APSAD

14 February 2018

Ministerial Drug and Alcohol Forum
c/- Commonwealth Department of Health
By email to nationaldrugstrategy@health.gov.au

**Re: Submission on the Consultation Draft of the National Alcohol Strategy 2018-2026**

Thank you for providing an opportunity for APSAD, the Australasian Professional Society on Alcohol and other Drugs, to comment on the Consultation Draft.

APSAD is the Asia Pacific's leading multidisciplinary organisation for professionals involved in the alcohol and other drug field. In addition, we strive to promote improved standards in clinical practice and in research into this and allied subjects. APSAD is dedicated to promoting improved standards in clinical practice for medical practitioners and other health professionals who deal with alcohol and other drug-related problems in the course of their work and is also involved in promoting population health, particularly as it relates to preventive interventions concerning alcohol, tobacco, pharmaceutical products and illicit drugs. It also provides a network of alcohol and other drug professionals in Australia, New Zealand and the Asia Pacific.

Through its internationally recognised scientific journal, the *Drug and Alcohol Review*, and its annual Scientific Conference, APSAD provides a forum for the latest research on the nature, prevention and treatment of physical, psychological and social problems related to the use of psychoactive substances.

APSAD currently has 310 members across Australia and around the world. The Society has particularly strong links with New Zealand and the Asia Pacific region. Our members represent a wide range of professional disciplines including general practitioners, nurses, physicians, psychologists, medical researchers, pharmacists, policy advisors, psychiatrists, educators, counsellors, social/behavioural researchers, administrators, and public health experts.

Rather than address the many components of the draft Strategy, this submission focuses on areas that best reflect APSAD's membership and the Society's key roles, namely

- Information systems and monitoring
- Treatment systems and treatment policy research
- The governance of the Strategy.

**Information systems and monitoring**

The stated aim of the Strategy is to prevent and minimise alcohol-related harms, and the single quantitative target proposed is a 10% reduction in alcohol consumption over the nine-year life of the Strategy. As those who drafted the Strategy would be aware, reducing per capita consumption does not necessarily reduce many significant types of alcohol-related harms. For some years Australia has experienced the phenomenon of falling per capita alcohol consumption accompanied by increasing levels of some types of alcohol-related

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harms as evidenced, for example, by the incidence of hospital emergency department presentations[1]. An implication of this is that a single quantitative target that focuses only on population-level per capita consumption, while valuable, is inadequate. Other feasible targets and robust indicators are needed that deal more directly with alcohol-related harms.

*Since the link between reducing alcohol consumption and reducing harms is multifaceted, we believe that substantial work should be done, in the first years of the Strategy, and as part of the Strategy, to develop far more coherent and effective indicators of alcohol-related harm, and more sophisticated indicators of alcohol consumption, than we currently have available*.

Current data sources, and many of the baseline indicators set out in the draft Strategy, are inadequate for the task. For example, APSAD understands that NDRI's National Alcohol Indicators Project is not funded separately from the Institute's core funding, which partly explains the relatively small volume of products from it, and their lack of timeliness - though we note the very high quality of the NAIP products. New funding will need to be allocated to develop and create more effective and sophisticated indicators for monitoring the progress of the Strategy. Furthermore, it will be necessary to amend the indicators set out in the current draft once the products of the indicator development work become available.

APSAD also suggests that the 10% reduction in alcohol consumption is too modest a target for a nine-year strategy. It could be appropriate, however, to have this as the midpoint target and, at that point, develop a new target for the out-years.

In many places in the draft Strategy, it is difficult to understand the basis upon which the suggested indicators have been selected. We doubt that the core work in this type of strategy development - mapping the indicators to the goals - has been conducted. It has certainly not been documented in the consultation draft. With respect to all four Priority areas, the listed 'Relevant indicators of change' are, in many cases, not directly relevant to monitoring and evaluating the stated goals and objectives. For example, with respect to Priority 1 'Improving community safety and amenity', with its objective of 'Better offender treatment and rehabilitation', none of the listed 'Relevant indicators of change' deal in any way with offender treatment and rehabilitation. Examples could be given of this problem in each of the four Priority areas. Furthermore, no information is given in the chapter on 'Monitoring progress' (pp. 26-7) on how the listed indicators relate to the stated goals and objectives. The rationale for their selection is opaque.

***Treatment systems and policy research***

For decades Australia has been punching well above its weight with respect to research in alcohol (and other drugs as well). This has been one of the outstanding achievements of the National Drug Strategy over the three decades in which it has been operating. Most of the significant alcohol research achievements have been in areas of epidemiology and treatment, and this is one of the powerful drivers of the high-quality specialist ATOD treatment services that we have in Australia. What has been largely (though not completely) lacking is well-resourced research into *alcohol treatment policy and systems* (in contrast to alcohol treatment services research). We have some outstanding examples of this type of work, including the Commonwealth Government-commissioned 'New Horizons' research conducted by DPMP at the national level[2], and the Drug Treatment Service review conducted by Turning Point, at the

[1] Livingston, M., Matthews, S., Barratt, M. J., Lloyd, B., & Room, R. 2010, 'Diverging trends in alcohol consumption and alcohol-related harm in Victoria', *Australian and New Zealand Journal of Public Health* vol. 34, no. 4, pp. 368-73.

[2] Ritter, A, Berends, L, Chalmers, J, Hull, P, Lancaster, K & Gomez, M 2014 (released Nov. 2015), *New Horizons: the review of alcohol and other drug treatment services in Australia. Final Report*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW, Sydney.

state level, some years earlier[3]. These stand out as rare examples of policy and systems research in the ATOD field.

The alcohol treatment service system lacks coherence. It has a confusing set of funding sources, resource allocation is not closely tied to needs and demands, quality assurance systems are inconsistent and of unknown efficacy, etc. Little policy and systems evaluation research is conducted. Sector governance is diffuse and opaque. This reflects, to a significant degree, the lack of policy and systems research in Australia, rather than any lack of capacity of the service delivery component of the system where excellent services are provided.

Part of the lack of coherence of the alcohol treatment service system is the diffusion of responsibilities for policy and its implementation. Responsibilities are found within the specialist ATOD sector; the mental health sector; the broader health sector including general medical practice, emergency medicine, psychology and psychiatry; the social welfare, child protection and income security sectors; etc.

Throughout its life, the National Strategies (Drug and Alcohol) have also failed to establish and implement a coherent, evidence-informed and properly resourced alcohol problems prevention agenda. One result of this is that we do not have well understood and developed systems for working upstream, in diverse sectors and inter-sectorally. All this reflects lack of investment in high-quality drug treatment and prevention policy and systems research under Australia's National Drug Strategy.

APSAD urges that the next draft of the National Alcohol Strategy include a section on strengthening alcohol policy and systems research nationally, and clarify that this will be funded as an integral part of the Strategy. Without doing so, our prevention, treatment and harm reduction service system will continue to operate in its current relatively incoherent manner.

**The governance of the National Alcohol Strategy**

APSAD is disappointed at the proposed arrangements for the future governance of the Strategy.

While we strongly support the decision to exclude drinks and related industry groups from formal roles in the governance structures and processes, we note the continuing powerful influences that those industry groups have on alcohol policy. This influence frequently leads to policy decisions that are the opposite of what high-quality Australian research has demonstrated to be necessary to reduce alcohol-related harms in this country. Examples of harmful policy decisions that have been made by governments under pressure from the liquor and related industries include refusing to reduce liquor trading hours and liquor outlet densities, and continuing to permit television advertising of alcoholic beverages, including during the hours when children are viewers. The Strategy could be strengthened by addressing these industry influences more directly, for example by a provision of the Strategy that all Australian political parties commit to ceasing accepting donations from individuals and organisations that profit from the promotion and selling of alcoholic beverages.

Another aspect of the governance arrangements that APSAD finds concerning is highlighted by the organisational chart on page 25 of the consultation draft. Every component of that chart connects to one or more other components with two-headed arrows. This should immediately raise a warning that the governance arrangements fail to assign responsibility for policy and its implementation to particular parts of the structures. Without assigning responsibility and

[3] Ritter, A, Berends, L, Clemens, S, Devaney, M, Richards, J, Bowen, K & Tiffen, R 2003, *Pathways: a review of the Victorian drug treatment service system: final report*, Turning Point Alcohol and Drug Centre, Fitzroy, Vic.

building transparency into the governance structures and processes, we end up with the situation that nobody is responsible, nor accountable, for identified aspects of policy development and implementation.

This is particularly problematic when we note that many of the interventions that research shows to be most effective in the alcohol area are the responsibilities of organisations outside of the ATOD sector narrowly-defined – and of ministries outside the health, justice and policing ministries included in the chart on page 25. Prominent examples include policy on taxation and advertising[4], and on child protection[5]. APSAD is concerned that the governance structures do not demonstrate any linkages to the people and organisations responsible for policy in these areas, nor for their accountability to the public for achieving sound health outcomes.

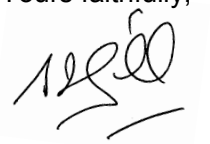
The National Drug Strategy document includes a provision that APSAD hopes will become a reality:

> It is expected that each jurisdiction will develop their own accompanying strategy action plan which details the local priorities and activities to be progressed during the Strategy lifespan[6].

APSAD suggests that the next draft of the National Alcohol Strategy includes corresponding provisions that commit the states and territories, and others responsible for implementing the Strategy, to develop alcohol action plans within their own areas of responsibility. In this context, we note and support the suggestion made by FARE/NAAA that the road safety sector (particularly at the state and territory level) provides some good models for the governance of a sector (like alcohol) where many policy actors exist, and co-ordinating their policies and actions is challenging[7]. The linked-up road safety policy efforts in Australia have been admired elsewhere as examples of what can be done in that area[8].

Thank you again for providing APSAD with the opportunity of making a submission on the consultation draft of the National Alcohol Strategy. Our Society and its members look forward to contributing further to the development and subsequent implementation of the Strategy.

Yours faithfully,



Dr Anthony Gill
**President**

[4] Babor, TF, Caetano, R, Casswell, S, Edwards, G, Giesbrecht, N, Graham, K, Grube, JW, Hill, L, Holder, H, Homel, R, Livingston, M, Osterberg, E, Rehm, J, Room, R & Rossow, I 2010, *Alcohol: no ordinary commodity - research and public policy*, 2nd edn, OUP, Oxford.

[5] Laslett, A.-M.L., Dietze, P.M., & Room, R.G. 2012, 'Carer drinking and more serious child protection case outcomes', *British Journal of Social Work*, vol. 43, no. 7, pp. 1384-1402.

[6] [Ministerial Drug and Alcohol Forum (Australia)] 2017, *National Drug Strategy 2017-2026*, Department of Health, Canberra, p. 3.

[7] http://fare.org.au/nas : 'Adopt the National Road Safety Strategy 2011-2020 frame as a model for the new National Alcohol Strategy'.

[8] International Technology Scanning Program 2006, *Halving Roadway Fatalities: A Case Study from Victoria, Australia 1989-2004*, Federal Highway Administration, U.S. Dept. of Transportation, Washington, DC, https://international.fhwa.dot.gov/halving_fatalities/halving_fatalities.pdf