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Promoting Healthy Communities: a Position Paper on Alcohol Policy and Public Health

A position paper and resolution adopted at the 1996 OPHA Annual General Meeting

Code: 1996-01 (PP) / 1996-01(RES) ***Status:*** Active

RESOLUTION

WHEREAS the unsafe consumption of alcoholic beverages has widespread health, social and economic consequences for individuals and society; and

WHEREAS population-based approaches aimed at controlling the availability of alcohol, complemented by harm reduction strategies aimed at vulnerable segments of the population, have proven to be effective in preventing or reducing alcohol-related harm; and

WHEREAS the Ontario Public Health Association has an important role to play in fostering the development and maintenance of healthy public policies aimed at preventing or reducing the risk of alcohol-related harm.

THEREFORE BE IT RESOLVED THAT OPHA adopt the principles and recommendations outlined in the position paper entitled, *Promoting Healthy Communities: a position paper on alcohol policy and public health,* as the basis for its position on alcohol policies at the local, provincial and federal levels;

BE IT FURTHER RESOLVED THAT the OPHA Substance Abuse Work Group work in conjunction with the OPHA Executive, Board and Membership to lobby and advocate to the appropriate levels of government.

Regarding resolutions, position papers and motions:

Status: Policy statements (resolutions, position papers and motions) are categorized as:

ACTIVE, if:

1. The activities outlined in the policy statement's implementation plan have not yet been completed; or
2. The policy statement addresses an issue that is currently relevant to public health in Ontario.

ARCHIVED, if:

1. The activities outlined in the policy statement's implementation plan have been completed; or
2. The policy statement addresses an issue that is not currently relevant to public health in Ontario or is not based upon the most current evidence. The statement remains the position of the OPHA until a new statement is adopted that effectively reverses or essentially negates all or major elements of an earlier statement. In this instance, the former supersedes the latter

PROMOTING HEALTHY COMMUNITIES

a position paper on alcohol policy and public health

Ontario Public Health Association

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EXECUTIVE SUMMARY

Alcohol is the drug of choice for most Ontarians. According to the General Social Survey, 74.4% of the province's residents aged 15 or older, consumed alcoholic beverages in 1993. And while alcohol is widely used, its consumption is not without risks.

The widespread use of alcoholic beverages is associated with a wide range of health and social problems, including traffic fatalities, suicides, sports and leisure injuries, violence and reduced productivity in the workplace. A recent nationwide economic cost study estimated that alcohol-related health care, law enforcement, social welfare services and productivity losses, cost Ontarians some $2.9 billion in 1992, or $270 for every man, woman and child in the province (Single et al., 1996).

Partners in Action, the substance abuse prevention strategy developed by the Ontario government in 1992, notes that "alcohol plays a part in a long list of society's most pressing problems (p. 7)." Yet the link between alcohol consumption and its attendant health, social and economic consequences is often masked by myths such as: "alcohol is harmless," "alcohol is only a problem for those who abuse it," "broad-based control policies have no impact on heavy drinkers," "alcohol only has negative consequences when consumed in large quantities," and "the most effective way to reduce alcohol-related problems is to educate the public about potential risks."

In fact, alcohol is a drug with attendant physiological effects. It has widespread health, social and economic consequences for individuals and for society. And although moderate alcohol consumption can have health benefits for some people, high risk drinking practices, such as drinking and driving, in fact result in thousands of preventable injuries and premature deaths every year.

Research shows that *comprehensive controls* on alcohol availability, such as taxes and limits on liquor store hours, can minimize harm to individuals and society. When complemented by *effective deterrence and enforcement measures* such as roadside breath testing, and *targeted injury prevention/harm reduction strategies* such as Designated Driver Programs, alcohol controls should be seen as crucial components of any population health strategy.

The Ontario Public Health Association believes that the cornerstones of healthy public policy with respect to alcohol are threefold:

a) Effective controls on alcohol
- alcohol prices and taxes that promote moderation
- controls on liquor sales and service that safeguard public health and safety
- policies that protect groups at risk
- regulations that promote responsible alcohol advertising, promotion and sponsorship practices
- effective deterrence, monitoring and enforcement.

b) Supportive environments
- federal and provincial leadership in, and support for, the prevention and reduction of alcohol related-problems
- an effective, integrated and community-based addictions treatment system
- preventive policies that move beyond alcohol to address the broader determinants of health.

c) Inclusive decision-making
- policy processes that are open, transparent and sensitive to community perspectives
- decisions that reflect a concern with public health and safety.

The OPHA commits itself to strengthening the public health voice in debates and discussions regarding alcohol policy by:

1) Lobbying for effective controls on the economic, physical and social availability of alcohol based upon the principles outlined in this paper

2) Advocating proactively for more effective health promotion, injury prevention and harm reduction measures at the municipal, provincial and federal levels

3) Educating people active in community health of the potential health and safety consequences of various alcohol-related policies and facilitating their effective involvement in the policy development process.

INTRODUCTION

In recent years, there has been a growing recognition of the importance of public policy in improving the health and well-being of Ontario residents. One of the major health risks that can be successfully addressed through policy initiatives is the unsafe consumption of alcoholic beverages.

Alcohol is the drug of choice for many in our communities. In 1993, the *General Social Survey* revealed that 74.4% of the province's residents aged 15 or older, consumed alcoholic beverages.[1] And although alcohol is widely used, its consumption is not without risks.

The widespread use of alcoholic beverages is associated with a range of health and social problems, including traffic fatalities, suicides, sports and leisure injuries, violence and reduced productivity in the workplace (Edwards et al., 1994; West et al., 1995). A recent nationwide economic cost study estimated that alcohol-related health care, law enforcement, social welfare services and productivity losses, cost Ontarians some $2.9 billion in 1992, or $270 for every man, woman and child in the province (Single et al., 1996).

Partners in Action, the substance abuse prevention strategy developed by the Ontario government in 1992, notes that "alcohol plays a part in a long list of society's most pressing problems" (p. 7). Yet the link between alcohol consumption and its attendant health, social and economic consequences is often masked by a myriad of social myths.

One of the most enduring misconceptions is that alcohol problems are experienced mainly by those who are dependant on alcohol — "alcoholics" — and that controls on alcohol availability unfairly restrict the freedoms of the vast majority of the population that drinks responsibly. In fact, traffic and crime statistics show that everyone in our society is at risk of alcohol-related problems — including those who do not drink. Policies aimed at the entire population can thus be effective in protecting and promoting public health and safety.

Another misconception is that heavy drinkers cannot be influenced by broad-based control policies. In fact, research has consistently found that the proportion of heavy drinkers is related to the alcohol consumption patterns of the entire population (Edwards et al., 1994). Public policies aimed at preventing alcohol-related problems among the entire population can thus be expected to stem the alcohol-related problems attributable to heavy drinkers as well.

A third common misconception is that alcohol-related problems result solely from drinking to or past the point of intoxication. The World Health Organization, among others, notes that even low or moderate levels of alcohol use can impair workplace and traffic safety, increase the risk of certain cancers and harm the development of the fetus. Accordingly, measures promoting the responsible use of alcohol are a necessary part of any effective population health strategy.

Finally, there is the myth that if people only knew about the risks associated with alcohol they would make healthier choices. Although education is an important part of any comprehensive prevention strategy, by itself; it is not very effective. Personal choice is not the only factor influencing alcohol-related problems. Indeed, research shows that the consumption of alcoholic beverages is related to a range of social, cultural, economic and environmental determinants. Alcohol prices, for example, are a major determinant of consumption. Health-oriented public policies that regulate the retail price of alcoholic beverages, such as differential rates of taxation on the basis of alcoholic content, are among the most effective regulatory mechanisms for promoting responsible drinking practices.

When the links between alcohol consumption and the broader determinants of health such as economic status, employment and social supports are considered, a wide range of policy options emerges. Communities with high rates of poverty and unemployment, and limited access to health, recreational and other services are particularly vulnerable to alcohol-related social problems (Mosher, 1994). To promote a healthier Ontario, those responsible for the development and implementation of alcohol policies need to recognize and, where possible, address these broader issues.

OPHA has long recognized the importance of policy in promoting health. It has also become increasingly aware of

[1] Statistics on rates of current drinking differ depending on research methodology and population sample. According to *Canada's Alcohol and Other Drugs Survey, 1994*, 69.4% of Ontarians aged 15 and older, consume alcohol (Health Canada, 1995). Among those aged 18 and older, 84% are estimated to drink according to ARF's 1995 *Ontario Alcohol and Other Drugs Survey* (West et al., 1995).

The wide-ranging consequences of alcohol misuse. In 1995, a work group was formed to advise the Board on alcohol policy issues. Its main task was to develop a position paper that would:

- inform OPHA lobbying and advocacy efforts on key alcohol-related policy issues
- raise the awareness of OPHA members regarding the importance of policy in dealing with alcohol-related problems, and
- facilitate public health involvement in the policy-making process.

In the pages that follow, we identify the assumptions on which this paper is based, as well as what we believe to be the cornerstones of health-oriented alcohol policy. We conclude by outlining potential steps that OPHA can take over the coming year — both independently and in collaboration with key partners — to help minimize and prevent alcohol-related harm to individuals and communities.

KEY ASSUMPTIONS

1. ***Alcohol is a drug with attendant physiological effects.***

Unlike other commercially-marketed beverages and foodstuffs, alcohol products contain ethanol — a psychoactive drug classified as a central nervous system depressant. The acute physiologic effects of alcohol include: sensory and motor changes, visual impairment, a decreased ability to focus and concentrate on stimuli, reduced capacity to process information and make decisions, reduced reaction tune and reduced fine motor control.

Alcohol is also an addictive substance. Repeated exposure leads to reduced sensitivity to the drug effects (tolerance). Removal is accompanied by recognized withdrawal syndrome, and a proportion of all individuals who use alcohol become dependent. In Ontario, it is estimated that 12% of the population over age 15 has experienced alcohol abuse or dependence[2] in their lifetimes (Ross, 1995).

2. ***Alcohol has widespread health and economic consequences for individuals and for society.***

In Canada, alcohol use is second only to smoking as the greatest preventable cause of premature death (Single et al., 1996). Exposure to ethanol over a period of time increases the risk of chronic liver disease, heart disease, several forms of cancer, damage to the central and peripheral nervous systems and other chronic health problems.

Alcohol is also a major factor in thousands of preventable injuries and premature deaths due to crashes, falls, suicides, fires, drownings and homicides. Statistics Canada estimates that in 1992, 855 Canadians died as a result of alcohol-related falls, another 1,115 died as a result of self-inflicted injuries and 1,640 perished in alcohol-related motor vehicle crashes (Williams, 1995). Men between the ages of 25 and 45 are the most likely to report drinking and driving; and the most likely to experience trauma related to alcohol (Bierness, 1995). Disproportionately large numbers of young people also die as a result of alcohol-related leisure craft crashes, drownings and suicides.

In addition to health and mortality effects, there are other personal and social costs associated with alcohol use including absenteeism and employment loss, family and social disruption, and the adverse effects of contact with the criminal justice system. Recent data indicate that roughly one in three Ontarians who use alcohol experienced at least one type of alcohol-related health, work, financial or interpersonal problem in 1994 (West et al., 1995).

Problems as a result of *others'* drinking are also common. A national survey conducted by Health Canada shows that, of the estimated *9.4 million* Canadians aged 15 and older who were negatively affected by alcohol in 1994:

- 19% were insulted or humiliated
- 11 % were pushed or shoved
- 7.5% were passengers in cars driven by drinking drivers

[2] As defined by the American Psychiatric Association in *Diagnostic and Statistical Manual of Mental Disorders, Third Edition.* Washington. DC: American Psychiatric Association. 1980.

- 0.4% (some 92,000 Canadians) were sexually assaulted by someone who had been drinking.

The same study found that among all age groups, young people were the most likely to report being passengers in a car driven by a drinking driver; or to be pushed, shoved or insulted by someone who had been drinking (Health Canada, 1995).

And while the toll of alcohol on individual and community health and safety is considerable, its economic impact is no less striking. Alcohol misuse in Canada accounts for $4.1 billion in lost productivity, $1.36 billion in law enforcement costs and $1.3 billion in direct health care costs. The total bill in 1992 — $7.5 billion — represents 40.8% of the costs associated with substance abuse[3], or 1.09% of Canada's Gross Domestic Product (Single et a1., 1996).

3. ***High risk drinking practices are strong predictors of alcohol-related problems.***

The way alcohol is used is often more important than the absolute amount consumed. Many people who use alcohol do not experience long term health or psychological effects. In fact, alcohol, whether in the form of spirits, beer, red wine or white wine, can have health benefits. There is evidence to suggest that small amounts of alcohol, in the order of one to two drinks in a day, can reduce blood clots and discourage the build up of arterial plaque — risk factors for coronary heart disease.

Despite some documented health benefits[4], alcohol remains high on the priority list of public health officials. Its costs are high, largely avoidable, and often involving young people. The most recent studies show that every year alcohol is responsible for some 86,000 hospitalizations and 6,700 deaths across Canada, many of them preventable (Single et al., 1996).

Identifying what constitutes higher and lower risk drinking behaviour is an area of active research. Many of the types of acute social consequences associated with alcohol, such as suicide, violence, motor vehicle and other crashes, are associated with the consumption of larger quantities, or with intoxication, as much as with any other measure of total dose. Drinking practices known to be "high risk" include:

a) *Long term, regular consumption of alcohol at high levels*, which can lead to serious chronic health problems, such as cirrhosis, pancreatitis and an increased risk of certain types of cancer. Alcohol can reduce the risk of heart disease for some people, but this must be weighed against the risk of other diseases. For young people, who are at low risk of death from heart disease, alcohol-related deaths from injuries far outweigh the health benefits (Ashley, Ferrence, Room et al., 1996). Recently, a major review of the impact of alcohol on health concluded that the overall risk of premature death increases with an average intake of 40g of alcohol per day (a little under three drinks) for men and 20g of alcohol per day (less than two drinks) for women (English et al., 1995).[5] Due to the increased risk of fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE), some experts advise women who are pregnant or breastfeeding to reduce their alcohol consumption or abstain from drinking altogether.

b) *The consumption of large amounts of alcohol at one time*. There is a clear relationship between blood alcohol level and the risk of injuries and deaths due to motor vehicle crashes, falls and sports mishaps. Regular consumption of large quantities of alcohol (i.e., more than 5 standard drinks at one time) leads to increased tolerance and may predispose drinkers to alcohol dependence. High alcohol consumption is also associated with increased self-reporting of family, work amid legal problems (West et al., 1995).

c) *Rapid drinking* causes a rapid increase in blood alcohol and raises the absolute levels of blood alcohol beyond an individual's tolerance level, often unintentionally. On average, the body metabolizes 2/3 of a standard drink per hour. [6]

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[3] The term substance generally includes tobacco, illicit drugs and alcohol.

[4] It should be noted that most studies on the health impacts of alcohol have been done on white, middle class males.

[5] A standard drink contains 12-14 grams of alcohol; the equivalent of 12 ox of beer (5% alcohol/volume), 5 oz of wine (12% alcohol) or 1.5 oz of spirits (40% alcohol). Drinking guidelines differ among jurisdictions and even within the health community. A committee composed of representatives from ARF and the Ontario Substance Abuse Bureau, among others, is currently developing consistent province-wide low risk drinking guidelines. Their best advice is expected to be released in 1997.

[6] Alcohol is generally processed at the rate of 15mg/100ml/hour. In addition to the amount of alcohol consumed and rapidity of consumption, blood alcohol concentration (BAC) is influenced by factors such as: gender, age, weight, mood, health status and fatigue. Although the legal driving limit is .08 per cent or 80 mg of alcohol per 100 ml of blood, impairment can occur at levels well below this level. Indeed drivers with BACs of .05 and above may be charged with impairment under provincial highway traffic laws.

d) *The combination of alcohol with activities which require alertness, judgment and physical coordination or skill* for safety reasons. The Traffic Injury Research Foundation (TIRF) estimates that in 1994, alcohol was a factor in 47% of motor vehicle fatalities, 50% of snowmobile and all-terrain vehicle fatalities and 88% of marine vehicle deaths in Canada (Bierness, 1996). Alcohol is also linked to work-related injuries, particularly in safety-sensitive industries such as transportation. Unfortunately, no hard Canadian data on alcohol and workplace injuries are available at this time.

e) *The use of alcohol in combination with other drugs or medications*, as this can result in serious drug interactions and toxic effects.[7]

f) *The consumption of alcohol by any individual who is otherwise at risk of health or psychological problems that could be brought on or aggravated by using alcohol*. Young people and inexperienced drinkers who have a low tolerance for alcohol, and who lack experience in managing the pharmacological effects of alcohol, must also exercise caution.

4. ***Comprehensive controls on alcohol availability, complemented by targeted injury prevention and harm reduction strategies, are very effective in minimizing alcohol-related harm to individuals and society.***

Proponents of alcohol controls hold that increased access to alcohol leads to increased consumption which leads to increased alcohol-related problems among the general population. They are supported by studies from around the world (Bruun at al., 1975, Wagenaar, 1987, Osterberg and Saila, 1991, Edwards et al., 1994) which show that a decrease in alcohol availability, whether due to: a) reduced supply as a result of a strike, shutdown, wartime rationing or prohibition, or b) reduced demand as a result of higher taxes or prices, is associated with lower rates of liver cirrhosis deaths, alcoholic psychoses, drinking and driving fatalities, public drunkenness, fights and domestic violence (Giesbrecht, 1995).

Currently, alcohol availability is controlled at the provincial level primarily through:

- minimum prices on alcohol products
- taxes ranging from 49% to 7l% of the retail price of alcohol
- retail alcohol monopolies operated by the Government of Ontario (Liquor Control Board of Ontario), the beer industry (Brewers Retail Inc.) and the Ontario wine industry (independently owned and operated outlets)
- licensing requirements for commercial establishments governing, among other things, bar closing hours, sales practices, and server training for some groups of licensees
- federal and provincial rules regarding alcohol advertising and promotion
- minimum legal drinking age of 19.

Deterrence and enforcement initiatives generally go hand in hand with limits on alcohol availability. Police, customs officials, Liquor Board inspectors, retailers, bar and restaurant operators, municipal governments and ordinary citizens all play a part in reducing federal *Criminal Code* and provincial liquor and *Highway Traffic Act* offenses ranging from drinking and driving, to liquor smuggling, to withholding liquor taxes, to selling alcohol to minors or intoxicated persons.

Programs such as R.I.D.E. (Reduce Impaired Driving Everywhere); the Designated Driver and Sober Operator Programs; Operation Lookout (a community-based program which encourages ordinary citizens to report impaired drivers); and the new Peel Last Drink Program (where police officers ask intoxicated driven where they had their last drink and pay a visit to the establishment) have been extremely effective in curbing drinking and driving and reducing the number of Ontarians killed or injured in alcohol-related incidents.

Graduated licensing (which prohibits new drivers from drinking and driving during their first two years behind the wheel), and newly improved ignition interlock systems (which prevent drivers from starting their cars if their breath shows signs of impairment) have also been effective in dealing with two groups at risk of alcohol-related harm: young people and repeat drinking drivers[8] (TIRF, 1994).

[7] For more information on alcohol and drug interactions, please refer to the *Compendium of Pharmaceuticals and Specialties* (CPS) published annually by the Canadian Pharmaceutical Association.

[8] Sixty-five percent of all suspensions for drinking and driving in 1994 were given to drivers who had been suspended at least once before (Bierness, in press).

While the goal of stabilizing or reducing average alcohol consumption remains high on the priority list of health advocates, efforts to minimize the physical, financial and social harm associated with alcohol, without necessarily requiring a reduction in consumption, are attracting attention. In general, harm reduction initiatives use education and a variety of environmental controls to:

- *reduce the number of heavy drinking occasions among specific populations such as high school and university students and young males* (i.e., leisure activities such as drop-in centres, after-school or weekend sports clinics, and alternative forms of entertainment for young people in communities where drinking has become a way to socialize and pass the time).

- *reduce alcohol-related harm and associated liability* (i.e., risk management policies in bars, municipalities, schools and workplaces; bylaws to control bush parties and after-hours clubs).

- *reduce the incidence of drinking to intoxication* (i.e. server intervention training which teaches servers to recognize the signs of impairment and avoid overservice; availability and promotion of food; limits on the number of drinks which may be purchased at any one time; standard container and serving sizes).

- *manage intoxication* (i.e., changes to the physical structure of bars to minimize injuries in case of a brawl; the requirement that drinks be sold in plastic cups rather than bottles to minimize the risk of someone being injured due to fights or fells; tents or rented buses to discourage teens who attend bash parties from drinking and driving; and designated driver or driver/escort programs to minimize the risk of alcohol-related crashes).

- *reduce the intake of ethanol and non-beverage alcohol* (i.e., limits on alcohol content of beer, wine and liquor; promotion of low alcohol and de-alcoholized beverages; controls on cooking wines and other non-beverage alcohol products).

Advocates of harm reduction are supported by research from Australia, for example, which suggests that "heavy drinking occasions" are stronger predictors of alcohol-related social problems such as impaired driving, alcohol related family dysfunction and employment problems, than average level of consumption (Single, 1994). Researchers theorize that those who experience problems — generally *low-level drinkers* who occasionally drink too much — tend to have lower physical tolerance and fewer social supports and coping skills than their harder drinking counterparts.

According to experts like the Canadian Centre on Substance Abuse's Eric Single (1995), the harm reduction approach should be seen as a complementary and practical way to enhance public health and safety in an era of diminished resources and increased de-regulation.

Of course, control policies, even when they are appropriately targeted and strategically enforced, are more effective when they are accepted by a significant proportion of the population. According to the ARF's 1995 Alcohol and Other Drugs Survey, over 70% of Ontarians support current alcohol tax levels and oppose alcohol sales in corner stores. And over three quarters favour warnings labels on alcoholic beverages, an increase in efforts to prevent intoxicated customers from being served, and government measures to educate the public about alcohol.

These findings are consistent with those of seven earlier representative surveys, and show that Ontarians in general favour a strong government role in restricting alcohol availability and raising public awareness about the risks associated with misuse.

THE CORNERSTONES OF HEALTHY ALCOHOL POLICY

The Ontario Public Health Association believes that the cornerstones of healthy public policy with respect to alcohol are threefold: 1) effective controls on alcohol; 2) supportive environments, and 3) inclusive decision-making. Each of these is described in greater detail in the pages that follow.

1. ***Effective Controls On Alcohol***

As we have seen, alcohol, although widely used, is a consumer product like few others. It is a drug with widespread health, safety and economic consequences. It is also a product whose impact reaches beyond the individual drinker. Countless men, women and children are needlessly put at risk, injured or killed as a result of others' misuse. And society spends billions of dollars annually in extra health care, policing and other services to deal with the problem — resources that, in an age of shrinking budgets, could be better allocated elsewhere.

The Ontario Public Health Association believes that controls on the physical, economic and social availability of alcohol are not only good for public health, they are good for public finances. Among other policies, we support:

a) alcohol prices and taxes which promote moderation

- minimum prices for all alcohol products
- lower prices for low-alcohol beverages
- alcohol taxes based upon the amount of absolute alcohol in a product
- price increases that, at minimum, keep pace with inflation.

b) controls on alcohol sales and service which safeguard public health and safely

- limits on alcohol outlet density, size, location, as well as days, hours and conditions of operation based on:
  i. consultations with local residents and businesses,
  ii. a careful analysis of potential impacts on public health and safety, and
  iii. the anticipated burden on health care and emergency services of increased access
- retail alcohol monopolies that do a good job of balancing social responsibility with consumer convenience and business concerns
- devolution of selected provincial powers enabling local governments to strengthen controls on alcohol sales and service in response to community concerns
- province-wide development of municipal alcohol policies
- mandatory server training for all those involved in the sales and service of alcohol.

c) policies which protect groups at risk

- maintenance of the current minimum legal drinking age
- graduated licensing for new drivers and zero tolerance for certain groups of drivers (i.e., motorcyclists, truckers and other transportation professionals, drivers convicted of an impaired driving offence)
- stronger restrictions on the sale of high alcohol cooking wine and other non-potable alcohol products, and tougher penalties for retailers who break the law
- the development of a provincial strategy aimed at reducing alcohol-related injuries, particularly among youth and young adults
- the development of alcohol policies with strong deterrence, education and early intervention components in schools, workplaces and community organizations
- the development of by-laws and prevention strategies at the local municipal level to control after-hours clubs, raves and bush parties in coordination with police

- the development of harm reduction policies and practices at the local/municipal level (involving both public health and treatment) to deal with chronic alcohol abusers who are homeless or living in poverty

- mandatory consumer health information on alcohol beverage containers, including information on standard servings and the risks associated with misuse

- consistent provincial guidelines regarding health-oriented alcohol consumption levels and practices

- increased unconditional financial support from the alcohol and hospitality industries to community-based organizations for more effective public education regarding alcohol misuse, and harm reduction measures such as designated driver programs.

d) regulations that promote responsible alcohol advertising and sponsorship practices

- continued pre-clearance of alcohol ads, at the final stage of production, by federal and provincial bodies with a strong public interest mandate

- more effective regulation of lifestyle alcohol advertising, promotions and sponsorships

- clear guidelines regarding industry-sponsored responsible drinking messages and public education programs, particularly those appealing to, or directed at, young people

- a cap on the total amount of alcohol advertising and improved mechanisms for monitoring compliance with existing or new regulations.

e) effective deterrence, monitoring and enforcement measures

- a stronger role for community groups in the monitoring and enforcement of federal and provincial advertising provisions, including membership in panels previewing and monitoring alcohol advertising

- the establishment of a province-wide hotline, funded through licensing fees, and widely promoted as a condition of licensing, to encourage licensees and community residents to find out more about their rights and obligations under various liquor acts and to deal with problems with licensed events or facilities

- provincial funding for a pilot project on the feasibility of introducing ignition interlock systems in Ontario to deal with repeat drinking drivers

- greater collaboration between local police, municipal health and safety staff and provincial liquor inspectors in regards to the enforcement of liquor laws, resulting in more frequent "walk-throughs" in licensed premises and events

- a more effective and open process for dealing with problem establishments/operators, and the introduction of stiff escalating fines, in addition to licence suspensions or revocations, for operators who break the law

- continued public- and private-sector support for effective deterrence and countermeasure programs such as R.I.D.E. and Operation Lookout, including money specifically allocated for the ongoing and widespread promotion of these programs

- province-wide expansion of the Last Drink Program.

2. ***Supportive Environments***

While effective, controls on alcohol availability are not enough. Alcohol consumption and related problems are influenced by a complex set of factors, including: cultural norms, access to employment opportunities, housing, social services, recreational alternatives and elective public education, health promotion and harm reduction initiatives. Policies, programs and other initiatives that build self-esteem and promote healthy living, strengthen the ability of individuals, families and communities to care for one another and help prevent and reduce alcohol-related harm. OPHA therefore supports:

a) continued federal and provincial leadership in, and support for, the prevention and reduction of alcohol related-problems

- the development of a new federal drug strategy or population-based approach, that recognizes alcohol misuse as a major public health threat, sets specific goals for the reduction of alcohol-related injury and disease in Canada, and outlines the federal government's role in this area

- continued support for the Ontario Substance Abuse Strategy, in a streamlined form, with clearer short- and long-term goals, timetables, outcome measures and adequate levels of funding

- continued federal and provincial support for the Canadian Centre on Substance Abuse and the ARF

- continued federal and provincial funding, at adequate levels, for community-based prevention, health promotion, early intervention and addictions treatment

- continued federal finding, at adequate levels, for research on alcohol policy, health promotion and addictions treatment, including money for innovative pilot projects, consistent data collection and program evaluation and dissemination

- annual progress reports and other tools that measure cost-effectiveness and promote public accountability.

b) an effective, integrated and community-based addictions treatment system

- adequate provincial funding for the development, delivery and evaluation of innovative early intervention programs

- a shift towards a treatment system that includes a full range of accessible, cost-effective services, is responsive to geographic, cultural and individual needs, and puts greater emphasis on early intervention

- funding for technologies and other tools that facilitate greater information-sharing and collaboration among addictions treatment, enforcement and prevention systems

- improved training for physicians and other front-line professionals regarding early identification and treatment of alcohol-related problems.

c) public policies that go beyond alcohol to address the broader determinants of health

- policies that reduce unemployment and economic disparity and promote equitable access to housing, transportation, education and training, and health and social services

- progressive efforts to eliminate poverty, illiteracy, homelessness and other barriers to full participation in Canadian society.

*3. **Inclusive Decision-Making***

Finally, inclusive decision-making is an important component of healthy public policy, particularly in relation to alcohol. While many enjoy alcohol and consume it responsibly, few are immune to its potentially devastating consequences. And we all have a stake in policies and decisions affecting our health and the health of our communities.

Accordingly, it is important that current and future decisions be made in an environment that welcomes public discussion, considers the opinion of a wide range of community groups and facilitates the development of policies that enhance public health and safety. OPHA therefore supports:

a) policy processes that are open, transparent and sensitive to community perspectives

- active consultation with communities affected

- direct community involvement in developing policy options

- timetables that allow communities to become effective partners in the policy process

- communication mechanisms that adequately explain the policy process and its outcomes.

b) decisions that reflect a concern with public health and safety

- a comprehensive analysis of public health and safety impacts of various policy options during the decision-making process

- a phased approach to policy implementation that makes room for adjustments based upon a systematic monitoring of intended and unintended health and safety impacts

- the use of “public interest” and “local option” provisions in legislation and policy statements for maximum flexibility in addressing local concerns.

ADVANCING HEALTHY ALCOHOL POLICY: OPHA's COMMITMENT

The Ontario Public Health Association (OPHA) commits itself to strengthening the public health voice in debates and discussions regarding alcohol policy by:

1. ***Lobbying for effective controls on the economic, physical and social availability of alcohol based upon the principles outlined in this paper.***

   Over the coming year, the OPHA Board and relevant committees will:

   - disseminate this paper to elected officials at the municipal, provincial and federal levels
   - meet with key government officials to discuss specific actions consistent with the principles herein
   - meet with key partners in the health and addictions field to gain their support for the ideas expressed in this paper and develop a common alcohol policy agenda/strategy
   - respond to opportunities for input on various alcohol policy issues at the federal and provincial levels through written submissions, presentations and other appropriate means
   - support local health units and others in their efforts to safeguard and promote health-oriented alcohol policies.

2. ***Advocating proactively for more effective health promotion, injury prevention and harm reduction measures at the municipal, provincial and federal levels.***

   Over the coming year, the OPHA will work with its members, the ARF, public health units, provincial associations and other key partners to:

   - promote the development of a strategy aimed specifically at reducing the incidence of alcohol-related injuries and deaths in Ontario
   - promote province-wide development of alcohol policies in the leisure, workplace and local government sectors, as well as other initiatives consistent with this paper.

3. ***Educating people active in community health about the potential public health and safety consequences of various alcohol-related policies and facilitating their effective involvement in the policy development process.***

   Over the coming year, the OPHA Substance Abuse Work Group will:

   - distribute this position paper to OPHA members, public health units, community health centres and other key groups
   - host a session on alcohol policy/alcohol de-regulation at the 1996 OPHA Conference
   - distribute an action pack on alcohol policy/alcohol deregulation to public health units, community health centres and others with an interest in the topic
   - promote membership involvement in the Alcohol Policy Network and APOLNET, its on-line service, through *HealthBeat* and *OPHA News*
   - co-sponsor with the Alcohol Policy Network among others, a minimum of 5 regional training, education and networking opportunities for people active in public and community health
   - seek ongoing funding for the OPHA Substance Abuse Project/Alcohol Policy Network beyond March 1997.

Conclusion

The years ahead present enormous opportunities — and challenges — for those in the public health field. Alcohol policy is an area where we can make a difference. OPHA commits itself to working with public and private sector partners, and the many committed individuals and organizations who have taken a leadership role in the field, to help build a healthier and safer Ontario for all.

BIBLIOGRAPHY

Addiction Research Foundation. *The Path of Least Resistance: The Trend to Normalize Alcohol*. Best Advice series. Toronto: Addiction Research Foundation, 1993.

Addiction Research Foundation. *Drugs in Ontario*. Toronto: Addiction Research Foundation, 1995.

Addiction Research Foundation, Canadian Centre on Substance Abuse and the Inter-Departmental Division of Drug and Alcohol Studies and the Department of Preventive Medicine and Biostatistics, "Moderate Drinking and Health, report of an International Symposium" in *Canadian Medication Association Journal*, 151(6), 1994.

Addiction Research Foundation. *Retail Alcohol Monopolies: Preserving the Public Interest*. Toronto: Addiction Research Foundation, 1993.

Adlaf, Edward, Frank J. Ivis, Reginald G. Smart and Gordon W. Walsh. *Ontario Student Drug Use Survey*, 1977-1995. Toronto: Addiction Research Foundation, 1995.

Alberta Liquor Control Board. *A New Era in Liquor Administration: The Alberta Experience*. St. Albert: Alberta Liquor Control Board, 1994.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition.* Washington, D.C.: American Psychiatric Association, 1980.

American Society of Addiction Medicine. *Principles of Addiction Medicine*. Chevy Chase, MD: American Society of Addiction Medicine, 1994.

Andrews, J. Craig. "The Effectiveness of Alcohol Warning Labels: A Review and Extension." *American Behavioral Scientist* Vol. 38, No. 4 (1995): 622-632.

Anglin, Lise (Ed.). *The Ontario Experience of Alcohol and Tobacco: New Focus on Accessibility, Violence and Mandatory Treatment. A Report of the Ontario Alcohol and Other Drugs Opinion Survey (OADOS)*, 1995.Toronto: Addiction Research Foundation, 1995.

Ashley, M. J., R. Ferrence, R. Room, S. Bondy, J. Rehm and E. Single, "Moderate drinking and health: Implications of recent evidence for clinical practice" in *Canadian Family Physician*, in press.

Bierness, D. J. et al. *Statistical Yearbook: Drinking & Driving in Ontario, 1993*. Ottawa: Drinking/Driving Countermeasures Office, Ministry of the Attorney General, 1993.

Bierness, D. J., H. M. Simpson, D. R. Mayhew and S. W. Brown. D*rinking and Driving in Ontario, Statistical Yearbook 1994 Highlights* (in press).

Butler, Barbara. *Alcohol and Drugs in the Workplace.* Markham, Ontario: Butterworths, 1993.

Canadian Centre on Substance Abuse. "Traffic Injury Research Foundation to Study Ignition Locks." *Action News* Vol. 6, No. 3 (1995): 5.

Canadian Centre on Substance Abuse (CCSA) National Working Group on Policy. "Fetal Alcohol Syndrome: An Issue of Child and Family Health. A Policy Discussion Paper," September 19, 1994.

Canadian Wine Institute. *The Impact of Privatization on the Distribution and Sale of Beverage Alcohol in Alberta*. Mississauga: Canadian Wine Institute, July 1994.

Chenier, Nancy Miller. *Substance Abuse and Public Policy*. Ottawa: Minister of Supply and Services Canada, 1995.

Conference Board of Canada. *The Economic Impact and Taxation Burden from the Distilled Spirits Industry*. Ottawa: Conference Board of Canada, 1995.

Danaher, Audrey and Carolyn Kato. *Making a Difference in Your Community: A Guide for Policy Change*. Toronto: Ontario Public Health Association, 1995.

De Pape, Denise, Marlene Leonard and Graham Pollett. "The Health Benefits of Municipal Alcohol Policy: A Role for Public Health," *PHERO* (Public Health and Epidemiology Reports Ontario), Oct. 27, 1995.

Edwards, Griffiths, et al.. *A Summary of Alcohol Policy and the Public Good. A Guide for Action.* Oxford, England: Oxford University Press and WHO Eurocare, December 1995.

English, D. R., et al. *The quantification of drug caused morbidity and mortality in Australia*. Canberra: Australian Government Publishing Service, 1995.

Erickson, Patricia G. "Harm Reduction: What It Is and Is Not." *Drug and Alcohol Review*, Vol 14 (1995): 283-285.

Giesbrecht, Norman and Paulette West. *Alcohol Policy, Consumption Patterns, and Related Harmful Effects of Drinking: Preliminary Report: Ontario 1994 Survey*. Toronto: Addiction Research Foundation, 1994.

Giesbrecht, Norman. *Proposed Privatization of Retail Alcohol Sales in Ontario: Health, Social, Economic and Safety Implications.* Toronto: Addiction Research Foundation, 1995.

Giesbrecht, Norman, Jacqueline Ferris and Paulette West. *Alcohol Policy Perspectives and Public Opinion: Trends and Patterns in Ontario*. Toronto: Addiction Research Foundation, 1993.

Health Canada. *Canada's Alcohol and Other Drugs Survey, 1994*. Ottawa: Minister of Supply and Services, 1995.

Health Canada. *Canada's Drug Strategy*. Ottawa: Minister of Supply and Services, 1992.

Holder, Harold D. *The State Monopoly as a Public Policy Approach to Consumption and Alcohol Problems: A Review of Research Evidence*, paper presented at Symposium on Alcohol Monopolies and Social/Health Issues, Toronto, October 27-30, 1992.

Homel, Ross. "Experiences of Australia in Achieving Reductions in Drinking and Driving Through Legal Measures," a paper presented at the conference Drinking and Driving - An Avoidable Evil? Strategies Against Alcohol-Related Traffic Accidents and Their Legal and Technical Implemention, Bonn, Germany, September 14-15, 1995.

James, D. *Alcohol Availability and Control: A Review of the Research Literature*. Alberta Alcohol and Drug Abuse Commission: Edmonton, Alberta, 1994.

Jazairi, Nuri T. *The Impact of Privatizing the Liquor Control Board of Ontario.* Toronto: Ontario Liquor Boards Employees' Union, September, 1994.

Lauzon, Léo-Paul and Michel Bernard. C*ontribution of the Liquor Control Board of Ontario to Public Finances, and Risks Associated with Privatization*. Montreal: University of Quebec, November 1995.

Laxer, Gordon, Duncan Green, Trevor Harrison and Dean Neu. O*ut of Control - Paying the Price for Privatizing Alberta's Liquor Control Board.* Ottawa: Canadian Centre for Policy Alternatives, September 1994.

Liquor Control Board of Ontario. *Taking on Tomorrow: LCBO Annual Report, 1993-94*. Toronto, 1994.

Liquor Licence Board of Ontario (LLBO). Y*ou and the Liquor Laws: Licensee Information.* Seminar booklet. Toronto: LLBO, 1995.

MacKinnon, David P. "Review of the Effects of the Alcohol Warning Label." In *Alcohol, Cocaine, and Accidents.* Totowa, New Jersey: Human Press (1995): 131-162.

Mayhew, Daniel R. *Prevention Measures for Young or Novice Drivers: A Safety Initiative of Private Insurance in Canada.* Paris, France: OECD, 1992.

McKeown, David. *Proposed Privatization of the Sale of Alcohol in Ontario*. Toronto: City of Toronto Public Health Department, 1996.

Mosher, James F. and Rose M. Works. *Confronting Sacramento. State Preemption, Community Control and Alcohol-Outlet Blight in Two Inner City Communities.* San Rafael, California: Marin Institute for the Prevention of Alcohol and Other Drug Problems, December, 1994.

Moskowitz, Joel. "The Primary Prevention of Alcohol Problems: A Critical Review of the Research Literature." *Journal of Studies on Alcohol*, Vol. 50, No. 1 (1989): 54 - 88.

"Municipal Alcohol Policies in Ontario: A Survey." *Municipal World*, Vol. 106, No. 1 (1996): 4 - 5.

National Centre for Research into the Prevention of Drug Abuse. *The Measurement of Alcohol Problems for Policy Project.* A first report of work in progress. Perth, Australia: Curtin University, 1995.

Ontario Ministry of Health. *Partners in Action: Ontario's Substance Abuse Strategy.* Toronto: Queen's Printer for Ontario, 1993.

Ontario Progressive Conservative Party. *Setting the Rules. A Common Sense Approach to the Modernization of the Liquor Control Board of Ontario*, backgrounder, Ontario PC.

Ontario Ministry of Health. *Ideas for Action on Alcohol.* Toronto: Queen's Printer for Ontario, 1990.

Ross, H.E., "DSM-IIIR Alcohol Abuse and Dependence and Psychiatric Comorbidity in Ontario: Results from the Mental Health Supplement to the Ontario Health Survey.," *Drug and Alcohol Dependence*, Vol. 39 (1995): 111-128.

Single, Eric. "Harm Reduction and Alcohol" in *The International Journal of Drug Policy*, Vol. 6, No. 1, 1995.

Single, Eric, Anne MacLennan and Patricia MacNeil. *Horizons 1994: Alcohol and Other Drug Use in Canada.* Ottawa: Health Canada and the Canadian Centre on Substance Abuse, 1994.

Single, Eric and Scott Worley. "Drinking in Various Settings as It Relates to Sociodemographic Variables and Level of Consumption: Findings from a National Survey in Canada, *Journal of Studies on Alcohol*, Vol. 54 (1993): 590-599.

Single, Eric, Lynda Robson, Xiaodi Xi and Jurgen Rehm. *The Costs of Substance Abuse in Canada, Highlights of a Major Study of the Health, Social and Economic Costs Associated with the Use of Alcohol, Tobacco and Illicit Drugs.* Ottawa: CCSA, 1996.

Single, Eric, et al.. *Alcohol and Drug Use: Results from the General Social Survey, 1993*. Ottawa: Health Promotion Directorate, Health Canada, 1994.

Smart, Reginald G. "Health Warning Labels for Alcoholic Beverages in Canada." *Canadian Journal of Public Health*, Vol. 81(1990): 280-284.

Smith, Ian. "Effect of Low Proscribed Blood Alcohol Levels (BALs) on Traffic Accidents Among Newly-licensed Drivers," *Medical Science Law*, Vol. 26, No. 2 (1986): 144 - 148.

Solomon, Robert M. *Alcohol and Legal Grief: A Guide to Municipal Alcohol Policy*. London, Ontario: University of Western Ontario, 1993.

Traffic Injury Research Foundation. *Dealing with DWI Offenders in Canada: Final Report, July 1994*. Ottawa: Traffic Injury Research Foundation, 1994.

Traffic Injury Research Foundation of Canada. *Alcohol Ignition Interlocks: Their Function and Role in Preventing Impaired Driving.* Ottawa: Traffic Injury Research Foundation, 1991.

Wagenaar, Alexander C. and Harold D. Holder. "Changes in Alcohol Consumption Resulting from the Elimination of Retail Wine Monopolies: Results from Five U.S. States," *Journal of Studies on Alcohol*, Vol. 56, No. 5, (Sept. 1995): 566 - 572.

West, Paulette, Norman Giesbrecht and Benita Pius. *Alcohol Policy, Consumption Patterns, Access to Alcohol, and Harmful Effects of Drinking. Preliminary Report: Based on the 1995 Ontario Alcohol and Other Drugs Opinion Survey*. Toronto: Addiction Research Foundation, 1995.

Williams, Bob. *Canadian Profile: Alcohol, Tobacco & Other Drugs 1995.* Toronto: ARF and CCSA,1995.

Wine Council of Ontario. *The Privatization Experience in North America: An Overview*. St. Catharines, Ontario: Wine Council of Ontario, October, 1994.

APPENDIX I
RESOLUTION

Whereas the unsafe consumption of alcoholic beverages has widespread health, social and economic consequences for individuals and society; and

Whereas population-based approaches aimed at controlling the availability of alcohol, complemented by harm reduction strategies aimed at vulnerable segments of the population, have proven to be effective in preventing or reducing alcohol-related harm; and

Whereas the Ontario Public Health Association has an important role to play in fostering the development and maintenance of healthy public policies aimed at preventing or reducing the risk of alcohol-related harm.

Therefore be it resolved that OPHA adopt the principles and recommendations outlined in the position paper entitled, *Promoting Healthy Communities: a position paper on alcohol policy and public health*, as the basis for its position on alcohol policies at the local, provincial and federal levels;

Be it further resolved that the OPHA Substance Abuse Work Group work in conjunction with the OPHA Executive, Board and Membership to lobby and advocate to the appropriate levels of government.

Motion to adopt resolution passed unanimously at OPHA Annual General Meeting, November 1996 in Toronto.