Ian W Webster AO
Emeritus Professor
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2 April 2016

The Honourable Mr Ian Callinan AC QC
Chairman
Independent Review of Lockouts, Last Drinks and 10 pm Liquor Laws
Department of Justice
NSW Government.

Dear Mr Callinan,

Thank you for the opportunity to make a submission to the inquiry into the NSW liquor reforms.

I am a physician and Professor of Public Health and Community Medicine. In these roles I have been involved in the treatment of persons directly and indirectly affected by alcohol-related injuries and violence. This involvement has been in public hospitals in NSW and elsewhere, rural practice and in the primary care of homeless people in inner Sydney.

Combined with this experience, as a teacher and researcher in community medicine and public health, I have been involved in governmental and non-government roles to do with service delivery and policy development aimed at reducing the toll of alcohol misuse at national, state and local levels.

These roles have been as - Chair of the review of the *National Campaign Against Drugs* (1992), President and now Patron of the *Alcohol and Drug Council of Australia*, Chair of the NSW *Expert Advisory Group on Drugs and Alcohol* from 1999 to 2013, chair of a several reviews and inquiries in NSW into a range of matters such as detoxification services and co-existing mental health and substance use problems and President of the *Ted Noffs Foundation,* now Patron. In related areas I have chaired the *Australian Suicide Prevention Advisory Council* since its inception in 1998 until 2014 and in 2012 and 2013 I was Commissioner on the *National Mental Health Commission*.

I was Foundation Chair and Director of the *Foundation for Alcohol Research and Education* (FARE) then known as the *Alcohol Education and Rehabilitation Foundation*.

From my direct experience of the harms that alcohol can cause individuals, of the imposition these harms have on families and communities and on the demands made on the resources of government in providing treatment and maintaining law and order, combined with the documented outcomes of the NSW Government's alcohol legislation reforms, I recommend to the Review that:

- The imposition of 1.30 am lock out and 3 am cessation of liquors sales in Sydney CBD Entertainment and Kings Cross Precincts be endorsed and continued.

- The restrictions on the sale of take-away liquor after 10 pm across NSW be endorsed and continued.

The attached submission covers the following areas:

- public health and prevention;
- alcohol and violence;
- alcohol's harms to other persons;
- the impact of alcohol on public hospitals and emergency departments;
- the introduction of lockouts; and,
- countervailing forces.

I appreciate the opportunity to make this submission and wish you well in your deliberations on this important issue.

Yours sincerely,

Ian W Webster AO

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Personal submission to the Independent Review of Lockouts, Last Drinks and 10 pm Liquor Laws

Ian W Webster AO

Emeritus Professor of Public Health and Community Medicine, UNSW.

Introduction:

Alcohol is embedded in the Australian culture. It can promote enjoyment and conviviality but it has the capacity to great harm to individuals and communities when misused. Alcohol misuse is a global public health problem. (World Health Organisation, 2014) Australia is no exception, our consumption is at the high end of the international league table. Alcohol has a causal role in more than 60 disease and injury groups.

When consumed to excess alcohol is strongly related to violence and injury especially in environments of dense population aggregations and in which alcohol is readily available. Such were the characteristics of the Kings Cross area when alcohol regulation was reformed.

Compared with other public health problems, measures aimed at protecting communities and individuals from harm directly compete with industries which promote, distribute and sell alcohol beverages. Other industries and enterprises – advertising, entertainment and gambling – are secondarily dependent on the alcohol industry. Therefore, strong regulation of the availability and supply of alcohol is needed to counteract the powerful commercial influences of the liquor and associated industries. This is where governments must stand for the good of the public.

This submission argues that the reforms to alcohol regulation in the Kings Cross and Sydney CBD Entertainment Precincts have effectively reduced the harms from alcohol in these areas. The Government's action in the interests of public health should be commended especially in the face of opposition from the powerful commercial interests of the alcohol and associated industries.

The NSW Government should consider extending these reforms more widely to other actual and potential high risk areas for alcohol-related violence, injury and deaths.

Public health and prevention:

The lockouts in the Kings Cross and Sydney CBD Entertainment Precincts and restrictions on takeaway liquor sales should be seen as public health measures to protect the community from harm.

Our society accepts that protecting and maintaining the public's health and preventing injury, disease and disablement is a responsibility of good government. This means individuals are prepared to share in certain restrictions on personal behaviour and perceived disadvantages for the common good. Public health actions aim to reduce risks to whole population, protect the most vulnerable and those at high risk and to contain high risk settings. In this way public health

measures improve the health and welfare of the community and their sense of well-being. Life expectancy increases.

Thus, immunisation programs, measures to prevent epidemic disease, child protection measures, seatbelts and random breath testing to prevent road injury and deaths, controls on food and medicine standards and other areas, are legislated responsibilities of government.

Because alcohol (and drugs) have the potential to harm, society accepts and demands similar responses by government to control and prevent these harms. Governments restrict the promotion (especially to minors) of alcohol, limit its availability and control aspects of the service of alcohol. Drug and alcohol treatment services, general health and social services and law enforcement are funded by governments to deal with the casualties.

Normal social intercourse and relationships – the social amenity of community life – can be impaired by heavy drinkers. The amenity of the physical environment and its aesthetics can be damaged by the actions of intoxicated persons. Governments are expected to preserve these aspects of community life.

Alcohol and violence:

Alcohol consumption is strongly related strongly to violence. It leads to impulsiveness, disinhibition of behaviour and impaired perception of events in the immediate environment. The drinker misreads gestures and body language of another person and misinterprets words, gestures, postures and actions as potential threats.

In an environment of heavy drinking others, especially younger males looking for a ‘night out’, this is a recipe for violence to emerge and to escalate. These are the circumstances - late at night on inner city streets, clubs and hotels - in which the seeds are sewn for violence and personal injury.

Localities of high density of alcohol outlets are where assaults, injuries and hospital attendances occur more frequently. (Livingstone et al., 2011) An environment which typifies King Cross and its environs.

Alcohol’s relation to violence goes well beyond the events seen in inner Sydney. Alcohol is a major factor in road injuries and deaths, domestic violence, assaults attended by police, accidental personal injury, burns and intentional injury and threats to others. I have compiled a list of these relationships compiled for teaching purposes, see Table 1.

Much police work is in response to alcohol. In NSW it is of the order of 50 to 70% for several offence categories. (Donnelly L, et al., 2007) In interviews I conducted with Northern Territory police in 1992, they said up to 90% of their work was alcohol-related crime and injury. (Personal observation, reviewing the National Campaign Against Drugs, 1992.)

Harm to others:

Compared with other substances, alcohol consumption causes much social harm. A study on behalf of the UK Drug Misuse Advisory Council which explored, from multiple perspectives and criteria, the harms caused by all substances, placed alcohol as the most harmful drug in that society. This study included the harms to others as well as to individual drinkers. (Nutt DJ et al., 2010)

In 2008 FARE funded research on alcohol's harm to others which looked beyond the impact of alcohol on an individual but the effect of a person's drinking on others – from strangers to close family members. It studied the inter-relationships of a drinker to family and household, work mates, friends and strangers, see Figure 1.

The principal findings are set out in Table 2 – showing frequent effects of a person's drinking on strangers, high level adverse effects on friends and family, high proportion of assaults attended by police and instances of domestic violence. Of great significance is the estimate that in one in three child protection cases in which the responsible adult was alcohol affected at the time of abuse.

FARE estimated the total harm from alcohol in Australia in 2008 as $36 billion per annum. (Laslett A-M et al.,2010) This ground-breaking study has received international recognition including by the World Health Organisation. Its methodology is now being applied in other countries.

The impact of alcohol on public hospitals and emergency departments:

Much of the work of a public hospital is alcohol-related – emergency, trauma and burns units, neurology, brain injury, mental health, drug and alcohol clinics, gastroenterology units and in services such as general medicine and surgery many of conditions treated have alcohol as underlying causal factor – several cancers, diseases of the liver and nervous system. Thirty to forty percent of patients in a public hospital are estimated to be using alcohol at hazardous and harmful levels. (Saunders J, 2016)

Alcohol-related presentations are under-recorded in the routine data collected by emergency departments as the focus in emergency presentation is on the nature and urgency of the injury, medical or mental health problem and in deciding on the priority of interventions. To accurately document the extent of alcohol-related events in EDs requires dedicated staff and recording processes need to be put in place. Because of the logistics such studies are infrequently done.

Emergency departments (EDs) are at the frontline of personal and community crises, the consequences of social unrest and casualties of antisocial behaviours. Alcohol-related injuries, medical conditions, mental health problems and suicide are a large part of these problems.

Committed health professionals are themselves exposed to risk in EDs. Dr Ergerton-Warburton and colleges report 97.9% of ED clinical staff have been exposed to verbal aggression, 92.9% - physical aggression and 87% felt unsafe in the presence of alcohol-affected patients. Sixty-eight percent reported 68% verbal aggression had been experienced often (a few times per month) or frequently (a few times per week) and 42% had often or frequently experienced physical aggression. They reported the negative impact alcohol-affected patients had on other patients in the ED and on waiting times. (Ergerton-Warburton et al., 2016)

A 'snap shot' survey on at 2.00 am Saturday 14th December 2013 of EDs in 106 Australian and New Zealand hospitals showed one in seven presentations were alcohol-related. Some EDs reported more than one third of presentations as alcohol-related. (Ergerton-Warburton et al., 2014)

At St. Vincent's Hospital, Darlinghurst in 2005, a study funded by the Alcohol Education and Rehabilitation Foundation (now FARE) and conducted by the New South Wales Bureau of Crime Statistics and Research showed one in three injury presentations had consumed alcohol beforehand and two of three of these were on licensed premises. One fifth of the injuries had been drinking at 'high risk' levels and of the assault injuries, half and been drinking at 'high risk' levels. A high level of resources was consumed managing these patients, see Table 3. (Poynton S et al., 2005)

In EDs in South Western Sydney in a study of alcohol-related injury, alcohol consumption and intensity of consumption 17% had been drinking in six hours prior to the injury. Twenty percent of presentations to the EDs had been drinking before the injury and 10% regularly abused alcohol. The risk of injury was doubled for those who had been drinking at licensed premises. Approximately 80% of the alcohol-caused admissions as in-patients were serious or life threatening. (Williams M, et al., 2008)

Patterns of ED attendance in rural NSW reflect similar patterns with the rates of problematic alcohol consumption being at twice the level found in the communities they serve. (Havad A, et al., 2012)

Lockouts:

The potential for 'lockouts' as an effective method to reduce alcohol-related violence in and around on-licence liquor premises was raised at the NSW Alcohol Abuse Summit in 2003. Amongst the Key Initiatives the Government announced in response to the Summit was that ". *consideration be given to legislation requiring late trading venues, which have been associated with significant alcohol-related crime or repeated offences, to maintain an incident register, have CCTV on premises and to employ security personnel."* These are the environments in which lockouts had been shown to be effective in UK, Europe and in local areas in Sydney.

What is now known as the "Newcastle experiment" of lockouts in the central business area had shown the effect on violence and injury and provided the model for what could be done in inner Sydney. (Menendez P et al, 2015)

King's Cross and its environs has been recognised for many years to be dangerous for pedestrians and patrons of premises especially at times of peak population concentrations, late at night and early morning hours from drinkers. These are the peak periods for presentations to St Vincent's Hospital's ED. As noted, alcohol-related violence and injury are increased in areas where the density of licensed premises and alcohol take-away outlets are increased. (Livingstone et al., 2011) Such is the environments of the Kings Cross and Sydney CBD Entertainment Precincts.

The Government's decision to regulate and implement 1:30 am lockouts, to the ordinary person, are seen to be entirely reasonable. Ceasing the sale and serving of alcohol after 3 am is also accepted as a reasonable response to alcohol-related violence and injury in licensed premises and adjacent inner city streets.

Outcomes of the legislative reforms for the regulation of alcohol by the New South Wales government:

Data collected by the BOCSAR, St Vincent's Hospital ED and police show substantial declines in the incidence of alcohol-related violence (assaults) and serious injuries treated at St Vincent's

Hospital ED. Over 12 months there has been a 32% reduction in assaults in King's Cross. The proportion of seriously injured alcohol related emergency presentations from 4.9% to 3.7% and alcohol-related serious injury presentations during high incidence times for alcohol ED presentations (6 pm Friday to 6 am Sunday) at St Vincent's ED decreased from 10.4% to 7.8%. (Menendez P et al., 2015; Fulde G et al., 2015)

These data, in addition to the personal accounts of trauma surgeons, local residents and police, indicate the Government has achieved a major public health success by reforming the alcohol regulations. And local residents report improved amenity and living environments of King's Cross and adjoining areas of Sydney.

Countervailing forces:

The alcohol industry has a history of contravening and ignoring measures to protect the social and physical health and well-being of the community at national and local levels. Their economic interests compete with the protection and maintenance of the public's health. This is a global issue and not only a problem for Australia. International and Australian research demonstrates repeatedly that actions by government are required to limit the harms caused by alcohol misuse in populations. The WHO regards alcohol as a major global health problem; it contributes to 5.9% of all deaths globally. (World Health Organisation, 2014)

Alcohol has an entrenched role in the Australian way of life. It can be enjoyed sensibly and appropriately so long as individual families and communities can exercise care and restraint in its consumption and it this is used to promote congenial and rewarding social intercourse and enjoyment. However, "responsible drinking" can be subverted by the excessive promotion, advertising and availability of alcohol in environments where the normal values and restraints on social relationships are fractured.

To deal with the issues of violence serious injury and death's in populated areas, in urban areas, and other 'hot spots' requires strong regulation of the availability and supply of alcohol to counteract the powerful commercial influences of the liquor industry. This is where governments must make a stand for the good of the public.

Recommendations:

- The imposition of 1.30 am lock out and 3 am cessation of liquors sales in Sydney CBD Entertainment and Kings Cross Precincts be endorsed and continued.

- The restrictions on the sale of take-away liquor after 10 pm across NSW be endorsed and continued.

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Tables and figures:

Table 1: Alcohol, injury and violence.

Category	Alcohol relationship
Motor vehicle accident deaths	31%
Motor vehicle accident injuries	25%
Burns deaths	20%
Severe burns	40-50%
Severe burns' unit admissions	Above 75%
Drownings	Above 50%
Boating accidents	Above 50%
Domestic violence	40%
Assaults	45-50%
Assaults	25-30%
Night time assaults	70-80%
Victim of antisocial behaviour in past 12 months	31%
Homicides	47% - both drinking in 60% of these (AIC)
Suicide & self-inflicted injury	32% males 29% females

Indigenous Alcohol related deaths	5-fold increase cf. non-Indigenous
Indigenous Alcohol caused deaths	21-fold increase cf. non-Indigenous
Indigenous Alcohol related homicide	18-fold increase cf. non-Indigenous
Hospital admissions	Previous estimates 20-25%
Emergency Departments attendances	30-40%
Emergency Departments at peak times	70%
EDs (international study) injuries	25-30%
EDs (international study) violent injuries	5 – 6 times more likely to be alcohol-related
EDs (international study) 12am – 6am Fri,Sat	56%
EDs suicide attempts and self-injury	60%
St Vincent's Hospital ED injury attendances	33% drinking
St Vincent's Hospital ED injury attendances	22% on licensed premises
St Vincent's Hospital ED assault victims	66% (2/3) had been drinking
St Vincent's Hospital ED injury attendances	20% BAC > 0.1%
St Vincent's Hospital ED assault cases	50% BAC > 0.1%
Costs to Australia	$17.2 B Collins and Lapsley updated to 2008; AERF total estimates $36 B (2008)
Costs of harms to others	$20 billion AERF (2008)
Costs to industry	$5.0 billion (n.b. has been updated since)
Work related injury	11% of the preventable injuries and deaths

Figure 1: The drinker's impact on others: main types of relationship.

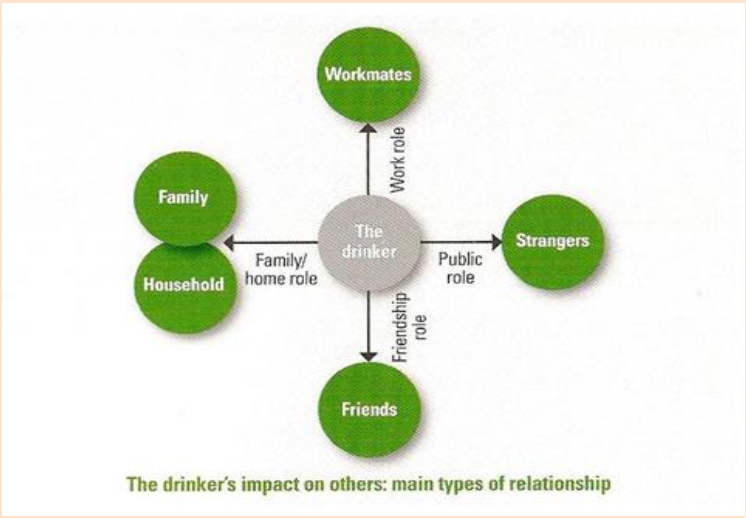

Table 2: Alcohol's harms to others

Harms to others

- ~ 75% adults negatively affected by others' drinking.
- > 30% neg affected by someone well known
- >10 m neg effects of a stranger's drinking in one year.
- >70,000 assault victims per year
- >24,000 victims of domestic violence
- >20,000 children abused [in 2006/07].
- $14 b out-of-pocket expenses lost wages & productivity.
- > $6 b in intangible costs.
- Additional $20 billion added to the Collins and Lapsley (updated to 2008) of $17.2 billion = $36 billion annually.

Table 3: Costs of alcohol-related injuries St. Vincent's Emergency Department, 2005.

Costs of alcohol-related injuries St Vincents Emergency Department, 2005

- 1/3 of injuries had consumed alcohol
  - 2/3 of these on licensed premises
- 1/5 of injuries drinking at 'high risk'
- ½ of assault injuries drinking at 'high risk'

= 5,500 staff hours = $1.38 m

- In NSW there are 143 EDs and 13 metro major trauma centres

Donnelly N, Poyton S, Scott L, Weatherburn D BOSCAR & Fulde G, St VH FARE 2005

Table 4: Detection of risky and problem drinking in rural EDS.

Risky/problem drinking in EDs in rural areas

Five rural EDs (n=1056) cf. rural residents (n=756)

- **AUDIT**
- **NHMRC 2001 guidelines**

	ED patients	Community
AUDIT	**39%**	**20%**
NHMRC – short-term	**26%**	**18%**
NHMRC – long term	**7%**	**3%**

Havad A, Shakeshaft AP and Conigrave KM. Prevalence and characteristics of risky alcohol consumption presenting to emergency departments in rural Australia. Emerg Med Australas. 2012; 24(3): 266-276.