Restoring THE BALANCE

A NEW APPROACH TO ALCOHOL IN AUSTRALIA

ST VINCENT’S HEALTH AUSTRALIA’S
ALCOHOL-RELATED HARM AND VIOLENCE POLICY
From what we see in our hospitals and treatment services, we know the damage alcohol can do and what needs to be done to reduce its impact.

Alcohol harm can’t be reduced through a single policy initiative or individual campaign. To achieve our goal will take constructive dialogue between governments, businesses, the community and health sectors, and the broader public, along with an integrated approach over many years.

WE WANT TO:

REDUCE ALCOHOL-RELATED ILLNESS AND INJURY IN AUSTRALIA BY 20% BY 2025, INCLUDING:

- ALCOHOL-RELATED EMERGENCY DEPARTMENT PRESENTATIONS.
- HOSPITAL ADMISSIONS FOR ALCOHOL USE DISORDERS.
- ALCOHOLIC LIVER DISEASE DEATHS.

THIS IS OUR PRIMARY AIM.
We recognise that alcohol has deep cultural and social significance in Australia and is of major economic importance.

Yet all the evidence points overwhelmingly to the fact Australia has an alcohol problem – one that is not restricted to a small proportion of heavy and/or dependent drinkers, and which is greater than that posed by any illegal drug – and requires our urgent intervention.

Unfortunately, alcohol policy has become the product of competing interests, values and ideologies.

Achieving our targets will require Australians and their governments to start thinking differently about alcohol and the way we interact with it.

It will require Commonwealth and state and territory governments to display the same level of commitment commonly shown towards tackling other major health issues, by embracing the reforms and providing the resources necessary to reduce its harm.

It’s time for Australia to take a new approach to alcohol to reduce its negative effects on our community.
Our two major tertiary public hospitals – St Vincent’s in Melbourne’s Fitzroy and St Vincent’s in Sydney’s Darlinghurst – have long catered to the entire spectrum of alcohol-related harm and violence, and by virtue of their locations, the horrific alcohol-fuelled injuries that occur in the entertainment precincts of both cities.

Australia’s first medically-based clinical and academic program for the treatment and study of alcohol dependence was established at St Vincent’s, Melbourne in 1964. St Vincent’s Sydney followed with its own similar program in 1971.

St Vincent’s Sydney’s Alcohol and Drug Service is a recognised leader in the management of alcohol and drug-related health problems including hospital inpatient, an outpatient Wellness Clinic, multidisciplinary care hospital liaison services, and a 20-bed non-medical residential withdrawal unit, Gorman House.

St Vincent’s Melbourne’s Department of Addiction Medicine offers a combination of in and outpatient services including the 12 bedroom DePaul House, a medical residential withdrawal unit, consultation liaison services, drink driving education, counselling and research.

More recently, St Vincent’s Health played a lead role supporting measures to reduce the availability of alcohol in Sydney’s inner city – advocacy that was an important factor in the NSW Government’s introduction of a suite of reforms, known commonly as the ‘lockout laws’, in February 2014.

The success of this advocacy was a catalyst to bring our resources, expertise and experience together to address alcohol-related harm and violence more broadly across Australia.
WE BELIEVE IT’S OUR RESPONSIBILITY, KNOWING WHAT WE KNOW AS ONE OF THE NATION’S LARGEST HEALTHCARE GROUPS, TO STAND UP AND SAY...

‘ENOUGH IS ENOUGH’
As a health organisation we are faced daily with the outcomes of the harmful consumption of alcohol across the lifespan.

This may be harm caused by alcohol-related road trauma or violence treated in our emergency departments, trauma wards, operating theatres or intensive care units. It may also be through the care of our patients with mental illness or chronic disease brought about by harmful alcohol consumption over the longer term. Or it may be through dealing with developmental problems arising from alcohol use in pregnancy, including foetal alcohol spectrum disorders.

The harms associated with alcohol and the increasing scientific evidence regarding the health outcomes influenced by alcohol is persuasive to anyone involved in health care and clearly indicates that action must be taken.

The effects of alcohol-related harm, however, extend beyond the individual and the health system and include social and economic costs of harm to families, communities and society at large.

Alcohol abuse or intoxication is implicated in violence – both domestic and public, unemployment, financial problems and poverty, drink driving, traffic accidents, industrial and work accidents, fires, falls, homelessness, and suicide.


Alcohol is second only to tobacco as the leading preventable cause of death and hospitalisation in Australia.
Alcohol’s harm to others costs Australians more than $20.6 billion, including $14.3 billion in tangible costs (eg: out-of-pocket costs, forgone wages or productivity, hospital and child protection costs) and $6.4 billion in intangible costs (the costs assigned to pain and suffering, and diminished quality of life).4

In Australia, 3.2 per cent of the total burden of disease is related to alcohol use.1

In Australia, alcohol kills 15 Australians every day, 5,554 each year (3,467 male deaths and 2,087 female deaths).2

Alcohol hospitalises 430 Australians every day, 157,132 each year (101,425 for males and 55,707 for females).3

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One-in-12 of all presentations to hospital emergency departments in Australia and New Zealand are alcohol-related, equating to more than half a million people each year. In peak times (6pm Friday night to 6am Sunday morning) the rate increases to one-in-eight.5

There were almost 30,000 police reported incidents of alcohol-related domestic violence in 2011 (excluding Queensland, South Australia, Tasmania and the Australian Capital Territory).6 Given less than half of incidents are reported to police - and are often the most severe cases - this figure likely under-represents the full extent of alcohol-related domestic violence.
A 10 per cent increase in off-licence liquor outlets is associated with a 3.3 per cent increase in domestic violence.7

For every 10,000 additional litres of pure alcohol sold at a packaged liquor outlet, the risk of violence experienced in a residential setting increases by 26 per cent.6

Studies have shown that 60 per cent of people presenting with injuries to emergency wards had consumed alcohol bought from a store in the hours leading up to their injuries.9

Ambulances are more commonly called to neighbourhoods near bottle shops, with areas near larger chain stores reporting even higher injury rates.10

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3 ibid.
alcohol-related harm

St Vincent’s Health Australia supports a coordinated national approach to alcohol harm minimisation that is underpinned by strong partnerships across the government and non-government sectors and industry.

St Vincent’s Health Australia acknowledges there is no single strategy that can offer a ‘quick fix’ or ‘silver bullet’ to the prevention of harmful consumption of alcohol. Countless reviews have concluded that an integrated approach is required.

However, the following interventions have been identified as effective and enjoying quantifiable benefits.

We believe their introduction will allow us to meet our goal of reducing alcohol-related illness and injury by 20% by 2025.
Australia’s alcohol taxation system should be coherent, consistent and based on public health principles.

Evidence consistently shows that alcohol consumption and harm are influenced by price. Alcohol taxation, as a means of increasing the price of alcohol, is one of the most effective policy interventions to reduce the level of alcohol consumption and its related problems. Evidence suggests that a 10 per cent increase in price is likely to lead to a five per cent decrease in consumption at population level. The Henry Review of Australia’s tax system identified alcohol taxation as an appropriate measure for improving social outcomes because of the high costs imposed by excessive alcohol consumption.

Alcohol products should be taxed on the basis of alcohol content/greatest level of harm (volumetric taxation) as recommended in the review.

A proportion of revenue from alcohol taxation should be directed towards initiatives that prevent alcohol-related harm (eg: an ‘Alco-line’ support hotline, similar to Quitline for smoking), provide support for people with alcohol-related problems, and conduct research into the prevention and treatment of alcohol-related harm.

The Commonwealth should regulate the minimum price (or floor price) of alcohol products.
In addition to curbing the economic availability of alcohol, its physical availability can be regulated by restricting the trading hours of on and off licence premises, the density of these outlets in a given locality, and the range of places in which it is sold. There is strong national and international evidence that extending the trading hours of alcohol outlets results in increases in alcohol-related problems and that the reduction in these hours can contribute to a reduction in these same problems.

In this context, there is a need to reassess approaches to the physical alcohol availability of alcohol which is regulated by state and territory governments through liquor licensing legislation. Liquor licensing laws may be used by governments to encourage and ensure the responsible sale of alcohol, and implement public health objectives. Objects or purpose clauses which include or emphasise public health, harm minimisation or alcohol-related harm reduction as an objective of legislation are important statements about the manner in which decisions should be made by licensing authorities. They may empower authorities to take into account the wider health implications of administrative decisions.

National guidelines need to be developed on alcohol outlet density and opening hours based on harm minimisation principles, evidence-based research and with input from local communities to guide liquor licensing agencies, planning departments and local government. Liquor licensing laws should also be exempt from National Competition Policy.

Alcohol should not be sold in pubs and clubs after 3am. All existing 24 hour liquor licenses should be abolished, with 10pm introduced as the latest time for packaged liquor sales (including from supermarket outlets).

St Vincent’s Hospital Sydney (SVHS) – which has within its catchment the greatest number of licensed premises in Australia – has played a leading role in advocating for tighter regulations to reduce alcohol-related harm and violence.

The hospital played a major part in convincing the NSW Government to introduce measures designed to curb alcohol-fuelled violence, particularly in Sydney’s CBD and Kings Cross, in February 2014.

SVHS’s experience of the laws – which include the statewide closure of bottle shops at 10pm and 3am last drinks within the city of Sydney’s entertainment precinct – is compelling:

- In the year following the introduction of the regulations, there was a 25% drop in seriously injured patients accessing the hospital’s emergency department during the busiest period (6pm Friday to 6am Sunday).
- The frequency at which people present at the hospital’s Emergency Department with alcohol-related issues – and the severity of those issues – has declined, with only three admissions to the hospital’s Intensive Care Unit, and no deaths, from the entertainment precinct over two years.

SVHS’s experience has been supported by independent evidence gathered by the NSW Bureau of Crime Statistics and Research’s (BOCSAR) showing a 45% reduction in assaults in Kings Cross and a 20% reduction in the CBD.

BOCSAR also found most areas within easy reach of the entertainment precinct showed no increase in violence.
3. Increase restrictions around the advertising, marketing and promotion of alcohol, with a focus on the welfare of young people.

International and national research has shown that exposure to repeat high-level alcohol promotion inculcates pro-drinking attitudes and increases the likelihood of heavier drinking.

There is also moderate but consistent evidence to suggest that point of sale promotions are likely to affect the overall consumption of underage drinkers, binge drinkers and regular drinkers. Ownership of alcohol-branded merchandise among non-drinking children and adolescents also predicts both early initiation to alcohol use and binge drinking.

Young people are exposed to too many instances of alcohol marketing, promotion and advertising and research shows it has a great impact on the age they start drinking.

We support ending all alcohol advertising in free-to-air TV sporting broadcasts, as well as on government owned infrastructure (eg: buses, shelters, sporting grounds).

Alcohol sponsorship of music events aimed at young people should be phased out as with alcohol sponsorship of sport, clubs or programs and the placement of alcohol brands, logos, slogans or related images on any sporting or other merchandise.

An independent panel should monitor clear and consistent standards in relation to all forms of alcohol advertising and promotion – including online and social media – with penalties for significant breaches.

4. Improve alcohol product labelling at points of sale and consumption to reduce harm.

Pictorial health warning labels should be mandated on all alcohol products and their packaging in Australia. The warnings should be developed independent of the alcohol industry, tested and frequently varied, and contain information on alcohol treatment and advice services.

One label should specifically relate to the risks of drinking alcohol during pregnancy. Health warning messages should be preceded by the text ‘HEALTH WARNING’.

Alcohol producers should be prohibited from including any positive health claims on their products, including representations of products as ‘low’ in alcohol or calories.

An independent examination must be held into the benefit of restrictions on packaging and product design of alcohol products, including alcohol-plain packaging laws similar to those introduced for tobacco in Australia.
Despite the significant prevalence of harms associated with heavy drinking across the Australian community, early intervention and management of problematic alcohol consumption compares poorly with other chronic disease conditions or lifestyle issues.

There is strong evidence that early and short-term interventions have a high level of efficacy in reducing alcohol-related harm. Brief interventions, particularly in primary healthcare settings, are very effective – especially with early high risk drinkers – and have been demonstrated to reduce alcohol consumption by about six standard drinks per week, as well as being cost and time effective.

Brief interventions conducted with individuals who have been affected by alcohol and presented at Emergency Departments have also shown to be effective.

A range of strategies to help prevent and delay the onset of alcohol use disorder should be funded from a levy on alcohol products, including:

- training for doctors and nurses – when in medical and nursing school – in the detection and management of alcohol use disorder;

- primary care nurses and GPs should be trained and incentivised to screen and conduct brief interventions;

- investment in research and innovation to deliver early interventions through new technology (eg: online, telehealth) to reach more people, earlier;

- evidence-based alcohol-related health promotion and prevention strategies, including information for parents on how to explain the risks and harms of alcohol use to their children; and

- funding for health education diversion programs for alcohol-related offences, particularly with under-age drinkers who come to police attention.
Only 1-in-10 Australians with alcohol dependence receive treatment in any given year. There is also an estimated gap of around 20 years from the onset of problem-drinking to seeking care for treatment.

Australian governments must commit more funding to expand treatment services to meet unmet needs, particularly among those facing the most significant barriers to accessing help, such as people in rural and regional areas, Aboriginal and Torres Strait Islanders, pregnant women, young people and prisoners.

Treatment and withdrawal services for alcohol dependence should be provided at all major hospitals and in specialist alcohol and drug services. The increased availability of such services will allow primary care doctors to more readily refer people with alcohol use disorder for help.

Treatment services need to offer stepped care as well as reflect the diversity of people’s needs and cultural backgrounds. Stepped care begins with low-intensity, low-cost treatments through to more intensive and comprehensive treatment where necessary.

Significantly increase funding for treatment services to meet demand.

There is a pressing need for the Commonwealth to take national leadership on reducing the harm from alcohol.

A first step would be to develop a national strategy to reduce alcohol-related harm, with actions funded from an increase in alcohol taxation.

We believe a national strategy – supported by a performance measurement framework – would assist to build the evidence-base through data collection and coordination of research. Evidence-based initiatives to tackle alcohol-related harms could then be prioritised, improving the cost-effectiveness of national efforts.

The accountability of all governments in reducing harms from alcohol must be improved, including developing and measuring progress against national targets.

A national strategy should also encompass alcohol’s role in family violence.

It’s estimated that in some parts of Australia, two-thirds of family violence incidences reported to police involve alcohol.

We support the development of a whole-of-government national framework to address alcohol’s role in family violence.

For example, such a framework would assist local and state governments to work together to change liquor licensing laws so family violence could be considered in planning applications for bottle shops, hotels and other alcohol outlets.

It would also improve integration and collaboration between services providing treatment for people with alcohol use disorder and other related services, including family and domestic violence and child protection programs.

Finally, a National Summit on Reducing Alcohol-related Harm and Violence – led by the Commonwealth and supported by the states and territories – would be a beneficial way of starting a broad national conversation about alcohol’s role in our society and charting a new way forward.

A national strategy to reduce alcohol-related harm.
We strongly encourage state and territory governments to continue, or to initiate, the collection of wholesale and retail sales data to monitor national levels of alcohol consumption, as well as consumption patterns associated with specific population groups and beverage choices. Such data should be available in the public domain.

GATHERING EVIDENCE TO SUPPORT OUR UNDERSTANDING OF ALCOHOL-RELATED HARM AND EFFORTS TO REDUCE ITS IMPACT.
The department’s work includes direct patient treatment, research, education, training and policy development. Its services include DePaul House – a 12-bedroom medical residential withdrawal unit where more than 500 patients a year from across Victoria undergo short-term medically supported withdrawal – as well as offering outpatient clinics, drink-driving education, and support and education to alcohol-dependent young people in custody. Currently the department is exploring treatments by trialling new medications for managing alcohol withdrawal symptoms; and dosing thiamine to prevent Wernicke-Korsakoff syndrome – a condition caused by thiamine deficiency and which is common among long-term alcohol users.

Since being established in 1964, St Vincent’s Hospital Melbourne’s Department of Addiction Medicine has been one of Australia’s leading centres in terms of prevention and treatment for people experiencing alcohol dependency.

Australia must begin collecting nationally standardised data on alcohol-related harms and make them available in the public domain. This should include increasing the collection of information about alcohol’s involvement with emergency services (eg: police, ambulances), emergency department and hospital admissions, and justice and community services (including family and domestic violence programs).

There is a need for accurate, timely and comprehensive indicators and monitoring of alcohol-related harms at a national and local level.

There is no national data on the prevalence of Foetal Alcohol Spectrum Disorder (FASD) in Australia which must be addressed through the development of a national repository that encourages the collection and sharing of standardised data.

FASD should be formally recognised as a disability and identified as an issue that affects the whole community. Given the higher rate of FASD among Aboriginal and Torres Strait Islander peoples, greater effort must be made to tailor evidence-based education campaigns for these groups about the risks of alcohol consumption during pregnancy, in consultation with the communities themselves.

Since being established in 1964, St Vincent’s Hospital Melbourne’s Department of Addiction Medicine has been one of Australia’s leading centres in terms of prevention and treatment for people experiencing alcohol dependency.
**NATIONAL TARGETS**

**REDUCE ALCOHOL-RELATED ALCOHOL-RELATED EMERGENCY DEPARTMENT PRESENTATIONS**

**WHAT’S NEEDED?**

**IMPROVING ALCOHOL REGULATION**

**ACTION POINTS**

1. Increase the price of alcohol to reduce consumption and related harms.
2. Use liquor licensing laws to ensure the responsible sale of alcohol.
3. Increase restrictions around the advertising, marketing and promotion of alcohol, with a focus on the welfare of young people.
4. Improve alcohol product labelling at points of sale and consumption to reduce harm.
Recognition that combating Australia’s problem with alcohol will require a nationally co-ordinated response based on constructive dialogue between governments, businesses, the community and health sectors, and the broader public.

**WE WANT TO:**

**ILLNESS AND INJURY IN AUSTRALIA BY 20% BY 2025, INCLUDING:**

- Hospital admissions for alcohol use disorders
- Alcoholic liver disease deaths

**EARLY INTERVENTION, TREATMENT AND TAKING A NATIONAL APPROACH**

5. Improve early intervention for alcohol use disorder.
6. Significantly increase funding for treatment services to meet demand.
7. A national strategy to reduce alcohol-related harm.

**GATHERING EVIDENCE TO SUPPORT OUR UNDERSTANDING OF ALCOHOL-RELATED HARM AND EFFORTS TO REDUCE ITS IMPACT**

8. Alcohol sales data is an essential component in providing a comprehensive picture of alcohol consumption and informing evidence-based public policy decisions.
9. There is a need for accurate, timely and comprehensive indicators and monitoring of alcohol-related harms at a national and local level.
10. There is no national data on the prevalence of Foetal Alcohol Spectrum Disorder (FASD) in Australia which must be addressed through the development of a national repository that encourages the collection and sharing of standardised data.
SERVING, SEEING AND STRIVING FOR SOMETHING GREATER

Founded by the Sisters of Charity 176 years ago, St Vincent’s Health Australia is the nation’s largest Catholic not-for-profit health and aged care provider and the largest non-government provider of public hospital services. Over 17,000 employees provide more than 1,000,000 episodes of compassionate, high quality care every year.

As a Catholic health care service we bring God’s love to those in need through the healing ministry of Jesus. We are especially committed to people who are poor or vulnerable.

Together, we are serving, seeing and striving for something greater.

Photo Credits
Page 3: Man drinking at cricket
Woman assisting drunk man
Man on gurney
Woman in bus shelter
Page 6: Crowd on footpath
Page 7: Police making arrest

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