

Draft National Alcohol Strategy 2018-2016: Submission concerning goals and monitoring progress (measures of success).

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Main points of this submission:

1. The Strategy should set detailed and ambitious goals, including reducing rates of specific alcohol-related harms; the overall target set out in the Draft Strategy is neither specific nor ambitious enough.
2. Measures to monitor progress should relate as directly as possible to the goals. Measurement of alcohol-related harms needs substantial improvement.
3. The Strategy's goals should include a 20% reduction in each of several main indicators of harmful drinking. In the early period of the Strategy, better and more complete measures of alcohol-related harms should be set, including harms to others besides the drinker, and on that basis ambitious goals should be set for reducing rates of specific alcohol-related harms.
4. There is thus a substantial need for the new alcohol strategy to invest substantial effort in building a monitoring and evaluation effort which can meet these needs.

This submission concerns the Consultation draft of the National Alcohol Strategy 2018-2026. Thank you for the opportunity to provide a submission concerning this. This submission is offered on behalf of the Centre for Alcohol Policy Research (CAPR), the only Australian research centre specifically focused on research relevant to alcohol policy. In addition to this submission, CAPR supports the submission prepared by the National Alliance for Action on Alcohol (NAAA) and the Foundation for Alcohol Research and Education (FARE).

After seven years without a National Alcohol Strategy, CAPR is pleased to see that the Ministerial Drug and Alcohol Forum (MDAF) has released the Consultation Draft for public consultation. It is also pleasing to see that the Consultation Draft has incorporated feedback from the public health and community sectors, largely aligns with a number of international strategies, and includes evidence-based measures that have been proven to be effective in preventing and minimising alcohol harm.

However a strategy is only as effective as its implementation. While the Consultation Draft provides a good summary of the evidence and outlines evidence-based "opportunities for action", it lacks

detail on implementation, and does not provide clear measurable targets and goals. Without clear priorities, commitments, timeframes and accountability mechanisms, a new National Alcohol Strategy will not succeed in substantially reducing either harmful alcohol consumption or alcohol-related social and health harms.

In particular, the Strategy needs to have clear targets and goals, and there needs to be provision for regular measurement of indicators of progress towards the targets. This submission comments only on these aspects of the Strategy: the targets, indicators and the proposed measures of success of the Draft Strategy, and proposes that the final strategy include a detailed plan to improve the measurement of success or otherwise of the Strategy.

1. The Strategy should set detailed and ambitious goals, including reducing rates of specific alcohol-related harms; the overall target set out in the Draft Strategy is neither specific nor ambitious enough.

The “consultation draft” of the National Alcohol Strategy 2018-2026 (Department of Health, 2017) lays out only one overall goal, as follows:

Targeting a 10% reduction in harmful alcohol consumption.

- alcohol consumption at levels that puts individuals at risk of injury from a single occasion of drinking, at least monthly.
- alcohol consumption at levels that puts individuals at risk of disease or injury over a lifetime. (p. 2)

This target is specified on an introductory summary page, “National Alcohol Strategy 2018-2026 at a glance”, and does not appear again in the document. The target of a 10% reduction appears to follow the lead of the goal for alcohol in WHO’s Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020 (WHO, 2013). It should be noted that this NCD strategy is only concerned with alcohol as a risk factor for chronic illness in the drinker, and not with alcohol’s other harms in terms of injuries and social harms, including harms to others. These other harms will be at least as much targets for improvement in an Australian strategy as chronic illness among risky drinkers. Also, the 10% goal is a notably less ambitious goal than those that the WHO’s Plan sets for other major NCD consumption risk factors: “a 30% relative reduction in prevalence of current tobacco use among persons aged 15+”, and “a 30% relative reduction in mean population intake of salt/sodium” (WHO, 2013, p. 5).

The Australian draft strategy offers a specification of what it means by “harmful alcohol consumption” in terms apparently linked to the first two “low-risk drinking guidelines” of the 2009 NHMRC Low-Risk Drinking Guidelines (NHMRC, 2009), although those guidelines do not specify “at least monthly” as the boundary which is above the limit for single-occasion drinking. But, curiously, the draft Strategy does not specify the actual number of drinks which are the limits for staying within the guidelines, although the rates cited as baseline “measures of success” on p. 26 are clearly referring to the NHMRC limit of not above two drinks per day average for the lifetime-risk limit and four drinks on a single occasion for the risk of injury limit. And it does not specify how the “10% reduction” should be distributed between the proportion averaging more than 2 drinks per day and the proportion which drinks more than four drinks on an occasion at least monthly. It should also be noted that the Australian low-risk drinking guidelines are a relevant set of criteria for setting limits with respect to harmful alcohol consumption, but are explicitly oriented to health harms to the drinker, and do “not take into account the consequences of drinking on others” (NHMRC, 2009, p. 9).

But drinking four drinks on an occasion, for instance, is a bad choice if one is planning to have to drive a vehicle afterwards.

The 10% reduction -- even as a goal which is further specified so there is a clear criterion for what would constitute success -- is not ambitious by the standards of other public health goals for optional behaviour which entails risks -- as illustrated above concerning the WHO Action Plan for NCDs. And in the way the Australian draft strategy formulates it, progress toward the goal can only be directly monitored from population survey data -- it cannot be monitored, for instance, from sales data, which does not capture patterns of drinking. General population self-reports of consumption routinely understate actual consumption, and the degree of understatement may vary across time -- which raises a further problem in using it in monitoring. The 2013 NDS Household Survey, for instance, accounted for only 53% of alcohol sales -- a coverage rate that had dropped four percentage points since 2001 (Livingston, 2015).

And even if the target is met somehow, it would not necessarily mean that rates of alcohol-related harm had declined. In recent Australian experience, alcohol consumption rates have fallen while some rates of alcohol-related harm have risen (e.g., Livingston et al., 2010). As this suggests, there are potentially strategies to reduced rates of a particular alcohol-involved harm other than by reducing the amount of drinking, and such "harm reduction" strategies which are effective should be part of a national alcohol strategy. Thus a strategy "to prevent and minimise alcohol-related harms" (Draft Strategy, p. 4) needs to specify reductions in alcohol-related harms as well as in patterns and levels of alcohol consumption.

Scattered through the document (pp. 15, 17, 20, 23) are a number of "relevant indicators of change", shown in Table 1. These indicators are revisited with minor variations (see Table 1) on pp. 26-27, under the heading "Monitoring progress". However, the draft strategy does not propose any specific goals for reduction of these indicators over its nine years.

2. We propose that the strategy have a wider and more ambitious set of goals for reducing harmful use of alcohol for its nine-year course.

(a) A goal of a 20% reduction from the 2017 levels should be set each of the three main indicators of drinking from self-report surveys:

- **the lifetime risk measure (percentage of those aged 15+ averaging more than two standard drinks per day),**
- **the single occasion risk measure (percentage of those aged 15+ at least once a month exceeding 4 drinks on an occasion), and**
- **the very high alcohol consumption measure (percentage of those aged 15+ consuming 11 or more drinks on an occasion at least monthly).**

The 20% reduction would also be a goal for change in total alcohol consumption per capita, as reflected in ABS statistics derived primarily from alcohol sales figures.

(b) An important part of the Strategy in its first years should be a double commitment with respect to goals for alcohol-related harm, including harms to others as well as to the drinker: (i) to update estimates for existing indicators and estimates of alcohol-related harms to allow for regular measurement from the initial years of the period 2018-2026; (ii) to develop better and more complete measures of alcohol-related harms for application in the latter part of the period, and to organise and coordinate data collection for these measures which will be comparable nationally. This part of the Strategy will require the provision of funding and other resources, starting early in the strategy period, for these efforts.

Table 1. Indicators for monitoring progress included in the draft alcohol strategy
(putting together the listings on pp. 26-27 and on pp. 15, 17, 20, 23 of the draft strategy)

Alcohol-related harm indicators:

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

Alcohol consumption indicators:

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

Dependence treatment coverage indicator:

- * **Proportion of people with alcohol dependence** receiving {treatment}/medical management.
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Key to Table 1:

{ } wording on pp. 26-27 (varying from wording in earlier lists).

* rate imputed from agency statistics, # survey-based rate, + based on alcohol sales data

Thus a crucial step in reformulating the Strategy is to include in it, as a specific budgeted task, rebuilding the system of measures to monitor progress. As an interim step, measures should be identified which can already be measured for 2017 or 2018. One of the goals of the Strategy needs to be to rebuild the monitoring system by developing new measures to be instituted in the first years of the Strategy period.

As discussed below, the problem with many of the indicators of alcohol-related harm is that the alcohol involvement in the harm is not routinely and uniformly collected in the records of Australian Emergency Departments, police, and other health and social response agencies, and is currently often estimated indirectly. Trends in such indirect estimates may reflect changes in factors other than alcohol involvement. Since it is the health and social harm from drinking that is the primary concern of an Alcohol Strategy,

3. Measures to monitor progress should relate as directly as possible to the goals. Measurement of alcohol-related harms needs substantial improvement.

The current system of measuring trends in alcohol-related harm for Australia and its jurisdictions is not fit for purpose. In the early 2000s, federal funding of the National Alcohol Indicators Project (NAIP) was a good start to developing a monitoring system. But specific funds for this purpose have dropped away, so that the NAIP does not have the resources to make further progress. There is also a need to face the issue of how the various governmental agencies which must cooperate in order to agree on and collect common measures are to be brought to the table. These agencies extend well beyond the jurisdiction of the departments included in the governance and structure of the Strategy as depicted in the draft Strategy (pp. 24-25).

While there are some issues also with the measures of alcohol consumption, the primary focus of new work needs to be on the measures of alcohol-related harms. We start with a description and critique of the five indicators of alcohol-related harms noted on pp. 26-27 of the Draft Strategy. The basic story here is that there is no ongoing compilation of these statistics, so that instead of the “baseline year” for a strategy being at its start in 2017 or 2018, the proposed baselines mentioned on pp. 26-27 vary and are currently several years out of date. The outdatedness is thus not simply a matter of routine delays in statistical compilation; it often reflects that there is no routine updating of a particular estimate, and that resources for this will need to be provided as part of the Strategy.

- For “Emergency Department (ED) presentations”, the “baseline year” specified in the draft Strategy is 2011-2012. This is the year reported in the most recent NAIP report on this measure (Lensvelt et al., 2015). This NAIP Bulletin used emergency department case records from all Australian jurisdictions except Tasmania and Western Australia (though Perth is included), and estimated alcohol-involved rates on the basis of ICD codes for injury as the primary diagnosis (in NSW, a free-text “presenting problem” instead of a primary diagnosis). The indicator of “alcohol-involved” was if the case came in on a weekend night (Friday and Saturday nights 22.00-03.59, Sunday night 18.00-23.59); these times of the week have been shown to be “high alcohol” hours. There is thus no direct measurement of any alcohol involvement in the injury.

This measure has a fairly long history in Australia, but it is rather problematic. To designate all cases on weekend nights as alcohol-related, and none at other times, is a rather heroic assumption. To use such a measure to chart trends over time assumes a great deal of stability in the degree of concentration of alcohol-involved cases on weekends, and in the ratio of alcohol-involved to other weekend cases. The historical reason for the lack of an alternative is that ED recording systems typically did not record the involvement of alcohol. But there have been codes in ICD to do this recording for several decades, and such codes have been increasingly used in Australian EDs. A new direct-recording indicator and system for collecting and aggregating it needs to be worked out, operating alongside the current indicator until the

new system operates acceptably, with the old system kept at least a little while longer to allow calibration of trends across the change.

- For “alcohol-attributable assaults”, the baseline year specified by the draft Strategy is 2012-2013. This is the estimation year in the relevant NAIP bulletin (Lensvelt, 2016), which relies heavily on the methods used by English et al. in their landmark 1995 publication, which was to apply a constant “alcohol-attributable fraction” (47%, as estimated by English et al., 1995) to the total of hospital admission which have an assault ICD code (X85-Y09) assigned in the record.

There has been substantial relevant further work on measuring the alcohol-attributable fraction for assault since English et al., including relevant Australian studies, which should be drawn on.

Drawing on police records (e.g., Briscoe & Donnelly, 2001), ambulance records, and on survey responses (e.g., ABS, 2013) for data in this area should also be investigated.

- For “alcohol-related offence data”, “various” is given rather than a year concerning when the baseline will be, reflecting that there is no Australia-wide compilation for these police-derived statistics. There is a strong need to develop this area of monitoring so that there is more complete and comparable data across Australia. There is considerable work to draw on here, for instance from NSW’s BOCSAR; the challenge will be to extend this kind of measurement and estimation nationwide.

Apart from motor vehicle and other traffic accidents and street violence, attention needs to be paid to developing statistical series on alcohol involvement in domestic violence (see, e.g., Miller et al., 2016).

- For “alcohol-attributable deaths”, the baseline year is 2005, the year reported on in the most recent relevant NAIP bulletin (Pascal et al., 2009). This bulletin relies heavily on a previous NAIP Bulletin (No. 1, published in 1999), which in turn credits (although with a few adjustments) the landmark publication by English et al. (1995). A more up-to-date estimation, in terms both of datasets used and of updated methods and estimated attributable fractions, is available from 2014, using data from 2010 (Gao et al., 2014). The methodology, refined in studies of risk factors in the burden of disease, applies age- and gender-specific “alcohol-attributable fractions” (AAFs) to deaths according to what is recorded as the primary cause of death; the AAFs are primarily based on meta-analyses of longitudinal epidemiological studies which measured alcohol consumption at a baseline and then recorded and analysed deaths in a follow-up period. Such a method assumes the AAF does not vary between societies or historic time-periods; for some causes of death, notably from injuries, this assumption is questionable. In terms of indicators for the National Strategy, it can be argued that a disaggregated measures would be more accurate and informative. One step might be to separate injuries from chronic diseases. Further distinctions by diseases categories should be considered.

Below are comments on two further indicators from the list in Table 1.

- “Experience of alcohol-related incident” is attributed to the National Drug Strategy Household Survey, with a baseline prevalence of 21.8% for the population aged 12+. This appears to come from Table 4.44 of the 2016 survey (see Data Tables Chapter 4 at AIHW, 2017). It reflects the

proportion of respondents aged 12+ who answered “yes” to having been verbally abused, physically abused, or put in fear by “any person under the influence of or affected by alcohol” in the previous 12 months. This indicator is valuable in that it has been collected every three years since well before the new Strategy period, but it is quite minimal in terms of measuring harms from others’ drinking, on which there has been substantial progress in Australia in recent years (Laslett et al., 2010; Callinan et al., 2016). Other potential existing indicators and potential new indicators should be developed, to give a more thorough measurement of harms to others from drinking, including harms beyond the limited scope of assaults and traffic injuries.

- **“Proportion of people with alcohol dependence receiving {treatment}/medical management”** is not well thought through as an indicator in the draft. While the other indicators nominated all have to do with drinking behaviour and associated problems, this indicator is presumably aimed at measuring the performance of treatment systems in “covering” treatment demand (though it should be noted that the drinker does not necessarily want such treatment). Australia has a specific AOD treatment system which treats cases with alcohol and drugs problems (for a small portion of the caseload, the problems are with others’ drinking or drug use). The population receiving treatment and advice from this system is heavily weighted towards marginalised persons with multiple problems, often ill-housed, alienated from their family, and not regularly employed. The National Minimum Dataset of treatment primarily measures the clientele of this system. Usually the clientele is divided on the basis of the “primary drug” for which they are admitted, but this is likely to underestimate those with alcohol-related problems, since the illicit status of other drugs often results in them being prioritised. The general health systems – both at the hospital level and in medical and psychiatric practices – also have substantial involvement in providing care and advice to those whose drinking may be classified as harmful. As the clinical research literature has developed, it has moved away from “dependence” as a suitable criterion for those who need or would benefit from clinical advice or intervention concerning their drinking. Frequently, a level or pattern of drinking or an AUDIT score is specified as the criterion against which to measure how well the health and welfare systems are “picking up” and providing assistance to those who are drinking too much (e.g., Babor et al., 2007; Rathod et al, 2016). Work needs to be done on choosing measures of how well the specialised treatment system and the general health system cover the populations of problematic drinkers (and members of their families) who would benefit from advice or treatment concerning their drinking and associated problems, and on developing ways in which such measurements can be done comparably on a national basis.

4. As discussed above, the list of indicators in the Consultation Draft have a number of problems, and do not adequately cover and measure the full range of alcohol-related harms to be addressed by the Strategy. **There is thus a substantial need for the new alcohol strategy to invest substantial effort in building a monitoring and evaluation effort which can accomplish this.**

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