Consultation paper

Renewing Queensland's Alcohol and Other Drugs Plan

Reducing alcohol related harm in Queensland – future opportunities

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– Not Government Policy –

Alcohol consumption and related harms

Alcohol is widely used in Australia. The most recently available survey data (from 2016) suggests that nearly three-quarters of Australians aged 14 and over consume alcohol, with 17per cent consuming alcohol at levels associated with long-term risk (>2 standard drinks per day on average) and 25 per cent engaging in at least one episode of risky single occasion drinking (>4 standard drinks) in the previous 12 months [1]. Per-capita alcohol consumption in Australia currently stands at around 9.5 litres of pure alcohol per person, placing Australia 17th out of the 34 OECD countries in terms of total consumption [2].

Alcohol consumption contributes to a wide range of health and social problems. These include the long-term effects and the immediate effects of intoxication. In April 2018, key alcohol and other drug (AOD) experts from around Australia ranked the harmful impacts across all substances. They rated alcohol by far the most harmful substance overall, combining a high ranking for impacts on the user (ranked 4/22 substances) and harms to others (ranked 1/22) [3].

The most recent Global Burden of Disease study, which compiled comprehensive global health data for 2016, linked alcohol with 60 acute and chronic health conditions [4] and Australian estimates for 2015 suggest it contributes to around 4.5 per cent of the total disease burden in the country. This far exceeds the impact of illicit drugs [5]. In Queensland, alcohol use contributed to 1300 deaths in 2011 and was responsible for 5per cent of the total burden of disease. This impact on health is more than three times greater than that for all illicit drug use combined [5, 6]. These impacts include immediate harms such as injuries and deaths due to road crashes, falls and violence, as well as long-term harms including liver disease, cancer and heart disease.

There are also well-established literatures highlighting alcohol's contribution to non-health outcomes, including crime and disorder, family dysfunction, workplace absenteeism and more [7-9]. Around half of all homicides in Australia involve alcohol (10), while around 5per cent of the population report being the victim of alcohol-related assault each year [1]. The most recent estimate suggests that alcohol's non-health impacts cost Australian society around $15 billion in 2010 [11]. These estimates excluded a range of impacts for methodological and data availability reasons, meaning this is surely an underestimate. For example, the cost of fetal alcohol spectrum disorder (FAS-D) was not included due to uncertainties in its incidence and impacts. FAS-D is a group of health and behavioural problems which stem from alcohol consumption during pregnancy and have lifelong impacts. In other countries, the

impact of FAS-D, even at relatively low rates, has been estimated to run into the billions of dollars [12, 13]. Per-capita consumption and risky drinking rates have declined nationally (and in Queensland) over the past decade [1, 14], although on many measures (e.g. alcohol-related hospital admissions and emergency presentations), harm rates have not dropped as steadily [15].

Queensland experiences high rates of alcohol problems - in the 2016 National Drug Strategy Household Survey, risky drinking rates were higher in Queensland than in any other jurisdiction except the Northern Territory [1]. Similarly, the most recent estimates (for 2015) of national hospital admission and emergency department presentation rates attributable to alcohol, put Queensland second to the Northern Territory [15]. In relation to alcohol-attributable deaths, Queensland rates are at about the national average [16]. No reliable cross-state measures of alcohol-related crime are available, but in the most recent data available (2013), Queensland has higher rates of assault-related hospital admissions [16] than most states, and surveys in night-time entertainment precincts between 2010 and 2018 found disproportionately high reports of aggression [17] in Queensland compared to other states.

Alcohol is deeply embedded in Australian society; it's use is routine and normalised. Reducing harms from alcohol remains a complex public policy challenge. Alcohol problems occur across socio-economic groups, but rates of harm are higher in marginalised and socio-economically disadvantaged groups, even where consumption patterns are similar [18, 19], suggesting that broader social policies have a role in reducing alcohol-related harms and social inequalities. Thus, policies which reduce social inequalities in the welfare, housing or other social response systems are likely to influence rates of harm from alcohol. However, for the purpose of this paper, we focus on policies explicitly aimed at alcohol-related harms. This paper will briefly outline some key policy options available to reduce these harms in Queensland. This is based on a survey of the published literature.

Supply reduction policies

Price-related policies

Interventions that effect the price of alcohol have been repeatedly shown to be effective at reducing alcohol consumption [20], alcohol-related harms [21] and to be among the most cost-effective alcohol interventions available [22-24]. Alcohol taxation is a federal issue, but one where states could provide important advocacy. Numerous modelling exercises and reviews have argued that changing the tax system so that all beverages are taxed based on their alcohol content rather than on their prices (as is currently the case for wine and cider), would be more logical and more effective [25, 26] than the current system.

Other pricing policy options exist at the state level, notably the implementation of a minimum unit price (MUP). This intervention sets a minimum price per standard drink at the retail level. It has a long history in Canadian provinces and has recently been implemented in the Northern Territory. A similar policy has just been introduced in Wales and is under consideration in Western Australia.

The evaluation evidence from Canada shows that increases in the minimum price the occurred between 2000 and 2010 are associated with reductions in consumption, [27] and harm rates, including deaths [28] and hospital admissions [29]. The introduction of an MUP in Scotland in 2018 was driven at least partly by a series of modelling studies that suggested that the minimum price would largely affect heavy drinkers, who drink the majority of cheap alcohol [30, 31]. Thus, the MUP is expected to reduce harms while having little impact on the cost of alcohol for light and moderate drinkers. Only preliminary evaluations are available from Scotland, but they suggest per-capita consumption has fallen relative to England following the introduction of the MUP [32, 33] with likely health benefits. Similarly, the introduction of the Northern Territory minimum price in 2018 has only been subject to preliminary evaluation. The early indications are that consumption of cask wine has fallen sharply and a range of harms have declined, although there are numerous other policy interventions in place in the NT that may have contributed to these declines [34].

Other pricing interventions are available. These include restrictions on discounting practices in off-premise outlets [35] and on price-based promotions in pubs and bars, including happy hours [36]. While these are likely to be effective, there are no thorough evaluations of such interventions and their population-level impacts are likely to be relatively small.

Liquor licensing and alcohol availability

Liquor licensing is managed at the state level, providing a range of potential policy levers for states to reduce alcohol-related harms. Key among these are policies aimed at reducing alcohol availability, either by limiting the number of places where alcohol is sold or by limiting when alcohol is available for sale. There is strong evidence that alcohol availability is an important contributor to rates of alcohol-related harm [37, 38].

Trading hours and lockouts

Reducing the late-night availability of alcohol has been shown to reduce rates of harm, especially violence, in many previous studies [39, 40]. Queensland introduced comprehensive restrictions in 2016, preventing the sale of alcohol after 3am in entertainment precincts and after 2am elsewhere. These restrictions, alongside the wide-ranging introduction of ID-scanners in pubs and bars, were aimed at reducing alcohol-related violence.

A comprehensive evaluation found evidence that they were effective, although the magnitude of the effects was smaller than those identified in earlier interventions in Newcastle [41, 42] and Sydney [43, 44]. Many jurisdictions have also implemented 'lock-outs' late at night, where venues are permitted to continue trading but not to admit new patrons. The evidence for the effectiveness of lockouts alone is not strong. Restricting hours of trade is more likely to be effective [45]. There are few studies available about the effect of reducing the hours of trade for off-premise outlets, although the evidence that does exist suggests reductions in night-time hours can reduce acute harms (e.g. violence and injuries), especially among young people [46-48].

Outlet density

An increasing number of high-quality, longitudinal studies in both Australia and internationally have found associations over time between the physical availability of alcohol and harm rates at the local level. In other words, increasing the number of alcohol outlets trading in a neighbourhood tends to increase rates of harm [49]. Australian studies broadly show that changes in the number of off-premise and on-premise outlets at the neighbourhood-level are associated with changes in a range of harms including street violence, family violence and chronic disease outcomes [50-53]. Policy interventions around alcohol outlet density remain challenging. Changing the liquor licensing processes so that communities are more likely to succeed when objecting to new outlets is one way of achieving change in this space [54]. There is suggestive evidence that for off-premise outlets, the amount of alcohol sold is at least as important as the number of outlets [55], which may imply that for large-scale outlets (i.e. 'big box' or large, retail chain liquor stores present higher risks than smaller outlets).

Home delivery

Online alcohol sales make up around 5% of the alcohol market in Australia in 2019, with annual growth estimated at around 14% per year [56]. This has likely accelerated under the various restrictions in place due to COVID-19 in 2020, but data is not yet available. There remains little evidence as to the likely impacts of this expansion of availability. Preliminary studies suggest fast delivery services (i.e. services offering delivery in less than 2 hours) and late-night deliveries are particularly associated with heavy drinking and these may be useful areas for policy intervention [57].

Other licensing interventions

New South Wales (NSW) has implemented targeted licensing enforcement since the early 2000s. This is based on rigorous data collected by police linking harms to particular venues. Extra enforcement resources have been devoted to bars and pubs responsible for high levels of harm. Evaluations of this approach suggest that it contributed to substantial declines in night-time violence in NSW [58]. Similar interventions overseas also make use of health system data to target enforcement [59]. Again, evaluations demonstrate significant reductions in late-night harms.

Demand reduction policies

Advertising restrictions

There is robust longitudinal evidence that exposure to alcohol promotions contributes to drinking among young people [60, 61]. Recent high-profile international research [62, 63] highlights how reducing alcohol advertising and marketing important to reduce harms in the longer term. Based on systematic reviews of the latest scientific evidence from around the world, there appears to be a causal association between alcohol advertising and drinking [63]. This

means that interventions which reduce exposure to alcohol marketing for young people will have long-term impacts on levels of drinking and alcohol-related harms. However, there remain few evaluations of effective interventions in this space [64] because restrictions are rarely introduced or are introduced in piecemeal ways that are easily bypassed. At the state level, the Victorian experience with restricting tobacco marketing and sponsorship in the 1980s provides a clear example of an effective intervention [65, 66].

Current Australian regulatory codes for alcohol advertising are ineffective both in terms of reducing exposure to advertising for young people and in terms of limiting the use of content that appeals to youth [67]. Policies that reduce exposure in particular settings or times, or that enforce controls on advertising content may be appropriate steps forward. These policies will contribute to shifting the norms around alcohol promotion and may have gradual and long-term impacts on drinking behaviour even without more rigorous restrictions.

Health promotion and education

Public health promotion campaigns around tobacco and drink-driving have been highly effective in changing attitudes and behaviours over decades in Australia [68], demonstrating the positive impact of long-term, focussed campaigns on public health. To be effective, a health promotion campaign around alcohol requires a long-term commitment and consistent, effective messaging. There are few examples of effective campaigns in the alcohol space [69] outside of road crashes [70]. Researchers have argued that this lack of effectiveness stems from the short-term and unfocussed nature of most alcohol public health campaigns [71].

School-based prevention programs are among the more popular interventions aimed at reducing alcohol-related harm. These programs aim to reduce harm both in the short-term (via reductions in adolescent drinking) and in the longer term (via healthier drinking patterns across the life course). Australian programs in schools have been shown to be effective, although the quality of the evaluations was relatively low [72] and more trials are needed. Broader reviews have highlighted the importance of matching intervention programmes to appropriate age groups with evidence, for example, that universal programs in early adolescence are relatively likely to be effective [73].

Primary healthcare interventions

Numerous trials have demonstrated that simple screening and brief interventions in primary healthcare settings (or in emergency departments) can be effective at reducing alcohol consumption [74, 75]. Despite this trial evidence, there remains substantial challenges to implementing and sustaining brief interventions in real world settings like GP clinics or emergency departments. This is partly due to the competing pressures on clinicians' time, lack of training and support from management [76]. Changes to health systems that can embed screening and brief intervention into clinical practice are likely to be effective at reducing risky drinking and associated harms, but there are few clear examples of effective implementation regimes. A recent Queensland trial of a phone-based brief intervention for young people presenting to emergency departments provides a promising example of a potential way forward [77], especially if it can be embedded in the system in a sustainable way.

Interventions for FAS-D

Fetal Alcohol Spectrum Disorder (FAS-D) can result from alcohol consumption during pregnancy and leads to a range of physical and behavioural problems which can stay with a child for their lifetime. Prevention interventions can occur at the primary or secondary level. Primary approaches include the evidence-based measures mentioned above that work to reduce alcohol consumption (such as pricing, restrictions on advertising/promotion, etc.) and targeted public education campaigns. Secondary prevention includes interventions aimed at women who are planning a pregnancy or are already pregnant, such as brief interventions in antenatal screening. Improving these interventions via training for health care professionals in delivering them appropriately is another avenue of potential effectiveness. In terms of primary prevention through public education campaigns, Australia does not currently have a coordinated national approach. The Pregnant Pause campaign, an initiative of the Foundation for Alcohol Research and Education (FARE) in Canberra, was found to increase women's awareness of the guidelines around alcohol and pregnancy [78]. FARE has recently been awarded funding by the Australian Government Department of Health to undertake a four-year national awareness campaign on alcohol and pregnancy starting in 2021. This campaign has four streams: the general public, health professionals, women at higher risk of having alcohol exposed pregnancies and Aboriginal and Torres Strait Islander peoples and will be the first national, coordinated campaign on FAS-D. State-wide public education and mass media campaigns harmonised with this national work may bring additional benefits.

The recent announcement that mandatory warning labels will be included on alcoholic beverages within three years provides further potential synergies in terms of public communication in this space.

Training for general practitioners to better discuss alcohol and pregnancy with women has been shown to be an effective secondary prevention approach [78, 79]. Similarly, efforts to reduce alcohol consumption during pregnancy in antenatal settings through brief interventions such as motivational interviewing have been found to be both effective [80] and acceptable [81] to women. However, there is currently no standardised approach used across the states and territories. A comprehensive practice change intervention is currently being trialled in NSW [82] that if effective, could assist other states with their maternity services planning and delivery.

Programs that have been tailored to address alcohol consumption in Indigenous communities have also shown success, with the community led Marulu foetal alcohol spectrum disorder Prevention Strategy in remote Western Australia found to have reduced alcohol use among pregnant women by 29.1% between 2010 and 2015 [83]. There is further scope within states to design and deliver culturally appropriate messages around alcohol and pregnancy through antenatal care to reduce the burden of FAS-D in Indigenous communities.

Interventions in Indigenous communities

Alcohol Management Plans

Queensland (along with Western Australia and the Northern Territory) have a long history of regulating alcohol in remote Indigenous communities. In Queensland, alcohol management plans (AMPs) have been in operation in discrete Indigenous communities for many years, although the particulars of their implementation are currently in flux.

Alcohol restrictions in these communities have been shown to reduce rates of injury [e.g. 84], although surveys of community residents have found at least as many negative impacts as positive ones [85]. In the NT, communities have been able to apply to be treated as 'General Restricted Areas' (GRAs) from the early 1980s and Alcohol Management Plans have been in place since 2010. These represent a broadly similar approach to the AMPs used in Queensland. Similarly, evaluations suggest that restrictions employed in the NT can reduce alcohol-related harms, but that community support depends substantially on the process by which restrictions were introduced [86].

A recent review of AMP-style interventions in Australia and globally came to similar conclusions [87]. The review found that implementing AMPs can be a successful way for communities and government to work together to reduce alcohol-related harms, but they will be more successful and more sustainable when driven by local community interests. Smith et al. also argue that AMPs need to incorporate interventions beyond restrictions focussed on supply, including harm reduction and demand reduction interventions. More broadly, policymakers at State and Federal levels need to consider the impacts of policy on these communities. For example, researchers have discussed the variety of ways that the introduction of Alcohol Management Plans in the NT in 2010 worked to undermine community controls around in alcohol in one particular community in the Territory [88].

Other interventions

A range of population-level interventions have been implemented in the Northern Territory since 2017 that are likely to have particular impacts on Aboriginal people. These include a revision of the Banned Drinkers Register, the deployment of liquor inspectors at packaged liquor outlets and more [89]. Evaluations are ongoing, but early signs suggest harm rates in the NT have declined markedly. Further work, focussing especially on issues of discrimination in policy implementation, is necessary to assess the broader sustainability of these interventions [88].

Conclusions

Opportunities to reduce harm in Queensland include:

- Consider the implementation of a minimum unit price to reduce the harms associated with very cheap alcohol
- Adjust the liquor licensing processes to a model similar to Western Australia, which places the onus of proof on the applicant for a new licence rather than on an objecting community
- Develop an evidence-based liquor licensing enforcement regime based on NSW or Cardiff models targeting high risk venues more effectively.
- Consider restrictions on the rapid delivery of alcohol after 9pm
- Embed a long-running alcohol public health campaign, ideally managed independent from government (in the way that the TAC manages traffic campaigns and QUIT tobacco campaigns) to ensure sustainability and enhance potential effectiveness
- Implement restrictions on alcohol marketing in key settings (e.g. sports stadiums, public transport) and work with the other states to develop a nationally consistent and effective regime to reduce exposure to alcohol ads for young people.
- Embed an evidence-based brief intervention regime into primary healthcare settings, supported by appropriate funding mechanisms to ensure sustainability.
- Similarly, implement evidence-based interventions around alcohol consumption during pregnancy and consider public education campaigns that complement national efforts to reduce FAS-D.

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