found that their exposure has fallen over between 1999 and 2011, it is theorised that this reduction may simply reflect the greater use of other advertising channels given the reduction in the use of television in alcohol advertising, as discussed previously. For instance, compared with 2016, there is an increase in the proportion of parents and guardians who believed their children under 18 were exposed to alcohol advertising while outside on the street (from 37% to 45%), at a licensed venue (from 35% to 42%) and on social media/internet (from 26% to 34%).[72]

A study of the effectiveness of compliance and complaint procedures in industry self-regulation codes in the UK, Europe, US, Canada and Australia concluded that current alcohol industry marketing complaint processes were ineffective at removing potentially harmful content.[73] For instance, this is reflected by the fact that 939 complaints were received by the Alcohol Advertising Review Board (the only independent advertising review body established in Australia so far, though also one that lacks statutory authority) over the five years of its operation since 2012.[74] A third of these complaints related to sport, indicating there is significant community concern around the link between alcohol and sport. There is a clear failure by both industry and governments in Australia to regulate alcohol advertising to the extent that would be regarded as satisfactory by the public.

## 7. Investing in a quality, effective treatment system

The RACP supports more adequate investments by governments at all levels including the Commonwealth in a quality and effective treatment system for people suffering from alcohol use disorders. This should include investing in enhancing the capacity of general practitioners to engagement in medical management of people with alcohol use disorders. Accordingly, we support the following recommendations in the Consultation Draft:

- The **entirety of the recommendations** of Priority 3 Objective 2
- Encourage **General Practitioners' engagement** in the Medical Management of People with Alcohol and Other Drug Disorders (Priority 3 Objective 1, point 5)

[70] Winter M, Donovan R, Fielder L. Exposure of children and adolescents to alcohol advertising on television in Australia. Journal of Studies on Alcohol and Drugs 2008;69(5):676–683; Fielder L, Donovan RJ, Ouschan R. Exposure of children and adolescents to alcohol advertising on Australian metropolitan free-to-air television. Addiction 2009 Jul;104(7):1157–1165; Victorian Department of Human Services. Alcohol beverage advertising in mainstream Australian media 2005 to 2007:
expenditure and exposure. Report commissioned by the Commonwealth Department of Health; 2009.
[71] Pettigrew S et al. The extent and nature of alcohol advertising on Australian television. Drug Alcohol Rev. 2012;31(6):797–802.
[72] FARE Annual Alcohol Poll 2017
[73] Noel, J. K., and Babor, T. F. (2017) Does industry self-regulation protect young people from exposure to alcohol marketing? A review of compliance and complaint studies. Addiction, 112: 51–56.
[74] Alcohol Advertising Review Board (2017) It's not fair play: Why alcohol must leave sport.

- Improve the frequency and quality of **screening and opportunistic interventions** for risky alcohol consumption, including through promotion and training of the ASSIST-BI (Priority 3 Objective 1, point 6)

We note that governments at both the Commonwealth and State/Territory levels have an important role to play in committing to enhanced levels of investment required in alcohol treatment services.

***The evidence***

The funding currently provided for alcohol and other drug treatment services is not commensurate with the needs of the population, particularly given that it is a good investment with one study estimating that for every $1 invested in alcohol or drug (AOD) treatment, society gains $7 [75]due to:

- reduced consumption of alcohol and other drugs
- improved health status
- reduced criminal behaviour
- improved psychological wellbeing and
- improved community participation.

Approximately 200,000 people receive AOD treatment in any one year in Australia. At the same time, modelled projections of the unmet demand for AOD treatment (that is the number of people in any one year who need and would seek treatment) are conservatively estimated to be between 200,000 and 500,000 people over and above those in treatment in any one year.[76] Breaking this unmet demand down by drug types, it is estimated that met demand rate is higher for 48%) compared to alcohol, which is at 27% (the met demand rate for all other drugs is 41%). Specifically, estimated met demand for alcohol treatment per annum is 92,780 people compared to 348,094 predicted demand[77].

GPs have an important role to play in the management of people with alcohol and other drug use disorders. There are an estimated 826,000 GP encounters a year involving alcohol or other drug use disorders (excluding encounters involving opioid pharmacotherapy which covered by a separate database) and 58% of these encounters or about 487,000 encounters a year are alcohol use disorders. [78]

Qualitative analysis based on surveys of stakeholders in the healthcare system have identified the following groups as having particularly high unmet demand for AOD treatment: [79]

- Young people
- Families and carers with children
- Offenders and prisoners
- Individuals with comorbid AOD and mental health problems
- Aboriginal and Torres Strait Islander (ATSI) people
- Culturally and linguistically diverse (CALD) people.

## 8. Implementation of the National FASD Strategic Action Plan

[75] Ettner, S., Huang, D., Evans, E., et al. (2006). Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? Health Services Research, 41(1), 192-213.
[76] Ritter A, Berends L, Chalmers J, et al. New Horizons: The review of alcohol and other drug treatment services in Australia
[77] Ritter A, Berends L, Chalmers J, et al. New Horizons: The review of alcohol and other drug treatment services in Australia
[78] Ritter A, Berends L, Chalmers J, et al. New Horizons: The review of alcohol and other drug treatment services in Australia
[79] Ritter A, Berends L, Chalmers J, et al. New Horizons: The review of alcohol and other drug treatment services in Australia

The RACP supports the implementation of the National FASD Strategic Action Plan, which is currently being developed, and other interventions to **improve detection and prevention of FASD** as set out in the entirety of the recommendations of the Consultation Draft under Priority 3, Objective 3. The Commonwealth government needs to advance this Strategic Action Plan as a priority in cooperation with State and Territory governments where appropriate.

***The evidence***

Australia lacks standardised data and recording of alcohol consumption during pregnancy and on the diagnosis and recording of people with FAS and FASD, but the available consumption statistics and epidemiological data on FASD prevalence from comparable countries suggest that FASD prevalence is higher than previously thought in Australia.[80] There are, however, significant disparities between the states and territories and between different populations in FAS and FASD rates with some communities having particularly high rates. For instance, the incidence of full and partial FAS may be as high as 12 per cent in some high-risk Aboriginal and Torres Strait Islander communities[81], which is amongst the highest in the world.

No safe low level of alcohol consumption during pregnancy has been established. The 2009 National Health and Medical Research Council (NHMRC) guidelines on alcohol consumption[82] state that, for women who are pregnant or planning a pregnancy, not drinking is the safest option. Yet it has been estimated that at least 38% of Australian women continue to drink while pregnant.[83]

It is very probable that there is substantial under-diagnosis of FASD because of the lack of awareness by clinicians[84] and their fear of stigmatising children and families. Late diagnosis of FASD is of concern because delay in diagnosis and provision of appropriate health and educational interventions increase the risk of adverse secondary outcomes.[85] One of the many barriers to better diagnosis of FASD in the population is the limited number of specially trained health professionals and specialist diagnostic clinics for FASD. Assessment and diagnostic guidelines developed internationally for FASD recommend the use of multidisciplinary teams of specially trained professionals who also take responsibility for training other health professionals.[86] Service models can be adapted depending on the circumstances, for example supplementing assessment services with telemedicine in rural and remote communities. Services should be underpinned by the use of standardised, nationally agreed diagnostic criteria for FASD and protocols for assessment.

[80] Burns, L., Breen, C., Bower, C. et al. (2013). Counting fetal alcohol spectrum disorder in Australia: the evidence and the challenges. Drug Alcohol Rev. 2013 Sep 32 (5):461-7. Doi: 10.1111/dar.12047. Epub 2013 Apr. 25. Review. PMID: 2361743

[81] Harris K, Bucens I. Prevalence of Fetal Alcohol Syndrome in the Top End of the Northern Territory. Journal of Paediatrics and Child Health 2003;39(7):528–533.

[82] National Health and Medical Research Council. Australian guidelines to reduce health risks from drinking alcohol. Canberra: Commonwealth of Australia; February 2009.

[83] O'Keeffe. L., Kearney. P., McCarthy. F. (2015) Prevalence and predictors of alchohol use during pregnancy: findings from international multicentre cohort studies. BMJ Open 2015;5:e006323 doi:10.1136/bmjopen-2014-006323.

[84] Elliott EJ et al. Fetal alcohol syndrome: a prospective national surveillance study. Archives of Disease in Childhood 2008;93(9):732–737; Pyett P. Fetal Alcohol Syndrome: a literature review for the 'Healthy pregnancies, healthy babies for Koori communities' report. Melbourne: Victoria Department of Human Services, Premier's Drug Prevention Council, 2007; Elliott EJ, Coleman K, Suebwongpat A, Norris S. Fetal Alcohol Spectrum Disorders (FASD): systematic reviews of prevention, diagnosis and management. HSAC Report 2008;1(9). Christchurch, New Zealand: University of Canterbury, Health Services Assessment Collaboration (HSAC).

[85] Yazdani P, Motz M, Koren G. Estimating the neurocognitive effects of an early intervention program for children with prenatal alcohol exposure. Canadian Journal of Clinical Pharmacology 2009;16(3):e453–e459.

[86] Peadon E, Fremantle E, Bower C, Elliott EJ. International survey of diagnostic services for children with Fetal Alcohol Spectrum Disorders. BMC Pediatr. 2008 April;8(12):1–8. doi: 10.1186/1471-2431-8-12.

## 9. Ignition interlocks for drink driving offenders

The RACP supports the use of ignition interlocks for drink driving offenders. Therefore, we express our support for the following recommendations in the Consultation Draft which either relate to or specifically endorse policies to include more systematic use of ignition interlock schemes:

- Implement and evaluate **new approaches to deter drinking and driving** and other alcohol related anti-social behaviours, (eg. ignition interlocks) (Priority 1, Objective 1, point 4)
- Implement and evaluate the effectiveness of approaches to **change repeat drink-driver offending behaviours**, for example ignition interlocks, treatment programs (Priority 1, Objective 3, point 3)

We note that implementation of these measures belongs most strategically at the State and Territory levels but hope that a common approach can be adopted across all Australian jurisdictions.

***The evidence***

Ignition interlock programs require people convicted of drink-driving offences to install an alcohol ignition interlock on their vehicle. This is a breath test device connected to the ignition of a vehicle to stop it from starting if the driver has been drinking alcohol. The intent of such programs is to enforce and specifically target a zero-alcohol limit on people identified as high-risk drinkers. Installation of ignition interlocks may be court ordered or voluntarily installed in exchange for benefits such as reduced licence disqualification/suspension periods. Some jurisdictions such as Western Australia[87] have already adopted or are considering adopting ignition interlock programs. Subject to some caveats, ignition interlock devices have been found to be effective means of increasing compliance with licence suspension and reducing recidivism[88]. In particular, one systematic review concluded that installation of ignition interlocks was associated consistently with large reductions in re-arrest rates for alcohol-impaired driving within both the earlier and later bodies of evidence but that following removal of interlocks, re-arrest rates reverted to levels similar to those for comparison groups.[89] Alcohol-related crashes also decreased while interlocks are installed in vehicles.

One cost benefit analysis using Australian data suggests that installation of interlock devices in all newly registered vehicles in Australia could potentially pass a cost benefit analysis. [90] While we are not advocating mandating the installation of such devices in new vehicles, the fact that such an extensive regulation could pass a cost benefit test suggests that its wider use specifically to target drink driving or repeat drink driving offenders would meet an even higher cost effectiveness threshold. The analysis estimated that up to 24 percent of all fatalities and up to 11 percent of all serious injuries could be saved in Australia per annum under this approach.

[87] https://www.transport.wa.gov.au/licensing/alcohol-interlock-scheme.asp

[88] Loxley W et al. The prevention of substance use, risk and harm in Australia: a review of the evidence. Canberra: Australian Government Department of Health and Ageing; 2004. http://espace.lis.curtin.edu.au/archive/00000284; Babor T et al. Alcohol: no ordinary commodity. New York: World Health Organization and Oxford: Oxford University Press; 2003; Marques P, Tippetts A, Voas R. The alcohol interlock: an underutilized resource for predicting and controlling drunk drivers. Traffic Injury Prevention 2003;4(3):188–194; Marques P et al. Estimating driver risk using alcohol biomarkers, interlock blood alcohol concentration tests and psychometric assessments: initial descriptives. Addiction 2010;105(2):226–239.

[89] Elder RW, Voas R, Beirness D, et al. Effectiveness of ignition interlocks for preventing alcohol-impaired driving and alcohol-related crashes: a Community Guide systematic review Am J Prev Med. 2011 ;40(3):362-76.

[90] Lahausse JA, Fildes BN. Cost-benefit analysis of an alcohol ignition interlock for installation in all newly registered vehicles. Traffic Inj Prev. 2009;10(6):528-37.

### 10. Alcohol health warning labels

The RACP supports the introduction of mandatory warning label requirements for alcoholic beverages, with specific guidelines on the placement, size, colour and text of the label so they are visible and recognisable; and a strict timeframe put in place for its comprehensive implementation. Therefore, we express our support for the following recommendation in the Consultation Draft

- Implement readable, impactful health-related **warning labels** (Priority 4, Objective 2, point 3)

We note that high level implementation of these measures belongs most strategically at the Commonwealth government level (e.g. through amending the Australia New Zealand Food Standards Code) but enforcement of mandatory labelling laws will then also require the support and enforcement of State and Territory governments.

***The evidence***

Alcohol health warning labels have an important role to play in reducing alcohol-related harms as they promote health messages at point of sale and at point of consumption. A 2014 evaluation of the effectiveness of the industry labels found that only 38 per cent of all products carried a pregnancy health warning (either text or pictogram), and only 6 per cent of women had seen any messages on alcohol products and only 4 per cent had seen any pregnancy warning labels.[91]

An immediate priority is requiring all alcohol products to be clearly labelled with warnings regarding the risks of alcohol consumption. Research shows that alcohol container warning labels have had some success in increasing awareness, reaching target audiences and, to a more limited extent, influencing individual behaviour.[92] Possible labels may include the warning that alcohol 'may increase cancer risk' and 'can cause birth defects'.[93] Studies on the effectiveness of health warning labels in the US have shown that their implementation has resulted in increased awareness of the health messages used on the labels.[94] Awareness of the health warning labels was highest among groups deemed high risk, including young people and heavy drinkers. Recall was highest for the message regarding the risk of birth defects resulting from alcohol consumption during pregnancy.[95] Exposure to labels was also found to stimulate conversations about the risks of alcohol consumption.[96] Respondents also reported that they were less likely to have driven 'when they probably should not have'.[97] According to an analysis of current evidence-based research on alcohol product labelling, the use of specific warning messages is more effective than the use of generic warning messages.[98]

## Summary and conclusions

This Consultation Draft sets out a well-considered strategy for addressing alcohol-related harms with a sound logic. In particular we welcome the approach of identifying defined high-risk population

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[92] Greenfield TK. Warning labels: evidence on harm-reduction from long-term American surveys. In M Plant, E Single, T Stockwell (eds). Alcohol: minimising the harm. London: Free Association Books; 1997.
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groups where appropriate and the development of indicators of progress applied across different priorities. However, the Consultation Draft could be improved by:

- committing to stronger and clearer recommendations for action including timeframes for action where appropriate;
- identifying more partnership and engagement opportunities for implementing the recommendations identified.
- a greater focus on the need to build the evidence base through research, with associated recommendations addressing this.

The RACP believes that the Consultation Draft could also be enhanced by adding the following recommendations:

- That the Commonwealth and State governments jointly initiate an inquiry into raising the minimum purchase age for alcohol.
- That State and Territory governments initiate measures to reduce the blood alcohol concentration (BAC) limit to zero for all drivers.
- That Commonwealth and State/Territory governments invest in better and more systematic data collection on alcohol sales and alcohol related harm.

We highlight the following sets of recommendations in the Consultation Draft as key to addressing alcohol related harms:

- The introduction of volumetric taxation for all alcoholic beverages and the direction of revenue from such taxation towards preventative health activities
- The introduction of a minimum floor price for alcohol
- More restricted trading hours for both licensed establishments and off-license liquor sales premises with a common set of restricted conditions to be implemented across all Australian jurisdictions
- Inclusion of density of existing alcohol trading outlets as a key consideration in the decision-making process by local governments for approving or denying an application for a new alcohol outlet
- Changes to allow local governments the ability to more flexibly customise alcohol licensing conditions, including by declaring ‘dry’ areas where appropriate
- The introduction of a single national advertising code covering content and placement with statutory penalties for breach and an end to alcohol sponsorship of sporting events. For this set of recommendations, we urge that restrictions be tighter than currently described in the Consultation Draft so that alcohol industry sponsorship of sporting events is prohibited, the current ACMA loophole allowing alcohol advertising during broadcast of sports programs during children’s viewing times should be closed and industry representation in the regulatory body that decides on whether there has been a breach of the new advertising code is explicitly ruled out.
- Enhanced levels of joint investments by Commonwealth and State/Territory governments in alcohol treatment services, including in measures to enhance GP engagement in the alcohol treatment system.
- Priority be given to implementation of the National FASD Strategic Action Plan currently under development.
- Implement and evaluate new approaches to deter drinking and driving and other alcohol related anti-social behaviours particularly through use of ignition interlock systems
- Introduction of mandatory warning label requirements for alcoholic beverages.