

Australia's key alcohol-related datasets



Flinders
UNIVERSITY



NCETA

Australia's National Research Centre
on AOD Workforce Development

Australia's key alcohol-related datasets

Ann Roche
Ken Pidd
Corey Taylor
Suzana Freegard

October 2011



Flinders
UNIVERSITY



NCETA

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

Citation details:

Roche AM., Pidd K., Taylor C., Freegard S. (2011).
Australia's key alcohol-related datasets. National
Centre for Education and Training on Addiction
(NCETA), Flinders University, Adelaide
South Australia.

ISBN: 978-1-876897-23-9

This work is copyright. Apart from any use as
permitted under the Copyright Act 1968, no part
may be reproduced without prior written permission
from the National Centre for Education and Training
on Addiction, available from Level 3B, Mark Oliphant
Building, Science Park, Bedford Park, South
Australia, 5042, Australia: Ph 61-8-8201-7535.

Published by the National Centre for Education and
Training on Addiction, Flinders University.

www.nceta.flinders.edu.au

Copies of this document can also be downloaded
from the NCETA website.

Design and Layout by Inprint Design

www.inprint.com.au

This resource on Australia's alcohol-related datasets was prepared by the National Centre for Education and Training on Addiction (NCETA) at Flinders University, South Australia. NCETA has a strong interest in issues relating to alcohol.

The National Centre for Education and Training on Addiction (NCETA) is an internationally recognised research centre that works as a catalyst for change in the alcohol and drugs (AOD) field. The Centre works to influence systems that affect workers through policy change, legislation, recruitment and best practice guidelines. The Centre was established in 1992 and is a collaborative venture between Flinders University, the South Australian Department of Health and the Australian Government Department of Health and Ageing.

A particular focus of NCETA is in relation to matters that pertain to alcohol data, and the quality of that data. Readers are directed to NCETA's website which contains a wide array of downloadable material of relevance to alcohol: www.nceta.flinders.edu.au

The NCETA team is also available for advice and further support in this area and can be contacted by phone 08 8201 7535 or via email nceta@flinders.edu.au

Acknowledgements

This resource was developed with funding from the Australian Government Department of Health and Ageing.

Foreword

This report provides an overview of Australian alcohol-related datasets. It was produced as part of the National Alcohol Data Knowledgebase (NADK) project. The National Centre for Education and Training on Addiction (NCETA) was commissioned by the Australian Government Department of Health and Ageing to undertake the development of the NADK.

The aim of the NADK is to present alcohol-related information, obtained from various select datasets, in a consistent, comparable and 'user friendly' manner. One of the challenges that faced the development of the NADK was the identification of relevant datasets that contained alcohol-related information.

Alcohol-related datasets

Australia has produced a large number of alcohol-related datasets that cover a diverse range of areas including health, social welfare, law enforcement, education, among others. These data sets can be difficult to locate, access, and utilise. In addition, important alcohol-related information is often contained in other larger and more detailed datasets.

Thus, the first stage of the NADK project involved the identification of alcohol-related data sets and an assessment of each dataset's suitability for inclusion in the NADK. This process was assisted by an expert working group, consisting of policy-makers, alcohol data custodians and alcohol researchers. A list of members of this expert working group is provided in Appendix B.

Each Australian alcohol-related dataset collected to-date has the potential to contribute to our understanding of the role that alcohol plays in the health and wellbeing of Australians. Despite the importance of these datasets, currently there is no single repository of alcohol-related data in Australia and accessing existing alcohol-related datasets can be a cumbersome and time consuming exercise. Moreover, no coordinated electronic database or directory of alcohol-related datasets is available.

Researchers, practitioners and policy-makers alike expect, and are expected, to use up-to-date information about alcohol to guide research efforts, treatment and policy recommendations. However, specific alcohol-related data can often be difficult to locate, access, and utilise. Alcohol-related datasets are extremely diverse and scattered across a variety of fields, including health, social welfare, roads and transport, education, criminal justice and social research. Relevant alcohol-related data is often also contained in other larger and more detailed datasets, for example the Australian Bureau of Statistics (ABS) National Health Survey and the Bettering the Evaluation and Care of Health (BEACH) general practitioner survey. Some organisations also undertake their own periodic surveys and data collection systems. These datasets can vary substantially in the frequency of collection, size and nature of the sample population, methods of data collection and their focus or purpose. Moreover, there has been little coordination of these datasets, few attempts to reconcile anomalies in different datasets, resulting in under-utilisation of available alcohol-related data.

The development of this resource serves as an important resource to assist the development of an alcohol research agenda, which was highlighted as a priority action area in the National Alcohol Strategy 2006-11, and the National Preventative Health Taskforce report: Taking preventative action - Response to Australia: The healthiest country by 2020.



Contents

Executive Summary	IX
Introduction	1
Method	3
Results	4
Discussion	5
Data gaps.....	5
Data limitations.....	6
Scope for data quality improvement.....	6
Key datasets	7
1. Alcohol and Other Drug Treatment Services – National Minimum Data Set (AODTS-NMDS).....	7
2. Apparent Consumption of Alcohol in Australia.....	7
3. Australian Secondary Students’ Alcohol and Drug Survey (ASSADS).....	7
4. Drug Use Monitoring in Australia (DUMA).....	7
5. National Community Mental Health Care Database.....	8
6. National Drug Strategy Household Survey (NDSHS).....	8
7. National Hospital Morbidity Database (NHMD).....	8
8. National Mortality Database (NMD).....	8
9. National Residential Mental Health Care Database.....	9
10. National Survey of Mental Health and Wellbeing (SMHWB).....	9
11. Australian Longitudinal Study on Women’s Health (ALSWH).....	9
12. Bettering the Evaluation and Care of Health (BEACH).....	9
13. Household Income and Labour Dynamics in Australia (HILDA) Survey.....	9
14. National Aboriginal and Torres Strait Islander Health Survey (NATSIHS).....	10
15. National Aboriginal and Torres Strait Islander Social Survey (NATSISS).....	10
16. National Coroners Information System (NCIS).....	10
17. National Health Survey (NHS).....	11
18. National Police Custody Survey (NPCS).....	11
19. National Prisoner Health Data Collection (NPHDC).....	11
20. Supported Accommodation Assistance Program (SAAP) National Data Collection.....	11
References	12
Appendix A	15
Appendix B	36
National Alcohol Data Knowledgebase Expert Working Group.....	36



Executive Summary

Australia has a plethora of alcohol-related data that can contribute to our understanding of the role played by alcohol in the health and wellbeing of individuals and the community overall. Datasets are established for differing purposes. There is no definitive dataset which serves the needs of all interested parties. Criteria to inform our understanding of quality data and the selection of particular datasets for specific tasks are needed.

A comprehensive examination of all Australian alcohol-related datasets was undertaken. Content, methods and approaches were examined. Criteria were established by which to nominate the most reliable datasets and to delineate the key characteristics of the datasets identified.

Selection criteria included:

- direct measures of health welfare
- social
- crime
- costs, sales
- or treatment issues
- data representativeness (national or for a specific sub-population)
- a valid and appropriate methodology
- and on-going, rather than one-off, data collection.

A total of 20 alcohol-related datasets were identified as meeting the quality criteria established from a total of 42.

The 20 key datasets identified were:

1. Alcohol and Other Drug Treatment Services – National Minimum Data Set (AODTS-NMDS)
2. Apparent Consumption of Alcohol in Australia
3. Australian Secondary Students' Alcohol and Drug Survey (ASSADS)
4. Drug Use Monitoring in Australia (DUMA)
5. National Community Mental Health Care Database
6. The National Drug Strategy Household Survey (NDSHS)
7. National Hospital Morbidity Database (NHMD)
8. National Mortality Database (NMD)
9. National Residential Mental Health Care Database
10. National Survey of Mental Health and Wellbeing (SMHWB)
11. Australian Longitudinal Study on Women's Health (ALSWH)
12. Bettering the Evaluation and Care of Health (BEACH)
13. Household Income and Labour Dynamics in Australia (HILDA) Survey
14. National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)
15. National Aboriginal and Torres Strait Islander Social Survey (NATSISS)
16. National Coroners Information System (NCIS)
17. National Health Survey (NHS)
18. National Police Custody Survey (NPCC)
19. National Prisoner Health Data Collection (NPHDC)
20. Supported Accommodation Assistance Program (SAAP) National Data Collection.

This document provides an overview of the 20 identified datasets and a description of each dataset's purpose, strengths, limitations and select publications. The overview of each dataset is presented according to the following headings:

1. Data custodian
2. Purpose
3. Methodology
4. Frequency
5. Date commenced/most recent
6. Participation
7. Strengths
8. Limitations
9. Recent publications.

Identification of the most reliable national alcohol-related datasets provides a useful aid to researchers, practitioners, policy makers and public commentators, and contributes to development of the evidence base to inform alcohol-related policy and practice in Australia. The identification of gaps and limitations in current datasets will also help improve alcohol-related data collection and appropriate data utilization into the future.

Introduction

In most developed countries, including Australia, alcohol use ranks second only to tobacco as a major contributor to the burden of disease risk [1]. The most recent estimation of the social cost of alcohol use to the Australian community exceeded \$15 billion for the 2004/05 financial year alone [2].

Due to the importance of this issue, Australian researchers, government departments and private organisations have for many years invested in the development of a plethora of alcohol-related data that collectively contribute to our understanding of the role of alcohol in our health and wellbeing.

Various Australian organisations produce a large number of alcohol-related datasets that cover a diverse range of areas including health, social welfare, law enforcement, education, among others. Such efforts are essential to understand the extent and nature of alcohol-related harm and for the development of effective responses.

The World Health Organization [3] recommends the on-going collection of data concerning alcohol consumption and related harms at a national level. The monitoring of such data is a pivotal factor in the development and implementation of effective policies [4] as it:

- quantifies the extent of consumption and harm and identifies trends over time
- identifies types of harm and groups most at risk
- provides baseline data for the evaluation of interventions.

A wide range of researchers, practitioners and policy makers alike expect, and are expected, to use up-to-date information about alcohol to guide research efforts, treatment and policy development. Moreover, users of alcohol-related information often need various types of information for different and specific purposes. However, determining what alcohol-related data are currently available and best suited to a given task can be problematic.

The range of concerns associated with alcohol means that alcohol data are by necessity collected for a multitude of purposes. Alcohol-related datasets are extremely diverse and scattered across a variety of health and social fields. There is no single definitive dataset which will serve the needs of all interested parties. In some cases, data are collected with a specific niche audience in mind, further restricting the wider utility of such data.

Hence, gaining a comprehensive picture of patterns of use and associated problems is not likely to be achieved through the use of one dataset alone, no matter how large the sample or rigorous the sampling methodology.

Researchers, policy makers and others are required to make use of multiple and disparate data sources in order to establish reliable estimates of the role and impact of alcohol in Australia [5, 6, 7]. However, this can be a challenging undertaking as many datasets are difficult to locate and access, and are often incompatible by design. The question therefore arises regarding which alcohol-related datasets provide the most appropriate data to use for a given purpose.

To address this question, it is important to establish the number and range of existing datasets that are potentially available, the information that these datasets contain and to assess the quality of the data contained in the datasets. Many existing alcohol-related datasets are collected and owned by disparate groups and bodies. Comprehensive knowledge about these datasets is largely lacking.

There are few individuals or organisations with a detailed overview of all alcohol-related data that exists in Australia, and there is no single repository of information about this data. Moreover, it is not immediately evident what criteria should be applied to determine the appropriateness, rigour or quality of a given dataset to assist individuals to make informed data selection choices.

To-date, there has also been little coordination between organisations that collect alcohol-related data in terms of collection frequency, method, and taxonomy as well as the size and nature of the sampling populations.

Thus, data concerning the same alcohol-related issue may differ substantially between datasets, and this can have important implications for the interpretation of information provided. For example, some collections use different survey questions to assess the same issue (e.g., alcohol consumption). This may result in different and incomparable measures and findings. Further, some datasets contain similar sample populations and sample sizes. However, differences in sampling methodologies may not allow for comparisons of similar subpopulation information across datasets.

As some datasets are more difficult to access than others, those with an interest in alcohol-related information may opt to use the datasets which are most readily available and accessible to them and not necessarily those best suited to their specific needs. A further limitation is that some of the largest collections contain extensive item banks that span a broad range of topics but are limited in terms of detailed alcohol-related content. Conversely, more detailed data may be obtained from other collections, but due to their narrow or niche nature problems may be encountered with sample sizes, methodology, representativeness and the depth of information on other variables contained within the dataset. Comparing results from different collections or establishing data-linkages between datasets can therefore present substantial challenges.

Clearly, a range of challenges confront anyone interested in accessing and utilising appropriate and high quality alcohol-related data in Australia. Moreover, even for those with relatively sophisticated knowledge of some alcohol-related datasets there are evident barriers in terms of working across different datasets.

In 2010, a project was sponsored by the Australian Government Department of Health and Ageing (DoHA) to provide a central repository of Australia's best available alcohol-related data, named the National Alcohol Data Knowledgebase (NADK). The aim of the NADK was to reconcile some of the aforementioned limitations and provide a comprehensive nationally consistent alcohol knowledgebase. This task was undertaken by the National Centre for Education and Training on Addiction (NCETA).

The development of a comprehensive, nationally consistent alcohol knowledge database represents an important contribution to achieving an improved understanding of alcohol-related issues. It also serves as a resource to assist the development of an alcohol research agenda, which was highlighted as a priority action area in the National Alcohol Strategy 2006-11 [8] and the National Preventative Health Taskforce report: Taking preventative action – A response to Australia: The healthiest country by 2020 [9].

Method

A scoping review and selection of key alcohol-related datasets was undertaken. Identifying Australia's quality datasets involved locating all potentially relevant datasets that contained alcohol-related information. The identification and assessment of alcohol-related datasets involved several steps. The method included a three-step process that entailed the identification of potential datasets, establishment of selection criteria, and finally the application of the criteria to candidate datasets to determine which datasets would be selected for inclusion.

First, potentially relevant datasets were identified. This process, together with the development of quality criteria, was assisted by an Expert Working Group consisting of policy makers, alcohol data custodians and alcohol researchers. The starting point for this step was the 2004 Australian Health and Welfare Institute's guide to Australian alcohol data [10] which lists major Australian data collections that specifically contain alcohol-related data. Information on alcohol-related datasets was also sourced from the Expert Working Group (see Appendix B), an internet search, and inquiries with relevant agencies.

While a range of social and health data can be used as surrogate measures of alcohol-related harm [11], only datasets that utilised direct measures of alcohol consumption or harm were considered.

Second, selection criteria were established on which to determine quality alcohol-related datasets. Then a comprehensive examination was undertaken of each dataset's content, methods and approaches in order to assess concordance with the selection criteria.

The main criteria for assessing relevance were:

1. the dataset contained information collected using direct measures of alcohol-related health, welfare, social, crime, costs, sales, or treatment issues
2. each dataset contained national data representative of the Australian population or specific sub-groups of the Australian population
3. the dataset utilised a valid and appropriate methodology
4. data collection was on-going, rather than one-off.

Results

A total of 42 potential datasets were identified and scrutinised. From these, 20 datasets met the quality criteria established. Summary details of the data custodian, purpose of collection, methodology, year of most recent collection, strengths and limitations of each dataset is presented in Table 1 (Appendix A also provides individualised summaries of each dataset). The 20 key datasets identified are:

1. Alcohol and Other Drug Treatment Services – National Minimum Data Set (AODTS-NMDS)
2. Apparent Consumption of Alcohol in Australia
3. Australian Secondary Students' Alcohol and Drug Survey (ASSADS)
4. Drug Use Monitoring in Australia (DUMA)
5. National Community Mental Health Care Database
6. The National Drug Strategy Household Survey (NDSHS)
7. National Hospital Morbidity Database (NHMD)
8. National Mortality Database (NMD)
9. National Residential Mental Health Care Database
10. National Survey of Mental Health and Wellbeing (SMHWB)
11. Australian Longitudinal Study on Women's Health (ALSWH)
12. Bettering the Evaluation and Care of Health (BEACH)
13. Household Income and Labour Dynamics in Australia (HILDA) Survey
14. National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)
15. National Aboriginal and Torres Strait Islander Social Survey (NATSISS)
16. National Coroners Information System (NCIS)
17. National Health Survey (NHS)
18. National Police Custody Survey (NPCC)
19. National Prisoner Health Data Collection (NPHDC)
20. Supported Accommodation Assistance Program (SAAP) National Data Collection.

The main alcohol-related information domains addressed were:

- consumption (volume, patterns, risk levels)
- harms (mortality, morbidity, mental health, crime)
- sales
- treatment
- special populations (students, female, Indigenous, prisoners, homeless).

The 20 datasets include national health surveys, specific AOD surveys, school surveys, law enforcement surveys, alcohol and drug treatment data collections, hospital separation data collections, registered death data collections, and mental health care episodes.

The 20 datasets address the following broad categories:

- treatment (1,12)
- consumption patterns and problems (2,6,17)
- youth (3)
- women (11)
- law enforcement and prisoners (4,18,19)
- mental health (5,9,10)
- morbidity, mortality/deaths (7,8,16)
- labour force (13)
- Indigenous (14,15)
- homeless (20).

Discussion

While a descriptive list of alcohol-related datasets had been compiled previously [10], this project involved the first attempt to comprehensively identify quality Australian datasets containing alcohol-related information. A total of 42 datasets containing alcohol-related information were identified of which 20 were assessed as on-going national data collections that contained relevant information collected by direct measures of alcohol consumption and/or related harms and that met the specified representativeness and methodology criteria.

This detailed examination and compilation of alcohol-related datasets indicates that Australia has substantial quality alcohol data available to inform policy and practice concerning alcohol-related harm. However, many of the datasets initially located did not meet the specified criteria for inclusion in the selection of Australia's quality data.

The implications of this are numerous. The fact that more than half the datasets reviewed did not meet the quality standards for inclusion stands as a cautionary note to potential data users about the possible limitations of available data. Much of Australia's alcohol-related data does not reach the standard set for quality data and highlights the scope that exists to improve and refine many of the existing datasets.

Moreover, as data collection is an expensive and resource-intensive exercise it underscores the potential for a better return on this significant investment. Ways in which this might be achieved are outlined below.

On a more positive note, a number of datasets that were not part of the final cut may nonetheless have inherent value. Such datasets include those which were not national but still of value at a local or jurisdictional level. It is noted that some issues may be best served by jurisdictional level data. In other instances, occasional or one-off data collections may also serve a specific need and hold considerable value in that regard. Hence, non-inclusion in the data list presented here does not necessarily suggest that those datasets are without value, but rather that their value needs to be closely assessed and considered in light of the criteria established for determination of data quality.

Data gaps

In the process of compiling and critiquing these datasets, data gaps and limitations in data collection methodologies were identified. While a number of national datasets concerning alcohol consumption and alcohol-related harm to health were identified, fewer national datasets were identified that contained information on other harms associated with alcohol use (e.g., crime, public safety, etc.). Both the National Drug Strategy Household Survey and the Drug Use Monitoring Australia survey collect some information concerning alcohol-related crime.

However, despite being collected on a jurisdictional basis, no national data on the extent of incidents of driving under the influence of alcohol or the extent of alcohol-related road traffic accidents is available. In the latter instance, the data gap that exists is not the basic collection of data but rather the failure to undertake the requisite step of national collation which is essential in Australia where jurisdictional data often predominate. Similarly, only one dataset provided limited information concerning annual per capita consumption. In addition, no readily available dataset contains alcohol wholesale and/or retail sales data at a national level. These gaps represent major limitations in Australia's alcohol data that warrant attention and remediation.

Data limitations

Another limitation of available alcohol-related data concerns differences in methodologies utilised by data collections that contained information on the same alcohol-related issue. As a result, data on the same alcohol issue (e.g., levels of consumption) can differ considerably across datasets. This makes it difficult to interpret and compare similar data across different data collections. Some of these differences relate to the type of measurement used.

For example, some collections use the graduated quantity frequency (GQF) method to measure consumption, while others use a measure of drinks consumed yesterday. The GQF method asks for the frequency of consuming various quantities of alcohol, with categories of amount consumed graduated down from large amounts to smaller amounts and the frequency consumed graduated down from very frequent to occasional consumption. The 'yesterday' method asks for detail on alcohol consumed the previous day. While the yesterday method may provide a more reliable measure of very recent consumption and annual levels of per capita consumption [12] the GQF method allows for the identification of infrequent high levels of consumption and provides more detail of long term patterns of consumption [3]. Similarly, some data collections use GQF cut points that are linked to Australian alcohol guidelines.

Such differences in alcohol consumption measures not only make comparison between data collections difficult, it limits the usefulness of data for trend analysis and data linkage.

Scope for data quality improvement

This review identified the high level of anomalies contained within Australia's major alcohol-related datasets, including those that met our quality inclusion criteria. Potential exists to improve and harmonise these datasets to allow greater scope for comparability. To-date there are no nationally agreed measures for the collection of alcohol-related data and there has been little coordination between data collections in terms of methodology or the size and nature of the sampling populations.

The development of alcohol-related data collection standards¹ and the establishment of a mechanism to improve collaboration and coordination between dataset custodians would improve the quality and cost effectiveness of current data collections. Such developments would also go some way toward addressing identified alcohol-related data gaps.

Despite the limitations of currently available national alcohol-related data, Australia has a substantial wealth of alcohol-related data to draw upon. The compilation and critique of alcohol-related datasets presented here will assist researchers, practitioners, policy makers and public commentators to access alcohol-related datasets and make more informed decisions about which dataset contains information that best meets their needs.

Encouraging researchers, policy makers and public commentators to pay greater regard to appropriate data selection to address specific alcohol-related questions will help achieve consistent and reliable estimates of the health and social effects of alcohol in Australia. In doing so, the identification of quality alcohol datasets as described here is also consistent with the current National Alcohol Strategy in that it will contribute to the development of the evidence base to inform policy and practice.

¹ See: Roche, A., Pidd, K., & Taylor, C. (2011). Alcohol data reporting standards. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.

Table 1: Australia's 20 Key Alcohol-related Datasets

Dataset and recent publications	Data custodian	Purpose	Methodology	Most recent collection	Strengths	Limitations
1. Alcohol and other Drugs Treatment Services – National Minimum Data Set [13, 14]	Australian Institute of Health and Welfare (AIHW)	A national collection of data concerning utilisation of and access to government-funded treatment service providers in both the government and non-government sectors.	On-going, mandatory collection of data using an agreed set of data elements.	2007/08	Regular collection of episodes of treatment, provides basic demographic information about treatment episodes where alcohol is the 'drug of concern', administrative dataset.	Does not include treatment data from non-specialist settings (e.g., prisons, sobering up shelters), counts treatment episodes rather than clients, limiting interpretation and definition of some data elements.
2. Apparent Consumption of Alcohol in Australia [15]	Australian Bureau of Statistics (ABS)	Provides estimates of the quantity of beer and wine available for consumption, and estimates of the quantity of pure alcohol available for consumption from beer, wine, spirits, and ready to drink pre-mixed products as well as estimates of per-capita consumption.	Consumption data estimated from alcohol supply data provided by other sources (e.g., excise data from Australian Taxation Office, import data from Australian Customs and Border Protection).	2008/09	Data is sourced from government agency administrative datasets and wine producers.	Only provides information on alcohol that is available for consumption, not what is actually consumed, stored or cellared, used in food production or discarded as waste.
3. Australian Secondary Students Alcohol and Drug Survey (ASSADS) [16, 17, 18]	Cancer Council of Victoria	A national survey of the prevalence and patterns of tobacco, alcohol and other drug consumption among Australian secondary school students.	Random sample of students enrolled in randomly selected schools across all Australian States and Territories.	2008	Active since 1984 and provides comprehensive data on alcohol consumption/prevalence patterns, other drug consumption and settings of use. Data collected in-person by research staff at schools, consistency of questions between survey waves.	Significant increase in students completing high school since the survey started impacting on trends in 16-17 year olds, potential impact of teachers present whilst surveys were completed. Current drinking patterns restricted to past 7 days. Risky drinking cut points restrict comparability with other data.
4. Drug Use Monitoring in Australia (DUMA)	Australian Institute of Criminology (AIC)	The DUMA program seeks to measure drug use among people recently apprehended by police, including questions regarding local drug markets and drug use patterns by detainees across time.	Data is collected quarterly from police detainees at nine sites across Australia.	2008	Comprehensive national on-going survey. Alcohol dependence assessed with validated scales, alcohol use data obtained for previous 48 hours, single-instance binge drinking and information about other drugs taken in conjunction with alcohol, some data collected on alcohol type, setting, and attitude/behavioural/self-perception questions.	The nine data collection sites may not provide data that is nationally representative of alcohol-related crime.

Dataset and recent publications	Data custodian	Purpose	Methodology	Most recent collection	Strengths	Limitations
5. National Community Mental Health Care Database [20]	Australian Institute of Health and Welfare (AIHW)	To collect data on all episodes of ambulatory mental health service contacts in order to monitor the mental health of Australians and to inform the quality and planning of mental health services.	Data are collected by State and Territory health authorities from their mental health care services. This collection occurs over a financial year.	2010	Contains mental-health related alcohol data from treatment services. Data collected using agreed and standardised data elements.	Collects data at a 'service episode' level rather than patient level. The quality of principal diagnosis data may be affected by variability in collection and coding practices across jurisdictions and individual service providers.
6. National Drug Strategy Household Survey (NDSHS) [21, 22, 23, 24]	Australian Institute of Health and Welfare (AIHW)	A national survey of Australian's awareness, attitudes and behaviours relating to tobacco, alcohol and illicit drug use.	A multi-stage stratified sample of Australian households.	2010	Has been active for a long period of time (since 1985) and provides comprehensive data on the types of alcohol and drugs used, patterns and prevalence of alcohol and other drug consumption, settings for use, alcohol- and drug-related behaviours and incidents and support for alcohol and other drug legislation and policy.	Some lack of question continuity between surveys, reported under-estimation of consumption prevalence, debate over sample representativeness, relatively low/declining response rate. Household based sampling excludes high risk groups such as those in prisons or the homeless.
7. National Hospital Morbidity Database (NHMD) [25]	Australian Institute of Health and Welfare (AIHW)	NHMD is compiled from data supplied by state and territory health authorities. It is a collection of electronic confidentialised summary records for separations (episodes of care) in public and private hospitals.	Mandatory collection of hospital separations data.	2008	National Health Data Dictionary definitions form the basis of the database ensuring data comparability with other AIHW databases, gives information regarding hospital separations, average length of stay, costs, etc. for patients with mental and behavioural disorders due to alcohol.	No detailed consumption data. Data collected at the service level (hospital separations) rather than patient level. Changing diagnostic practices and medical understanding of disease processes impact on coding of cause of death over time, and can lead to misclassification in causes of illness statistics.
8. National Mortality Database (NMD) [26]	Australian Institute of Health and Welfare (AIHW)	The AIHW National Mortality Database is primarily used for cause of death analysis, and contains demographic information for analysis of population groups.	Mandatory collection of registered death data.	2010	Collects data where cause of death is determined to be alcohol-related, some information collected about victimisation.	Changing diagnostic practices and medical understanding of disease processes impact on the coding of cause of death over time and can lead to misclassification in causes of death statistics.

9. National Residential Mental Health Care Database [27]	Australian Institute of Health and Welfare (AIHW)	Collects data on all episodes of residential mental health care provided by government funded residential mental health services to monitor the mental health of Australians and inform the quality and planning of mental health services.	Data are collected by State and Territory health authorities from their mental health care services.	2010	Contains mental health-related alcohol data from treatment services (principal diagnosis of 'mental and behavioural disorders due to use of alcohol'). Data collected using agreed and standardised data elements.	Collects data at a 'service episode' level rather than patient level. The quality of principal diagnosis data may be affected by variability in collection and coding practices across jurisdictions and individual service providers.
10. National Survey of Mental Health and Wellbeing (NSMHW) [28, 29]	Australian Bureau of Statistics (ABS)	Provides information on selected lifetime and 12-month prevalence of: Anxiety, Affective and Substance Use disorders. Information is provided on level of impairment, health services used for mental health problems, physical conditions, social networks and care-giving.	A multi-stage stratified sample of Australian households	2007	Comprehensive information on alcohol-related mental health and other mental/physical health indicators.	Declining response rate. Household based sampling excludes high risk groups such as those in prisons or the homeless.
11. Australian Longitudinal Study on Women's Health (ALSWH) [30, 31, 32, 33]	Research Centre for Gender, Health and Ageing, University of Newcastle	The Australian Longitudinal Study on Women's Health, widely known as Women's Health Australia, examines factors that influence health among women who are broadly representative of the entire Australian population. The study takes a comprehensive view of all aspects of health throughout women's lifespan.	Longitudinal population survey of three randomly selected age cohort groups.	2010	Large nationally representative sample derived from Medicare records, frequency and single-instance quantity of alcohol consumption is collected, high retention rate.	Survey is tailored to age cohorts (e.g. questions about high-consumption days are not asked of all cohorts), under-estimation of alcohol consumption, low response rate, higher attrition rates amongst abstainers and high-volume drinkers, lack of temporal specificity for questions.
12. Bettering the Evaluation and Care of Health (BEACH) [34, 35]	Australian General Practice Statistics Classification Centre	The BEACH program collects information about the clinical activities in general practice in Australia.	Random sample of general practitioners.	2009	Consistent questions since survey commencement, specific questions on alcohol consumption patterns detailing amount and frequency, and treatment related questions (e.g., referral, prescribed medication).	Alcohol questions only asked of patients > 18 yrs, lack of specificity in diagnostic terms, no information on patient participation rates, low response rate (~30%), patients may under-report alcohol problems, under-estimation of GP intervention, patients may attend more than once during sample period, under-estimate of drinking prevalence compared to other surveys, measures may lack sensitivity.
13. Household Income and Labour Dynamics in Australia (HILDA) Survey [36]	The Melbourne Institute	To collect longitudinal data on household composition, employment, income and wealth, and health and well-being.	A panel survey of a multi-stage stratified sample of Australian households.	2010	Longitudinal survey that collects data on a wide range of demographic and health variables including the quantity and frequency of alcohol use.	The only alcohol measures are basic quantity and frequency of consumption.

Dataset and recent publications	Data custodian	Purpose	Methodology	Most recent collection	Strengths	Limitations
14. National Aboriginal and Torres Strait Islander Health	Australian Bureau of Statistics (ABS)	The National Aboriginal and Torres Strait Islander Health Survey was designed to collect information from Indigenous Australians about health related issues, including health status, risk factors and actions, and socioeconomic circumstances.	Random dwellings in discrete Indigenous communities/ outstations from an Indigenous Community Frame using 2006 Census counts and 2006 Community Housing and Infrastructure Needs Survey.	2004/05	Personal interviews, high response rate (78%), extensive categorisation of types of alcohol consumed, questions formerly part of the National Health Survey (2001) and methodology is similar so results are directly comparable.	Excludes <18 year olds in questions on alcohol. Consumption data collected using 3 day recall may misrepresent patterns and infrequent risky drinking. Risky drinking cut points may restrict comparability with other data.
15. National Aboriginal and Torres Strait Islander Social Survey (NATSISS) [38]	Australian Bureau of Statistics (ABS)	The NATSISS provides information on demographic, social, environmental and economic indicators, including: personal and household characteristics; geography; language and cultural activities; social networks and support; health and disability; education; employment; financial stress; income; transport; personal safety; and housing.	Random dwellings in discrete Indigenous communities/ outstations from an Indigenous Community Frame using 2006 Census counts and 2006 Community Housing and Infrastructure Needs Survey.	2008	Personal interviews, extensive measures to increase response rate, extensive categorisation of types of alcohol consumed, persons <18 years old were included in alcohol questions.	Data only collected on quantity of alcohol 'usually' consumed. This may underestimate the prevalence of infrequent high risk level drinking.
16. National Coroners Information System (NCIS) [39]	Victorian Institute of Forensic Medicine (VIFM)	A national database of coronial information of all deaths reported to an Australian coroner since July 2000 (2001 for Queensland).	Data includes; personal details, demographics, time/location/activity of incident, mechanism of injury, and medical cause of death for all deaths reported to a coroner. Full text reports may also include police narrative of circumstances surrounding the incident, autopsy report, toxicology report and coroner's findings.	On-going	Comprehensive on-going collection of coronial data. Can include police reports and toxicology data that indicate alcohol-related causes.	Alcohol data collected as 'Object or Substance Producing Injury' where alcohol toxicity played a role, requires correct coding of mechanism coded as 'poisoning' and object as 'alcohol', alcohol is also coded as a 'contributing factor' to a person's death whether caused by them or by another person without being able to delineate. Only contains data on deaths reported to a coroner.

17. National Health Survey (NHS) [40]	Australian Bureau of Statistics (ABS)	Collects health status information about the population, health-related aspects of lifestyle such as smoking, diet, and alcohol consumption and use of health services and other actions people had recently taken for their health.	A multi-stage stratified sample of Australian households.	2007/08	Personal interview design, high response rate (91%), extensive categorisation of types of alcohol consumed.	Declining sample size, no consumption information for persons <18 years old before 2008, alcohol measures (3 day recall) may misrepresent patterns of consumption and infrequent risky drinking. Cut points used restrict comparability with other data.
18. National Police Custody Survey (NPCS) [41]	Australian Institute of Criminology (AIC)	Obtains information on extent and nature of police custody incidents over one month. Identifies flows in/out of custody, who goes into custody and why, and comparisons over time.	Data collected for every occasion a person is taken into custody and physically lodged in a police cell, at any location in Australia during a one month period.	2002	A comprehensive national dataset of criminal offences and demographics of offenders. Alcohol offences incl. e.g. driving under the influence and public drunkenness.	Missing data for many variables. Only provides data for those taken into custody no alcohol data for offenders arrested for other offences. Survey conducted for one month only. Doesn't address seasonal crime variation (e.g., driving under the influence, public drunkenness).
19. National Prisoner Health Data Collection (NPHDC) [42]	Australian Institute of Health and Welfare (AIHW)	To monitor health of Australian prisoners and inform and evaluate planning, quality and delivery of prisoner health services.	Data collected as part of a census conducted over one week of all prison entrants who visited a clinic and/or taking prescribed medication.	2009	AUDIT-C used to collect data on alcohol consumption, and a range of other health data collected including alcohol-related mental health.	Data only collected during census week and restricted to new entrants and those seeking/receiving health services (<50% prison pop) raising concerns re: representativeness.
20. Supported Accommodation Assistance Program (SAAP) National Data Collection [43]	Australian Institute of Health and Welfare (AIHW)	To monitor government funded specialist homeless services and welfare of disadvantaged and at risk Australians and inform the quality and planning of homeless services. Collects information on client demographics and types of services provided.	Data recorded by service providers during/ following client contact and forwarded to AIHW when contact ends or for on-going support at the end of each financial year.	2007/08	Problematic Drug/Alcohol/Substance Abuse: an option for 'Main Reason For Seeking Assistance'. Data collected using agreed and standardised data elements.	Unable to separate alcohol from drug/substance abuse. Some data elements require client consent with high levels of non-response for some questions.

Key:

AIHW = Australian Institute of Health and Welfare

ABS = Australia Bureau of Statistics

AIC = Australian Institute of Criminology

References

- [1] World Health Organization. Global health risks. Mortality and burden of disease attributable to selected major risks. WHO. Geneva; 2009. Available: www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf (accessed July 15th 2011).
- [2] Collins D.J., Lapsley H.M. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05. Department of Health and Ageing. Canberra; 2008.
- [3] World Health Organization. International guide for monitoring alcohol consumption and related harms. WHO. Geneva, Switzerland; 2000, Available: http://whqlibdoc.who.int/hq/2000/who_msd_msb_00.4.pdf (accessed July 15th 2011).
- [4] Rehm J., Scafato E. Indicators of alcohol consumption and attributable harm for monitoring and surveillance in European Union countries. *Addiction*, 2011; 106 (Sup. 1): 1-4.
- [5] Laslett A.M., Catalano P., Chikritzhs T., Dale C., Doran C., Ferris J., et al. Alcohol Education and Rehabilitation Centre for Alcohol Policy Research. The Range and Magnitude of Alcohol's Harm To Others. AER Turning Point Alcohol and Drug Centre. Melbourne; 2010.
- [6] National Health and Medical Research Council. Australian guidelines to reduce health risks from drinking alcohol. NHMRC. Canberra; 2009.
- [7] Roche A., Bywood P., Freeman T., Pidd K., Borlagdan J., Trifonoff A. The Social Context of Alcohol Use in Australia. National Centre for Education and Training on Addiction. NCETA. Flinders University. Adelaide; 2009.
- [8] Ministerial Council on Drug Strategy. National Alcohol Strategy 2006-2011. MCDS. Canberra; 2006.
- [9] National Preventative Health Taskforce. Taking Preventative Action. A Response To Australia: The Healthiest Country By 2020. NPHT. Canberra; 2010.
- [10] Australian Institute of Health and Welfare. A guide to Australian alcohol data. AIHW Cat No. PHE 52. Canberra; 2004.
- [11] Stockwell T., Chikritzhs T., Brinkman S. The role of social and health statistics in measuring harm from alcohol. *Journal of Substance Abuse*, 2000; 12: 139-154.
- [12] Stockwell T., Donath S., Cooper-Stanbury M., Chikritzhs T., Catalano P., Mateo C. Under-reporting of alcohol consumption in household surveys: A comparison of quantity-frequency, graduated-frequency and recent recall. *Addiction*, 2004; 99: 1024-1033.
- [13] Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia 2007-08: findings from the National Minimum Data Set. AIHW. Bulletin, no. 74. Cat No. AUS 118. Canberra; 2009.
- [14] Australian Institute of Health and Welfare. Alcohol and other drug treatment services National Minimum Data Set. National Health Data Dictionary. Version 12. AIHW Cat No. HWI 51. Canberra; 2003.
- [15] Australian Bureau of Statistics. Apparent Consumption of Alcohol, Australia. ABS. Cat No. 4307.0.55.001. Canberra; 2008-09.
- [16] White V., Smith G. Australian secondary school students' use of tobacco, alcohol, and over the counter and illicit drugs in 2008. Centre for Behavioural Research in Cancer, Cancer Control Research Institute, Cancer Council of Victoria, Melbourne; 2009.

- [17] Livingstone M. Recent trends in risky alcohol consumption and related harm among young people in Victoria, Australia. *Australian and New Zealand Journal of Public Health*, 2009; 32(3): 266-271.
- [18] Scully M., Dixon H., White V., Backmann K. Dietary, physical activity and sedentary behaviour among Australian secondary students in 2005. *Health Promotion International*, 2007; 22(3): 236-245.
- [19] Gaffney A., Jones W., Sweeny J., Payne J. Drug use monitoring in Australia: 2008 annual report on drug use among police detainees. Australian Institute of Criminology. Canberra; 2010.
- [20] Australian Institute of Health and Welfare. Mental health services in Australia, 2007-08. *Mental Health Series No. 12*. AIHW Cat No. HSE 88. Canberra; 2010.
- [21] Australian Institute of Health and Welfare. 2007 National Drug Strategy Household Survey: first results. AIHW. *Drug Statistics Series No 20*. Cat No. PHE 98. Canberra; 2008.
- [22] Australian Institute of Health and Welfare. 2007 National Drug Strategy Household Survey: detailed findings. AIHW. *Drug Statistics Series No. 22*. Cat No. PHE 107. Canberra; 2008.
- [23] Greenfield T.K., Kerr W.C. Alcohol measurement methodology in epidemiology: recent advances and opportunities. *Addiction*, 2008; 103: 1082-1099.
- [24] Stockwell T.R., Zhao J. What did you drink yesterday? Public health relevance of a recent recall method used in the 2004 Australian National Drug Strategy Household Survey. *Addiction*, 2008; 103: 919-928.
- [25] Australian Institute of Health and Welfare. Australian hospital statistics 2008-09. AIHW. *Health Services Series No. 17*. Cat No HSE 84. Canberra; 2010.
- [26] Australian Institute of Health and Welfare. Australia's health 2008. AIHW. Cat No. AUS 99. Canberra; 2008.
- [27] Australian Institute of Health and Welfare. Mental health services in Australia, 2007-08. AIHW. *Mental Health Series No. 12*. Cat No. HSE 88. Canberra; 2010.
- [28] Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of Results 2007. ABS. Cat No. 4326.0. Canberra; 2007.
- [29] Baillie A.J., Teesson M. Continuous Categorical and mixture models of DSM-IV alcohol and cannabis disorders in the Australian community. *Addiction*, 2010; 105(7): 1246-1253.
- [30] Furuya H., Young A.F., Powers J.R., Byles J.E. Alcohol consumption and physical health-related quality of life in older women using the transformation of SF-36 to account for death. *Japanese Journal of Alcohol & Drug Dependence*, 2008; 43(2): 97-109.
- [31] Clemens S., Matthews S. Comparison of a food-frequency questionnaire method and a quantity-frequency method to classify risky alcohol consumption in women. *Alcohol & Alcoholism*, 2008; 43(2): 223-229.
- [32] Powers J., Young A. Longitudinal analysis of alcohol consumption and health of middle-aged women in Australia. *Addiction*, 2008; 103: 424-432.

- [33] Clemens S., Matthews S., Young A.F., Powers J. Alcohol consumption of Australian women: Results from the Australian Longitudinal Study on Women's Health. *Drug and Alcohol Review*, 2007; 26(5): 525-535.
- [34] Proude E.M., Britt H., Valenti L., Conigrave K.M. The relationship between self-reported alcohol intake and the morbidities managed by GPs in Australia. *Bio Medical Central Family Practice*, 2006; 7(1): 17.
- [35] Degenhardt L., Knox S., Barker B., Britt H., Shakeshaft A. The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia. *Drug and Alcohol Review*, 2005; 24(6): 499-506.
- [36] Breunig R., Weiss A., Yamauchi C., Gong X. & Mercante J. (2011). Child Care Availability, Quality and Affordability: Are Local Problems Related to Maternal Labour Supply?. *Economic Record*. 2011; 87(276): 109-123.
- [37] Trewin D. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey 2004-05. ABS. Cat No. 4715.0. Canberra; 2006.
- [38] Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Social Survey 2008. ABS. Cat No. 4714.0. Canberra; 2009.
- [39] McNeilly B., Ibrahim J.E., Bugeja L., Ozanne-Smith J. The prevalence of work-related deaths associated with alcohol and drugs in Victoria, Australia, 2001-6. *Injury Prevention*, 2010; 16: 423-428.
- [40] Australian Bureau of Statistics. National Health Survey: Summary of results, 2007-08. ABS. Cat No. 4364.0. Canberra; 2009.
- [41] Taylor N., Bareja M. Australian Institute of Criminology. 2002 Police Custody Survey, Technical & Background Paper No. 13. Canberra; 2005
- [42] Australian Institute of Health and Welfare. The Health of Australia's Prisoners – 2009. AIHW Cat No. PHE 123. Canberra; 2010.
- [43] Australian Institute of Health and Welfare. Mental health services in Australia, 2007-08. AIHW Cat No. HSE 88. Canberra; 2010.

Appendix A

Key datasets

A total of 20 datasets were identified:

1. Alcohol and Other Drug Treatment Services– National Minimum Data Set (AODTS-NMDS)
2. Apparent Consumption of Alcohol in Australia
3. Australian Secondary Students' Alcohol and Drug Survey (ASSADS)
4. Drug Use Monitoring in Australia (DUMA)
5. National Community Mental Health Care Database
6. The National Drug Strategy Household Survey (NDSHS)
7. National Hospital Morbidity Database (NHMD)
8. National Mortality Database (NMD)
9. National Residential Mental Health Care Database
10. National Survey of Mental Health and Wellbeing (SMHWB)
11. Australian Longitudinal Study on Women's Health (ALSWH)
12. Bettering the Evaluation and Care of Health (BEACH)
13. Household Income and Labour Dynamics in Australia (HILDA) Survey
14. National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)
15. National Aboriginal and Torres Strait Islander Social Survey (NATSISS)
16. National Coroners Information System (NCIS)
17. National Health Survey (NHS)
18. National Police Custody Survey (NPCC)
19. National Prisoner Health Data Collection (NPHDC)
20. Supported Accommodation Assistance Program (SAAP) National Data Collection

Of these 20 datasets, the first 11 were selected to provide alcohol-related information via the NADK. Additional criteria for inclusion in the NADK were that the datasets contained the most comprehensive relevant alcohol-related data, compared to similar datasets, and that this data could be analysed in a manner consistent with the data reporting standards adopted for the NADK².

Outlined below is an overview of the 20 identified datasets and a description of each dataset's purpose, strengths, limitations and select publications. The overview of each dataset is presented according to the following headings;

1. Data custodian
2. Purpose
3. Methodology
4. Frequency
5. Date commenced/most recent
6. Participation
7. Strengths
8. Limitations
9. Recent publications.

² See: Roche, A., Pidd, K., & Taylor, C. (2011). Alcohol data reporting standards. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.

1. Alcohol and Other Drug Treatment Services - National Minimum Data Set (AODTS-NMDS)

- 1.1 Data custodian:** Australian Institute of Health and Welfare (AIHW)
- 1.2 Purpose:** The AODTS–NMDS is a national collection of data concerning utilisation of and access to government-funded treatment service providers in both the government and non-government sectors. These data are collated by state and territory health authorities and compiled into a national data set by the Australian Institute of Health and Welfare (AIHW).
- 1.3 Methodology:** On-going, mandatory collection of data using an agreed set of data elements.
- 1.4 Frequency:** Collected continuously, reports released annually.
- 1.5 Date commenced:** 1998; most recent: 2007-2008.
- 1.6 Participation:** Most recent (2007-2008) - 153 998 treatment episodes were reported, of which 65 702 (45%) detailed alcohol as the principal 'drug of concern'.
- 1.7 Strengths:** Regular collection of episodes of treatment. Provides basic demographic information about treatment episodes where alcohol is the 'drug of concern'. Administrative dataset used hence sampling error is not an issue.
- 1.8 Limitations:** Does not include treatment data from non-specialist settings (e.g., prisons, sobering up shelters). Counts episodes rather than clients, which limits the interpretation and definition of some data elements.
- 1.9 Recent publications** Australian Institute of Health and Welfare (2009). Alcohol and other drug treatment services in Australia 2007-08: findings from the National Minimum Data Set. Bulletin no. 74. Cat. no. AUS 118. Canberra: AIHW.

Australian Institute of Health and Welfare (2003). Alcohol and other drug treatment services National Minimum Data Set. National Health Data Dictionary. Version 12. AIHW Cat. No. HWI 51. Canberra: AIHW.

2. Apparent Consumption of Alcohol in Australia

- 2.1 Data Custodian:** Australian Bureau of Statistics.
- 2.2 Purpose:** Provides estimates of the quantity of beer and wine available for consumption, and estimates of the quantity of pure alcohol available for consumption from beer, wine, spirits, and ready to drink pre-mixed products as well as estimates of per-capita consumption.
- 2.3 Methodology:** Consumption data estimated from alcohol supply data provided by other sources (e.g., excise data from Australian Taxation Office, import data from Australian Customs and Border Protection).
- 2.4 Frequency:** Annual.
- 2.5 Date commenced:** 2002-2003; most recent: 2008-2009.
- 2.6 Participation:** Not applicable.
- 2.7 Strengths:** Data is sourced from government agency administrative datasets and wine producers.
- 2.8 Limitations:** Only provides information on alcohol that is available for consumption, not what is actually consumed. It does not take into account alcohol that is stored or cellared, used in food production or discarded as waste.
- 2.9 Recent publications:** 4307.0.55.001 - Apparent Consumption of Alcohol, Australia, 2008-09
<http://abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/48BD96605A358A0ACA256F16007D736D?opendocument>

3. Australian Secondary Students' Alcohol and Drug Survey (ASSADS)

- 3.1 Data Custodian:** Cancer Council of Victoria.
- 3.2 Purpose:** A national survey of the prevalence and patterns of tobacco, alcohol and other drug consumption among Australian secondary school students.
- 3.3 Methodology:** Random sample of students enrolled in randomly selected schools across all Australian States and Territories.
- 3.4 Frequency:** Triennial.
- 3.5 Date commenced:** 1984; most recent: 2008.
- 3.6 Participation:** Most recent (2008) - 24,408 secondary school students age 12-17 years.
- 3.7 Strengths:** Has been active for a long period of time (since 1984) and provides comprehensive data on types of alcohol and drugs used, patterns and prevalence of alcohol and other drug consumption and settings of use. Data collected in-person by research staff at schools. Consistency of questions between survey waves.
- 3.8 Limitations:** Significant increase in students completing high school since the survey started impacting on trends in 16-17 year olds. Potential impact of teachers being present whilst surveys were being completed. Patterns of current drinking restricted to past 7 days. Cut points set in measures of risky drinking restrict comparability with other sources of data.
- 3.9 Recent publications:** White, V. & Smith, G. (2009). Australian secondary school students' use of tobacco, alcohol, and over the counter and illicit drugs in 2008. Centre for Behavioural Research in Cancer, Cancer Control Research Institute, Cancer Council of Victoria, Melbourne.

Livingstone, M. (2008). Recent trends in risky alcohol consumption and related harm among young people in Victoria, Australia. *Australian and New Zealand Journal of Public Health*, 32(3): 266-271

Scully, M., Dixon, H., White, V. & Backmann, K. (2007). Dietary, physical activity and sedentary behaviour among Australian secondary students in 2005. *Health Promotion International*, 22(3): 236-245.

4. Drug Use Monitoring in Australia (DUMA)

- 4.1 Data custodian:** Australian Institute of Criminology (AIC).
- 4.2 Purpose:** The DUMA program seeks to measure drug use among people recently apprehended by police. The program examines the relationship between drugs and crime, and monitors local drug markets and drug use patterns by detainees across time. The DUMA program includes an alcohol survey aimed at collecting offenders' self-reported information on excessive consumption of alcohol and associated behavioural factors.
- 4.3 Methodology:** Data is collected quarterly from police detainees at nine sites across Australia.
- 4.4 Frequency:** Quarterly.
- 4.5 Date commenced:** 1999; most recent: 2008.
- 4.6 Participation:** Most recent (2008) - 4,107 adult (≥ 18 years) detainees.
- 4.7 Strengths:** Comprehensive national on-going survey. Drug use data corroborated with urinalysis. Alcohol dependence assessed with validated scales. Alcohol use data obtained for previous 48 hours. Single-instance binge drinking information and information about other drugs taken in conjunction with alcohol collected. Some data collected on alcohol type (beer, spirits, etc.), setting, and attitude/behavioural/self-perception questions.
- 4.8 Limitations:** Focus is on drugs other than alcohol. The alcohol addendum is not conducted at every DUMA site nor is it conducted every quarter. Unlike other drugs, self-reported alcohol use is not corroborated with objective tests. The nine data collection sites may not provide data that is nationally representative of alcohol-related crime.
- 4.9 Recent publications:** Gaffney, A. Jones, W., Sweeny, J., Payne, J. (2010). Drug use monitoring in Australia: 2008 annual report on drug use among police detainees, Australian Institute of Criminology, Canberra.

5. National Community Mental Health Care Database

- 5.1 Data custodian:** Australian Institute of Health and Welfare (AIHW).
- 5.2 Purpose:** To collect data on all episodes of ambulatory mental health service contacts in order to monitor the mental health of Australians and to inform the quality and planning of mental health services. Data collected includes demographic, clinical and administrative data on clients of community mental health care services.
- 5.3 Methodology:** Data are collected by State and Territory health authorities from their mental health care services. This collection occurs over a financial year. The data are collated and validated by State and Territory health authorities prior to supply of the data sets to AIHW.
- 5.4 Frequency:** Data collected continuously and collated yearly.
- 5.5 Date commenced:** 1996-1997; most recent: 2010.
- 5.6 Participation:** All government funded specialist community mental health care services.
- 5.7 Strengths:** Contains mental-health related alcohol data from treatment services (principal diagnosis of 'mental and behavioural disorders due to use of alcohol'). Data collected using agreed and standardised data elements.
- 5.8 Limitations:** Collects data at a 'service episode' level rather than patient level. The quality of principal diagnosis data may be affected by variability in collection and coding practices across jurisdictions and individual service providers.
- 5.9 Recent publications:** Australian Institute of Health and Welfare (2010). Mental health services in Australia, 2007-08. Mental health series no. 12. AIHW Cat No. HSE 88, Canberra.

6. National Drug Strategy Household Survey (NDSHS)

- 6.1 Data custodian:** Australian Institute of Health and Welfare (AIHW).
- 6.2 Purpose:** A national survey of Australian's awareness, attitudes and behaviours relating to tobacco, alcohol and illicit drug use.
- 6.3 Methodology:** A multi-stage stratified sample of Australian households.
- 6.4 Frequency:** Triennial.
- 6.5 Date commenced:** 1985; most recent: 2010.
- 6.6 Participation:** Most recent (2007) - 23,356 Australians aged 12 years or older.
- 6.7 Strengths:** Has been active for a long period of time (since 1985). It provides comprehensive data on the types of alcohol and drugs used, patterns and prevalence of alcohol and other drug consumption, settings for use, alcohol- and drug-related behaviours and incidents and support for alcohol and other drug legislation and policy.
- 6.8 Limitations:** Some lack of question continuity between surveys. Reported under-estimation of consumption prevalence. Relatively low and declining response rate. Household based sampling excludes high risk groups such as those in prisons or the homeless which affects sample representativeness.
- 6.9 Recent publications:** Australian Institute of Health and Welfare (2008). 2007 National Drug Strategy Household Survey: first results. Drug Statistics Series number 20.Cat. No. PHE 98. Canberra: AIHW.

Australian Institute of Health and Welfare (2008). 2007 National Drug Strategy Household Survey: detailed findings. Drug statistics series no. 22. Cat. No. PHE 107. Canberra: AIHW.

Greenfield, T K. Kerr, W C. (2008). Alcohol measurement methodology in epidemiology: recent advances and opportunities. *Addiction* 103: 1082-1099.

Stockwell, T R. Zhao, J. et al. (2008). What did you drink yesterday? Public health relevance of a recent recall method used in the 2004 Australian National Drug Strategy Household Survey. *Addiction* 103: 919-928.

7. National Hospital Morbidity Database (NHMD)

- 7.1 Data custodian:** Australian Institute of Health and Welfare (AIHW).
- 7.2 Purpose:** The NHMD is compiled from data supplied by the state and territory health authorities. It is a collection of electronic confidentialised summary records for separations (that is, episodes of care) in public and private hospitals in Australia. Diagnoses, procedures and external causes of injury are recorded using the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM).
- 7.3 Methodology:** Mandatory collection of hospital separations data.
- 7.4 Frequency:** Annual.
- 7.5 Date commenced:** 1993; most recent: 2008.
- 7.6 Participation:** All hospital separations in Australia.
- 7.7 Strengths:** The National Health Data Dictionary definitions form the basis of the database ensuring data comparability with other AIHW databases. It gives information regarding hospital separations, average length of stay, costs, etc. for patients with mental and behavioural disorders due to alcohol.
- 7.8 Limitations:** No other detailed information regarding consumption, patterns over time, etc. Data collected at the service level (hospital separations) rather than patient level. Changing diagnostic practices and medical understanding of disease processes impact on the coding of cause of death over time, and can lead to misclassification in causes of illness statistics.
- 7.9 Recent publications:** Australian Institute of Health and Welfare (2010). Australian hospital statistics 2008-09, Health Services Series no.17. Cat No. HSE 84, Canberra.

8. National Mortality Database (NMD)

- 8.1 Data custodian:** Australian Institute of Health and Welfare (AIHW).
- 8.2 Purpose:** The AIHW National Mortality Database is primarily used for cause of death analysis, and contains demographic information for analysis by population groups such as age, sex, Indigenous status, country of birth and geographic location.
- 8.3 Methodology:** Mandatory collection of registered death data.
- 8.4 Frequency:** Data collected and collated annually.
- 8.5 Date commenced:** 1965; most recent: updated every calendar year.
- 8.6 Participation:** All registered deaths from 1965 onwards.
- 8.7 Strengths:** Collects data where cause of death is determined to be alcohol-related. Some information collected about victimisation. Several items of interest flagged in the data (drowning, firearms, drugs, etc.).
- 8.8 Limitations:** Changing diagnostic practices and medical understanding of disease processes impact on the coding of cause of death over time and can lead to misclassification in causes of death statistics.
- 8.9 Recent publications:** Australian Institute of Health and Welfare (2008). Australia's health 2008, Cat No. AUS 99, AIHW, Canberra.

9. National Residential Mental Health Care Database

- 9.1 Data custodian:** Australian Institute of Health and Welfare (AIHW).
- 9.2 Purpose:** To collect data on all episodes of residential mental health care provided by government funded residential mental health services in order to monitor the mental health of Australians and to inform the quality and planning of mental health services. Data collected includes demographic, clinical and administrative data on clients of community mental health care services.
- 9.3 Methodology:** Data are collected by State and Territory health authorities from their mental health care services. This collection occurs over a financial year. The data are collated and validated by State and Territory health authorities prior to supply of the data sets to the AIHW.
- 9.4 Frequency:** Data collected continuously and collated yearly.
- 9.5 Date commenced:** 1996-1997; most recent: 2010.
- 9.6 Participation:** All government funded residential mental health care services (except for those funded under the Aged Care Act, 1997).
- 9.7 Strengths:** Contains mental health-related alcohol data from treatment services (principal diagnosis of 'mental and behavioural disorders due to use of alcohol'). Data collected using agreed and standardised data elements.
- 9.8 Limitations:** Collects data at a 'service episode' level rather than patient level. Funding variations across jurisdictions limit data from some states/territories. The quality of principal diagnosis data may be affected by variability in collection and coding practices across jurisdictions and individual service providers.
- 9.9 Recent publications:** Australian Institute of Health and Welfare (2010). Mental health services in Australia, 2007-08. Mental Health Series no. 12. AIHW Cat No. HSE 88, Canberra.

10. National Survey of Mental Health and Wellbeing (SMHWB)

10.1 Data custodian: Australian Bureau of Statistics (ABS).

10.2 Purpose: The survey provides information on the prevalence of selected lifetime and 12-month mental health disorders by three major disorder groups: Anxiety disorders, Affective disorders and Substance Use disorders. It also provides information on the level of impairment, the health services used for mental health problems, physical conditions, social networks and care-giving.

10.3 Methodology: A multi-stage stratified sample of Australian households.

10.4 Frequency: Two to date.

10.5 Date commenced: 1997; most recent: 2007.

10.6 Participation: 8,800 Australians aged ≥ 16 years.

10.7 Strengths: Provides comprehensive information on alcohol-related mental health and other mental/physical health indicators.

10.8 Limitations: Declining response rate. Household based sampling excludes high risk groups such as those in prisons or the homeless.

10.9 Recent publications: 4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results 2007. <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0>

Baillie, A J. Teesson, M. (2010). Continuous, categorical and mixture models of DSM-IV alcohol and cannabis disorders in the Australian community. *Addiction*, 105(7), 1246-1253.

11. Australian Longitudinal Study on Women's Health (ALSWH)

11.1 Data custodian: Research Centre for Gender, Health and Ageing, University of Newcastle.

11.2 Purpose: The Australian Longitudinal Study on Women's Health, widely known as Women's Health Australia, examines factors that influence health among women who are broadly representative of the entire Australian population. The study goes beyond a narrow perspective that equates women's health with reproductive and sexual health, and takes a comprehensive view of all aspects of health throughout women's lifespan.

11.3 Methodology: Longitudinal population survey of three randomly selected age cohort groups.

11.4 Frequency: Triennial.

11.5 Date commenced: 1995; most recent: 2010.

11.6 Participation: 40,000 initially with approx > 50% retention.

11.7 Strengths: Large nationally representative sample derived from Medicare records. Fifteen years of data. Frequency and single-instance quantity of alcohol consumption is collected. High retention rate.

11.8 Limitations: Survey is tailored to age cohorts (e.g. questions about high-consumption days are not asked of all cohorts), possible under-estimation of alcohol consumption, low response rate, higher attrition rates amongst both abstainers and high-volume drinkers, lack of temporal specificity for questions so problems with recall may under-estimate consumption.

11.9 Recent publications: Furuya H., Young A.F., Powers J.R. & Byles J.E. (2008). Alcohol consumption and physical health-related quality of life in older women using the transformation of SF-36 to account for death. *Japanese Journal of Alcohol & Drug Dependence*, 43(2): 97-109.

Clemens S. & Matthews S. (2008). Comparison of a food-frequency questionnaire method and a quantity-frequency method to classify risky alcohol consumption in women. *Alcohol & Alcoholism*, 43(2): 223-229.

Powers J. & Young A. (2008). Longitudinal analysis of alcohol consumption and health of middle-aged women in Australia. *Addiction*, 103: 424-432.

Clemens S., Matthews S., Young A.F. & Powers J. (2007). Alcohol consumption of Australian women: Results from the Australian Longitudinal Study on Women's Health. *Drug and Alcohol Review*, 26(5): 525-535.

12. Bettering the Evaluation and Care of Health (BEACH)

12.1 Data custodian: Australian General Practice Statistics Classification Centre.

12.2 Purpose: The BEACH program continuously collects information about the clinical activities in general practice in Australia including characteristics of the GPs, patients seen, reasons people seek medical care and problems managed. For each problem managed; medications prescribed, advised, provided, clinical treatments and procedures provided, referrals to specialists and allied health services, tests ordered including pathology and imaging.

12.3 Methodology: Random sample of general practitioners.

12.4 Frequency: Annual.

12.5 Date commenced: 1998; most recent: 2009.

12.6 Participation: Random sample of 1000 GP's, with 100 consecutive consultations from each GP recorded.

12.7 Strengths: Consistent questions since commencement of the survey. It contains specific questions on alcohol consumption patterns detailing amount and frequency. Also contains treatment related questions (e.g., referral, prescribed medication).

12.8 Limitations: Alcohol questions are only asked of patients above the age of 18. Lack of specificity of terms used in diagnosis. No information on participation rates of patients. Low response rate (~30%). Patients may be less likely to self-report alcohol problems. Under-estimation of GP intervention (i.e. the advice given to a patient regarding alcohol problems may not be regarded by the GP as a medical issue and not recorded). Patients may attend more than once during the sample period. Under-estimate of drinking prevalence compared to other surveys. Measures may lack sensitivity.

12.9 Recent publications: Proude E.M., Britt H., Valenti L., & Conigrave K.M. (2006). The relationship between self-reported alcohol intake and the morbidities managed by GPs in Australia. *BMC Family Practice*, 7(1):17.

Degenhardt L., Knox S., Barker B., Britt H., & Shakeshaft A. (2005). The management of alcohol, tobacco and illicit drug use problems by general practitioners in Australia. *Drug & Alcohol Review*, 24(6):499-506.

13. Household Income and Labour Dynamics in Australia (HILDA) Survey

13.1 Data custodian: The Melbourne Institute.

13.2 Purpose: To collect longitudinal data on household composition, employment, income and wealth, and health and well-being.

13.3 Methodology: A panel survey of a multi-stage stratified sample of Australian households.

13.4 Frequency: Annual.

13.5 Date commenced: 2001; most recent: 2010.

13.6 Participation: Latest (Wave 9) - 17,630.

13.7 Strengths: Longitudinal survey that collects data on a wide range of demographic and health variables including the quantity and frequency of alcohol use.

13.8 Limitations: The only alcohol measures are basic quantity and frequency of consumption.

13.9 Recent publications: Breunig, R., Weiss, A., Yamauchi, C., Gong, X. & Mercante, J. (2011). Child Care Availability, Quality and Affordability: Are Local Problems Related to Maternal Labour Supply?. *Economic Record*, vol. 87, no. 276, pp. 109-123.

14. National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)

14.1 Data custodian: Australian Bureau of Statistics (ABS).

14.2 Purpose: The National Aboriginal and Torres Strait Islander Health Survey was designed to collect a range of information from Indigenous Australians about health related issues, including health status, risk factors and actions, and socioeconomic circumstances.

14.3 Methodology: Random selection of dwellings within a random selection of discrete Indigenous communities and outstations across Australia from a specially developed Indigenous Community Frame, constructed using 2001 Census counts and information collected in the 2001 Community Housing and Infrastructure Needs Survey.

14.4 Frequency: Only one survey conducted to-date.

14.5 Date commenced: 2004-2005; most recent: 2004-2005.

14.6 Participation: 10,439 Indigenous Australians of all ages.

14.7 Strengths: Personal interview design. High response rate (78%). Extensive categorisation of types of alcohol consumed. Questions were formerly part of the National Health Survey (2001) and methodology is similar so results are directly comparable.

14.8 Limitations: Does not include those <18 years old in questions on alcohol. Details of consumption (type and amount of drink) only collected for the three most recent days on which they had consumed alcohol which may misrepresent patterns of consumption and may not measure infrequent high levels of drinking. Cut points set in measures of risky drinking restrict comparability with other sources of data.

14.9 Recent publications: Trewin, D. (2006). National Aboriginal and Torres Strait Islander Health Survey 2004-05. Australian Bureau of Statistics Catalogue. No. 4715.0.

15. National Aboriginal and Torres Strait Islander Social Survey (NATSISS)

15.1 Data custodian: Australian Bureau of Statistics (ABS).

15.2 Purpose: The NATSISS provides information on a range of demographic, social, environmental and economic indicators, including: personal and household characteristics; geography; language and cultural activities; social networks and support; health and disability; education; employment; financial stress; income; transport; personal safety; and housing.

15.3 Methodology: Random selection of dwellings within a random selection of discrete Indigenous communities and outstations across Australia from a specially developed Indigenous Community Frame, constructed using 2006 Census counts and information collected in the 2006 Community Housing and Infrastructure Needs Survey.

15.4 Frequency: Every six years.

15.5 Date commenced: 2002; most recent: 2008.

15.6 Participation: 13,307 (82% response rate).

15.7 Strengths: Personal interview design. Extensive measures to increase response rate. Extensive categorisation of types of alcohol consumed. Persons <18 years were included in alcohol questions.

15.8 Limitations: Data only collected on quantity of alcohol 'usually' consumed. This may underestimate the prevalence of infrequent high risk level drinking.

15.9 Recent publications: 4714.0 - National Aboriginal and Torres Strait Islander Social Survey 2008
<http://abs.gov.au/AUSSTATS/abs@.nsf/mf/4714.0/>

16. National Coroners Information System (NCIS)

16.1 Data custodian: The Victorian Institute of Forensic Medicine (VIFM).

16.2 Purpose: The NCIS is a national database of coronial information of all deaths reported to an Australian coroner since July 2000 (2001 for Queensland).

16.3 Methodology: Data includes; personal details, demographics, time of incident, location of incident, activity of incident, mechanism of injury, and medical cause of death are recorded for all deaths reported to a coroner. Full text reports stored in the NCIS may also include the police narrative of circumstances surrounding the incident, the autopsy report, the toxicology report and the coroner's findings.

16.4 Frequency: Uploaded from jurisdictions nightly.

16.5 Date commenced: 2000; most recent: on-going.

16.6 Participation: All deaths reported to all coroners' offices in Australia.

16.7 Strengths: Comprehensive on-going collection of coronial data. Can include police reports and toxicology data that indicate alcohol-related causes.

16.8 Limitations: Alcohol data collected as 'Object or Substance Producing Injury', where alcohol toxicity plays a role, requires correct coding of mechanism coded as 'poisoning' and object as 'alcohol'. Alcohol is also coded as a 'contributing factor' to a person's death whether caused by them or by another person without being able to delineate. Only contains data on deaths reported to a coroner. May only provide limited information on the extent of alcohol-related deaths as toxicology data is normally only collected if a post-mortem is conducted, and the presence of alcohol at post-mortem can be difficult to determine.

16.9 Recent publications: McNeilly, B., Ibrahim, J. E., Bugeja, L., & Ozanne-Smith, J. (2010). The prevalence of work-related deaths associated with alcohol and drugs in Victoria, Australia, 2001-6. *Injury Prevention*, 16, 423-428.

17. National Health Survey (NHS)

17.1 Data custodian: Australian Bureau of Statistics (ABS).

17.2 Purpose: The National Health Survey collects information about the health status of the population, health-related aspects of lifestyle such as smoking, diet, and alcohol consumption and the use of health services and other actions people had recently taken for their health.

17.3 Methodology: A multi-stage stratified sample of Australian households.

17.4 Frequency: Triennial.

17.5 Date commenced: 1989; most recent: 2007-2008.

17.6 Participation: Most recent (2007-08) - 20,788 Australians over the age of 14 years.

17.7 Strengths: Personal interview design. High response rate (91%). Extensive categorisation of types of alcohol consumed.

17.8 Limitations: Declining sample size. No consumption information for persons <18 years before 2008. Alcohol measures used (recall of three most recent days) may misrepresent patterns of consumption and may not measure infrequent high levels of drinking. Cut points set for measures of risky drinking restrict comparability with other sources of data.

17.9 Recent publications: 4364.0 National Health Survey: Summary of results, 2007-08
<http://abs.gov.au/ausstats/abs@.nsf/PrimaryMainFeatures/4364.0?OpenDocument>

18. National Police Custody Survey (NPCS)

18.1 Data custodian: Australian Institute of Criminology (AIC).

18.2 Purpose: The survey aims to obtain information on the extent and nature of police custody incidents over a one month period in order to identify flows into and out of police custody, who goes into custody and why, and to provide comparisons of those in custody over time.

18.3 Methodology: Data collected for every occasion a person is taken into custody and physically lodged in a police cell, at any location in Australia during a one month period.

18.4 Frequency: Irregular.

18.5 Date commenced: 1988; most recent: 2002.

18.6 Participation: Latest (2002) - 27,047 occurrences of being placed in custody in October 2002.

18.7 Strengths: Provides a comprehensive national dataset of criminal offences and demographics of offenders. Also includes alcohol offences such as driving under the influence and public drunkenness.

18.8 Limitations: Problems with missing data for many variables. Only provides data for those taken into custody, not all crime (e.g., in the case of public drunkenness only data on those taken into protective custody is collected). No alcohol data regarding offenders arrested for other offences is collected. Survey only conducted for a one month period. Patterns and prevalence of alcohol crime (e.g., driving under the influence, public drunkenness) may vary throughout the year.

18.9 Recent publications: Taylor, N & Bareja, M. (2005). 2002 Police Custody Survey, Technical & Background Paper No. 13, Australian Institute of Criminology, Canberra.

19. National Prisoner Health Data Collection (NPHDC)

19.1 Data custodian: The Australian Institute of Health and Welfare (AIHW).

19.2 Purpose: To monitor the health of Australian prisoners and to inform and evaluate the planning, quality and delivery of prisoner health services.

19.3 Methodology: Data were collected as part of a census of prisoners conducted over a one week period on all prison entrants, all prisoners who visited a clinic and all prisoners who were taking prescribed medication while in custody.

19.4 Frequency: Annual census, to date collection has only been reported once.

19.5 Date commenced: 2009; most recent: 2009.

19.6 Participation: 549 prison entrants, over 3,700 incarcerated prisoners who visited a prison clinic, and over 4,900 prisoners who were taking prescribed medication whilst in custody.

19.7 Strengths: AUDIT-C used to collect data on alcohol consumption, and a range of other health data collected including alcohol-related mental health.

19.8 Limitations: Data is only collected during census week and collection is restricted to new entrants and those seeking or receiving health services. Data is not collected from prisoners not receiving or seeking health services (>50% of the prison population) which raises questions concerning representativeness.

19.9 Recent publications: Australian Institute of Health and Welfare (2010). The Health of Australia's Prisoners – 2009, AIHW Cat No. PHE123, Canberra.

20. Supported Accommodation Assistance Program (SAAP) National Data Collection

20.1 Data custodian: The Australian Institute of Health and Welfare (AIHW).

20.2 Purpose: To monitor support provided by government funded specialist homeless services in order to monitor the welfare of disadvantaged and at risk Australians and to inform the quality and planning of homeless services. Information on client demographics and types of services provided are collected.

20.3 Methodology: Data recorded by service providers during or immediately following client contact and forwarded to AIHW when contact ends or for on-going support at the end of each financial year.

20.4 Frequency: Data collected continuously and collated yearly.

20.5 Date commenced: 1985; most recent: 2007-2008.

20.6 Participation: Most recent (2007-08) - 1,562 non-government, community and local government agencies funded under the SAAP (92.1% participation rate).

20.7 Strengths: 'Problematic Drug/Alcohol/Substance Abuse' is an option for 'Main Reason For Seeking Assistance' criterion. Data collected using agreed and standardised data elements.

20.8 Limitations: Unable to separate alcohol from drug/substance abuse. Some data elements require client consent for collection which results in high levels of non-response for some questions.

20.9 Recent publications: Australian Institute of Health and Welfare (2010). Mental health services in Australia, 2007-08. Mental Health Series no. 12. AIHW Cat No. HSE 88, Canberra.

Appendix B

National Alcohol Data Knowledgebase Expert Working Group

Members:

Steve Allsop (National Drug Research Institute)
 Jane Andrews (Department of Health and Ageing)
 Merry Branson (Australian Bureau of Statistics)
 Bernadette Berlusconi (Department of Health and Ageing)
 Kate Conigrave (Sydney University)
 Robyn Davies (Department of Health and Ageing)
 Susan Donath (Royal Childrens Hospital Melbourne)
 Neil Donnelly (NSW Bureau of Crime Statistics and Research)
 Jenny Fleming (University of Tasmania)
 Pauline Griffiths (WA Drug and Alcohol Office)
 Margaret Hamilton (Australian National Council on Drugs)
 Maurice Hermann (Indigenous Community Volunteers)
 John Herron (Australian National Council on Drugs)
 Amber Jefferson (Australian Institute of Health and Welfare)
 David Kavanagh (Queensland University of Technology)
 Belinda Lloyd (Turning Point)
 Richard Mattick (National Drug and Alcohol Research Centre)
 Rob Moodie (University of Melbourne)
 Jim O'Shea (Alcohol, Education and Rehabilitation Foundation)
 George Phillips (Department of Health and Ageing)
 Jeff Rich (VicHealth)
 Amanda Roxburgh (National Drug and Alcohol Research Centre)
 Robin Room (Turning Point)
 Jane Shelling (Alcohol and Drug Council of Australia)
 Linda Stevens (Department of Education, Employment, and Workplace Relations)
 Jenny Taylor (Department of Health and Ageing)
 Maree Teesson (National Drug and Alcohol Research Centre)
 Adam Tomison (Australian Institute of Criminology)
 Maria Travers (Department of Health and Ageing)
 Peter Walkear (Australian Bureau of Statistics)
 John Wiggers (University of Newcastle)
 Rob White (University of Tasmania)
 Vicki White (Cancer Council, Victoria)
 Katie Willis (Australian Institute of Criminology)

NCETA Staff:

Ann Roche (Chair)
 Ken Pidd
 Corey Taylor



NCETA

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

Level 3B, Mark Oliphant Building
Laffer Drive, Science Park
Bedford Park SA 5042

Phone: +61 8 8201 7535

Fax: +61 8 8201 7550

Email: nceta@flinders.edu.au