NATIONAL ALCOHOL POLICY

For Public Consultation

OCTOBER 2016

This document is being launched for public consultation on the 6th October 2016.

The public consultation shall be open for six weeks until the 17th November 2016.

Any suggestions and feedback can be sent to the email address;

alcoholpolicy.mfss@gov.mt

This document can be downloaded from the Ministry for Family and Social Solidarity website www.mfss.gov.mt.

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Minister's forward,

The Maltese population is very concerned about the number of road injuries and fatalities on our roads as a result of drunk driving.

It is very encouraging for me as a minister for Family and Social Solidarity therefore responsible for the welfare services in Malta to see this year's ESPAD results. As these results show that the consumption of alcohol, illicit drugs and smoking are on the decline within the 15/16 years cohort. Educational campaigns in media and in schools are starting to give results.

Yet I am concerned that alcohol consumption although illegal to consume or purchase under the age of 17, it seems that it is easily available to purchase and consume in public places.

But we don't have to allude ourselves and think that we solved the addictions within our youths. While these reductions in the student population are very encouraging further efforts may be directed towards young people between the ages of 18 to 24.

In the latest General Population Survey (2014) just over three quarters (75.9%) of the respondents, equivalent to some 209,000 individuals indicated that they have consumed alcohol at least once in their lifetime. The results reported in this survey, may to some extent be compared with the findings registered in the past ESPAD Surveys in which substance use prevalence was measured every 4 years amongst 15-16 year old students within all secondary schools in Malta since 1995. Students, who participated in the 2007 and 2011 ESPAD surveys, would now be aged between 18-24 years and would therefore fall into this age cohort of this General Population Study. When looking at this age cohort, this survey reported lifetime use of alcohol at 87.2%

In the coming weeks and months I like to see our National Agency be more proactive and look within to see if what we have been doing in the last 3 decades is still relevant for today. I like to see our Agency in collaboration with the University of Malta invest in research and innovative programmes, practices and standards to be in a better position to tackle this habit within our society.

Hon Michael Farrugia

Minister for the Family and Social Solidarity

Purpose of National Alcohol Policy

When used irresponsibly, alcohol negatively impacts the individual, families and the entire society. Within this Draft National Alcohol Policy, a multifaceted multi-sectoral approach is identified as necessary in order to minimise harm. Multi-sectoral collaboration between legislators, the police, health and social care providers, and the alcohol and tourist industry, is required to ensure the effective implementation of this policy. The areas addressed in the 24 actions recognise the need to develop, implement and evaluate practices, measures and programmes that are socially and culturally appropriate.

The National Alcohol Policy identifies general measures addressed to the entire population as well as measures targeting young people. No single measure will be effective if taken in isolation. Through this policy, the Ministry responsible for social policy, through the National Coordinating Unit for Drugs and Alcohol, aims to ensure that there is consolidation of initiatives and coordination between the various Ministries, voluntary organisations and other bodies who are required to commit themselves to preventing alcohol use among those aged under seventeen and reducing the harmful use of alcohol among adults that includes drink driving. The policy per se is thus an attempt to reduce and prevent the potential harm and negative consequences of alcohol on the individual, the family and society at large.

1. Background

1.1 International Context

The European Region of the World Health Organisation has the highest per capita alcohol consumption in the world. Alcohol consumption has been identified as a major risk factor for the burden of disease and for premature mortality globally, and as a substantial problem in the WHO European Region. A recent report indicated that in the EU, 1 in every 7 deaths in men and 1 in every 13 deaths in women in the group aged 15–64 years was due to alcohol consumption[1].

On average, adult per capita alcohol consumption decreased overall in the European region by 12.4% in the period between 1990 and 2010 with the largest decline in consumption observed in southern Europe (-28.2%), followed by the central-western and western country group (-12.5%). In the Nordic countries, consumption showed some decline and then increased, with 2010 levels of consumption slightly above the 1990 level (+1.6%). A similar trend to that of the Nordic countries, with a more pronounced upswing in consumption, is observed in the central-eastern and eastern country group (+7.3%).

There are huge variations among countries, with a European average of 9.24 litres of pure alcohol consumed per year (WHO Europe 2010). Alcohol consumption at harmful levels is estimated to be responsible for approximately 195,000 deaths each year in the EU as a result of cancer, liver cirrhosis, road traffic and other accidents, homicides, suicides and neuropsychiatric conditions (European Commission 2007). In addition, alcohol also has a serious impact on those persons living in close proximity to the drinker as it is responsible for around 50% of all violent crime to the person, about 40% of all domestic violence, 2000 homicides, 10,000 deaths of people other than the drink-driver and some 17% of cases of child abuse and neglect. Alcohol

[1] http://www.euro.who.int/__data/assets/pdf_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf

related problems are the result of a complex interplay between the individual use of alcoholic beverages and the surrounding cultural, economic, physical environment, and political and social contexts.[2]

1.2 Maltese Context

The consumption of alcohol has long been a part of traditional culture in Malta. The *Strategy for the Prevention and Control of Non-communicable Diseases in Malta* was launched in 2010 and is now being updated, clearly identifies alcohol as an important risk factor linked to chronic diseases such as heart and liver disease as well as cancers.

1.2.1 Alcohol use in the youth population

Data from ESPAD shows how since 1999, the trend has been a downward decline in most patterns of alcohol use among young people aged 15 and 16. Lifetime use of alcohol (40+ times) declined from 36% to 20% in 2015. Alcohol use in the last 12 months (20+ times) declined from 51% in 1999 to 19% in 2015, while alcohol use in the last 30 days declined from 30% to 11%.

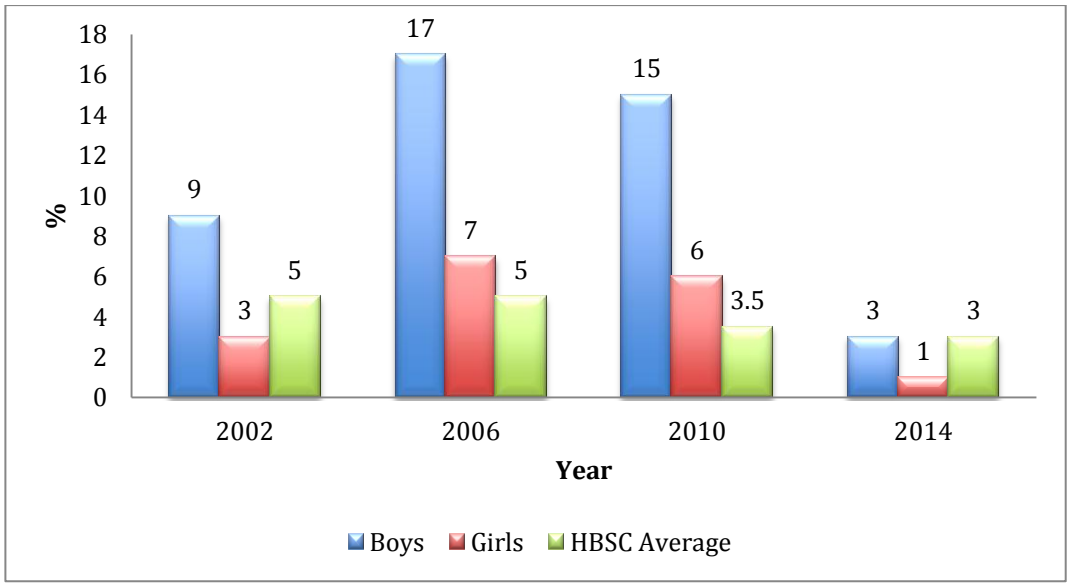
Heavy episodic drinking in the last month (drinking more than 5 drinks in a row) declined from 57% in 2007 to 47% in 2015. Lifetime drunkenness also registered a decline with 45% reported having been drunk in 2007 and 38% in 2015. Drunkenness in the last 30 days also declined from 19% in 2007 to 15% in 2016. Those reporting being drunk at 13 years or younger declined from 14% in 1999 to 8% in 2015. While these reductions on use in the student population are very encouraging further efforts may be directed towards young people in an effort to prevent alcohol use in the first place in those seventeen and under.

[2] http://www.euro.who.int/__data/assets/pdf_file/0017/190430/Status-Report-on-Alcohol-and-Health-in-35-European-Countries.pdf

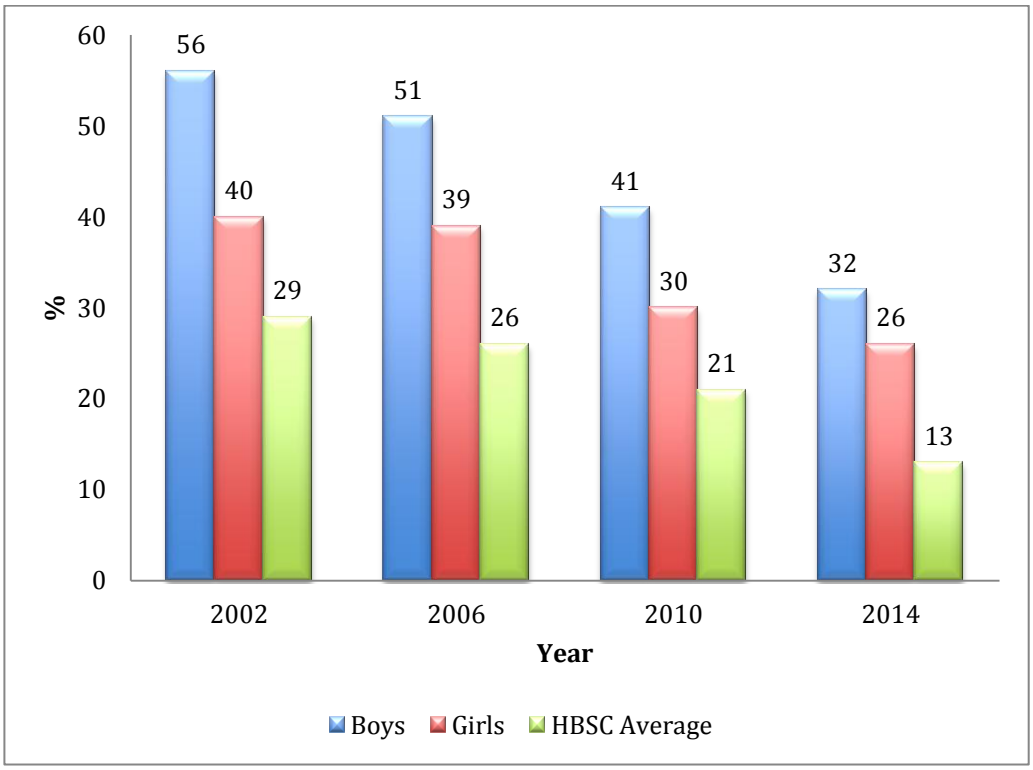
Trends: Alcohol Use
Percentage of students by year

	1999	2003	2007	2011	2015	Change (2011-2015)
Lifetime use of alcohol 40+ times	36	33	33	30	20	-10
Alcohol use 20+ times: last 12 months	51	32	32	28	19	-9
Alcohol use 10+ times: last 30 days	20	20	20	18	11	-8
Heavy episodic drinking: last 30 days	/	/	57	56	47	-8
Heavy episodic drinking 3+ times: last 30 days	/	/	32	31	22	-8
Lifetime drunkenness	/	/	45	44	38	-6
Drunkenness: last 12 months	/	/	38	37	31	-6
Drunkenness: last 30 days	/	/	19	20	15	-5
Drunk at 13 or younger	14	13	10	11	8	-3

The Health Behaviour in School aged Children (HBSC) survey sponsored by WHO and conducted in Malta along with a number of other countries, looks at drinking habits in children aged 11, 13 and 15 years. The trend for this survey complement those identified in the ESPAD survey with declines for most patterns of use. A decline is evident from 2002 to 2014 in 11 year olds who drink alcohol at least once a week.



There has also been a decline among 13 and 15 year olds reporting drinking alcohol at least once a week.



In 2002 25% of boys and 18% of girls aged 15 reported having been drunk on two or more occasions. This has increased slightly in 2014 with 26% of boys and 28% of girls reporting such behaviour. This data identifies this age group as being particularly at risk and consequently amenable to policy actions to reduce alcohol abuse on their behalf.

1.2.2 Alcohol use in the general population

In the latest General Population Survey (2014) conducted in Malta and Gozo, just over three quarters (75.9%) of the respondents, equivalent to some 209,000 individuals indicated that they have consumed alcohol at least once in their lifetime; this corresponds to similar data which was presented in the 2001 General Population Surveys which had also reported lifetime use of 75.6%. Seven in every ten respondents (70.6% or 194,000) indicated that they have consumed alcohol in the last

12 months which shows a slight increase of 1.3% or some 4,000 over data reported in 2001 (69.3%). Almost three in every five respondents (58.8% or 162,000) reported to have drunk alcohol in the last 30 days.

When compared to the figures registered in 2001 (56.2%) the percentage of persons having consumed alcohol in the last 30 days shows the greatest increase of 2.6% or some 7,000. Of the respondents who have drunk alcohol in the last month, 12% indicated that they do so daily or almost daily. This shows a decrease of 1.1% over 2001 which had reported such consumption at 13.1%. This means that 6.8% or some 19,000 of the total population of 274,820 consume alcohol on a daily / almost daily basis.

The results reported in this survey, may to some extent be compared with the findings registered in the past ESPAD Surveys in which substance use prevalence was measured every 4 years amongst 15-16 year old students within all secondary schools in Malta since 1995. Students who participated in the 2007 and 2011 ESPAD surveys, would now be aged between 18-24 years and would therefore fall into this age cohort of this General Population Study. When looking at this age cohort, this survey reported lifetime use of alcohol at 87.2% which shows a similar percentage compared to the 92% reported in 2007 and the 90% reported in 2011 ESPAD surveys. Use of alcohol in the last 12 months was reported by 85% of those aged between 18-24 years whilst similar percentages were reported in ESPAD in 2007 (87%) and 2011 (86%). When comparing the use of alcohol in the last 30 days, such consumption was reported to be 73% in the 2007 ESPAD and 75.9% in this survey.

When analysing the findings by the gender of the respondents, it can be concluded that respondents who are current consumers of alcohol are mainly males. In fact, results show that of the current alcohol consumers, 59% are males and 41% are females. Again, the figures presented here show similar trends which were reported in the 2001 survey which stood at 61% for male consumers while the remaining 39% were females. Moreover, it is also important to note that the life time prevalence of alcohol consumption is the highest in the Northern and Southern Harbour regions but as far as current use of alcohol is concerned this is evenly spread throughout the island as was the case for the 2001 estimates. It results that 17.2 is the mean age for

first time consumption of alcohol among respondents. Here again, similar trends were reported in 2001 with the mean age reported that of 17.4 years. Almost 61% of the respondents (168,000) indicated that they drank alcohol for the first time when they were between 16 and 19 years of age.

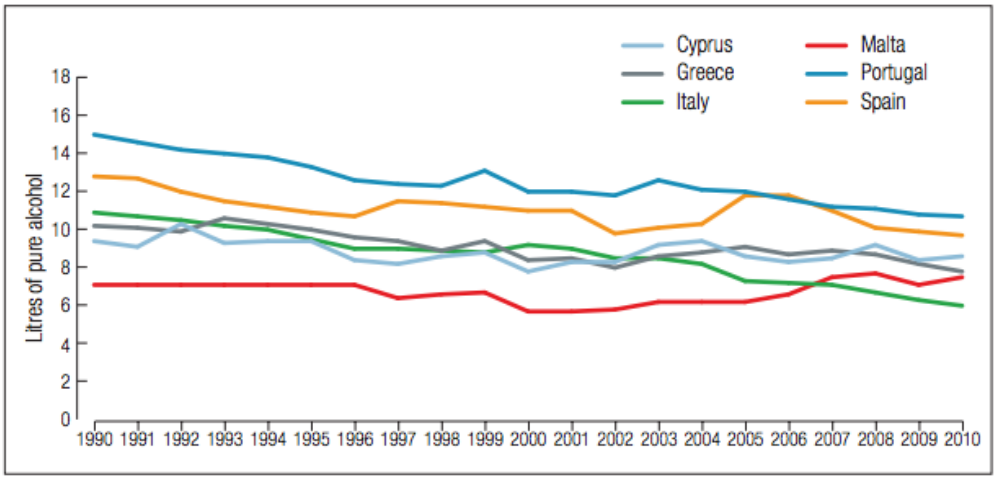
Lifetime, last year and last month consumption of alcohol is the highest among respondents aged between 18 and 24 years of age, and this decreases with increasing age brackets. Last month consumption of alcohol amongst the 18 and 24 year old cohort stood at 76% (some 30,000 of the 40,000 age cohort) while that of 60 to 65 year olds stood at 51% (some 18,000 of the 36,00 that makes up this age cohort), meaning a difference of 25%. Moreover, it is pertinent to note that while seven in every ten 60 to 65 year old have ever drank alcohol, a high nine out of every ten 18 to 24 year olds indicated that they have consumed alcohol. Similar trends were also reported in 2001 with 90% of 18-24 year olds reporting having ever used alcohol whilst about 67.5% of 60 to 65 year olds had reported lifetime drinking. A high 77.5% of ever drinkers of alcohol are also current drinkers, an increase of 2.5% over 2001(75%).

Although the highest percentages of these are aged between 18 and 24 years of age, percentages do not decrease drastically among the older age brackets. Continuation of alcohol consumption is more present among males than females. While 85%, of the male respondents who have ever consumed alcohol, are current consumers, this is the case for 69% of the female respondents. Almost 70% of current drinkers drink alcohol once a week or less often. Results also show that males tend to be more frequent consumers of alcohol. In fact, while 37% of the males who have ever consumed alcohol, indicated that they drink alcohol daily, almost daily or several times a week, the same response was given by a lower percentage of the female (19%) ever consumers of alcohol.

The per capita alcohol consumption for 2010 for Malta was estimated to be 7.9 litres of pure alcohol as shown in the figure below and for the years up to latest figures available that of 2014 it has not changed much, 6.9, 7.7, 8.6 and 8.5 litres respectively. In effect, whereas most countries in the South have seen a reduction in per capita consumption over the years, Malta's consumption has remained the same

and not contributed to the overall reduction seen in the southern countries especially that of Italy. Hence, this policy is an attempt to reduce per capita consumption with the aim of reducing the numbers that may in turn resort to the harmful use of alcohol and its consequences.

Fig. 1.7. Adult per capita consumption of recorded alcohol by country from 1990 to 2010 in southern Europe



Alcohol Consumption per capita (Source: Status Report on Alcohol and Health in 35 European Countries)

1.2.3 Drink Driving

Drink driving is the indisputable cause of a considerable number of deaths, temporary and permanent disability, hospitalisation and other negative consequences on Maltese roads. Measures against drink driving are a cornerstone of any alcohol policy. Generally speaking, the objective of policy is to reduce the incidence of drink driving in order to reduce the rate of fatal and non-fatal accidents. In order to achieve this objective, the police must be given the authority to carry out *frequent, random* breathalyser testing, while the amount of alcohol permissible in the driver's blood must be lowered in line with current scientific evidence. Thirdly, the punishment meted out to those who transgress has an effective deterrent effect while ensuring that the driving-licence is restored only when efforts have been made to educate or treat errant drivers.

With regard to drink driving on Maltese roads, the number of Court proceedings for drink driving and the number of breathalyser tests carried out are collected by the

Malta Police Force. The law regarding breathalyser tests was introduced on 25th May 1998. Where a breathalyser test results positive and the individual refuses to undergo the test or the test is incomplete, Court action is taken. The difference between the number of breathalyser tests carried out and the number of persons arraigned is the number of persons that result negative.

BREATHILYZER 2009-2016 (to date)				
Year	Positive tests/arraigned	Guilty	Not Guilty	Sub Judice
2009	81	43	38	0
2010	42	36	6	0
2011	140	117	24	0
2012	173	85	86	2
2013	180	108	72	0
2014	211	146	54	11
2015	183	104	51	28
2016	139	63	18	58

Source: Malta Police Force

2. Policy Aims

This policy contends that a comprehensive alcohol policy can better address the reality of alcohol use and its associated problems by reflecting a commitment to the health, safety and welfare of Maltese society. Three main policy aims have been identified in this regard;

1. Addressing underage drinking in Malta. This policy action requires a zero tolerance approach.

2. Addressing excessive drinking in the general population. This policy aims to reduce the detrimental effects of alcohol use by steering the consumption of alcoholic beverages and drinking habits in a more healthy direction so that moderate and responsible drinking becomes personally and socially acceptable and favoured in the Maltese culture.

3. Addressing the negative effect of drink driving.

4. Policy Actions

4.1 Policy actions to address underage drinking in Malta

It is well understood and established that averting drinking in adolescence leads to less problems when older related to drinking habits. Moreover, alcohol per se may stunt brain development in this age cohort with the resulting consequences. Hence the following actions are to be undertaken to reduce the prevalence of alcohol consumption in those under the age of seventeen.

Action 1: Enforce legislation so as to tangibly limit the sale, purchase, consumption and supply of alcoholic products to persons under the age of 17 years.

Action 2: Require all sellers of alcoholic products to place a clear and prominent indicator about the prohibition of alcohol sales to minors, and in case of doubt request that each alcohol purchaser provides appropriate evidence of having reached full legal age.

Action 3: Harsher penalties against sellers and distributors who are found guilty of contravening the law.

Action 4: Within supermarkets and other general retail stores, alcoholic products should be placed in a section clearly separated from the sale of other products.

Action 5: Introduce media literacy programmes to create a critical culture amongst recipients of media messages about alcohol.

Action 6: The distribution of free alcoholic products (including brand related paraphernalia such as t-shirts, ashtrays, glasses, caps, etc.) should be prohibited to minors.

Action 7: As a Corporate Social Responsibility Measure the alcohol manufacturers and retailers will setup a fund for the Ministry for Family and Social Solidarity or its appointed agency responsible for the alcohol rehabilitation to use for education campaigns.

Action 8: Provide broad access to effective and comprehensive education geared towards primary, secondary, sixth form, vocational educational levels as well as parents on the use of alcohol, through evidence-based health promotion principles seeking to involve all educational establishments, youth organisations and professional bodies.

Action 9: Provide the relevant selective and indicative prevention measures to support those under the age of seventeen who have resorted to the use of alcohol.

Indicators pertaining to the success or not of the actions above will be put in place and monitored on a yearly basis by the National Co-ordinating Unit based in the Ministry for the Family and Social Solidarity. The main outcome to be achieved by introducing the nine actions above is that of a reduction in the use of alcohol by those aged under seventeen years of age which may be gauged by recording the prevalence of such in this age cohort.

4.2 Policy actions to address harmful alcohol use in the general population

With regard to those aged eighteen or above, it is also well established that of those who drink, at least one in five, will do so harmfully. This results in dependency or Alcohol Use Disorder and the accompanying consequences. Hence, if one is to attempt to reduce the occurrence of such, tried and tested actions that reduce access and availability need to be put in place as outlined in the actions below.

Action 10: Monitor and control the impact of pricing on the harm caused by alcohol.

Action 11: Introduce server training as compulsory in licensed outlets.

Action 12: Increase server liability (where those providing alcohol may be held responsible for consequences of inappropriate practices).

Action 13: Introduce stronger physical environment criteria in order to;
a) Reduce overcrowding and inconvenient access,
b) Provide good ventilation and hygiene and
c) Promote an expectation of normative behaviour.

Action 14: Enforce good practices such as;
(a) Requesting proof of age
(b) Providing adequate management of violence and other non-acceptable behaviour and
(c) Refraining from serving the intoxicated.

Action 15: Develop mechanisms to restrict the excessive consumption of alcohol at events where the likelihood of violence may escalate.

Action 16: Provide interventions for alcohol - abusing offenders and their families.

Action 17: Amend the Occupational Health and Safety Authority Act (Chapter 424, ACT XXVIII of 2000) to address alcohol misuse at the work place and make mandatory the adoption of alcohol abuse policies at the work place.

These actions will be monitored by established indicators that assess the drinking habits of the general population which to date have been used in the conduct of the general population survey.

4.3 Actions to reduce negative effects of drink driving

The now all too common outcome of drink-driving, that of a fatal accident, need to be tackled to reduce this unnecessary loss of life.

Action 18: Amend legislation so as to enable law enforcement officers to carry out random breath testing as well as behavioural road side tests.

Action 19: Introduce a BAC limit of 0.2 g/l for: learner drivers, novice drivers having held a driving licence for less than two years, motorcyclists, drivers of lorries weighing more than 3.5 tonnes, or carrying dangerous goods.

Action 20: Introduce a BAC of 0.0 g/l for drivers carrying passengers against payment such as Minibuses, Buses, Taxis and Chauffer Driven Cars.

Action 21: Amend legislation to reduce BAC from 0.8g/l to 0.5g/l for all other drivers.

Action 22: Amend legislation to increase stricter penalties for drink-driving offences.

Action 23: Introduce mandatory assessment, education and treatment for drink driving offenders.

Action 24: Promote designated driver campaigns.

Once again the actions above will be monitored on a yearly basis and will include the number of breathalyser tests conducted and the number exceeding the stipulated limits as well as the number of fatal and non-fatal accidents as a result of drink driving.

4. Monitoring, Co-ordination and Implementation of the National Alcohol Policy

In line with the objectives outlined above, Government shall attribute high priority towards strengthening the co-ordination structure so as to ensure the effective involvement of all players coming from the various ministries, advisory bodies, voluntary and private organisations and other relevant bodies.

Monitoring of the policy using key indicators will take place on a yearly whereas an evaluation of the Policy will follow after a period of five years in which it will be possible to assess the effectiveness of the implementation of actions described in this policy.

This section identifies the relevant institutions and outlines the roles and responsibilities of the different bodies that make up the institutional framework and determine and contribute to the realisation of this policy.

Body responsible for Policy Development:

- The National Addictions Advisory Board, shall though the Director responsible for policy development within the Ministry responsible for social policy, submit policy proposals for the consideration of the Minister responsible for social policy. As and where necessary, these submissions will eventually be forwarded for the consideration of the Cabinet Committee for Social Affairs prior to their being discussed by Cabinet with a view to being adopted as national policy.

Body responsible for the Policy Implementation:

- The National Co-ordinating unit for Drugs and Alcohol within the ministry responsible for social policy shall bring together all stakeholders so as to facilitate the effective implementation of the National Alcohol Policy. Such a Unit will:

(a) implement and monitor the provisions of the National Alcohol Policy;
(b) promote co-ordination and ensure effective co-operation among stakeholders, namely relevant Ministries and Departments, voluntary and private organisations with a view to achieve and enhance the realisation of the National Alcohol Policy;
(c) collect, analyse and distribute data on alcohol misuse/abuse in co-ordination with all the ministries, departments and entities involved;

(d) evaluate the impact of alcohol misuse/abuse; and

(e) ensure that alcohol policy measures are realised at all levels.

5. Conclusion.

Government acknowledges the possibility that changing trends and circumstances may necessitate amendments to this policy. In this regard any recommendations are to be forwarded for due consideration to the Ministry responsible for the Family and Social Solidarity on email address alcoholpolicy.mfss@gov.mt, Government's lead Ministry in this field. Government will officially review this policy after a nominal period of five years.