CHAPTER 4: Alcohol: Reshaping the drinking culture in Australia

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CHAPTER 4: Alcohol: Reshaping the drinking culture in Australia – Reducing the harm from alcohol

Introduction

In the past, Australia has held an impressive track record in taking bold action to prevent and reduce the harm caused by alcohol. Our drink driving campaigns, low taxes on light beer and thiamine fortification of bakers' flour are examples of prevention measures that have been exported around the world. Measures such as these are now decades old, however, and while they provide a foundation to build upon, more determined and progressive action is required to tackle the nature and extent of the harmful drinking culture that prevails in Australia today and as we head towards 2020.

> *'Alcohol use is embedded in a complex network of social, structural and cultural determinants as well as individual factors' (Quote from submission)*

All Australians, whether drinkers or non-drinkers, are touched in some way by the negative consequences of harmful alcohol consumption. These consequences include public intoxication, alcohol-fuelled violence, property damage, workplace absenteeism, road injury and alcohol-attributable diseases. Importantly, all Australians have a role to play in reshaping our drinking culture, including our governments, law enforcement agencies, the health and welfare sector, the alcohol beverage and related industries, local communities, families and individuals.

The rationale for action

Alcohol plays many roles in contemporary Australian society – as a relaxant, as an accompaniment to socialising and celebration, as a source of employment and exports, and as a generator of tax revenue. It is intrinsically part of Australian culture. The majority of Australians who regularly drink do so in moderation: around three quarters (72.6%) of Australians drink below levels for long-term risk of harm.(1)

However, short-term consumption of alcohol at harmful levels, while only occasional, is also a prominent feature of Australia's drinking culture. One in five (over 20%) Australians aged 14+ years drink at short-term risky/high-risk levels at least once a month.(1) Put another way, this equates to more than 42 million occasions of binge drinking in Australia each year. According to the current National Alcohol Strategy, 'too many Australians now partake in "drunken" cultures rather than drinking cultures' and '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'.(2)

Australia's overall per capita consumption of alcohol is high by world standards, with the country currently ranked within the top 30 highest alcohol-consuming nations, out of a total of 180 countries.(3) Consumption accounts for just over 3% of the total burden of disease and injury in Australia: nearly 5% in males and 1.6% in females.(4) There is little difference between men and women in the risk of alcohol-related harm at low levels of drinking.

At higher levels of drinking, the lifetime risk of alcohol-related *disease* increases more dramatically for women, and the lifetime risk of alcohol-related *injury* increases more dramatically for men.(5) Age is also an important variable in the health burden caused by alcohol, as harm from alcohol-related accident or injury is disproportionate among younger people. Over half of all serious alcohol-related road injuries occur among 15–24-year-olds. In addition, it is known that alcohol

consumption at a young age can adversely affect brain development and is linked to alcohol-related problems later in life.(5)

In Australia, concern among the general public about the adverse health and social effects of alcohol is prominent. A recent survey of Australians revealed that 84% of people are concerned about the impact of alcohol on the community.(14) These consequences include harm to family members (including children), friends and workmates, as well as to bystanders and strangers. The impact of drinking on children, by their parents and/or other adults, is a particular concern: 13% of Australian children aged 12 years or less are exposed to an adult who is a regular binge drinker.(6) It has been estimated that 31% of parents involved in substantiated cases of child abuse or neglect experience significant problems with alcohol use.(7)

> *'Apart from a desire to take the cost pressures off Australia's acute care system into the future, one of the other major drivers for a prevention agenda in health is the relationship between the health of the community, workforce participation and our national productivity' (Quote from submission).*

Beyond the impact of alcohol on the health and wellbeing of individuals and communities, harmful consumption of alcohol also impacts significantly across a diverse range of other areas, including workforce productivity, healthcare services such as hospitals and ambulances, road accidents, law enforcement, neighbourhood amenity, property damage and insurance administration. The cost to the Australian community from alcohol-related harm in 2004/05 was estimated to be more than $15 billion.(8) Much of this cost is borne outside the health system. One of the major tangible costs is lost productivity in the workplace ($3.5 billion). An estimated 689,000 Australians attend work under the influence of alcohol each year.(9) Other costs outside the health system include road accidents (over $2 billion), crime ($1.6 billion) and lost productivity in the home ($1.5 billion). It is also estimated that alcohol is responsible for insurance costs totalling $14 million.(8)

There are variations in alcohol consumption across Australia, and different impacts on specific high-risk population groups. Per capita alcohol consumption varies significantly between urban and rural areas, between Indigenous and non-Indigenous Australians, and between Australian states and territories.

EXAMPLES:

- While the prevalence of drinking at short-term risky/high-risk levels at least monthly is close to 19% in New South Wales and just over that figure in Victoria, it is more than 28% in the Northern Territory.(1)
- Alcohol consumption levels (and alcohol-attributable mortality and morbidity) are consistently found to be lower for people living within major cities when compared to other regions.
- There are specific high-risk population groups whose consumption of alcohol requires special considerations. These include young people, pregnant women, older people, people who have a mental health condition, people who have multiple and complex health and social issues (for example, drug dependence, homelessness, general poor health), and certain occupational groups.

In order to reduce the health and other burdens caused by alcohol, the Taskforce recommends the long-term goal of reshaping Australia's drinking culture to produce healthier and safer outcomes. A key component of reshaping the drinking culture in Australia will involve de-normalising intoxication. While alcoholism or alcohol dependence is often cited as the most serious alcohol problem, in Australia it is excessive single occasion drinking that produces far greater and wider-reaching impacts on the health, safety and wellbeing of individuals and communities.

Recent Australian research for the development of a national alcohol social marketing initiative reports the challenge for communication is that intoxication is closely linked to alcohol per se:

> *'When we simply asked participants about their earliest memories in relation to alcohol there was an overwhelming tendency to leap to their first drunk experience. Further, these experiences were recalled with a sense of pride and nostalgia, even though the stories inevitably involved some embarrassment.'(10)*

By reducing the social acceptability of intoxication, Australia can shift towards a healthier and more sustainable drinking culture, one that does not forgo the enjoyment of safe, sensible and social drinking. A multi-pronged prevention strategy that includes a complementary set of actions is required to support this cultural shift, using economic levers such as taxation, legislative and regulatory measures, policing and law enforcement approaches, boosting support for local communities and individuals, as well as increasing awareness and shifting attitudes in the general community.

The place of alcohol in the lives of Australians, particularly in terms of aspects of the physical availability and the promotion and marketing of alcohol, is generally deregulated by governments or self-regulated by the alcohol industry. This situation has contributed to an exacerbation of alcohol-related problems across the community. It is now critical that we plan the future regulation of alcohol in Australia along a continuum that begins with self-regulation, potentially moving to co-regulation and independent regulation. As outlined in Chapter 1, this approach has been referred to as 'responsive regulation'. It begins with the regulator attempting persuasion, escalating with more punitive regulation if persuasion proves ineffective.(11)

Australia has a unique window of opportunity to significantly expand this type of action in the prevention of alcohol-related harm. In part, this opportunity grows from increased community and political concern about the harmful consumption of alcohol (especially focused on youth drinking), and a heightened willingness from all levels of government to take action in the area. There is also an emerging leadership role in the prevention of alcohol-related harm being taken by police chiefs, emergency services and hospital emergency department physicians across all states and territories. The evidence base upon which important policy decisions can be made is now more robust – it is now clear which of the various policies and programs hold the most promise of being effective, and which offer the least. It is also apparent that there are potential synergies with other public health efforts to address tobacco, obesity and a range of chronic diseases.

> *'It is clear that a prevention agenda requires cross-sectoral, multilevel interventions that extend beyond the health sector into actions in sectors such as housing, welfare, justice, industry, employment, education, family and community service, Indigenous Affairs and communication' (Quote from submissions)*

Despite the fact that there is currently a positive and growing national interest in addressing the negative aspects of alcohol use, and despite very effective reductions in drink driving, there is difficulty in moving from rhetoric to the establishment of coherent, cooperative, strategic and effective action. This situation might be compared to the place of and responses to tobacco smoking in Australia in the

1960s and 70s. Reshaping the nation's drinking culture will therefore require long-term and multi-sectoral effort. Preventing alcohol-related harm must be a responsibility shared among all levels of government, industry and communities.

The contribution of individual behavioural change in reshaping Australia's drinking culture cannot be overlooked, nor underestimated. In March 2009, the National Health and Medical Research Council (NHMRC) published new guidelines on how individuals can reduce the health risks that arise from their alcohol consumption (for further detail, see key action area 2).

Targets

If its recommendations are implemented, the Taskforce aims to achieve the following targets by 2020:

- Reduce the proportion of Australians aged 14+ years who drink at **short-term** risky/high-risk levels at least monthly from 20.4% to 14.3%
- Reduce the proportion of Australians aged 14+ years who drink at **long-term** risky/high-risk levels from 10.3% to 7.2%
- Reduce the proportion of Australian secondary school students aged 12–17 years who are current drinkers and consume alcohol at harmful levels from 31.0% to 21.7%

These targets reflect the Taskforce's long-term vision of a safer drinking culture for Australia. Achieving these targets will require substantial community effort, leadership, sustained effort and new funding.

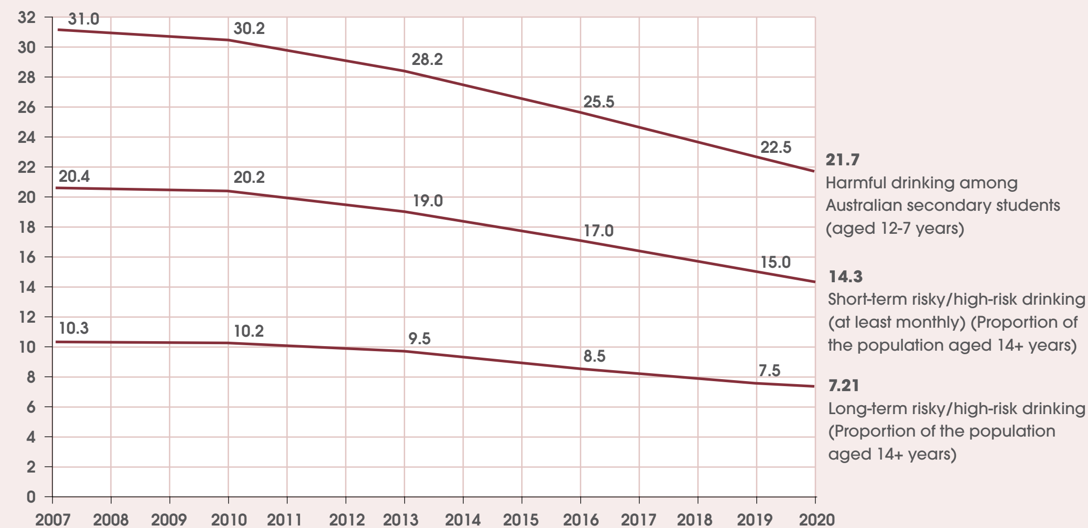
Currently, one in five (20.4%) Australians aged 14+ years drink at short-term risky/high-risk levels at least once a month, and one in 10 (10.3%) drink at long-term risky/high-risk levels.(9) Reducing the prevalence of both short-term 'binge' drinking and long-term 'regular heavy' drinking will be important. Achieving the target of a 30% reduction in both groups, as proposed in the Taskforce Discussion Paper, would see the prevalence of short-term risky/high-risk drinking drop to 14.3% and long-term risky/high-risk drinking drop to 7.2%.

The Taskforce has also set a target for reducing the prevalence of drinking at harmful levels by Australians aged under 18 years, which is now at record levels. Alcohol consumption at harmful levels among Australian secondary school students aged 12–17 years who are current drinkers increased from 26% in 1999 to 31% in 2005.(12) Achieving the target of a 30% reduction in this category would see the prevalence of harmful drinking among Australian secondary school students aged 12–17 years who are current drinkers drop from 31% to 21.7%. In this context it is important to acknowledge that the overall proportion of 12–17-year-old Australian students who drink on a weekly basis has declined from 35% in 1999 to 29% in 2005.(12)

In order to monitor and measure progress towards the three 2020 targets, interim targets need to be set. As shown in Figure 4.1, the Taskforce has set interim targets for the years 2010, 2013, 2016 and 2019. Importantly, these interim target years coincide closely with the triennial National Drug Strategy Household Survey and the Australian School Students' Alcohol and Drug (ASSAD) Survey, the results of which can be used to assess achievement of the interim targets. Should the monitoring of interim targets indicate that progress is not being made at the required rate, this should be a prompt for more responsive regulation in relation to the availability, pricing and promotion of alcohol.

Figure 4.1:

Interim targets for alcohol consumption, 2007–2020



* Note: Harmful drinking among Australian secondary students (aged 12–17 years) refers to ***current drinkers*** who on any day in the week before the survey are male and consumed 7 or more standard drinks and are ***current drinkers*** who are female who consumed 5 or more standard drinks. Short-term risky/high-risk level of alcohol consumption = 7 or more standard drinks on any one day for males; 5 or more standard drinks on any one day for females. Long-term risky/high-risk level of alcohol consumption = 29 or more standard drinks per week for males; 15 or more standard drinks per week for females.

Source: 2007 data from AIHW.(9) 2007 data for Australian secondary students is based on 2005 data from White & Hayman.(12)

The definitions of drinking at short-term risky/high-risk levels (at least once a month) and at long-term risky/high-risk levels that have been adopted for the above targets are based on the previous Australian alcohol guidelines. (13) Currently, these definitions remain as the convention for describing the drinking patterns of the Australian population, notwithstanding the important changes contained in the guidelines themselves that were published in March 2009. However, in the longer term, it is anticipated that the accepted definitions for describing the drinking patterns of the Australian population will need to be modified to reflect the new NHMRC guidelines.

Key action areas

Key action area 1:	Improve the safety of people who drink and those around them
Key action area 2:	Increase public awareness and reshape attitudes to promote a safer drinking culture in Australia
Key action area 3:	Regulate alcohol promotions
Key action area 4:	Reform alcohol taxation and pricing arrangements to discourage harmful drinking
Key action area 5:	Improve the health of Indigenous Australians
Key action area 6:	Strengthen, skill and support primary healthcare to help people in making healthy choices
Key action area 7:	Build healthy children and families
Key action area 8:	Strengthen the evidence base

Key action area 1: Improve the safety of people who drink and those around them

The negative effects of alcohol consumption are far-reaching, extending well beyond accidents and diseases to a range of adverse social consequences, for both drinkers and those around them.

> *'Addressing the cultural place of alcohol in the broader Australian community is critical if we are to effect longer-term change in attitudes and behaviours' (Quote from submission).*

In Australia, concern among the general public about the adverse health and social effects of alcohol is prominent. A recent survey of Australians revealed that 84% of people are concerned about the impact of alcohol on the community.(14) These consequences include harm to family members (including children), friends and workmates, as well as to bystanders and strangers. The negative impacts of drinking by individuals is felt regularly by many Australians: 13.1% of Australians report being 'put in fear' by a person under the influence of alcohol, and 25.4% report being subjected to alcohol-related verbal abuse.(9)

Alcohol-related disturbance and assault ranges from acts of vandalism, offensive behaviour and disruption to far more serious antisocial behaviour, which can result in violence or injury to others.(5) Hence, it is not surprising that much of the time and resources of policing in Australia are related to incidents involving alcohol. Alcohol is significantly associated with crime, with some studies suggesting that alcohol is involved in up to half of all violent crimes and a lesser but substantial proportion of other crimes.(5) There is also a link between drinking and domestic violence. In men who are already predisposed towards domestic violence,

alcohol increases the risk of violence.(5) Alcohol consumption also increases the risk of being a victim of domestic violence.(5)

In recent years there has been a significant liberalisation of state and territory liquor licensing laws, and a corresponding growth in the diversity and number of alcohol outlets, both on- and off-premises. Recent research from three states(15-19) has demonstrated consistent links between the availability of alcohol in a region and the alcohol-related problems experienced there. In particular, these studies have linked rates of violence to density of alcohol outlets. The results of this research are clear: liberalising alcohol availability is likely to increase alcohol-related problems.

This outcome calls into question the general assumption behind regulatory changes over the past two decades, made in accordance with National Competition Policy – that the number and type of alcohol outlets should be determined by market demand for the product, without primary consideration of the potential impact on local communities' health, economy and amenity. Widespread feedback received by the Taskforce indicates that it is time for the granting, compliance and enforcement of liquor licences to be taken more seriously by governments, licensees and enforcement agencies.

The Taskforce believes that improving liquor control laws in each state and territory is a critical element in this reassessment, including refocusing the primary objective of such laws on harm minimisation. Recognising the net benefits to the Australian community that would accrue from strengthening the public health focus of liquor control legislation it would be appropriate to exempt such regulation from the constraints of National Competition Policy.

In addition to regulating the number of alcohol outlets, regulation of their opening hours must be a core component of managing the availability of alcohol. There is a substantial body of international and Australian work that has examined the impact of changes to licensed premises' trading hours on levels of alcohol consumption and rates of related harms.(20) Most Australian studies have shown that increased trading hours have been accompanied by significantly increased levels of alcohol consumption and/or harms. There is also a question of whether particular types of outlets or their design and location tend to attract increased levels of alcohol consumption and/or violence. There is good evidence that certain premises contribute disproportionately to problems,(20) highlighting the need to further examine the types of outlets that are related to assaults. Further studies of these factors, such as alcohol sales, opening hours, capacity and venue style, could provide substantial insights into how different outlets contribute to the effect of outlet density on alcohol-related problems.

It is clear that effective law enforcement is the key ingredient to ensure the efficacy of strategies that aim to alter drinking contexts as a way of preventing harmful consumption of alcohol. While all Australian jurisdictions do have bans on serving intoxicated and underage persons, it is the extent to which these laws are adequately enforced that determines their effectiveness. Similarly, although very popular, the effectiveness of Responsible Service of Alcohol (RSA) programs is also contingent on proper enforcement.(20) Without concerted efforts by police and/or liquor licensing authorities to enforce existing liquor laws, the imposition of RSA policies and/or training has limited impact on the behaviour of servers or the intoxication levels of patrons.(20) RSA programs have the potential to raise awareness of relevant issues, and when highly publicised, the threat of substantial financial penalty has been shown to be particularly effective at motivating behaviour change among licensees. This in turn has resulted in reduced levels of alcohol-related harms, but it is not clear whether such financial penalties remain effective in the long term without frequent and highly visible examples of enforcement.(20) There is also evidence of RSA programs being effective when they include a mandatory component combined with effective enforcement.(21)

In addition to training bar staff in the responsible service of alcohol, there have also been programs designed to train staff in managing aggressive behaviour, given the reality that some patrons could already be intoxicated when they enter a bar and that some aggressive behaviour may not necessarily be alcohol related at all.(21) There have been very few evaluations of such programs, although there is evidence that they can improve staff and patron interactions generally, but the long-term sustainability of these improvements relies on maintaining training and standards of practice.

Proactive or intelligence-led policing has been successful in some parts of the world, and has been partially adopted in some Australian jurisdictions.(21) It involves monitoring alcohol-related incidents in and around licensed premises, combined with regular police visits to licensed premises most often linked to alcohol problems.

FOR EXAMPLE:

- The New South Wales police have adopted a system of enforcing liquor laws through the collection of data such as feedback to police about any alcohol-related crimes that have followed drinking at a specific licensed premises.(22) Known as the *Alcohol Linking Program*, this intelligence-led enforcement system has been shown to reduce alcohol-related crime. Similar approaches are now being trialled and implemented in other jurisdictions.

These approaches require resources, especially at the state level, and it is important for the business case to be developed for an increased focus on policing and enforcement of liquor licensing and liquor control laws. The business case would underpin the development of a new Council of Australian Governments (COAG) national partnership on policing and enforcement.

Since the 1970s, Australian states and territories have been world leaders in driving down rates of drink driving through mass media campaigns and a blood alcohol concentration limit of 0.05, backed by an enforcement regime of random breath testing (RBT). However, road accidents caused by alcohol continue to represent great social costs to the community, totalling more than $2.2 billion each year.(8) There is solid evidence that random breath testing loses much of its effect if levels of enforcement are too low or if the enforcement effort is insufficiently targeted.(23) A recent Australian study has estimated that increased enforcement, equivalent to one test per licence holder per year, would yield benefits estimated to be in the range of $780 million to more than $1 billion.(24)

In Australia, voluntary codes of bar practice involving alcohol beverage and related industries, such as alcohol retailers, hoteliers, licensed clubs and major event organisers, typically take the form of 'liquor accords'. Where they are local and community-based, and involve licensees, other businesses, local government authorities, community representatives and police, such initiatives often aim to reduce alcohol-related harm in the late-night drinking environment.(20)

Locally developed 'accords' have many possible components, such as RSA programs, drink discounting bans, trained security personnel, provision of food, use of safe glassware and alcohol containers, and environmental modifications to reduce conflict and thereby reduce the risk of violence.(25)

Few accords have been formally evaluated, and among those that have, most have been unable to demonstrate effectiveness in either short- or (particularly) long-term reduction of alcohol-related harms.(20) The appeal of accords tends to lie in the development of local communication networks, the facilitation of local input, a sense of local 'control' and improving public relations through open negotiations, rather than in actual reduction of harm. Even so, improved communication and participation may also be perceived as desirable and worthwhile outcomes in some circumstances. It is strongly recommended that voluntary regulation such as this is accompanied by effective law enforcement.(25)

PARTNERSHIP EXAMPLE:

'Lockouts' are increasingly utilised as a licensing intervention in Queensland, Western Australia (Perth) and Victoria (Warrnambool, Ballarat, Bendigo and Melbourne CBD) as one method of reducing late-night migration between venues and associated anti-social behaviours. The Victorian Branch of the Australian Hotels Association (AHA), along with their local members, have been important partners in ensuring the implementation of the Ballarat lockout, citing it as the best example of the usefulness of this type of licensing intervention. The terms and conditions of the Ballarat lockout were negotiated in good faith by the affected licensees (guided by AHA (Vic)), the Mayor and executives of the City of Ballarat, and the Victoria Police Licensing Inspector for the region.(26)

Action 1.1

States and territories to harmonise liquor control regulations, by developing and implementing best practice nationally consistent approaches to the policing and enforcement of liquor control laws.

Action 1.2

Increase available resources to develop and implement best practice for policing and enforcement of liquor control laws and regulations.

Action 1.3

Develop a business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations

Action 1.4

Provide police, other law enforcement agencies and private security staff with information and training about approaches to complying with and enforcing liquor licensing laws and managing public safety.

Action 1.5

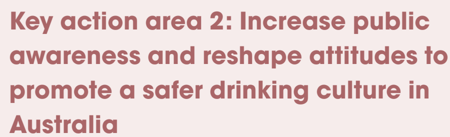
Change current system to ensure local communities and their local governments can manage existing and proposed alcohol outlets through land use planning controls.

Action 1.6

Establish the public interest case to exempt liquor control legislation from the requirements of National Competition Policy.

Action 1.7

Support the above through partnerships with the alcohol beverage and related industries and data collection and monitoring of alcohol sales, policing, and health and social impacts.



Key action area 2: Increase public awareness and reshape attitudes to promote a safer drinking culture in Australia

One of the best examples of successfully shifting the drinking culture in Australia has been the introduction and enforcement of drink driving legislation, and the accompanying mass media campaigns. While this approach was first perceived to be a radical alcohol policy experiment, it has ultimately become one of Australia's great public health success stories.

Since their introduction, there has been considerable research conducted into the effectiveness of public health and safety campaigns, both within Australian and overseas. A systematic review of evaluations of various mass media campaigns that were aimed at reducing drink driving and alcohol-related road accidents in Australia, New Zealand and North America found that campaigns which were carefully planned, well executed, attained adequate audience exposure and were implemented in conjunction with other ongoing prevention activities, such as high-visibility enforcement, have been effective in reducing drink driving and alcohol-related crashes.(27)

An Australian review(28) of several Australian road safety campaigns, which incorporated findings of two international meta-analyses of road safety mass media campaigns,(29, 30) has highlighted some of the key success factors for such campaigns. These factors include:

- Those with a persuasive orientation and which use emotional rather than rational appeals tend to have a greater effect on the relevant measure of effect. In contrast, information-based and educative approaches have been associated with less effective campaigns.
- The use of explicit theoretical models and prior qualitative or quantitative research to inform the development of mass media campaign messages and execution has been found to increase the effectiveness of campaigns.
- The use of public relations and associated publicity appears to be more important to the outcome of the campaign than the use of enforcement. However, the combination of public relations and enforcement as supporting activities shows particularly large effects.

The effectiveness of public health mass media campaigns can be enhanced not only by complimentary enforcement measures, but also by a range of other policy interventions, such as taxation. As noted in the Strategy chapter on tobacco, a study of the impact of various tobacco control policies and televised anti-smoking campaigns on adult smoking prevalence in Australia found that increases in the real price of cigarettes along with the mass media campaigns, broadcast at sufficient exposure levels and at regular intervals, have been critical for reducing population smoking prevalence.(31) The study found there was a 0.3-percentage-point reduction in smoking prevalence by either exposing the population to televised anti-smoking commercials at an average of almost four times per month – 390 Target Audience Rating Points (TARPS) per month – or by increasing the cost of a pack of cigarettes by 0.03% of gross average weekly earnings. Another Australian study, which assessed the impact of the population-based skin cancer prevention program *SunSmart*, found that population-based prevention programs incorporating substantial televised mass media campaigns into the mix of strategies are highly effective in improving a population's sun-protective behaviours.(32)

Australia's successes in public health and safety-oriented mass media campaigns provide substantial guidance and confidence to pursue similarly constructed campaigns aimed at reshaping Australia's drinking culture. To date, a significant obstacle in the development of a well-planned, adequately resourced, coordinated and effective national alcohol

campaign has been the negative perception of previous campaigns – with the notable exception of campaigns targeting drink driving behaviour. Several past campaigns have focused solely on young people's drinking, rather than that of adults, and have been short-term, one-off initiatives with insufficient reach and limited evaluation. If any meaningful and lasting behavioural change among Australian drinkers of all ages is to be achieved, this cycle of ad hoc, fleeting alcohol campaigns must be broken.

Recent research for the development of a new national alcohol social marketing initiative concludes that while such youth-focused campaigns can achieve positive results, they operate in a social environment where young people are exposed to a significant amount of contrary messages. Hence, a more sustainable approach would be to aim to effect wider change in societal behaviour towards alcohol.(10) The research concludes that the best opportunity for effecting a change in Australia's drinking culture will be in the targeting of attitudes towards intoxication, or more specifically, the perceived acceptability of intoxicated behaviour. It is recommended that the development of an alcohol social marketing campaign consider a staged approach by:

- Initially raising the consciousness of drinkers about the health and safety effects of their drinking on those around them
- Following this by targeting various segments of the population (young males, females, older people, parents) regarding the downside of intoxication (for example, shame, embarrassment and humiliation)

The target audience for a major new national alcohol social marketing campaign must be the whole community: all Australians who drink, not only those who experience alcohol dependence, as well as those who are negatively affected by somebody else's drinking. The planned timeframe for the campaign must be at least 15 to 20 years – long enough to underpin the national alcohol strategy for the next two decades and achieve significant changes in Australia's drinking culture.

Action 2.1

Develop and implement a comprehensive and sustained social marketing and public education strategy at levels likely to have significant impact, building on the National Binge Drinking Campaign and state campaigns

Action 2.2

Embed the main themes and key messages within a broad range of complementary preventative health policies and programs

Ensuring that future alcohol social marketing campaigns complement and support other policy interventions and programs will be critical for their success, especially in relation to particular settings where alcohol polices and programs are being implemented. Settings where there are concentrations of young people in early adulthood, such as TAFEs and universities, provide a valuable opportunity for increasing awareness and promoting safer and healthier attitudes and behaviours in relation to alcohol. Research suggests that alcohol education and prevention programs aimed at this population should target them prior to their arrival on campus, utilising web-based communications.(34) Recently, online alcohol education and prevention programs have been trialled and evaluated in North America, New Zealand and to a limited extent in Australia, and appear to offer the potential to address the harmful drinking culture that is common among tertiary students.(35-37)

Australian workplaces are a setting with great potential for targeting and assisting people who consume alcohol in harmful ways. There are at least two important rationales for workplace interventions addressing the harmful consumption of alcohol: to improve productivity, and to improve workplace safety.

(25) In the Australian context, approaches to workplace alcohol issues are influenced by occupational health and safety laws and polices, and the creation of prevention strategies must be considered in this context. Employee Assistance Programs (EAP) provide a potential opportunity for interventions that are known to be effective, such as brief interventions for high-risk drinkers.

A recent study of alcohol consumption by Australian workers and the impact of alcohol consumption on absenteeism has pointed to the need for workplace education to influence young employees' attitudes and behaviours regarding alcohol use.(38) The study also suggests that there is a need to take a 'whole of workplace' approach when designing and implementing prevention strategies that target both 'problem drinkers' and workers who drink at short-term risk levels, even infrequently, because the latter have an elevated risk of alcohol-related workplace absenteeism.(38) As discussed in Chapter 1, there is also a need to address structural factors in the workplace as a more sustainable prevention measure, including reducing stressful working conditions that may lead to health-damaging behaviour such as the harmful consumption of alcohol.(39)

Action 2.3

> ***Introduce basic strategies in the workplace to prevent and reduce alcohol-related harm in a range of key industries.***

The contribution of individual behavioural change in reshaping Australia's drinking culture cannot be overlooked, nor underestimated. In March 2009, the NHMRC published new guidelines on how individuals can reduce the health risks that arise from their alcohol consumption.(5) Research since the previous, 2001 edition of the guidelines has reinforced earlier evidence on the risks of alcohol-related harm, including a range of chronic diseases, accidents and injury.

The 2009 guidelines take a new approach to developing population-health guidance, that:

- Goes beyond looking at the immediate risk of injury and the cumulative risk of chronic disease, to estimating the overall risk of alcohol-related harm over a lifetime
- Provides advice on lowering the risk of alcohol-related harm, using the level of one death for every 100 people as a guide to acceptable risk in the context of present-day Australian society
- Provides universal guidance applicable to healthy adults aged 18 years and over (Guidelines 1 and 2), guidance specific to children and young people (Guideline 3), and to pregnant and breastfeeding women (Guideline 4)(5)

AUSTRALIAN GUIDELINES TO REDUCE HEALTH RISKS FROM DRINKING ALCOHOL(5)

Guideline 1: Reducing the risk of alcohol-related harm over a lifetime:

For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.

Guideline 2: Reducing the risk of injury on a single occasion of drinking:

For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

Guideline 3: Children and young people under 18 years of age:

A. Parents and carers should be advised that children under 15 years of age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important.

B. For young people aged 15–17 years, the safest option is to delay the initiation of drinking for as long as possible.

Guideline 4: Pregnancy and breastfeeding:

A. For women who are pregnant or planning pregnancy, not drinking is the safest option.

B. For women who are breastfeeding, not drinking is the safest option.

Guideline 1 is based on calculations of the lifetime risk of harm from drinking, from a chronic disease or through accident or injury, which estimates that for both men and women, the lifetime risk of death from alcohol-related disease or injury remains below 1 in 100 if no more than two standard drinks are consumed on each drinking occasion, even if the drinking is daily.(5)

Guideline 2 is based on research showing that as more alcohol is consumed on a single occasion, skills and inhibitions decrease while risky behaviour increases, leading to a greater risk of injury during or immediately after that occasion.(5)

There is little difference between men and women in the risk of alcohol-related harm at low levels of drinking. However, as mentioned previously, at higher levels of drinking, the lifetime risk of alcohol-related disease increases more quickly for women and the lifetime risk of alcohol-related injury increases more quickly for men.(5) On this basis, the NHMRC has advised equivalent levels of drinking for both and men in order to remain at low risk of harm.

Key action area 3: Regulate alcohol promotions

Alcohol marketing and promotion is a global activity, with the largest corporations promoting their products across the world.(21) Marketing strategies include an integrated mix of advertising on television, radio, the internet, print media, sponsorship of sports and cultural teams and events, point-of-sale and other promotions, product placement and product design, including the packaging and naming of alcohol beverages.

While the Australian Government currently spends approximately $10 million on alcohol-related health campaigns each year, total alcohol advertising expenditure in Australia is reported to be $119 million.(40) Based on estimates from the United States, it is likely that two to three times this amount is spent on

'unmeasured' advertising, such as sponsorships, point-of-sale promotions, giveaways, branded materials and special events.(41) It is significant that the figure is exclusive of sponsorship of sports and cultural events by alcohol companies, as such events generally represent a substantial marketing investment by large alcohol companies in Australia. It also does not take account of extensive promotion for many sales outlets. A recent study found that alcohol-industry sponsorship of sportspeople, and in particular the provision of free or discounted alcoholic beverages, is associated with hazardous drinking.(42)

The broader impact of advertising upon individuals can be seen as having both immediate effects, such as influencing decision making with regard to brand preference, as well as longer term effects, for instance reinforcing pro-drinking messages.(21) In this way, both the content and context of advertising and the frequency of media exposure can have an impact on individuals' attitudes and behaviours. While the effect of alcohol advertising on young people's alcohol consumption is often disputed by advertisers and the alcohol beverage and related industries, these arguments are often based on studies that are flawed because of methodological and theoretical weaknesses.(43)

A recent systematic review of longitudinal studies examined the impact of alcohol advertising and media exposure on adolescent alcohol consumption. The study concluded that alcohol advertising and promotion is associated with an increased likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol.(44) A study into the effect on young people of portrayals of alcohol consumption in television commercials and in movies found a causal link between exposure to alcohol commercials and drinking role models on acute alcohol consumption.(45) Another recent study of the effects of ownership of alcohol-branded merchandise (ABM) by young people found that among those who had previously not drunk alcohol, ABM ownership is independently associated with increased susceptibility and initiation to drinking and binge drinking.(46)

As discussed later, the young brain is particularly vulnerable to long-term damage from the toxic effects of alcohol when it is consumed regularly at risky/high-risk levels, at least until the age of 25.

Unlike tobacco advertising, which was banned in Australia in 1995, there are no alcohol advertising bans in Australia. Some restrictions, including advertising content controls, apply (see below). Alcohol advertising in Australia is subject to a number of different laws and codes of practice. The Australian Association of National Advertisers Code of Ethics covers general advertising issues. Other applicable laws and codes include:

- The Trade Practices Act
- State and Territory fair trading legislation
- The Commercial Television Industry Code of Practice
- The Commercial Radio Code of Practice
- The Outdoor Advertising Code of Ethics
- The Alcohol Beverages Advertising Code (ABAC)

The Commercial Television Industry Code of Practice states that alcohol advertisements can only be shown during M, MA or AV classification periods. However, on weekends and public holidays alcohol advertisements can be shown as an accompaniment to the live broadcast of a sporting event.

Alcohol advertising is covered in detail by the Alcohol Beverages Advertising Code (ABAC) Scheme. Currently voluntary, the scheme covers only certain forms of direct advertising, such as television, radio, print, outdoor and, more recently, internet advertising. The ABAC Scheme is funded and administered entirely by the alcohol industry. Australian, state and territory governments are involved through the presence of one government representative on the ABAC Management Committee.

The main aims of the scheme are to ensure that alcohol advertising presents a responsible approach to drinking, and does not have appeal to children or adolescents. Among other rules in the code, the administration of the following is often questioned by community members: 'Advertisements for alcohol beverages must not depict the consumption or presence of alcohol beverages as a cause of or contributing to the achievement of personal, business, social, sporting, sexual or other success' (ABAC 2008, Clause C (i)).(47)

In 2003 the Ministerial Council on Drug Strategy (MCDS) considered a report on the effectiveness of the ABAC Scheme. Some issues of concern identified include:

- The current system does not address public health concerns about alcohol advertising and use
- The high dismissal rate for complaints about alcohol advertisements heard by the Advertising Standards Bureau does not engender community confidence in the complaint system
- The current system does not apply to all forms of advertising; for example, packaging, electronic advertising, sponsorships, point-of-sale advertising and promotions
- The effectiveness of the current system is compromised by the amount of time taken to resolve complaints(48)

Despite the ABAC Scheme's rule to discourage advertising that has 'strong or evident appeal to children or adolescents', research shows that a substantial amount of alcohol advertising is communicated to young people. For example, a recent study found that in 2007 Australian adolescents were exposed to significant levels of alcohol advertising from free-to-air television.(49) The study found that in Melbourne, four of the 30 top alcohol beverage brands generated similar or greater exposure to 13–17-year-olds compared with those aged 18–29 years.(49)

An international expert on alcohol advertising and public health has recently cautioned that televised promotions will become increasingly challenging for Australian regulators over the coming decade, as television channels continue to expand globally, offering advertisers even greater opportunities for reaching narrow age demographics, and as a proliferation of new digital television channels emerge in Australia. In this context, it is advised that standards for alcohol advertisers must be strengthened.(50)

As a self-regulatory scheme, ABAC's effectiveness largely depends on the independence of its complaints body with powers to sanction.(51) Recent research has revealed that less than three in 10 (28%) people surveyed reported an awareness of restrictions or regulations covering the advertising of alcohol, in terms of what can be said or shown. It is estimated that only 3% of the total adult population are aware of the existing ABAC Scheme and know what it relates to.(52) Among the 30% of people who reported being concerned about any alcohol advertising, only 2% had made a formal complaint.(43)

Until the above issues are addressed, pressure remains to move to a more tightly regulated advertising environment with strict government controls. The World Health Organization (WHO) recently recommended that governments be supported:

- To effectively regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and of sponsorship of cultural and sports events, in particular those that have an impact on younger people
- To designate statutory agencies to be responsible for monitoring and enforcement of marketing regulations
- To work together to explore establishing a mechanism to regulate the marketing of alcoholic beverages, including effective regulation or banning of advertising and sponsorship, at the global level(53)

In April 2009, the MCDS agreed to a series of reforms for strengthening the alcohol industry's existing self-regulatory system that will be presented to COAG, including:

- Mandatory pre-vetting of all alcohol advertising
- Expanding the ABAC management committee to have a more balanced representation between industry, government and public health
- Expanding the adjudication panel to include a representative specialising in the impact of marketing on public health
- Expanding the coverage of the scheme to include emerging media, point of sale, naming and packaging
- Meaningful and effective sanctions for breaches of the code(54)

Given the significant shortcomings of the ABAC Scheme to date, it is appropriate to plan the future regulation of alcohol advertising in Australia along a continuum that began with self-regulation, moving towards co-regulation as indicated by the MCDS and then to independent regulation if co-regulation is found to be ineffective. This form of responsive regulation begins with the regulator attempting persuasion, escalating with greater regulation if persuasion proves to be ineffective.(11)

In summary, the Taskforce has reviewed the arguments regarding the links between advertising and alcohol consumption and alcohol-related harm, and has also taken into account submissions which disagree with this association. Having considered all the evidence to hand, the Taskforce is of the strong view that reducing the exposure of young people to alcohol promotions is an essential element in reducing alcohol-related harm in Australia. This is further reinforced by evidence that young people are highly vulnerable to the effects of alcohol up to the age of 25.

The Taskforce is particularly concerned about the high levels of alcohol advertising and promotion to which adolescents and young Australians are exposed during live sport broadcasts, during other high adolescent/child viewing times, through sponsorship of sport and cultural events, such as sponsorship of professional sporting codes, and through youth-oriented print media and internet-based promotions.

Action 3.1

In a staged approach phase out alcohol promotions from times and placements which have high exposure to young people aged up to 25 years.

In recent years a number of high-profile sportsmen have reportedly been involved in alcohol-related violence and sexual violence, setting very negative examples for young Australians to follow. Despite the stated willingness of the national sporting codes to address these problems, much work remains to be done. This progress could be assisted by the development of enforceable codes of conduct with meaningful penalties

Action 3.2

Introduce enforceable codes of conduct requiring national sporting codes to take greater responsibility for individuals' alcohol-related player behaviour.

One of the most formidable obstacles to effective public education campaigns on alcohol is product advertising by the alcohol industry that intentionally promotes pro-drinking messages to the general population, much of which also reaches young people. In response, the governments of some countries have sponsored counter-advertising programs, which provide health advice about alcohol.(21) These might include public services announcements, or warning messages within actual product advertisements. Counter-advertising may be a more pragmatic option than banning advertising altogether, but it is important that

its message not be compromised. Although rare, there are examples of well-planned and implemented counter-advertising programs that have had some success, particularly in building support for public health-oriented alcohol controls.(21) There is also very strong evidence from other public health areas such as tobacco about the value of such approaches.

Warning labels on alcohol products, while not required in Australia, have a high level of public support. Evaluations of alcohol warning labels are generally limited to the US experience, where small, text-style labels were implemented in 1989. While there is some evidence of effects on knowledge and attitudes, there is as yet no evidence that warning labels, as a single policy measure, influence drinking behaviour.(55)

By contrast, the tobacco labelling experience offers strong evidence that warning labels can be effective not only in increasing information and changing attitudes, but also in changing behaviour. The successful use of tobacco warning labels suggests that alcohol warning labels should:

- Be graphic and attention-getting
- Occupy a considerable portion of the package surface, for example at least 25% of the physical space
- Involve rotating and changing messages

Perhaps most importantly, labels should complement, and be complemented by, a wider range of strategies aimed at changing behaviour.

Recently, the Australia and New Zealand Food Regulation Ministerial Council (ANZFRMC) considered a report on alcohol warning labels and the evidence of their effectiveness on risky alcohol consumption. The report was developed in response to the announcement by COAG to curb alcohol misuse and binge drinking among young people. The ANZFRMC has referred this report to the MCDS to allow a single and coordinated response to COAG as a part of its broad and comprehensive approach to reducing binge drinking.(56)

Action 3.3

Require health advisory information labelling on containers and packaging of all alcohol products to communicate key information that promotes safer consumption of alcohol.

Action 3.4

Require counter-advertising (health advisory information) that is prescribed content by an independent body within all alcohol advertising at a minimum level of 25% of the advertisement broadcast time or physical space.

Members of the public can make complaints about alcohol advertisements

Under the alcohol industry's current self-regulatory system for alcohol advertising, known as the Alcoholic Beverages Advertising Code (ABAC) Scheme, alcohol advertisements in Australia must:

a. Present a mature, balanced and responsible approach to the consumption of alcohol.

b. Not have a strong or evident appeal to children or adolescents.

c. Not suggest that the consumption or presence of alcohol beverages may create or contribute to a significant change in mood or environment (and accordingly must not depict the consumption or presence of alcohol beverages as a cause of or contributing to the achievement of personal, business, social, sporting, sexual or other success).

d. Not depict any direct association between the consumption of alcohol beverages, other than low alcohol beverages, and the operation of a motor vehicle, boat or aircraft or the engagement in any sport (including swimming and water sports) or potentially hazardous activity.

e. Not challenge or dare people to drink or sample a particular alcohol beverage, other than low alcohol beverages, and must not contain any inducement to prefer an alcohol beverage because of its higher alcohol content.

f. Comply with the Advertiser Code of Ethics adopted by the Australian Association of National Advertisers.

g. Not encourage consumption that is in excess of, or inconsistent with, the Australian Alcohol Guidelines issued by the NHMRC.

h. Not refer to the ABAC Scheme, in whole or in part, in a manner which may bring the scheme into disrepute.

Anybody wishing to complain about an alcohol advertisements which they believe is in breach of the above, can do so by lodging a complaint with the Advertising Standards Bureau at www.adstandards.com.au.

Key action area 4: Reform alcohol taxation and pricing arrangements to discourage harmful drinking

The price of alcohol clearly impacts on consumption patterns. Australian and international studies confirm that when alcohol increases in price, consumption is reduced.

A recent systematic review of 112 studies examined the relationships between alcohol tax or price levels and alcohol sales or self-reported drinking. The review concluded that alcohol price and tax increases are related inversely to drinking levels; in other words, policies that raise the price of alcoholic beverages are an effective means of reducing alcohol consumption.(57) In addition, studies have shown that price increases reduce problems due to alcohol, including binge drinking and a variety of alcohol-related harms (for example, motor vehicle accidents, cirrhosis mortality and violence).(58-60)

However, it should be recognised that price does not act in isolation from a range of other influences. The current National Alcohol Strategy observes that Australia's drinking cultures are driven by a complex mix of powerful, intangible social forces. These forces include habits, customs, images, 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.(2) Given the complexity of the relationship between alcohol price and consumption, it is important that when alcohol taxation arrangements are being developed, the relationship between the price of individual

alcohol products and consumption amongst particular groups of drinkers is carefully modelled against known price elasticity and existing consumption patterns.

The Taskforce notes that alcohol taxation is currently the subject of a review by Federal Treasury (the Henry Review), which is considering the future of the entire tax and transfer payment system in Australia. Under Australia's current alcohol tax system, different products – beer, wine and spirits – are all taxed differently. The result is that very different amounts of tax are payable on a standard drink, depending on beverage type, alcohol concentration, container size, size of producer and the pre-tax price of the product.(61) From a public health perspective, some of these differences are desirable, such as the relatively low tax on low-strength beer as an incentive for the production and consumption of such products. However, some differences under the current regime are a cause for concern (see Figure 4.2 and the box below). In this context, it is also important to consider that the production costs of alcohol products vary considerably between product types (for example, spirits are relatively inexpensive to manufacture compared to beer and wine products), which in turn has a bearing on the ultimate cost price to consumers.

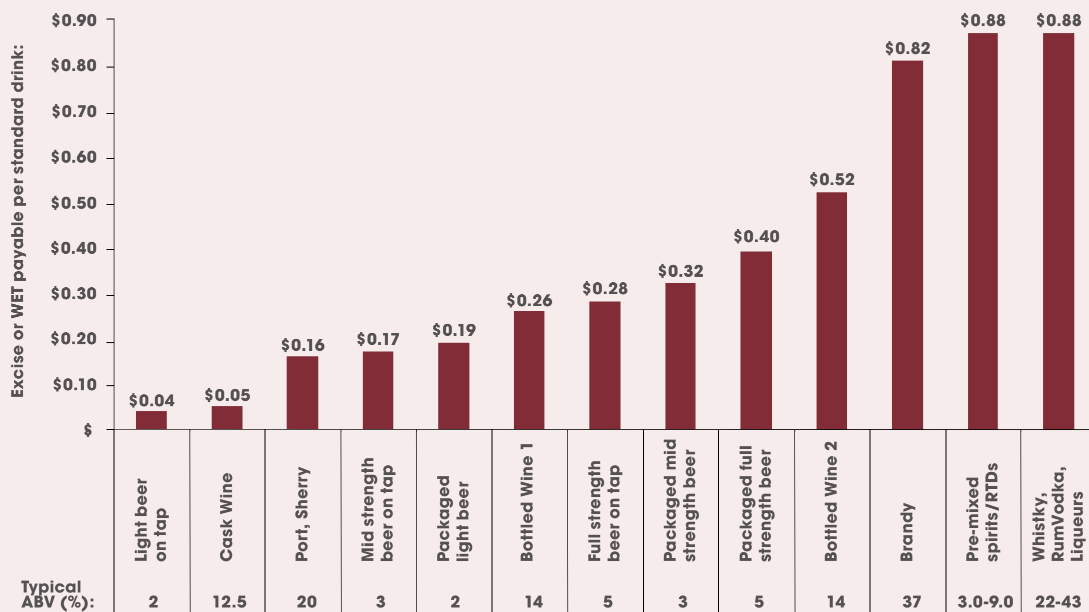
CASK WINE: A TAX ANOMALY

The tax on typical cask wine is only $0.05 per standard drink compared to $0.32 per standard drink of mid-strength beer, despite the vastly different alcohol volumes in these products: 12.5% alcohol by volume (ABV) compared to 3.0% ABV, respectively (see Figure 4.2). The extraordinarily low price of cask wine is due to the low rate of tax that applies to such products, and is a major contributing factor to the significant involvement of this type of alcohol in harmful drinking, particularly among people who are alcohol dependent and among those Indigenous Australians who drink at harmful levels.

During the 1990s, the Northern Territory Government applied a modest levy on the sale of cask wine, a beverage shown to contribute disproportionately to alcohol-related harm in that jurisdiction. Prior to the introduction of the levy, quarterly per capita consumption of cask wine among persons aged 15 and older was 0.73 litres. During the levy period, consumption fell to .49 litres. Following the removal of the levy, consumption rose to 0.58 litres. Imposition of the levy had no significant effect on the consumption of other beverages.(62)

Figure 4.2:

Tax payable per standard drink* of alcohol, various products, Australia, as at 2 February 2009



Note: *Includes a 1.15% ABV excise-free concession for beer. WET payable per standard drink of wine is based on a 4-litre cask of wine selling for $13 (incl. GST) ('Cask wine'), a 750ml bottle of wine selling for $15 (incl. GST) ('Bottled wine 1'), a 750ml bottle of wine selling for $30 (incl. GST) ('Bottled wine 2'), and a 750ml bottle of port selling for $13 (incl. GST) ('Port, sherry'). A standard drink is equal to 0.001267 litres or 10 grams of pure alcohol.

Source: Values have been calculated using the excise rates for beer and spirits, and the wine equalisation rate (WET) for wine, published by the Australian Tax Office as at 2 February 2009.(63)

While we have a good understanding of the flaws or lack of logic in Australia's current alcohol taxation system, and broad agreement on the principles upon which reforms should be based, our knowledge of precise solutions is limited, and more scholarly work in the area is clearly required. Even the best designed Australian studies are hamstrung by the dearth of accurate alcohol consumption data,(64) thus curtailing accurate planning, monitoring and evaluation of alternative tax models. A volumetric approach to alcohol taxation across all alcohol products is often suggested by both public health experts and some quarters of the alcohol industry as the most sound basis for alcohol taxation. However, in its simplest form, such a model is still inadequate to reduce overall alcohol consumption and the prevalence of heavy drinking. For instance, if a flat rate of tax per litre of pure alcohol was applied across all product types, the average price of spirits would drop, while the price of low-strength beer would increase.

Instead, a 'tiered' volumetric system is recommended by the Taskforce. This system would be inclusive of stepped increases in tax rates that provide economic incentives for the production and consumption of lower strength alcohol products, and disincentives for the production and consumption of the highest-risk alcohol products. In this way, taxation would reflect the negative externalities attributable to certain products.

Action 4.1

Commission independent modelling under the auspices of Health, Treasury and an Industry panel for a rationalised tax and excise regime for alcohol that discourages harmful consumption and promotes safer consumption.

In addition to taxation, it is also desirable to influence the price of alcohol by regulating the minimum price (floor price) of alcohol products, thereby aiming for a real shift in per capita consumption rather than just product preference. Studies have shown that pricing of the cheapest alcohol products has the most influence on overall consumption, as there is less scope for down-shifting in quality within beverage categories. A move towards regulating the minimum price of alcohol will require the establishment of a public interest case, to the satisfaction of the National Competition Council, that minimum price regulation would produce a net public benefit for the Australian community.

Action 4.2

Develop the public interest case for minimum (floor) price of alcohol to discourage harmful consumption and promotes safer consumption.

The Australian Government collected a total of $3.5 billion in 2007–08 from the excise on beer and spirits and the Wine Equalisation Tax.(65) This raises important questions relating to the use of government revenue collected from alcohol taxation, including whether all or part of this revenue should be directed to pay for the costs of alcohol problems in the community. The Northern Territory Government's *Living with Alcohol* program provides the best Australian example of such an approach.

In 1992 the Northern Territory Government used a hypothecation approach by placing a levy of 5 cents per standard drink on the sale of alcohol products with more than 3% ABV. The government then used the revenue to fund a range of alcohol prevention measures in the territory.(66) These measures included funding for new and existing alcohol education programs and expanded treatment and rehabilitation services. Evaluations of this approach found that combining alcohol taxes with comprehensive programs and services designed to reduce the harm from alcohol were associated with significant declines in alcohol-attributable mortality in the Northern Territory.(67, 68)

This approach could also include using proceeds from taxation to replace alcohol sponsorship of sporting and cultural events.

Action 4.3

Direct a proportion of revenue from alcohol taxation towards initiatives that prevent alcohol-related societal harm.

Key action area 5: Improve the health of Indigenous Australians

'No health and wellbeing issue in Australia is worse or more urgent than the impoverishment and appalling health status of Indigenous people. Aboriginal and Torres Strait Islander peoples should command high priority under preventative health programs' (Quote from submissions).

Indigenous populations are a particularly high risk group in Australia with regard to the health and social impacts of alcohol consumption. Indigenous Australians are about twice as likely to abstain from alcohol as non-Indigenous Australians, but those who do drink may be up to six times more likely to drink at high-risk levels than non-Indigenous people.(69)

Alcohol is associated with 5% of the burden of disease and injury borne by Indigenous Australians, in particular through homicide, violence and suicide.(70) In 2002–03 the rate of hospital admission among Indigenous males for conditions related to high levels of alcohol use, such as acute alcohol intoxication, alcoholic liver disease, harmful use and alcohol dependence, was between two and seven times greater than for non-Indigenous males.

Other studies have shown that the rates of death from wholly alcohol-caused conditions among residents of Western Australia, South Australia and the Northern Territory are almost eight times greater for Indigenous males than for non-Indigenous males, and 16 times greater for Indigenous females than for other females.(71) The level of alcohol-attributable death among young Indigenous Australians (aged 15–24 years) has also been shown to be almost three times greater than for their non-Indigenous counterparts – with the divergence between the two populations apparently increasing in recent years.(72) Drinking while pregnant is also associated with Foetal Alcohol Spectrum Disorders, which are estimated as being between three and seven times as common in the Indigenous population as in the non-Indigenous.(70)

EXAMPLE:

A 2007 study by Chikritzhs et al. estimated alcohol-attributable mortality for Indigenous residents in each of the 17 former ATSIC zones, and found that:

- Over the five-year period from 2000 to 2004, an estimated 1145 (nearly 5% per 10,000 population) Indigenous Australians died from alcohol-attributable injury and disease caused by drinking.
- In 2004 alcohol-attributable death rates for Indigenous people in the Central Northern Territory (14 per 10,000) and northern Western Australia (10 per 10,000) were more than double the national rate for Indigenous people (just over four per 10,000) for that year.
- Suicide (19%) and alcoholic liver cirrhosis (18%) are the two most common causes of alcohol-attributable death among Indigenous men.
- For Indigenous women, alcoholic liver cirrhosis (27%), haemorrhagic stroke (16%) and fatal injury caused by assault (10%) were the most common causes of alcohol-attributable death.
- The average age at death from the most common alcohol-attributable conditions was 35 for Indigenous men and 34 for Indigenous women.(73)

Alcohol is prominent in family and community violence in Indigenous communities. Among the total recorded homicides over the period 1999–2000 to 2004–05, 69% of Indigenous homicides involved both the victim and offender having consumed alcohol at the time of the offence; in contrast, the figure for non-Indigenous homicides was 20.4%.(73)

Indigenous people are more likely than non-Indigenous people to be victims of domestic violence. The main reason both Indigenous and non-Indigenous people sought Supported Accommodation Assistance Program (SAAP) assistance in 2005–06 was to escape domestic or family violence (31.4% of Indigenous people and 21.3% of non-Indigenous people).(73)

A recent study of the key approaches and actions required to reduce the harm from alcohol consumption in Indigenous communities recommended five specific actions, including:

1. Resourcing of interventions from the primary healthcare setting
2. Reform and increased support for treatment and rehabilitation services
3. Actions on pricing of alcohol, including a broad review of Australia's alcohol taxation policy as part of a comprehensive approach to alcohol problems in Australia
4. Action to restrict alcohol supply, including numbers and types of licences and hours of sale, especially for takeaway licences
5. Supporting community agency and action through the establishment of local community leadership groups(70)

In addition, it is also important to build upon existing responses to the problem of alcohol consumption in Indigenous communities that are supported and known to be working effectively. Among the diverse Indigenous communities across Australia, there is now a wide range of locally conceived approaches to preventing and responding to harmful consumption of alcohol and the negative health and social consequences. Some small regional or remote communities in Australia with relatively large Indigenous populations have introduced sales bans on the alcohol products most frequently involved in harmful drinking, such as cask wine and cask fortified wine. According to evaluations of these approaches, several of the bans have resulted in reduced alcohol-related harm within the communities where they exist.

Another example of alcohol restrictions known to be effective in reducing harm in some Australian Indigenous communities are referred to as 'dry community declarations'.(20) Some remote Indigenous communities in Western Australia, the Northern Territory and South Australia have declared themselves 'dry' using provisions of state/territory legislation. The key element of such dry area declarations is a combination of Indigenous community control and statutory authority, along with police enforcement for ensuring that dry community declarations reach their potential. Evidence suggests that although there are shortcomings (for example, sly grogging) and associated costs to this approach, overall there have been reductions in consumption and alcohol-related harm.

Since the 1980s, 'sobering-up centres' have been established in many parts of Australia, particularly Indigenous communities, as humane forms of care for publicly intoxicated individuals, and as an alternative to individuals being arrested and held in police cells and watch houses.(74) In many ways, these centres function primarily as a broad harm-reduction measure, rather than as a treatment program. Sobering-up centres are not a detoxification centre, nor are they aimed at long-term rehabilitation; rather, their role is to keep people out of police custody to reduce alcohol-related harm and to offer practical care in a safe environment for a limited time, including protection, shelter and food.(74) Nevertheless, they could provide an opportunity for interventions that can be effective.

Sometimes related to these centres are night patrols, which are a particularly common alcohol harm-reduction strategy in many Indigenous communities.(25) Night patrols provide transport to safe locations for intoxicated persons, particularly in remote areas.(25) Evaluations of the effectiveness of night patrols, on their own, as an intervention have been somewhat equivocal although they have been rated effective in communities where they exist in reducing alcohol-related violence and getting intoxicated people off the streets.(25)

The National Indigenous Drug and Alcohol Committee (NIDAC), an important voice in Indigenous alcohol and other drugs policy in Australia, has endorsed the *National Drug Strategy – Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*(75) as the basis of any approach to the reduction of alcohol-related harm among Indigenous Australians. Within this framework, NIDAC has also recommended consideration of the following key principles when developing and implementing any policies and programs aimed at preventing alcohol-related harm in Indigenous communities:

1. Indigenous people should be involved at all stages of the development and implementation of strategies to address harmful alcohol use in their communities.
2. The capacity of Indigenous communities to deliver alcohol intervention initiatives should be actively encouraged and resourced – including an expanded program of workforce development.
3. Any strategies to reduce alcohol-related harm should be evidence-based and culturally secure.
4. Strategies to specifically address harmful alcohol use should be conducted in conjunction with strategies to address the underlying social determinants of such use.

As recommended by the fourth principle above, it is important to acknowledge that universally targeted preventative health initiatives will also be highly effective among Indigenous communities. Such initiatives could include alcohol taxation, regulating the physical availability of alcohol, policing and law enforcement, placing restrictions on alcohol promotions and producing public awareness campaigns. While not diminishing the importance of developing culturally and locally appropriate adaptations of such initiatives, this acknowledgement emphasises the importance of addressing some of the underlying determinants of harmful consumption of alcohol in Australia.

Action 5.1

Increase access to health services for Indigenous people who are drinking at harmful levels.

Action 5.2

Support local initiatives in Indigenous communities.

Action 5.3

Establish a reliable, regular and sustained system for the collection and analysis of population statistics on alcohol and drug use among Indigenous people.

Action 5.4

Establish and fund a multi-site trial of alcohol diversion programs.

Action 5.5

In communities that desire them and which are large enough to support them, the availability of night patrols and sobering-up shelters should be expanded.

Key action area 6: Strengthen, skill and support primary healthcare to help people in making healthy choices

'The primary healthcare system has an important role within the whole of society, integrated approach to tackling chronic disease' (Quote from submission)

Brief interventions in primary healthcare settings for early-stage alcohol problems are consistently identified as a key ingredient in a comprehensive alcohol prevention strategy. Such interventions are regarded as relatively inexpensive, taking very little time and being able to be implemented by a wide range of health and welfare professionals.(25) Their benefit as a preventative measure arises from their relative effectiveness in treating early-stage problem drinking, preventing the need for later, more intense and costly treatment.(51)

Brief interventions typically involve the provision of advice and information to 'at risk' drinkers in the context of a consultation by a primary care physician. This information is initially conveyed verbally, usually during a primary care consultation for a different health issue. The initial screening may be complemented by a range of additional supports, including the provision of printed information, follow-up telephone calls, and drinking diaries to record and monitor alcohol consumption. The cost of brief interventions may include recruitment and training of health professionals, provision of resources and materials, and the additional cost of the consultation time.(76) In the Australian context, screening and brief counselling by a GP increases the consultation from Level B to Level C (lasting at least 20 minutes), thus incurring a small additional Medicare cost for every patient who is counselled.(24)

EXAMPLES:

- A 2007 Cochrane Database Systematic Review of the effectiveness of brief alcohol interventions in primary care populations found they consistently produced reductions in alcohol consumption.(77)
- A 2008 Australian study examining the potential cost savings of a comprehensive program of brief interventions estimated that $5.8 billion in costs to the community could potentially be saved each year.(24) The study emphasises that given the total estimated social costs of alcohol in 2004/05 were over $15 billion, this potential saving represents an enormous reduction in the overall costs of alcohol for the community.

In Australia, brief interventions are as yet a relatively untapped opportunity, due in part to the need for greater recognition of the role that the primary health workforce can play. (51) Efforts during the 1980s and early 1990s to introduce more systematic screening, early identification and potentially brief or extended responses were variously tried. These included the Coordinator of Alcohol and Drug Education in Medical Schools program (CADEMS), which supported curriculum development for undergraduate medical students; a range of general practice trials, especially in New South Wales, sometimes in association with other specific interventions including tobacco; efforts to develop a combined risk-screening instrument for a number of conditions; and studies of the use of screening instruments (especially AUDIT) in hospital settings.

Follow up has been patchy. Even where the uptake and utility under experimental conditions was promising, the longer term effort and cost required to achieve widespread involvement has not been sustained. An Australian study of the effectiveness of brief interventions in hospital emergency departments suggests they have the potential to significantly reduce subsequent alcohol-related injuries.(51) For assessments and brief

interventions to become part of routine practice for doctors, nurses and other health professionals, an approach at the level of health system funding and expectations is needed. It is unrealistic to expect overstretched health service providers to implement this strategy without reimbursement or other recognition.

In addition, referral pathways may be unclear and the links between primary care practitioners and community-based alcohol and drug services need to be strengthened and promoted; for example, utilising the *Headspace* (youth mental health promotion) service sites.

Action 6.1

Enhance the role of primary healthcare organisations in preventing and responding to alcohol-related health problems.

Action 6.2

Develop a more comprehensive network of alcohol-related referral services and programs to support behaviour change in primary healthcare.

People with alcohol dependence combined with other psychiatric disorders have higher rates of primary healthcare service usage than those without such disorders. An Australian study, published in 2009, found that alcohol dependence combined with mental health disorders has a significant impact on GP service in Australia. High rates of service use by individuals with such comorbidities are a considerable burden for GP services.(78)

Specialised alcohol and other drug treatment and early intervention programs are essential components of a preventative approach to the harmful consumption of alcohol. In 2005–06 there were a total of 145,000 drug treatment episodes recorded in Australia, of which 56,000 (or 39%) patients were treated for alcohol problems.(79) While this figure may appear high, it is perhaps relatively low given the estimated 585,000 Australians who drink at levels considered to be high risk to health in the long term, many of whom might be considered the potential target group for treatment.(1) While treatment and prevention are traditionally viewed as separate and sometimes unrelated activities, it is critical that specialised treatment programs are embraced as part of a legitimate approach to preventing and reducing alcohol-related harm.

Internationally, the evidence base regarding the treatment of alcohol problems is very well developed and is now at the stage of determining what is best practice rather than attempting to determine if treatment can work; this is particularly the case in Australia.(25) Effective alcohol treatment options include motivational interviewing, brief interventions, social skills training, community reinforcement approaches, relapse prevention and some aversion therapies.(25) There is evidence that mutual help programs such as 12-Step Facilitation Therapy, which encourages attendance at Alcoholics Anonymous (AA) meetings, are particularly effective for severely dependent drinkers with low levels of social support.(25) Although popular and widely used, there are also treatments which have little evidence of efficacy, including insight-orientated psychotherapy, confrontation counselling, relaxation training, general 'alcoholism counselling', education and milieu therapy.(25)

Pharmacotherapies for alcohol dependence include disulfiram, naltrexone and acamprosate. Reviews have found that naltrexone and acamprosate are the safest and most effective of the three pharmacotherapies in the long and intermediate terms, respectively.(25)

Action 6.3

Increase access to primary healthcare services and improve health outcomes for hard-to-reach disadvantaged individuals who are at risk of alcohol-related health problems.

Low-risk drinking guidelines have been adopted in many countries, including Australia, as a resource for health professionals. They are often the basis for advice on the health risks of alcohol consumption for the general adult population and for particular sub-groups. Guidelines potentially fulfil an important function as supporting information for other measures known to be effective, such as brief interventions in primary care, and as the basis for health promotion programs and social marketing campaigns. In Australia, new guidelines have been informed by updated estimates of the risks over a lifetime from alcohol consumption.(5) While it has been reported that the health benefits of alcohol can be achieved with an intake of half a standard drink per day, emerging evidence indicates that previous studies claiming significant health benefits of alcohol consumption have tended to overestimate any positive effects.(5) As a result, the new Australian guidelines advise that it should be noted that the potential benefits from alcohol can also be gained from other means, such as exercise or by modifying the diet.(5)

FACTORS THAT AFFECT SUSCEPTIBILITY TO ALCOHOL

Sex – the same amount of alcohol leads to a higher blood alcohol concentration in women than in men, as women tend to have a smaller body size, a lower proportion of lean tissue and smaller livers than men. On the other hand, the higher level of risk-taking behaviour among men means that, over a lifetime, male risks exceed female risks for a given pattern of drinking.

Age – in general, younger people are less tolerant to alcohol, and have less experience of drinking and its effects. In addition, puberty is often accompanied by risk-taking behaviours. Later in life, as people age, their tolerance for alcohol decreases and the risk of falls, driving accidents and adverse interactions with medications increases.

Mental health – people who have, or are prone to mental health conditions (for example, anxiety and depression, schizophrenia) may have worse symptoms after drinking. Alcohol can also trigger a variety of mental health conditions in people who are already prone to these conditions.

Other health conditions that are made worse by alcohol – people who already have health conditions caused or exacerbated by alcohol, such as epilepsy, alcohol dependence, cirrhosis of the liver, alcoholic hepatitis or pancreatitis, are at risk of the condition becoming worse if they drink alcohol.

Medication and drug use – alcohol can interact with a wide range of prescribed and over-the-counter medications, herbal preparations and illicit drugs. This can alter the effect of either the alcohol or the medication and has the potential to cause serious harm to both the drinker and others.

Family history of alcohol dependence – people who have a family history of alcohol dependence (particularly among first-degree relatives) have an increased risk of developing dependence themselves.

Source: NHMRC 2009.(5)

Key action area 7: Build healthy children and families

It is a reality that the most visible effects of drinking on others, particularly the spouse or partner of a drinker and their children, result from accidents and injury (including violence) during or after drinking occasions. When families have to deal with a relative's harmful drinking, violence, injury or even death, the consequences can cause great suffering.

'The patterns of health and illness throughout life are strongly influenced by patterns that are established early in life. Biological and environmental risk and protective factors, together with early life experiences, affect long term health and disease outcomes' (Quote from submission)

As mentioned previously the impact on children of drinking by their parents and/or other adults is a particular concern: 13% of Australian children aged 12 years or less are exposed to an adult who is a regular binge drinker.(6) It has been estimated that 31% of parents involved in substantiated cases of child abuse or neglect experience significant problems with alcohol use.(7) There is also a link between drinking and domestic violence. In men who are already predisposed towards domestic violence, alcohol increases the risk of violence.(5) Alcohol consumption also increases the risk of being a victim of domestic violence.(5) Witnessing domestic violence, particularly violence that occurs over long periods of time at intense levels, can have a severe emotional impact on children.(80) This impact appears to be even more profound if the children's mother is the victim of domestic violence.(80)

In 2002 the NSW Department of Community Services reported that up to 80% of investigated child abuse reports were associated with parental substance abuse. Similarly, the Victorian Department of Human Services reported that 65% of children in foster care presented with backgrounds of drug and alcohol misuse, and that 62% of parents with a psychiatric problem were also affected by substance misuse.(6) In 2004 the Department for Community Development in Western Australia found that up to 50% of child protection cases involved parental substance misuse concerns (cited in (81)). A study by the South Australian Department for Families and Communities found that parental substance misuse was associated with children's entry into care in approximately 70% of cases.(81)

Notwithstanding the influence of various determinants of alcohol-related harm, such as the economic and physical availability of alcohol, marketing and promotions, and wider social norms and pressures, family history is a strong predictor of developing an alcohol-related problem. Genetic factors are also as a matter of importance, with evidence showing that children of alcoholic parents appear to be at significantly greater risk of dependence themselves than those of non-alcoholic parents. (82, 83) Drinking practices within the family environment are an important consideration because, depending upon the circumstances, they can be either a positive or negative influence on the drinking behaviour of young people. Exposure to a family culture that accepts heavy drinking may contribute to the development of dependence in the children of heavy drinkers.(84)

'Increase the focus on prevention aimed at addressing health risks for unborn children through maternal health services and support to parents and carers, given the importance of early interventions on lifelong outcomes' (Quote from submission)

THE RISK OF FOETAL ALCOHOL SPECTRUM DISORDERS

Rates of drinking during pregnancy are high in Australia, with recent surveys reporting rates of 47%. Between 19% and 44% of Indigenous women drink alcohol in pregnancy, and between 10% and 19% drink at harmful levels.(5)

Maternal alcohol consumption can result in a spectrum of harms to the foetus. Although the risk of birth defects is greatest with high, frequent maternal alcohol intake during the first trimester, alcohol exposure throughout pregnancy (including before pregnancy is confirmed) can have consequences for development of the foetal brain. It is not clear whether the effects of alcohol are related to the dose of alcohol and whether there is a threshold above which adverse effects occur.(85) This uncertainty is reflected in policy regarding alcohol use in pregnancy within Australia and overseas.(86)

Although the risks from low-level drinking (such as one or two drinks per week) during pregnancy are likely to be low, a 'no-effect' level has not been established, and limitations in the available evidence make it impossible to set a 'safe' or 'no-risk' drinking level for women to avoid harm to their unborn baby. Evidence also shows that alcohol may adversely affect lactation, infant behaviour (for example, feeding) and psychomotor development of the breastfed baby.(5)

Rates of risky drinking in Australia peak amongst young people, and alcohol-related harm are substantial for both adolescents and young adults. Drinking contributes to the three leading causes of death among adolescents – unintentional injuries, homicide and suicide – along with risk-taking behaviour, unsafe sex choices, sexual coercion and alcohol overdose. (5) A recent study of self-reported harm found that drinkers under the age of 15 are much more likely than older drinkers to experience risky or antisocial behaviour connected with their drinking, and the rates are also somewhat elevated among drinkers aged 15–17 years.(87) Initiation of alcohol use at a young age may increase the likelihood of negative physical and mental health conditions, social problems and alcohol dependence. Regular drinking in adolescence is an important risk factor for the development of dependent and risky patterns of use in young adulthood. An additional risk to the health and safety of young people who consume alcohol is illicit drug use. There is a range of documented adverse outcomes from illicit use of drugs, and consuming alcohol together with illicit drugs can have dangerous or lethal consequences.(5)

Childhood and adolescence are critical times for brain development. The brain is more sensitive to alcohol-induced damage during these stages, while being less sensitive to cues that moderate alcohol intake. The young brain is particularly vulnerable to long-term damage from the toxic effects of alcohol when it is consumed regularly at risky/high-risk levels, at least until the age of 25.

Action 7.1

Protect the health and safety of children and adolescent brain development.

According to recent research, the average age at which young Australians first consume a full standard drink of alcohol is 17 years. (1) This is despite the fact that the minimum legal purchase age for alcohol in all Australian jurisdictions is 18 years. However, new evidence suggests that average age may be best examined by age cohort.(41)

Of more concern is the fact that the prevalence of drinking at harmful levels by Australians aged under 18 years is now at record levels. Alcohol consumption at harmful levels among Australian secondary school students aged 12–17 years who are current drinkers increased from 26% in 1999 to 31% in 2005.(12) While minimum legal purchase age refers to the age at which alcohol can actually be lawfully purchased by a person, this is distinct from the age at which alcohol can be consumed, sometimes referred to as the legal drinking age. The distinction is important because while all state and territory laws in Australian prohibit a minor from purchasing alcohol, they do not necessarily prohibit consumption in certain circumstances.

Clearly, consistent enforcement of laws regarding purchase age is critical if we are to achieve a shift in the average age of initiation and an overall reduction in alcohol-related harm among young people. It must be acknowledged that consumption of alcohol by children and adolescents in the home and in certain social settings is often sanctioned by parents, often in the belief that it is relatively harmless or might be helpful in educating young people about alcohol.(88) The majority of young Australians who report drinking at home also report parents as the primary suppliers of their alcohol.(12)

In New South Wales, it is now an offence to supply alcohol to minors in a private home without the direct approval of a parent or guardian. This has often been referred to as the state's 'secondary supply' law. Whilst the impact of this law upon youth drinking is not yet known, legislation of this kind has been welcomed by advocates of preventing alcohol-related harm among young people. There is currently considerable community interest in the introduction of similar laws in other Australian jurisdictions.(88)

In the United States, where minimum legal purchase age for some time ranged between 18 and 21 years, several studies have found that increasing the age limit is an effective means of reducing road crash death and injury among teenagers and young adults. Some studies have also found that a higher legal minimum drinking age is associated with reductions in alcohol consumption among young people. (20) There is, therefore, some evidence that raising the minimum legal purchase age to 21 years can reduce teenage drinking, as well as harms. A recent commentary on attempts to increase the minimum purchase age in New Zealand to 20 years demonstrates that popular debate convinced a majority of the public that raising the age would be an appropriate way to reduce young people's harm from drinking.(89)

In Australia, Toumbourou et al. have recommended that a first step in this direction would be better monitoring of alcohol-related developmental harms, using longitudinal and other developmental research.(90) Recent Australian research on the effects of drinking during adolescence for predicting alcohol-related outcomes in young adulthood concludes that any drinking during adolescence, even at the low-risk levels, may have negative consequences for adulthood. (91)

In the interests of promoting the health and welfare of young Australians, and raising awareness of the need to reshape our drinking culture over the life course, community engagement and informed discussion on this issue is now warranted.

Action 7.2

Support parents in managing alcohol issues at all stages of their children's development through community-level approaches.

Action 7.3

Measure the impact of harmful consumption of alcohol on families and children by ensuring all population surveys that collect data to monitor drug use and drug trends across Australia collect information on parental status or childcare responsibilities of drinkers.

WHAT FAMILIES CAN DO

Sometimes parents feel they are no longer an important influence in their teenagers' lives, and that their children's decisions about alcohol use are beyond their control. This is not the case. While they are not the only influence in teenagers' lives, what parents do, what they believe and what they say to their children can have an important influence on young people's decisions. Discussions about alcohol should begin before children reach the age of 10 to 11 years. Children are never too young to start talking about the effects of alcohol and they need to know what their parents think about drinking. They also need to know what their parents expect. Starting such discussions early also encourages open conversations in future and gives parents practice in discussing the issues before they become sensitive topics.

Parents and other adults are powerful role models that children copy as they grow older. Alcohol consumption is very much a part of the Australian lifestyle, and parents who drink can teach children how to use alcohol in low-risk ways by modelling responsible use such as providing alternatives to alcohol, avoiding driving after drinking and following the NHMRC guidelines on low-risk drinking. Parents need to establish and enforce clear standards for teenage behaviour. It is important that parents set an example they are happy for their teenagers to copy, and that they know what's going on in their children's lives and know their whereabouts. Effective communication between parents and teenagers is important and parents should take responsibility for this. Teenagers are less likely than younger children to ask for information so parents need to make time, take the initiative and talk with them about a wide range of topics.(92)

Key action area 8: Strengthen the evidence base

'The importance of strong links between researchers and practitioners that develop understanding of how best to translate research into practice are essential' (Quote from submissions)

It is critical that preventative health policies and programs relating to alcohol are informed by sound data on alcohol consumption and alcohol-related harm in the Australian population.(64) The WHO has recommended that public health monitoring of alcohol use should include credible estimates of per capita alcohol consumption, derived from alcohol sales data, in addition to well-conducted population surveys of drinking patterns.

There is an urgent need to collect and analyse nationally consistent data about alcohol sales, consumption, outlets and alcohol-related health and safety outcomes. This data will then inform the modelling of safer patterns of alcohol consumption in different communities and settings, and the monitoring of the impact of changes in alcohol policies, alcohol availability and other factors.

Currently, information on levels and patterns of alcohol consumption in Australia is diverse. It can be difficult to identify the key features for purposes of monitoring trends in drinking and related harm, and the possible opportunities for intervention. Unfortunately, some of the most significant and valuable data is not readily available to the public health field. For example, alcohol sales data, while it is known to be collected and analysed by the alcohol beverage industry, is not available for the purposes of the Taskforce, nor indeed is it easily accessed for public health research purposes in general. The Taskforce notes with some concern that continuation of the most accessible datasets on alcohol consumption levels in Australia, collected and compiled by the Australian Bureau of Statistics (ABS), is currently under review. Efforts are urgently required to seek the continuation of this valuable dataset.

If collection and reporting of this data were to cease, Australia would be the only Organisation for Economic Co-operation and Development (OECD) country not to collect national alcohol consumption data.

There are several important reasons why the collection of alcohol sales data in Australia should be improved rather than abandoned. (64) Such data can be used to:

- Monitor trends in per capita alcohol use, which is strongly related to adverse health outcomes such as liver cirrhosis, motor vehicle crashes and suicide
- Facilitate studies of the relationships between changes in the level of per capita alcohol consumption and both population health outcomes and social harms (for example, arrests for assault and public disorder)
- Provide a benchmark to gauge the accuracy of national alcohol consumption surveys
- Enable the sales volumes of each beverage type to be estimated at local levels
- Evaluate the effectiveness of government community initiatives to reduce alcohol-related harm and the effects of liquor licensing changes on alcohol consumption

The collection and reporting of alcohol sales data would entail only a small cost to the alcohol industry, which already provides these data to commercial market research companies.(64) The collection of a range of other datasets will also be important for appropriate planning, monitoring and evaluation of alcohol policies and programs. These include datasets on places of drinking, the duration of drinking occasion, and reasons for drinking; datasets on the harm to drinkers and harm to others, such as police datasets; child and family welfare agency datasets; health service datasets; and a range of other datasets that capture the impact of alcohol on sectors such as local government, fire services and insurance.

Action 8.1

Develop a system for nationally consistent collection and management of alcohol wholesale sales data to inform key alcohol policy developments and evaluations.

Action 8.2

NPA to define a set of essential national indicators on alcohol consumption and health and social impacts by reviewing what is currently available and what is also required.

Action 8.3

Expand the collection of patterns of drinking data to include place of drinking, duration of drinking occasion, and reasons for drinking.

Action 8.4

Improve utilisation of key datasets on the harm to drinkers and harm to others.

ALCOHOL: IMPLEMENTATION PLAN

Summary of action required and how progress will be measured

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
Key action area 1: Improve the safety of people who drink those around them			
1.1 *States and territories to harmonise liquor control regulations, by developing and implementing best practice nationally consistent approaches to the policing and enforcement of liquor control laws, including:* ■ Outlet opening times, outlet density ■ Accreditation requirements prior to the issuing of a liquor licence ■ Late-night and other high-risk outlets ■ Responsible Serving of Alcohol (RSA) and training model	Lead agency: ■ MCDS Partners: ■ State and territory liquor licensing authorities ■ Police services ■ Local government ■ Alcoholic beverage and related industries ■ Health authorities	Years 1–4 Develop best practice approaches for liquor control legislation for implementation by states and territories. Consultation with the alcohol industry. Years 5–8 All states and territories introduce legislation to implement best practice approaches. Years 9–11 and ongoing States and territories to monitor and report on enforcement of legislation.	Agreed best practice approach is introduced within two years. Alcohol outlet opening times. Alcohol outlet density (state/LGA region/capital city/high-risk areas). Number of liquor licences issued where RSA training and accreditation completed prior to issuing licence. Monitoring of type and extent of alcohol promotions.
1.2 *Increase available resources to develop and implement best practice for policing and enforcement of liquor control laws and regulations, relating to:* ■ Optimal levels of enforcement of drink-drinking laws ■ Intelligence-led, outlet-focused systems of policing and enforcement ■ Annual review of liquor licences as part of annual licence renewal process ■ Demerit points penalty systems for licensees who breach liquor control laws, with meaningful and graduated penalties depending on severity and frequency of offence ■ Monitoring and reporting on enforcement of legislation	Lead agency: ■ MCDS ■ Department of Health and Ageing Partners: ■ State and territory police services and law enforcement agencies ■ State and territory liquor licensing authorities ■ Local government ■ Alcoholic beverage and related industries	Years 1–4 Develop best practice nationally consistent approaches to policing and enforcement of liquor control laws. Development of national monitoring and reporting framework and collection of baseline measures. Years 5–8 Monitoring and reporting on enforcement of legislation.	Reporting and monitoring framework developed as part of best practice approach for policing and enforcement. Baseline measures identified and collected. Annual reporting of performance measures.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
1.3 *Develop a business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations.*	Lead agency: ■ All governments (Australian/state/ territories Partners: ■ State and territory police services and law enforcement agencies ■ State and territory liquor licensing authorities ■ Local government ■ Alcoholic beverage and related industries	Years 1–4 Develop a business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations. Years 5–8 Implement COAG national partnership agreement on policing and enforcement of liquor control laws and regulations. Legislation introduced as required. Years 9–11 and ongoing Continue to implement performance-based National Partnership Agreement on policing and enforcement of liquor control laws and regulations.	The business case for a new COAG national partnership agreement on policing and enforcement of liquor control laws and regulations is developed within four years.
1.4 *Provide police, other law enforcement agencies and private security staff with information and training about approaches to complying and enforcing liquor licensing laws and managing public safety.*	Lead agency: ■ State and territory liquor licensing authorities Partners: ■ State and territory police services and law enforcement agencies ■ Local government ■ Alcoholic beverage and related industries	Years 5–8 Develop training package. Disseminate information and training.	Training packages developed for each jurisdiction. Monitoring of the delivery of training package to all new and existing law enforcement personnel.
1.5 *Change current system to ensure local communities and their local governments can manage existing and proposed alcohol outlets through land use planning controls to:* ■ Estimate and take into consideration the impact of proposed new alcohol outlets on outlet density levels, the health and safety of the local community, and neighbourhood amenity prior to granting a licence ■ Determine the most desirable mix of outlet types ■ Determine the appropriate conditions for new licences such as operating hours, noise restrictions and fees for cost recovery purposes ■ Require an annual liquor licence renewal subject to satisfactory compliance	Lead agency: ■ All governments; MCDS Partners: ■ National Local Government Drug and Alcohol Advisory Committee ■ Local government ■ State and territory liquor licensing authorities ■ Alcoholic beverage and related industries	Years 5–8 Consultation and development of best practice approach. Implement approach in local communities and refine as necessary to ensure consistency with best practice approaches mentioned in previous actions.	Alcohol outlet opening times. Alcohol outlet density (state/LGA region/capital city/ high-risk areas). Community opinions on issues such as outlet density, impact on neighbourhood amenity, noise levels, perceived safety, overall satisfaction with current approach. Data collection and monitoring of alcohol sales, policing, and health and social impacts; e.g: ■ Alcohol-related violence and crime ■ Alcohol-related hospital admissions

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
1.6 *Establish the public interest case to exempt liquor control legislation from the requirements of National Competition Policy.*	Lead agency: ■ National Competition Council Partners: ■ State and territory liquor licensing authorities ■ Local government ■ Alcoholic beverage and related industries	Years 1–4 Commission the public interest case in order for liquor control legislation and other regulatory measures to be exempt from National Competition Policy.	Establishment of the public interest case.
1.7 *Support the above through:* ■ Partnerships with health and law enforcement groups and the alcohol beverage and related industries, such as alcohol retailers, hoteliers, licensed clubs, local communities and major event organisers ■ Data collection and monitoring of alcohol sales, policing, and health and social impacts (refer also to key action area 8)	Lead agency: ■ National Prevention Agency (NPA) Partners: ■ State and territory liquor licensing authorities ■ State and territory police services and law enforcement agencies ■ Local government ■ Alcoholic beverage and related industries ■ Health groups	Years 1 – 4 Establish partnerships with the alcohol beverage and related industries.	Partnerships established. Data collections established for alcohol sales, policing and health and social impacts – trends over time.
Key action area 2: Increase public awareness and reshape attitudes to promote a safer drinking culture in Australia			
2.1 *Develop and implement a comprehensive and sustained social marketing and public education strategy at levels likely to have significant impact, building on the National Binge Drinking Campaign and state campaigns to:* ■ Help build a national consensus on safer alcohol consumption ■ Raise awareness and understanding of NHMRC alcohol guidelines ■ De-normalise intoxication ■ Raise awareness of the longer term risks and harmful consequences of excessive alcohol consumption	Lead agency: ■ NPA Partners: ■ MCDS ■ State and territory health departments and other relevant agencies ■ Road Safety authorities ■ Nationally based NGOs	Years 1–4 Identify effective campaign messages through qualitative research and review of other campaigns. Potential campaign themes may include the health consequences of risk drinking and the impact of risk drinking on the safety of others. Develop first wave of the campaign. Implement the campaign. Years 5–8 Evaluation and campaign tracking. Develop and implement new phase of comprehensive, sustained social marketing strategy.	Percentage of target audiences (including adults, young people and low SES) who: ■ Have seen advertising used in recent campaigns ■ Can name themes covered in advertising (unprompted and prompted) ■ Correctly identify health risks and social disadvantages of harmful consumption of alcohol ■ See such disadvantages as salient and relevant to themself ■ Change in measures such as knowledge, attitudes, awareness, intention and behaviour relating to harmful consumption of alcohol

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
2.2 *Embed the main themes and key messages within a broad range of complementary preventative health policies and programs, such as:* ■ Schools and tertiary education settings ■ Community-based sport and recreation settings ■ Community-based cultural groups	Lead agency: ■ NPA Partners: ■ State and territory education departments ■ National, state and local sporting codes ■ Schools ■ Local government ■ Cultural organisations	Years 5–8 and ongoing	Proportion of the community who can identify health risks and social disadvantages of alcohol and see these disadvantages as potentially salient and relevant to themselves or others. Change in measures such as knowledge, attitudes, awareness, intention and behaviour relating to alcohol and risk drinking. Measures of risky alcohol use associated with participation or attendance at sporting events.
2.3 *Introduce basic strategies in the workplace to prevent and reduce alcohol-related harm in a range of key industries, including:* ■ Offering regular basic health checks for employees ■ Development of evidence-informed workplace policies ■ Employee assistance programs	Lead agency: ■ NPA Partners: ■ State and territory workplace safety authorities ■ Chambers of commerce and industry ■ Employer groups ■ Trade unions	Years 5–8 Develop strategy to promote comprehensive workplace health programs for alcohol, obesity and tobacco. Model policies, incentives and evaluation measures developed and implemented. Baseline measures collected. Implementation commences. Years 9–11 Focus expands to private sector workplaces. Development of partnership arrangements and incentives.	Increased number of workplaces implementing health policies with a focus on nutrition, physical activity, alcohol and tobacco. Increased number of workplaces with health programs. Number of employees with access to healthy programs in the workplace and the proportion who use them. Uptake of workplace policies and programs by public sector agencies at the Australian/state/territory and local government level. Active transport to and from work, level of physical activity, healthy eating, risky drinking and smoking by employees. Uptake of incentives by the private sector.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
Key action area 3: Regulate alcohol promotions			
3.1 *In a staged approach:* ■ Phase out alcohol promotions from times and placements which have high exposure to young people aged up to 25 years, including: ■ Advertising during live sport broadcasts ■ Advertising during high adolescent/child viewing ■ Sponsorship of sport and cultural events. (e.g. sponsorship of professional sporting codes; youth-oriented print media; internet-based promotions) ■ Consider whether there is a need for additional measures to address alcohol advertising and promotion across other media sources	Lead agency: ■ MCDS Partners: ■ National sporting codes	Years 1–4 Introduce a co-regulatory approach to alcohol promotions agreed by MCDS in April 2009. Monitor and evaluate the effectiveness of the co-regulatory approach to alcohol promotions agreed by MCDS in April 2009. Ban the sale of alcohol-branded merchandise. Year 4 Introduce independent regulation through legislation if the co-regulatory approaches are not effective in phasing out alcohol promotions from times and placements which have high exposure to young people up to 25 years. Years 5–8 Continue phase out of alcohol promotions from times and placements which have high exposure to young people aged up to 25 years. Commence phase out of sponsorship including national sporting codes and cultural events. Years 9–11 Continue phase out of sponsorship including national sporting codes and cultural events. Identify any additional measures required to address alcohol promotion across other media sources.	Number and type of alcohol promotion, marketing and sponsorship arrangements which are most likely to appeal to or have an impact on children and young people. Change in community attitudes to alcohol – adults and young people.
3.2 *Introduce enforceable codes of conduct requiring national sporting codes to take greater responsibility for individuals' alcohol-related player behaviour.*	Lead agency: ■ Australian Government Partners: ■ National sporting codes	Years 5–8 Develop and implement enforceable codes of conduct.	Code developed and implemented. Changes in community attitudes. Changes in sporting organisations, officials and players' knowledge, attitudes, intentions and behaviour.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
3.3 *Require health advisory information labelling on containers and packaging of all alcohol products to communicate key information that promotes safer consumption of alcohol, including:* ■ The current NHMRC Australian Guidelines to Reduce Health Risks from Drinking Alcohol ■ Text and graphic warnings about the range of health and safety risks of alcohol consumption ■ Nutritional data ■ Ingredients ■ Clearly legible information on the amount of alcohol by volume and number of standard drinks	Lead agency: ■ Food Standards Australia New Zealand (FSANZ) Partners: ■ Alcoholic beverage and related industries ■ Health authorities	Years 1 – 4 Introduce requirements for health advisory information.	Community attitudes, awareness and knowledge of warnings, labels and key messages.
3.4 *Require counter-advertising (health advisory information) that is prescribed content by an independent body within all alcohol advertising at a minimum level of 25% of the advertisement broadcast time or physical space.*	Lead agency: ■ Australian Government Partners: ■ Australian Competition and Consumer Commission ■ Health authorities ■ Advertising industry ■ Alcoholic beverage and related industries	Years 5–8 Specify, develop and implement the arrangements and content for the counter-advertising initiative. Develop operating principles to guide the industry. Consultation. Years 9–11 If required, introduce legislation to require counter-advertising and implement arrangements.	Awareness of counter-advertising and key messages. Change in measures such as knowledge, attitudes, awareness, intention and behaviour relating to alcohol and risk drinking. Industry compliance with counter-advertising requirements.
Key action area 4. Reform alcohol taxation and pricing arrangements to discourage harmful drinking			
4.1 *Commission independent modelling under the auspices of Health, Treasury and an industry panel for a rationalised tax and excise regime for alcohol that discourages harmful consumption and promotes safer consumption.*	Lead agency: ■ Commonwealth Treasury (Henry Review) Partners: ■ Australian Government and State and Territory Health Departments ■ Australian Tax Office ■ Australian Customs ■ Alcoholic beverage and related industries ■ Individuals and organisations within public health and health economics	Years 1–4 Commission modelling.	Prices of alcoholic beverages differ significantly according to their alcohol content and/or their potential to cause harm.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
4.2 *Develop the public interest case for minimum (floor) price of alcohol to discourage harmful consumption and promotes safer consumption.*	Lead agency: ■ National Competition Council Partners: ■ Alcoholic beverage and related industries ■ Health and law enforcement groups	Years 1–4 Develop the public interest case. Years 5–8 Legislate new pricing regime, including minimum price, based on work completed in the first phase. Years 9–11 Implement legislation of new pricing regime, including minimum price, based on work completed in the first and second phases.	The minimum price per standard drink for all alcoholic beverage types and containers of a certain size is regulated.
4.3 *Direct a proportion of revenue from alcohol taxation towards initiatives that prevent alcohol-related societal harm.*	Lead agency: ■ Commonwealth Treasury Partners: ■ NPA	Years 1–4 and ongoing	An appropriate amount of alcohol taxation revenue is directed to fund programs that aim to prevent underage drinking and risky/high-risk drinking.
Key action area 5: Improve the health of Indigenous Australians			
5.1 *Increase access to health services for Indigenous people who are drinking at harmful levels through:* ■ Providing resources to primary healthcare providers ■ Training of staff, including Indigenous health workers ■ Expanding both community-based and residential alcohol treatment programs ■ Increasing health service capacity to facilitate coordinated case management of alcohol-dependent persons	Lead agency: ■ Australian Government Partners: ■ National Aboriginal Community Controlled Health Organisation (NACCHO) ■ Aboriginal Community Controlled Health Organisations (ACCHO) ■ National Indigenous Health Equality Council	Years 1–4 and ongoing Development of a coordinated implementation plan to expand alcohol treatment programs in the community as well as residential and improve coordinated care.	Availability of alcohol treatment services in public, private and NGO sectors. Access to alcohol treatment services by SES, age, ethnicity, Indigenous status etc. Evaluation of the coordinated implementation plan.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
5.2 *Support local initiatives in Indigenous communities, including:* ■ Restricting the physical availability of products ■ Reduce the number, density and/or opening hours of licensed premises in areas of high alcohol-related harm ■ Strengthening enforcement of RSA ■ Establishing local groups of senior Indigenous men and women to promote greater individual and family responsibility in relation to alcohol	Lead agency: ■ Australian Government Partners: ■ NACCHO ■ ACCHO ■ NIDAC ■ Indigenous organisations such as Land Councils and Housing Associations ■ State and territory liquor licensing authorities ■ State and territory police services and law enforcement agencies ■ Local government ■ Alcoholic beverage and related industries	Years 1–4 and ongoing	Level of risky drinking in Indigenous communities. Alcohol outlet opening times. Alcohol outlet density. Community opinions on issues such as outlet density, impact on neighbourhood amenity, noise levels, perceived safety, overall satisfaction with current approach. Data collection and monitoring of alcohol sales, policing, and alcohol-related health and social impacts; e.g: ■ Alcohol-related violence and crime ■ Alcohol-related hospital admissions, road accidents, injuries etc
5.3 *Establish a reliable, regular and sustained system for the collection and analysis of population statistics on alcohol and drug use among Indigenous people.*	Lead agency: ■ Australian Institute of Health and Welfare (AIHW) Partners: ■ NIDAC ■ Office for Aboriginal and Torres Strait Islander Health ■ NACCHO ■ ABS ■ Public health research bodies	Years 1–4 Identify options to enhance data collections on alcohol and drug use among Indigenous people. Years 5–8 Implement system.	Robust and sustained data collections and analysis of alcohol and drug use among Indigenous people is available within two years.
5.4 *Establish and fund a multi-site trial of alcohol diversion programs.*	Lead agency: ■ Australian Government Partners: ■ NACCHO ■ ACCHO ■ State and territory police services and law enforcement agencies ■ State and territory health departments	Years 1–4 Identify trial methodology and sites, and evaluative research component. Years 5–8 Implement, monitor and evaluate trial.	Trials successfully established in a range of sites with support of key partners. Trials evaluated and results reported.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
5.5 In communities that desire them and which are large enough to support them, the availability of night patrols and sobering-up shelters should be expanded.	Lead agency: ■ Australian Government Partners: ■ NACCHO ■ ACCHOs ■ NIDAC ■ Indigenous organisations such as Land Councils and Housing Associations ■ Local government ■ State and territory police services and law enforcement agencies ■ State and territory health departments	Years 1–4 Invite expressions of interest from local communities to establish and/or expand night patrols and sobering-up shelters.	Availability and use of sobering-up shelters and night patrols. Indigenous community opinions on issues such as night patrols, impact on neighbourhood amenity, noise levels, perceived safety, overall satisfaction with current approach. Data collection monitoring of alcohol sales, policing, and alcohol-related health and social impacts. For example: ■ Alcohol-related violence and crime ■ Alcohol-related hospital admissions, road accidents, injuries etc
Key action area 6: Strengthen, skill and support primary healthcare to help people in making healthy choices			
6.1 Enhance the role of primary healthcare organisations in preventing and responding to alcohol-related health problems by: ■ Reviewing the incentive structure for alcohol-related health checks in the primary healthcare settings that are both universal and targeted at high-risk groups ■ Further developing their role in coordinating collaborative initiatives such as individual and group referral programs for alcohol-related risk factors ■ Increasing the uptake of pharmacotherapy treatment for alcohol dependence, by GPs and specialist alcohol and drug treatment services ■ Promoting the NHMRC guidelines on low risk drinking	Lead agency: ■ COAG Partners: ■ Divisions of General Practice ■ Australian Medical Association (AMA) ■ Royal Australian College of Physicians (RACP) ■ Health Insurance Commission ■ State and territory health departments ■ Primary Health Services ■ Primary Care Networks	Years 1–4 Review current incentives for alcohol-related health checks. Develop training and support for primary health workforce. Years 5–8 Implement new incentives. Evaluate progress.	Review of current incentive structure completed and reported to COAG, including recommendations. Occasions of brief alcohol-related health checks in primary healthcare services. Rates of pharmacotherapy treatment provided for alcohol dependence through primary healthcare services.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
6.2 *Develop a more comprehensive network of alcohol-related referral services and programs to support behaviour change in primary healthcare by:* ■ Implementing quality standards and an accreditation system ■ Brokering through existing primary healthcare services ■ Strengthening links with general practice and community-based alcohol and drug services and coordinating through primary healthcare organisations ■ Including the role of practice nurses ■ Utilising the Headspace (youth mental health promotion) service sites	Lead agency: ■ Australian Government with the Divisions of General Practice Partners: ■ AMA ■ RACP ■ Health Insurance Commission ■ State and territory health departments ■ Primary Health Services ■ Primary Care Networks ■ Drug and Alcohol Treatment Services ■ Australian Nursing Federation ■ Drug and Alcohol Nurses Association	Years 1–4 Establish quality standards and identify referral network. Years 5–8 and ongoing Provide funding for services to achieve quality standards and implement referral networking. Quality accreditation.	Referrals between primary healthcare services and specialist alcohol treatment services. Quality accreditation system developed. Quality accredited health services. Brief interventions for alcohol issues undertaken by practice nurses.
6.3 *Increase access to primary healthcare services and improve health outcomes for hard-to-reach disadvantaged individuals who are at risk of alcohol-related health problems by:* ■ Limiting the costs of primary healthcare for disadvantaged groups, such as co-payments ■ Providing outreach and culturally appropriate services ■ Providing opportunistic brief interventions for alcohol when also addressing other key health risks such as smoking and/or obesity	Lead agency: ■ Australian Government with the Divisions of General Practice Partners: ■ AMA ■ RACP ■ Health Insurance Commission ■ State and territory health departments ■ Primary Health Services ■ Primary Care Networks ■ Drug and Alcohol Treatment Services ■ Australian Nursing Federation ■ Drug and Alcohol Nurses Association	Years 1–4 Identify existing barriers to primary healthcare for hard-to-reach disadvantaged individuals. Years 5–8 Pilot a range of programs that increase access for hard to-reach disadvantaged individuals.	Removal of major barriers for hard-to-reach disadvantaged individuals who require access to primary healthcare services. Service outcomes for hard-to-reach disadvantaged individuals at risk of alcohol-related health problems.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
Key action area 7: Build healthy children and families			
7.1 *Protect the health and safety of children and adolescent brain development by:* ■ Developing nationally consistent principles and practices regarding the supply of alcohol to minors without parental/guardian consent ■ Promoting informed community discussion about the appropriate age for young people to begin drinking	Lead agency: ■ MCDS Partners ■ State and territory police services and law enforcement agencies ■ Lead agency: ■ NPA ■ Maternal and child health services	Years 1–4	All states have consistent legislation and monitoring systems in place by 2010. Number of complaints. Community attitudes to young people and drinking, and supply of alcohol to minors.
7.2 *Support parents in managing alcohol issues at all stages of their children's development through community-level approaches including:* ■ Broad dissemination and implementation of the NHMRC guidelines on the risks of alcohol consumption for young people aged under 18 years and for women who are pregnant or breastfeeding ■ School-based parent networking for mutual support and information sharing ■ Local policing programs to proactively liaise with families, schools and communities at times when alcohol may pose risks to the health and safety of young people ■ Provision of practical advice for handling alcohol issues among children and adolescents at key life stages and settings, including commencement of secondary education, in sport settings, during periods of stress, at times of family disruption or breakdown, and in school leaving years	Lead agency: ■ MCDS Partners ■ Maternal and child health services ■ State and territory health departments ■ State and territory education departments ■ Schools ■ State and territory police services and law enforcement agencies	Years 1–4 Develop information and materials and dissemination strategy. Years 5–8 Disseminate information and materials. Evaluate impact.	Knowledge, attitude and awareness of NHMRC guidelines and health risks associated with alcohol use, particularly for young people. Local programs established and program evaluation completed. Data collected on alcohol-related health and social impacts for young people; e.g: ■ Alcohol-related violence and crime ■ Alcohol-related hospital admissions, road accidents, injuries etc ■ Population-level surveys of young people – sources of alcohol supply and sales, levels of risk drinking, experience of alcohol-related harms
7.3 *Measure the impact of harmful consumption of alcohol on families and children by ensuring all population surveys that collect data to monitor drug use and drug trends across Australia collect information on parental status or childcare responsibilities of drinkers.*	Lead agency: ■ AIHW	Years 5–8 and ongoing	Data collections include this measure by 2010.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASURE
Key action area 8: Strengthen the evidence base			
8.1 *Develop a system for nationally consistent collection and management of alcohol wholesale sales data to inform key alcohol policy developments and evaluations that includes:* ■ Funding for data collection and provision by the alcohol beverage and related industries; and ■ Funding for regular and ongoing data management, analysis and reporting by the Australian Bureau of Statistics. ■ Continuation of current accessible datasets on alcohol consumption levels in Australia, collected and compiled by the Australian Bureau of Statistics	Lead agency: ■ NPA Partners: ■ MCDS ■ State and territory liquor licensing authorities ■ Australian Bureau of Statistics ■ Alcoholic beverage and related industries	Years 1–4 Fund data collection. Years 5–8 and ongoing: Quarter and/or annual reporting.	Data collection funded. Data collected and reported.
8.2 *NPA to define a set of essential national indicators on alcohol consumption and health and social impacts by reviewing what is currently available and what is also required.*	Lead agency: ■ NPA Partners: ■ AIHW ■ ABS ■ Public health research bodies	Years 1–4	National alcohol indicator dataset finalised and collection commences 2011.
8.3 *Expand the collection of patterns of drinking data to include place of drinking, duration of drinking occasion, and reasons for drinking.*	Lead agency: ■ AIHW	Years 5 – 8 and ongoing	Data collected.
8.4 *Improve utilisation of key datasets on the harm to drinkers and harm to others, including:* ■ Police data including that relating to random breath testing, ignition interlock devices, and crimes against property and crimes against the person ■ Child and family welfare agency data ■ Health services data including hospitals, primary care services, ambulance services and specialist treatment services ■ Local government data on management of public space, clean-up costs, noise issues and enforcement of local laws ■ Other relevant datasets including fire services, property insurance and medical insurance	Lead agency: ■ NPA Partners: ■ AIHW ■ State and territory health departments ■ State and territory education departments ■ State and territory police services and law enforcement agencies ■ Local government ■ Emergency services ■ Insurance industry ■ ABS ■ Alcoholic beverage and related industries	Years 5–8	Data collected and appropriate mechanisms in place to link datasets and sources to enable analysis of data on alcohol-related harm.

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