NATIONAL ALCOHOL STRATEGY

2006 - 2009

Towards Safer Drinking Cultures

National Alcohol Strategy 2006 - 2009

Ministerial Council on Drug Strategy
May 2006.

This document was endorsed by the Ministerial Council on Drug Strategy at its meeting in Perth on 15 May 2006.

The document was prepared for the Ministerial Council by the Strategy Development Team, with direction from the Project Management Group and four advisory groups appointed by the Intergovernmental Committee on Drugs (see Appendix 2).

For information on the National Drug Strategy
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ISBN: 1 74186 051 2

Online ISBN: 1 74186 052 0

Publication Approval Number: 3900

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EXECUTIVE SUMMARY

Alcohol plays an important role in the Australian economy. It generates substantial employment, retail activity, export income and tax revenue. Alcohol also has an important social role. It is a familiar part of traditions and customs in this country and is often used for relaxation, socialisation and celebration. Eighty three percent of Australians reported drinking alcohol in 2004. It is a drug that can promote relaxation and feelings of euphoria. It can also lead to intoxication and dependence and a wide-range of associated harms.

The annual cost to the Australian community of alcohol-related social problems was estimated to be $7.6 billion in 1998-99. Globally, alcohol-related death and disability accounts for 4.0 percent of the total cost to life and longevity (compared to 4.1 percent for tobacco), even after factoring in any health protective effects of alcohol consumption.

Although the per capita consumption of alcohol in Australia has declined since the 1980's it remains high by world standards. There are patterns of use that are of particular concern. For example, drinking to intoxication is associated with wide-reaching impacts on the health, safety and wellbeing of individuals and communities. Such drinking is not a random occurrence. Many of the dangers of alcohol for those who drink, and those around them, are misunderstood, tolerated or ignored. The harms associated with unsafe alcohol use, including drinking to intoxication, are now well documented in the research literature. There is also widespread concern about the drinking patterns associated with harm among those who are responding to those harms in some way on a day-to-day basis. Developing Australia's drinking cultures to produce healthier and safer outcomes is the key challenge for this Strategy.

The National Alcohol Strategy 2006-2009

The *National Alcohol Strategy 2006-2009* (the *Strategy)* is a plan for action developed through collaboration between Australian governments, non-government and industry partners and the broader community. It outlines priority areas for coordinated action to develop drinking cultures that support a reduction in alcohol-related harm in Australia. The *Strategy* seeks to reflect the *National Drug Strategy: Australia's integrated framework 2004–2009* and build on the previous alcohol strategy. It also supports the key result areas of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006*, which was endorsed by the MCDS in August 2003.

The *Strategy* is based on extensive consultations with over one thousand key stakeholders around Australia and a review of the most recent research literature and other data relating to trends in alcohol consumption and harm in Australia. The inclusion of liquor licensing authorities, police and local government in the consultation process represents an effort to integrate with other key groups including the health sector and the alcohol beverage and hospitality industry.

Strategy Development Principles

Development of the *Strategy* has been guided by a set of principles that have influenced the research methods, the frameworks used for analysis, and decision-making on policy specific issues. The principles are:

- Build on past and present efforts
- Consult
- Seek evidence
- Contemplate future trends and issues
- Focus on some key areas
- Identify realistic responses.

Strategy Goal

The goal of the *Strategy* is to prevent and minimise alcohol-related harm to individuals, families and communities in the context of developing safer and healthy drinking cultures in Australia.

Strategy Aims

To achieve this goal, the *Strategy* has four aims:

1. Reduce the incidence of intoxication among drinkers.
2. Enhance public safety and amenity at times and in places where alcohol is consumed.
3. Improve health outcomes among all individuals and communities affected by alcohol consumption.
4. Facilitate safer and healthier drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability.

In light of the evidence of alcohol-related harm in the general community and within specific sub-populations, both universal approaches to reduce overall consumption and strategies targeted to reduce harm are needed in Australia.

Priority Areas for the Strategy

Reflecting these aims, the following four priority areas have been nominated as the focus of the *Strategy*:

- Priority Area 1: Intoxication
  - 1A Increase community awareness and understanding of the extent and impacts of intoxication.
  - 1B Improve enforcement of liquor licensing regulations.
  - 1C Ensure the inclusion of Aboriginal and Torres Strait Islander groups to identify specific responses for Aboriginal and Torres Strait Islander communities.
  - 1D Implement strategies to reduce the outcomes of intoxication and associated harm in and around late night (extended hours) licensed premises and outlets.

- Priority Area 2: Public Safety and Amenity
  - 2A Prevent and reduce alcohol-related injuries.
  - 2B Revise, develop where necessary, and disseminate best practice guidelines.
  - 2C Increase the capacity of local communities, including government, to address public health and safety issues associated with alcohol.

- Priority Area 3: Health Impacts
  The following responses relate to the health system and therefore do not necessarily include other responses that can positively affect the health impacts of alcohol, many of which are recommended elsewhere in the *Strategy*.

3A Initiate a national effort to enhance the capacity and legitimacy of the nursing profession in addressing alcohol-related health problems.
3B Promote primary care settings as an accessible and non-stigmatising opportunity for health promotion, prevention and treatment of alcohol use problems.
3C Improve capacity and encourage a system-wide health response to people at risk of short-term and longer-term alcohol-related health problems.
3D Support whole-of-community initiatives to reduce alcohol-related health problems.

- Priority Area 4: Cultural Place and Availability
  4A Strengthen the regulation of alcohol availability including liquor licensing controls.
  4B Investigate price-related levers to reduce consumption of alcohol at harmful levels.
  4C Monitor and review alcohol promotions.
  4D Develop and implement social marketing campaigns to reduce alcohol-related harms.
  4E Develop a shared vision for long-term culture change with the aim of reducing alcohol-related harm and developing safer and healthy drinking cultures in Australia.
  4F Examine the legal aspects of alcohol availability.

A fifth area of the *Strategy*, 'Where To From Here?' identifies actions required to support the implementation of the *Strategy*, including:

- Coordinated and integrated approaches
- Building the research agenda
- Data collection
- Monitoring and evaluation
- Developing the workforce
- Developing partnerships and links
- Shaping the future - providing strong leadership.

The recommended responses are listed under the four priority areas and the fifth section focussing on implementation of the *Strategy*.

1. INTRODUCTION

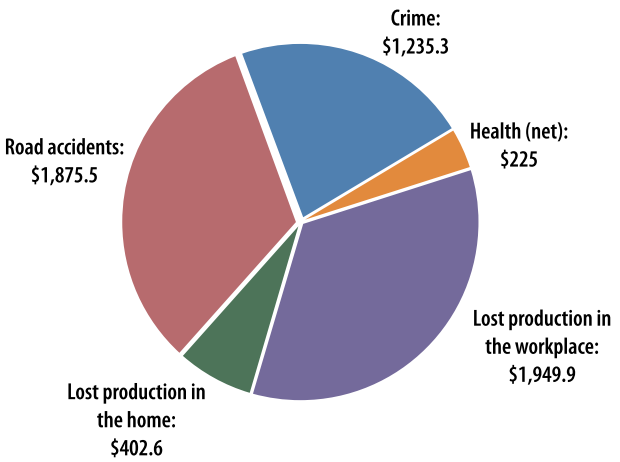
1.1 Why does Australia need a National Alcohol Strategy?

Alcohol enjoys enormous popularity and special significance in Australian society. It is used for relaxation, socialisation and celebration. Alcohol also plays a significant role in the Australian economy, generating substantial employment, retail activity, export income and tax revenue. There is also evidence that alcohol can benefit the health of some individuals, if consumed at low levels, by contributing to the reduction of cardiovascular disease risk from middle-age onwards. Everyday, thousands of Australians benefit in some way from alcohol.

Alcohol also has great significance because it is a drug. It is a psychoactive substance that can promote relaxation and feelings of euphoria. However, it can also impair motor skills and judgement, produce intoxication and dependence, cause illness and death and have other harmful effects on our daily social, economic and living environments. Globally, alcohol-related death and disability accounts for 4.0 percent of the total cost to life and longevity (compared to 4.1 percent for tobacco). This figure is adjusted to reflect any health protective effects but it does not include other costs, such as alcohol-related social harms (Babor et al. 2003).

In Australia, the annual cost to the community of alcohol-related social problems was estimated to be $7.6 billion ($5.5 billion tangible) in 1998-99. The greatest costs are borne by workplaces as a result of reductions in the size and capacity of the workforce and worker absenteeism due to alcohol-related issues (see Figure 1). These costs are partly offset by the net government revenue from alcohol-related taxes, which is estimated to be $5.5 billion in 2004/05 (DSICA 2005). The alcohol industry is also a significant contributor to the broader Australian economy, contributing $18.3 billion in 2004-05, and directly employing 36,000 people and indirectly contributing to the employment of 205,000 people in pubs, taverns and bars (DSICA 2005).

Figure 1. Annual tangible costs of alcohol abuse, Australia ($AUD millions) (Source: Collins and Lapsley 2002).



Many of the dangers of alcohol for Australians who drink, and for those around them, are misunderstood, tolerated or ignored. This is particularly apparent with regards to intoxication. The paradoxical affinity that Australians have for a drug that is harmful to so many, so often, has become the hallmark of many of the nation's drinking cultures.

Today there is not a single drinking culture in Australia, but a great diversity, reflecting the varied and changing meanings that alcohol occupies in our lives. Common among these cultures, however, is an unsafe approach to alcohol. To put it plainly, too many Australians now partake in 'drunken' cultures rather than drinking cultures. The harms that result from this include deaths, injuries, disease, crime, violence, fires, drowning, verbal abuse, unemployment and family breakdown. To continue in this direction is in nobody's interests; not individual Australians, their families and wider communities nor the alcohol beverage and related industries. Developing Australia's drinking cultures to produce healthier and safer outcomes is the key challenge for the *National Alcohol Strategy 2006-2009*.

1.2 What is the National Alcohol Strategy?

The National Alcohol Strategy is a plan for action developed through collaboration between Australian governments, non-government and industry partners and the broader community. It outlines priority areas for coordinated action to develop drinking cultures that support a reduction in alcohol-related harm in Australia. The *National Alcohol Strategy 2006-2009* has been developed following consultation with key stakeholders and a review of the most recent research literature and other data relating to trends in alcohol consumption and harm in Australia. The *Strategy* seeks to reflect the *National Drug Strategy: Australia's integrated framework 2004–2009*, which was endorsed by the MCDS in May 2004.

Priorities of Australia's ***National Drug Strategy 2004–2009:***

1. Prevention
2. Reduction of supply
3. Reduction of drug use and related harms
4. Improved access to quality treatment
5. Development of the workforce, organisations and systems
6. Strengthened partnerships
7. Implementation of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006*
8. Identification and response to emerging trends.

(MCDS 2004)

The *National Alcohol Strategy 2006-2009* is consistent with the National Drug Strategy, although the status of alcohol as a legal drug requires that the priorities be more specifically developed to address particular aspects of supply and certain patterns of use. The *National Alcohol Strategy 2006-2009* also supports the six key result areas of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006*, which was endorsed by the MCDS in August 2003.

Key Result Areas of the *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006:*

1. Enhance community capacity to address current and future issues and promote their own health and wellbeing.
2. Whole-of-government effort in collaboration with non-government organisations to reduce drug-related harm.
3. Substantially improved access to health and wellbeing services that address drug issues.
4. Holistic approaches, from prevention to treatment and continuing care, that are locally accessible.
5. Workforce initiatives to enhance capacity of community-controlled and mainstream service organisations.
6. Improved ownership and partnerships of research, monitoring, evaluation and dissemination of information.

(MCDS 2003)

1.3 How has the Strategy been developed?

A project management group and four advisory groups, comprising representatives from a variety of jurisdictions and sectors, have developed the *National Alcohol Strategy 2006-2009*.

The four advisory groups are:

- Health and Social Issues Advisory Group
- Research Advisory Group
- Alcohol Beverage and Hospitality Advisory Group
- Regulation, Enforcement and Public Amenity Advisory Group

The inclusion of liquor licensing authorities, police and local government in the consultation process represents an effort to engage these with other key groups including the health sector and the alcohol beverage and hospitality industry. Strategy development has also been guided by a set of principles that have influenced the selection of process and priority setting.

Principles

- Build on past and present efforts.
- Consult.
- Seek evidence.
- Contemplate future trends and issues.
- Focus on some key areas.
- Identify realistic responses.

The third of these principles cannot always be met. While an evidence base should always be sought in developing alcohol policy, this is sometimes not possible because new issues and questions can emerge ahead of the answers. In this context, it is necessary to approach policy decisions with some caution, akin to a public health concept termed the 'precautionary principle' (Babor et al 2003).

The main method used in developing the *Strategy* was analysis of information and opinions collected from:

- the project management group and advisory groups;
- public comments on the consultation paper;
- national consultation forums with key stakeholders;
- consultations with experts;
- a review of the local and international literature;
- a review of recent trends in alcohol consumption and harm in Australia; and
- a review of recent developments and achievements in alcohol policy at the international, national, state/territory and local level.

A summary of the findings of the national consultations for the development of the *National Alcohol Strategy 2006-2009* is provided within the four priority areas of the *Strategy*.

Snapshot of the consultations

Consultations with more than 1,000 stakeholders
23 consultations forums around Australia
600 feedback forms received
42 written submissions received
10 Web responses received

2. STRATEGIC FRAMEWORK

2.1 What are the priority areas of the Strategy?

A major challenge in developing the strategic direction for the *National Alcohol Strategy 2006-2009* is setting the key priorities for action. Given the many and diverse issues and responses identified in the national consultation, the review of recent literature and data, and in the previous National Alcohol Strategy, clear priorities for action are needed. While there is significant overlap and links between the issues identified, some emerge as higher priorities than others because of their broad and continuing impact. Most of these offer opportunities for collaborative action.

The following four priority areas have been nominated as the focus of the *National Alcohol Strategy 2006-2009*:

- Priority Area 1: Intoxication
- Priority Area 2: Public Safety and Amenity
- Priority Area 3: Health Impacts
- Priority Area 4: Cultural Place and Availability

Focusing on these four priority areas does not mean that some issues, such as those outlined as 'key strategic areas' in the previous National Alcohol Strategy, will not receive attention. Instead, many issues will be integrated across the strategic framework in an effort to build linkages and encourage complementary responses. In addition to the responses recommended in each of the priority areas, Section 5 of the *Strategy* focuses on 'Where to from here?' and includes implementation issues and priorities in research, evaluation and workforce development.

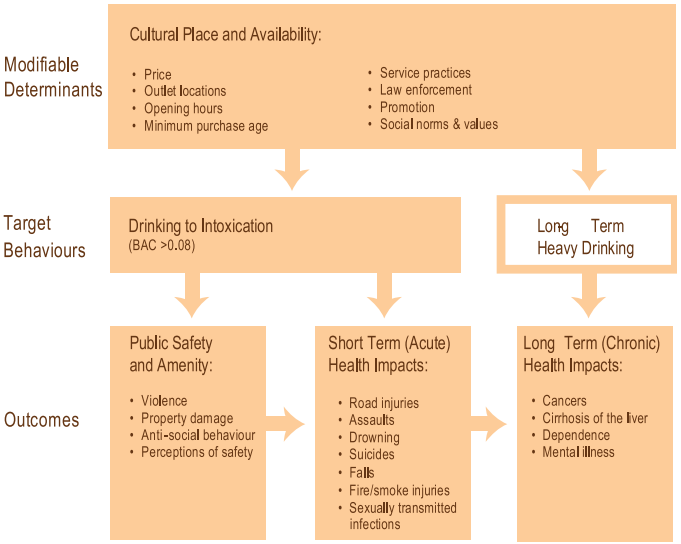
Figure 2 summarises the relationships between the priority areas. It illustrates that although the determinants, behaviours and outcomes of alcohol-related harm are distinct, many are linked and interact.

The underlying premise of the *Strategy* is that the cultural place and availability of alcohol represent major determinants, or influences, of behaviours that lead to alcohol-related harm. Throughout the national consultations and the *Strategy* development process there was broad consensus that the most harmful of these behaviours is drinking to intoxication. Therefore, *Intoxication* is targeted as the first priority area of the *Strategy*.

The impact of intoxicated behaviour on public safety and amenity has been increasingly recognised as a major social problem in Australia today. Therefore, *Public Safety and Amenity* is recommended as the second priority area.

As the health outcomes of drinking at harmful levels, both in the short and long-term, continue to be identified as a major preventable disease burden in Australia, *Health Impacts* is identified as the third priority area of the *Strategy*. The *Cultural Place and Availability* of alcohol is addressed specifically in the fourth priority area, underpinning and reinforcing efforts in the other priority areas.

Figure 2. Alcohol-related harm: determinants, behaviours, and outcomes
Source: Adapted from Kypri, K. A social ecology of alcohol-related harm (in preparation).



There are other social and structural determinants of patterns of alcohol consumption and of alcohol-related harm including socio-economic status, availability of opportunities for education and employment, disposable income, housing and access to public transport. When examining alcohol consumption and its impacts globally as well as within communities in Australia, the stage of development of the community can significantly influence benefits and burdens associated with alcohol and highlight particular issues. These factors are beyond the scope of this *Strategy* but might be significant for some sub-groups.

Table 1. Alcohol in the leading 12 selected risk factors as global causes of disease burden

DEVELOPING COUNTRIES		***DEVELOPED COUNTRIES***
High Mortality	*Low Mortality*	
Underweight	Alcohol	Tobacco
Unsafe sex	Blood pressure	Blood pressure
Unsafe water	Tobacco	Alcohol
Indoor smoke	Underweight	Cholesterol
Zinc deficiency	Body mass index	Body mass index
Iron deficiency	Cholesterol	Low fruit & veg. intake
Vit A deficiency	Lo fruit/veg intake	Physical inactivity
Blood pressure	Indoor smoke	Illicit drugs
Tobacco	Iron deficiency	Unsafe sex
Cholesterol	Unsafe water	Iron deficiency
Alcohol	Unsafe sex	Lead exposure
Lo fruit /veg intake	Lead exposure	Childhood sexual abuse

Source: Adapted from ***Alcohol in the Global Burden of Disease, 2000 (% total DALYS) (WHO, 2002)***

2.2 What are the goals and aims of the Strategy?

The following goal and aims have been developed to reflect and support the strategic intent of the *National Alcohol Strategy 2006-2009*.

Goal

- Prevent and minimise alcohol-related harm to individuals, families and communities in the context of developing safer and healthy drinking cultures in Australia.

Aims

- Reduce the incidence of intoxication among drinkers.
- Enhance public safety and amenity at times and in places where alcohol is consumed.
- Improve health outcomes among all individuals and communities affected by alcohol consumption.
- Facilitate safer and healthy drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability.

2.3 What is the scope of the Strategy?

Through the consultations and research for the *Strategy*, a wide variety of issues and recommended responses have been identified, including new and innovative responses. All of the potential responses identified have been scrutinised in relation to what are known to be the critical factors for successful drug policy in Australia, as recognised by the *National Drug Strategy 2004-2009* (see Table 1).

Table 2. Features of Australian drug policy

Harm minimisation – recognises the need to use a wide range of approaches in dealing with drug-related harm, including supply reduction, demand reduction (including abstinence oriented interventions) and harm reduction strategies.
Comprehensive approaches – encompasses the harmful use of licit drugs (tobacco, alcohol and pharmaceutical drugs), illicit drugs and other substances (inhalants, kava).
Inter-sectoral partnerships – between health, law enforcement and education agencies, affected communities, business and industry.
A balanced approach – across all levels of government, between supply reduction, demand reduction and harm reduction strategies, between preventing use* and harms and facilitating access to treatment. *MCDS (2004)*

*** In relation to alcohol, 'preventing use' includes preventing risky and high risk drinking and preventing underage drinking.**

In light of the evidence of alcohol-related harm in the general community and within specific sub-populations, both universal approaches to reduce consumption and strategies targeted to reduce harm are needed in Australia.

What is proposed represents a public health approach and it should be recognised that 'public health often competes with other social values such as free trade, open markets and individual freedom' (Babor et al 2003). Australia has provided leadership and received international acclaim for public health and social policies designed to reduce morbidity and mortality associated with drink driving, speeding and not wearing seatbelts, to nominate just a few. Striking the balance is a significant challenge for the development of an effective National Alcohol Strategy.

2.4 What type of response is recommended?

A set of characteristics emerges as essential in developing responses to the four priority areas of the *National Alcohol Strategy 2006-2009*. It is intended that all responses recommended for implementation possess the following characteristics:

1. Evidence-based with capacity for process, impact, and outcome evaluations.
2. Achievable within *Strategy* timeframe.
3. Balance of whole-of-population and targeted strategies.
4. Link to or build upon existing responses.
5. Clearly relate to a longer-term vision to reduce harm.

Where there is limited or no evidence base, the precautionary principle could apply and expert opinion may be sought.

There are many different groups that need to be involved in taking action to achieve the goal and aims of this *Strategy*. Some responses will require partnerships while government or interest group action might achieve others. It will be important to engage the broader community in contemplation of, and conversations about, alcohol issues in developing some responses.

3. CONTEXT OF THE STRATEGY

3.1 What has occurred since the previous Strategy?

International

One of the most significant developments at the international level has been the release of the World Health Organisation's (WHO) sponsored report Alcohol: *No Ordinary Commodity: Research and Public Policy* (Babor et al 2003). This body of work represents a significant advance in our understanding of the application of evidence in the development of effective alcohol policies.

Growing international concern about alcohol has prompted several countries with a similar socio-political and cultural profile to Australia to develop national strategies to reduce alcohol-related harm. This includes New Zealand, England, Ireland, Scotland, Canada, Sweden, and the USA's strategy to reduce underage drinking.

International trade agreements have served to weaken national level alcohol controls, which has raised public health concern and led to calls for an international framework convention or treaty on alcohol. Concern has also arisen from the possible inclusion of alcohol in the Pacific Island Countries Trade Agreement (PICTA). As a significant exporter of alcohol, Australia has a responsibility and is in a position to provide leadership to regional neighbours to minimise the social and public health risks associated with increased availability of alcohol.

National

In May 2004, the *National Drug Strategy: Australia's Integrated Framework 2004–2009* was endorsed by the MCDS. It provides the framework for the *National Alcohol Strategy 2006-2009* and other national strategies, including:

- *National Drug Strategy Aboriginal and Torres Strait Islander People's Complementary Action Plan 2003–2006*
- *National Tobacco Strategy 2004–2009*
- *National Cannabis Strategy (under development)*

These strategies relate to other recent national strategies for mental health, suicide prevention, road safety, injury prevention, nutrition and others.

New nationally relevant research and resources on alcohol issues have also been published, such as:

- *Counting the costs: Estimates of the social costs of drug abuse in Australia in 1998–9* (Collins & Lapsley 2002)
- *2004 National Drug Strategy Household Survey* (AIHW 2005)
- *Australian Alcohol Indicators 1990–2001* (Chikritzhs et al 2003) and the *National Alcohol Indicators Project* (NAIP) Bulletins 1 to 7
- *The Prevention of Substance Use, Risk and Harm in Australia: A Review of the Evidence* (Loxley et al 2004)
- Revised edition of *The Grog Book – Strengthening Indigenous Community Action on Alcohol* (Brady 2005)

Other recent national achievements include the work of the Alcohol Education and Rehabilitation Foundation (AERF) and a range of initiatives of the Australian National Council on Drugs (ANCD) and the Intergovernmental Committee on Drugs (IGCD) (including working groups and projects). Other peak bodies also contribute, such as the Alcohol and Other Drug Council of Australia (ADCA),

the National Alcohol Beverage Industries Council (NABIC) and, most recently, the Australian Drug Foundation (ADF) through its *Thinking Drinking 2020: Achieving Cultural Change* conference in February 2005. New and emerging bodies have also been observed, such as the Community Alcohol Action Network (CAAN) and the alcohol industry sponsored foundation Drinkwise Australia.

States and territories

Most states and territories are involved in alcohol policy-related activities, including the development or implementation of strategies for dealing with alcohol-related harms in their jurisdictions and liquor licensing reviews. Examples include:

- Outcomes of New South Wales Summit on Alcohol Abuse 2003: Changing the Culture of Alcohol Abuse in New South Wales, including the forthcoming NSW Youth Alcohol Action Plan 2006-2009, and NSW Alcohol Disease Prevention Plan 2006-2009
- Western Australia Alcohol Plan 2006-2009
- Queensland Alcohol Management Plans (2002→) and the 17-point Brisbane City Safety Action Plan (2005)
- Parliament of Victoria, Drugs and Crime Prevention Committee Inquiry into Strategies to Reduce Harmful Alcohol Consumption (2004/05)
- The Northern Territory's Alcohol Framework Interim Report and Final Report (2004) and the earlier Living with Alcohol Program (1992-2002).

Local

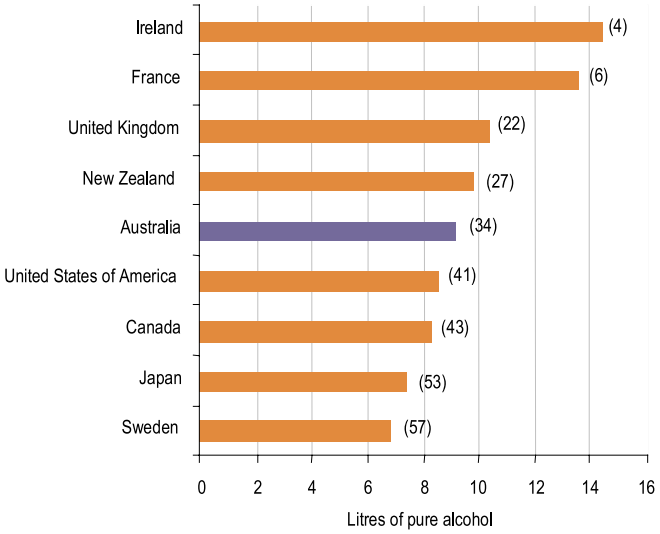
Local governments around Australia are involved in developing and delivering an array of alcohol harm minimisation programs. They support existing and emerging national and state/territory strategies and work at a local level with business and industry, community groups and residents. The role of local government in responding to alcohol issues includes direct service provision, such as public health, information, family and children, aged care and welfare services, land use planning and public space management, road safety, and co-enforcement with other regulatory agencies to provide a consistent and multifaceted approach.

Given this activity across the country, now is a timely opportunity to engage the nation in coordination and action using the goal, aims and principles of the *National Alcohol Strategy 2006-2009* as the blueprint.

3.2 What are the current consumption patterns and emerging trends?

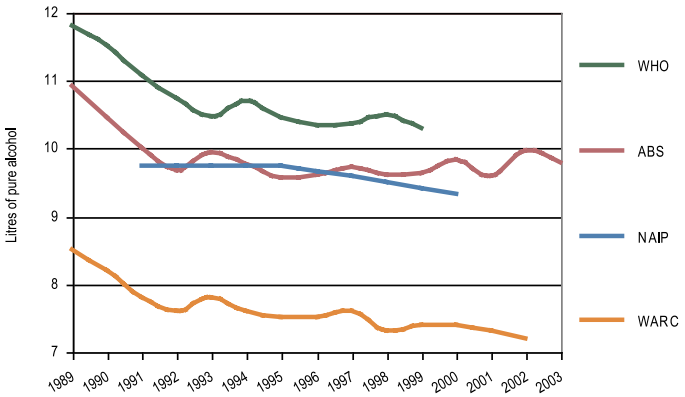
Data relating to both aggregate level (per capita) alcohol consumption and to specific sections of the Australian community provides important information in the *Strategy* formulation process. Per capita consumption is 'to a considerable extent, related to the prevalence of heavy use, which in turn is associated with negative effects' (Babor et al 2003, p31). Per capita alcohol consumption in Australia is relatively high, ranked 34th out of 185 countries compared by the WHO. Figure 3 shows the WHO's most recent estimate of per capita alcohol consumption in Australia compared to other selected developed countries.

Figure 3. Total adult per capita alcohol consumption, selected countries (by rank out of 185) (Countries selected with similar cultural, social and economic profile) (Source: WHO 2005)



The availability of reliable data on alcohol consumption in Australia remains a contentious issue. While there are estimates of per capita alcohol consumption in Australia, there are no longer any accurate records of actual consumption since the collection of wholesale alcohol sales data ceased in some jurisdictions in 1997. Consequently, there are now at least four different estimates published from four different sources using four different methodologies (see Figure 4). The main reasons for differences between estimates relate to the source of the primary data and assumptions about the drinking population. For instance, while both the World Advertising Research Centre's (WARC) and Australian Bureau of Statistics (ABS) estimates are derived using the same source data of total litres of pure alcohol consumed each year, the WARC estimates are derived using the total population of Australia, while the ABS estimates are derived using the population aged 15 years and over. The result is that the WARC estimates are likely to be a significant under-estimate of per capita alcohol consumption in Australia. However, it must still be emphasised that the estimates from the ABS, the National Alcohol Indicators Project (NAIP), and the WHO are also likely to contain some inaccuracies.

Figure 4. Per capita alcohol consumption in Australia, various sources, 1989 to 2003 (Sources: WHO 2005; ABS 2005b; NAIP=Chikritzhs et al 2003; WARC 2005).

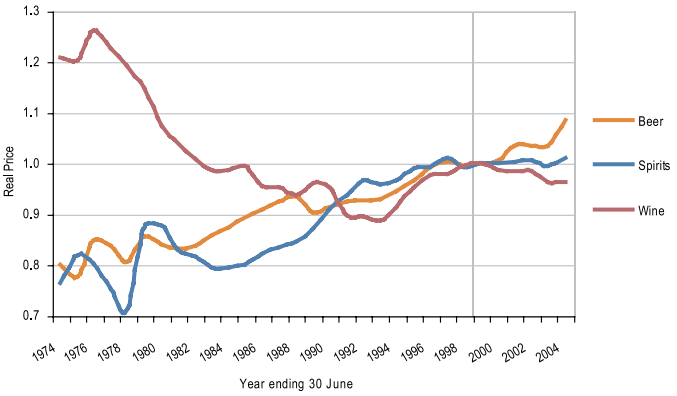


While estimates of per capita consumption of alcohol in Australia over the past 20 years vary depending on the source and basis of analysis used, they do show a similar trend.

The available consumption estimates for Australia show:

- Per capita alcohol consumption in Australia steadily declined from the late 1980s until early 1990s when the consumption began to fluctuate.
- Over the past decade there has been a steady increase in the proportion of the Australian population who drink, reaching 83 percent in 2004 (AIHW 2005).
- 1.46 million Australians consume alcohol on a daily basis, 600,000 (41 percent) of whom are aged sixty years or older (AIHW 2005).
- The real price of alcohol in Australia has remained relatively low, and dropped in some cases. For example, a glass of wine costing $1.00 in 1998-99 has dropped in real terms, to $0.96 in 2003-04.

Figure 5. Prices of alcoholic beverages relative to other consumption (1998/99 = 1.0), Australia, 1973-74 to 2003-04 (Source: ADCA 2005)



- The price of spirits in Australia, in real terms, has remained almost unchanged over the past decade.
- One in five (20.6 percent) Australians drink at levels that are risky or a high risk of harm in the short-term at least once a month. This is particularly evident among young adults (AIHW 2005)[1].
- Australians aged 20–29 are the most likely of all age groups to drink at levels that are risky or a high risk of harm in the short-term (AIHW 2005).
- Between 2001 and 2004, the proportion of Australian women who drank at least weekly increased from 33 percent to 35 percent (AIHW 2005).
- Around one third of males (30.5 percent) and one quarter of females (25 percent) aged in their 20s drink at risky or high risk levels for short-term harm at least once per month (AIHW 2005).
- In 2001, 85 percent of the total alcohol consumed by 14 -17 year old females was drunk at risky/high risk levels for short-term harm. For males this figure was 80 percent (Chikritzhs et al 2003).

[1] **See Appendix 3 for explanation of low risk, risky, and high risk drinking.**

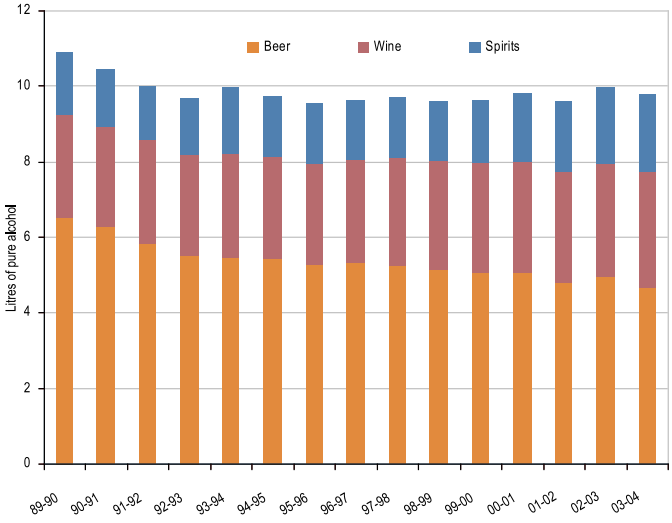
- Between 1990 and 2003, the trend in total alcohol-caused deaths showed a general decline, similar to that for per capita consumption (Chikritzhs et al 2003).

- Following a period of national decline in youth alcohol-attributable deaths during the 1990s, in more recent years, several states and territories have begun to record increases (Chikritzhs & Pascal 2004).

- Aboriginal and Torres Strait Islander peoples are less likely to be current drinkers compared to the general population, although those who do drink are more likely to do so at risky levels. Aboriginal and Torres Strait Islander youth, compared to their non-Aboriginal and Torres Strait Islander counterparts, are 2.3 times more likely to die from alcohol-related causes (Chikritzhs & Pascal 2004).

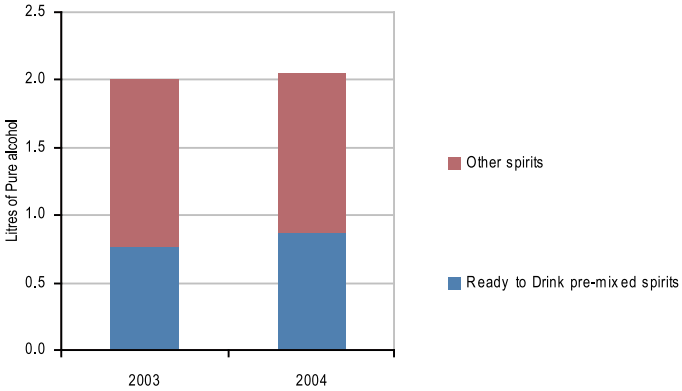
- There have been significant shifts in the alcoholic product preferences in Australia, characterised by declines in the consumption of beer and increases in the consumption of wine and spirits (see Figure 6).

Figure 6. Per capita alcohol consumption by product type, Australian population aged 15+ years, 1989 to 2004 (year ending 30 June) (Source: ABS 2005b)



- The increases in consumption of spirits have been driven by increased consumption of 'Ready to Drink' (RTDs) pre-mixed spirits products (see Figure 7).

Figure 7. Per capita alcohol consumption by type of spirits, Australian population aged 15+ years, 2003 to 2004 (year ending 30 June) (Source: ABS 2005b)



- Recent research into the alcohol beverage preferences of 15-17 year olds (about their drinking within previous three months) has found that amongst males, there has been a decrease in the proportion who reported consuming full-strength beer, from 46 percent in 2000 to 36 percent in 2004, but an increase in the proportion who reported consuming pre-mixed spirits, from 14 percent to 36 percent over the same period (King et al 2005).

- This trend was even more pronounced among females, where there has been a decrease in the proportion who reported consuming full-strength beer, from 15 percent to 8 percent, but an increase in the proportion who reported consuming pre-mixed spirits, from 14 percent to 62 percent (King et al 2005).

In summary, these data show that Australia's per capita alcohol consumption, as best it can be estimated, remains relatively high in comparison to many other developed countries and has fluctuated since the mid to late 1990s. A reduction in negative consequences associated with alcohol consumption can be expected if a downward trend in risky and high risk consumption patterns occurs. Reductions in harm would also be expected from per capita decline along with targeted interventions to address some specific sub-populations (youth, including underage drinkers, Aboriginal and Torres Strait Islander peoples and those drinking to intoxication).

3.3 What are the public perceptions about alcohol consumption and how to respond?

There has been a recent increase in public concern about alcohol. Respondents to the 2004 National Drug Strategy Household Survey (AIHW 2005) were asked: *When people talk about 'drug problem,' which are the first two drugs you think of?* Ten percent of respondents nominated alcohol, compared to 7.8 percent in 2001 (AIHW 2005).

When the general population was asked to nominate possible measures to reduce alcohol-related harm the following responses were given by more than half of those surveyed:

- increasing the number of alcohol-free events (63.3 percent);
- increasing the number of alcohol-free dry zones (63.3 percent);
- Serving only low-alcohol beverages at sporting events (60.6 percent);
- limiting TV advertising until after 9.30 pm (71.4 percent);
- more severe penalties for drink driving (85.9 percent);
- stricter laws against serving drunk customers (83.8 percent);
- restricting late-night trading of alcohol (51.9 percent);
- strict monitoring of late-night licensed premises (72.1 percent);
- increasing the size of standard drink labels on alcohol containers (66.4 percent); and
- adding national drinking guidelines to alcohol containers (69.9 percent).

One third or more supported reducing pub and club trading hours, banning alcohol sponsorship at sporting events and increasing the tax on alcohol to pay for health, education and treatment of alcohol problems (AIHW 2005).

Research that relates to the four priority areas is presented in the next sections. Key findings from the national consultations are also reported in these sections. While not from a general population sample, these data do capture frequently expressed views and opinions. A brief outline of the consultation methodology can be found in Appendix 4.

4. PRIORITY AREAS

4.1 Priority Area 1:

Intoxication

Aim: Reduce the incidence of intoxication among drinkers

4.1.1 What is the issue?

Drinking to intoxication or being 'drunk' or 'pissed', as it is colloquially referred to in Australia, is a major cause of short-term alcohol-related illness, injury and social problems. Despite this, some people identify alcoholism or alcohol dependence as the most serious alcohol-related problem. The reality, however, is that excessive single occasion drinking produces far greater and wider-reaching impacts on the health, safety and wellbeing of individuals and communities. This is because of the high incidence of drinking to intoxication, the high number of people affected directly and indirectly within the general population, and because much of the injury and many of the lives lost are among young adults. It is also because intoxication produces substantial direct and indirect costs, many associated with increased likelihood of other risky behaviours such as unsafe sex, amenity issues (such as cleaning) and insurance payouts.

Intoxication as described in current *Australian Alcohol Guidelines*

(NHMRC 2001)

- There is no consistent or formally agreed definition.
- Usually refers to blood alcohol concentration (BAC) elevated above 0.05 or 0.08 percent, but this is not universally agreed.
- **Intoxicated persons cannot function within their normal range of physical/cognitive abilities.**
- It is a subjective feeling, the experience of a substantial effect of alcohol on mood, cognition and psycho-motor function.

Intoxication is not a new issue, nor is it confined to the realm of public health. For the first half of the 1900s, drunkenness offences comprised more than half of the charges presented at Australian Magistrates' Courts (DCPC 2001). Since then, there has been a move towards dealing with intoxication more as a public health issue than a criminal justice problem. A number of jurisdictions have now decriminalised public drunkenness as an offence (Australian Capital Territory, New South Wales, Northern Territory, South Australia, Tasmania, and Western Australia), although in some it remains an offence (Queensland and Victoria).

Whether it is public or private intoxication, there is continuing concern among individuals, law enforcement and health personnel, local government and some community leaders about the extent and cost of intoxication.

Key findings of consultations

Drinking to intoxication:

- is the issue of greatest concern in the community
- is a normalised activity for many Australians who routinely drink to get drunk
- is often not recognised as a drinking 'problem'
- often leads to serious harms such as violence and crime, road crashes, as well as verbal abuse
- occurs frequently in public settings, such as in and around licensed premises
- occurs despite Responsible Service of Alcohol (RSA) programs being in place
- also occurs in private settings, is expected as a cultural norm among many groups, and is reinforced by adult behaviours
- should be addressed more actively by the alcohol beverage and hospitality industry
- is often difficult for police to adequately respond to due to the impact on resources and staff
- appears to be associated with the increasing availability and promotion of alcohol
- is seen to have decreasing tolerance in the community
- is a focus of concern about younger drinkers; especially by parents

The effects of intoxication on the individual are well documented and include psychomotor impairment, delayed reaction time, disinhibition, impaired judgement, emotional changes and other behavioural changes. Of course, not all occasions of intoxication result in major social harm or great catastrophe, but none of the health benefits of alcohol are delivered when it is consumed at levels causing intoxication. What is more likely to result are the social harms both for the individual drinker and for those around them, such as injury, verbal abuse, violence, traffic crashes, drowning and other harmful outcomes.

A Global Problem

A recent international study on alcohol-related harm by the WHO reported several important findings regarding intoxication:

- Impairment from intoxication is biological, but is also affected by social expectations and cultural norms.
- Occasional intoxication occurs among most drinkers and, even if infrequent, can cause substantial harm. The likelihood of harm from a particular episode of intoxication is higher among infrequent drinkers than regular drinkers.
- Preventing intoxication would significantly reduce the harm from alcohol.
- The social and physical context affects the potential for harm from intoxication, hence strategies are needed that protect the drinker by altering the drinking context.

(Babor et al 2003).

Impacts

Intoxication is not a random occurrence. This is particularly evident among young adults (AIHW 2005). Australians aged 20–29 are the most likely of all age groups to drink at levels risky or high risk for short-term harm. Around one third of males (26 percent) and one quarter of females (26 percent) aged in their 20s drink at risky or high levels for short-term harm at least once per month (AIHW 2005).

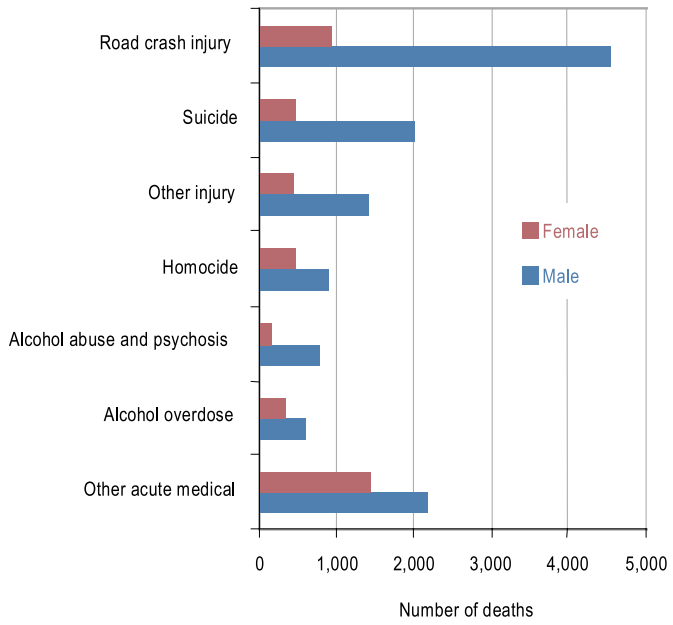
A drunken culture?

- A reputation for heavy drinking has been part of white Australia's national myth from rum corps during initial British colonisation, to drunkenness in the gold diggings, to the lasting traditions of bush workers' "shouts" and the end of week "work and burst" drunken blowouts (Room 1988).
- Today, more than one third (35.4 percent) of the Australian population consumes alcohol at levels that are risky or a high risk for harm in the short-term at least once a year (AIHW 2005).
- Almost two thirds (62.3 percent) of all alcohol in Australia is consumed at levels that are risky or a high risk for short-term harm.

(Chikritzhs et al 2003).

Harms to people who become intoxicated are felt most by those in the young adult years, and mostly by males. Of the 16,756 deaths from acute conditions due to drinking at levels risky or high risk to health between 1992 and 2001, three quarters (74.3 percent) were male. Of these, more than one quarter (27 percent) were aged 15–29 years. The most common cause of death related to intoxication among Australian males is road crash injury (see Figure 8). Other injuries, particularly those resulting from violence involving alcohol, are also a major contributor to the number of deaths.

Figure 8. Estimated number of deaths from acute conditions due to drinking at levels risky or high risk to health, Australia, 1992–2001. (Source: Chikritzhs et al 2003).



Intoxication also causes an enormous amount of preventable illness and injury requiring medical treatment, which puts an immense strain on the health system. Between 1993–94 and 2000–01, 391,283 hospitalisations for acute conditions due to drinking at levels risky or high risk to health were recorded. As shown in Table 2, many of these conditions are also likely to involve costly emergency services including fire and ambulance, law enforcement agencies and social support services.

Fire fatalities involving alcohol

- Queensland's fire service estimates 20 percent of fire deaths are alcohol-related, and this is higher for males and those aged 25-29 years. The majority of these deaths occur in accidental/preventable fires and at night, particularly between the hours of 9.30pm and 5.00am. Half of the victims recorded 0.20 BAC.
- The NSW Drug Summit reported that 44 percent of fire injuries are associated with alcohol consumption.
- Victoria's metropolitan fire service reported that two out of six preventable fatalities from fire in 2004 were alcohol-related.

(Community Education Department: MFB 2005)

Table 3. Estimated number of hospitalisations from acute conditions due to drinking at levels risky or high risk to health, Australia, 1993–94 to 2000–01 (Source: Chikritzhs et al 2003).

Cause	Number
Road crash injury	47,167
Attempted suicide	20,374
Assault	76,115
Other injury	116,177
Alcohol overdose	10,094
Alcohol abuse and psychosis	85,355
Other acute medical	36,002

There is now a greater acknowledgment of the link between alcohol consumption and injury. *The National Injury Prevention Plan* (2004) and the *National Aboriginal and Torres Strait Islander Peoples Safety Promotion Strategy* (2004) also outline a range of actions designed to reduce the number and severity of injuries, including those associated with alcohol.

An issue that has received much media attention recently is that of drink spiking. This is a complex issue that warrants further research and evidence-informed responses.

Drink Spiking

The *National Project on Drink Spiking: Investigating the nature and extent of drink spiking in Australia*:

- was the first comprehensive investigation of drink spiking in Australia;
- obtained evidence directly from victims of drink spiking, data from police in each Australian jurisdiction, data from the Centre Against Sexual Assault, and reports from the operation of a national Drink Spiking Hotline;
- estimated that for the year ending 30 June 2003, between 3000 and 4000 suspected incidents of drink spiking occurred in Australia and approximately one third of these incidents involved sexual assault;
- noted that the incidence of these suspected drink spiking sexual assaults is very small compared with the much larger numbers of sexual assaults in general that are reported to police; and,
- found that alcohol is the predominant drug identified in drink spiking cases.

(Taylor 2004)

Aboriginal and Torres Strait Islander peoples

It is important to note that whilst a lower proportion overall of Aboriginal and Torres Strait Islander peoples than the general population drink alcohol, and drink less frequently, those Aboriginal and Torres Strait Islander peoples who do drink generally consume at much more harmful levels (Gray et al 2004). Figures show that in 2001, ¬Indigenous males and females were 1.5 times more likely to drink at risky or high risk levels for short-term harm than their non-Indigenous counterparts (Gray et al 2005). Aboriginal and Torres Strait Islander peoples are more than seven times more likely to be hospitalised for acute intoxication than the rest of the Australian population. The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006* (MCDS 2003) outlines key actions to reduce alcohol-related harms in this population.

Good Practice

Sobering Up Shelters (SUS)

- In Australian States and Territories where public drunkenness has been decriminalised, intoxicated people can be taken to a shelter instead of police cells.
- These places are special Sobering Up Shelters (SUS) and provide a safe, caring and respectful environment for people to sober up and opportunities for their health issues and other needs to be addressed.
- The process of being picked-up and sobered-up at an SUS helps to educate people about what is acceptable behaviour.
- SUSs are a source of valuable data on the population of people who drink to intoxication in public that can potentially be analysed to identify their needs and plan strategies to respond.

Brady (2005)

Nyoongar Patrol (Perth)

- The City of Perth in collaboration with other partners set up the Nyoongar Patrol to assist Indigenous people who are homeless or affected by alcohol or other substances.
- The aim of the outreach service is to provide health and welfare services to reduce harms to individuals and the community.

King and Richards (2003)

Underage drinking to intoxication

The drinking preferences and patterns among young Australians are also a concern. Over 80 percent of all alcohol consumed by 14-17 year olds is drunk at risky or high risk levels for short-term harm (Chikrtzhs et al 2004). In 2004, almost a third of 12-15 year olds drank alcohol, and this figure rose to three quarters for 15-16 year olds (AIHW 2005). Furthermore, 17.1 percent of young people aged 12-17 drank at risky or high risk levels for short-term harm within the past 12 months (AIHW 2005b). The consequences of these drinking patterns are twofold. Firstly, there are the short-term effects, and secondly there is also evidence from cohort studies that early initiation to alcohol use is related to more frequent use, higher consumption levels and the development of alcohol-related harms in adulthood (Loxley et al 2005). Over the ten years 1993-2002, an estimated 501 underaged drinkers died from alcohol-related injury caused by risky or high risk drinking, and in 1999/00, there were 3,300 14-17 year olds hospitalised for alcohol-related conditions (Chikrtzhs et al 2004).

Between 34 and 50 percent of males aged 15-17 years who drank within the previous three months reported consuming alcohol at higher risk levels (equivalent to seven or more standard drinks), while among females, the rate was between 42 and 47 percent (equivalent to five or more standard drinks) (King et al 2005). Among those male drinkers consuming alcohol at higher risk levels there has been a reduction in the proportion drinking beer (77- 59 percent) and an increase in those drinking pre-mixed spirits (18-51 percent) while those who reported drinking spirits (not pre-mixed) remained relatively stable. Among females consuming alcohol at higher risk levels, there was a significant shift to pre-mixed spirits/liqueurs, from 21 to 78 percent while the proportion drinking other beverage categories declined (King et al 2005).

Reducing Intoxication – public licensed environments

To reduce the incidence of intoxication, responsible service practices in licensed environments are recommended, but need to be accompanied by formal law enforcement which leads to the reduced serving of intoxicated people. As all Australian jurisdictions have responsible service laws in place, encouraging responsible service is usually more a matter of enforcing existing laws than creating new ones.

(Loxley et at 2005)

A significant proportion of alcohol-related harm occurs in or in the vicinity of licensed premises. Some licensed drinking environments are associated with a disproportionate level of alcohol-related harm, and drinking at peak times intensifies the impact on local communities. Much of this harm involves assaults where young men are the victims or perpetrators (Doherty and Roche 2003). Recent research has recommended strategies for reducing alcohol-related harm associated with licensed environments (See Table 3).

Table 4: Principles for Effective Policing of Licensed Drinking Environments (Source: Doherty and Roche 2003)

Licensing	Ensure liquor licence decisions consider community and patron safety.
Management	Ensure management practices comply with legislative requirements, and reduce risk of harm to staff and patrons.
Staff training	Ensure bar staff, security and management understand their legal obligations
Responsible service	Ensure staff understand and engage in responsible server practices
Premises design	Ensure the premises are designed in a way that minimises potential for harm
Responsible marketing	Ensure the licensed premises are promoted in a way that does not encourage violence or excessive consumption
Community education	Reduce alcohol-related social disorder by improving public awareness of liquor laws
Public transport	Ensure sufficient public transport is available, to disperse patrons quickly and prevent drink driving
Collaborative crime reduction	Establish cooperation between police, licensees, liquor authorities, local councils and the community and develop collaborative strategies to reduce alcohol-related incidents
Enforcement policies	Ensure a visible police presence at and around licensed venues and events, and ensure action is taken for breaches of liquor and other legislation

4.1.2 What responses are recommended?

1A Increase community awareness and understanding of the extent and impacts of intoxication.

- Continue to work with industry to develop labelling of alcohol products to facilitate knowledge and self-monitoring through readily seen, consistent, graphic standard drinks labelling.
- Promote the Australian Alcohol Guidelines aiming for consistency and clarity of messages across all alcohol-related health and safety arenas.
- Develop a nationally agreed and workable definition of intoxication.
- Increase community understanding of liquor licensing laws and requirements for the responsible service of alcohol in the context of harm reduction.

1B Improve enforcement of liquor licensing regulations.

- Increase capacity of police, local government and liquor licensing authorities to enhance enforcement of liquor licensing laws, particularly those relating to serving people who are intoxicated.
- Examine the liquor licensing laws in each jurisdiction with regard to the adequacy and appropriateness of current penalties for breaches and the feasibility of developing a demerit points system, especially for serious and repeat offences.
- Support the refinement and improve the reliability of data linkage efforts to facilitate an early warning system of possible trouble spots and provide opportunities for proactive policing at a local level, including possible liaison and coordination with local government, alcohol industry bodies and health programs.

1C Ensure the inclusion of Aboriginal and Torres Strait Islander groups to identify specific responses for Aboriginal and Torres Strait Islander communities.

- Provide and improve access for Aboriginal and Torres Strait Islander peoples to the current police diversion, pre-sentencing programs, and legal aid for alcohol-related offences.
- Build capacity to provide a full range of treatment and rehabilitation options and resources to Aboriginal and Torres Strait Islander peoples in rural and remote areas, in collaboration with mainstream services.
- Reduce harm for Aboriginal and Torres Strait Islander families and communities by implementing harm reduction strategies outlined in the Complementary Action Plan and strategies outlined in national injury prevention plans and safety promotion strategies.

1D Implement strategies to reduce the outcomes of intoxication and associated harm in and around late night (extended hours) licensed premises and outlets.

- Conduct periodic appraisals of compliance with legislation, regulations and good practice guidelines in late night (extended hours) liquor outlets in conjunction with other measures such as local accords where these are in place.
- Develop and implement additional specialised Responsible Service of Alcohol (RSA) training in conjunction with the alcohol distribution industry and support for premises that are high risk environments for intoxication, particularly late night licensed premises.
- Establish nationally consistent RSA training programs such that these are recognised and accepted across the country.

- Require all managers of liquor outlets to undergo appropriate training in the responsible sale and serving of alcohol.

- Improve and enhance the knowledge base of the extent of drink spiking and associated criminal victimisation and increase capacity to effectively prevent, reduce and manage the incidence of drink spiking.

4.2 Priority Area 2:

Public Safety and Amenity

Aim: Enhance public safety and amenity at times and in places where alcohol is consumed.

4.2.1 What is the issue?

The forgotten problems

Although public discussion has often concentrated on alcohol-related problems connected with disease and other medical conditions, alcohol is also linked to consequences in the social realm, which have been called the forgotten dimension.
(Babor et al 2003)

There are significant social harms and harms to the physical environment that result from risky and high risk consumption of alcohol. They include crimes against persons such as threats and assaults, and crimes against property, such as vandalism. The harms also include anti-social behaviour such as public disorder and bodily fluid spills. There are also harms resulting from reckless acts and accidents involving alcohol, such as road accidents, falls, drownings, poisonings and burns. Some of the harms are highly visible, such as vandalism and litter, others are more hidden, such as domestic violence, while others are invisible, such as reduced feelings of safety.

Key findings of consultations

The impacts of alcohol on public safety and amenity:

- potentially affect everybody in some way, regardless of age, gender, socio-economic status, or whether or not they drink
- reduce feelings of safety in public places
- are wide-ranging and include road accidents, violence, property damage, and public disorder
- are felt most at a local level and hence have become a burden upon families, workplaces and local communities
- are often left to business and local governments to manage, including responding to complaints from the public
- occur at all times/days of the week, but peak late at night
- often result from drinking to intoxication in licensed venues
- are exacerbated by the nature of the drinking environment
- are not improving at previous rates under the existing laws (such as. 0.05 BAC driving limit) and enforcement practices (for example, random breath testing in country areas)
- also include injuries and deaths from fires, drowning, poisonings, and workplace injuries

Responses to these sorts of issues have not featured highly in Australia's previous National Alcohol Strategy. This *Strategy* aims to increase awareness and understanding of these issues and identify evidence-based responses to address them where available. The involvement of liquor licensing, law enforcement and local government authorities from all jurisdictions, together with the alcohol beverage and hospitality industry, in the development of the *Strategy* has been key to prioritising this direction.

Violence and abuse

It is not surprising that much of the time and resources of policing in Australia is related to incidents involving alcohol. One study reported that alcohol is involved in 62 percent of all police attendances, 73 percent of assaults, 77 percent of street offences, 40 percent domestic violence incidents, and 90 percent of late night calls (10 pm to 2 am) (Doherty & Roche 2003).

Alcohol is a major factor in homicides. It has been reported that 34 percent of homicide perpetrators and 31 percent of homicide victims were alcohol affected at the time of the homicide occurring (SCRGSP 2005). In 65 percent of Aboriginal and Torres Strait Islander homicides, both the victim and the perpetrators were under the influence of alcohol, in contrast to 24 percent of homicides among the general population (SCRGSP 2005).

In Australia, it is estimated that 47 percent of all perpetrators of assault and 43 percent of all victims of assault were intoxicated prior to the event (English et al 1995). In a single year (1998-99), there were 8,661 people admitted to Australian hospitals with injuries from alcohol-related assaults; 62,534 alcohol-related assaults were reported to police in the same year, and it is estimated that many more went unreported. Of the hospitalisations with injuries from alcohol-related assaults, 74 percent were male and two thirds were aged 15 to 34 years (Matthews et al 2002).

Perceptions of safety

A recent survey of the Australian population revealed that over a 12-month period:

- 24.9 percent were verbally abused
- 4.4 percent were physically abused
- 13 percent were put in fear

by a person/s under the influence of alcohol.
AIHW (2005)

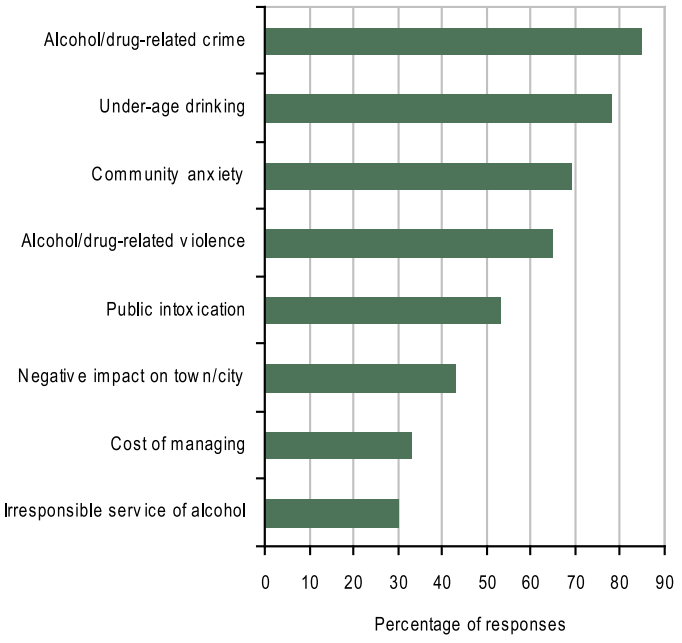
A flow-on effect of the widespread prevalence of alcohol-related violence and abusive behaviour in Australia is a reduction in community perceptions of safety. This occurs not only among those who have been victims of alcohol-related violence, but also among the general community. Furthermore, while most intoxicated people do not actually pose a direct risk to others, the perception that they may cause harm still has the potential to frighten and intimidate others. This, in turn, impacts on perceptions of liveability and the business confidence in areas where there are particularly high rates of alcohol-related problems.

In a recent survey of crime and feelings of safety, 12 percent of Australians identified drunkenness as a major concern in their neighbourhood; 27 percent identified property damage and 23 percent identified concerns about individuals and groups engaged in anti-social behaviour (loitering, loutish behaviour, etc) as a problem in their local neighbourhood (ABS 2003).

Local impacts and responses

It is at the local level that alcohol-related harm is often most acutely felt. Alcohol issues are recognised by Australian local governments as the most significant drug-related issue they have to deal with. A recent survey of 98 local governments in Australia found that alcohol and drug-related crime, underage drinking, community anxiety and violence are the main alcohol and drug issues facing local governments (see Figure 9). The survey found that community anxiety is a greater concern among urban councils (77 percent) compared to rural councils (43 percent), while direct alcohol-related issues (public intoxication, irresponsible serving and underage drinking) are the main concern for local governments with smaller populations (under 25,000) (IGCD Local Government Sub-Committee 2001).

Figure 9. Main alcohol and drug-related issues reported by local government (IGCD 2001)



The costs for local government in addressing alcohol-related issues are substantial. Figures for Queensland, show that in that state alone, local governments spend $62 million each year on public safety and order initiatives (LGAQ 2004). It is also likely that a sizeable proportion of the $240 million spent by local government cleaning public space in that state can be attributed to managing alcohol-related litter, bodily fluid spills, and other by-products of alcohol consumption that impact on local environments (LGAQ 2004).

Good Practice

Licensed premises pick-up the cleaning bill

A large regional local government authority in Victoria has recently increased the municipal rates charges for properties with late night liquor licenses. The higher rates reflect the additional costs to Council in managing the waste and public space impacts of these premises.

Land Use	Rates ($)	Annual cost to a property with a Capital Improved Value of $500,000
Farm	0.002544	$1,272
Residential	0.002544	$1,272
Commercial	0.005539	$2,769
Petroleum production	0.007706	$3,853
Late night liquor license	0.010176	$5,088
Auto & aluminium production	0.010176	$5.088

Additional municipal charges apply to all properties and waste service charges to residential properties.

(Source: City of Greater Geelong 2005)

Local communities have opportunities to influence decisions about alcohol in their community. Many jurisdictions invite comment from local councils when considering liquor sales applications. Some councils underutilise this opportunity because of limited resources or experience. Other councils have developed guidelines that allow both direct feedback and indirect attention to these matters in their day-to-day decision-making; including decisions about building and planning permits that often precede applications for liquor licences. This provides an opportunity for more systematic consideration of local interest and issues. As part of key regulatory functions, there is an underutilised ability to include consideration of preventing alcohol-related harm and other problems.

The role of licensed premises

A partial solution to a bigger problem

Lockouts

- In many parts of Australia, trading hours of licensed premises have been extended and densities have increased
- Associated with this is increasing offending (for example, violence, assault, property damage) outside licensed venues
- In some localities, early morning 'lock-outs' have been introduced whereby patrons are unable to enter premises within one or two hours of closing, preventing all patrons exiting simultaneously and congregating on the streets
- Having to lock potential customers out of venues for reasons of safety is not a sign of civil drinking. It is another proof that patrons are drinking and being served while intoxicated
- Lockouts are said to be successful in reducing street violence but the problem they manage is an artefact of the extension of trading hours

(Source: Australian Drug Foundation 2005)

An important factor in alcohol-related violence is the setting where drinking occurs. The majority of alcohol-related incidents occur in a minority of licensed venues. A study in inner Sydney found that 60 percent of all assaults at hotels and nightclubs occurred within a select group of venues representing just 12 percent of the total number of hotels and nightclubs in the area (Briscoe & Donnelly 2003). Australian studies have generally confirmed that alcohol-related violence most commonly occurs in inner-city hotels, in the early hours of Saturday and Sunday mornings, and usually among young adult males (Doherty & Roche 2003). Recent research indicates that the problem has not shown signs of improving, despite increasing community concern, the spread of locally-based 'alcohol accords' and related safety initiatives, and the introduction of harm reduction as a purpose in all liquor control legislation with Australian jurisdiction (Matthews et al 2002).

Good Practice

NSW Alcohol Linking Program

- Commenced in 1996 with the aim of reducing intoxication and alcohol-related crime by identifying licensed premises that may be serving alcohol irresponsibly.
- Linking Program data 'links' the incidence of alcohol-related crime to intoxication, and enables policing resources to be directed appropriately to reduce crime and the fear of crime.
- Research and evaluation of areas where the Linking Program has been operating have indicated an average reduction in alcohol-related crime of 13 percent.

(NSW Police 2005)

Alcohol-related harm in private settings

Private settings, including homes, family events, youth and adult parties, are often locations for alcohol-related harm. It is likely that much of this harm goes unreported.

Good Practice

Queensland Police Party-Safe Program

- Everyone enjoys going to or hosting a party, and for young people it is a typical part of growing up and celebrating special occasions with friends.
- While most parties are fun for everyone involved, intoxicated guests or gatecrashers can sometimes ruin the occasion.
- Queensland Police has developed a Party-Safe program that provides practical tips to assist in holding successful, enjoyable and safe parties for everyone concerned including parents, hosts and guests.
- There is also a Party-Safe registration form so that party hosts can register their party with the local police.
- Registering a party will provide the police with details they need to know if they are called to the party to deal with an incident.

(Queensland Police 2005)

A worrying aspect of alcohol consumption in private settings is the provision of alcohol to minors. Increasingly, parents and other hosts are exposed to considerable pressure from both other adults and young people, and can be confused about their legal obligations and about how best to prevent and manage the incidence of underage drinking. In addition to the ways parents sometimes make alcohol available to children, parental and adult influence as role models is a critical issue as behaviours may be replicated by young people around them.

While not always occurring in private settings, excessive alcohol has been found to be an important factor in 50 percent of cases of domestic physical and sexual violence (SCRGS 2005). Between 1993-94 and 2000-01, it is estimated that there were 21,487 hospitalisations of females in Australia for injuries from alcohol-related assault (Chikritzhs et al 2003). Other recent research into domestic violence within selected parts of Australia found that 18 percent of adults surveyed had experienced some form of violence by a current or ex partner and that alcohol misuse was one of the variables found to be strongly associated with these occurrences (Dal Grande et al 2003).

Drink driving

Despite great progress in preventing and reducing drink driving, alcohol use is a major contributing cause of road injury in Australia. A substantial reduction in alcohol-related road deaths occurred following a national campaign to reduce drink driving. From 1981 to 1996 alcohol-related road fatalities decreased from 44 percent to 29 percent of all road crash deaths. This equates to a reduction in the mortality rate due to alcohol-related motor vehicle crashes from 5.71 to 3.29 per 100,000 persons. The reduction was attributed to increased legislation, enforcement, and social marketing campaigns aimed at deterring drink driving.

Despite these improvements, it is estimated that between 1990 and 1997, 31 percent of all driver and pedestrian deaths on Australian roads were alcohol-related (Chikritzhs et al 2000). In these cases, the driver or pedestrian had a BAC level over 0.05. What is even more concerning is that of these fatalities, 28 percent had a BAC over 0.10, and 23 percent had a BAC over 0.15. Also of concern is the high rate of alcohol involvement in fatalities from pedestrian collisions and single vehicle non-collisions, which in Western Australia, for example, represent 30 percent and 33 percent of such fatalities respectively. It is in these contexts that some call for a higher tiered range of penalties for serious and multiple drink driving offences (Baker et al 2005), and lowering the legal BAC to 0.00 or 0.02 as a way of more clearly disassociating drinking from driving.

The most recently available figures indicate that between 1992 and 2001, 5,489 people died from road crash injuries due to risky and high risk drinking (Chikritzhs et al 2003). Death rates from road accidents are much greater in rural and remote areas, especially for males. Rural rates are one-and-a-half to two times the metropolitan rate, and remote area rates are more than double. Unlicensed driving, by persons who have had their licence disqualified for drink driving, is also a widespread problem and undermines many strategies aimed at preventing and reducing road injuries. It is estimated that up to 70 percent of people who lose their licence drive without one during their suspension as the risk of being caught is low (Loxley et al 2005). Although the evidence base is relatively small, it appears that the fitting of ignition interlock devices, which require drivers to provide a BAC breath sample before starting their vehicle, does reduce the risk of re-offending

while they are fitted (Loxley et al 2004). There is also recent Australian research indicating the value of brief interventions, with a treatment and rehabilitation focus, that target serious drink drive offenders who have had their license disqualified for an extended period of time (Sheehan et al 2005).

Good Practice

'Think, Don't Drink and Drive, Stay Alive'

- In 2002, Tumbarumba Shire Council (NSW), in collaboration with local police and licensees, implemented a program to reduce drink driving in this small isolated community.
- The program comprised a community education program and the purchase of a bus by licensees to provide alternative transport for patrons of their premises.
- It proved to be a popular initiative and was associated with a reduction of the incidence of drink driving.
- The program is a demonstration of the potential for collaborative projects to reduce alcohol-related harms.

(King & Richards 2003)

Aboriginal and Torres Strait Islander peoples are over-represented in road accidents by approximately 3.5 times compared to the general population. It is estimated that in 1997 there were 31 Aboriginal and Torres Strait Islander deaths per 100,000, compared with 10 deaths per 100,000 for general population (Brice 2000). There is now a large body of Australian research evidence of the link between alcohol consumption levels and Aboriginal and Torres Strait Islander road trauma (ATSB 2004; Alati et al 2000; Brice 2000; Harrison et al 2001).

The workplace

The impact of alcohol problems upon workplaces in Australia is significant, costing business at least $1.9 billion per year (Collins and Lapsley 2002). The costs are associated with absenteeism, reduced productivity, work injuries and deaths. Research on the extent and nature of alcohol use at work, out of work hours (but affecting work), or at work-sanctioned social events is extremely limited (Loxley 2004). Developing workplace programs is complex and requires consideration of health, ethical, legal and industrial relations issues (Loxley 2004).

Good Practice

- A recent review of the evidence base relating to workplace strategies to prevent, reduce and manage alcohol-related issues in the workplace reached a number of important conclusions.
- Generally, there is no strong empirical evidence that any particular workplace alcohol prevention strategy delivers benefit in terms of reduced consumption or lower levels of harm.
- There are, however, logical and theoretical arguments to support a range of strategies such as:
  - occupational health and safety policies
  - employee assistance programs for those experiencing problems
  - primary prevention interventions such as modifying the physical working environment that may encourage problematic alcohol use, such as hazardous working conditions, or aspects of the culture and organisation of the workplace such as poor promotion opportunities
  - breath testing for safety-sensitive occupations
  - information, education and brief intervention programs
  - broad-spectrum health promotion programs
  - whole-of-community approaches

  (Loxley 2004)

This is clearly an area where further research would be of value in building the evidence base for appropriate policy responses.

4.2.2 What responses are recommended?

2A Prevent and reduce alcohol-related injuries.

- Investigate the current evidence base and public interest in a range of measures to reduce alcohol-related road injury, particularly:
  - establishing lower BAC limits for all drivers;
  - establishing that all statutory maximum penalties for repeat drink driving offenders should relate to the BAC of the offender and the number of prior offences committed;
  - creating a "serious" offender category and appropriate penalties for multiple drink drive offenders;
  - creating a specific category for first time offenders with high BACs;
  - examining the appropriateness of installing ignition interlock devices on vehicles of certain categories of offenders such as multiple drink drive offenders and those with high BACs;
  - providing alcohol-related brief interventions, treatment and rehabilitation support for drink drive offenders, as part of re-licensing requirements, in an effort to reduce recidivism; and
  - exploring potential for consistency between Australia and New Zealand and possible other countries in our region in relation to recommended low risk drinking levels.

- Conduct trial demonstration projects that aim to reduce drink driving in regional and rural areas, in partnership with key stakeholders.

- Coordinate with the National Public Health Partnership to ensure the realisation of alcohol-related injury objectives in the National Injury Prevention Plan; especially related to injury other than road traffic injuries.

- Introduce basic strategies in the workplace to prevent and reduce alcohol-related harm in a range of key industries including:
  - development of evidence-informed workplace policies;
  - alcohol and drug awareness initiatives in the workplace; and,
  - employee assistance programs.

- Explore opportunities to engage with the insurance industry to develop strategies to minimise the risk associated with alcohol use.

2B Revise, develop where necessary, and disseminate best practice guidelines on:

- Environmental design and place management to reduce alcohol-related harm on and around licensed premises.

- Private host responsibility, particularly for parents, in partnership with police, schools, local government and family groups.

- Provision, management and promotion of late night transport options, including taxis and designated driver programs from licensed premises.

- Management of alcohol-related issues at public events.

- Responding to drinking in public places among communities of concern, in both urban and regional locations.

- Support and safety services for people who are intoxicated in public settings.

- Harm minimisation and health promotion in community sports club settings where alcohol-related harm occurs.

2C Increase the capacity of local communities, including government, to address public health and safety issues associated with alcohol.

- Examine opportunities for local government to:
  - consider the costs and benefits of liquor licensing applications in their area, including when exercising their building and planning regulatory authority; and,
  - recover the additional costs of maintaining public amenity in areas with high densities of late night liquor outlets through measures such as differential rates and the application of direct fees and charges related to licensing provisions.

- Develop a 'toolkit' to assist local government and local communities to participate in liquor licensing decision-making processes.

- Support the inclusion of alcohol as a priority issue in local community safety initiatives.

- Continue to monitor the impact of arrangements by Aboriginal and Torres Strait Islander communities for restricted availability and total bans on alcohol in the context of reducing violence and enhancing public safety in and around Indigenous communities.

- Encourage and support Aboriginal and Torres Strait Islander communities to develop local solutions to particular problems, including those who have the opportunity and decide to go 'dry' and require health and social support services to assist people to cease drinking.

4.3 Priority Area 3:

Health Impacts

Aim: Improve health outcomes among all individuals and communities affected by alcohol consumption.

4.3.1 What is the issue?

There are positive and negative health impacts from alcohol consumption. When consumed at low levels, there is evidence, albeit debated (Emberson et al. 2005; Fuchs et al. 2004), that alcohol can provide some health benefits for certain age and gender groups. The physical benefits include reducing the risk of cardiovascular disease from middle age onwards. The social benefits include assisting in relaxation, enhancing social interactions, and contributing to traditions and cultural festivities. When used to excess alcohol can produce profoundly negative health and social outcomes. The adverse health outcomes from alcohol consumption range from short-term problems, such as injuries from road accidents and violence, to long-term health problems, such as liver disease, cancers and alcohol dependence. One in ten Australians consume alcohol at levels that are risky or a high risk to health in the long-term. Those aged in their twenties are the most at risk – 14.4 percent of males and 15.1 percent of females in 20-29 year age group consume alcohol at levels that are risky or a high risk for harm in the long-term (Source: AIHW 2005).

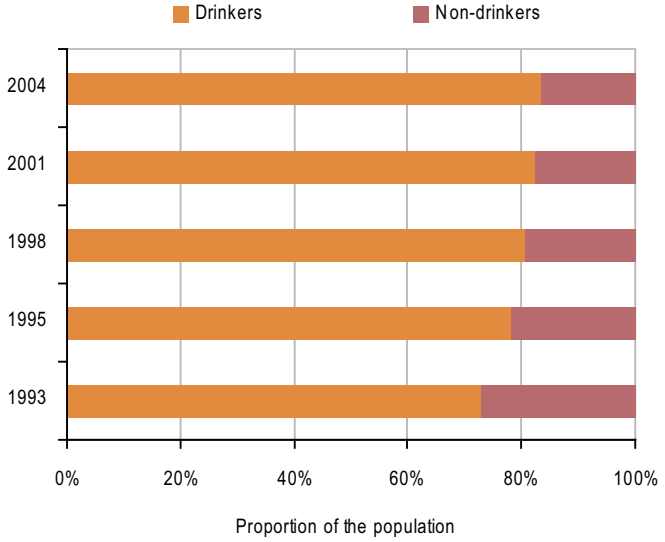
Key findings of consultations
The health impacts of alcohol:

- are not all negative and include some health benefits for some individuals if consumed at low levels
- should be addressed within a whole-of-population approach, rather than only targeting specific high risk groups
- reflect broader socio-economic and structural issues in Australian society
- are both short-term and long-term and this is not fully understood by the general community
- could be reduced if the official Australian Alcohol Guidelines for low risk drinking were more easily comprehended
- are different but equally important for all life stages, including the young, women of childbearing age, and older people
- are most evident among Aboriginal and Torres Strait Islander peoples and people experiencing alcohol dependence
- are not adequately screened nor treated in the mainstream health system at present
- are often multiple and complex, and often include poly-drug use and other significant issues including mental illness

The scale of the problem

In Australia, it is not realistic or desirable to advocate for total abstinence from drinking for the whole population. Current trends show a decline in the number of people in Australia who do not drink and a decline in the number of people who are stopping drinking (see Figure 10).

Figure 10. Proportion of the population who are drinkers and non-drinkers, Australia, 2004 (Source: AIHW 2005).



A more sensible and sustainable goal is to cultivate cultures that embrace a harm minimisation approach. The starting point for such a strategy is to identify the healthy and unhealthy aspects of current drinking cultures, and the causes of harm, and to identify responses known to be effective in fostering and reducing these, respectively.

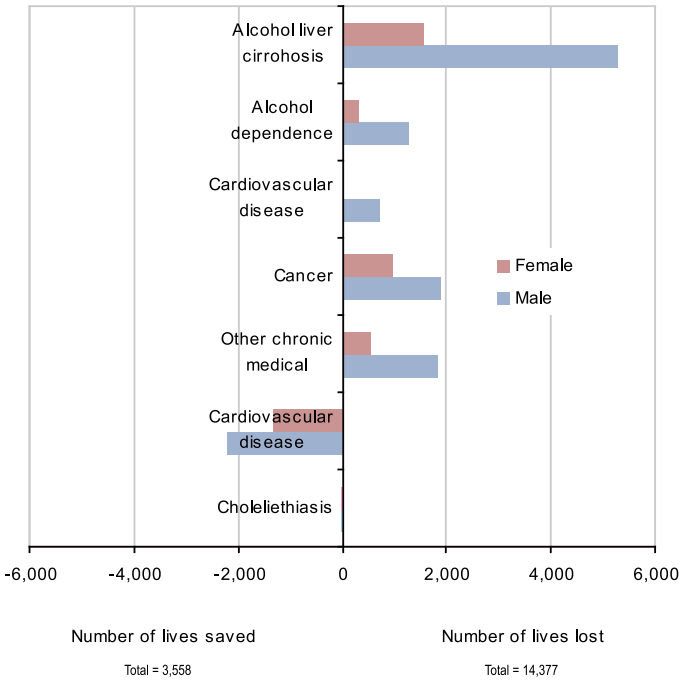
A global problem

- Four percent of the worldwide global burden of disease is attributable to alcohol, which accounts for almost as much death and disability globally as tobacco and hypertension (Room et al 2005).
- Alcohol has been shown to be causally related to more than 60 different medical conditions (Rehm 2003).
- In Australia, it is estimated that alcohol consumption accounts for 4.9 percent of the total burden of disease and injury (Mathers et al 1999).

Death and illness

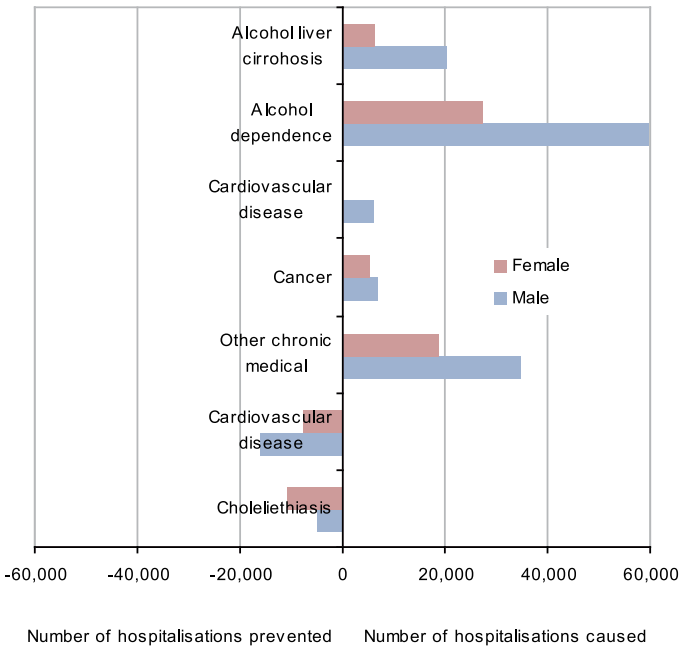
It is important to consider both the short-term and long-term health impacts of harmful consumption of alcohol as both result in significant morbidity (disease and injury) and mortality (death). In addition to the estimated 16,756 Australians who have died from acute conditions, between 1992 and 2001 there were an estimated 14,377 deaths in Australia from chronic conditions due to drinking at risky or high risk levels. Three quarters (76 percent) of these were males and around half (47 percent) of all deaths from risky or high risk drinking for long-term harm were due to alcoholic liver cirrhosis (see Figure 11).

Figure 11. Estimated number of lives lost and saved for chronic conditions due to drinking at levels risky or high risk to health, by sex, Australia, 1992-2001 (Source: Chikritzhs et al 2003).



Despite the significant loss of life from drinking at risky or high risk levels for long-term harm, it is estimated that some lives were saved as a consequence of long-term moderate drinking. A similar pattern exists in the number of hospitalisations for chronic conditions from drinking at risky or high risk levels for long-term harm, albeit much larger in scale (see Figure 12).

Figure 12. Estimated number of hospitalisations caused and prevented for chronic conditions due to drinking at levels risky or high risk to health, by sex, Australia, 1993/94-2000/01 (Source: Chikritzhs et al 2003).



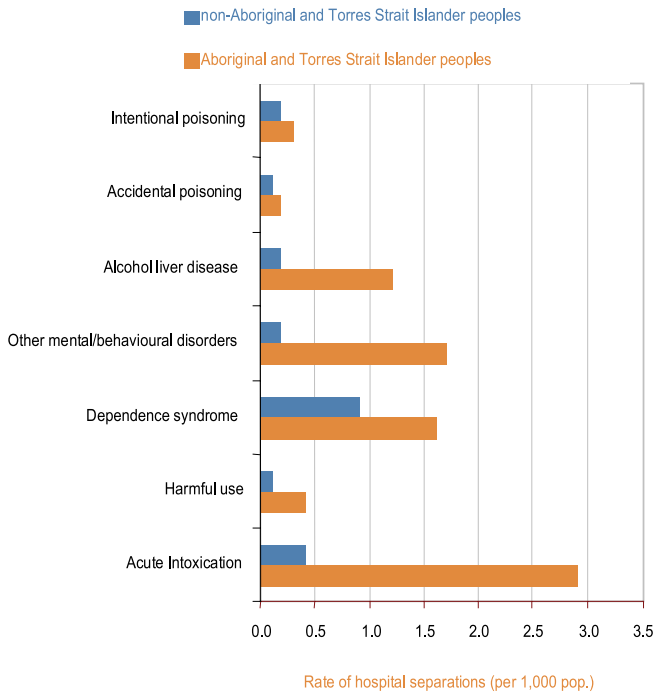
The most common alcohol-related chronic condition for hospitalisation was alcohol dependence. Between 1993-94 and 2000-01, there were 87,186 hospitalisations for alcohol dependence, two thirds of which were males.

A recent report ***Overcoming Indigenous Disadvantage*** (SCRGSP 2005) reported several key indicators of the health impacts of alcohol upon Aboriginal and Torres Strait Islander peoples:

- Regardless of sex and region, between 1990 and 1997, there were markedly higher rates of alcohol-related deaths among Aboriginal and Torres Strait Islander peoples, than the remainder of the Australian population.
- Between 1990 and 2002, young Aboriginal and Torres Strait Islanders were more than twice as likely as young people in the general population to die from alcohol-related causes.
- Death rates among young Aboriginal and Torres Strait Islanders have not improved in the past eight years.

While the leading causes of alcohol-related mortality and morbidity among Aboriginal and Torres Strait Islander peoples are similar to the remainder of the population, the rates at which these occur are considerably higher than those among the general population. For seven major alcohol-related conditions, Aboriginal and Torres Strait Islander peoples are significantly more likely to be hospitalised than the general population (see Figure 13).

Figure 13. Hospital separation rates related to alcohol use by Aboriginal and Torres Strait Islander status, Australia, 2002-03 (Source: SCRGSP 2005).



Particular health concerns

While the available evidence suggests that the birth prevalence of foetal alcohol syndrome (FAS) is relatively small in Australia, the condition is a particular issue of concern in Aboriginal and Torres Strait Islander communities (O'Leary 2004). In Western Australia, recent estimates of the prevalence of FAS are 2.76 per 1,000 births among Aboriginal and Torres Strait Islander children, compared to 0.02 per 1,000 births among children in the general population (Bower et al 2000). The prevalence of FAS in the Northern Territory was 0.68 per 1,000 live births in the general population and between 1.87 and 4.7 per 1,000 live births for Aboriginal and Torres Strait Islander peoples between 1990 and 2000 (Harris and Bucens 2003). Better and more consistent data and evidence are needed about the full range of alcohol-related birth defects, so that specific interventions can be well informed.

Long-term consumption of alcohol at harmful levels is a contributing factor in a number of mental health conditions, including alcoholic psychosis, alcohol dependence syndrome and alcohol-related dementia and Wernicke-Korsakoff syndrome. Recent research provides more evidence of the association between prior alcohol dependence and current depression (Caldwell et al 2002, Hasin & Grant 2002). Risky and high risk alcohol consumption also increases the risk of self-harm and suicide attempts (Borges et al 2004).

Good Practice

Prevention of Wernicke-Korsakoff syndrome

- The Wernicke-Korsakoff syndrome is seen in some long-term heavy drinkers and is caused by thiamine deficiency. The condition is characterised by neural atrophy and many affected individuals become permanently disabled and require long-term institutional care.
- In the early 1980s, research found the prevalence rate in Australia to be the highest recorded in the world.
- In an attempt to prevent cases of Wernicke-Korsakoff syndrome, thiamine supplementation of bread-making flour was introduced in 1990. Since this time, there has been a significant decrease in the incidence of Wernicke-Korsakoff syndrome

(Harper et al 1998).

There are complex health issues arising from harmful consumption of alcohol and the use of other drugs, referred to as poly-drug use. In Australia, alcohol is often the primary drug among poly-drug users, whereas the community focus and principal concern is on illicit drugs, creating a complex cultural and political overlay. *The Alcohol and Other Drug Treatment Services National Minimum Data Set* for 2002-03 found that in 42 percent of alcohol treatment cases, patients' use of other drugs was also a concern (AIHW 2004). The interactions between other drugs (tobacco, illicit and prescription) and alcohol are complex. Australian studies reveal a close association between heroin overdose and alcohol consumption at harmful levels at the time of overdose. Australian research has also found that among cannabis users, alcohol was almost universally used on a regular basis, with most users consuming alcohol at harmful levels.

The ageing of the Australian population is an important issue to consider in developing alcohol policy. It should not be a cause for alarm, but should signal the need for long-term research and planning. As the population ages, the number of older Australians at risk of alcohol-related problems increases. While only 3 percent of 20–29 year olds are daily drinkers, 17 percent of people aged 60+ years are (AIHW 2005).

There were over 110,000 hospitalisations of people over the age of 64 for alcohol-attributable injury or disease over a 9-year period (1993/94-2001/02). Falls precipitated the majority of these in both men and women for all sub-groups in the older years. Among those over 84 years, 63 percent of women's alcohol-attributable hospitalisations and 64 percent of men's were related to falls. (Chikritzhs & Pascal, 2005). Older people are more vulnerable to harms from alcohol due to lower tolerance, increased sensitivity and increased likelihood of interaction with other medications. In some circumstances, there may be a lack of awareness of the potential for interaction, particularly among older people who take prescription medications. This can contribute to a significant number of alcohol-related fall injuries. It is possible, in an elderly population, for consumption to remain steady while the ability to tolerate that level of consumption decreases, leading to alcohol-related problems without any increase in consumption.

Interventions and treatment

Good Practice

The Lifestyle Prescriptions initiative

- Aims to make it easier for GPs to provide healthy lifestyle advice to their patients, focusing on five risk factors: alcohol, tobacco, nutrition, physical activity and obesity.
- The Lifestyle Prescriptions Resource Kit contains consumer resources (posters, pamphlets, checklists), practitioner resources (script pads, assessment tools and evidence and guidelines for each of the five risk factors), and an educational CD-ROM on motivational interviewing.

Australian Government: Department of Health and Ageing (2003)

During 2003–04, there were 136,869 closed treatment episodes in specialist alcohol and other drug treatment services reported in the *Alcohol and Other Drug Treatment Services National Minimum Data Set collection* (AIHW 20045b). In 38 percent of treatment episodes, alcohol was the principal drug of concern, the highest prevalence of all drugs. Despite these high numbers in treatment, figures suggest that there are potentially many more Australians in need of treatment for alcohol dependence than those who have received it.

Who is receiving treatment?

- It is estimated that 459,400 Australians consume alcohol at levels considered to be high risk to health in the long-term (AIHW 2005).
- However, each year only 41,000 Australians register for alcohol-related treatment at government-funded alcohol and other drug treatment agencies (AIHW 2005c).
- On average there are only 35,000 prescriptions each year for the two major pharmacotherapy treatment drugs for alcohol dependence, known as Acamprosate and Naltrexone (HIC 2005)
- New modes of delivering treatment, such as the *Initiating Controlled Drinking by Correspondence Program*, may help to reach those who don't have the time or financial resources to attend clinics, or are uncomfortable in seeking face-to-face treatment

(Thiagarajan 2005).

The low uptake of some proven treatment options for alcohol dependence, such as early and brief interventions and pharmacotherapy for alcohol dependence, despite their proven effectiveness is an issue. Brief interventions are known to be effective in early detection and prevention of alcohol-related health problems. There are opportunities for such interventions in general practice settings and throughout the primary care system. An important factor in applying this approach is establishing effective links between different parts of the system, including general practice, hospital accident and emergency departments, alcohol and drug treatment services, and mental health services. Links outside the traditional health system are also important, including areas such as welfare, housing and other specialist support services.

Specialist services

In many states there is a commitment to ongoing quality accreditation of specialist alcohol and drug treatment services. These initiatives need to be supported nationally to ensure better client treatment outcomes. In Western Australia, the quality accreditation process of specialist alcohol and drug treatment services has been extended to incorporate measures of evidence based practice uptake.

Health professionals

Many health professionals currently lack the resources, support, and ongoing information and training, required to effectively assess and treat patients with alcohol issues. GPs are already a leading profession in responding to alcohol-related health issues in the community, and this should be built on. Eighty-five percent of the population attend a GP each year, and 90 percent every two years; although attendance of some groups, such as young males, is low. A recent survey of general practice activity in Australia found that 'at-risk' levels of alcohol intake were reported by 27 percent of the 32,000 adult patients surveyed, and that patient counselling and advice relating to alcohol is one of the 13 most common clinical treatments provided by GPs in Australia (Britt et al 2004). There are opportunities for GPs to access support and resources for treating people with alcohol issues and mental illness, such as the Better Outcomes in Mental Health Care Initiative.

In the 1990's positions were funded in all medical schools to develop core alcohol and drug curriculum and support teaching efforts and other activities. This program – Coordinators for Alcohol and Drug Education in Medical Schools (CADEMS) contributed to the development of a text and companion work book. However, in the absence of on-going funding, few medical schools have retained a position for a dedicated individual to ensure that this element of education is delivered within the teaching program.

Good Practice

'The local men in this town typically don't come into the clinic until they're really sick. So, we do outreach to the local pubs to talk with the regulars about their health and do some basic health screening, blood pressure checks, diet, exercise. In our town, there are only six local shops, but three of them sell alcohol'.

Community health nurse in small town, regional Victoria

One professional group that warrants particular attention at this time are nurses and midwives. Nurses and midwives have extensive opportunities for patient contact and opportunities for imparting health information and advice. Along with GPs, nurses and midwives comprise the largest profession at the front line of alcohol and drug health issues in the community. They have key roles in brief interventions, routine screening, assessments, treatment support and referral. Nurses are present in accident and emergency departments, general and community health services and obstetric and gynaecology services, mental health services and other specialist areas, and they are increasingly present in general practice. Some undergraduate nursing courses include alcohol and drug subjects in their curricula, including Flinders, Adelaide, South Australia, Wollongong and some of the Australian Catholic Universities. However, many registered nurses and midwives have not had an opportunity to develop skills in alcohol and drug nursing and have not had exposure to alcohol and drug issues through undergraduate or postgraduate education.

4.3.2 What responses are recommended?

The following responses relate to the health system and therefore do not necessarily include other responses that can positively affect the health impacts of alcohol, many of which are recommended elsewhere in this Strategy.

3A Initiate a national effort to enhance the capacity and legitimacy of the nursing profession in addressing alcohol-related health problems.

- Support efforts to include alcohol and drug education in all undergraduate nursing and midwifery curricula.

- Mandatory policy to be developed to ensure that, in all health care settings nurses and midwives automatically assess all patients for levels of consumption of alcohol and define strategies for intervention and clinical management of intoxication and withdrawal, where appropriate.

- Provide nursing and midwifery staff with resources to support alcohol-related screening and early interventions in primary care settings, including hospital accident and emergency departments, general practice, and mental health services.

- Support further development of the Nurse Practitioner role in relation to alcohol and drugs.

3B Promote primary care settings as an accessible and non-stigmatising opportunity for health promotion, prevention and treatment of alcohol use problems.

- Increase the uptake of pharmacotherapy treatment for alcohol dependence, by GPs and specialist alcohol and drug treatment services, including attention to appropriate programs for use with alcohol dependent Aboriginal and Torres Strait Islander peoples.

- Provide a full range of approaches to Aboriginal and Torres Strait Islander peoples to address the impact of alcohol, tobacco and other drugs, and social and emotional wellbeing and issues related to co-morbidity.

- Develop and integrate an alcohol and drug component within the national Better Outcomes in Mental Health initiative to address alcohol dependence and co-morbidity issues in the community.

3C Improve capacity and encourage a system-wide health response to people at risk of short-term and longer-term alcohol-related health problems.

- Explore the potential effectiveness of the development of an assessment and treatment program for offenders where alcohol appears to significantly contribute to a criminal offence.

- Increase the feedback and referral for alcohol-related assessment and treatment from hospital accident and emergency departments to specialist alcohol and other drug services and to GPs.

- Support the ongoing implementation of quality accreditation systems in specialist alcohol and drug treatment services including review of the uptake of evidence based practice.

- Continue working with Aboriginal and Torres Strait Islander community leaders to identify programs that show promise in preventing and responding to alcohol-related health issues in their communities and support wider implementation and evaluation.
  - This could include building on programs such as the Indigenous Alcohol and other Drug National Train the Trainer Pilot Program.

- Establish a profile of the spread and treatment funding allocations to mainstream and targeted services and explore the relationship of funding to alcohol specific indicators such as those associated with alcohol use, indices of harm such as the burden of disease and demand for services.

3D Support whole-of-community initiatives to reduce alcohol-related health problems.

- As part of the cyclical review of the Australian Alcohol Guidelines:
  - consider any special needs for population sub-groups - pregnant women, young people, Aboriginal and Torres Strait Islander peoples, older people, and people who have experienced alcohol dependence;
  - continue to recognise non-drinking options; and,
  - consider the potential for distribution and use of these guidelines to other countries in our region that may request access to such specialist expertise (including consideration of consistency between Australia and New Zealand).

- Recognise the importance of thiamine fortification in preventing serious alcohol-related disease. Examine the potential for its inclusion in alcoholic beverages and the cost-effectiveness of such a measure, while ensuring ongoing provision of thiamine supplementation in flour used in baking.

- Support community-wide health promotion initiatives that have the potential to prevent and reduce alcohol-related harms, with emphasis on supporting local communities in developing and implementing such initiatives.

- Address the co-occurrence of depression and alcohol use and possible treatment responses with a view to multi-pronged prevention initiatives.

- Support consistent data collection on Foetal Alcohol Spectrum Disorders in the general population and in high risk groups.

- Monitor developments in Australia and overseas to address the problem of Foetal Alcohol Spectrum Disorders and identify best practice approaches to reduce its incidence, particularly in Aboriginal and Torres Strait Islander communities.

4.4 Priority Area 4:

Cultural Place and Availability

Aim: Facilitate safer and healthier drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability.

4.4.1 What is the issue?

In Australia today, alcohol retains deep-rooted cultural significance. Few question the cultural place of alcohol or its availability. This cultural acceptance of alcohol also appears to include its harmful impacts among some groups. Australians value the positive part that alcohol plays in their lives, but in general are largely unaware of many of the problems and costs associated with alcohol.

The nation's drinking cultures are driven by a mix of powerful, intangible social forces – such as habits, customs, images and norms, and other interlocking and equally powerful, tangible forces relating to the social, economic and physical availability of alcohol – such as promotion and marketing, age restrictions, price, outlets, hours of access and service practices.

Key findings of the consultations

The cultural place of alcohol:

- is driven by the normalisation of alcohol into everyday Australian consumer behaviour
- is not considered to be part of a 'drug' culture
- does make some positive contributions to Australian society being intrinsic to the cultural significance of socialisation, entertainment, celebration, and hospitality
- is influenced by the promotion of alcohol through advertising and other methods of product marketing
- will not change by telling young people they drink too much

The availability of alcohol:

- has proliferated, especially the number of licensed outlets, providing both on-premises and packaged liquor
- is increasingly driven by the National Competition Policy guidelines that are now reflected in liquor control laws
- is also driven by social forces such as the way alcohol is promoted, which is sometimes exploitive of women and young people
- should be restricted to encourage low risk drinking using price-related levers such as tax to partly achieve this
- should be more tightly regulated, especially for high risk and vulnerable groups in the community
- is most effectively regulated by enforcement of liquor licensing laws

The cultural place and availability of alcohol is a complex issue, but this need not be a reason for inaction. If it is acknowledged that culture change is a key strategy to reduce alcohol-related harm, it then follows that a starting point should be to identify what sort of drinking cultures are desirable.

There are lessons from successes in other fields, such as the cultural changes that have accompanied a reduction in smoking in Australia, the acceptance of compulsory seat belt wearing and support for random breath testing.

The key to these achievements has been a multifaceted approach involving efforts focusing on social values and norms, including community information and social marketing, as well as on regulation and enforcement. Perhaps the most critical factor in successful cultural change has been the clear definition of a long-term vision and a solid commitment from key stakeholders to work towards this vision.

Social availability

The wide-ranging ways in which alcohol is promoted is a major force behind Australia's drinking cultures. Advertising in mainstream media, especially print and television advertising is particularly influential, especially upon young and impressionable groups in the community. There is also evidence of significant peer pressure placed upon many Australian children in the uptake of drinking and equally strong peer pressure placed upon some parents to condone this. Research is required to more fully explain forces behind these social pressures and assess the risks of alcohol use for children and young people.

Social acceptance

The misuse of alcohol, and accordingly alcohol policy are complex areas. In many circumstances, especially Indigenous communities, the misuse of alcohol is a symptom of broader problems. Yet in other settings, especially around young people, it can often result from the simple social acceptance of drinking to excess.
(Winemaker's Federation of Australia 2005)

While there are general population guidelines for alcohol use (see NHMRC 2002), there has been a lack of attention to drinking patterns in adolescence. Efforts to identify safer alcohol use patterns among young people typically focus on short-term harms and major long-term harms. However, young people are unique in that they are also exposed to 'developmental harms' (Toumbourou 2005). Hence, there is still a need to develop a more substantial evidence base on the likely impacts of responses such as increasing the legal purchase age (for example, from 18 to 21 years) in Australia.

Raising the legal purchase age from 18 to 21 years

Arguments for:

- Current patterns of alcohol use in the adolescent and young adult age group have significant net social costs.
- Estimates are that it could have reduced the number of preventable deaths in the 15-24 age group between 1990 and 2002 by 320 (12 percent).
- It would add to benefits already enjoyed from other policies such as drink-drive law.
- It may reduce overall levels of adolescent alcohol use.
- Prior to the mid-20s, the human brain is still developing and emerging evidence associates the prevalent patterns of youth binge drinking with brain damage.
- Australian tolerance toward youth alcohol use is giving rise to historically high rates of binge drinking amongst young women.

Arguments against:

- It may foster intolerance to harm minimisation policies, and this would be counterproductive.
- It may lead to an increase in adolescent experimentation with illicit drug use.

(Toumbourou 2005)

The most common means of obtaining alcohol by underage drinkers is from friends and family (Chikritzhs et al 2004). Of all 12-17 year old Australian school students surveyed in 2002, 11 percent of males and 8 percent of females bought their last alcoholic drink themselves. Parents were the most common source of alcohol, with 38 percent of males and females indicating their parents were the source of their last drink. Students indicated that the three main places they drank alcohol were the family home, a friend's home or a party (White and Hayman 2004).

Clearly, there is a need for a wide range of responses to underage and youth drinking, but the most important strategies to consider are those proven to work, including stricter enforcement of the existing purchase age restrictions and higher penalties for suppliers (licensed outlets, unsanctioned adults, others) of alcohol to underage persons in public and private venues. Other interventions may include information, support and awareness programs for parents, early interventions for at-risk young people, and harm reduction measures targeting underage drinking.

A role for all adults

Unless we change the culture of drinking in the adult community, we're only going to have a marginal impact on the way young people behave.

Dr Neal Blewett,
President of the Alcohol and Other Drugs Council of Australia,
(Quoted in Gooch 2005).

While alcohol prevention campaigns targeting young people can achieve positive results, it can be argued that as long as young people continue to be exposed to one-sided positive depictions of drinking through alcohol promotion, and continue to witness adults' intoxicated behaviour being modelled, and often celebrated by adult drinkers and in the media, these positive results will be only temporary. A more sustainable approach to achieving positive cultural change amongst Australian drinkers, thereby achieving an impact on youth drinking, would be to target intoxicated behaviour across society (Carroll 2005). This approach would seek to reduce the perceived acceptability of intoxicated behaviour and its concomitant alcohol-related harm amongst Australian drinkers.

As a parallel approach to reducing the acceptability of intoxicated behaviour and alcohol-related harm, there needs to be strong promotion of awareness of the Australian Alcohol Guidelines and education about standard drink measures amongst all Australian drinkers. At the same time, there is a key role for an ongoing information strategy to raise awareness of the extensive costs of harmful use of alcohol to individuals, families, communities and the Australian economy. It is important that national social marketing campaigns that aim to prevent alcohol-related harms are planned in conjunction with other information efforts, especially peer education and school-based drug education programs that engage parents as well as young people. Research evidence suggests that school-based drug education on its own will only have a modest impact but this can be enhanced with appropriately planned synergy with high profile media linked efforts.

Partnerships

The Re-Thinking Drinking program for students

- An example of long-standing stakeholder co-operation and multi-sectoral partnerships.
- In 1993, the Australian Associated Brewers Inc (AAB) identified the lack of harm minimisation teaching materials in schools as a resource gap and provided $1.3 million towards research and development for a new program.
- The Youth Research Centre of the University of Melbourne undertook research and development work on the student kits and training.
- A number of state and independent education departments participated in trialling the teaching materials and the initial training of teachers.
- The Australian Government funded the revision of the materials to ensure they were culturally appropriate for Indigenous students and distributed these to all schools in October 2004.
- The Australian Council for Health, Physical Education and Recreation has maintained availability of the resource and revised the materials for the second edition.

(AAB 2005)

It is vital that alcohol promotions be regulated to ensure public health and safety interests are upheld. The alcohol beverage industry introduced its own self-regulatory alcohol advertising system in 1989 prior to the involvement of the MCDS in 2002, in what is now seen by the alcohol beverage industry as a 'co-regulatory' system. This involves guidelines for advertising that have been negotiated with government, and an emphasis on the independent handling of consumer complaints, with all costs being borne by the alcohol industry (ABAC 2004). In parallel with these changes, the MCDS has established some monitoring mechanisms. These regulatory measures will continue to play an important role in shaping safer and healthier drinking cultures in Australia. Under the Alcohol Beverages Advertising Code, advertisements, including those on the Internet, in a retail context, or related to promotion of alcohol at events, must:

- present a balanced, mature and responsible approach to the consumption of alcohol;
- not have a strong appeal to children or adolescents;
- not suggest that consumption can create change in mood or environment, or success of a personal, business, sporting or sexual kind;
- not depict association between consumption (other than low strength alcohol) and use of motor vehicle, boat or aircraft;
- not challenge or dare people to drink or offer inducements to drinking a product because of its higher alcohol content;
- comply with Australia's Advertiser Code of Ethics; and
- not encourage consumption that is inconsistent with the Australian Alcohol Guidelines.

Some ongoing monitoring of advertising and the implementation of the advertising code is necessary to continue to ensure improvement in compliance and timely action. There is also a need to promote the advertising guidelines while ensuring that community members who wish to object to specific alcohol advertisements are able to do so.

Changing the drinking culture

- There are many different cultures in Australia, especially in relation to alcohol, and different groups attach different values to alcohol and its role in their lives.
- Culture is about values, the social understandings or rules that connect us, and the importance and worth of various activities, objects and experiences.
- Lifestyle change, how people use alcohol, is not culture change per se.
- Effective cultural change must be driven by a fundamental shift in the cultural norms that underpin risky drinking patterns.
- The community needs to reassess what is 'socially acceptable' in relation to the consumption of alcohol.
- Cultural change is likely to be difficult, taking years, if not decades, to achieve.
- Cultural change will require a variety of co-ordinated approaches drawing together stakeholders across many different interrelated sectors.

Another shaper of our social attitudes to alcohol is the law. For instance, in Australia today, there can be legal ramifications of being intoxicated when engaged in criminal activity. The leading Australian court decision on criminal liability and self-induced intoxication is the decision of the High Court in *The Queen v. O'Connor ("the O'Connor's case")*, which requires that where evidence of self-induced intoxication raises any doubt as to whether a defendant has acted voluntarily or intentionally, he or she should be acquitted (PVLRC 1999). This principle has become the law in all Australian common law jurisdictions (Australian Capital Territory, New South Wales, South Australia, and Victoria) but is different in jurisdictions that have adopted legislative codes (Northern Territory, Queensland, Tasmania, and Western Australia). While there are some similarities between the jurisdictions' criminal codes, they are far from uniform (PVLRC 1999). With regards to Commonwealth criminal law, the *Criminal Code Amendment Act* was enacted in 1998 to significantly reduce the use of self-induced intoxication as a defence. Further consideration does need to be given to achieving national uniformity and community understanding.

Economic Availability

Research shows that using price-related levers, such as higher tax rates on alcohol, and hypothecating (assigning) the taxation revenue for alcohol specific government initiatives, is highly effective in preventing and reducing alcohol-related harm (Loxley et al 2005). It is generally expected that price-related levers have differential impacts upon some groups in the community, such as low and limited income groups, young people, older people and Aboriginal and Torres Strait Islander peoples. Nonetheless, these differentials are potentially beneficial from a public health perspective and they highlight the need for demand reduction and harm reduction responses for particular groups.

Good Practice

Northern Territory's Living with Alcohol Program

- The recently evaluated *Living with Alcohol Program* (1992-2002) was funded by a government levy on drinks containing 3%+ alcohol by volume.
- The levy was collected by the NT Government and funded community education campaigns, worker training and additional treatment services.
- Legislative changes reduced the drink driving limit and placed restrictions on serving people who were intoxicated.
- The result was a significant reduction in alcohol-attributable deaths and financial cost savings to government.
- The evaluation found that positive outcomes resulted from both the treatment programs and increases in real price through alcohol taxation.

(Chikritzhs et al 2004)

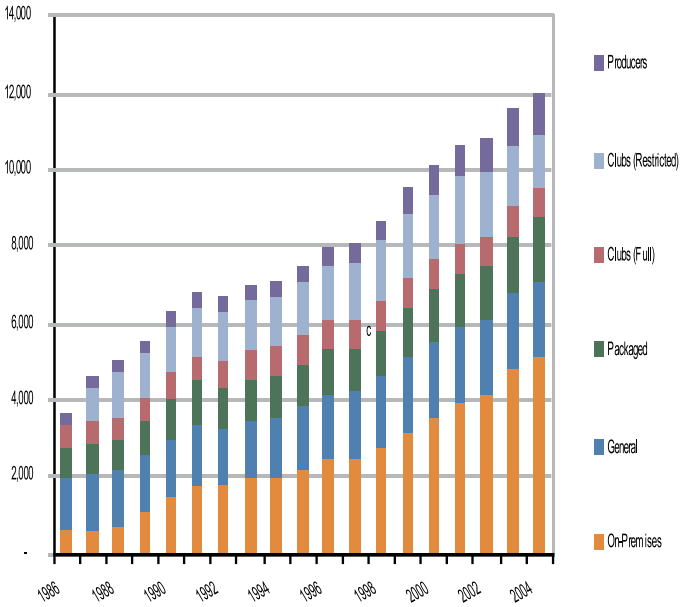
The impact of alcohol taxation on sustainability of the alcohol beverage and hospitality industries needs to be considered. Higher taxation may need to aim for neutral impacts on alcohol-related industries, in order to be accepted by industry and the community. This is a complex domain where historic arrangements are

difficult to change. Nevertheless, the logic of taxation on alcoholic beverages according to their alcohol content (the so-called volumetric approach to alcohol taxation) is difficult to refute. The current system can result in the same tax for a 3.5% alcohol volume drink as a 6% alcohol volume drink. A new tax structure that increases the affordability of low-strength alcoholic beverages is one potential way of achieving both public health and economic benefits.

Physical Availability

In many parts of Australia, the availability of alcohol has proliferated, due in part to relaxation of laws governing the issuing of liquor licences to reflect National Competition Policy principles. In Victoria, for example, the number of liquor licences has increased almost three-fold since 1986, climbing from around 4,000 to more than 12,000 (See Figure 14).

Figure 14. Growth in the number of liquor licences in Victoria, 1986 to 2004 (Source: Consumer Affairs Victoria 2005)



Some have suggested that more open availability of alcohol may foster a moderate, European-style drinking culture. A better understanding of so-called 'European drinking' might provide cause for some hesitation about this suggestion. Nevertheless, whether a culture consistent with moderate drinking would be achieved simply by making alcohol more available without other measures to change Australia's drinking cultures is highly questionable, particularly in light of evidence showing the continuing level of alcohol-related harm in communities where the physical availability has increased. Furthermore, there is now recognition that at the local level, such as individual suburbs, the level of outlet density is highly predictive of levels of alcohol-related harm (Loxley et al 2004; Stockwell. & Gruenewald 2001). In any analysis of the impact of additional licences, it is important to consider the nature of the licence as the consequences for measures of harm are likely to be different when comparing, for example, an additional licensed restaurant with an extra extended hours night club. Further research is required rather than developing policy built only around the existing small evidence base.

Effective liquor licensing is good for everyone

Alcohol is one component of a product mix that includes entertainment, food, gaming and social interaction. For this reason, effective management of the consumption of alcohol has commercial as well as regulatory advantages. The AHA believes that unfettered access to alcohol products can undermine initiatives to promote the responsible service of alcohol. We suggest an effective licensing regime that controls access to, and places effective responsibility on, sellers of alcohol products.
Australia Hotels Association (2005)

All liquor control legislation in Australia now includes reference to one of the objects of liquor control, the reduction of alcohol-related harm. However, the extent to which implementation of these Acts has effectively addressed this object has not been reviewed. Police in most jurisdictions report resource and judicial issues as the major barriers to effective enforcement. The public also has concerns about the apparent limited opportunities for input into the decision-making processes when new liquor licences or changes to existing liquor licences are considered.

Achieving cultural change

A number of central points on changing Australia's drinking culture emerged from the Thinking Drinking 2020 conference held in 2005:

- The role of **social marketing strategies** in health promotion.
- The role of targeted **community mobilisation campaigns**, including in the workplace, in schools, licensed venues and other leisure settings.
- The need to consider **re-regulating alcohol promotions**.
- The ongoing development of coordinated, multi-sectoral **framework conventions** on alcohol policy.
- Whether governments should consider various **taxation reforms** including volumetric arrangements, as well as further restrictions on alcohol availability and supply.
- The need for an increase in **alcohol treatment** and withdrawal services.

(Source: Roche et al 2005)

The extent of alcohol-related problems among Aboriginal and Torres Strait Islander communities remains a major national concern. Patterns of drug use among Aboriginal and Torres Strait Islander peoples have been shaped by social, cultural, economic and historical factors.

While there are important differences between some of the problems facing Aboriginal and Torres Strait Islander peoples and the general population, the physical availability of alcohol is a major determinant that is common to both. Of course, responses targeting Aboriginal and Torres Strait Islander communities should consider the needs of people in all locations, not only in remote communities. It is acknowledged that alcohol issues among Aboriginal and Torres Strait Islander communities are also driven by broader issues such as poverty, dispossession and dislocation, and efforts to reduce alcohol-related harm would be enhanced by wider reaching strategies that address the housing, education and economic issues in these communities.

Aboriginal and Torres Strait Islander communities have a great depth of knowledge and experience in building efforts to change drinking cultures, and have potential to advise on and support efforts of this kind in the wider Australian community. It is to be remembered that when compared to the broader Australian community, a greater proportion of Aboriginal and Torres Strait Islander peoples are non-drinkers.

4.4.2 What responses are recommended?

4A Strengthen the regulation of alcohol availability including liquor licensing controls.

- Establish a working group to consider the impact of National Competition Policy on liquor licensing arrangements.
- Develop a nationally consistent approach and legislation regarding secondary supply of alcohol to minors.
- Increase community involvement in liquor licensing decision-making processes and in responding to related concerns, with emphasis on supporting Aboriginal and Torres Strait Islander communities to advocate for restrictions in the availability of bulk wine in areas affecting these communities.
- Review the mechanisms developed and implemented and the outcomes of the inclusion of the object of harm reduction in liquor control legislation in each jurisdiction.

4B Investigate price-related levers to reduce consumption of alcohol at harmful levels.

- Focus ongoing dialogue on price-related levers to reduce consumption of alcohol at harmful levels.

4C Monitor and review alcohol promotions.

- Implement monitoring and annual reporting on the advertising and promotion of alcohol.
- Maintain prohibition of alcohol promotion that encourages rapid and/or high levels of alcohol consumption.

4D Develop and implement social marketing campaigns to reduce alcohol-related harms.

- Develop a social marketing campaign with the aims of:
  - reducing the perceived acceptability of intoxicated behaviour;
  - promoting the Australian Alcohol Guidelines and standard drink labels and measures; and,
  - increasing awareness of the significant costs to individuals, families, communities and the Australian economy of harmful use of alcohol.
- Ensure that there is appropriate research and thorough consultation to inform the development of social marketing campaigns aimed at Aboriginal and Torres Strait Islander peoples, acknowledging differences in relevant communication messages.
- Ensure social marketing campaigns are comprehensive, targeted and well coordinated, and developed with thorough consultation mechanisms with key community partners and audiences, including the alcohol beverage and hospitality industry, the health sector, law enforcement, school-based drug education programs, young people and local communities.

4E Develop a shared vision for long-term culture change with the aim of reducing alcohol-related harm and developing safer and healthy drinking cultures in Australia.

- Develop an annual national alcohol action audit with an accompanying forum to promote implementation and to ensure accountability of all parties to the National Alcohol Strategy.

4F Examine the legal aspects of alcohol availability specifically in relation to:

- The realisation of stated objects in liquor licensing legislation in each jurisdiction.
- The use of alcohol consumption in the legal defence of diminished responsibility.
- The supply of alcohol to minors.

5. WHERE TO FROM HERE?

Integrated and coordinated responses

The process for implementing the *National Alcohol Strategy 2006-2009* and building capacity is critical to its success. *The National Drug Strategy* highlights the need for coordinated and integrated approaches. The mechanisms that apply to the National Alcohol Strategy include:

- Disseminating, communicating and promoting the *Strategy* nationally to key stakeholders.
- Building partnerships, including partnerships between governments, affected communities, and service providers.
- Implementing the key action areas of the *National Drug Strategy – Aboriginal and Torres Strait Islander Complementary Action Plan 2003-2006*.
- Coordinating outcomes through complementary integrated national, state and territory strategies and structures, and internationally (where appropriate).

Responsibility for action in related areas of law enforcement, criminal justice, health and education, rests with government agencies at all levels, the community sector, business and industry, the media, research institutions, local communities and individuals.

The implementation of the Key Result Areas of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006* would be enhanced by extending the timeframe for implementation of the Complementary Action Plan to bring it into line with the *National Drug Strategy 2004-2009*.

Building the research agenda

Responding to alcohol concerns requires ongoing development of the evidence base to inform policy and practice.

Given the emergence of new evidence and the importance of developing informed policy and programs it will be necessary to conduct a comprehensive review of evidence on alcohol consumption and alcohol-related harms, and responses, during the life of the *Strategy*.

The consultation process identified the need to build a research agenda to evaluate current approaches and to develop innovative strategies to address emerging issues. Issues already identified include the need to:

- Convene a national forum of key research stakeholders and undertake a follow-up project to develop a comprehensive alcohol research agenda to address current gaps and future needs.
- Undertake a future forecasting project to identify alcohol consumption trends, net health, social and economic impacts, and demographic changes such as population ageing, to assist responsive and innovative policy and practice development.
- Review the aetiological fraction methodology to accurately reflect the total effect of alcohol consumption in Australia.
- Schedule a repeat of the 1994 National Drug Strategy Household Survey – Urban Aboriginal and Torres Strait Islander Peoples Supplement.

Data collection

Inconsistent or inadequate data collection was identified as a major concern throughout the consultation process. This serves to inhibit the development of effective responses.

Data collection needs to be strengthened:

- Implement a nationally consistent approach to the collection of alcohol wholesale sales data and/or other appropriate measures of alcohol consumption, in consultation with key stakeholders in each jurisdiction including government, business, and research bodies.
- Develop a national approach to the collection of alcohol-related offence information and best practice response procedures in collaboration with law enforcement in each jurisdiction, that is sensitive to the range of operational priorities.
- Explore opportunities for data collection by hospitals and emergency departments in relation to alcohol-related presentations and admissions, including place of last drink.
- Develop an understanding of the extent of alcohol-related harm by supporting better collection and integration of data from a range of sources.
- Explore opportunities for the collection of local data related to alcohol for use in targeted interventions and policy.

Monitoring and evaluation

Individual jurisdictions will continue to share best practice examples of programs and strategies consistent with the priority areas of the National Alcohol Strategy.

An evaluation of the National Alcohol Strategy will be necessary to determine what impact the strategies and actions have towards changing community drinking cultures.

Indicators of alcohol consumption among young people, such as those developed by DSICA, will provide a useful contribution to monitoring and evaluating the *Strategy* (DSICA 2005).

Developing the workforce

The National Drug Strategy recognises the need for effective workforce strategies and provides details on what actions will be taken. These actions apply to the National Alcohol Strategy. More specifically, there is a sense that alcohol has been less of a focus than illicit drugs in the past few years and attention will need to be given to enhance capacity to provide effective responses.

Specific attention will be given to:

- Support inclusion of alcohol and drug education in all undergraduate nursing curricula.
- Support the development of the nurse practitioner program in relation to alcohol and drugs.
- Increase the capacity of the mental health workforce to respond to co-morbid alcohol and mental health disorders.
- Increase the capacity of Aboriginal and Torres Strait Islander community health workers to respond to alcohol issues through the MCDS Indigenous Alcohol and other Drug National Train the Trainer Pilot Program.
- Increase the capacity of police and emergency services workforces in responding to alcohol-related issues.

Developing partnerships and links

A hallmark of the Australian approach to drug policy has been the capacity to forge partnerships to achieve policy goals. This approach continues to be of critical importance. For instance, in order to develop evidence-based responses to alcohol-related road injuries, there is a need for greater partnerships with the road traffic authorities in all jurisdictions. The National Alcohol Strategy requires strong partnerships and shared responsibility across all levels of government, and with a range of sectors, organisations and peak bodies, including:

- law enforcement
- criminal justice
- liquor licensing authorities
- peak alcohol and drug bodies
- health providers (including addiction medicine specialists, nurses, GPs, and others)
- welfare, housing and other social service groups
- alcohol manufacturers, distributors and retailers
- sporting and other recreational bodies
- parent groups
- educators
- road traffic authorities
- local government
- emergency services (including fire)
- bodies concerned with alcohol that commission research

Shaping the future - providing strong leadership

A feature of Australia's approach to alcohol policy has been a commitment to work multilaterally and regionally. Australia is recognised internationally for the development of alcohol policy and is in a position to provide leadership in the development of international treaties or agreements on alcohol. This leadership is also expected by virtue of our status as a major alcohol-producing nation. In this role Australia is well positioned to advise on the health and social impacts arising from the inclusion of alcohol in free trade agreements in the Asia-Pacific region.

- Australia should continue to build international partnerships with the aim of reducing alcohol-related harm, particularly in the Asia-Pacific Region.

Nationally, there will be a need for leadership and collaborative effort to realise the goals of the *Strategy* and prepare for the challenges of changing drinking patterns 10 to 20 years into the future. This *Strategy* needs to set the scene for the place of alcohol in our day-to-day lives further into the future than the five years of its specific effect. In this sense, the National Alcohol Strategy needs to move us towards safer dinking cultures in shaping our community's future.

APPENDIX 1

Snapshot of the consultations

Consultations with more than 1,000 stakeholders
23 consultations forums around Australia
600 feedback forms received
42 written submissions received
10 Web responses received
250 new research reports, articles and books reviewed

Consultations with special interest groups and national bodies

- Alice Springs Council
- Australian Drug Foundation (ADF)
- Australia Hotels Association (AHA), Victoria, Tasmania and National office
- Australian National Council on Drugs (ANCD)
- Centre for Adolescent Health (CAH)
- Department of Human Services (DHS), Victorian Government
- Drug & Alcohol Services, South Australian Government (DASSA)
- National Alcohol Beverage Industries Council (NABIC)
- National Drug Research Institute (NDRI)
- Odyssey House
- Royal Australian College of Physicians (RACP)
- Victoria Police
- WA Drug and Alcohol Office
- Others

National consultation forums

- Thinking Drinking 2020 Conference - Melbourne
- 8th National Rural Health Conference – Alice Springs
- Hobart
- Perth
- Western Australian Network of Alcohol and other Drug Agencies (WANADA) - Perth
- Whyalla
- Adelaide
- South Australian Network of Drug and Alcohol Services Inc (SANDAS) - Adelaide
- National Local Government Drug and Alcohol Advisory Committee - Melbourne
- Shepparton
- Melbourne
- Victorian Alcohol and Drug Association Inc (VAADA) - Melbourne
- Canberra
- Dubbo
- NSW Network of Alcohol and Drug Agencies Inc (NADA) - Sydney
- Sydney
- Port Macquarie
- Cairns
- Brisbane
- Alice Springs
- Darwin
- Drug and Alcohol Nurses of Australasia (DANA) Conference- Canberra
- Australian Winter School Conference - Brisbane

Written submissions received

- Alcohol and Other Drugs Council of Australia (ADCA)
- Alcohol, Tobacco and other Drugs Council of Tasmania
- Australian Associated Brewers (AAB)
- Australian Divisions of General Practice (ADGP)
- Australian Drug Foundation (ADF)
- Australian Hotels Association (AHA)
- Australian Psychological Society (APS)
- Australian Red Cross
- Australian Wine Research Institute
- Banyule City Council
- Beyondblue
- Commission for Children and Young People, New South Wales Government
- Consumer Affairs Victoria
- Department of Gaming and Racing, New South Wales Government
- Department of Health, New South Wales Government
- Department of Human Services, Victorian Government
- Distilled Spirits Industry Council of Australia (DSICA)
- Drug and Alcohol Multicultural Education Centre
- Drug and Alcohol Nurses of Australasia Inc (DANA)
- Drug and Alcohol Office, Western Australian Government
- Drug and Alcohol Services South Australia (DASSA)
- Drug Education Network (DEN) Tasmania
- Drug Free Australia Ltd
- Health Priorities and Suicide Prevention Branch, Department of Health & Ageing, Australian Govt
- Hunter New England Population Health
- Ms Ann Kingsbury
- Ms Sarah Lindenmayer
- Mater Health Services
- National Local Government Drug and Alcohol Advisory Committee
- Mr Nick Pastalatzis
- Public Health Association of Australia
- Queensland Police Service
- Racing, Gaming and Licensing Division, Northern Territory Government
- Ms Vicki Russell
- South Australia Police
- Townsville City Council
- Tangentyere Council
- VicHealth
- Western Australian Coalition Against Drugs
- Mr Keith Williams
- Winemakers' Federation of Australia
- Mr Ken Wriedt

APPENDIX 2

Project Management and Advisory Groups for the Development of the National Alcohol Strategy 2006-2009:

Strategy Development Team

Professor Margaret Hamilton, University of Melbourne
Mr Trevor King, Turning Point Alcohol and Drug Centre
Mr Brian Vandenberg, Turning Point Alcohol and Drug Centre

Project Management Group

Professor Margaret Hamilton – Australian National Council on Drugs (ANCD)
Mr David Crosbie – Australian National Council on Drugs (ANCD)
Assistant Commissioner Madeleine Glynn – South Australia Police
Mr Rob Griggs – Department of Gaming and Racing, New South Wales Government
Ms Jenny Hefford – Department of Health and Ageing (DOHA), Australian Government
Mr Paul McDonald / Ms Irene Tomaszewski – Department of Human Services (DHS), Victorian Government
Mr Terry Mott, National Alcohol Beverage Industries Council (NABIC)
Ms Coralie Ober – University of Queensland
Mr Bill Pryor – Office of Liquor and Gambling Commissioner, South Australian Government
Assistant Commissioner Bob Waites – New South Wales Police

Health and Social Issues Advisory Group:

Dr Maggie Brady – Australian National University (ANU)
Dr Ngiare Brown – Alcohol Education and Rehabilitation Foundation (AERF)
Mr Keith Evans – Department of Health, South Australian Government
Mr Gary Kirby – Department of Health, Western Australian Government
Dr Chris McAuliffe – Australian Divisions of General Practice (ADGP)
Mr David McGrath – Department of Health, New South Wales Government
Professor John Saunders – University of Queensland
Ms Jann Smith – Department of Health and Human Services, Tasmanian Government
Dr Kyp Kypri – University of Newcastle

Alcohol Beverage and Hospitality Advisory Group:

Mr Anthony Ball – Clubs Australia & New Zealand
Mr Gordon Broderick – Distilled Spirits Industry Council of Australia (DSICA)
Mr Ross Burns – Liquor Merchants Association of Australia (LMAA)
Mr Shaun Gaskett / Mr Bill Healey – Australian Hotels Association (AHA)
Ms Sam Hudson – Australian Associated Brewers (AAB)
Mr Terry Mott – National Alcohol Beverage Industries Council (NABIC)
Mr Stephen Strachan – Winemakers Federation of Australia (WFA)
Mr Jayson Westbury – Australian Liquor Stores Association (ALSA)

Research Advisory Group:

Professor Steve Allsop – National Drug Research Institute (NDRI)
Dr Tom Carroll – Carroll Communications
Mr Mark Cooper-Stanbury – Australian Institute of Health and Welfare (AIHW)
Professor Richard Mattick – National Drug & Alcohol Research Centre (NDARC)
Dr Judy Putt – Australian Institute of Criminology (AIC)
Professor Ann Roche – National Centre for Education and Training on Addiction (NCETA)

Regulation, Enforcement and Public Amenity Advisory Group:

Mr John Goldsworthy – Department of Transport and Regional Services (DOTRS), Australian Government
Mr Rob Griggs – Department of Gaming and Racing, New South Wales Government
Chief Superintendent Denis Edmonds / Chief Inspector Ashley Lange – South Australia Police
Mr Brian Long - Fairfield City Council, New South Wales
Senior Constable Scott Mitchell – Northern Territory Police
Ms Jude Munro – City of Brisbane, Queensland

APPENDIX 3

Definition of low risk, risky and high risk drinking. (Source: National Health and Medical Research Council (NHMRC) (2001), Australian Alcohol Guidelines)

Summary of guidelines for low risk drinking.

1. Alcohol consumption at levels shown below is **not** recommended for people who:
- have a condition made worse by drinking
- are on medication
- are under 18 years of age
- are pregnant
- are about to engage in activities involving risk or a degree of skill (eg driving, flying, water sports, ski-ing, operating machinery).

2. Otherwise risk levels for the following patterns of drinking are as follows*:

For risk of harm in the short-term:				For risk of harm in the long-term:			
	Low risk (standard drinks)	**Risky** (standard drinks)	**High risk** (standard drinks)		**Low risk** (standard drinks)	**Risky** (standard drinks)	**High risk** (standard drinks)
Males on any one day	Up to 6 No more than 3 days per week	7 to 10	11 or more	**Males** on an average day Overall weekly level	Up to 4 per day Up to 28 per week	5 to 6 per day 29 to 42 per week	7 or more per day 43 or more per week
Females on any one day	Up to 4 No more than 3 days per week	5 to 6	7 or more	**Females** on an average day Overall weekly level	Up to 2 per day up to 14 per week	3 to 4 per day 15 to 18 per week	5 or more per day 29 or more per week

***Note:**

1. It is assumed that the drinks are consumed at a moderate rate to minimise intoxication, eg for men no more than 2 drinks in the first hour and 1 per hour thereafter, and for women, no more than 1 drink per hour.
2. These guidelines apply to **persons of average or larger size**, ie above about 60 kg for men and 50kg for women. Persons of smaller than average body size should drink within lower levels.

(Table based on International Guide for Monitoring Alcohol Consumption and Related Harm, WHO, Geneva, 2000)

APPENDIX 4

National Consultation Report

Review of Current Status of Research Evidence

The evidence base outlined in the companion background paper to the previous strategy – Alcohol in Australia: Issues and Strategies (MCDS 2001) was updated by the National Drug and Alcohol Research Centre. Further review of recent literature was undertaken by Turning Point Alcohol and Drug Centre over the duration of the *Strategy* development process.

Consultation Paper

The National Alcohol Strategy (2006-2009) consultation process commenced with the development of a consultation paper in April 2005. The paper, designed to stimulate debate, was informed by input from the project management and advisory groups and a preliminary review of relevant research. The paper was posted on the Commonwealth Department of Health and Ageing website [http://www.alcohol.gov.au] and coincided with nation-wide advertisements inviting on-line submissions and feedback. Hard copies were also posted to key audiences and provided to participants at all community consultations.

Who Was Consulted?

With the assistance of state and territory members of the IGCD and peak bodies, a broad cross-section of key stakeholders (including health, police, liquor licensing, education, beverage and hospitality industry and all tiers of government) were invited to attend consultation forums in metropolitan and some country regions around the country. Participants provided verbal and written feedback on key issues and strategies. Separate informant interviews were scheduled with key stakeholders. Workshops were held at four national conferences to provide opportunity for debate and input into the *Strategy* development process.

Project snapshot:

- Consultations with more than 1,000 stakeholders
- 23 consultation forums around Australia
- 600 feedback forms received
- 42 written submissions received
- 10 Web responses received

Data Analysis

A content analysis was performed on all on-line and other submissions, transcripts of forum and conference discussions, and written feedback collected at all forums and conferences.

Use of Consultation Findings

Key comments and themes were extracted and included in the body of the report. Four themes were nominated as priority areas for the new Strategy:

(1) Intoxication;
(2) Public safety and amenity;
(3) Health impacts; and
(4) Cultural place and availability

The 'potential response' data were aligned with the priority areas and evaluated against the available research evidence. This formed the basis for recommending a series of strategies for addressing the four priority areas.

These strategies were also reviewed to ensure consistency with policy documents such as the *National Drug Strategy: Australia's Integrated Framework 2004-2009* and the *National Drug Strategy Aboriginal and Torres Strait Islanders People's Complementary Action Plan 2003-2006*.

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