Too many risky drinkers; too little alcohol law reform

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Alcohol (ethyl alcohol) has been a source of delight, comfort, and therapeutics for *Homo sapiens* from our early hunter-gatherer beginnings. Alcohol’s compelling intoxication was a likely factor in maintaining optimism and hope during periods of hardship, and its analgesic and antibacterial properties further contributing to survival, especially through providing sterile fluid to drink.

The downside of alcohol intoxication would have been sporadically evident in individual heavy consumers from ancient times, but the advent of predictable availability of large quantities of alcohol through industrial production took alcohol harm to a new level of social impact, which continues to this day, now being further fuelled by marketing science.

Many effects of intoxication are less obvious than falling down drunk. For example, alcohol’s ability to induce sadistic behaviour at reasonably low consumption levels has been known for some time now. More recently, we have been shown alcohol’s ability to induce a near psychotic misinterpretation of the emotion being expressed on other people’s faces as one of threat, particularly in men. These insights help in the understanding of why violence and mayhem so often breaks out at heavy drinking ‘social’ events.

Alcohol is our favourite and most well-known recreational drug, and like every other drug, there are benefits and costs that are best to consider before consumption, which are strongly influenced by the dose consumed. Acute and chronic overdosing on alcohol can cause a myriad of harms, in both the short and long term, to both health and social life.

Many of these harms afflict the drinkers but, in contrast to tobacco where the effects are mainly on the consumers themselves, alcohol harm is more likely to be disseminated. Heavy drinking commonly affects the drinker’s partner, children, relatives, friends, neighbours, co-workers, people living in the same household, or strangers. In the New Zealand general population, harm from others’ drinking is more frequently reported than harm from one’s own, especially for women and young people.

There is an enormous amount of alcohol harm in New Zealand directly caused by very high numbers of risky drinkers. In 2008–2010, New Zealanders 15 years and over were consuming an average of 10.9 litres of pure alcohol each year, which is 165 grams of alcohol or 16.5 standard drinks per week. However these figures include people who don’t drink at all and ignore the large gender differences in consumption. In New Zealand, more men drink than women, and they drink considerably more. In fact, the 85% of men who were drinkers consumed an average of 18.6 litres of alcohol per year (28 standard drinks per week), and the 75% of women who were drinkers consumed an average 8.5 litres of alcohol.
per year (13 standard drinks per week). This is the equivalent of 4 bottles of wine per drinking man, and 2 bottles of wine per drinking woman on average per week. It sounds like a lot and it is.

The Health Promotion Agency’s new “low-risk” drinking guidelines advise a maximum of 10 standard drinks per week for women and 15 for men. This advice was based on evidence of harm resulting from different levels of consumption, and is similar to new drinking guidelines in Canada and Australia.

So in New Zealand, the average consumption of drinkers is well over the low-risk guideline for both men and women. This is not to say that everyone drinks in a risky manner. We know that most 15 and 16 year olds are not drinking their share of this average, and there are many other drinkers who don’t drink nearly this much. However, these figures suggest that balancing these lower-risk drinkers is a large number of drinkers consuming at even higher volumes.

Wells and colleagues found that 25% of people aged 15 years and over in New Zealand were heavy drinkers—700,000 individuals. The World Health Organization (WHO) per capita consumption levels described above suggest this is likely to be an underestimate.

The presence of very high numbers of risky drinkers and tolerance of drunkenness help explain why there is so much harm from alcohol in New Zealand. This includes fights, falls, fires, accidents, road deaths, family violence, self-harm, suicide, teenage pregnancy, fetal alcohol spectrum disorder, sexual assault, absenteeism, eroded work productivity, chronic disease (especially cancer), mental illness and addiction. It also helps explain the extent of social cost from alcohol, conservatively estimated to be NZ$4.4 billion in 2005/2006.

Emergency departments are among the frontline agencies dealing with those consequences of drinking that demand immediate attention. Although the magnitude of the alcohol problem is well known to those who work in emergency departments (EDs), published information is surprisingly sparse.

This is why the two papers in this issue of the Journal—by Ardagh and colleagues documenting research at the Christchurch Hospital ED—are important. This research quantified the impact of alcohol presentations on the ED and described the drinking behaviour of people presenting as a result of alcohol use.

Their key findings were that 5% of all presentations are alcohol-related, with a bias towards these acute presentations being in people who are young, male and presenting on a Saturday night. The median amount of alcohol consumed prior to these presentations was a staggering 14 standard drinks (more than a whole week’s worth of alcohol consumed in one session) ranging up to a death-defying 71 standard drinks, albeit self-reported in an intoxicated state). Where known, the alcohol was sourced half the time from liquor stores (48%), and around a quarter of the time each from supermarkets (22%) and on-licence premises (26%), with only 4% from home (home-brew, duty-free).

The authors rightly suggest this study will assist in assessing the impact of any alcohol policy changes, by establishing a baseline. However alcohol policy changes are hard to come by.
The Sale and Supply of Alcohol Act 2012 was a pitiful response by the National Party-led government to the monumental review of alcohol in New Zealand by the Law Commission in 2009/2010. All of the most effective recommendations of the Commission’s final report Alcohol in our Lives: Curbing the Harm were ignored. Of particular note, there were no new substantial measures addressing the demand side of alcohol consumption—marketing and pricing.

The new Act did, however, include an untested strategy of enabling local councils to reduce the accessibility of alcohol through establishing restrictions to the hours of purchase of alcohol as well as the density of alcohol outlets in their area through local alcohol policies (LAPs). While this provides the best opportunity from the new legislation to reduce harm in local communities, any council which dares to put up reformative restrictions on trading hours or liquor outlet density will be challenged and potentially held up in appeal courts. Of 22 provisional LAPs produced, 15 have been appealed by the alcohol industry so far.

We are not expecting any significant reductions in alcohol-related harm, including alcohol-related presentations to ED, as a result of this new Act, unless the terms of engagement between councils and the industry are substantially altered.

However, on 1 December 2014 the first substantial alcohol law reform for a generation will come into force, with a new drink-driving limit of 0.05g per 100ml for drivers over 20, and we can confidently expect a reduction in alcohol-related harm to follow.

Of course, one effective strategy is not going to be enough for the transformation of the dominating culture of risky drinking. As with tobacco policy reform, phasing out marketing and increasing the price of alcohol will be fundamental to achieving culture change.

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References


