International Journal of Drug Policy 45 (2017) 25–32

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

Experience of harm from others' drinking and support for stricter alcohol policies: Analysis of the Australian National Drug Strategy Household Survey

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ARTICLE INFO

Article history:
Received 20 December 2016
Received in revised form 23 February 2017
Accepted 2 May 2017

Keywords:
Alcohol
Harm to others
Policy
Public opinion
Attitudes

ABSTRACT

Background: Previous research indicates that those who have experienced alcohol-related harm from others are more likely to support stricter alcohol control policies. This study investigates the association between types of harm experienced because of others' drinking and support for stricter alcohol control policies.

Methods: Data from 20,570 Australians aged 18 and over who completed the 2013 National Drug Strategy Household Survey was used. Questions about experience of alcohol-related harm from others – being put in fear and abuse (verbal or physical) – were asked. Support for stricter alcohol control policies was quantified by a mean policy support score across 18 alcohol policy questions.

Results: Twenty seven percent of respondents reported harm from someone's drinking. Respondents who were put in fear had a higher level of support for stricter alcohol control policies than respondents who were not harmed ($p < 0.001$), regardless of whether they were abused or not. Conversely, respondents who experienced abuse but were not put in fear did not significantly differ in their support for stricter policies from those who experienced no harm.

Conclusion: It is the apprehension of harm (i.e. having been put in fear), and not the experience of harm itself (i.e. abuse), which is related to people's support for stricter alcohol policies. These findings suggest that perceiving others' intoxication as dangerous to oneself may motivate support for stricter alcohol policies.

Introduction

Alcohol is a significant contributor to harm in our societies (Gao, Ogeil, & Lloyd, 2014; WHO, 2014). However, alcohol's ubiquity in societies like Australia ensures its harmful effects are often under-acknowledged by the public and in the political arena (Rehm, Lachenmeier, & Room, 2014). In addition to causing harm to the drinker, harmful use of alcohol impacts the health and economic status of those around the drinker and in the wider society (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011; Laslett et al., 2010; Rehm et al., 2009). The Australian alcohol policy landscape is complex and varied (Howard, Gordon, & Jones, 2014) and, despite evidence of a recent decline in per-capita alcohol consumption (Livingston & Dietze, 2016), there remains a need to improve alcohol control policies in Australia to reduce alcohol-related harms (Howard et al., 2014; Lensvelt et al., 2015).

From a public health perspective, alcohol policies aim to reduce the harmful effects of alcohol to individuals and to societies (Babor et al., 2010), and some are effective in doing so (Anderson, Chisholm, & Fuhr, 2009; Room, 1984). Alcohol policies differ in effectiveness, target population and practical and financial feasibility (Anderson et al., 2009; Babor et al., 2010; Cook, Bond, & Greenfield, 2014; Lancaster & Matthew-Simmons, 2013). In spite of their apparent benefits, many of the most effective policies for reducing alcohol-related harm (for example, taxation on alcohol products, and restrictions on the availability of alcohol (Anderson et al., 2009; Lancaster & Matthew-Simmons, 2013) receive relatively weak support from the public (Babor et al., 2010; Lancaster & Matthew-Simmons, 2013). Conversely, some less-effective alcohol policies, such as alcohol education programs in schools (Anderson et al., 2009; Lancaster & Matthew-Simmons, 2013), receive stronger support (Babor et al., 2010; Lancaster & Matthew-Simmons, 2013).

Public opinion on policies influences the likelihood that they will be implemented and enforced (Page & Shapiro, 1983). Whilst the responsiveness of policies to public opinion is influenced and

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http://dx.doi.org/10.1016/j.drugpo.2017.05.002
0955-3959/

sometimes compromised by the interests of political parties, business enterprises and social movement organisations (Burstein, 1998, 2003; Smith, 1999), stronger public support for policies tends to increase the chance of those policies being implemented in democratic countries (Burstein, 2003; Page & Shapiro, 1983; Room, Giesbracht, Graves, & Greenfield, 1995). Moreover, Room et al. (1995) explain that public opinion can influence the effectiveness of restrictive policies; for instance, when people demonstrate their opposing attitudes towards restrictive alcohol policies by intentional evasion of those restrictions – for example, when alcohol is brought to and consumed in alcohol-free public places and events. Given the potential for policies to reduce harm caused by alcohol in societies (Anderson et al., 2009; Babor et al., 2010; Lancaster & Matthew-Simmons, 2013), it is important to understand what influences public support for alcohol policies and how public opinions of alcohol policies change over time in a variety of countries (Room et al., 1995; Storvoll, Rossow, & Rise, 2014) to allow the implementation of effective policies to combat the harmful impacts of alcohol in a range of culturally and socio-politically-diverse nations.

Research investigating public opinion towards alcohol policies has increased internationally since the turn of the century. Previous public opinion studies have predominately investigated population trends over time, and analysed how socio-demographic characteristics and one's own drinking patterns and problems relate to different alcohol-related policy opinions (see – Greenfield, Ye, & Giesbrecht, 2007; Österberg, Lindeman, & Karlsson, 2014; Rossow & Storvoll, 2014; Seo, Chun, Newell, & Yun, 2015; Tobin, Moodie, & Livingstone, 2011). Heavier drinkers have tended to oppose policy restrictions (Callinan, Room, & Livingston, 2014), despite their drinking leading to an increased risk of harm to themselves and others. Meanwhile, a recent study conducted by Greenfield et al. (2014) investigated the association between experience of alcohol-related harm attributable to the drinking of others and support for stricter alcohol control measures. The study used data from the 2010 US National Alcohol Survey to compare the experience of harm from others' drinking with alcohol policy opinions, finding support for their hypothesis, that those who had experienced harm from others' drinking would be more likely to support alcohol control policies. The authors, however, noted the limits of their policy attitude scale (based on three core items), so that further research should be conducted on a fuller set of alcohol policy opinion items (Greenfield et al., 2014). Whether being a victim of harm from others' drinking is associated with increased support for alcohol policies, and how this association varies according to the type of harm experienced, is yet to be investigated in an Australian sample or using a comprehensive set of alcohol policy opinion items.

Using data from the 2013 National Drug Strategy Household Survey (NDSHS) (AIHW, 2015), this paper investigates the association between experience of harm because of others' drinking – specifically, fear, verbal abuse and/or physical abuse – and support for eighteen alcohol control policies in Australian respondents. It is hypothesised that experience of such harm will correlate with increased support for a range of alcohol policies, particularly those surrounding hazardous behaviours.

Design and methods

Data and sample

The NDSHS is the principal survey of licit and illicit drug use in Australia, dating back to 1985; the 2013 survey was the 11th to be undertaken (AIHW, 2014). In 2013, 23,855 Australians aged 12 years or older answered questions about their drug use, and their attitudes and behaviours towards drug use, with a response rate of 49.1% (AIHW, 2014). There was some under-representation of the employed population, people who have not completed year 12 or higher education, single person households, people who did not speak English predominately in the home, and those in the lowest socioeconomic deciles. However, the survey data was weighted to reflect Australian population distributions for sex, age, household size and region of residence to control for this, and the weighted data can be considered highly representative (AIHW, 2014).

Participants were excluded from all analyses if they were less than 18 years of age (N = 1159) or did not answer at least 12 of the 18 alcohol policy questions (N = 1627) or did not answer any of the harm questions (N = 223). Further, participants were excluded if they answered 'no' to one or more harm questions but then did not answer another harm question (N = 276), as we could not be certain that they were not harmed. There were 872 respondents that answered 'yes' to one or more harm questions and left another blank. These respondents were retained in the sample on the assumption that such respondents had left questions that did not apply to them blank, as discussed by Callinan and Room (2012) in a similar situation. Results were run with and without this final group of participants, with no impact on results. As a result, 20,570 respondents were included in the analysis. The final sample comprised 9091 men (49.5%) and 11,479 women (50.6%), with a mean age of 45.8 years.

Measures

The NDSHS has 18 alcohol-related policy questions (see Table 1) which ask respondents to rate their level of support for each policy on a five-point Likert scale. Response categories were: (1) strongly oppose, (2) oppose, (3) neither support nor oppose, (4) support, and (5) strongly support. Principal components analysis with direct oblimin rotation grouped policy items into four different types of policies – each of which encompassed policies that share similar characteristics in terms of level of support and types of respondents who support or oppose them. A similar analysis conducted by Callinan et al. (2014) on the 2010 NDSHS found a similar, albeit slightly different, four-factor structure based on 16 alcohol policy items. The single-factor structure, titled 'overall', considers all 18 items together. The four subscales are increasing alcohol-free space and events, restricting price and availability, increasing promotional limits and warnings, and controlling hazardous behaviour. The items corresponding to these groups are shown in Table 1. Respondents' mean scores on the 18 policy items, and on each of the four types of alcohol policies, were used as outcome variables which quantified respondents' support for alcohol policies on an ordinal scale ranging from 1 (least support) to 5 (most support). The alpha reliability coefficients for the sets of items comprising the four policy type attitudes scales, and the overall policy attitudes scale, ranged from 0.79 to 0.94, indicating good internal consistency for the outcome measures. Furthermore, Supplementary Table 1 depicts a direct oblimin rotated components matrix which describes how each of the 18 policy items loaded onto four components and thus subdivided into the four alcohol policy type subscales.

Drawing from the three primary alcohol-related harm questions which asked respondents 'In the last 12 months, did any person under the influence of or affected by alcohol . . . ' (i) 'verbally abuse you?', (ii) 'physically abuse you?', and (iii) 'put you in fear?', an overall harm variable was derived. Analyses were initially run on the three items separately, however there was no difference in results between the two types of abuse. The primary indicator used to measure harm included the following categories; none of the three harms had been experienced, respondents had been put in fear but not verbally or physically abused, respondents had experienced both fear and abuse, and respondent had been abused without having been put in fear. Analyses were run with verbal and physical abuse entered as separate variables (Supplementary Table 2), with no real differences