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PROMOTING HEALTHY COMMUNITIES
A Framework for Alcohol Policy and Public Health in Ontario

A position paper adopted by the
Ontario Public Health Association (OPHA)

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The original position paper was adopted by the OPHA membership in 1996. In 2003, the position paper was updated and the commitment to alcohol policy was reaffirmed at the Annual General Meeting.

The section entitled 'Key Assumptions', prepared by Dr. Susan Bondy, formerly of the Addiction Research Foundation, has not changed substantially from the original document.

CONTENTS

Executive Summary

Policy controls strive to achieve a balance between business and economic interests, as well as the health and safety of the population. The purpose of this report is to provide the Ontario Public Health Association (OPHA) with a foundation on which to base advocacy efforts with respect to alcohol policy interventions and to facilitate the involvement of the Public Health field in alcohol policy issues. Key assumptions, cornerstones of health-oriented alcohol policy, and potential steps OPHA and the public health field can take to inform those involved in alcohol policy development, are discussed.

Even after taking into account the economic impacts of alcohol sales, there is evidence to support the use of comprehensive controls on alcohol availability (e.g. taxes or limits on liquor store hours) to minimize harm to individuals and society. When complemented by effective deterrence and enforcement measures (e.g. roadside breath testing) and targeted injury prevention / harm reduction strategies (e.g. Low-Risk Drinking Guidelines) alcohol controls are crucial components of any population health strategy.

After considering the research literature and other available data, OPHA believes the cornerstones of healthy public policy with respect to alcohol are:

1) 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

2) Supportive environments

- federal and provincial leadership in, and support for, the prevention and reduction of alcohol related-problems
- an effective, integrated and client-focused addictions treatment system
- preventive policies that move beyond alcohol to address the broader determinants of health

3) Inclusive decision-making

- policy processes that are open, transparent and sensitive to community perspectives, as well as business and economic interests
- decisions that reflect concern with public health and safety

The OPHA commits itself to strengthening the public health voice in debates and discussions regarding alcohol policy by using the foundation outlined in this paper.

Introduction

In recent years, there has been growing recognition of the importance of public policy in improving the health and well-being of Ontario residents. The unsafe consumption of alcoholic beverages is a major health risk that can be successfully addressed through policy initiatives at local, provincial and federal levels (see Appendix A).

Alcohol is the drug of choice for many in our communities. In 1993, the *General Social Survey* (Single et al, 1994) revealed that 74.4% of the province's residents aged 15 or older, consumed alcoholic beverages [i]. In 2001, the Ontario Student Drug Use Survey (Adlaf & Paglia, 2001) reported that 65.6% of students indicated they consumed alcohol in the past year. 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., 1995; West et al., 1995). In 1996, a nationwide economic cost study estimated that alcohol-related health care, law enforcement, social welfare services and productivity losses, cost Ontarians $2.9 billion in 1992, which is approximately $270 per each Ontarian (Single et al., 1996).

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 only those who are dependent on alcohol (i.e. alcoholics) experience alcohol problems and that controls on alcohol availability unfairly restrict the freedoms of the vast majority of the population that drinks responsibly. Traffic and crime statistics show that everyone in our society, including those who do not drink, are at risk of alcohol-related problems (Edwards et al, 1995; Single et al, 1996; Pernanen & Brochu, 1997). Population based policy strategies can 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 i.e. when population consumption levels are down, alcohol related problems at all levels of drinking are down (Edwards et al., 1995). Therefore, federal or provincial policies aimed at preventing alcohol-related problems within Canada and Ontario can be expected to reduce 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 (Jernigan, 2001). 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. Education is an important part of any comprehensive prevention strategy. However, the evidence indicates that on its own education is of limited value. Personal choice is not the only factor influencing alcohol-related problems; the consumption of alcoholic beverages is related to a range of social, cultural, economic and environmental determinants (Edwards et al, 1995; Jernigan, 2001; National Forum on Health, 1996). Alcohol prices, for example, are a major determinant of consumption (Edwards et al, 1995). 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 particularly 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 et al, 1994). To promote a healthier Ontario, those responsible for the development and implementation of alcohol policies need to recognize and address these broader issues.

OPHA has long recognized the importance of policy in promoting health. It has also become increasingly aware of the wide-ranging consequences of alcohol misuse. In 1995, a work group was formed to advise the Board on alcohol policy issues. A position paper entitled, *Promoting Healthy Communities*, was developed to inform OPHA lobbying and advocacy efforts on key alcohol-related policy issues; to raise the awareness of OPHA members regarding the importance of policy in dealing with alcohol-related problems; and to facilitate public health involvement in the policy-making process.

Recently, the work group decided to revise the position paper so that it was relevant for current OPHA policy discussions. This paper, an updated version of the original document, emphasizes the role of alcohol policy at various levels, assists the examination of issues such as the proposal to reduce Blood Alcohol Content in the Criminal Code and considers the health, social and economic implications of alcohol sales and consumption. Assumptions on which this paper is based are identified, as well as the cornerstones of health-oriented alcohol policy. The paper concludes by outlining strategies that OPHA can take each year, independently or in collaboration with partners, to influence alcohol policy, so as to 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, alcohol products contain ethanol, which is a psychoactive drug classified as a central nervous system depressant. The acute physiologic effects of alcohol include: visual impairment, a decreased ability to focus and concentrate, reduced capacity to process information and make decisions, reduced reaction time and reduced fine motor control. Consumption over 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 an addictive substance. Repeated consumption 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[ii] in their lifetimes (Ross, 1995).

Many people who consume alcohol do not experience long-term physiological effects. In fact, low to moderate consumption of alcoholic beverages (spirits, beer, red wine, white wine) has demonstrated physical, psychological and social benefits such as reduced risk of coronary heart disease or ischemic stroke in certain circumstances (Ashley et al, 1997). Although there are some documented health benefits for selected groups[iii], research also demonstrates that the general population can greatly benefit from interventions that foster safe environments through alcohol policy controls.

2. Alcohol has widespread health and economic consequences for individuals and communities.

While there are social and health benefits to moderate alcohol consumption, alcohol is also a major factor in thousands of preventable injuries and premature deaths due to crashes, falls, suicides, fires, drownings and homicides[iv]. Alcohol also increases risk for diseases such as various cancers, coronary heart disease and hemorrhagic stroke, cirrhosis and unipolar major depression (Rehm et al, 2003). According to a 1999 report from the Canadian Centre on Substance Abuse (CCSA), motor vehicle collisions, alcohol liver cirrhosis and suicide accounted for the largest number of alcohol-related deaths in 1995-1996, while falls, alcohol dependence syndrome and motor vehicle collisions accounted for the largest number of alcohol-related hospitalizations. In Canada, alcohol use is second only to smoking as the greatest preventable cause of premature death (Single et al., 1996).

Drinking and driving statistics in Ontario show that among fatally injured drunk drivers, men outnumbered women ten to one and that drivers aged 19-24 have the highest rate of alcohol related fatalities (Bierness & desGroseilliers, 1997). Large numbers of young people also die as a result of alcohol use in leisure craft crashes, drownings and suicides (Jernigan, 2001).

In addition to health and mortality effects, there are 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. Data indicate that one in three Ontarians who consume alcohol experience at least one type of alcohol-related health, work, financial or interpersonal problem (West et al., 1995).

Problems that result from *others'* drinking are also common. Among Canadians aged 15 and older, a national survey determined: 19% were insulted or humiliated; 11% were pushed or shoved; 7.5% were passengers in cars driven by drinking drivers; and 0.4% (approximately 92,000 Canadians) were sexually assaulted by someone who had been drinking (Health Canada, 1995). The same study found that 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.

While the effects of alcohol use on individual and community health and safety are considerable, the 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. In total, alcohol represents $7.5 billion or 40.8% of the costs associated with all substance abuse[v], or 1.09% of Canada's Gross Domestic Product (Single et al., 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. Every year alcohol is responsible for approximately 86,000 hospitalizations and 6,700 deaths across Canada (Single et al., 1996), many of which are preventable. Identifying what constitutes higher and lower risk drinking behaviour is an area of active research. Drinking practices with evidence to support associated health or safety risks 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. For young people, who are at low risk of death from heart disease, alcohol-related deaths from injuries far outweigh the health benefits (Ashley et al., 1996). 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 (approximately three standard[vi] drinks) for men and 20g of alcohol per day (less than two drinks) for women (English et al., 1995).

b) ***The consumption of large amounts of alcohol at one time***. There is a relationship between blood alcohol level and the risk for injuries and death. As well, 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 and legal problems (West et al., 1995).

c) ***Rapid drinking*** causes a rapid increase in blood alcohol beyond an individual's tolerance level, resulting in alcohol poisoning. On average, the body metabolizes 2/3 of a standard drink per hour. Alcohol is generally processed at the rate of 15 mg/100ml of blood/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, and height. Other factors such as fatigue and mood will influence the amount of impairment at a particular BAC.

d) ***The combination of alcohol with activities, which require alertness, judgment and physical coordination or skill*** for safety reasons. Alcohol is clearly linked to work-related injuries and fatalities (CCSA, 1995). The Traffic Injury Research Foundation (TIRF) estimates that alcohol is a factor in 39% of motor vehicle fatalities, 64% of snowmobile and all-terrain vehicle fatalities and 45% of marine vehicle deaths in Canada (Bierness & desGroseilliers, 1997). More recent data reveals the problem is still significant with 30% of all motor vehicle fatalities involving a drunk driver (TIRF, 2001). Although the legal driving limit under the Criminal Code of Canada is .08 per cent or 80 mg of alcohol per 100 ml of blood, impairment can occur at levels well below this level. In Ontario, police can suspend a licence for 12 hours if a person has a BAC of .05 or more. Also in Ontario, if a driver with a graduated licence is caught driving with a BAC above 0, the licence can be suspended for one month.

e) ***The use of alcohol in combination with other drugs or medications***, as this can result in serious drug interactions and toxic effects. For example, combining alcohol with antidepressants can lead to depression of the central nervous system and impairment of motor skills (Prevention Source BC, 2000)[vii].

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***. The Low-Risk Drinking Guidelines (Centre for Addiction & Mental Health, 1997) suggest drinking less or not at all if you have health problems such as liver disease or mental illness. Young people and inexperienced drinkers who have a low tolerance for alcohol, who lack experience in managing the pharmacological effects of alcohol or have a family history of drinking problems, must also exercise caution. Due to the risk of Fetal Alcohol Spectrum Disorder (FASD)[viii], experts advise that women who are pregnant, trying to get pregnant, or breastfeeding should reduce their alcohol consumption or abstain from drinking altogether.

4. ***Comprehensive controls on alcohol availability, complemented by targeted injury prevention and harm reduction strategies, are 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. Research demonstrates

that a decrease in alcohol availability, whether due to *reduced supply* (strike, shutdown, wartime rationing, prohibition) or *reduced demand* (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; Bruun et al., 1975; Wagenaar & Holder, 1987; Osterberg & Saila, 1991; Edwards et al., 1994).

Currently, alcohol availability is governed at the provincial level through legislation such as the *Liquor Licence Act, Liquor Control Act and Regulations*, the *Alcohol Advertising Guidelines*. The federal *Code for Broadcast Alcohol Advertising* also plays a role. The actual sale and service of alcohol in Ontario is regulated by the Liquor Control Board of Ontario (LCBO) and the Alcohol and Gaming Commission of Ontario (AGCO).

Some policies on alcohol availability include:

- minimum prices on alcohol products
- taxes included in 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 in Ontario

Deterrence and enforcement initiatives are often linked with limits on alcohol availability. Police, customs officials, AGCO inspectors, retailers, bar and restaurant operators, municipal governments and ordinary citizens all play a part in reducing federal (e.g. Criminal Code) and provincial (e.g. Liquor Licence Act, Highway Traffic Act) offenses. Such offenses can include drinking and driving, liquor smuggling, withholding liquor taxes, or selling alcohol to minors.

Programs such as R.I.D.E. (Reduce Impaired Driving Everywhere); the Designated Driver and Sober Operator Programs; and Operation Lookout (a community-based program which encourages ordinary citizens to report impaired drivers) have been effective in curbing drinking and driving and reducing the number of Ontarians killed or injured in alcohol-related incidents.

Graduated licensing prohibits new drivers from drinking and driving during their first two years behind the wheel. Ignition interlock systems prevent drivers from starting their cars unless they are sober. These initiatives have been effective in reducing drinking and driving among young people and convicted drinking drivers (TIRF, 1994; Beck et al, 1999; Mann et al, 1997; Bierness & desGroseilliers, 1997).

While many health officials continue to advocate for reduced alcohol consumption, efforts are also being made to minimize the physical, financial and social harms

associated with alcohol, without necessarily requiring a reduction in alcohol use. Harm reduction initiatives are using education in combination with a variety of policy and environmental controls to:

- *reduce the number of heavy drinking occasions*[ix] among specific populations such as high school and university students, and within communities where drinking has become a way to socialize and pass the time rather than engaging in other forms of entertainment (leisure activities, drop-in centres, sports clinics)
- *reduce alcohol-related harm and associated liability* (e.g. 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* (e.g. server intervention training which teaches servers to recognize the signs of impairment and avoid over service; 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* (e.g. 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 falls; rented buses to discourage teens who attend bush parties from drinking and driving; designated driver or driver/escort programs to minimize the risk of alcohol-related crashes)
- *reduce the intake of ethanol and non-beverage alcohol* (e.g. limits on alcohol content of beer, wine and liquor; promotion of low alcohol and de-alcoholized beverages; controls on cooking wines)

Harm reduction strategies are supported by a body of research that suggests that heavy drinking occasions are strong predictors of alcohol-related social problems. (Single et al., 1994). The research indicates that those who experience problems (i.e. social or moderate drinkers who occasionally drink too much) tend to have lower physical tolerance and fewer social supports and coping skills than their heavier drinking counterparts. Harm reduction approaches 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 (Single, 1995).

Control policies, even when they are appropriately targeted and strategically enforced, are more effective when a significant proportion of the population accepts them. In 1995 the Addiction Research Foundation[x] determined that over 70% of Ontarians supported current alcohol tax levels; opposed alcohol sales in corner stores; and favored warning labels on alcoholic beverages, increased efforts to prevent intoxicated customers from being served and government measures to educate the public about alcohol (West et al, 1995). Ongoing monitoring of public opinion on alcohol issues has continued to demonstrate general public approval of systemic alcohol controls to prevent the problems associated with alcohol consumption (Anglin et al, 2001, 2003). These findings show that Ontarians 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

OPHA believes that the cornerstones of healthy public policy with respect to alcohol are threefold:

1. Effective Controls On Alcohol

Controls on the physical, economic and social availability of alcohol are good for public health. In addition to these benefits to the public health, effective alcohol policies can result in important cost savings to enforcement, health care and industry. Policies worthy of support include:

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 safety*
- provincial limits on alcohol outlet density, size, location, as well as days, hours and conditions of operation based on: i) consultations with local residents, businesses and governments about health, social and economic impacts, 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 balance social responsibility with consumer convenience and business interests
- 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 in Ontario

c) Policies at each government level that protect all Ontarians

Local
- the development of alcohol policies with strong deterrence, education and early intervention components in schools, workplaces and community organizations
- the development of policies to control after-hours clubs, raves and bush parties in coordination with police, with emphasis on by-laws and prevention strategies at the local/municipal level
- the development of harm reduction policies and practices at the local/municipal level (involving both public health and treatment) to deal with chronic alcohol abuse among the homeless or those living in poverty

Provincial

- maintenance of the current minimum legal drinking age
- graduated licensing for new drivers and zero tolerance for certain groups of drivers (eg., 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
- consistent provincial guidelines regarding health-oriented alcohol consumption levels and practices (e.g., Low-Risk Drinking Guidelines, ARF, 1997)

Federal

- mandatory consumer health information on alcohol beverage containers, including information on standard servings and the risks associated with misuse
- requirements for 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
- reduction of the Blood Alcohol limit for driving specified in the Criminal Code of Canada to 50 mg%
- strong and continued financial support for the renewed Canada's Drug Strategy announced in 2003, as well as links to the proposed national injury prevention strategy.

d) *Federal and Provincial 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 health and safety organizations (e.g., public health units and the Ontario Public Health Association) 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 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[xi]
- provincial funding for research and pilot projects related to drinking and driving interventions and other alcohol-related problems
- greater collaboration among 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, which includes stiff escalating fines, and licence suspensions or revocations for operators who break the law
- continued public- and private-sector support for effective deterrence and counter-measure programs such as R.I.D.E. and Operation Lookout, including money specifically allocated for the ongoing and widespread promotion of these programs
- support for community involvement in initiatives to reduce over-service of alcohol and alcohol-related violence, e.g., the CAMH Safer Bars project.

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 effective public education, health promotion and harm reduction initiatives. Policies, programs and other initiatives should strive to build self-esteem; 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

- continued efforts by the federal government to provide leadership in addressing alcohol policy through population based strategies that recognize alcohol misuse as a major public health threat; to set specific goals for the reduction of alcohol-related injury and disease in Canada; and to outline the federal government's role in this area, e.g., financial support for the renewed Canada's Drug Strategy
- support for an Ontario substance abuse strategy to specify short and long-term goals, timetables, outcome measures and support though adequate funding
- continued federal and provincial support for the Canadian Centre on Substance Abuse and the Centre for Addiction and Mental Health

- continued federal and provincial funding, at adequate levels, for community-based prevention, health promotion, early intervention and addictions treatment such as funding for campaigns to promote low-risk drinking
- continued federal and provincial funding, at adequate levels, for research on alcohol policy, health promotion and addictions treatment, including money for innovative pilot projects, monitoring, program evaluation and dissemination
- annual progress reports from federal, provincial and local governments that measure cost-effectiveness and promote public accountability

b) *An effective, integrated and client-centered 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 at all levels of government that reduce unemployment and economic disparity and promote equitable access to housing, transportation, education, 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

Inclusive decision-making is an important component of healthy public policy, particularly in relation to alcohol, which is the most commonly used drug in Ontario. Policy discussions should acknowledge the unique health and social consequences of alcohol consumption, as well as the economic impact in the province. In 2001 the LCBO showed net sales of $2.7 billion, with over $850 million being paid to the government through dividends, and over $1.8 billion through taxes and licenses. Such substantial revenues are a significant piece of the provincial government's income. There is the concomitant responsibility to mitigate alcohol related harms through the provision of adequate funds for prevention.

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. This will be done by bringing scientific evidence and community perspectives to those involved in alcohol policy development at the local, provincial and federal levels.

Since the first OPHA position paper on alcohol policy in 1991, there have been significant changes in the landscape. The business of selling alcohol has continued to provide significant revenues for the province and accessibility has increased even though the public continues to indicate in public opinion survey research that no increase in availability is needed.

The following cornerstones of healthy public policy with respect to alcohol will guide the work of OPHA:

1. ***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

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

3. ***Inclusive decision-making***
   - policy processes that are open, transparent and sensitive to community perspectives, as well as business and economic interests
   - decisions that reflect concern with public health and safety

The OPHA commits itself to strengthening the public health voice in debates and discussions regarding alcohol policy by using the foundation outlined in this paper.

Through its membership and workgroups OPHA will engage in a process that scans the environment, identifies what is working well, and draws attention to measures which have the potential to prevent or mitigate harm.

By identifying priorities, OPHA and the public health field will continue to support the cornerstones of healthy public policy with respect to alcohol through lobbying efforts,

advocacy and education of key partners, government officials and others involved in community health.

The years ahead present enormous opportunities – and challenges – for those in public and community health. 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 that have taken a leadership role in the field. Together we can build a healthier and safer Ontario for everyone.

Appendix A: Alcohol Policy 101

The Alcohol Policy Network (APN)[*] developed a resource entitled *Alcohol Policy 101* to provide those interested in alcohol policy with one-stop access to basic resources in Ontario, Canada and abroad. Key players in the policy process and useful reference documents for those wishing to do further research are identified. More detailed information is available from: http://www.apolnet.org/

What is alcohol policy?
Alcohol policy is *"what governments and institutions do or don't do about alcohol and the conditions and problems associated with its misuse."* Alcohol policy is the responsibility of public institutions such as parliament, cabinet and government ministries and agencies, as well as places where people live, work, play and study. It includes inaction and the perpetuation of the status quo. Finally, alcohol policy recognizes that alcohol-related problems arise out of a complex relationship among the individual, the drug (alcohol), and the broader cultural, political, social, economic and physical environment.

To be effective, alcohol policy must include not only measures to educate the public about the consequences of alcohol misuse, or interventions that focus primarily on treating or punishing those who may be putting at risk their own or others' health and safety, but also regulatory and other environmental supports that promote the health of the population as a whole. Alcohol taxes; limits on days, hours, places and conditions of alcohol sale and service; drinking and driving countermeasures; minimum legal drinking age; restrictions on alcohol advertising and promotion; and efforts to improve access to employment, health care, education, housing, recreation and political decision-making have all been shown to reduce alcohol-related problems. When combined into a "policy mix", alcohol policy measures such as these are most likely to be effective.

[*] The Alcohol Policy Network (APN) is a network of individuals and organizations across Ontario concerned about the impact of alcohol on communities. It is a project of the Ontario Public Health Association, an independent charitable organization founded in 1949 to strengthen the impact of people active in public and community health throughout Ontario.

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

[ii] As defined by the American Psychiatric Association in *Diagnostic and Statistical Manual of Mental Disorders (1980).* The DSM-IV is the most recent update, published in 1994.

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

[iv] Please see http://secure.cihi.ca/cihiweb/en/downloads/bl_otrjul2002_e.pdf for recent alcohol related trauma statistics.

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

[vi] A standard drink contains 13.6 grams of alcohol; the equivalent of 12 oz of beer (5% alcohol/volume), 5 oz of wine (12% alcohol) or 1.5 oz of spirits (40% alcohol). A team of medical and social researchers affiliated with the University of Toronto and the Centre for Addiction and Mental Health developed province wide Low-Risk Drinking Guidelines based on these standards because of inconsistencies amongst jurisdictions and within communities.

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

[viii] Information and recent research about FAE/FAS/FASD can be obtained from the Alcohol Related Birth Injury Resource Site [http://www.arbi.org/research/research.html] and from MotherRisk at the Hospital for Sick Children in Toronto.

[ix] The Centre for Addiction and Mental Health defines heavy or binge drinking as 5 or more drinks on the same occasion (e.g., Adlaf & Paglia, 2001).

[x] The Centre for Addiction and Mental Health was created in 1998 through the merger of the Clarke Institute of Psychiatry, the Addiction Research Foundation, the Queen Street Mental Health Centre and the Donwood Institute.

[xi] Licensees or residents can call the Alcohol and Gaming Commission of Ontario at 1(800)522-2876 for questions or concerns related to the liquor licence hearing process.