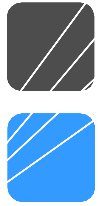

Turning Point
Alcohol & Drug Centre

From evidence to policy and public health interventions

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Strategies to reduce rates of alcohol problems differ in their effectiveness

- *Alcohol – No Ordinary Commodity: Research and Public Policy* (Oxford UP, 2003)
- A study under WHO auspices by a group of scholars from 9 countries:
  - T. Babor, R. Caetano, S. Casswell, G. Edwards, N. Giesbrecht, K. Graham, J. Grube, P. Gruenewald, L. Hill, H. Holder, R. Homel, E. Österberg, J. Rehm, R. Room, I. Rossow
- Considering
  - Evidence of effectiveness
  - Breadth of support in the literature
  - Extent of cross-cultural testing
  - Costs to implement and sustain

Some strategies are **in**effective (though often popular)

- Voluntary industry codes, e.g. of bar practice
- Alcohol education in schools
- Warning labels
- Public service messages
- Promoting alternatives -- Alcohol-free activities
- Designated drivers and ride services

Others are effective:
a list of 10 "best practices", based on the international evaluation literature

Alcohol control policies

- Minimum legal purchase age
- Government monopoly of retail sales
- Restriction on hours or days of sale
- Outlet density restrictions
- Alcohol taxes

Drink-driving countermeasures

- Sobriety check points
- Lowered BAC limits
- Administrative license suspension
- Graduated licensing for novice drivers

Brief interventions for hazardous drinkers

The best practices differ in cost-effectiveness

- Analysis for WHO as part of CHOICE (Choosing Interventions that are Cost-Effective) Programme
  - D. Chisholm, J. Rehm, M. van Ommeren, M. Monteiro & U. Frick, "The comparative cost-effectiveness of interventions for reducing the burden of heavy alcohol use". *Journal of Studies on Alcohol* 65:782-793, 2004.
- In "South-East Asia B" (Thailand, Indonesia, Sri Lanka):
  - Cost effectiveness per DALY saved, in order from best:
    - Random traffic breathtests
    - Screening and brief medical advice
    - Weekend closing day
    - Taxes (not counting revenue from taxes)
    - Advertising ban

  ~4-fold difference between most and least cost-effective
- Combination of brief medical advice, higher taxes & ad. ban estimated to save 238 DALYs/million population at a cost of US $864/DALY

What is politically feasible is often ineffective, what is effective is often politically difficult.

	popular	effective
education and persuasion	+	
deterrence	±	+
alternatives	+	
insulating use from harm	±	±
availability & taxes		+
treatment (as prevention)	+	

not a good correspondence -- why?

- the simple answer:
  - effective strategies opposed because they will hurt economic interests
- but also:
  - conflict with competing values and ideologies
  - a particular society has done what is easily accepted, further effective steps are hard

Some reasons for the muted responses: 1

- Alcohol as “our drug”
  - Part of everyday life or rhythm of week
  - Positive valuatuons: sociability, nutrition, “time out”
  - Politicians, civil servants, media quite “wet”
- Protective effects for heart seen as balancing harms
  - This is an error – net effects negative, even at individual level
  - No evidence of protective effect at population level – heart disease does not go down when alcohol consumption rises
- Alcohol important in many economies
  - Export earnings
  - Government revenues
  - Part of the earnings of many: storekeepers, hospitality employees, farmers
- Influence of alcoholic beverage companies

Some reasons for the muted responses: 2

- Dominance of ideology of the free market
  - Consumer sovereignty
    - Buy whatever we want when and where we want it
  - Competition as a public good
  - Trade agreements and dispute mechanisms
    - Alcohol treated as an ordinary commodity
- Symbolism of alcohol, drinking, abstaining
  - Many meanings of drinking and intoxication:
    - Intoxication as adult status, rebellion, personal autonomy
    - Drinking as central to celebration, partying, clubbing
    - Commensality, symbolic exchange as social bonding
    - Restrained drinking as a symbol of self-control

Parallel tracks forward:

1. Moving toward evidence-based practice – **which requires developing the evidence**

- Develop the epidemiological and other evidence of the extent and nature of particular alcohol-related problems
- Plan and implement policies/interventions to reduce rates of problems
- Evaluate the effects of a policy change
  - Planned experiments – usually "quasi-experiments" with controls
  - "Natural experiments" (= no research input on the design)
- Build provision (and funding) for evaluation into any policy change
- Adjust policy/intervention in view of evaluation results

A key example: developing evidence for reducing harm from intoxication - 1

- Routes to reducing or influencing intoxicated harm:
  - through the drinkers:
    - What is the meaning of intoxication in different worlds of heavy drinkers? How drunk is "drunk"? Relation to number of drinks?
    - The management of intoxication in the drinking group
      - What are the realities of MacAndrew and Edgerton's "within limits clause"?
    - The excuse value of intoxication (to what audience?)
      - Violence, sexual violence, accidents
  - through liquor licensing and enforcement:
    - The effectiveness of enforcing "no service for the already drunk"
    - General police responsibility vs. dedicated inspectors
    - Developing an evidence base for liquor licensing and enforcement

Reducing harm from intoxication - 2

- Routes to reducing or influencing intoxicated harm (cont'd):
  - through the drinking environment – planning the ”Night-time economy”
    - Reducing density of licenses, hours of sale
    - Effects of shifts in zoning, changes in design requirements
    - Effects of conditions on licenses
- Looking back from the harm for clues to reduction
  - police incident reports for assaults, domestic violence, drink driving: location, timing, co-factors
    - Trial of routine recording of ”where last drink?” etc.
  - ambulance and hospital emergency services
    - Routine or repeated monitoring of alcohol in injuries
    - Case-crossover and other control designs
    - Study of contexts and co-factors

Parallel tracks forward:
2. Action on policy: two examples from Australia:
(i) Driving down traffic casualties in Victoria

- Compulsory seatbelts 1970
- Random breath-testing 1976
- Cameras for red lights 1983; speed 1986
- "Speed kills" campaign; bike helmets mandatory 1990
- Mobile radars 1996
- Lowered speed limit in residential areas; anti-speed measures 2001-2002
- → **Deaths in 1970: 1061; in 2003: 330**

(ii) Driving down tobacco-related deaths

- High taxes
- Advertising bans and controls
- Smoking bans: workplaces; restaurants and pubs, etc.
- Graphic warnings, media campaign
- Enforcement of age limits; regulations of sales outlets
- Nicotine replacement products
- Brief interventions by health professionals
- Countering tobacco industry influences
- International Framework Convention on Tobacco Control
- **→ 28 million cigarettes in 1980; 20 million in 1997**

http://www.quit.org.au/quit/FandI/fandi/c02s1.htm

(Yet Australian efforts were critiqued by California program leaders: "a monumental paucity of funds and political will", *MJA* 178:313-4, 2003.)

Characterizing success

- Clear goals: reducing the harm to a minimum
  - Consensus that the existing burden of disease/injury is unacceptable
- Professionals as advocates
- A long-term perspective– in terms of decades
- Cross-sector collaboration
  - e.g. for transport safety: Transport Industry Safety Group: coroner, road & transport industry, community and regulatory bodies
- Initiatives in terms of what is possible at the time, cumulating over time
- Sometimes the unthinkable becomes possible
  - e.g., a smoking ban in pubs

Building an agenda for alcohol – some examples of concrete initiatives

- Reducing intoxication
  - Liquor licensing enforcement
  - Focus enforcement on trouble spots (identified by data collection)
  - Social marketing to reduce acceptability of intoxication, increase awareness of costs of drinking
- Reducing social harms from drinking
  - Lower BAC limits for driving; other drink-driving countermeasures
  - A focus also on other alcohol-related injuries
  - Use design and management to reduce harm from drinking in public places
  - Transport options for & other management of late-night drinking
- Reducing adverse health impacts of drinking
  - Broaden health-system capacity and implementation of assessment and brief advice
  - Mandate safety measures such as wearing seat-belts
  - Raise taxes
- Shifting the cultural place & availability of alcohol
  - Monitor and regulate alcohol advertising
  - Separation and identification of alcohol as a risky commodity

Joining the policy dialogue

- The limits of technocracy
- Experience-based policy advocacy
  - Alcohol and drug counselors
  - Emergency service & other doctors and nurses
  - Mental health clinicians
  - Police and community response staff
  - Social workers, family counselors, clergy
- at community levels:
  - Licensing decisions about on- and off-licenses
  - Community planning to minimize alcohol-related harms
- at regional and national levels:
  - Supporting preventive legislation
  - Encouraging enforcement or laws and regulations; supporting funding for it
- at the international level:
  - Pushing for exclusion of alcohol from free trade agreements
  - Supporting a strong leading role for WHO in reducing alcohol problems

Alcohol policy requires thinking and action -- at multiple levels -- in many arenas

- Local, regional, national and international levels all interconnect
  - Local evidence and action can contribute to the international level
  - The international level can facilitate or galvanize the local level
- Alcohol problems reach across departmental and professional boundaries
  - Developing the evidence base requires cross-disciplinary work
  - Implementing alcohol policies requires action across departments and services