DRAFT

NATIONAL ALCOHOL STRATEGY

2019–2026

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

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National Alcohol Strategy 2019–2026

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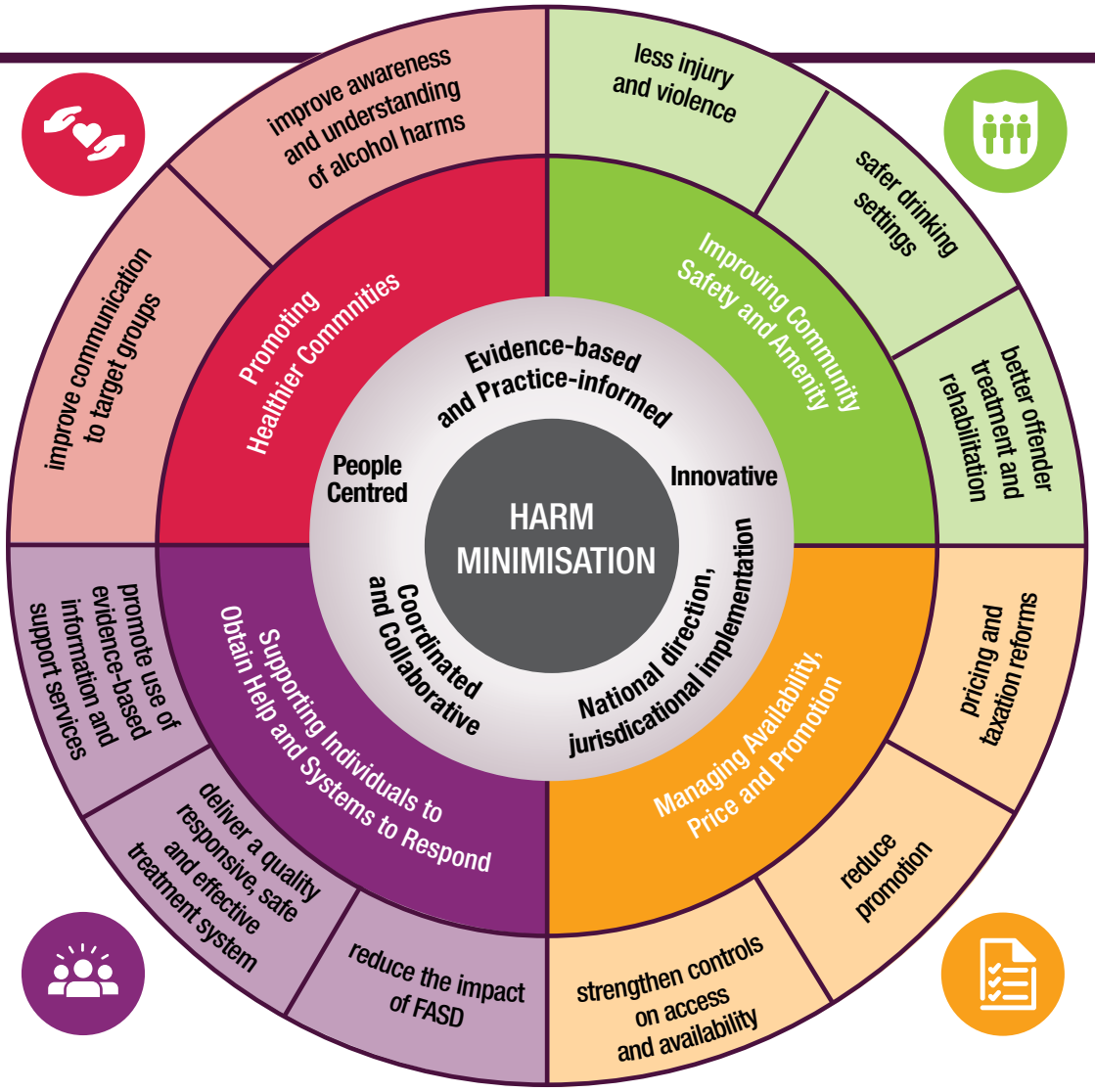
This Strategy acknowledges the importance of Aboriginal and Torres Strait Islander people's relationships with each other and with the broader Australian community. It responds to the overwhelming message from Australians of all backgrounds, that we share a desire to be connected to our communities,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

THE NATIONAL ALCOHOL STRATEGY 2019–2026 AT A GLANCE

Aim

To prevent and minimise alcohol-related harms among individuals, families and communities by:

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



PURPOSE OF A NATIONAL ALCOHOL STRATEGY

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

The Strategy builds on the existing efforts and responses to prevent and minimise alcohol-related harms, and provides a guide for focusing and coordinating population-wide and locally appropriate responses to alcohol-related harm by governments, communities and service providers. The Strategy also reiterates Australia's commitment to the *World Health Organization (WHO) Global Action Plan for the Prevention of and Control of Non-Communicable Diseases 2013–2020*, which includes a voluntary target of a reduction in harmful alcohol consumption of 10% by 2025.[1]

The Strategy also reflects Australia's support for *WHO's Global Strategy to Reduce Harmful Use of Alcohol*[2] (including strong alignment between the overarching aim, goals and priority areas of this Strategy with the priorities and areas of action of the Global Strategy) and the *United Nations 2030 Agenda for Sustainable Development Goals*.[3]

Implementation of the Strategy, including decisions of funding, legislation and programs, is the responsibility of jurisdictions. It is expected that in taking action to support implementation of this Strategy that jurisdictions will apply an evidence based approach to contribute to the objectives of the Strategy. The mix of actions adopted in individual jurisdictions and the details of their implementation may vary to reflect local and/or national priorities.

Progress will be monitored by the Ministerial Drug and Alcohol Forum (MDAF) and the National Drug Strategy Committee (NDSC) *(see Governance)*. However, it is important to recognise that overarching responsibility for many of the priorities and policy options identified throughout the Strategy does not sit within the portfolios represented on the MDAF and NDSC and that alcohol-related policy has a much broader reach. As such, it will be important that in monitoring and reporting on implementation and progress of the Strategy that the MDAF and NDSC draw appropriate links with other relevant Council of Australian Government (COAG) structures to ensure a coordinated and whole-of-government approach is taken to prevent and reduce alcohol related harm in response to the Strategy.

Importantly, this Strategy recognises that preventing and minimising alcohol-related harms in Australia cannot be achieved by governments alone, and that coordination and collaboration across jurisdictions, portfolios and the community is essential. Alcohol harms can be closely intertwined with mental health problems, a lack of social connection, experiences of trauma and exacerbated by a lack of income, employment, housing and education. Effective interventions require a cross-agency response, including health care, education, social services, liquor regulators, law enforcement, the justice system and local government.

A strength of Australia's approach to reducing alcohol-related harm has been the strong and enduring partnerships developed between governments, non-government organisations and community groups. This Strategy seeks to further strengthen these partnerships, including through the establishment of a new Alcohol Reference Group (Reference Group).

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

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

Development of the Strategy

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

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

A second phase of consultation was undertaken in 2018 to further inform the strategic direction and priorities of the Strategy which included written submissions and a targeted stakeholder roundtable.

The Strategy operates as a sub-strategy of the *National Drug Strategy 2017–2026*[4] and as such is underpinned by the principle of harm minimisation (encompassing demand, supply and harm reduction).

Furthermore, this Strategy will cover a eight-year period (2019–2026) so that it aligns with the conclusion of the overarching *National Drug Strategy 2017–2026*. In recognition of the need to ensure that emerging issues are considered over the life of the Strategy, the NDSC will receive regular reports from the Reference Group which can highlight any new and emerging issues of concern. A mid-point review of the Strategy will also be undertaken.

There are three other national sub-strategies of the *National Drug Strategy 2017–2026* that closely align with and support the aim of this Strategy:

- *National Aboriginal and Torres Strait Islander People's Drug Strategy 2014–2019;*[5]
- *National Alcohol and Other Drug Workforce Development Strategy 2015–2018;*[6] and
- *National Fetal Alcohol Spectrum Disorder Strategic Plan 2018–2028.*[7]

The Strategy has been developed and endorsed by the NDSC and MDAF.

ALCOHOL AND ALCOHOL-RELATED HARM

Where are we now?

Australia's overall consumption of alcohol (on a per capita basis) and the percentage of people reporting abstinence from alcohol has either declined or remained stable between 2009 and 2016.[8] In addition, significant improvements have been observed in abstinence over the same period among younger Australians.[9]

On a per capita basis there were 9.4 litres of pure alcohol available for consumption per person in 2016–17.[10] This is equivalent to an average of 2.6 standard drinks per day per person aged 15 years and over, which is down from 2.7 from 2015–16.[11] While Australia does not have the highest alcohol consumption per capita in the WHO regions, research has shown that a large proportion of Australians are concerned about alcohol.[12]

Almost 90% of adults report having consumed alcohol at some point over their lifetime and 80% consume at least some alcohol in the previous 12 months.[13]

Alcohol is an intrinsic part of Australian culture and it plays a central role in most people's social lives. Research clearly illustrates that whether people are celebrating, socialising, networking, relaxing, commiserating, or rewarding themselves—alcohol plays an integral role.[14]

Most Australians do not drink at levels that put them at risk of disease or injury, however, more than a quarter do drink at levels that put them at risk of injury from a single occasion of drinking (at least monthly) and 17% drink at levels that put them at risk of disease or injury over a lifetime. Drinking at these levels presents a significant social cost due to the increased risk of alcohol related disease, street and family violence, sexual assault and motor vehicle crashes.[15]

This *National Alcohol Strategy 2019–2026* ('the Strategy') provides a framework for directing national and local action to prevent and minimise these harms.

Harms associated with alcohol

Examples of harms associated with alcohol include:

- contributing (second only to tobacco) to Australia's burden of disease—with alcohol use being linked as a risk factor/contributor to more than 200 chronic diseases (including seven types of cancer);[16]
- acting as one of Australia's leading causes of drug-related death (second only to tobacco)—with more than 5,500 deaths estimated to be attributable to alcohol annually;[17]
- contributing significantly to violence and assaults—including domestic, family and intimate partner violence;[18]
- high economic and service delivery impacts on community services—including policing,

health, justice and local government services;[19]

- contributing to avoidable injury and motor vehicle crashes;[20]
- cause of birth defects and behavioural and neurodevelopmental abnormalities including Fetal Alcohol Spectrum Disorder (FASD) which have life-long impacts; and
- Reductions in productivity in the workplace.

1 in 4 Australians are drinking alcohol at risky levels

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

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

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

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

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

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

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

Sources: see panel on page 40 for details

Measures taken to date

Australia has implemented a range of measures to reduce alcohol-related harm, including liquor licensing and service regimes, education programs to raise awareness about the dangers of harmful drinking, drink driving campaigns combined with law enforcement initiatives such as random breath testing, responsible service of alcohol training programs, and a range of prevention, early intervention and treatment programs. However, there are still a significant number of Australians consuming alcohol at risky levels, impacting their health and potentially also the wellbeing of others around them.

Australia has national guidelines: *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* (the Guidelines), which help to define levels of alcohol consumption where risks to harm (including injury and disease) are minimised. These Guidelines go beyond looking at the short-term risks of alcohol consumption, to life-time risks of alcohol-related harm.[21] The Guidelines are used as the basis of defining risky or harmful drinking throughout this Strategy and are provided for reference at Appendix A.

According to the Guidelines, many drinkers consume alcohol responsibly, however, a substantial proportion of drinkers consume alcohol at a level that is considered to increase their risk of alcohol-related harm. Age is an important determinant of health risks related to alcohol. Harm from alcohol-related accident or injury is experienced disproportionately by younger people, and harm from alcohol-related disease is more evident among older people.

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

Among recent drinkers, 6.7% had injured themselves or someone else because of their drinking in their lifetime and 2.3% had done so in the last 12 months.[22] Very high-risk drinkers that consumed 11 or more standard drinks on a single occasion at least monthly were about five times as likely as recent drinkers to have injured themselves or someone else due to their drinking in the last 12 months.[23] Around 10% of Australians (who consume alcohol) report driving a motor vehicle after drinking,[24] and 40% of young risky drinking Australians having been in a vehicle with an alcohol-affected driver.[25]

People often do not recognise that they are consuming alcohol in quantities damaging to their health and tend not to associate themselves as problem drinkers. Many are unaware of alcohol consumption's contribution to cancer, cerebrovascular, cardio-vascular, liver and digestive disease. Results from the 2016 National Drug Strategy Household Survey (NDSHS) show that risky drinkers (lifetime and single occasion risk) are more likely to believe they can consume above the recommended guidelines without affecting or putting their health at risk.[26]

This may be the result of a relatively poor understanding of alcohol's contribution to Australia's burden of disease, including being linked with more than 200 chronic diseases,[27] and not associating some of their own health conditions with their alcohol consumption.

But this is not just a health issue or public safety issue—it has a whole of society impact, including on productivity. Risky drinkers were more likely to miss at least one day of work in the past 3 months due to their alcohol use than low-risk drinkers.[28]

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

Disproportionate Impacts of Alcohol-Related Harm

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

The Strategy identifies the following priority population groups:

Aboriginal and Torres Strait Islander people

Overall, Aboriginal and Torres Strait Islander people are more likely to abstain from drinking alcohol than non-Aboriginal and Torres Strait Islander people (31% compared with 23% respectively). However, among those who did drink, higher proportions drank at risky levels (20% exceeding the lifetime risk guidelines) and were more likely to experience alcohol-related injury than non-Aboriginal and Torres Strait Islander people (35% compared to 25% monthly, respectively).[29]

For this reason, Aboriginal and Torres Strait Islander people suffer from disproportionate levels of harm from alcohol, including alcohol-related mortality rates that are 4.9 times higher than among non-Aboriginal and Torres Strait Islander people.[30]

The poorer overall health, social and emotional wellbeing of Aboriginal and Torres Islander people than non-Aboriginal and Torres Strait Islander people are also significant factors which can influence drinking behaviours.[31]

People in remote areas

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

People in remote and very remote areas were 1.5 times as likely as people in major cities to consume five or more drinks at least monthly and 2.4 times as likely to consume 11 or more drinks (at least monthly).[32]

People with co-morbid mental health conditions

Research has linked alcohol use with mental health problems in many ways. For example, alcohol misuse can promote the development of mental health disorders such as depression, anxiety and/or social problems—around 37% of people who report problems with alcohol also have a co-occurring anxiety and/or mood disorder. The risk of having a mental illness is around four times higher for people who drink alcohol heavily than for people who do not.[33]

Pregnant women (or those planning a pregnancy)

Alcohol consumption whilst planning a pregnancy, during pregnancy, or while breastfeeding can result in birth defects, behavioural and neurodevelopmental abnormalities, including Fetal Alcohol Spectrum Disorder (FASD). Data from states and territories have estimated FASD rates at 0.01 to 1.68 per 1000 births in the total population[34] and 0.187 to 4.7 per 1000 births for the Aboriginal and Torres Strait Islander population.[35] There is evidence that indicates some communities are experiencing much higher incidences of FASD and therefore the lifelong impacts of FASD, with up to 1 in 5 school aged children being affected.[36]

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

Around 1 in 2 women report consuming alcohol during their pregnancy, with 1 in 4 women continuing to drink after they are aware they are pregnant. Of these women, 81% drank monthly or less with 16.2% drinking 2–4 times a month.[37]

Teenagers and young adults

While the number of teenagers choosing to abstain from alcohol is increasing (72% in 2013 to 82% in 2016), once this age group begin to drink alcohol they are more likely to drink to become intoxicated than any other age group (1 in 5 people in their 20s). Recent data shows that 15% of younger Australians drink more than 11 drinks on a single occasion at least monthly.[38]

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

Data has also highlighted that 13% of deaths 14–17 year olds can be attributable to alcohol.[39]

The Strategy acknowledges that there are other population groups that also experience higher levels of harm that should be considered when developing targeted responses to prevent and minimise alcohol-related harm:

People with impaired cognition, people diagnosed with or suspected to have FASD

FASD is a diagnostic term for the range of physical, cognitive, behavioural and neurodevelopmental abnormalities which can result from maternal drinking during pregnancy.

Research shows that there are lifelong consequences associated with FASD and those with impaired cognition, which can lead to significant secondary impairments, such as academic failure, substance misuse, mental ill-health, difficulties living independently, problems obtaining and maintaining employment and early contact with the justice system.[40, 41]

People whose parents/guardians experience alcohol dependence

People for whom parents or guardians experience alcohol dependence are often children and are not only more likely to be brought to the attention of child protection services but also to be repeatedly reported. The relationship between parental substance use and outcomes for children is complex and involves an array of risk and protective factors.[42] This population group tends to be placed in out-of-home care earlier and to remain longer; reunification with parents/guardians is often delayed while they undergo assessment and treatment.[43]

Adults in their 40s, 50s and 60s

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

Approximately 1 in 5 adults in these age groups drink at risky levels, averaging more than two standard drinks a day. Data has also shown a significant increase in people in their 50s and 60s consuming 11 or more standard drinks on at least a single drinking occasion in the last year (11.9% and 6.1% respectively).[44]

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

Older people (65+)

There is an increasing prevalence of harmful drinking among people aged 65 and over with these individuals the most likely age group to drink daily (19.5% of males; 8.7% of females).[45]

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

Psychosocial factors, such as bereavement, retirement, boredom, loneliness, homelessness and depression among older people can also be associated with higher rates of alcohol consumption.[46]

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

Lesbian, gay, bisexual and transgender people

People who identify as lesbian, gay, bisexual or transgender are more likely than heterosexual people to drink alcohol at levels that place themselves at risk of immediate and lifetime alcohol-related harm.

Lesbian, gay, bisexual and transgender people are less likely than heterosexual people to be abstainers or ex-drinkers (14.4% compared to 21.3%); are more likely to be lifetime risk drinkers (25.8% compared to 17.2%); and, more likely to consume 11 or more standard drinks on a monthly and yearly basis (12.6% compared to 6.9%, and 27.8% compared to 15.3%).[47]

People from culturally and linguistically diverse (CALD) backgrounds

While risky alcohol consumption is lower in non-English speaking populations (5.4%) than English-speaking populations (18.7%),[48] people from CALD backgrounds with alcohol use problems are a priority population because of the barriers they may face to receiving appropriate help and support.

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

A STRATEGIC RESPONSE

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

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

Evidence-based and practice-informed

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

Coordinated and collaborative

Effective interventions require multi-faceted, cross-agency responses with strong and enduring partnerships between governments, non-government organisations and community groups. There is a commitment to building strong new partnerships that can contribute to progress against the aim of the Strategy. Coordination and collaboration supports jurisdictions to develop better responses and innovations within the national approach that can inform and benefit all jurisdictions by sharing practices and learning.

Innovative

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

People-centered and proportionate to the potential for harm

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

National direction, jurisdictional implementation

The Strategy describes the nationally agreed goal of harm minimisation for preventing and reducing alcohol-related harms among individuals, families and communities. This includes agreed national priority areas of focus and policy options. However, funding and implementation occurs at all levels of government including Commonwealth, state and territory governments and local governments.

Jurisdictional implementation allows for governments to take action relevant to their jurisdiction with a national harm minimisation approach and strategies should reflect local circumstances and address emerging issues and drug types. It is expected that jurisdictions will prioritise actions that are evidence-informed and demonstrated to have the greatest impact on preventing and reducing alcohol-related harms. Industry, local businesses, community groups and individuals can also take action in reducing alcohol related harms.

Responsibility for alcohol policy is shared across all levels of government and a range of portfolios (which vary from jurisdiction to jurisdiction). The policy options identified throughout the Strategy are provided as examples only of activities or initiatives that might be considered by the responsible jurisdiction/s and do not mean they are being actively pursued or considered.

Priority Areas of Focus

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

- **Improving community safety and amenity;**
    - Working to better protect the health, safety and social wellbeing of those consuming alcohol and those around them.
- **Managing availability, price and promotion;**
    - Reducing opportunities for availability, promotion and pricing contributing to risky alcohol consumption.
- **Supporting individuals to obtain help and systems to respond;**
    - Facilitating access to appropriate treatment, information and support services.
- **Promoting healthier communities;**
    - Improving the understanding and awareness of alcohol-related harms in the Australian community.

Policy Options

The Strategy highlights a number of options under each of the priority areas of focus. These are examples of activities or initiatives that could be considered at either local, jurisdictional (state and territory) or national levels, including a mix of broad population approaches and targeted approaches. The responsibility for implementation of any actions under the National Alcohol Strategy may be the responsibility of local government, the Commonwealth or the states and territories alone, or can be shared between jurisdictions.

It is expected that in taking forward action under the Strategy, that jurisdictions will prioritise activities with the strongest evidence base for contributing to progress against the objectives of the Strategy.

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

Monitoring Progress

The impacts of alcohol-related harm and the responsibilities for implementation of alcohol policy extend across all levels of government and portfolios, as well as community service, public health and non-government sectors. Responsibilities also vary across jurisdictions, for example while the Australian Government is responsible for taxation, the issue of a minimum floor price is the responsibility of state and territory governments.

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

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

PRIORITY AREAS OF FOCUS

The *National Alcohol Strategy 2019–2026* identifies four priority areas of focus to prevent and minimise alcohol-related harm in Australia:

PRIORITY 1:
IMPROVING COMMUNITY SAFETY AND AMENITY

The majority of Australians do not drink alcohol at risky levels. Nevertheless, alcohol related harms can still have a significant impact.

Australians can be affected by reduced amenity and anti-social behaviour (such as street noise, having to avoid public parks, or petty costs from damaged property). Community safety and amenity can be impacted through contribution to experiences of violence and assault, crime (including drink driving and crashes), additional social costs and lost productivity, and reduced capacity within community services (including emergency departments, ambulance services and police departments), At the extreme end, alcohol are implicated in child abuse and neglect or physical violence or death.

In 2015–16, an estimated 162,400 Australians experienced physical assault where the offender was under the influence of alcohol (37.2% of total physical assaults).[49] Research has also shown that alcohol is involved in 34% of intimate partner violence incidents.[50]

Using national child protection data and estimating from Victorian measures of alcohol involvement, almost 20,000 children across Australia were victims of substantiated alcohol-related child abuse in 2006–2007.[51] Data from New South Wales has highlighted that the greatest cost to government in responding to alcohol-related harm was being borne by police.[52]

The World Health Organization (WHO) has noted that harmful use of alcohol and drugs is a commonly cited risk factor for experiencing and perpetrating intimate partner violence and sexual violence.[53] Greater attention should be paid to the relationship between access to alcohol and family violence in light of the evidence showing that alcohol misuse increases the severity and frequency of family violence.

There is also a high correlation between alcohol and motor vehicle crashes and the substantial trauma and harm they cause. Sustained efforts to prevent and prosecute drink-driving over recent decades have resulted in a significant fall in the proportion of road fatalities involving a driver under the influence of alcohol, however drink-driving is still a factor in 1 in 4 road fatalities.[54] This number remains far too high and underlines the importance of further enhancing enforcement and education around drink-driving.

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

Relevant indicators of change:

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

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

POLICY OPTIONS

OBJECTIVE 1 Less injury and violence

	Responsibility
Build the capacity of local community stakeholders to identify and respond to prevent harm.	Shared
Investigate, assess and implement new approaches to deter drinking and driving and other alcohol related anti-social behaviours, (eg. mandatory sobriety conditions for repeat offenders, linked ID scanners to prevent entry to venues, ignition interlocks and improvements to the extent and quality of alcohol education).	Shared
Plastic glassware in high-risk venues and settings.	States and Territories
Support high risk communities to declare themselves as 'dry' communities, which refer to an assortment of by-laws, regulations and other statutes all of which restrict or forbid the consumption of liquor within a certain area.	States and Territories
Implement policy and legislation around serving restrictions after a set time and the type of drinks which can be purchased and cessation of sales.	States and Territories
Accessible public transport.	States and Territories

POLICY OPTIONS

OBJECTIVE 2 Safer drinking settings

	Responsibility
Mobile assistance patrols:	Shared
- Support volunteers and charity groups to provide support and advice to at risk groups.	Shared
- Supporting more efficient and collaborative enforcement of liquor licensing and public conduct laws.	States and Territories
- Supporting licensing decision making and sharing of information on good practices to achieve out-comes that contribute to reducing or minimising alcohol-related harm and ill-health.	States and Territories
Ensuring venues and local governments work to the best evidence-based design specifications using Crime Prevention Through Environmental Design (CPTED)	States and Territories
Require licensees to ensure staff are trained in the Responsible Service of Alcohol and monitor and support compliance with such service standards.	States and Territories
Provide and enforce alcohol free areas to help ensure public safety and amenity.	States and Territories
Provide opportunities for residents to declare their private premises “alcohol-free” and support to enforce such declarations.	Local governments

POLICY OPTIONS

OBJECTIVE 3 Better offender treatment and rehabilitation

	Responsibility
Implement and evaluate the effectiveness of approaches to change repeat drink-driver offending behaviours, for example ignition interlocks, treatment programs.	Shared
Treatment which addresses substance use and other anti-social behaviours (such as violence and drink driving) including within the prison and drug treatment systems.	Shared
Early intervention and screening for first-time offenders, including diversion programs and options for referral to evidence-informed interventions or treatment services.	States and Territories

PRIORITY 2:
MANAGING AVAILABILITY, PRICE AND PROMOTION

As outlined previously, Australia's overall consumption of alcohol (on a per capita basis) has been in decline for the past 40 years, and the percentage of people reporting abstinence from alcohol has either increased or remained stable between 2009 and 2016.[55] In addition, significant improvements have been observed in abstinence over the same period among younger Australians.[56]

This is in spite of the fact that some research indicates that alcohol has become more readily available and affordable in Australia over the last decade.[57]

The World Health Organization has identified that taxation, restricting availability and implementing bans on advertising are the most efficient strategies to minimise the harmful use of alcohol. Furthermore, measures to reduce the availability of alcohol through strengthened controls on price and promotion can contribute to the outcomes of improving public safety and amenity.

In comparison with many other countries, Australia already has substantial regulatory regimes in place including price controls through excise and GST applied to alcoholic products and advertising controls.

There is a large body of research, showing that in countries where substantial alcohol deregulation has occurred, increasing alcohol availability has resulted in increased risky drinking, assault rates, child maltreatment, drink-driving, car crashes and hospital admissions.[58,59,60,61,62,63,64,65]

As mentioned above, Australia has implemented a range of measures to reduce alcohol-related harm, including liquor licensing and service regimes, education programs to raise awareness about the dangers of harmful drinking, drink driving campaigns combined with law enforcement initiatives such as random breath testing, responsible service of alcohol training programs, and a range of prevention, early intervention and treatment programs.

Price control measures are shown to reduce heavy drinking and alcohol related harm, as those who consume higher amounts of alcohol pay more.[66] A number of Australian and international reports suggest raising the price of the cheapest forms of alcohol by setting a minimum floor price will have a significant impact on risky drinking.[67] Floor prices have been shown to reduce the proportion of young people who are heavy drinkers, to reduce underage and binge drinking, to delay intentions among younger teenagers to start drinking and to slow progression towards drinking larger amounts.[68]

Owing to the nature of such measures, such policy proposals affect all consumers, including the majority of the population that does not drink at levels that put them at risk of disease or injury.

In relation to advertising, evidence shows that both the content and context of alcohol promotion and the frequency of media exposure can have an impact on attitudes and behaviours.[69] There is a strong association between exposure to alcohol advertising and young people's drinking.[70]

Alcohol advertising in Australia is regulated under several intersecting codes and overseen at varying levels of responsibility where issues of content, platform and placement are dealt with separately. The operation of these codes, in part, aims to protect minors from exposure to alcohol products. The relationship between alcohol advertising and sponsorship of sporting events is another issue that is raised in discussions relating to exposure of young people to alcohol advertising.

The new focus on social media and digital marketing presents differences in terms of regulatory and health promotion responses and the potential risks for exposure to alcohol advertising by minors. This will be an issue that is monitored closely over the lifespan of the Strategy.

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

Relevant indicators of change:

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

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

POLICY OPTIONS

OBJECTIVE 1 Strengthen controls on access and availability

	Responsibility
Improved awareness and enforcement of secondary supply legislation (and consideration for nationally consistent approach).	Shared
Interupt illegal importation.	Shared
Effective policing and enforcement, including test-purchasing which allows police officers to identify licensed premises including supermarkets selling alcohol to under 18s.	States and Territories
Review duty free restrictions.	Shared
Licensing procedures that consider known factors for risks and harms, drawing on local evidence and local community views.	States and Territories
Registration and accreditation of licensees and key support staff, including minimum skills/ knowledge assessment.	States and Territories
National standardisation of Responsible Service of Alcohol requirements.	States and Territories
Build the capacity of local community stakeholders to contribute to liquor licencing processes.	States and Territories and local government

POLICY OPTIONS

OBJECTIVE 2 Pricing and taxation reforms to reduce risky alcohol consumption

	Responsibility
Introduction of a minimum floor price for alcohol.	States and Territories
Direct revenue from alcohol taxation towards preventive health activities (including a focus on alcohol-related harm) and alcohol and other drug treatment services.	Commonwealth
Taxation reforms such as volumetric taxation.	Commonwealth

POLICY OPTIONS

OBJECTIVE 3 Minimise promotion of risky drinking behavious & other inappropriate marketing

	Responsibility
Implement measures to reduce alcohol advertising exposure to young people (including online).	Shared
Measures to prevent inappropriate promotion of discounted/low priced alcohol.	Shared
Effective controls on alcohol promotion to protect at-risk groups including youth and dependent drinkers.	Shared
Promotion of measures that support changing individual and community attitudes towards excessive alcohol consumption.	Shared
Extend the single national advertising code to cover placement and content across all media which provides consistent protection of exposure to minors regardless of programming.	Commonwealth

PRIORITY 3:

SUPPORTING INDIVIDUALS TO OBTAIN HELP AND SYSTEMS TO RESPOND

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

Treatment is an important part of reducing the harm from alcohol use, recognised by the release of the *United Nations Sustainable Development Goal 3.5*, to *'Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol'*.[71] Effective treatment includes outpatient, inpatient and community based treatment services, as well as medication assisted treatment for alcohol dependence. An effective alcohol treatment sector includes government, non-government and private services, and relies on a knowledgeable and engaged primary care sector.[72] This Strategy affords an opportunity to contribute to this goal by ensuring treatment coverage consistent with the treatment coverage of other health conditions and prevention efforts in line with the harm experienced in Australia.

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

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

Technology can be a key driver in providing brief interventions and information about access to other services, with the ability to respond when a person decides to seek help in a timely manner. These initial contacts can be anonymous, quick and triage the person to the best available help in the moment they are seeking it. Such interventions can play an important role in encouraging a person to make changes to reduce their alcohol consumption. Tools such as the ASSIST-BI[73] (an easy to follow and evidence-based screening and brief intervention program) could be expanded and adapted for particular professional groups and promoted widely as an evidence based approach to screening and providing brief interventions.

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

The provision of high quality alcohol-related harm and risk information is particularly important during pregnancy and breastfeeding. Supporting women to avoid alcohol can reduce the risks of long term damage to the developing baby. Significant work has been done to develop resources for health professionals and the specialist alcohol and drug sector, including the *Australian Diagnostic Guide for FASD*,[74] and best practice resources for alcohol and drug dependent women for example, *Women Want to Know*.[75] Further work is required to disseminate appropriate resources, provide adequate training and have alcohol consumption conversations as part of standard practice in the antenatal setting. In addition, as almost half of all pregnancies in Australia are unplanned, it is imperative that health professionals ask patients about alcohol consumption prior to pregnancy awareness when unintended exposure to alcohol is common.[76]

Services and support for adults with alcohol-induced brain injury (including FASD)[77] is an important component of the health care and social services response.

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

Relevant indicators of change:

- **Alcohol during pregnancy:** Proportion of pregnant women consuming alcohol during their pregnancy
- **Alcohol attributable deaths:** Age standardised population rates (per 10,000) of alcohol-attributable deaths for adults (15+ years)
- **Proportion of people with alcohol dependence:** Proportion of people who complete an episode of care where alcohol is identified as the primary drug of concern.

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

POLICY OPTIONS

OBJECTIVE 1 Promote use of evidence-based information and support services

	Responsibility
Centralise information on alcohol-related referral services and programs to support improved referral processes in primary healthcare.	Shared
Implement evidence-informed digital-health options with particular attention to reaching those who would not normally access treatment.	Shared
Strengthen partnerships and communication between services to support early identification of problems and ensure treatment and ongoing care, including between alcohol treatment child protection and family violence services; and detoxification and rehabilitation and aftercare services.	Shared
Implement parenting support programs (such as the positive parenting program and nursing mother home visit programs) and develop information and support services for alcohol-dependent parents, especially of new-borns, to reduce parental alcohol consumption and improve child development prospects.	Shared
Encourage General Practitioners' engagement in the Medical Management of People with alcohol dependency.	Shared
Improve the frequency and quality of screening and opportunistic interventions for risky alcohol consumption, including through promotion and training of the ASSIST-BI.	Shared
Provide further education and training to health and other professionals for the treatment of alcohol problems.	Shared

POLICY OPTIONS

OBJECTIVE 2 Deliver a quality, responsive, safe and effective treatment system	Responsibility
Increase screening, assessment, referral and treatment in primary health care settings and coordination between primary care acute and specialist services.	Shared
Expand the range of intervention options from brief and early interventions through to withdrawal management, psycho-social interventions, residential rehabilitation, community care and aftercare programs.	Shared
Implement settings based approaches to identifying, screening, assessment, brief interventions and referral to minimise alcohol-related problems (for example, sexual health services, needle syringe programs, maternity, mental and community health, justice health services).	Shared
Ensure specific services for people with severe alcohol and other drug problems are available.	Shared
Enhance the capacity of generalist healthcare, community, welfare and support services.	Shared
Implement tailored interventions across a range of health care settings including more investment in detoxification and rehabilitation services for individuals who cannot be treated in the community.	Shared
Improve availability of effective psychosocial treatment (such as counselling, cognitive behaviour therapies, etc) and social approaches including employment and housing programs.	Shared

POLICY OPTIONS

OBJECTIVE 3 Implementation of *National FASD Strategic Action Plan*	Responsibility
Implementation of the *National FASD Strategic Action Plan.*	Shared
Improve FASD prevention through community awareness, and improved FASD detection,diagnosis and access to therapy	Shared
Increase awareness of the full range of treatment options for women at risk, including outpatient counselling and relapse prevention medicines for dependence.	Shared
Promote harms to developing baby as a result of maternal alcohol consumption in school and university curricula.	Shared
Disseminate, promote and provide training to support the use of established resources.	Shared
Improve access to support services, including through the National Disability Insurance Scheme.	Shared

PRIORITY 4:
PROMOTING HEALTHIER COMMUNITIES

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

However, there is currently poor understanding and awareness among the population in relation to risky alcohol consumption. In 2016, 32% of males and 9.1% of females thought they could drink three or more drinks every day (exceeding the lifetime risk of harm guidelines) without putting their health at risk.[78]

Regular repetition of evidence-informed messages will, over time help to create the groundswell for positive changes to attitudes and a cultural shift towards healthier and lower risk alcohol consumption behaviours. It is important to encourage consistent messaging across all media in relation to the harms of alcohol.

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

There is evidence to suggest that Australians are already open to the idea of needing to address their alcohol consumption as part of a healthier lifestyle. Almost half (48%) of recent drinkers (consumed at least 1 serve of alcohol in last 12 months) took action to reduce their alcohol intake in 2016 and the main reason for doing this was due to concern for their health.[79]

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

Relevant indicators of change:

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

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

POLICY OPTIONS

OBJECTIVE 1 Improve the awareness and understanding of alcohol harms

	Responsibility
Support the NHMRC's *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* to provide the highest standard of evidence-informed guidelines for health professionals, policy makers and the Australian community on reducing health risks associated with drinking alcohol.	Shared
Once finalised, promote and translate key messages of the revised NHMRC guidelines to support informed decisions about alcohol consumption, and promote better public understanding of alcohol-related harms.	Shared
Further educate Australians about safe drinking, including in relation to health impacts of excessive drinking (e.g. links with cancer, liver disease, violence and injury, weight gain, chronic diseases, substance dependence and mental illness).	Shared
Improve capacity of communities to identify, prevent and minimise alcohol-related harm through evidence-based activities.	Shared
Develop guidelines and information on alcohol-related harm for older Australians.	Shared
Development of public health campaigns promoting the risks and harms associated with alcohol consumption.	Shared

Implement evidence based secondary-supply programs to reduce underage drinking.	Shared
Promote measures that facilitate and encourage cultural change by shifting attitudes towards excessive alcohol consumption and promoting messages of moderation or abstinence.	Shared
Update and implement the *National Guidelines for the Treatment of Alcohol Problems.*	Commonwealth

POLICY OPTIONS

OBJECTIVE 2 Improve communication to target groups	
	Responsibility
Targeted communications to promote healthy behaviours which are informed by the evidence of what works to at-risk groups.	Shared
Improve availability of point-of-sale information on risks of harmful consumption.	Shared
Promote the national online portal of alcohol related health information for parents, students, teachers and community organisations (www.positivechoices.org.au).	Shared
Implement health-related warning labels such as pregnancy warning labels.	Commonv

GOVERNANCE

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

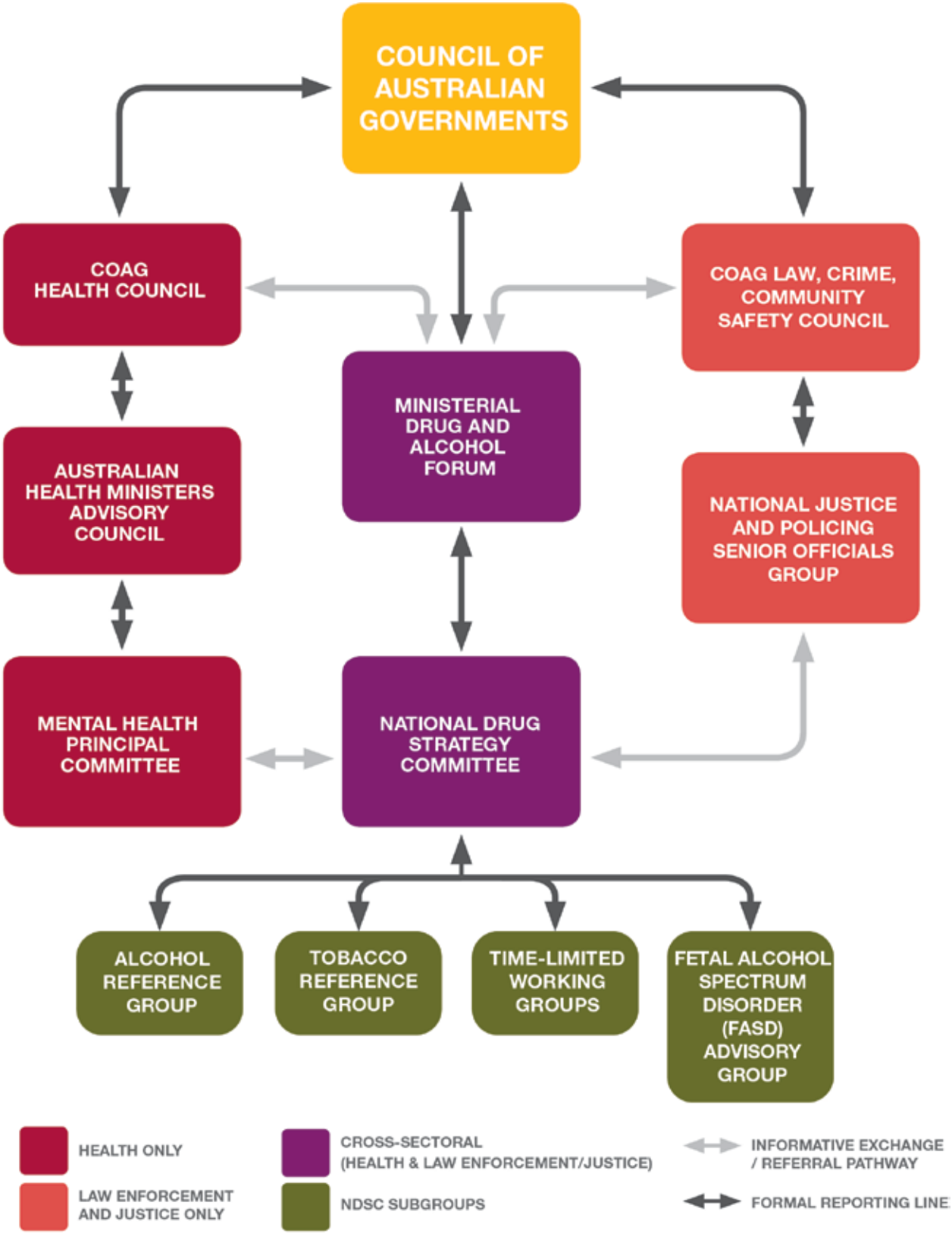
As a sub-strategy of the *National Drug Strategy 2017–2026*, this Strategy is overseen by the Ministerial Drug and Alcohol Forum (MDAF) which is supported by the National Drug Strategy Committee (NDSC).

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

A key action of this Strategy is the establishment of a new Reference Group within the *National Drug Strategy 2017–2026* governance framework. The updated governance arrangements are depicted in the diagram on the following page.

While the membership and terms of reference will be determined by the MDAF, it is expected that the new Reference Group will be responsible for:

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



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

MONITORING PROGRESS

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

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

In acknowledging that responsibilities for alcohol policy extend across all levels of government and across portfolios, the MDAF will work closely with other COAG structures and responsible Ministers to ensure a coordinated and whole-of-government approach in overseeing and monitoring progress of the Strategy.

Measures of Success

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

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

Indicator	Baseline (%)	Data Source/s
Lifetime risk: Proportion of people exceeding the NHMRC guidelines for lifetime risk	17.1 14.7	NDSHS NATSISS
Single Occasion risk: Proportion of people exceeding the NHMRC guidelines for single occasion risk	25.5 30.1	NDSHS NATSISS
Very high alcohol consumption: Proportion of population consuming 11 or more standard drinks at least monthly	24.8 (12+)	NDSHS
School children: Proportion of school students (aged 12–17) who drank more than 4 drinks on one day in past seven days	5.6	ASSAD
Age first tried alcohol: Average age at which young people aged 14–24 first tried alcohol	16.1	NDSHS

Indicator	Baseline (%)	Data Source/s
Alcohol during pregnancy: Proportion of pregnant women consuming alcohol during their pregnancy	34.7 9.8	NDSHS NATSISS
Emergency Department (ED) presentations: Estimated rates of alcohol-related ED presentations on Friday, Saturday and Sunday nights per 1,000 persons	9.07 2011–12	NAIP
Alcohol-attributable assault hospitalisations: Age standardised population rates (per 10,000) of alcohol-attributable hospitalisations for adults (15+ years)	11.4 2012–13	NAIP
Alcohol-related offence data including violence and motor vehicle accidents	*Various*	State and territory governments
Experience of alcohol-related incident	21.8 (12+)	NDSHS
Alcohol attributable deaths: Age standardised population rates (per 10,000) of alcohol-attributable deaths for adults (15+ years)	3,143 (2005)	NAIP
Total alcohol consumption per capita	9.7L (2015–16)	ABS apparent consumption
Proportion of people with alcohol dependence receiving treatment	*TBC*	ABS, PBS and National Minimum Dataset of treatment

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

The *Australian guidelines to reduce health risks from drinking alcohol* (the Guidelines), overseen by the NHMRC were developed following extensive reviews of national and international evidence.

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

The Guidelines are currently (at the time of writing this Strategy) being reviewed and are due to be published in 2020. This section of the Strategy will be updated when the new guidelines have been finalised. The 2009 guidelines are summarised below for reference and to clearly articulate risky and harmful drinking as defined in this Strategy.

The Guidelines state:

GUIDELINE 1 **Reducing the risk of alcohol-related harm over a lifetime**	For healthy men and women, drinking **no more than two standard drinks on any day** reduces the lifetime risk of harm from alcohol-related disease or injury.
GUIDELINE 2 **Reducing the risk of injury on a single occasion of drinking**	For healthy men and women, drinking **no more than four standard drinks on a single occasion** reduces the risk of alcohol-related injury arising from that occasion.
GUIDELINE 3 **Children and young people under 18 years of age**	For children and young people under 18 years of age, **not drinking alcohol is the safest option**.
GUIDELINE 4 **Pregnancy and breastfeeding**	For women who are pregnant or planning a pregnancy, **not drinking is the safest option**. For women who are breastfeeding, **not drinking is the safest option**.

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

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

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

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

Harm Minimisation

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

Demand Reduction

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

Supply Reduction

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

Harm Reduction

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

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

DEMAND REDUCTION

Approach	Strategies
Price mechanisms	✔ Excise tax increases
	✔ Volumetric excise tax
	✔ Minimum floor price
	✔ Regulate price discounting and bundling
Build community knowledge and change acceptability of use	✔ Social marketing strategies, including campaigns, as part of a comprehensive response
	✔ Evidence based secondary supply programs
	✔ Promotion of National Health and Medical Research Council's Australian Guidelines to Reduce Health Risks from Drinking Alcohol
Restrictions on promotion	✔ Enforced advertising standards and restrictions
	✔ Regulate price promotion
	✔ Regulate promotion at point of sale
	✔ Regulate promotions in key settings, such as those aimed at young people
Treatment	✔ Outpatient, inpatient and community based treatment services
	✔ Medication assisted treatment for alcohol dependence
	✔ Family-support programs that can positively impact on patterns of drug use (including intergenerational patterns)
	✔ Post treatment support programs to reduce relapse

SUPPLY REDUCTION

Approach	Strategies
Regulating retail sale	Retail licensing schemes supported by strong enforcement and retailer education Coordinated medication management system
	Restricting the type of retailers or venues that can sell
	Limiting the density of licensed retailers and venues
	Limiting trading hours
	Responsible alcohol service schemes
	Liquor licensing restrictions
	Detect and disrupt sales of prohibited products
	Declaration of dry communities
	Lower strength alcohol sale requirements
Age restrictions	Ban sale to people under 18
	Secondary supply restrictions
Border control	Interrupt illegal importation and enforce payment of excise tax
	Duty free restrictions
Regulating or disrupting production and distribution	Regulating production
	Regulating wholesaler distribution
	Detect and disrupt illegally produced products

HARM REDUCTION

Approach	Strategies
Safe transport and sobering up services	Access to public transport
	Mobile assistance patrols
	Sobering up facilities
Safer settings	Cessation of sales at earlier times
	Lock out times
	Promotion of responsible venue operations
	Dry areas
	Mandatory plastic glassware in high risk venues
	Availability of free water at licensed venues
	Lock out times
	Emergency services responses to critical incidents
	Maintenance of public safety

Endnotes

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All information in this publication is correct as of January 2019