



CONSULTATION DRAFT

NATIONAL
ALCOHOL
STRATEGY

2018–2026

A national framework to prevent and
minimise alcohol-related harms among
individuals, families and communities.



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National Alcohol Strategy 2018–2026

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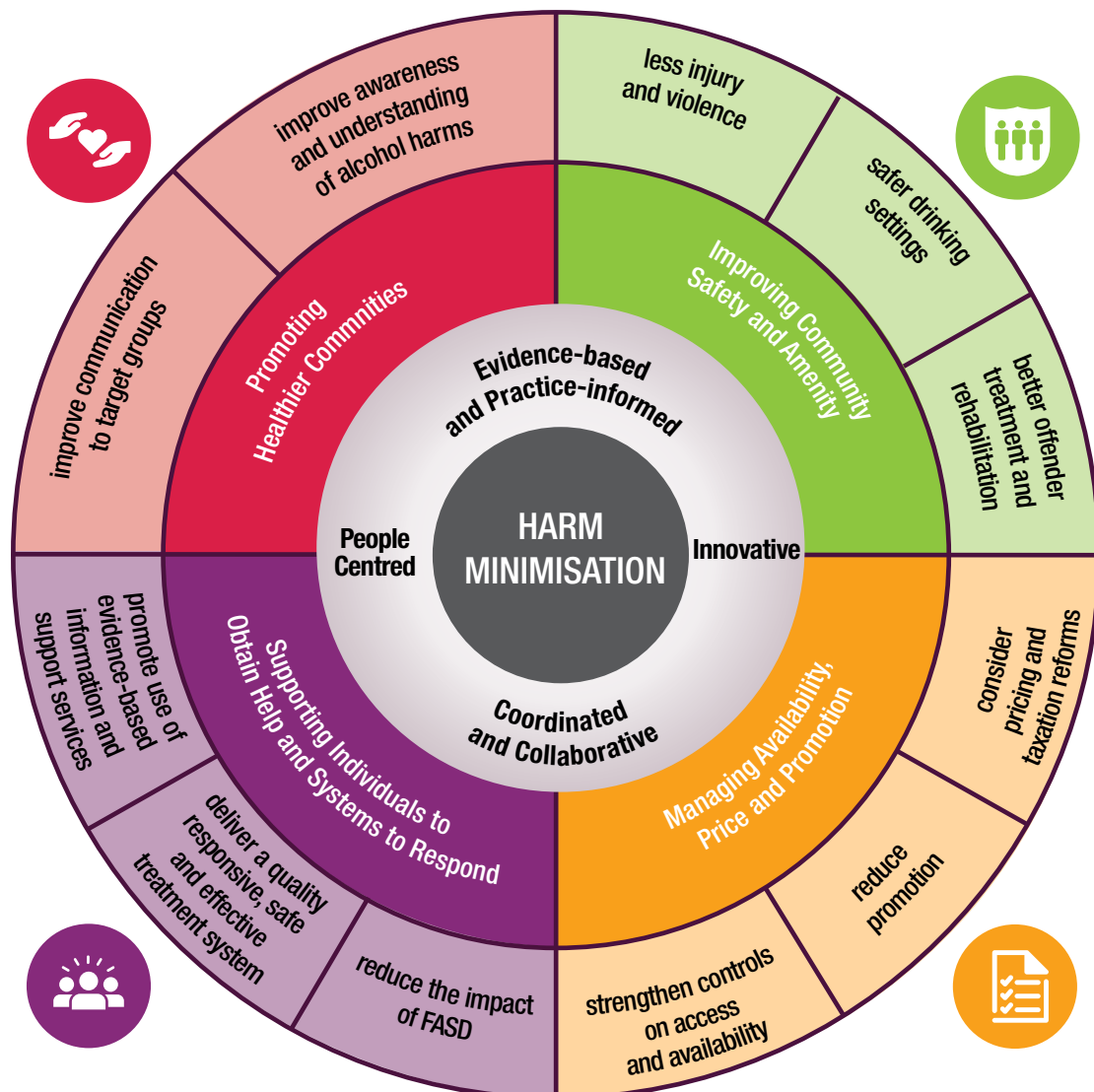
This Strategy acknowledges the importance of Aboriginal people's relationships with each other and with the broader Australian community. It responds to the overwhelming message from Australians of all backgrounds, that we share a desire to be connected to our communities, to feel as if we have something to aspire to and be valued and respected.

THE NATIONAL ALCOHOL STRATEGY 2018–2026 AT A GLANCE

Aim

To provide a national framework to prevent and minimise alcohol-related harms among individuals, families and communities by:

- Identifying agreed national priority areas of focus and opportunities for action;
- Promoting and facilitating collaboration, partnership and commitment from the government and non-government sectors; and
- Targeting a 10% reduction in harmful alcohol consumption.
 - alcohol consumption at levels that puts individuals at risk of injury from a single occasion of drinking, at least monthly.
 - alcohol consumption at levels that puts individuals at risk of disease or injury over a lifetime.



INTRODUCTION

Alcohol in Australia

Alcohol is a complex issue in Australian society.

It is the most widely used drug in Australia, with almost 90% of adults reporting having consumed alcohol at some point over their lifetime and 80% consuming at least some alcohol in the previous 12 months.¹

Most Australians do not drink at levels that put them at risk of disease or injury, however, more than a quarter do drink at levels that put at risk of injury from a single occasion of drinking (at least monthly) and 17% drink at levels that put them at risk of disease or injury over a lifetime. Drinking at these levels presents a significant social cost due to the increased risk of alcohol related disease, street and family violence, sexual assault and road accidents.²

This *National Alcohol Strategy 2018–2026* ('the Strategy') provides a framework for directing national and local action to prevent and minimise these harms.

Harms associated with alcohol

The harms associated with alcohol are equivalent to, or greater than, those for illicit drugs. Examples of these harms include:

- ✔ Contributing (second only to tobacco) to Australia's burden of disease—with alcohol use being linked as a risk factor/contributor to more than 200 chronic diseases (including seven types of cancer);³
- ✔ Acting as one of Australia's leading causes of drug-related death (second only to tobacco)—with more than 5,500 deaths estimated to be attributable to alcohol annually;⁴
- ✔ Contributing significantly to violence and assaults—including domestic, family and intimate partner violence;⁵
- ✔ High economic and service delivery impacts on community services—including policing health, justice and local government services;⁶
- ✔ Contributing to avoidable injury and road accidents;⁷
- ✔ Cause of birth defects and behavioural and neurodevelopmental abnormalities including Fetal Alcohol Spectrum Disorder (FASD) which have life-long impacts; and
- ✔ Reductions in productivity in the workplace.

PURPOSE OF A NATIONAL ALCOHOL STRATEGY

For more than 30 years the Commonwealth, state and territory governments have collaborated to provide comprehensive, evidence-informed approaches for reducing harm from alcohol. This Strategy continues the long-standing national commitment to tackling risky alcohol use and related harm in the community through a combination of law enforcement, prevention, early intervention and health care strategies.

The Strategy builds on the existing efforts and responses to prevent and minimise alcohol-related harms, and provides a guide for focusing and coordinating population-wide and locally appropriate responses to alcohol-related harm by governments, communities and service providers. The Strategy also reiterates Australia's commitment to the *World Health Organization Global Action Plan for the Prevention of and Control of Non-Communicable Diseases 2013–2020*, which includes a voluntary target of a reduction in harmful alcohol consumption of 10% by 2025.⁸

The Strategy also reflects Australia's support for the World Health Organization *Global Strategy to Reduce Harmful Use of Alcohol*⁹ (including strong alignment between the overarching aim, goals and priority areas of this Strategy with the priorities and areas of action of the Global Strategy) and the United Nations *2030 Agenda for Sustainable Development Goals*.¹⁰

Importantly, this Strategy recognises that coordination and collaboration across jurisdictions, portfolios and the community is essential. Alcohol harms can be closely intertwined with mental health problems, a lack of social connection, experiences of trauma and exacerbated by a lack of income, employment, housing and education. Effective interventions require a cross-agency response, including health care, education, social services, liquor regulators, law enforcement, the justice system and local government.

Preventing and minimising alcohol-related harms in Australia cannot be achieved by governments alone. A strength of Australia's approach to reducing alcohol-related harm has been the strong and enduring partnerships developed between governments, non-government organisations and community groups. This Strategy seeks to further strengthen these partnerships, including through the establishment of a new Alcohol Reference Group (Reference Group) (involving non-government and government sector representatives).

Membership of the Reference Group will be drawn from representatives of all levels of government (Commonwealth, state and territory and local governments), as well as non-government, health, policing and research sectors. Membership of the Reference Group will be determined by the National Drug Strategy Committee (NDSC). The proposed role of the Reference Group is detailed later in the Strategy (see *Governance*).

The alcohol manufacturing industry, wider retail and hospitality industries, advertising, broadcasting and sporting industries play a significant role in Australia's economy and social fabric. These industries also have a responsibility in supporting and taking appropriate action to prevent and minimise alcohol-related harms through the lawful, responsible supply of alcohol and their ability to influence drinking behaviours.

While acknowledging the relevance and responsibility of the alcohol industry and associated industries to contribute to the prevention and minimisation of alcohol-related harms, it is also acknowledged that they will not be eligible for membership of the Reference Group.

Development of the Strategy

The development of the Strategy has been informed by a national consultation process in 2015, which included focus groups, key informant interviews, online survey feedback and written submissions.

This consultation informed the identification of the challenges facing Australia in relation to alcohol related-harm, as well as the underpinning strategic principles, the key priorities of focus, priority populations, and opportunities for action.

A second phase of consultation was undertaken in 2017 to further inform the strategic direction and priorities of the Strategy.

The Strategy operates as a sub-strategy of the *National Drug Strategy 2017–2026*¹¹ and as such is underpinned by the principle of harm minimisation (encompassing demand, supply and harm reduction).

Furthermore, this Strategy will cover a nine-year period (2018–2026) so that it aligns with the conclusion of the overarching *National Drug Strategy 2017–2026*. In recognition of the need to ensure that emerging issues are considered over the life of the Strategy, the NDSC will receive regular reports from the Reference Group which can highlight any new and emerging issues of concern. A mid-point review of the Strategy will also be undertaken.

There are two other national sub-strategies that closely align with and support the aim of the National Alcohol Strategy 2018–2026:

- ✔ The *National Aboriginal and Torres Strait Islander People's Drug Strategy 2014–2019*;¹² and
- ✔ The *National Alcohol and Other Drug Workforce Development Strategy 2015–2018*.¹³

The Strategy has been developed and endorsed by the NDSC and the Ministerial Drug and Alcohol Forum.



**1 in 4
Australians**
are drinking alcohol
at risky levels

Alcohol can be
purchased for
**less than
40 cents
per standard
drink**



10–15%
of emergency
department
presentations are
alcohol-related

25%
of all frontline police
officers' time is taken
by alcohol-related
crime



1 in 2 women
who are pregnant
consume alcohol
during their
pregnancy



Alcohol was
involved in **34%**
of intimate partner
violence incidents;
and **29%** of family
violence incidents

Alcohol is a
**leading cause
of drug-related
death – with
more than
5,500 deaths**
estimated to be
attributed to alcohol
in any year



1 in 4
of all road fatalities
can be attributed to
drink driving



In Australia there is
**1 licenced
venue for every
317 people**

Alcohol was the **most common drug of
concern** for people accessing specialist treatment
in 2015–16 accounting for **32% of episodes**

Sources: see panel on page 33 for details

ALCOHOL-RELATED HARM: WHERE ARE WE NOW?

Australia is regularly reported or casually referred to as having an “alcohol culture” where not consuming alcohol can be viewed as being “unAustralian”.^{14, 15, 16}

There are many Australians for whom this perception of the cultural norm contributes to increased risk of serious harm and development of harmful drinking patterns. Examples of alcohol being embedded in the Australian culture include drinking to intoxication being seen as a rite of passage to adulthood, the perception that celebration and consuming alcohol are intrinsically linked, public figures are glorified for drinking alcohol, widespread alcohol availability and accessibility of cheap alcohol products, social and peer pressure/expectation to consume alcohol and exposure to alcohol advertising and promotion.

Australia’s overall consumption of alcohol (on a per capita basis), and the percentage of people reporting abstinence from alcohol has either declined or remained stable between 2009 and 2016,¹⁷ with significant improvements observed among younger Australians.¹⁸

However, there are still a significant number of Australians consuming alcohol at risky levels, impacting their health and potentially also the wellbeing of others around them. Australia has national guidelines: *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*, which help to define levels of alcohol consumption where risks to harm (including injury and disease) are minimised. These guidelines go beyond looking at the short-term risks of alcohol consumption, to life-time risks of alcohol-related harm.¹⁹ The Guidelines are used as the basis of defining risky or harmful drinking throughout this Strategy and are provided for reference at Appendix A.

Harmful patterns of drinking have been associated with a variety of acute harms including alcohol poisoning and injuries due to intoxication, pedestrian injuries and fatalities, drownings, suicides, work accidents, crime, public disorder, road traffic accidents and interpersonal violence.

Among recent drinkers, 6.7% had injured themselves or someone else because of their drinking in their lifetime and 2.3% had done so in the last 12 months.²⁰ Very high-risk drinkers that consumed 11 or more standard drinks on a single occasion at least monthly were about 5 times as likely as recent drinkers to have injured themselves or someone else due to their drinking in the last 12 months.²¹ Around 10% of Australians (who consume alcohol) report driving a motor vehicle after drinking,²² and 40% of young Australians having been in a vehicle with an alcohol-affected driver.²³

People often do not recognise that they are consuming alcohol in quantities that are damaging to their health and tend not to associate themselves as problem drinkers.

This may be the result of a relatively poor understanding of alcohol’s contribution to Australia’s burden of disease, including being linked with more than 200 chronic diseases,²⁴ and not associating some of their own health conditions with their alcohol consumption. Many are unaware of alcohol consumption’s contribution to cancer, cerebrovascular, cardio-vascular, liver and digestive disease.

But this is not just a health issue or public safety issue—it has a whole of society impact, including on productivity. Risky drinkers were more likely to miss at least 1 day of work in the past 3 months due to their alcohol use than low-risk drinkers.²⁵

This Strategy supports approaches to prevent and minimise harmful alcohol consumption among those most at risk as well as broader population-based measures. The Strategy also recognises that efforts need to be focused on strategies for preventing and minimising alcohol-related harms in all locations where harms occur as a result of alcohol consumption.

Disproportionate Impacts of Alcohol-Related Harm

This Strategy recognises that alcohol-related harms are not experienced uniformly across the population, with disproportionate levels of harm being experienced within some contexts and communities.

Aboriginal and Torres Strait Islander people

Overall, Aboriginal and Torres Strait Islander people are more likely to abstain from drinking alcohol than non-Aboriginal and Torres Strait Islander people (31% compared with 23% respectively). However, among those who did drink, higher proportions drank at risky levels (20% exceeding the lifetime risk guidelines) and were more likely to experience alcohol-related injury than non-Aboriginal and Torres Strait Islander people (35% compared to 25% monthly, respectively).²⁶

For this reason, Aboriginal and Torres Strait Islander people suffer from disproportionate levels of harm from alcohol, including alcohol-related mortality rates that are 4.9 times higher than among non-Aboriginal and Torres Strait Islander people.²⁷

The poorer overall health, social and emotional wellbeing of Aboriginal and Torres Strait Islander people than non-Aboriginal and Torres Strait Islander people are also significant factors which can influence drinking behaviours.²⁸

People in remote areas

People residing in remote areas have reported drinking alcohol in quantities that place them at risk of harm at higher levels than those living in less remote regions.

People in remote and very remote areas were 1.5 times as likely as people in major cities to consume 5 or more drinks at least monthly and 2.4 times as likely to consume 11 or more drinks (at least monthly).²⁹

People with co-morbid mental health conditions

Research has linked alcohol use with mental health problems in many ways. For example, alcohol misuse can promote the development of mental health disorders such as depression, anxiety and/or social problems—around 37% of people who report problems with alcohol also have a co-occurring anxiety and/or mood disorder. The risk of having a mental illness is around four times higher for people who drink alcohol heavily than for people who do not.³⁰

Pregnant women (or those planning a pregnancy)

Alcohol consumption during pregnancy can result in birth defects and behavioural and neurodevelopmental abnormalities including Fetal Alcohol Spectrum Disorder (FASD). Data from states and territories have estimated FASD rates at 0.01 to 1.7 per 1000 births in the total population and 0.15 to 4.70 per 1000 births for the Aboriginal and Torres Strait Islander population.³¹ There is evidence that indicates some communities are experiencing much higher incidences of FASD and therefore the lifelong impacts of FASD.³²

The relationship between the consumption of alcohol during pregnancy and the expression of FASD is complex, but avoiding drinking before or during pregnancy eliminates the risk of FASD.

Around 1 in 2 women report consuming alcohol during their pregnancy, with 1 in 4 women continuing to drink after they are aware they are pregnant. Of these women, 81% drank monthly or less with 16.2% drinking 2–4 times a month.³³

Teenagers and young adults

While the number of teenagers choosing to abstain from alcohol is increasing (72% in 2013 to 82% in 2016), once this age group begin to drink alcohol they are more likely to drink to become intoxicated than any other age group (1 in 5 people in their 20s). Recent data shows that 15% of younger Australians drink more than 11 drinks on a single occasion at least monthly.³⁴

Such risky drinking behaviour can lead to acute alcohol-related harms and to undertaking risky or antisocial behaviour. Social pressures can also influence young people to consume alcohol in harmful ways. Additionally, due to their developing brains and bodies, young people may be more vulnerable to the physical effects of alcohol and impairment of cognitive performance.

Data has also highlighted that 13% of deaths in 14–17year olds can be attributable to alcohol.³⁵

Adults in their 40s, 50s and 60s

Some people in these age groups may drink more frequently than other age groups, as alcohol becomes part of their daily routine, or may be continuing drinking habits from earlier years.

Approximately 1 in 5 adults in these age groups drink at risky levels, averaging more than 2 standard drinks a day. Data has also shown a significant increase in people in their 50s and 60s consuming 11 or more standard drinks on at least a single drinking occasion in the last year (11.9% and 6.1% respectively).³⁶

The frequency of their drinking can lead to many long-term health risks such as liver disease, high blood pressure and cancer.

Older people (70+)

There is an increasing prevalence of harmful drinking among people aged 65 and over with these individuals the most likely age group to drink daily (19.5% of males; 8.7% of females).³⁷

As older people may have a lower physical tolerance for alcohol, and alcohol can exacerbate other health conditions or interact with prescription medication, they have increased susceptibility to harmful alcohol use. Older people are also at increased risk of experiencing alcohol-related harm due to physiological changes associated with the natural ageing process including falling or injuring themselves or forgetting to take medications because of the use of alcohol.

Psychosocial factors, such as bereavement, retirement, boredom, loneliness, homelessness and depression) among older people can also be associated with higher rates of alcohol consumption.³⁸

With alcohol being the most common substance of misuse among older people, under-detection of alcohol problems is of immediate concern. Alcohol misuse in the older population can increase further if older people continue drinking habits that they have developed over their lifetime without considering these aforementioned risks. A lack of sound alcohol screening to detect risky drinking may result in a greater need for treatment, longer duration of treatment, increased use of ambulance services, and higher rates of hospital admission.

Lesbian, gay, bisexual and transgender people

People who identify as lesbian, gay or bisexual are more likely than heterosexual people to drink alcohol at levels that place themselves at risk of immediate and lifetime alcohol-related harm. Lesbian, gay, bisexual people are less likely than heterosexual people to be abstainers or ex-drinkers (14.3% compared to 21.3%); are more likely to be lifetime risk drinkers (25.8% compared to 17.2%); and, more likely to consume eleven or more standard drinks on a monthly and yearly basis (12.6% compared to 6.9%, and 27.8% compared to 15.3%).³⁹

People from culturally and linguistically diverse (CALD) backgrounds

While risky alcohol consumption is lower in non-English speaking populations (5.4%) than English-speaking populations (18.6%),⁴⁰ people from CALD backgrounds with alcohol use problems are a priority population because of the barriers they may face to receiving appropriate help and support.

Services for alcohol dependent users should consider specific risk factors faced by CALD populations, such as cultural sensitivities and support for English as a second language. These significant barriers can increase the vulnerability of people from CALD backgrounds, particularly the most vulnerable sub-populations of youth, migrants and refugees.

A STRATEGIC RESPONSE

This Strategy provides a guide to inform ongoing development, promotion and coordination of national and locally delivered evidence-based and practice-informed responses to agreed priorities.

As a sub-strategy of the *National Drug Strategy 2017–2026*, this Strategy is built on the overarching principle of harm minimisation (including the three pillars of demand, supply and harm reduction) and shares its underpinning strategic principles. The following additional strategic principles have been identified to guide Australia’s approach to preventing and minimising alcohol-related harm:

Evidence-based and practice-informed

Responses will be evidence-based, and where evidence does not yet exist for the most effective interventions, actions will be guided by the best available information and practice. Robust evaluation of the Strategy, new policy interventions and responses will contribute to the future evidence base.

Coordinated and collaborative

Effective interventions require multi-faceted, cross-agency responses with strong and enduring partnerships between governments, non-government organisations and community groups. There is a commitment to building strong new partnerships that can contribute to progress against the aim of the Strategy.

Innovative

Innovative actions that challenge traditional approaches should be investigated and trialled (where an appropriate evidence-base is lacking). Original and novel approaches to preventing and minimising alcohol-related harm should be encouraged where best-practice approaches are lacking.

People-centred and proportionate to the potential for harm

Whole of population approaches should be supplemented by targeted responses that recognise the disproportionate risks and harms experienced across different populations, communities and the lifespan (prenatal, antenatal and postnatal, childhood, adolescence through adulthood, mature age and across generations).



Priority Areas of Focus

The Strategy identifies four agreed national priority areas of focus for preventing and reducing alcohol-related harms in Australia:



Opportunities for Action

The Strategy highlights a number of opportunities for action under each of the priority areas of focus. These opportunities are examples of activities or initiatives that could be considered at either local, jurisdictional (state and territory) or national levels, including a mix of broad population approaches and targeted approaches.

The Strategy also provides relevant examples of evidence-based and practice-informed approaches outlined in the *National Drug Strategy 2017–2026* at Appendix B that may contribute to progress against these priorities.

Monitoring Progress

The impacts of alcohol-related harm and the responsibilities for implementation of alcohol policy extend across all levels of government and portfolios, as well as community service, public health and non-government sectors.

In recognition of the wide range of impacts and responsibilities, a key action of this Strategy is the establishment of a new Reference Group.

Membership of the Reference Group will be determined by the NDSC and be drawn from representatives of all levels of government (Commonwealth, state and territory and local governments), as well as non-government, health, policing and research sectors. See *Governance* for more detail on the role of the Reference Group.

PRIORITY AREAS OF FOCUS

The *National Alcohol Strategy 2018–2026* identifies four priority areas of focus to prevent and minimise alcohol-related harm in Australia:





PRIORITY 1:

IMPROVING COMMUNITY SAFETY AND AMENITY

Harmful alcohol consumption adversely impacts community safety and amenity—through contribution to experiences of violence and assault, crime (including drink driving and accidents), additional social costs and lost productivity, and reduced capacity within community services (including emergency departments, ambulance services and police departments).

The impacts from the drinking of others vary dramatically. At one end of the spectrum, Australians are affected by reduced amenity and anti-social behaviour (such as street noise, having to avoid public parks, or petty costs from damaged property). At the other end harms can be severe, such as child abuse and neglect or physical violence or death. In 2015–16, an estimated 162,400 Australians experienced physical assault where the offender was under the influence of alcohol (37.2% of total physical assaults).⁴¹ Research has also shown that alcohol is involved in 34% of intimate partner violence incidents, with more than half of the alcohol consumed during such purchased between 500 m and 10 km from the incident location.⁴² Using national child protection data and estimating from Victorian measures of alcohol involvement, almost 20,000 children across Australia were victims of substantiated alcohol-related child abuse in 2006–2007.⁴³ Data from New South Wales has highlighted that the greatest cost to government in responding to alcohol-related harm was being borne by police.⁴⁴

The World Health Organization has noted that harmful use of alcohol and drugs is a commonly cited risk factor for experiencing and perpetrating intimate partner violence and sexual violence.⁴⁵ Greater attention should be paid to the relationship between access to alcohol and family violence in light of the evidence showing that alcohol misuse increases the severity and frequency of family violence.

There is also a high correlation between alcohol and road accidents and the substantial trauma and harm they cause. Sustained efforts to prevent and prosecute drink-driving over recent decades have resulted in a significant fall in the proportion of road fatalities involving a driver under the influence of alcohol, however drink-driving is still a factor in one-in-four road fatalities.⁴⁶ This number remains far too high and underlines the importance of further enhancing enforcement and education around drink-driving.

There have been significant actions taken by several states and territories and/or local communities to improve community safety and amenity. There are substantial opportunities to consider the lessons learned, observe the successes and consider more widespread implementation of such evidence-based and practice-informed approaches and (where appropriate) national implementation of proven effective measures.

The following at risk-populations are prioritised for the goal of improving safety and community amenity: Aboriginal and Torres Strait Islander people; teenagers and young adults, adults in their 40's, 50's and 60's; people with comorbid mental health conditions, people in remote areas, people in contact with the criminal justice system, lesbian, gay, bisexual and transgender people, and the general community.

Relevant indicators of change:

- ✓ **Emergency Department (ED) presentations:** Estimated alcohol-related ED presentations on Friday, Saturday and Sunday nights per 1,000 persons
- ✓ **Alcohol-attributable hospitalisations:** Age standardised population rates (per 10,000) of alcohol-attributable hospitalisations for adults (15+ years)
- ✓ **Alcohol-related offence data:** Including violence and motor vehicle accidents
- ✓ **Experience of alcohol-related incidents.**



Goal: Improve safety and community amenity by working to better protect the health, safety and social wellbeing of those consuming alcohol and those around them.

objective
1

Less injury and violence

objective
2

Safer drinking settings

objective
3

Better offender treatment and rehabilitation

Opportunities for action

Implement policy and legislation around serving restrictions after a set time and the type of drinks which can be purchased and cessation of sales.

Build the capacity of local community stakeholders to identify and respond to prevent harm.

Support communities to declare themselves as 'dry' communities.

Implement and evaluate new approaches to deter drinking and driving and other alcohol related anti-social behaviours, (eg. mandatory sobriety conditions for repeat offenders, linked ID scanners to prevent entry to venues, ignition interlocks and improvements to the extent and quality of alcohol education).

Plastic glassware in high-risk venues and settings.

Accessible public transport.

Provide and enforce alcohol free areas to help ensure public safety and amenity.

Ensuring venues and local governments work to the best evidence-based design specifications using Crime Prevention Through Environmental Design (CPTED)

Require licensees to ensure staff are trained in the Responsible Service of Alcohol and monitor and support compliance with such service standards.

Provide opportunities for residents to declare their private premises "alcohol-free" and support to enforce such declarations.

Mobile assistance patrols:

Supporting greater and more efficient enforcement of liquor licensing and public conduct laws.

Supporting licensing decision making to achieve outcomes that contribute to reducing or minimising alcohol-related harm and ill-health.

Early intervention and screening for first-time offenders, including diversion programs and options for referral to evidence-informed interventions or treatment services.

Treatment which addresses substance use and other anti-social behaviours (such as violence and drink driving) including within the prison and drug treatment systems.

Implement and evaluate the effectiveness of approaches to change repeat drink-driver offending behaviours, for example ignition interlocks, treatment programs.



PRIORITY 2: MANAGING AVAILABILITY, PRICE AND PROMOTION

Alcohol has become more readily available and affordable in Australia over the last decade.

Research demonstrates that as alcohol availability increases, consumption and alcohol-related problems increase. Conversely, when availability is restricted, alcohol use and associated problems decrease. There is a large body of research, mostly from Australia, New Zealand, the United States and Scandinavian countries where substantial alcohol deregulation has occurred, highlighting that increasing alcohol availability has resulted in increased risky drinking, assault rates, child maltreatment, drink-driving, car crashes and hospital admissions.^{47, 48, 49, 50, 51}

The World Health Organization has identified that taxation, restricting availability and implementing bans on advertising are the most efficient strategies to minimise the harmful use of alcohol. They are highly cost-effective in reducing the alcohol-attributable deaths and disabilities at the population level.⁵² Furthermore, measures to reduce the availability of alcohol through strengthened controls on price and promotion are key to achieving the outcomes of improving public safety and amenity (Priority 1).

However, these present challenges for Governments to implement due to the conflicting needs of disparate stakeholders. Successfully responding to these challenges lies in balancing these conflicts and ensuring the overarching aim of minimising alcohol-related harm and promoting and protecting health and wellbeing are met.

There is good evidence that higher alcohol prices decrease both alcohol consumption and alcohol-related harms while lower prices increase them. This effect is seen in overall consumption as well as in “heavy” or “problem” drinkers, and in harms to the drinker as well as to others.⁵³

The most commonly identified pricing strategies relate to volumetric taxation for alcohol (i.e. taxing products on the amount of alcohol they contain) and establishment of a minimum floor price. There is evidence showing that the volumetric taxation of alcohol is an effective approach for reducing heavy drinking and alcohol related harm, as those who consume higher amounts of alcohol would be expected to pay more. Furthermore, a number of Australian and international reports suggest raising the price of the cheapest forms of alcohol by setting a minimum floor price will have a significant impact on risky drinking.⁵⁴

Evidence demonstrates that influencing the price of the cheapest drinks on the market by establishing a floor price has a larger impact on total consumption than does increasing the prices of more expensive drinks, which tends to produce shifts in product preference.⁵⁵

Younger people amongst whom the risk of alcohol-related harms is particularly high are especially responsive to changes in alcohol prices. Increased alcohol prices have been shown to reduce the proportion of young people who are heavy drinkers, to reduce underage and binge drinking, to delay intentions among younger teenagers to start drinking and to slow progression towards drinking larger amounts.⁵⁶

Alcohol promotion has also been associated with a range of effects, from influencing immediate decisions about brand preference, to increasing the likelihood that adolescents will start to use alcohol and to drink more if they already drink alcohol. Both the content and context of advertising and the frequency of media exposure can have an impact on attitudes and behaviours.

There is a strong association between exposure to alcohol advertising and young people's drinking. Alcohol advertising in Australia is regulated under several intersecting codes and overseen at varying levels of responsibility where issues of content, platform and placement are dealt with separately. The operation of these codes, in part, aims to protect minors from exposure to alcohol products but their effectiveness in achieving this is ineffective with over 94% of Australian students aged 12 to 17 reporting having seen alcohol advertising on TV⁵⁷ and around half of all alcohol advertising being screened during "children's viewing times".⁵⁸

The relationship between alcohol advertising and sponsorship of sporting events is another issue of concern in considering exposure of young people to alcohol advertising, and one that the current arrangements do not address.

The new focus on social media and digital marketing by a range of local and global alcohol industry companies presents substantial challenges both in terms of regulatory and health promotion responses and the potential risks for exposure to alcohol advertising by minors. This will need to be an issue that is monitored very closely over the lifespan of the Strategy.

This Strategy recognises the opportunity to strengthen the codes and operation of them to reduce the exposure of alcohol advertising to young people.

This Strategy also provides an opportunity to consider the transparency of licencing decisions and the role of communities in contributing to these decisions as a way of preventing and minimising alcohol-related harms.

The following at risk-populations are prioritised for the goal of price, availability and promotion: Aboriginal and Torres Strait Islander people; teenagers and young adults, adults in their 40's, 50's and 60's; older people, people with comorbid mental health conditions, lesbian, gay, bisexual and transgender people, people in remote communities and the general community.

Relevant indicators of change:

- ✔ **Lifetime risk:** Proportion of people exceeding the National Health and Medical Research Council (NHMRC) guidelines for lifetime risk
- ✔ **Single occasion risk:** Proportion of people exceeding the NHMRC guidelines for single occasion risk
- ✔ **Very high alcohol consumption:** Proportion of population consuming 11 or more standard drinks at least monthly
- ✔ **School children:** Proportion of school students (aged 12–17) who drank more than 4 drinks on one day in past seven days
- ✔ **Age first tried alcohol:** Average age at which young people aged 14–24 first tried alcohol
- ✔ **Total alcohol consumption per capita.**



Goal: Reducing opportunities for availability, promotion and pricing contributing to risky alcohol consumption.

objective
1

Strengthen controls on access and availability

objective
2

Pricing and taxation reforms to reduce risky alcohol consumption

objective
3

Minimise promotion of risky drinking behaviours and other inappropriate marketing

Opportunities for action

Effective policing and enforcement, including test-purchasing for enforcement of age restrictions.

Licensing procedures that consider outlet density, trading hours, impact on amenity, and related risks and harms, drawing on local evidence and local community concerns.

Registration and accreditation of licensees and key support staff, including minimum skills/knowledge assessment.

National standardisation of Responsible Service of Alcohol requirements.

Improved awareness and enforcement of secondary supply legislation (and consideration for nationally consistent approach).

Build the capacity of local community stakeholders to contribute to liquor licencing processes.

Interrupt illegal importation, duty free restrictions.

Introduction of a minimum floor price for alcohol.

Taxation reform to include volumetric taxation (*as recommended by the Henry Tax Review*).

Direct revenue from alcohol taxation towards preventative health activities (including a focus on alcohol-related harm) and alcohol and other drug treatment services.

Align a single national advertising code which covers placement and content across all media which provides consistent protection of exposure to minors regardless of programming.

Implement regulatory measures to reduce alcohol advertising exposure to young people (including in sport and online).

Regulatory measures to prevent promotion of discounted/low priced alcohol including bulk-buys, two-for-one offers, shop-a-dockets and other promotions based on price.

Effective controls on alcohol promotion to protect at-risk groups including youth and dependent drinkers.



PRIORITY 3:

SUPPORTING INDIVIDUALS TO OBTAIN HELP AND SYSTEMS TO RESPOND

Many Australians require support and help as a result of their alcohol use. It is important that when people make the decision to reduce or stop their alcohol consumption, services are available to respond to that decision in a timely manner. Equally, family, carers or friends may need support or advice for themselves or for the person of concern. Asking for help can be difficult, and it is critical that services are able to engage with help seekers in the moment and offer practical first contact support.

Treatment is an important part of reducing the harm from alcohol use, recognised by the release of the *United Nations Sustainable Development Goal 3.5*, to ‘*Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol*’.⁵⁹ Effective treatment includes outpatient, inpatient and community based treatment services, as well as medication assisted treatment for alcohol dependence. An effective alcohol treatment sector includes government, non-government and private services, and relies on a knowledgeable and engaged primary care sector. This Strategy affords an opportunity to contribute to this goal by ensuring treatment coverage consistent with the treatment coverage of other health conditions and prevention efforts in line with the harm experienced in Australia.

This Strategy has identified the importance of people seeking help being able to access the service that best meet their needs.

Frontline service providers (including health professionals and other related workers) should be equipped and encouraged to deliver early and opportunistic brief interventions as part of their ongoing duties. Pathways to care and opportunistic interventions at point of access, particularly in hospital settings where there is a high prevalence of people presenting for health-related issues that are related to alcohol-related harm, are currently not being utilised systematically or in any coordinated fashion.

Technology can be a key driver in providing brief interventions and information about access to other services, with the ability to respond when a person decides to seek help in a timely manner. These initial contacts can be anonymous, quick and triage the person to the best available help in the moment they are seeking it. Such interventions can play an important role in encouraging a person to make changes to reduce their alcohol consumption. Tools such as the ASSIST-BI⁶⁰ (an easy to follow and evidence-based screening and brief intervention program) could be expanded and adapted for particular professional groups and promoted widely as an evidence based approach to screening and providing brief interventions.

It is also important to build capacity and capability of the treatment service system, acknowledging the roles of primary care (particularly in terms of screening, brief intervention and referrals) and specialist services, and the interface between them to seize the opportunities that exist in preventing and advising on harms and risks.

The provision of high quality alcohol-related harm and risk information is particularly important during pregnancy and breastfeeding. Supporting women to avoid alcohol can reduce the risks of long term damage to the developing baby. Significant work has been done to develop resources for health professionals and the specialist alcohol and drug sector, such as best practice resources for alcohol and drug dependant women, *Women Want to Know*⁶¹ and the Australian Diagnostic Guide for FASD.⁶² Further work is required to disseminate appropriate resources, provide adequate training and have alcohol consumption conversations as part of daily practice. Importantly, a new National FASD Strategic Action Plan is currently (at the time of writing this Strategy) being developed to support further evidence-based and practice-informed action to reduce the impact of FASD across Australia.

Services and support for adults with alcohol-induced brain injury (including FASD) is an important component of the health care and social services response.

Families and peers also play an important role in helping people reduce their risky alcohol consumption and need to have access to current and evidence-based information.

The following at risk-populations are prioritised for the goal of supporting individuals to obtain help and the system to respond: Aboriginal and Torres Strait Islander people; teenagers and young adults, women who are pregnant or planning pregnancy; adults in their 40's, 50's and 60's; older people, people with comorbid mental health conditions, lesbian, gay, bisexual and transgender people, people in remote communities; people in contact with the criminal justice system and the general community.

Relevant indicators of change:

- ✔ **Alcohol during pregnancy:** Proportion of pregnant women consuming alcohol during their pregnancy
- ✔ **Alcohol attributable deaths:** Age standardised population rates (per 10,000) of alcohol-attributable deaths for adults (15+ years)
- ✔ **Proportion of people with alcohol dependence** receiving medical management.



Goal: Facilitating access to appropriate treatment, information and support services.

objective
1

Promote use of evidence-based information and support services

objective
2

Deliver a quality, responsive, safe and effective treatment system

objective
3

Implementation of National FASD Strategic Action Plan

Opportunities for action

Centralise information on alcohol-related referral services and programs to support improved referral processes in primary healthcare.

Implement evidence-informed e-health options with particular attention to reaching those who would not normally access treatment.

Strengthen partnerships and communication between services to support early identification of problems and ensure treatment and ongoing care, including between:

- alcohol treatment child protection and family violence services; and
- detoxification and rehabilitation and aftercare services.

Implement parenting support programs (such as the positive parenting program and nursing mother home visit programs) and develop information and support services for alcohol-dependent parents, especially of newborns, to reduce parental alcohol consumption and improve child development prospects.

Encourage General Practitioners' engagement in the Medical Management of People with Alcohol and Other Drug Disorders.

Improve the frequency and quality of screening and opportunistic interventions for risky alcohol consumption, including through promotion and training of the ASSIST-BI.

Increase screening, assessment, referral and treatment in primary health care settings and coordination between primary care acute and specialist services.

Expand the range of intervention options from brief and early interventions through to withdrawal management, psycho-social interventions, residential rehabilitation, community care and aftercare programs.

Implement settings based approaches to identifying, screening, assessment, brief interventions and referral to minimise alcohol-related problems (for example, sexual health services, needle syringe programs, maternity, community health, justice health services).

Ensure specific services for people with severe alcohol and other drug problems are available.

Enhance the capacity of generalist healthcare, community, welfare and support services.

Implement tailored interventions across a range of health care settings including more investment in detoxification and rehabilitation services for individuals who cannot be treated in the community.

Improve availability of effective psychosocial treatment (such as counselling, cognitive behaviour therapies, etc) and social approaches including employment and housing programs.

Implementation of the National FASD Strategic Action Plan.

Improve FASD prevention through community awareness, and improved FASD detection and diagnosis.

Increase awareness of the full range of treatment options for women at risk, including outpatient counselling and relapse prevention medicines for dependence.

Promote harms to developing baby as a result of maternal alcohol consumption in school and university curricula.

Disseminate, promote and provide training to support the use of established resources.

Improve access to support services, including through the National Disability Insurance Scheme.



PRIORITY 4: **PROMOTING HEALTHIER COMMUNITIES**

A key aspect to reducing alcohol-related harm includes effective health promotion and prevention. Messages need to be informed by the evidence, and communications targeted to at-risk populations and populations experiencing disproportionate harm.

However, there is currently poor understanding and awareness among the population in relation to risky alcohol consumption. In 2016, 32% of males and 9.1% of females thought they could drink 3 or more drinks every day (exceeding the lifetime risk of harm guidelines) without putting their health at risk.⁶³

Regular repetition of evidence-informed messages will, over time help to create the groundswell for positive changes to attitudes and a cultural shift towards healthier and lower risk alcohol consumption behaviours. Australians are currently subjected to mixed messaging via news and public promotion of alcohol (such as the association between sport and alcohol promotion/consumption and unbalanced reporting of alcohol health impacts). It is important to encourage consistent messaging across all media in relation to the harms of alcohol.

There is a need to improve personal knowledge and susceptibility of the harms associated with risky drinking and to ensure local communities provide a policy environment that support low risk drinking choices and discourages risky drinking. This Strategy encourages leveraging opportunities for embedding alcohol risk literacy in other programs, encouraging healthy lifestyle choices and health promotion activities to actively reduce the risks associated with alcohol consumption.

There is evidence to suggest that Australians are already open to the idea of needing to address their alcohol consumption as part of a healthier lifestyle. Almost half (48%) of recent drinkers (consumed at least 1 serve of alcohol in last 12 months) took action to reduce their alcohol intake in 2016 and the main reason for doing this was due to concern for their health.⁶⁴

The foundation of promoting healthier communities is ensuring the availability of a strong evidence base. Evidence is constantly improving, and priorities and effective responses will develop during the term of the Strategy. Supporting research and building and sharing evidence is a key mechanism that allows a national approach to leverage better outcomes from local implementation. This requires ongoing research into consumption levels, consumption behaviours, harms and impacts. Regulators and service providers should encourage the use of this research to inform innovative responses. Innovative responses should be evaluated, and outcomes promoted and disseminated, further contributing to the body of evidence.

The following at risk-populations are prioritised for the goal of promoting healthier communities: Aboriginal and Torres Strait Islander people; teenagers and young adults, adults in their 40's, 50's and 60's; people in remote areas; older people, people with comorbid mental health conditions, lesbian, gay, bisexual and transgender people, and the general community.

Relevant indicators of change:

- ✓ **Total alcohol consumption per capita**
- ✓ **Lifetime risk:** Proportion of people exceeding the NHMRC guidelines for lifetime risk
- ✓ **Single occasion risk:** Proportion of people exceeding the NHMRC guidelines for single occasion risk
- ✓ **Very high alcohol consumption:** Proportion of population consuming 11 or more standard drinks at least monthly
- ✓ **School children:** Proportion of school students (aged 12-17) who drank more than 4 drinks on one day in past seven days
- ✓ **Age first tried alcohol:** Average age at which young people aged 14–24 first tried alcohol.



Goal: Improving the understanding and awareness of alcohol related harms in the Australian Community, particularly to those experiencing disproportionate risks and harms.

objective
1

Improve awareness and understanding of alcohol harms

objective
2

Improve communication to target groups

Opportunities for action

Support the NHMRC's *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* to provide the highest standard of evidence-informed guidelines for health professionals, policy makers and the Australian community on reducing health risks associated with drinking alcohol.

Update and implement the National Guidelines for the Treatment of Alcohol Problems.

Promote and translate key messages of the revised NHMRC guidelines to support informed decisions about alcohol consumption, and promote better public understanding of alcohol-related harms.

Challenge perceptions of risk among Australians about safe drinking levels, including in relation to health impacts (e.g. links with cancer, liver disease, violence and injury, weight gain, chronic diseases, substance dependence and mental illness).

Improve capacity of communities to identify, prevent and minimise alcohol-related harm through evidence-based activities.

Develop guidelines and information on alcohol-related harm for older Australians.

Development of public health campaigns promoting the risks and harms associated with alcohol consumption.

Implement evidence based secondary-supply programs to reduce underage drinking.

Targeted communications to promote healthy behaviours which are informed by the evidence of what works to at-risk groups.

Improve availability of point-of-sale information on risks of harmful consumption.

Implement readable, impactful health-related warning labels

Promote the national online portal of alcohol related health information for parents, students, teachers and community organisations (www.positivechoices.org.au).

GOVERNANCE

The differing roles and responsibilities of the Commonwealth and state and territory governments relating to alcohol require a cross-jurisdictional commitment to share information, coordinate responses and achieve legislative and broader policy consistency where possible.

As a sub-strategy of the *National Drug Strategy 2017–2026*, this Strategy is overseen by the Ministerial Drug and Alcohol Forum which is supported by the NDSC.

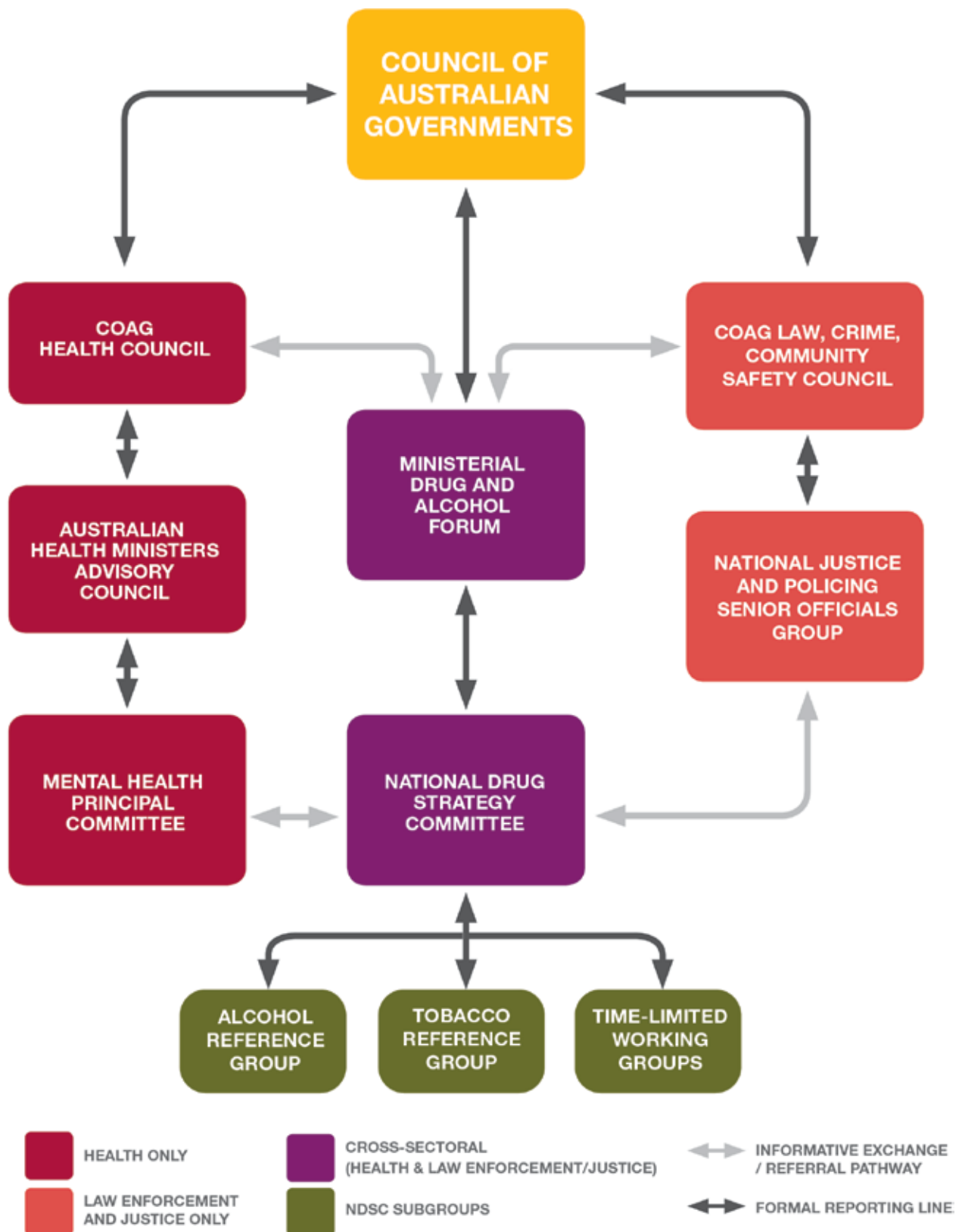
The Strategy has been developed with input from a wide range of stakeholders, including governments, health groups, police, community-based organisations, and researchers. As such it is important that each of these groups have an ongoing role in monitoring and implementing the Strategy.

While industry organisations have been involved in consultation processes to support the identification of priority areas for this strategy, Australia does not support any ongoing role for industry in setting or developing national alcohol policy. This Strategy does recognise, that industry bodies have a responsibility to contribute to efforts preventing and minimising alcohol-related harms.

A key action of this Strategy is the establishment of a new Reference Group within the National Drug Strategy governance framework. The updated governance arrangements are depicted in the diagram on the following page.

While the Terms of Reference will be determined by the NDSC, it is expected that new Reference Group will be responsible for:

- ✔ Developing a reporting framework to assess progress relating to the aim and priorities of this Strategy which will be submitted to the NDSC;
- ✔ Developing a research and evidence agenda;
- ✔ Identifying data system gaps and develop a framework to address those gaps;
- ✔ Providing the NDSC a report every three years on Australia's progress against the goal of a 10% reduction in harmful alcohol consumption over the life of the Strategy;
- ✔ Development of a detailed mid-point review and evaluation of the Strategy; and
- ✔ Providing advice (as required) to the NDSC identifying issues that may emerge and/or evolve over the life of the strategy.



Updated post National Drug Strategy following Council of Australian Governments (COAG) council restructure (current at the time of printing). Governance structure for law enforcement and justice are currently being revised. This diagram will be updated in 2018 prior to finalisation.

MONITORING PROGRESS

The measurement of how effective the Strategy is and demonstrating progress being made is important. Measuring progress will also inform future evidence-informed policies.

While the reporting framework will be developed by the Reference Group (to be established) for consideration by the NDSC, it is expected that annual activity reports relating to alcohol specific actions will be included in the annual reports being developed for the Ministerial Drug and Alcohol Forum under the *National Drug Strategy 2017–2026*, with a more detailed report to be provided to COAG every three years.

Measures of Success

A range of data exists to measure reductions in alcohol-related harm and risks of alcohol-related harm.

As identified against the Priority Areas for Focus, the following indicators and baseline data will be utilised to demonstrate progress being made under the Strategy, including the goal of a 10% reduction in harmful alcohol consumption. Key data sources are the Australian Secondary School Alcohol and Drug survey (ASSAD), National Drug Strategy Household Survey (NDSHS), National Aboriginal and Torres Strait Islander Social Survey (NATSISS), National Alcohol Indicators Project (NAIP), Australian Bureau of Statistics (ABS) and the Pharmaceutical Benefits Scheme (PBS).

Indicator	Baseline (%)	Data Source/s
Lifetime risk: Proportion of people exceeding the NHMRC guidelines for lifetime risk	17.1	NDSHS
	14.7	NATSISS
Single Occasion risk: Proportion of people exceeding the NHMRC guidelines for single occasion risk	25.5	NDSHS
	30.1	NATSISS
Very high alcohol consumption: Proportion of population consuming 11 or more standard drinks at least monthly	24.8 (12+)	NDSHS
School children: Proportion of school students (aged 12–17) who drank more than 4 drinks on one day in past seven days	5.6	ASSAD
Age first tried alcohol: Average age at which young people aged 14–24 first tried alcohol	16.1	NDSHS
Alcohol during pregnancy: Proportion of pregnant women consuming alcohol during their pregnancy	34.7	NDSHS
	9.8	NATSISS
Emergency Department (ED) presentations: Estimated rates of alcohol-related ED presentations on Friday, Saturday and Sunday nights per 1,000 persons	9.07 2011–12	NAIP

Indicator	Baseline (%)	Data Source/s
Alcohol-attributable assault hospitalisations: Age standardised population rates (per 10,000) of alcohol-attributable hospitalisations for adults (15+ years)	11.4 2012–13	NAIP
Alcohol-related offence data including violence and motor vehicle accidents	<i>Various</i>	State and territory governments
Experience of alcohol-related incident	21.8 (12+)	NDSHS
Alcohol attributable deaths: Age standardised population rates (per 10,000) of alcohol-attributable deaths for adults (15+ years)	3,143 (2005)	NAIP
Total alcohol consumption per capita	9.7L (2015–16)	ABS apparent consumption
Proportion of people with alcohol dependence receiving treatment	<i>TBC</i>	ABS, PBS and National Minimum Dataset of treatment

APPENDIX A: AUSTRALIAN GUIDELINES TO REDUCE HEALTH RISKS FROM DRINKING ALCOHOL

The National Guidelines, overseen by the National Health and Medical Research Council (NHMRC), were developed following extensive reviews of national and international evidence.

It is intended that as well as presenting a reasonable baseline level of risk related to alcohol consumption, they can also assist the wider community to have a better understanding of the harms that can occur from alcohol.

The guidelines are currently (at the time of writing this Strategy) being reviewed and are due to be published in late-2018. This section of the Strategy will be updated when the new guidelines have been finalised. The 2009 guidelines are summarised below for reference and to clearly articulate risky and harmful drinking as defined in this Strategy.

The guidelines state:

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	For children and young people under 18 years of age, not drinking alcohol is the safest option.
GUIDELINE 4 Pregnancy and breastfeeding	For women who are pregnant or planning a pregnancy, not drinking is the safest option. For women who are breastfeeding, not drinking is the safest option.

APPENDIX B: ALCOHOL AS A PRIORITY SUBSTANCE IN THE *NATIONAL DRUG STRATEGY 2017–2026*

The *National Drug Strategy 2017–2026* identifies alcohol as one of the seven priority substances requiring focus and attention. The inclusion of alcohol as one of these priority substances is a result of the significant cost of alcohol-related harm (estimated to be \$36 billion in 2010), its contribution to premature death, disability, disease and hospitalisation, the impact of alcohol on violence (including family and domestic violence), links to child neglect, and the impact of FASD on individuals, families and the community.

The *National Drug Strategy 2017–2026* also provides many examples of key evidence-based and practice-informed approaches across the three pillars of harm minimisation to tackle alcohol-related harm.

These approaches again need to be considered when examining the agreed priorities under this Strategy.

Harm Minimisation

The overarching principle of Australia's National Drug Strategy is that of harm minimisation, which comprises three pillars:

Demand Reduction

Preventing the uptake and/ or delaying the onset of use of alcohol, tobacco and other drugs; reducing the misuse of alcohol, tobacco and other drugs in the community; and supporting people to recover from dependence through evidence-informed treatment.

Supply Reduction

Preventing, stopping, disrupting or otherwise reducing the production and supply of illegal drugs; and controlling, managing and/or regulating the availability of legal drugs.

Harm Reduction

Reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community.

The following tables were included in the National Drug Strategy 2017–2026 as examples of evidence-based and practice-informed approaches to harm minimisation for alcohol. They are provided here again for reference

DEMAND REDUCTION

Approach	Strategies
Price mechanisms	<ul style="list-style-type: none">✓ Excise tax increases✓ Volumetric excise tax✓ Minimum floor price✓ Regulate price discounting and bundling
Build community knowledge and change acceptability of use	<ul style="list-style-type: none">✓ Social marketing strategies, including campaigns, as part of a comprehensive response✓ Evidence based secondary supply programs✓ Promotion of National Health and Medical Research Council's Australian Guidelines to Reduce Health Risks from Drinking Alcohol
Restrictions on promotion	<ul style="list-style-type: none">✓ Enforced advertising standards and restrictions✓ Regulate price promotion✓ Regulate promotion at point of sale✓ Regulate promotions in key settings, such as those aimed at young people
Treatment	<ul style="list-style-type: none">✓ Outpatient, inpatient and community based treatment services✓ Medication assisted treatment for alcohol dependence✓ Family-support programs that can positively impact on patterns of drug use (including intergenerational patterns)✓ Post treatment support programs to reduce relapse

SUPPLY REDUCTION

Approach	Strategies
Regulating retail sale	<ul style="list-style-type: none">✔ Retail licensing schemes supported by strong enforcement and retailer education✔ Coordinated medication management system✔ Restricting the type of retailers or venues that can sell✔ Limiting the density of licensed retailers and venues✔ Limiting trading hours✔ Responsible alcohol service schemes✔ Liquor licensing restrictions✔ Detect and disrupt sales of prohibited products✔ Declaration of dry communities✔ Lower strength alcohol sale requirements
Age restrictions	<ul style="list-style-type: none">✔ Ban sale to people under 18✔ Secondary supply restrictions
Border control	<ul style="list-style-type: none">✔ Interrupt illegal importation and enforce payment of excise tax✔ Duty free restrictions
Regulating or disrupting production and distribution	<ul style="list-style-type: none">✔ Regulating production✔ Regulating wholesaler distribution✔ Detect and disrupt illegally produced products

HARM REDUCTION

Approach	Strategies
Safe transport and sobering up services	<ul style="list-style-type: none">✔ Access to public transport✔ Mobile assistance patrols✔ Sobering up facilities
Safer settings	<ul style="list-style-type: none">✔ Cessation of sales at earlier times✔ Lock out times✔ Promotion of responsible venue operations✔ Dry areas✔ Mandatory plastic glassware in high risk venues✔ Availability of free water at licensed venues✔ Lock out times✔ Emergency services responses to critical incidents✔ Maintenance of public safety

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All information in this publication is correct as of November 2017