



**NCETA**

*Australia's National Research Centre  
on AOD Workforce Development*



**Flinders**  
UNIVERSITY

## NCETA Submission

**Re:**

**NATIONAL ALCOHOL STRATEGY:  
2018-2026**

**Consultation Draft**

**February 2018**

## About NCETA

The National Centre for Education and Training on Addiction (NCETA), located within Flinders University's College of Medicine and Public Health in South Australia, is an internationally recognised research and training centre that works as a catalyst for change in the alcohol and other drug (AOD) field. NCETA's core business is the promotion of workforce development (WFD) principles; research and evaluation of effective practices; investigating the prevalence and effect of AOD use in society; conducting training needs analyses; and the provision of training and other workforce development approaches. We have developed training curricula, programs and resources, and provided training programs, to cater for the needs of: specialist AOD workers; frontline health and welfare workers; Indigenous workers; community groups; mental health workers; police officers; and employers and employee groups. The Centre focuses on supporting evidence-based change and specialises in change management processes, setting standards for the development of training curriculum content and delivery modes, building consensus models and making complex and disparate information readily accessible to workers and organisations.

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## Background

The development of the draft National Alcohol Strategy 2018-2026 represents an opportunity to both build on the success of the previous National Alcohol Strategy 2006-2011 and to respond to existing and emerging issues.

The National Centre for Education and Training on Addiction (NCETA) submits the following response to the consultation draft National Alcohol Strategy 2018-2026. In doing so, we note that the draft Strategy appropriately focuses on alcohol-related harms and identifies potential strategies to address those from a harm reduction perspective.

NCETA has a particular interest in alcohol-related issues, having undertaken a large number of studies including:

- A comprehensive national review of liquor licensing legislation in all eight jurisdictions focusing on its application and enforcement from a policing perspective
- A three year trial of a comprehensive alcohol harm reduction intervention in Australian manufacturing workplaces<sup>1</sup>. NCETA produced a report for employers, policy-makers and workplace health practitioners on implementing a comprehensive and tailored intervention designed to reduce alcohol-related harm in the workplace. The report is available for download from NCETA's [website](#).
- Secondary data analyses and dissemination of findings from various alcohol-related data sources e.g., the National Drug Strategy Household Survey (NDSHS), Alcohol and Other Drug Treatment Services National Minimum Data Set, National Hospital Morbidity Database, Australian Secondary Students' Alcohol and Drug Survey, and Drug Use Monitoring in Australia. NCETA has used these data analyses to inform:
  - The development and maintenance of the Alcohol Section of the [National Alcohol and Drug Knowledgebase \(NADK\)](#) – Australia's most comprehensive and fully accessible information on alcohol consumption patterns, alcohol and employment / health / crime, alcohol treatment, and alcohol use among young people
  - An examination of the patterns, prevalence and correlates of alcohol use for the South Australian Primary Health Networks (PHN). The data was localised by breaking it down into PHN regions and, where possible, Statistical Area Levels 4 and 3.
- A systematic review of school-based alcohol interventions including the production and dissemination of an easily accessible information booklet [Alcohol education: What really works for schools](#) for use by educators
- A program of work examining alcohol use among older people and strategies for health and welfare professionals to prevent and reduce alcohol-related harm among this cohort. In particular:
  - NCETA, in collaboration with Peninsula Health, Victoria, produced [Preventing and Reducing Alcohol- and Other Drug-Related Harm among Older People: A practical guide for health and welfare professionals](#) to assist clinicians in

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<sup>1</sup> The project was funded by VicHealth and was conducted by NCETA in collaboration with LeeJenn Health Consultants and the City of Greater Dandenong's South East Business Network.

primary health care, general health and welfare services, and specialist AOD agencies.

- NCETA, in collaboration with Middlesex University (UK) and Matua Raki (NZ) conducted an International Massive Open Online Course (MOOC) to assist AOD and aged care sector workers respond to alcohol use and related harms among older people.

NCETA's submission to the draft consultation National Alcohol Strategy addresses the following issues:

1. The workplace
2. Young people, the role of schools, and the impact of school-to-work transition
3. Alcohol-related family and domestic violence
4. Alcohol-related data
5. Alcohol use among older people
6. Liquor licensing legislation
7. Alcohol's interaction with medicines such as benzodiazepines and opioids
8. Alcohol and cancer
9. Alcohol use in rural and remote areas
10. Inequalities and alcohol
11. Aboriginal and Torres Strait Islander people
12. Relationship between methamphetamine use and risky alcohol consumption
13. Responding to alcohol use – workforce development implications
14. Ensuring consistency across service delivery models.

In addressing these issues, NCETA also highlights the importance of appropriate workforce development (WFD) initiatives to enhance the capacities of the specialist and generalist AOD workforces to prevent and minimise alcohol-related harm in Australia.

## Key issues to be addressed in the National Alcohol Strategy

### 1. The workplace

The workplace is an important but largely overlooked alcohol harm reduction setting. It is important that the National Alcohol Strategy includes objectives and opportunities for action that incorporate evidence-based strategies applicable to the workplace.

Most risky drinkers are employed. For example in 2016:

- 86.6% of employed Australians (approx. 8,925,000) were current drinkers
- 33.0% (approx. 2,170,000) regularly drank at short-term risky levels
- 21.0% (approx. 3,400,000) drank at long-term risky levels (Australian Institute of Health & Welfare, 2017).

Alcohol use among employed Australians results in substantial harms as well as economic and social costs:

- Alcohol use contributes to 11% of workplace accidents/injuries (Pidd et al., 2006)
- Alcohol-related absenteeism costs employers approximately \$2 billion per annum (Roche et al., 2016)
- Total lost workplace productivity due to alcohol use is estimated to cost more than \$6 billion per annum
- Less quantifiable negative effects such as presenteeism (Cooper & Dewe, 2008), and co-worker wellbeing (Dale & Livingston, 2010) also have implications for workplaces, individual workers, and the wider community.

Individual and workplace factors can contribute to a workplace culture of alcohol use, reflecting:

- Workplace customs (e.g., social networks, managerial practices)
- Working conditions (e.g., physical conditions, working hours)
- Workplace controls (e.g., levels of supervision, policies);
- Factors external to the workplace (e.g., individual and wider social norms) (Pidd & Roche, 2008).

These factors combine to create a workplace culture that can support or discourage risky drinking both at, and away from, the workplace (Pidd & Roche, 2008).

The workplace, therefore, offers a unique opportunity for the implementation of effective alcohol harm reduction, early intervention and prevention strategies (Pidd, Roche, Cameron et al., (2018). Such strategies are likely to be successful because:

- Employees spend a substantial amount of time at work, maximising exposure to early intervention and prevention strategies
- Intervention/prevention initiatives can be tailored to workforce groups with comparably higher prevalence of risky alcohol use such as:
  - Construction industry employees

- Mining industry employees
  - Tradespersons
  - Male workers aged 20-29 years
  - Rural/regional workers
- Risky alcohol use can negatively affect workplace safety, productivity and worker health, and employers are likely to support strategies in these areas; thereby offering a motivation for change
- Existing workplace health and safety and industrial relations frameworks can incorporate early intervention and prevention strategies in a cost effective manner without affecting the workplace production process
- Alcohol-related prevention and harm reduction messages delivered in the workplace are likely to extend to the wider community (Pidd & Roche, 2015).

In addition, workplace interventions / strategies are more likely to be effective if tailored to meet the needs of workplace settings and incorporated into existing day-to-day workplace practices to maximise uptake and sustainability (Pidd, Roche, Cameron et al., 2018).

The workplace can also provide an effective pathway to treatment for employees particularly for those who fail to recognise their use as a problem and who may lack the motivation to address their use. The threat of job loss can be an effective motivator to seek treatment, and similarly, the promise of having a job to return to following treatment can be an effective motivator to complete treatment.

It is important that the National Alcohol Strategy highlights the central role of the workplace as a treatment pathway in responding to alcohol-related issues among employed people.

## 2. Young people, the role of schools, and the impact of school-to-work transition

The draft National Alcohol Strategy identifies teenagers and young people as an at-risk population.

While rates of alcohol use are actually decreasing among younger people, young adults aged 18-24 are the age group most likely to consume 11+ drinks on a single drinking occasion (Australian Institute of Health and Welfare, 2017).

Schools have a key role to play in providing alcohol education to young people. There are, however, a number of key issues for schools to address. These include: competing curricula demands; lack of program evaluation; and education is not the only sector that addresses alcohol use among people. Schools looking to introduce or revise alcohol education programs should ensure that such programs:

- Are based on accurate information and supported by good quality research
- Go beyond factual information and focus on harm minimisation
- Use diverse and interactive teaching styles
- Have clear, appropriate and achievable goals and objectives
- Are supported by adequate teacher training and assistance

- Adopt a whole-of-school approach focusing on student resilience and social connectedness (Roche, Lee, & Cameron, 2014).

Beyond the school setting, the critical school-to-work transition period is a pivotal developmental point for young people's psychological wellbeing, particularly among those under 25 years of age (Pidd, Roche et al., 2017). While employment can be a protective factor, workforce entry can also increase the risk of alcohol-related harm (Roche, Pidd & Kostadinov, 2014). For many young people, entering the workforce can be demanding and these challenges can be compounded by stressful working conditions.

It is crucial that the National Alcohol Strategy acknowledges and addresses the school-to-work transition period to optimise the key opportunity it presents for prevention and intervention for young people.

### **3. Alcohol-related family and domestic violence**

The draft consultation document highlights the need for greater attention to be directed to the relationship between alcohol use and family violence, and recommends the continued strengthening of partnerships between the AOD and family violence services.

There is, however, a need for the broader healthcare workforce, and more specifically the AOD sector, to develop the knowledge and skills to identify and provide support to clients experiencing family and domestic violence (Garcia-Moreno et al., 2015). This may include providing support through empathic listening, ongoing psychosocial support and referral to other services (RACGP, 2014; Garcia-Moreno et al., 2015). It also includes understanding what actions should, and should not, be taken in situations that are potentially risky for clients.

NCETA's *Can I Ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence* resource recommends that, where possible, all AOD workers should have the capacity to provide a basic level response to potential family and domestic violence, including:

- An awareness of family and domestic violence issues
- Knowledge about their organisation's family and domestic violence policy and procedures
- The ability to respond sensitively and appropriately (White, Roche, Nicholas et al., 2013).

It is therefore crucial that the National Alcohol Strategy contains objectives and opportunities for action that include the following:

- All AOD clients, and especially female clients, are asked about family and domestic violence
- All AOD services and workers appropriately support clients who may be experiencing family and domestic violence. This may include:
  - Prioritising the safety of adults and children who are experiencing family and domestic violence
  - Developing personal safety plans with the client

- Multi-organisation and cross sectoral engagement including information sharing and agreed-upon referral pathways (White, Roche, Nicholas et al., 2013).

### *Harms to others*

In addition to specific concerns related to the relationship between alcohol and family and domestic violence, there is also a wider range of concerns related to harms that can be incurred through another's use of alcohol at risky levels. Recent examination of data on harms to others indicates that there is a strong relationship between financial distress and associated increases in distress and decline in quality of life (Greenfield, Karriker-Jaffe, Kaplan et al., 2015). Financial troubles due to someone else's drinking have also been found to be significantly associated with poor mental health (Ferris, Laslett, Livingston et al. 2011).

These negative impacts of alcohol use disproportionately affect women and children (Livingston, Wilkinson, & Laslett, 2010). Greater attention is required to address financial problems that result from others' drinking given their dire consequences in both the short and long term. The issue of gender is particularly important in this regard. Attention is also drawn to the growing understanding of the nature of poverty among older women and its increased prevalence. This issue has been largely overlooked to-date.

## 4. Alcohol-related data

The draft consultation document notes the existence of a range of data sources that are available to monitor alcohol consumption patterns, and to measure reductions in alcohol-related harm and risks of alcohol-related harm.

Australia has a large number of excellent data sources that can inform research on alcohol use. There is scope for enhanced data extraction, synthesis and triangulation to identify patterns, prevalence and correlates of alcohol use and related harms. More sophisticated and refined use and dissemination of available alcohol-related data should comprise a fundamental building block of the National Alcohol Strategy.

As part of its core business, NCETA regularly undertakes secondary analyses of alcohol-related data to examine changes in patterns of alcohol use, treatment episodes and hospitalisations over time by age, gender and employment status. This data is synthesised and triangulated and used to inform the development and provision of evidence-based services.

With the recent establishment of 31 Primary Health Networks (PHNs) across Australia, in part as a mechanism for the distribution of resources and prioritisation of response strategies, there is a greater need to undertake more detailed data analyses at smaller geographical areas. NCETA has recently worked with the PHNs in South Australia to analyse various alcohol-related datasets<sup>2</sup> by PHN regions and where possible, Statistical Area Levels 4 and 3. These analyses are being used by the PHNs to assist future commissioning of services and development of localised AOD response strategies including workforce development plans.

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<sup>2</sup> These data sets included the: National Drug Strategy Household Survey (NDSHS), Australian Secondary Students' Alcohol and Drug Survey (ASSADS), Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS), National Prescribing Data, Pharmaceutical Benefits Scheme (PBS), SA Health Emergency Department Data Collection (presentations), South Australian Admitted Patient Activity (Hospital Separations), Illicit Drug Reporting System (IDRS), and Ecstasy and Related Drugs Reporting System (EDRS).

It is imperative that the National Alcohol Strategy recognises the potential of the available data and advocates for better use of existing datasets to inform the development and implementation of service provision and alcohol policies.

The importance of accurate and up-to-date data and information is further underscored in the National Alcohol and Drug Knowledgebase (NADK) produced by NCETA on behalf of the Australian Government Department of Health. The Alcohol section of the NADK provides general information about alcohol, as well as up-to-date data on the drinking patterns and behaviours of Australians, and the consequences of risky consumption. Information is presented in a series of Frequently Asked Questions (FAQs) designed for easy access by members of the public, policy makers, service providers, and researchers.

It is recommended that the National Alcohol Strategy includes information about and a link to the NADK. This could be appropriately located under the objectives of:

- Improve awareness and understanding of alcohol harms
- Improve communication to target groups.

## 5. Alcohol use among older people

The draft National Alcohol Strategy recognises that older Australians are an at-risk population for alcohol-related harm. In recent years, there have been unprecedented increases in risky drinking among older age groups, including from those aged 50 years and over. The baby boomer generation (i.e., those born between 1946 and 1964) are demographically and socially distinct in a number of ways, including their attitudes and behaviours concerning alcohol.

The draft Strategy also recommends that guidelines and information on alcohol-related harm are developed for older Australians. However, NCETA's recent work on alcohol use among older Australians highlights that, in addition to focusing on the cohort aged 70 years and over, there is also a need to ensure that people aged 50 years and over are offered:

- Appropriate evidence-based information about the effects of harmful drinking
- Access to effective screening, assessment and treatment (Roche & Kostadinov, 2017).

It is recommended that the Draft Strategy be revised to address a wider age range of 'older people' and to incorporate those over 50 rather than limiting attention to those aged over 70 years.

There are various barriers that make it difficult for older people to access support and treatment for alcohol-related issues. These include:

- Health-care practitioners and family members being reluctant to ask questions about an older person's alcohol use and incorrectly attributing the symptoms of problematic alcohol use to getting older
- Older people being reluctant to seek help due to embarrassment, lack of transport or inappropriate treatment services for older people (Rao & Roche, 2017, Roche & Kostadinov, 2017).

Hence, responding to alcohol use among older Australians requires a coordinated approach between the AOD, broader health and community services and aged care sectors, including:

- More resources designed to assist services to cope with increasing demand
- Improved understanding of the impact of alcohol use on older people and appropriate interventions
- Changes in health service provision within and across sectors.

As part of NCETA's Grey Matters research program, in 2015 NCETA in collaboration with Peninsula Health, Victoria produced [Preventing and Reducing Alcohol- and Other Drug-Related Harm among Older People: A practical guide for health and welfare professionals](#).

This unique resource is the first of its type to provide guidance to:

- Workers to help them increase their skills and knowledge to work effectively with older clients
- Organisations to help them adapt their services and make them more accessible and inclusive for this population (Nicholas, Roche, Lee et al., 2015).

It is important that the National Alcohol Strategy includes strategies aimed at:

- Health care services and the aged care sector working together to:
  - Prevent problematic alcohol use among older people
  - Provide age-appropriate treatment and harm minimisation services
- Clinicians being provided with appropriate evidence-based knowledge and skills to better identify and treat alcohol-related issues in their older clients / patients (Rao & Roche, 2017, Roche & Kostadinov, 2017).

## 6. Liquor licensing legislation

The existing liquor licensing legislation in each Australian jurisdiction attempts to balance the interests of the alcohol and hospitality industries while aiming to minimise the associated community harms (Trifonoff, Andrew, Steenson, et al., 2011). This can be a difficult balancing act, and there is a need for key stakeholders such as police, liquor licensing authorities, licensees and the broader community to continue to have ongoing input into the development, implementation and enforcement of liquor licensing legislation (Trifonoff, Andrew, Steenson, et al., 2011).

While the draft consultation document, under Priority 1: Improving community safety and amenity and Priority 2: Managing availability, price and promotion, identifies and addresses the importance of robust, dynamic and evidence-based liquor licensing legislation, there are nevertheless a number of additional opportunities for action that could be included in the National Alcohol Strategy:

- That minimising the harm associated with alcohol consumption remains the central tenet of liquor licensing legislation in Australia
- There is an imperative to ensure that police and other enforcement personnel responsible for enforcing liquor licensing legislation are provided with ongoing, up-to-date and evidence-based information and training on enforcing the legislation.

## 7. Alcohol's interactions with medicines such as benzodiazepines and opioids

A key omission in the National Alcohol Strategy consultation paper is a reference to the important relationship between alcohol and medicines including benzodiazepines and opioids. Of particular concern is the increased risk of fatal overdose when combining depressant drugs such as alcohol, benzodiazepines and opioids. Other consequences of using more than one of these drugs at a time include:

- Increased risks of accidents or injury
- Increased risk of non-fatal overdose resulting in ongoing health problems (National Drug and Alcohol Research Centre, 2014).

Benzodiazepines and prescribed opioids are used at higher levels among older age groups. Older members of the Australian population are also consuming alcohol at increasingly risky levels (Australian Institute of Health and Welfare, 2017, Rao & Roche, 2017). These combined behaviours have the potential to interact synergistically to a detrimental effect.

To avert predictable problems and harms, including the potential for death, greater awareness of contra-indicated co-occurring consumption patterns is required among the general public and all healthcare professionals, as well as those working in the aged care sector and/or with older people in particular (Nicholas, Roche, Lee et al., 2015).

## 8. Alcohol and cancer

Despite a strong association between alcohol consumption and various types of cancer, the level of awareness of the link between alcohol consumption and increased risk of cancer remains low.

### *Established link between alcohol and seven types of cancer*

The World Health Organization (WHO) has confirmed that drinking alcohol can cause at least the following seven types of cancer:

- Bowel (colon and rectum)
- Breast
- Gullet (oesophagus)
- Larynx
- Liver
- Mouth
- Upper throat (Baan, Straif, Grosse et al., 2007, World Health Organization, 2018).

The main carcinogenic component of alcohol is ethanol, which damages cells in a way that makes them more prone to becoming malignant. It also affects female hormones, stimulating cell proliferation and increasing the risk of breast cancer. Combining alcohol with smoking tobacco multiplies the rate of tissue damage and increases the risk of cancer (World Health Organization, 2018).

### *Reduced consumption = reduced risks*

There is a clear dose–effect relationship between alcohol and cancer i.e., higher alcohol consumption equals a greater risk of cancer. For example, a woman increases her risk of breast cancer by 50% when drinking four glasses of wine a day and by 130% when drinking eight glasses a day. As there is no identified lower threshold this means that even small amounts of alcohol increase the risk of cancer (World Health Organization, 2018).

The dose–effect relationship also holds true in reverse i.e. any reduction in alcohol consumption reduces the risk of developing alcohol-related cancer (World Health Organization, 2018).

### *Association between alcohol and cancer often overlooked*

Given the limited attention that has been directed to the relationship between alcohol and cancer, it is not surprising that levels of awareness are relatively low. A recent Australian study found that while respondents were aware of the dangers of alcohol and its association with driving, operating machinery and pregnancy, there were substantially lower levels of awareness in relation to alcohol and chronic diseases such as cancer (Pettigrew, Jongenelis, Pratt et al., 2016). The lowest level of awareness was for the link between alcohol and cancer, despite the fact that alcohol has been implicated in the two leading causes of death in the developed world i.e., cardiovascular disease and cancer (Pettigrew, Jongenelis, Pratt et al., 2016).

The findings from the Pettigrew et al. (2016) study support earlier research which examined South Australians' perceptions of alcohol as a risk factor for cancer (Bowden, Delfabbro, Room et al., 2014). Bowden et al. (2014) found that while community perceptions of the link between tobacco smoking and cancer were high (more than 90%) only 36.9% of respondents were aware of the link between alcohol and cancer.

### *Examples of effective measures and policies*

The European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 outlines three of the most cost-effective policy areas (the “best-buys”) to reduce alcohol-related harm and improve population health:

- Increasing price via taxation
- Restricting access to retail alcohol
- Imposing a ban on alcohol advertising.

Another important policy option is the implementation of brief intervention programs in primary care settings for individuals experiencing hazardous or harmful alcohol consumption. Screening and brief interventions for alcohol are an evidence-informed approach to addressing the needs of patients presenting in primary care. In 2017, the WHO Regional Office for Europe published a training manual for screening and brief interventions, designed to equip health-care professionals with adequate skills in supporting patients to change their drinking behaviour (World Health Organization, 2018).

### *Workforce development implications*

To-date, relatively little attention has been directed to the causal relationship between alcohol and cancer. As a consequence, most health care professionals and AOD specialists are under-informed and ill-equipped to appropriately tackle this issue. Greater professional development is required for all healthcare workers including those with policy and research

roles. Particular attention is also required for programs directed at the general public from a preventive and early intervention perspective.

Considerable scope exists for the National Alcohol Strategy to:

- Highlight the largely overlooked relationship between alcohol and cancer
- Reinforce the important message that alcohol use is associated with an increased risk of cancer
- Call for the implementation of effective measures to reduce the overall use of alcohol.

## 9. Alcohol use in rural and remote areas

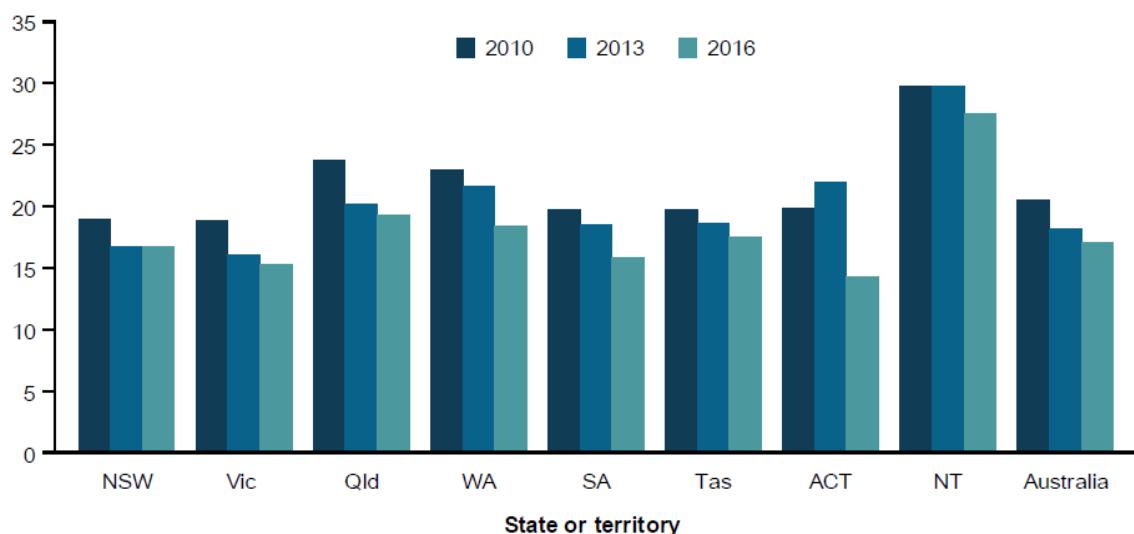
There are substantial jurisdictional and regional variations in both patterns of alcohol use and associated harms. It is important that these variations are addressed in the Strategy.

The draft National Alcohol Strategy identified people living in remote communities as an at-risk population. The draft consultation paper also noted that people residing in remote areas reported drinking alcohol in quantities that placed them at risk of harm at higher levels than those living in less remote regions. However, there is scope to make these issues more explicit.

For instance, the 2016, NDSHS found regular risky drinking was highest in rural locations (remote: 46.5%; very remote: 49.2%; other geographical locations: 36.1%-39.7%; nationally: 37.3%). The NT had the highest prevalence of risky drinking (48.5%), followed by Qld (41.6%) and Tasmania (41.0%) (Australian Institute of Health and Welfare, 2017).

Findings from the Northern Territory (NT) in the 2016 NDSHS further highlight the importance of focusing on people in remote communities, with the NT having the highest rates nationally for:

- Lifetime risky drinking (28% vs 17%) (Figure 1)
- Single occasion drinking (i.e., 5+ standard drinks on a single occasion at least once in the past year) (36% vs 26%) (Figure 2) (Australian Institute of Health and Welfare, 2017).



(a) On average, had more than 2 standard drinks per day.

**Figure 1: Lifetime risky drinkers(a), by state and territory, people aged 14 or older, 2010-2016 (%)**

Source: AIHW (2017). National Drugs Strategy Household Survey 2016: Detailed findings.



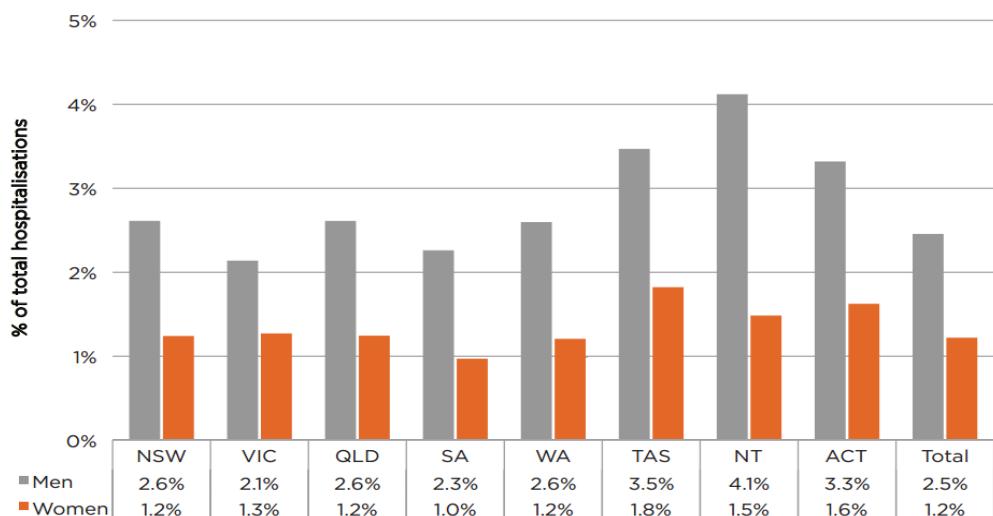
(a) Had more than 4 standard drinks on a single drinking occasion at least once a month.

**Figure 2: Single occasion risky drinkers<sup>(a)</sup>, by state and territory, people aged 14 or older, 2010-2016 (%)**

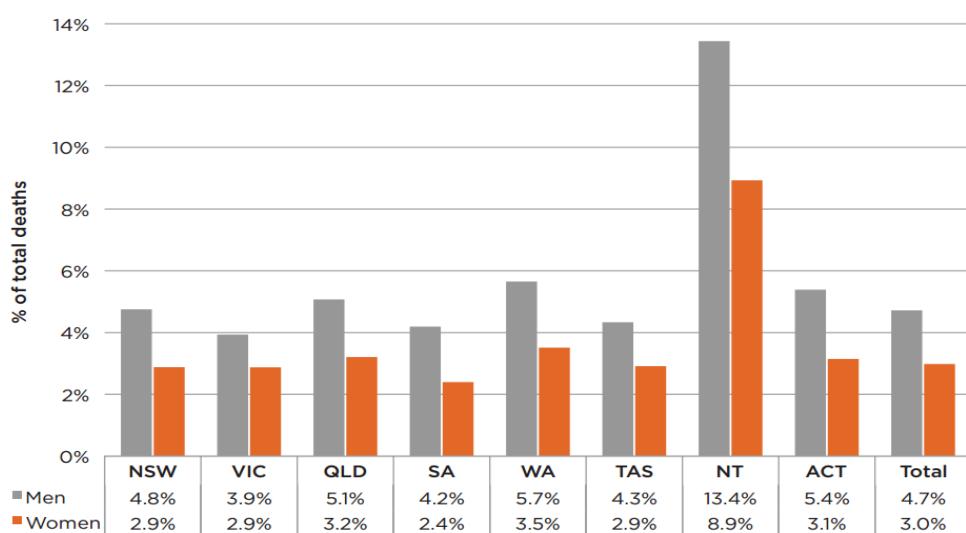
Source: AIHW (2017). National Drugs Strategy Household Survey 2016: Detailed findings.

Beyond an examination of regional variations in alcohol prevalence rates, there is a need to examine levels of alcohol-related harm. In 2010, across all jurisdictions and nationally, the NT had the highest proportion (4.1%) of alcohol-attributable hospitalisations for males (Figure 3) (Gao, Ogeil & Lloyd, 2014).

In 2010, the NT also had the highest proportion of alcohol-attributable deaths for both males (13.9%) and females (8.9%) (Gao, Ogeil & Lloyd, 2014). Compared to the national average, the NT rate was approximately three times higher for both males and females (Figure 4) (Gao, Ogeil & Lloyd, 2014).



**Figure 3: Proportion of hospitalisations attributable to alcohol by state and territory in Australia, 2010**  
Source: Gao, C., Ogeil, R., & Lloyd, B. (2014). Alcohol's burden of disease in Australia. Canberra: FARE and VicHealth in collaboration with Turning Point.



**Figure 4: Proportion of deaths in men and women attributable to alcohol by state and territory in Australia, 2010**

Source: Gao, C., Ogeil, R., & Lloyd, B. (2014). Alcohol's burden of disease in Australia. Canberra: FARE and VicHealth in collaboration with Turning Point.

The draft consultation paper does not include any specific strategies aimed at reducing the prevalence of alcohol use and responding to the related harms in remote communities.

It is essential that the need for appropriate primary and secondary level interventions specifically tailored to age and gender groups and subpopulations within rural and remote locations is addressed in the National Alcohol Strategy. There are also a number of service access barriers that people in rural and remote areas encounter that need to be identified in the Strategy including:

- Lack of adequate transport
- Delayed access to appropriate treatment
- Lack of anonymity, confidentiality and greater community stigma (Roche & McEntee, 2016).

Responses that could be considered in the National Alcohol Strategy to address these barriers include a greater focus on provision of professional services such as online and telephone counselling, video-conferencing, and the development of a range of other innovative digital health and virtual support and intervention strategies including greater use of telehealth / telemedicine.

## 10. Inequalities and alcohol

The consultation draft Strategy does not address the relationship between social determinants, inequities, and alcohol consumption/harms. A study by NCETA in 2015 found complex and multi-directional relationships between social inequities and alcohol use and related harms (Roche, Kostadinov, Fischer et al., 2015). In general, advantaged groups tended to drink more often, while disadvantaged groups tended to drink larger quantities. However, people living in lower socio-economic circumstances experienced more harm than those who were more advantaged after consuming the same amount of alcohol (Roche, Kostadinov, Fischer et al., 2015).

The study also found that the alcohol-related harms which disproportionately accrued to disadvantaged populations were difficult to resolve if “upstream” social determinants<sup>3</sup> were not addressed (Roche, Kostadinov, Fischer et al., 2015). Further, there was a need to reduce the likelihood of unintended consequences and / or displacement effects from policies aimed at managing alcohol-related problems (Roche, Kostadinov, Fischer et al., 2015).

In 2013, the Community Affairs Reference Committee identified the need for improvements to underlying determinants such as education, employment, housing and social engagement as a priority for addressing social inequities (Community Affairs Reference Committee, 2013).

While Australia has implemented numerous alcohol-related policies, most do not explicitly aim to reduce inequities, and some may inadvertently exacerbate existing inequities (Roche, Kostadinov, Fischer et al., 2015).

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<sup>3</sup> The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. They include economic policies and systems, development agendas, social norms, social policies and political systems (World Health Organization, 2018).

Examples of appropriate interventions that could potentially decrease inequities in alcohol consumption and related harms include:

- Town planning, zoning and licensing to prevent disproportionate clustering of outlets in disadvantaged areas
- Interventions targeting licensed venues
- Interventions targeting vulnerable populations (Roche, Kostadinov, Fischer et al., 2015).

A key gap identified in NCETA's inequity study was lack of relevant data and the lack of attention to available data on alcohol-related inequities. To address this gap it is suggested that the National Alcohol Strategy should include actions to:

- Improve alcohol consumption data collections to enable greater disaggregation by socio-economic factors beyond age and sex. These improvements could be used to monitor the differential impacts of policies and interventions on social groups
- Further examine the effectiveness of interventions to reduce alcohol-related harm which focus on equity or the distribution of impacts across the population (Roche, Kostadinov, Fischer et al., 2015).

## 11. Aboriginal and Torres Strait Islander people

While the draft National Alcohol Strategy identifies Aboriginal and Torres Strait Islander people as an at-risk population group, it does not do so within the context of social and historical colonisation, dispossession of land and culture, and economic exclusion (Gray, Cartwright, Stearne et al., 2017).

A recent review exploring the harmful effects of alcohol use among Aboriginal and Torres Strait Islander people identified that effective policy responses need to:

- Address the underlying social and economic disadvantages that Aboriginal and Torres Strait Islander people encounter
- Include Aboriginal and Torres Strait Islanders as key players in the design and implementation of interventions to address harmful alcohol use in their communities with a focus on capacity building in community-controlled organisations (Gray, Cartwright, Stearne et al., 2017).

The review also highlighted that, in relation to the provision of AOD services, there is a need for greater access to a holistic range of services including:

- Better integration of alcohol treatment services with primary health care and social and emotional wellbeing services
- Provision of AOD services in areas that are currently underserved
- Provision of services to Aboriginal and Torres Islander sub-groups e.g., women and young people
- A focus on building organisational and workforce capacity to ensure that services are able to be delivered appropriately (Gray, Cartwright, Stearne et al., 2017).

Consideration should be given to revising the current iteration of the National Alcohol Strategy to take into greater account strategies aimed at addressing the social determinants of alcohol use among Aboriginal and Torres Strait Islander people, while ensuring that individuals, organisations and communities are involved in the decision-making and implementation of services.

## 12. Relationship between methamphetamine use and risky alcohol consumption

Considerable attention has been focused on the use of crystal methamphetamine in recent years, with concern about the range of potential harms that can be associated with its short- and long-term use. However, one issue often over-looked is the relationship between methamphetamine use and risky alcohol consumption.

Methamphetamine is a stimulant that allows the user to remain alert and awake for longer periods of time. Research has indicated that methamphetamine users are more likely to be risky drinkers than users of other illicit drugs and the community in general. Some studies have indicated that certain methamphetamine users specifically seek out the drug to enable them to drink alcohol for longer periods of time and in greater quantities, and experience less awareness of the intoxicating effects of the alcohol. The potential harms associated with these behaviours are clearly evident and warrant attention in the National Alcohol Strategy.

## 13. Responding to alcohol use – workforce development implications

Workforce attrition in recent years stemming from severe funding cutbacks across the AOD sector, has resulted in a large loss of corporate knowledge. In addition, the AOD sector comprises a substantial proportion of older workers who are nearing retirement and whose expertise will be lost to the sector in the not too distant future.

Both of these factors underscore the importance of proactively recruiting new workers and providing those workers, and those in generic health and human services roles where tackling alcohol-related issues is of paramount importance, with the appropriate evidence-based knowledge, skills and resources.

The dissemination of accurate evidence-based knowledge and skills is more crucial than ever before. There is also an emerging knowledge base in many areas including the relationship between alcohol and cancer, Fetal Alcohol Spectrum Disorder, stress, and prevention that necessitates new workforce development strategies and supports.

## 14. Ensuring consistency across service delivery models

With the emergence of PHNs as commissioning agents for AOD services there is potential for fragmentation and inconsistency of alcohol-related approaches. It is crucial that the Strategy provides guidance to new commissioning agents to ensure implementation of evidence-based policies and practice. This guidance also needs to reinforce the following objectives of the Primary Health Network Grant Programme Guidelines:

1. Address the increased demand for access to drug and alcohol treatment services
2. Support region specific, cross-sectoral and integrated approaches to drug and alcohol treatment services, based on the needs of clients locally, and focused on improving care coordination at the local level

3. Facilitate and support evidence-based treatment for clients using a range of substances
4. Promote linkages with broader health services, including mental health services, to better support integrated treatment and referral pathways to support clients with comorbid mental health disorders
5. Ensure Indigenous-specific and culturally appropriate drug and alcohol treatment services for Indigenous Australians are linked with broader Indigenous health services
6. Promote quality improvement approaches and support health professionals through education and training (Department of Health, 2016).

# **Summary of Recommendations**

In view of the issues raised in this submission, NCETA recommends that the draft National Alcohol Strategy be revised to include:

## **1. The workplace**

That the National Alcohol Strategy:

- Indicates the untapped potential for the workplace as a setting in which to implement effective alcohol harm reduction, early intervention and prevention strategies
- Includes objectives and strategies that apply evidence-based strategies to address alcohol-related harm in the workplace
- Highlights the central role of the workplace as a treatment pathway in responding to alcohol-related issues among employed people.

## **2. Young people, the role of schools, and the impact of school to work transition**

That the National Alcohol Strategy:

- Acknowledges the scope for schools to provide evidence-based alcohol education to young people
- Reinforces the importance of alcohol education programs in schools being based on accurate information, supported by rigorous research, and adopting a whole-of-school approach in building student resilience and social connectedness
- Identifies and addresses the school-to-work transition period as a key opportunity for prevention and intervention for young people.

## **3. Alcohol-related family and domestic violence**

That the National Alcohol Strategy:

- Highlights the relationship between alcohol and family and domestic violence and that:
  - All AOD services and workers appropriately support clients who may be experiencing family and domestic violence
  - All AOD clients, and especially female clients, are asked about family and domestic violence
  - The AOD and broader health sector are provided with opportunities to develop the knowledge and skills to identify and respond to clients experiencing family and domestic violence.

## **4. Alcohol-related data**

That the National Alcohol Strategy:

- Recognises the potential of the available data and advocates for better use of existing data to inform the development and implementation of service provision and alcohol policies

- Includes information about and a link to the National Alcohol and Drug Knowledgebase (NADK).

## **5. Alcohol use among older people**

That the National Alcohol Strategy:

- Incorporates a wider age range in relation to ‘older people’ to include those aged over 50 and is not limited to people aged 70 years and over
- Includes strategies aimed at:
  - Health care services and the aged care sector working together to:
    - Prevent problematic alcohol use among older people
    - Provide age-appropriate treatment and harm minimisation services
  - Clinicians being provided with appropriate evidence-based knowledge and skills to better identify and treat alcohol-related issues in their older clients.

## **6. Liquor licensing legislation**

That the National Alcohol Strategy:

- Ensures that harm minimisation remains the central tenet of liquor licensing legislation in Australia
- Ensures that police and other law enforcement personnel responsible for enforcing liquor licensing legislation are provided with ongoing and up-to-date and evidence-based information and training on enforcing the legislation.

## **7. Alcohol’s interaction with medicines such as benzodiazepines and opioids**

That the National Alcohol Strategy:

- Recognises the important relationship between alcohol and medicines such as benzodiazepines and opioids
- Raises awareness of the general public, healthcare professionals and people working in the aged care sector of contra-indications associated with using alcohol in combination with some medicines.

## **8. Alcohol and cancer**

That the National Alcohol Strategy:

- Highlights the association between alcohol and various types of cancer
- Reinforces messages that alcohol use is associated with an increased risk of cancer
- Calls for the implementation of effective measures to reduce the overall use of alcohol
- Includes strategies that provide:
  - Healthcare workers with professional development opportunities designed to improve their understanding of the causal relationships between alcohol and cancer

- Information to the general public about prevention and early intervention strategies.

## **9. Alcohol use in rural and remote communities**

That the National Alcohol Strategy:

- Addresses the need for appropriate primary and secondary level interventions tailored to age and gender groups and subpopulations within rural and remote locations
- Includes a greater focus on the provision of online and telephone counselling, videoconferencing and a range of other innovative digital health and virtual support strategies to people living in rural and remote areas.

## **10. Inequalities and alcohol**

That the National Alcohol Strategy:

- Acknowledges the differential impact of alcohol use on advantaged and disadvantaged groups in society
- Improves alcohol consumption data collection to enable greater disaggregation by socio-economic factors beyond age and sex
- Further examines the effectiveness of interventions to reduce alcohol-related harm which focus on equity or the distribution of impacts across the population.

## **11. Aboriginal and Torres Strait Islander people**

That National Alcohol Strategy:

- Addresses the social determinants of alcohol use among Aboriginal and Torres Strait Islander people
- Acknowledges the importance of including Aboriginal and Torres Strait Islander people, organisations and communities in decision-making and implementation of AOD prevention activities and treatment services.

## **12. Relationship between methamphetamine use and risky alcohol consumption**

That the National Alcohol Strategy:

- Highlights the relationship between and harms associated with methamphetamine use and risky alcohol consumption
- Identifies strategies to raise awareness of the concurrent alcohol and methamphetamine and harms among AOD workers and the broader healthcare sector.

## **13. Responding to alcohol use – workforce development implications**

That the National Alcohol Strategy:

- Highlights the importance of providing new AOD workers, and people working in generic health and welfare roles, with appropriate evidence-based knowledge, skills and resources to respond to alcohol-related issues

- Recommends workforce development initiatives aimed at supporting workers to respond new and emerging issues of concern.

#### **14. Ensuring consistency across service delivery models**

That the National Alcohol Strategy:

- Provides guidance to the PHNs and other commissioning agents on the implementation of evidence-based AOD policies and practices
- Ensures that the guidance reinforces the objectives of Primary Health Network Grant Programme Guidelines.

## References

- Australian Institute of Health and Welfare. (2017). *National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214.* Canberra: AIHW.
- Baan, R., Straif, K., Grosse, Y., Secretan, B., Ghissassi, F., Bouvard, V., Altieri, A., & Cogliano, V. (2007). Carcinogenicity of alcoholic beverages. *The Lancet Oncology*, 8(4): p. 292-293
- Bowden, J.A., Delfabbro, P., Room, R., Miller, C.L., & Wilson, C. (2014). Alcohol consumption and NHMRC guidelines: Has the message got out, are people conforming and are they aware that alcohol causes cancer? *Australian and New Zealand Journal of Public Health*, 38(1): p.66-72.
- Community Affairs Reference Committee. (2013) *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health Report "Closing the gap within a generation"*. Canberra: Commonwealth of Australia.
- Cooper, C., & Dewe, P. (2008). Well-being-absenteeism, presenteeism, costs and challenges. *Occupational Medicine*, 58(8): p. 522-524.
- Dale, C.E., & Livingston, M.J. (2010). The burden of alcohol drinking on co-workers in the Australian workplace. *Medical Journal of Australia*, 193(3): p. 138-140.
- Department of Health. (2016). *Primary Health Network Grant Programme Guidelines: Annexure A2 – Drug and Alcohol Treatment Services*. Retrieved from [https://www.health.gov.au/internet/main/publishing.nsf/Content/F4F85B97E22A94CACA257F86007C7D1F/\\$File/Annexure%20A2%20-%20Drug%20and%20Alcohol%20Treatment%20Services%20-%20April%202017.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/F4F85B97E22A94CACA257F86007C7D1F/$File/Annexure%20A2%20-%20Drug%20and%20Alcohol%20Treatment%20Services%20-%20April%202017.pdf).
- Ferris, J.A., Laslett, A-M., Livingston, M.J., Room, R., & Wilkinson, C. (2011). The impacts of others' drinking on mental health. *Medical Journal of Australia*, 195(3): p. S22-S26.
- Gray, D., Cartwright, K., Stearne, A., Saggers, S., Wilkes, E., & Wilson, M. (2017). Review of the harmful use of alcohol among Aboriginal and Torres Strait Islander people. *Australian Indigenous HealthReviews*, No. 19.
- Greenfield, T.K., Karriker-Jaffe, K., Kaplan, L.M., Kerr, W.C., & Wilsnack, S.C. (2015). Trends in Alcohol's Harms to Others (AHTO) and co-occurrence of family-related AHTO: The four US National Alcohol Surveys, 2000-2015. *Substance Abuse: Research and Treatment*, (Suppl 2): p. 23-31.
- Livingston, M., Wilkinson, C., & Laslett, A-M. (2010). Impact of heavy drinkers on others' health and wellbeing. *Journal of Studies on Alcohol and Drugs*, 71(5): p. 778-785.
- National Drug and Alcohol Research Centre (2014). *Polydrug use: What you need to know about mixing drugs*. Canberra: Australian Government Department of Health.
- Pettigrew, S., Jongenelis, M., Pratt, I.S., Liang, W., Slevin, T., Chikritzhs, T., & Glance, D. (2016). Australian drinkers' perceptions of alcohol-related risk by consumption status. *Addiction Research & Theory*, 24(6): p. 507-513
- Pidd, K., & Roche, A. M. (2008). Changing workplace cultures: An integrated model for the prevention and treatment of alcohol-related problems. In D. Moore & P. Dietze (Eds.), *Drugs and Public Health* (pp. 49-59). Melbourne, Australia: Oxford.

Pidd, K., Roche, A., Cameron, J., Lee, N., Jenner, L., & Duraisingam, V. (2018). Workplace alcohol harm reduction intervention in Australia: Cluster non-randomised controlled trial. *Drug and Alcohol Review*. doi:10.1111/dar.12660.

Pidd, K., Roche, A., Duraisingam, V., Trifonoff, A., & Kostadinov, V. (2017). *Wellbeing & alcohol & other drug use among construction industry apprentices*. Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University.

Rao, R., & Roche, A. (2017). Substance misuse in older people: Baby boomers are the population at highest risk. *BMJ*, 358(j3885). doi:<https://doi.org/10.1136/bmj.j3885>

Roche, A., & Kostadinov, V. (2017). Beer, bongs and baby boomers: The unlikely tale of drug and alcohol use in the over 50s. *The Conversation*, 23 August.

Roche, A., Kostadinov, V., Fischer, J., Nicholas, R., O'Rourke, K., Pidd, K., & Trifonoff, A. (2015). Addressing inequities in alcohol consumption and related harms. *Health Promotion International*, 30(suppl 2), ii20-ii35. doi:10.1093/heapro/dav030.

Roche, A., Lee, N., & Cameron, J. (2014). *Alcohol Education: What Really Works in Schools?* In. Adelaide, South Australia: National Centre for Education and Training in Addiction (NCETA), Flinders University.

Roche, A., Pidd, K., & Kostadinov, V. (2014). Trainee chefs' experiences of stress, bullying, and coping in commercial kitchens. *Journal of Health, Safety and Environment*, 30(2): p. 59-269.

Roche, A., & McEntee, A. (2016). Ice and the outback: Patterns and prevalence of methamphetamine use in rural Australia. *Australian Journal of Rural Health*, Early online view. doi:10.1111/ajr.12331.

Trifonoff, A., Andrew, R., Steenson, T., Nicholas, R., & Roche, A. M. (2011). *Liquor Licensing in Australia: An Overview*. Adelaide, SA: National Centre for Education and Training on Addiction (NCETA), Flinders University.

White, M., Roche, A., Nicholas, R., Long, C., Gruenert, S., & Battams, S. (2013). *Can I Ask...? An alcohol and drug clinician's guide to addressing family and domestic violence*. Retrieved from Adelaide, South Australia.

World Health Organization. (2018). *Raising awareness of the link between alcohol and cancer*. Retrieved from <http://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/news/news/2018/02/raising-awareness-of-the-link-between-alcohol-and-cancer>.

World Health Organization. (2018). *What are social determinants of health?* Retrieved from [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/).