The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is concerned that, despite the significant harm incurred by the misuse of alcohol in Australia and New Zealand each year, there is a lack of awareness of the need for evidence-based programs and treatments to address this. Alcohol is associated with a range of mental illnesses and excessive consumption can lead to brain function impairment and injury. The RANZCP advocates for increased investment in evidence-based methods for reducing alcohol-related harm and research in the area so as to be able to develop more effective early intervention, prevention and treatment approaches.

Background

Alcohol is a psychoactive substance that impacts upon the health of the individual and the community. Alcohol is widely consumed in both Australia and New Zealand and when used responsibly it can be enjoyed safely. The effects of alcohol on an individual can vary significantly; these variations relate to factors such as sex, age, medication use and physical and mental comorbidities. Despite these variations, there are broad recommendations for safe levels of drinking in countries across the world. The New Zealand Ministry of Health recommends that women drink no more than 2 standard drinks a day and no more than 10 standard drinks a week, while men should drink no more than 3 standard drinks a day and no more than 15 standard drinks a week (Ministry of Health, 2016a). Australian guidelines suggest that both men and women limit themselves to 2 standard drinks a day (NHMRC, 2009).

However, while moderate use of alcohol is a part of life for many Australians and New Zealanders, overall consumption of alcohol in our communities is high and a significant proportion of people suffer alcohol-related harm. Young people are particularly at risk of alcohol-related harm, with 80% of 14 year olds in Australia (AIHW, 2014) and 56% of 15–17 year olds in New Zealand (Ministry of Health, 2015) having consumed alcohol in the past 12 months in 2013.

In 2012, around 5.9% of all deaths globally (around 3.3 million in number) and 5.1% of the global burden of disease and injury were attributable to alcohol consumption, making it overall the third highest global risk factor for disease and disability. There is clear evidence that alcohol consumption is linked to a range of negative health outcomes and can reduce quality of life (WHO, 2014). The RANZCP argues that for alcohol, like other substances associated with harms to health such as tobacco, effective evidence-based policies and treatment strategies should be implemented to minimise harms.

Systematic screening followed by brief intervention plays a critical role in identifying high-risk drinkers, or those who have engaged in risky or potentially risky consumption, and introducing treatment and management of their conditions. GPs may be best placed to undertake this important first step given that they are the most frequent point of contact with the health-care system. Australian evidence suggests that screening and brief interventions in primary care settings for alcohol use disorders can be cost effective as a means of reducing alcohol-related harm (Wutzke et al., 2001). It is worth noting that interventions can be as simple as a brief discussion of the Alcohol Use Disorder Identification Tool (AUDIT). The additional advantage of the AUDIT is that it can be used in a wide variety of primary and community care settings and so reach a larger number of patients.
Evidence

Long term overconsumption of alcohol can cause permanent damage to both physical and mental health. In Australia in 2010, 5,554 deaths were attributable to alcohol (Gao et al., 2014) and in New Zealand it is estimated that 600–1,000 people die each year from alcohol-related causes (ARPHS, 2010).

Alcohol is a component cause of more than 200 different types of disease and injury (WHO, 2014). The harms related to alcohol are linked to patterns and volume of consumption. Short-term excessive alcohol consumption or binge drinking, is associated with a significant burden of intentional and unintentional injury, including road traffic accidents, falls, drowning and poisoning (WHO, 2014). Long-term alcohol consumption causes or contributes to a wide range of adverse health outcomes, including maternal and perinatal diseases, a number of cancers, diabetes mellitus, neuropsychiatric disorders, cardiovascular diseases, infectious diseases, gastrointestinal disorders and chronic liver disease (WHO, 2014).

Excessive alcohol consumption has a detrimental effect on mental health with a well-documented relationship between alcohol abuse and mental health issues. Alcohol can cause impairment of brain function and long-term brain injury (Zahr et al., 2011) and promote the development of mental health conditions including depression and anxiety (Currie et al., 2005; WHO, 2014). The combination of alcohol misuse and depression presents a tragically high-risk profile for suicidal behaviour and suicide (Sher, 2006; Hufford, 2001; New Zealand Law Commission, 2009). Alcohol use disorders may also be associated with other psychiatric comorbidities including psychosis, personality disorders, eating disorders and somatoform disorders (Gordon, 2008). People with pre-existing mental health conditions are also more likely to use alcohol (Kessler et al., 1997). Thus, alcohol use disorders and alcohol dependence contribute significantly to the burden of mental illness.

Overconsumption of alcohol also leads to far-reaching societal costs and indirect harms to others (Connor and Caswell, 2012). This includes harm to family members including children, to friends and work colleagues, and to bystanders and strangers. Many of these social consequences can result in affront, violence or injury to others.

A New Zealand-based study found that the prevalence of such harms to others can be higher than the harms to the individual from their own drinking (Connor and Caswell, 2012). In Australia, it is estimated that more than 10 million people each year experienced the negative effect of a stranger’s drinking and over 70% of Australians were affected in some way by another person’s drinking (Laslett et al., 2010).

The tangible and intangible costs to the community as a result of alcohol use are considerable, and include the impact of crime, violence, treatment costs, loss of productivity, absenteeism and premature death or disability (Collins and Lapsley, 2008). These costs have been estimated at about $5.3 billion per year in New Zealand (Slack et al., 2009) and up to $15 billion per year in Australia (Collins and Lapsley, 2008).

As well as the harms that alcohol may have on the general community in Australia and New Zealand, there are additional risks and concerns for population groups as set out below.

Perinatal health

Women who drink alcohol during pregnancy increase the risk of foetal alcohol spectrum disorder (FASD) and other preventable health conditions in their newborns (WHO, 2014). FASD can lead to learning and behavioural problems which can be severe, complex and continue into adulthood. While alcohol use does not always lead to poor parenting behaviour, when consumed at levels that lead to maladaptive behaviours and psychological changes, parental alcohol consumption can place the child at risk of abuse and neglect. As such, excessive alcohol consumption is associated with all major forms of child abuse and neglect, including domestic and family violence (CFCA, 2015).
The prevalence of FASD in Australian and New Zealand communities is difficult to estimate as there is no national data and no routine screening for FASD. Detection of FASD can also be complicated because parents and doctors may not realise that FASD is the cause of the child’s developmental issues, maternal intake of alcohol can be difficult to measure, alcohol may not be the only drug consumed during pregnancy, and other factors may be contributing to the child’s learning and behavioural issues (Ministry of Health, 2016b). More research is required to develop a more accurate understanding of the prevalence of FASD (Ministry of Health, 2016b).

**Children and adolescents**

Binge drinking particularly affects the developing brain of children and adolescents. Attention must be paid to the co-existence of alcohol misuse and physical and mental health issues during childhood and adolescence, the age period where the majority of substance abuse disorders develop. Alcohol use, when initiated at a young age, elevates the risk of mental health and social problems (NHMRC, 2009). Young people with co-existing mental health problems and alcohol misuse are more likely to exhibit risky behaviours, experience complex mental health problems and suffer further harms, including self-harm, relative to their age group who do not use alcohol.

Research shows that drinking contributes to three leading causes of death among adolescents – unintentional injuries, homicide and suicide (Stephens, 2006; Miller et al., 2007). The likelihood of risky sexual behaviour also increases when alcohol is involved, including unprotected sex and sexual coercion (NHMRC, 2009). Drinkers under 15 years of age are much more likely than older drinkers to experience risky or antisocial behaviour connected with their drinking (NHMRC, 2009).

While Australian data from 2010 suggested that young adults and teenagers were more likely to consume alcohol at levels that placed them at increased short-term and long-term risk (AIHW, 2011), it also appeared that there was a trend towards increasing abstinence from alcohol in this age group (Livingston, 2014). 42% of New Zealanders aged 15–17 reported having first drunk alcohol before the age of 15 (Ministry of Health, 2015).

**Older people**

In addition to intoxication, alcohol dependence and abuse, older people may incur particular harms when drinking alcohol. Many older people take medications that are incompatible with alcohol and the physiological effects of ageing can increase the effects of alcohol consumption. There are also a wide range of health conditions linked to drinking among older people including liver disease, high blood pressure, cancer and stroke while pre-existing health conditions may worsen with even low levels of alcohol consumption (HPA, 2014).

Due to the complex mechanisms of alcohol-related harm during old age, there is no consensus on how to gauge harmful drinking among older people. Some studies have indicated that around 1 in 10 older people in Australia and New Zealand use alcohol hazardously (Dent et al., 2000; HPA, 2014) though many investigators have suggested the need to decrease the threshold for harmful drinking levels in later life due to the increased effects of alcohol and greater associated risks. One US study which took into account the context of co-existing medical conditions, functional status, medication use and other health risks found more than half of older people were drinking at harmful levels (Wilson et al., 2013).

Older people tend to be under-represented in drug treatment services (Ruth, 2011) and screening for dangerous alcohol consumption among this population faces numerous obstacles which can impact its accuracy (Bright, 2011; HPA, 2014). More research is required to better define, identify, prevent and treat hazardous alcohol consumption among older people.

**Aboriginal and Torres Strait Islander and Māori populations**

Aboriginal and Torres Strait Islander peoples in Australia and Māori in New Zealand experience an excessive burden of alcohol-related harm. Australian data consistently shows that although the proportion of Aboriginal and Torres Strait Islander peoples who consume alcohol is lower than that of the non-Indigenous population, Aboriginal and Torres Strait Islander peoples who do consume
alcohol do so at more hazardous levels and are 1.5 times more likely than non-Indigenous individuals to drink at risky levels for both single occasions and lifetime harm (AIHW, 2014).

In New Zealand, the average quantity of alcohol consumed on a single typical drinking occasion by Māori individuals is 40% greater than for non-Māori, across age groups and genders (Ministry of Health, 2007). Māori adults were also more likely to report starting to drink before the age of 15 years (Ministry of Health, 2015). Research indicates Māori, compared with the non-Māori population, experience greater harm and injury attributed to alcohol (Research New Zealand, 2012; New Zealand Law Commission, 2009).

**Recommendations**

The RANZCP supports evidence-based approaches to reducing the availability and accessibility of alcohol. These strategies, as supported by a number of sources (RACP and RANZCP, 2016; Babor et al., 2010), are summarised as follows:

- universal screening and the use of brief intervention approaches for alcohol use disorders in primary care, community health, psychiatry and emergency department settings (Demirkol et al., 2011)
- investment in reducing stigma in order to promote help-seeking for alcohol-related problems (SIARG, 2013)
- the raising of alcohol prices through excise taxes and the introduction of a minimum price per standard unit of alcohol (Grossman et al., 1994; New Zealand Law Commission, 2009)
- the raising of legal minimum purchasing age and consideration of strategies to limit volume of alcohol and types of alcohol that can be sold to young people (RACP and RANZCP, 2016; New Zealand Law Commission, 2009)
- cross-agency and integrated strategies aimed at reducing alcohol accessibility, including mechanisms targeting the number and geographical density of outlets and hours in which alcohol is sold (RACP and RANZCP, 2016; Research New Zealand, 2012).
- independent regulation of the marketing and advertising of alcohol, with consideration of mandatory health-warning labelling, and specific legislation addressing advertising and promotion to young people (Smith and Foxcroft, 2009)
- counter-measures against drink-driving, including the lowering of the blood alcohol (BAC) limit to zero for those under 20 years of age (Albalate, 2008)
- further investment in evidence-based strategies to address alcohol-related health problems, with greater access to care, especially for vulnerable populations including Indigenous populations (Tran et al., 2009)
- supports, training and resources for family/whānau and support networks of people with alcohol use disorder to assist them in providing care and safeguarding their own mental health (RANZCP, 2014)
- the incorporation of stories of recovery into public education to demonstrate that alcohol misuse and dependence are treatable and to encourage help-seeking behaviours (Pescosolido et al., 2010)
- the challenging of Australian and New Zealand 'drinking cultures' to give legitimacy to alternatives such as responsible drinking or abstinence (RACP and RANZCP, 2016)
- the early identification of children with FASD and supporting initiatives to reduce FASD in the population (Ministry of Health, 2016)
- more research in order to develop more effective services to address alcohol-related harms that affect Aboriginal and Torres Strait Islander peoples and Māori
- investment into further training opportunities for health professionals, including psychiatrists, in identifying, assessing and intervening to address alcohol-related harms.
The RANZCP also supports further research into measures to address harms in vulnerable populations as follows:

- research into innovative tools targeting alcohol use, and particularly binge drinking, in young people
- further research into the development of a diagnostic tool for FASD in order to enable consistent and universal screening
- research into how best to engage with Aboriginal and Torres Strait Islander and Māori communities to develop sustainable programs to address alcohol-related harms in these populations (RACP and RANZCP, 2016).

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Disclaimer
This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

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