BACKGROUND PAPER:

ALCOHOL & OTHER DRUGS

Author(s): Rowena Wylie
Contact Details:

Date:

TABLE OF CONTENTS

Acknowledgments

I would like to acknowledge the input and support of the following people:

- Jenny Williams (former PCP Project Officer) who undertook much of the background research for the paper
- The agencies and individuals who took part in the stakeholder consultations

1. PURPOSE & SCOPE

This paper has been prepared to provide background information on alcohol and other drugs to inform the priority setting process and development of the Southern Grampians Shire and Glenelg Shire Municipal Public Health & Wellbeing Plans and the PCP Strategic Plan for 2013-2017. It includes statistics on alcohol and other drugs, why it is a concern to organisations and communities, key themes from the stakeholder consultations, some of the recommended prevention approaches and our proposed future direction.

The paper focuses on Southern Grampians and Glenelg Shires, and includes alcohol, tobacco and other drugs. However, the primary focus is on alcohol.

Where the term alcohol and other drugs (AOD) is used, it includes tobacco.

2. ALCOHOL

Alcohol use is widely accepted in Australian culture. Most Australians drink alcohol to relax, socialise and celebrate and do so at levels without adverse effects. However, a substantial proportion of people drink at levels that increase their risk of alcohol-related harm, which often has negative consequences for them as individuals, as well as for their families, friends and the community.

Alcohol accounts for 3.2% of the total burden of disease and injury in Australia, 4.9% in men and 1.6% in females.[1] Harmful levels of alcohol consumption are associated with increased risk of chronic disease, injury and premature death and is related to the causes of more than 60 different medical conditions.[2]

2.1. Assessing Risk of Alcohol-Related Harm

The 2009 National Health and Medical Research Council (NHMRC) Guidelines3 took a new approach (from the 2001 Guidelines) beyond immediate risk of injury and the cumulative risk of chronic disease, to estimating the overall risk of alcohol-related harm over a lifetime. The Guidelines (see below) now include how to reduce lifetime risk, single occasion risk and guidelines specific for young people under 18 years and pregnant and breastfeeding women. The revised Guidelines made quite substantial changes to the 2001 Guidelines, reducing the number of drinks for males. There has not been a public education campaign about the Alcohol Guidelines since they were revised; recent research found that 95% of Australians do not know the number of standard drinks associated with reduced lifetime and short term health risks.[4]

NHMRC Guidelines

The Australian guidelines for reducing health risks associated with the consumption of alcohol are:

1. **Lifetime risk:** for healthy men and women, drinking no more than two standard drinks a day reduces the lifetime risk of harm from alcohol-related disease or injury.
2. **Single occasion risk:** for healthy men and women, drinking no more than four standard drinks reduces the risk of alcohol-related injury from that occasion.
3. Children and young people under 18 years: not drinking is the safest option.
4. **Pregnancy and breastfeeding:** for pregnant women or those planning a pregnancy and breastfeeding women, not drinking is the safest option.

[1] Begg et al 2008, cited in VicHealth Reducing alcohol-related harm in the workplace 2012

[2] VicHealth, Reducing alcohol-related harm in the workplace 2012

[3] National Health and Medical Research Council, Australian Guidelines to Reduce Health Risks from Drinking Alcohol 2009

[4] Livingston 2012, cited in Mathews, R & Callinan, S, (2013) *Over the limit: A profile of Australians who drink in excess of the recommended guidelines,* www.fare.org.au

2.2. Alcohol-related harm: prevalence

National

The prevalence of adults consuming alcohol at levels risky to their lifetime health has plateaued over recent years.[5] In 2011-12 19.5% of adults drank more than two standard drinks on average per day, exceeding the 2009 NHMRC lifetime risk guideline. Whilst this level may not seem major cause for concern, when combined with the rate of drinking at levels of short term risk it is significant: over 50% of all drinkers exceeded either guideline one or two in the previous 12 months.[6]

There are particular groups who are more likely to consume alcohol at risk levels.

Lifetime Risk

According to the 2010 National Drug Strategy Household Survey (NDSHS)[7], one quarter of all drinkers consumed an average of two or more drinks daily.

Gender: A larger proportion of men (34% of drinkers) than women (17% of drinkers) exceeded guideline one.

Age: Drinkers aged 20 -29 years were most likely to exceed the guideline (31%), followed by 40 -59 year drinkers (26%) and 30 – 39 year old drinkers (25%).

Gender & Age: Male drinkers aged 20 – 29 years were most likely to consume in excess of guideline one (40%) and did so at twice the rate of female drinkers aged 20 – 29 years (21%).

Indigenous status: Aboriginal and Torres Strait Islander people who drink alcohol were more likely than non-Indigenous Australians to exceed guideline one, with 39% compared to 25% respectively. However, it is important to note that a larger proportion of Aboriginal and Torres Strait Islander people abstain from alcohol (25%) than do non-Indigenous Australians (19%).

Household income: A greater proportion (29%) of drinkers from high income households ($104,000+) exceeded guideline one than those (24%) from lower income households (<$41,599). In addition, tis trend is even stronger if abstainers were taken into account as the rate of abstainers is lower (8%) in the highest income bracket than in the lowest income bracket (over 25%).

Sexuality: Homosexual or bisexual people were more likely to exceed guideline one (29%) than heterosexual people (20%).[8]

Single Occasion Risk

Almost half of drinkers surveyed in the 2010 NDSHS consumed more than four standard drinks in a session over the past year. The rates and frequency of heavy drinking are significant. The NDSHS found that:

- over 40% exceeded guideline two at least monthly
- almost one in six drinkers consume 11 or more standard drinks per occasion at least monthly.9

---

[5] Australian National Preventive Health Agency (ANPHA), *State of Preventive Health Report 2013*. Report to the Australian Government Minister for Health Canberra; ANPHA 2013

[6] Mathews, R & Callinan, S, (2013) Over the limit: A profile of Australians who drink in excess of the recommended guidelines, www.fare.org.au

[7] Ibid (Mathews)

[8] Australian Institute of Health & Welfare, NDSHS 2010 Report, Supplementary Tables, 2011

[9] Mathews, R & Callinan, S, (2013) Over the limit: A profile of Australians who drink in excess of the recommended guidelines, www.fare.org.au

Gender: Male drinkers were far more likely to exceed guideline two than women, with 59% of male drinkers doing so compared to 38% of female drinkers. Men also exceeded the guideline more frequently with half exceeding it at least monthly compared to only 28% of women.

Age: Drinkers aged 20 - 29 years exceeded guideline two at the highest rate (70%), with 34% doing so monthly to weekly and 27% doing so weekly or more often. The 14-19 year old drinkers were the next most likely, with 63% exceeding guideline two, with 31% doing so monthly to weekly and 22% at least weekly.

Gender and Age: There are higher levels of drinking in excess of guideline two for 20 - 29 year old male drinkers (76%), compared with women (64%). Those aged 14 – 19 years are next highest, particularly young men (66%), with 28% doing so weekly or more often. 59% of young women drinkers aged 14-19 years drank in excess of guideline two, with 17% doing so weekly or more often. The rate for women drinking in excess of guideline two drops significantly from 30 years, with 32% of women aged 40-49 years exceeding guideline two. By contrast 59% of male drinkers aged 40-49 years drink in excess of guideline two, with nearly half of them doing so monthly or more often. This shows that not only is there is significant single occasion excessive drinking by young men but also by middle aged men.

Indigenous Status: Two thirds of Aboriginal and Torres Strait Islander people who drink alcohol exceeded guideline two at least once in the past year compared with approximately half of non-Indigenous Australians, and did so more frequently. One third of Aboriginal and Torres Strait Islander people who drink exceeded the guideline weekly or more often compared with 18 % of non-Indigenous Australians.

Household income: A reverse socioeconomic gradient is evident whereby over 60% of drinkers from the highest income households exceeded guideline two in the past year, a rate double that from the lowest income households (36%).The frequency also increased with household income.

Sexuality: homosexual or bisexual people drank at levels exceeding guideline two at least weekly at higher rates (26%) than heterosexual people (16%).[10]

State

One in ten Victorians drinks more than healthy limits at least weekly, putting themselves (and others) at risk of harm.[11] Approximately 700 Victorians die from the effects of alcohol every year.[12]

Over the ten years from 1995/96 to 2004/05 the number of Victorians hospitalised due to alcohol-caused injury or illness increased by 77% to 23,144. Victoria recorded the largest increase in Australia, at more than double the national average.[13]

Local

Local data indicates that Southern Grampians and Glenelg have a significant proportion of people at risk of short term harm from alcohol consumption. In Glenelg the rate is 14%, which ranks at 17th of the 79 Local Government Areas. In Southern Grampians it is slightly higher at 16.4%, ranking 8th in the state. The state average is 10.2% of people are at risk of short term harm from alcohol consumption.[14]

---

[10] Australian Institute of Health & Welfare, NDSHS 2010 Report, Supplementary Tables, 2011

[11] www.health.vic.gov.au/aod/strategy/index.htm, accessed 25/03/13

[12] Crown Content 2010, cited in Australian Drug Foundation Prevention Research Quarterly No. 19 2012

[13] National Drug Research Institute, National Alcohol Indicators Bulletin No.12 2009

[14] Department of Health, 2010 Local Government area statistical profiles, 2011

The rate of alcohol related-assault to people aged 18-24 in Southern Grampians and Glenelg has dropped in recent years but remains higher than the state average. In 2009/10 the rate for alcohol-related assaults to people aged 18 – 24 was 52 per 10,000 in Southern Grampians, compared with 31 for Victoria.[15]

Data from Victoria Police and the Monash University Accident Research Centre provide the following indicators by town:

Town (Postcode)	Family Violence incidents with suspected alcohol	Drink Driving Infringement Notices Issued	Alcohol-related Hospital Admissions for Injury
Hamilton (3300)			
- 2008/09	48.0	31.4	13.8
- 2009/10	48.9	43.4	24.0
Portland (3305)			
- 2008/09	60.2	32.1	14.4
- 2009/10	34.5	28.1	17.7
Heywood/Dartmoor (3304)			
- 2008/09	43.1	7.2	0.0
- 2009/10	21.5	0.0	18.0
Casterton (3311)			
- 2008/09	120.9	24.2	0.0
- 2009/10	30.2	30.2	30.2
Victorian 5 Year Average 2005/10	26	22	14

Note: Rates per 10,000 population; data available by postcode

Research indicates that the density of alcohol outlets is indicative of the level of alcohol-related harm: as density increases so do levels of assault. The number of licensed premises per head of population in rural Victoria is significantly higher than the state average. In the Southern Grampians the number of licensed premises is 36 per 10,000 residents aged 15+, and in Glenelg Shire it is 32, compared with only 27 in Victoria.[16]

2.3. Impact of Alcohol – why we need to act

Alcohol is one of the main causes of death, injury and disease internationally (Sterling University, 2013).[17]

Impacts on individuals

High risk alcohol use contributes significantly to injury, disease, disability and death. It accounts for 3.2% of the total burden of disease and injury in Australia; 4.9% in males and 1.6% in females."18 The health impact of harmful levels of alcohol use are short term effects such as motor vehicle injuries, alcohol poisoning, injuries from assaults and family violence and deliberate self harm.

[15] Turning Point, Alcohol-related harms and Use Across Victorian LGAs: 2000/01 to 2009/10, 2012

[16] Turning Point, Alcohol-related harms and Use Across Victorian LGAs: 2000/01 to 2009/10, 2012

[17] Health First: An evidence-based alcohol strategy for the UK, Stirling University 2013

[18] Begg et al 2008 cited in VicHealth Reducing alcohol-related harm in the workplace 2012

Longer term effects include cognitive impairment, cardiovascular disease, liver disease, mental illness, cancers and diabetes.19 Both short term and long term health impacts of the harmful consumption of alcohol are of concern. Overall more people die from the acute effects of alcohol than the long-term or chronic effects.[20]

Among young adults, alcohol is responsible for the majority of drug-related deaths and hospital episodes, causing more deaths and hospitalisations in this group than all illicit drugs and many more than tobacco (NHMRC 2009).

People who have problems with alcohol and other drugs may also have mental health issues (dual diagnosis). It can be difficult to tell which comes first as there are many reasons for dual diagnosis. There may also be other issues that increase the risk, such as using alcohol and other drugs to cope with mental illness symptoms or other stresses; in addition use of alcohol and other drugs may trigger a mental health issue.

Impacts on children, families and communities

The cost of alcohol-related harm to the Australian community is estimated to be at least $15.3 billion per year. "Much of this is borne outside the health system and includes road accidents (over $2 billion), crime ($1.6 billion) and lost productivity in the home ($1.5 billion)."[21]

Many of the costs are borne by someone other than the drinker, such as through alcohol-related assault, family violence, child abuse and drink driving. It is estimated that alcohol-related harm to others costs the community $20 billion per year in addition to the $151.3 billion above. [22]

- 70,000 Australians were victims of alcohol-related assault in 2005, including 24,000 who were victim of alcohol-related domestic violence.(add ref)
- Almost 20,000 children were victims of alcohol-related (substantiated) child abuse in 2006-07(add ref)
- In 2010, 22% of recent drinkers 14 years or over put themselves or others at risk of harm while under the influence of alcohol, with driving a car the most common activity (13% of drinkers). (add ref)

Impacts on organisations

In its evidence review, *Reducing alcohol-related harm in the workplace*,[23] VicHealth notes that risky alcohol use also has negative impacts on organisations. These include workplace accidents, injuries and fatalities, reduced productivity, poor work relations and increased absenteeism (due to illness) and presenteeism (reduced performance due to health conditions).

Workplace safety is put at risk from staff who are intoxicated or who have a hangover and have reduced performance such as impaired coordination, slow reaction times and poor judgment.

This can impact on the size of the available workforce, staff turnover and early retirement. High risk alcohol use can also result in economic burdens such as lost productivity, compensation payments and employer liabilities. Lost productivity in the workplace attributable to alcohol costs $3.5 billion per year.

---

[19] NHMRC 2009 cited in VicHealth Reducing alcohol-related harm in the workplace 2012

[20] NHMRC 2005, cited in Preventive Health Taskforce, *Australia: the Healthiest Country by 2020,* 2009

[21] Collins & Lapsley cited in VicHealth Reducing alcohol-related harm in the workplace 2012 p8

[22] Laslett et al 2010, cited in VicHealth Reducing alcohol-related harm in the workplace 2012 p8

[23] VicHealth, Reducing alcohol-related harm in the workplace 2012

2.4. Consultations - Alcohol

Consultations were undertaken with key stakeholders in Southern Grampians and Glenelg Shires (see Appendix 1 for a list of stakeholders consulted). Key themes:

- Alcohol is embedded in our culture, particularly in sport and at some workplaces; alcohol is consumed for all celebrations.
- Binge drinking continues to be a significant issue for young people and the binge drinking culture is accepted eg footy finals.
- Alcohol readily available and cheap, with lots of liquor outlets.
- Adults are supplying underage young people (their own children and others'), despite recent research on the impact of alcohol on the adolescent brain and the introduction of the Victorian secondary supply laws in 2011.
- Those at risk are not just young people.
- There has been an increase locally in alcohol-related violence and criminal offences.
- We need to show some leadership and to "walk the talk" in local government, health, schools and other organisations and employers, such as through organisational policies, how we host events and in promotion of treatment services.
- There is too much focus on individual responsibility and treatment/ education; we need more emphasis on and funding for prevention, long term solutions (not one-offs), leadership and population level interventions.
- Capacity is an issue - AOD treatment services are not funded for prevention or project work and there are limited knowledge, skills and resources in the local workforce in other sectors.
- We need to recognise that it is the responsibility and role of all of us to address risky alcohol consumption. We should consider our liabilities as parents/ community members and organisations/ workplaces, including our individual and organisation's reputation and financial consequences.
- Excessive alcohol use is a taboo subject, except in relation to young people. It is not discussed within the community or is seen as "too hard"; service providers often don't discuss it with clients, we should take a "no wrong door" approach and promote/ refer to AOD treatment services.

2.5. Evidence for Prevention

Harmful alcohol use is a significant preventable health issue. There is significant evidence available on effective prevention strategies at all levels – national, state, local government and individual organisation/ workplace level.

WHO

The World Health Organisation (WHO) has identified evidence-based strategies and interventions to reduce alcohol-related harm.[24] The WHO states that evidence-based policies and programs should use an appropriate combination of the following strategies:

- Regulating the marketing of alcohol (particularly those which influence young people)
- Regulating and restricting the availability of alcohol

[24] World Health Organisation, Evidence-based strategies and interventions to reduce alcohol-related harm, Report by Secretariat to 60th World Health Assembly 2007

- Drink-driving legislation and enforcement
- Reducing demand through taxation and pricing
- Raising awareness and support for policies
- Accessible and affordable treatment services
- Broad screening programs and brief interventions against harmful alcohol use.

Local Government

Local governments are a key player in supporting the Public Health and Wellbeing Act 2008 through their role in protecting, improving and promoting health within their municipality. Local governments have a significant role in alcohol management as alcohol is consumed in local businesses, sports clubs and other facilities.

The federal and state governments have responsibility for the most effective strategies for reducing alcohol consumption, such as regulation on the affordability and availability of alcohol.[25] However, local governments also have the capacity to prevent short and long-term harm from alcohol in their communities.

Key strategies for local government to take[26] [27] are:

- Restricting the concentration of licensed premises through policy and planning schemes.
- Promoting safer drinking cultures such as:
    - an alcohol management plan for council event
    - alcohol-free events or hosting dry or family areas at existing events, particularly when there is a focus on young people's participation
    - supporting community sports clubs to ensure compliance with Responsible Serving of Alcohol requirements and diversifying fund raising so they are less reliant on alcohol sales
    - restricting alcohol consumption in public spaces (parks, main streets, beaches) and outdoor dining areas on public land such as footpaths.
- Building partnerships with local stakeholders including local police, liquor licensees, health and community services and community members; council may choose to invite partners' input to assessing liquor license applications and monitor local alcohol-related issues.

Workplaces

These include our individual characteristics, the availability of alcohol, how alcohol is consumed around us and the workplace culture, structures and environment.

Population groups most at risk are men, young people aged 14 -29 years, those in lower skilled and manual occupations and those in particular industries (agriculture, retail, hospitality, manufacturing, construction and financial services).

Workplace factors that can increase high risk alcohol include:

- Availability of or access to alcohol (physical and social)

[25] Australian Drug Foundation Prevention Research Quarterly No. 19 2012

[26] VicHealth Reducing harm from alcohol, Local government action guide no.9 2012

[27] Australian Drug Foundation Prevention Research Quarterly No. 19 2012

- Organisational culture (ie attitudes, norms, practices and expectations)
- Structures and controls (ie supervision, rules and regulations)
- Environment and working conditions (including shift work, long hours, lack of access to services, low-level of supervision, low-level of work control, level of alienation)
- Low group cohesion and work conflict
- Work stress
- Discrimination, bullying and harassment

In *Reducing alcohol-related harm in the workplace. An evidence review,*[28] VicHealth found that access to alcohol is critical. Evidence from Australia and internationally shows that increased availability of or access to alcohol is associated with increased risk.

Healthy workplaces can help improve productivity and increase employee engagement and satisfaction. Most working-age Australians spend around one-third of their waking lives at work and 90% of the Australian workforce drinks alcohol. The health problems of individual staff can affect others in the workplace, co-workers, managers and the organisation as whole.

Workplaces provide a positive setting for promoting health:

- Employment and working conditions are key social determinants of health: evidence links fair, safe and secure employment with good health, and low job security and conditions with poor health.
- Workplaces directly influence the physical, mental, economic and social wellbeing of employees, with a flow on to their families and community.
- The workplace provides an ideal environment and infrastructure to support promotion of health to a large audience.

Implementing an effective intervention on alcohol in a workplace will assist in recognition of that workplace as a healthy workplace and a good employer. It can also support any workplace accreditation processes.

What is effective in workplaces?

VicHealth's evidence review aimed to identify workplace interventions that reduce alcohol-related harm. While the review found that the literature on workplace is "largely descriptive, with methodological limitations", it does provide some guidance about promising practice in this area. Interventions that have the greatest impact are tailored, multi-faceted and developed in consultation with and with support of key stakeholders. Effective responses to alcohol-related harm recognise that there is no single reason for risky alcohol use, no single alcohol problem and no single effective response.

The VicHealth review focused on interventions that target change at the organisational and systems levels. This approach involves all stakeholders and makes change in the workplace culture and infrastructure as well as in policy, procedures and practices. It can bring benefits to both the workplace and the individual, whereas individually focused interventions can be effective at the individual level but don't necessarily have benefits at the organisational level. A whole-of-workplace intervention can complement existing practices which mainly focus at the individual employee level.

Key features of workplace best practice

VicHealth's evidence review highlighted the key features of best practice interventions:

[28] VicHealth Reducing alcohol-related harm in the workplace. An evidence review,2012

- Addresses the broad range of risks across the whole workforce (not the needs a few severely dependent individuals).
- Accounts for the complexity: there is no single reason for risky alcohol use, no single alcohol problem and no single effective response. It needs to take into account each organisation and site.
- Evidence-informed: use research to guide and inform interventions and monitor and evaluate the impact on employees and work practice.
- Multifaceted: interventions that are multifaceted and address both employees and the organisation. Organisational strategies should include access to alcohol (physical and social), organisational culture, structures and controls and the workplace environment and working conditions.
- Prioritise high risk: priorities interventions in high risk occupations and workplaces with high risk population groups.
- Clear goals in consultation: the goals of the interventions need to be clear (may be broad or narrow focus) and developed in consultation with key stakeholders.
- Engage all staff in the development process.
- Assess the risk: treat alcohol like any other health and safety issue by assessing the risk and influencing factors at each work site and developing a specific response.
- Tailor the response to the individual workplaces, site and culture

Workplace Interventions

Two examples of workplace interventions include:

Achievement Program

The Department of Health, in conjunction with the Centre of Excellence in Intervention and Prevention Science (CEIPS), has developed the Achievement Program (a Healthy Together Victoria initiative) to support the development of healthy workplaces and workforces. The Achievement Program focuses on five health priority areas including alcohol and is an evidence based program. The alcohol component is currently being developed and will be available later in 2013.

Awareness in the Workplace

The Australian Drug Foundation (ADF) provides a fee-based service to workplaces to assess alcohol and drug risks and provide sustainable solutions that reduce the risks of alcohol and drug related harm. ADF Aware is an alcohol and drug employee elearning program. It complements other Occupational Health & Safety and wellbeing programs within the workplace and reflects the organisation's position on alcohol management.

3. TOBACCO AND OTHER DRUGS

3.1. Smoking: prevalence

National

In 2011/12, 16% of Australians aged 18+ smoked daily, which has decreased significantly from 37% in 1977.

Gender: The rate is higher among men (18%) than women (14%).

Socioeconomic Status: The rate is much higher for people experiencing socioeconomic disadvantage. In 2011/12 the smoking prevalence in the most disadvantaged areas was 2.4 times that in most advantaged areas.[29]

Remoteness: Smoking increases with geographic remoteness. The daily smoking rates for people in major cities is 15%, compared with 20% in inner regional, 23% in outer regional areas and 27% in remote Australia.

Indigenous Status: Smoking is more prevalent among Aboriginal and Torres Strait Islander peoples, with almost one in two people over 15 years smoking, with a slightly higher rate for males (49%) than females (45%).

State

New Cancer Council Victoria data released in September 2013 showed regular smoking rates in Victoria have dropped to a record low of 13.3%.[30] Almost 60% Victorian adults and more than 70% of those aged 18-29 have never smoked.

Gender: The rate for males (16%) was higher than for females (11%).

Socioeconomic Status: Of particular interest was that the prevalence of regular smoking declined most rapidly amongst the most disadvantaged Victorians between 2005 and 2012. This is in contrast to the trend in previous years for smoking rates to decline fastest amongst Victoria's most advantaged.

Impact of Smoking

Tobacco smoking is one of the largest preventable causes of death and disease in Australia. (Begg et al 2008. Cited in Preventive Health), with over 7% of the burden of disease in Australia attributed to smoking (Aust Healthiest Country?). Tobacco kills one-third to one-half of all people who use it, on average 15 years prematurely (DHS 2008). Almost 4000 Victorians die every year from smoking-caused disease.[31] Smoking contributes to many cancers and respiratory, cardiovascular and other diseases.

In addition, secondhand smoke exposure has been linked to many harmful health effects particularly in unborn babies, infants and children. These include Sudden Infant Death Syndrome (SIDS), lower birth weight and lung and respiratory infections.[32]

[29] ABS Cat. No. 4704.0, 2011, cited in ANPHA State of Preventive Health Report 2013

[30] QUIT http://www.quit.org.au/news/?id=34588, accessed 3/9/13

[31] Ibid

[32] VicHealth, Reducing tobacco use. Local government action guide no. 8, 2012

3.2. Other Drugs - Prevalence

There is a range of illicit drugs which are used by Australians, as outlined below.

Cannabis	At a national level cannabis is the most commonly used illicit drug, with just over 10% of the population using it in 2010.[33] Similarly in Victoria cannabis was the most common illicit drug of concern among clients of government-funded Victorian specialist AOD treatment services in 2009/10 (25% of clients).[34]
Ecstasy	At a national level ecstasy remains as the second most commonly used illicit drug, with 3% of the population using it in 2010.
Amphetamine type stimulants (ATS)	At a national level, ATS (excluding MDMA ie ecstasy) were used by 2% of the population, which has been decreasing since 1998. In 2009/10 the proportion of AOD clients citing stimulants as the primary drug of concern was 9%, similar to previous years. This includes crystal methylamphetamine (also known as 'ice').
Cocaine	According to the 2010 NDSHS, the proportion of Australians reporting recent use of cocaine increased from 1.6% in 2007 to 2.1%, across all age groups.
Heroin and other opioids	The proportion of the population reporting recent use of heroin (in the last 12 months) in 2010 remained very low at 0.2%, with a similar level in Victoria.

Misuse of pharmaceutical drugs: The most common drugs used for non-medical purposes and benzodiazepines and opioids. According to the 2010 NDSHS, recent use of pharmaceutical drugs for non-medical was 4.2%. Benzodiazepines and other minor tranquilisers: A small proportion of AOD clients (2%) cited them as the primary drug of concern.

Local stakeholders reported a significant increase in number and volume of exchanges through the Needle & Syringe Program in Southern Grampians and Glenelg. Needles are largely used for illicit drugs

Age: The 20-29 year age group accounted for the greatest recent use of cannabis, ATS, cocaine and ecstasy. In a 2011 national survey of Australian secondary school students, over 12% of 16 and 17 year olds reported using cannabis in the last month; there were very low rates of other drugs used by this group, other than alcohol and tobacco.[35]

Gender: Young males in [particularly involved in risky drug use and harm.

Socioeconomic Status: There is an association of drug use and social disadvantage and is strongest for illicit drugs and for more problematic patterns of drug use, including dependence.[36]

Impact of Other Drugs

There are a range of health risks associated with both illicit drugs and misuse of prescription drugs including death and other long-term health issues including dependence. Drug use can also cause social, psychological and legal problems and significant harm to users' families and the broader community. This can include the loss in workplace productivity, occupational health and safety risks

[33] AIHW, cited in *Illicit Drug Data Report 2010-11*, Australian Crime Commission, 2012

[34] Summary of the Victorian Drug Statistics Handbook: Patterns of Drug Use and related harm in Victoria for the period July 2009 – June 2010, Turning Point, 2012

[35] Australian secondary schools students' use of tobacco, alcohol and over-the-counter and illicit substances in 2011, Cancer Council Victoria, 2012

[36] Loxley, W. et al, *The Prevention of Substance Use, Risk and Harm in Australia: a review of the evidence,* The National Drug Research Institute and the Centre for Adolescent Health, 2004

and the costs to our health and criminal justice systems. Use of many drugs in combination with alcohol can exacerbate risk of harm. Cannabis use during adolescence is associated with later mental health issues and conduct problems. Heavy use of amphetamine-type drugs are associated with reckless and aggressive behaviour and if sustained over days may precipitate a psychosis. Injecting drug users have the risk of dependence, opiate overdose and the transmission of blood borne viruses (such as HIV/AIDS and hepatitis C).

3.3. Consultation – Smoking & Other Drugs

During the key stakeholder consultations key themes in discussing other drugs were:

- Alcohol is still of the greatest concern, though there is also considerable use of cannabis and tobacco.
- Cannabis and amphetamines (including ice) are widely available across the catchment and are very affordable.
- There is some use of prescription drugs, particularly by young people and they are very affordable.
- There is increasing acceptance and "normalising" of drug use, including higher SES/ young professionals and "party pills".
- Partnership work is the key to prevention, so that limited resources and funding is pooled and more effective.
- AOD clients unable to get prescriptions in towns where there is limited bulk billing (eg Hamilton)

3.4. Best Practice - Tobacco

VicHealth[37] suggests some key strategies for local government to take:

- Ensure enforcement of regulations such as cigarette sales to minors, point-of-sale advertising and smokefree venues
- Promote smokefree environments such as in outdoor public areas, and with local businesses and community groups.
- Support national and state anti-smoking campaigns through support for cessation programs, encouraging staff to quit smoking, working with other services to target high risk groups and raising community awareness about smoking and second hand smoke.

QUIT Victoria's *An integrated tobacco control health promotion strategy* for PCPs and their partners includes best practice strategies such as individual screening, risk assessment and referral, education for health and other professionals, social marketing and health information, supporting workplaces and community groups to become smokefree and enforcing tobacco-related legislation.

For adolescents, school based education alone has been ineffective in the long term in preventing adolescents from taking up smoking but is effective when provided in conjunction with other interventions such as media campaigns and smokefree policies.[38]

[37] VicHealth, Local government action guide on reducing tobacco use no.8, 2012

[38] Backinger, C.L., Fagan, P., Matthews, E. et al, *Adolescent and young adult tobacco prevention and cessation: current status and future directions,* http://tobaccocontrol.bmj.com/content/12/suppl_4/iv46.full.html#related-urls , accessed 30/4/13

3.5. Best Practice - Other Drugs

The evidence on prevention of substance use has its limitations, however, it "shows that integrated and collaborative responses that span regulation, enforcement, social marketing, service provision and advocacy are generally more effective in achieving sustainable change than isolated and one-off activities."[39]. Prevention strategies are most effective when they:

- aim to improve the social development environments for children and young people.
- are maintained over a number of years across the life-course
- incorporate multiple strategies in different settings such as family, school, community and peer groups

More specifically, strategies should:

- seek to reduce risk factors that lead young people to become involved in risky drug use and harm
- use targeted, early intervention strategies to strengthen protective factors for those most at risk
- incorporate law enforcement for controlling supply, influencing and reinforcing community values, diverting early offenders and protecting the community
- include community to address social determinants related to social disadvantage and disconnection

Indigenous prevention strategies:

- need to address the underlying social determinants of Indigenous inequality (including economic development)
- involve Indigenous people as equal partners in the development and implementation
- provide adequate resourcing, including adequate and appropriate services
- take a holistic and coordinated approach that includes Indigenous community-controlled organisations, all levels of government and all sectors.

Key influences on drug use by young people are factors such as family functioning, school performance, peer influence, temperament and local drug availability.

The strength of evidence of interventions and their effectiveness varies considerably and assessments are often based on small studies or overseas programs not trialled in Australia; however examples of effective interventions include:

- *Childhood*: family home visitation, parent education, school preparation to enhance learning potential, and school organisation and behaviour management programs.
- *Adolescence*: school drug education (short-term impact), parent education strategies, intensive strategies including family intervention and preventive case management for with highest risk factors; strategies are most effective when implemented over a number of years and incorporate more than one intervention.[40]

[39] Department of Human Services, Resource guide for planning effective community drug prevention, 2008

[40] Loxley, W. et al, *The Prevention of Substance Use, Risk and Harm in Australia: a review of the evidence,* The National Drug Research Institute and the Centre for Adolescent Health, 2004

One of the key challenges to an effective prevention framework is the need for significant resourcing over a long period of time. In addition, the framework needs to broad based and have strong cross sector collaboration.

4. CONTEXT

National Priorities

The Australian National Preventive Health Agency (ANPHA) includes reducing the harmful consumption of alcohol and smoking as two of the three priorities in its Strategic Plan 2011-15. Key areas for action on alcohol include changing Australia's drinking culture (including strategies for workplaces), taxation and pricing-related mechanisms, regulation and licensing, responsible marketing, improving the health of Indigenous Australians and building the capacity of primary health's focus on alcohol. There have been varying levels of progress across the alcohol actions to date.[41].

In relation to smoking, tobacco control is the key area for action for ANPHA, through increases to taxation on tobacco, increased funding for social marketing and expansion of Graphic Health Warnings on tobacco packaging. The federal government was also the first in the world to introduce plain packaging for cigarettes.

The National Drug Strategy 2010-15 is a coordinated national strategy for minimising the harms of alcohol and other drugs. The strategy focuses on three pillars – harm reduction, supply reduction, demand reduction. Under this overarching strategy, a new National Alcohol Strategy will be developed to continue the work under the existing alcohol strategy. The National Alcohol Strategy 2006-11 identified alcohol intoxication as a key issue and called for cultural change on Australia's drinking habits.

The National Tobacco Strategy 2012-18 (a sub-strategy of the National Drug Strategy 2010-15) focusses on the three pillars of harm reduction, supply reduction, demand reduction. Priority areas include actions to eliminate the remaining advertising, promotion and sponsorship of tobacco products, reduce affordability, increase smokefree areas, mass media and public education, strengthen cessation services, and consider further work on the contents, product disclosure and supply.

State Priorities

In 2012 the Department of Health released its *Reducing the alcohol and drug toll. Victoria's Plan 2013-17*. Areas for action on alcohol include promoting a healthy and safe drinking culture, liquor license reforms and alcohol and drug education in schools. One of the initiatives is to expand the Achievement Program to workplaces, including alcohol and smoking components.

The Plan also includes action to improve regulation of drugs and medicines, improve evidence on misuse of pharmaceutical drugs, further education for health professionals and consumers on misuse of prescription drugs, maintain and strengthen laws and enforcement on illicit drug use and dealing and improve treatment and diversion programs for drug users.

The Victorian Tobacco Control Strategy 2008-13 focuses on reducing promotion, tougher enforcement, measures to reduce second hand smoke including smoking bans in cars carrying children and on school grounds, social marketing and promoting smoking cessation.

Great South Coast

[41] Foundation for Alcohol Research & Education, A red light for preventive health. Assessing progress against the Preventive Health Strategy's alcohol-specific actions, 2013

A number of Local Governments in Great South Coast have identified alcohol as one of their priorities for the MPHWPs for the next four years.

5. GLENELG AND SOUTHERN GRAMPIANS: APPROACHES AND CAPACITY

5.1. Work to date

There has been considerable work undertaken locally on alcohol and other drugs. Many have focused on education and harm minimisation for young people, involving Glenelg Southern Grampians Drug Treatment Service, health services, schools, Victoria Police and Brophy Family & Youth Services.

Two particular pieces of work are relevant in the context of this paper. The first, the Southern Grampians and Glenelg Drug and Alcohol Action Plan 2010-12, is relevant as it was a catchment wide, cross sector integrated health promotion action plan; the second as it was a Shire wide program implemented in workplaces. They provide some insights into the local landscape and capacity for prevention work on alcohol and other drugs.

Southern Grampians and Glenelg Drug and Alcohol Action Plan

The Southern Grampians and Glenelg Drug and Alcohol Action Plan 2010-12 was developed by the Southern Grampians & Glenelg Primary Care Partnership and its partner agencies. The Plan had a focus on alcohol as the main priority and took a health promotion approach across the areas of social acceptability and responsibility, social connection and resilience, availability and access and service integration and partnership. It also included some strategies on tobacco.

There was significant progress in some areas such as:

- increased participation in the Australian Drug Foundation's Good Sports Program (GSP)
- increased community awareness and understanding of the issues through the development of parent resources, a two year media campaign and community forums
- harm minimisation initiatives at events
- cross sector family violence training, and
- significant work in increasing social connection and a focus on providing more effective access and services for vulnerable groups in the community.

However, progress in other areas was limited such as on the development of a local government liquor outlet policy, smoke-free external areas policies and service integration strategies; the integrated implementation monitoring process lacked strong support.

The key to progress of the Plan was capacity (staff and resources), commitment and readiness. While the Plan deliberately included only strategies which could be incorporated into organisations' core business, the level of capacity was still quite limited. Most progress was made where there was significant capacity and commitment such as through the GSP (a dedicated Project Officer), social connection work (a PCP Project Officer with dedicated time) and the parents support work (resourced by staff from Brophy, Victoria Police, Quamby, DEECD and PCP).

Even though the Plan had been endorsed by the PCP, both Shire Councils and key partners, there were some strategies which were not able to be implemented due to issues of readiness and organisational commitment.

Challenging the Stereotypes

Western District Health Service implemented the Challenging the Stereotypes (Go For your Life) Program in workplaces across Southern Grampians Shire from 2008-10. The Project was managed by a partnership team including members from WDHS, PCP and Southern Grampians Shire. Considerable knowledge and understanding of the barriers and enablers about running programs in workplaces was developed through the implementation and evaluation process. Key enablers included management involvement, workplace champions, thorough planning and documentation, stable partnerships, regular monitoring and support by project manager. Barriers included lack of time by workplace champions, lack of flexibility and the greater difficulty in engaging employees at larger organisations.

5.2. Local Prevention System Capacity

Based on the last four years' implementation of the Southern Grampians & Glenelg Drug and Alcohol Action Plan, there has been limited capacity for prevention of alcohol-related harm and use of tobacco and other drugs. This has recently reduced further with some of the positions which enabled progress to be made in the past, no longer existing (eg Brophy and DEECD positions).

Governance: Work on alcohol and other drugs needs to be managed in a way that streamlines the work and ensures that there is strategic oversight. The PCP Executive Committee provides a professional, strategic body which could provide direction, monitor and support this work. Members are senior officers within PCP partner organisations who could provide leadership and influence key stakeholders. There is a need to support organisations in integrating the implementation of interventions. This could potentially be a peer support process with additional support and resourcing through the PCP staff team.

Partnerships: The PCP has many active members who are involved in its meeting structure, and various working groups and networks. The partnership has strong ties and high levels of trust and many members have a keen interest in health promotion in alcohol and other drugs. However, they have little capacity for undertaking additional work on the ground. Similarly other networks such as the Glenelg and Southern Grampians Youth Networks have a strong interest in the issue of alcohol and other drugs, particularly in relation to young people, but do not have capacity for action.

Great South Coast Medicare Local (GSC ML) has also identified alcohol and other drugs as a key area of focus for their work. At this stage the direction is more focused on improving the service system and accessing services, than an upstream health promotion focus. However, it will be important to continue developing partnerships with GSC ML to value add across the continuum.

Leadership: There is strong leadership in the areas of alcohol and other drugs across the catchment, particularly by Glenelg Southern Grampians Drug Treatment Service (Quamby) and Victoria Police. However, their focus is largely on addressing the consequences of alcohol-related harm and drug use. There is a need to identify and build new leadership, which may be developed through taking a workplace approach. Organisational management and human resource managers have a clear interest in seeing alcohol and other drug issues being addressed in workplaces and the broader community; by 'walking the talk' as a workplace, it is anticipated that it will raise organisational understanding, demonstrate leadership and role modeling as well as influencing organisational decision making regarding alcohol and other drugs.

Resources: As mentioned above, there is very limited capacity to undertake preventive action on alcohol and other drugs. Most resources are found in service provision addressing the negative outcomes of alcohol and other drugs, such as drug and alcohol treatment, Victoria Police and health services.

There is potential for some increase in health promotion resources working in the area of alcohol and other drugs within Portland, with both Portland District Health and Dhauward-Wurrung Elderly & Community Health Service identifying this area as a priority health promotion area for their organisations. This will be further considered in the implementation plan development.

However, there is potential to incorporate responsibility for action within workplace infrastructure. Some leadership and support for workplaces is available through PCP management and staff. Workplaces which register for the Achievement Program will also receive support from the Achievement Program team at the Centre for Excellence in Intervention and Prevention Science (CEIPS).

Outside of the workplace intervention strategies, considerable new investment in health promotion in the area of alcohol and other drugs will be required.

Workforce: Expertise about alcohol and drug issues exists within a number of PCP partner agencies; however, this is largely around treatment, with less knowledge in the prevention area. There is a need for some workforce development and training to increase understanding of the issues and knowledge of prevention strategies.

6. FUTURE DIRECTION AND RATIONALE

As an outcome of the background research for this briefing paper, the key stakeholder consultations and discussions throughout the Municipal Public Health and Wellbeing Plan (MPHWP) process it has been agreed that alcohol and smoking will be included as priorities for both Glenelg and Southern Grampians 2013-2017 MPHWPs and the PCP Strategic Plan. This priority focus and realistic objectives have been developed by taking into account the qualitative and quantative local data, the strong policy direction and current capacity of the prevention system. Alcohol will be the primary focus, with smoking as the secondary focus; both areas of work will take a workplace settings approach and will be led by PCP staff. No specific prevention work will be undertaken on other drugs, however the PCP and its partners will continue to support and promote the relevant services in the area.

Alcohol continues to be a major issue in our catchment. There is also good evidence on preventing alcohol-related harm. There is considerable local expertise and experience in both treatment and prevention of alcohol-related harm.

There is commitment to take preventive action on alcohol, however, there is limited capacity (leadership, workforce and funding) and, as discussed above, not necessarily the understanding or readiness to initiate significant changes supported by the best-practice evidence, such as restricting licenses through policy and planning, liquor licensing accords or changes to serving of alcohol at local events, in sports clubs or workplace functions.

Given the above capacity limitations, there was discussion as to whether it was feasible to undertake work on alcohol but there was overwhelming agreement by stakeholders that there needed to be some ongoing work. Stakeholders agreed that key leaders and decision makers need more awareness and understanding of the issues and need to take responsibility. The evidence shows that alcohol-related harm is not limited to young people and hence responsibility and ownership of the problem needs to be taken on by the whole community. Key leaders have a responsibility to “walk the talk” and be part of the solution at a strategic and operational level.

Workplaces provide an opportunity to take some leadership with potential impact on individual employees, their families and friends, organisations and the community as a whole. By creating a healthy workplace environment, organisations also reap benefits for their productivity, occupational health and safety, corporate reputation and employee satisfaction. Workplaces of focus should be those that potentially can contribute the most to leadership and influence regarding prevention work for alcohol and other drugs, such as local government, health services, community service providers and media outlets. Workplaces of focus should be those that potentially can contribute the most to leadership and influence regarding prevention work for alcohol and other drugs, such as local government, health services, community service providers and media outlets.

Smoking remains a big issue, leading to significant deaths and contributing to many cancers and other diseases. While rates of smoking have decreased significantly, there are still some groups in the population with high rates of smoking. There is good evidence for prevention strategies and

there has been some interest from key stakeholders to be involved. Given the limited capacity in the region it is considered as a secondary priority behind alcohol. There will be opportunities to include action on smoking as an "add-on" to alcohol work, and in implementing workplace programs. Individual organisations have also indicated interest in undertaking other tobacco prevention initiatives.

Other drugs – while there is evidence that other drugs are an issue in our catchment, with significant impact for those affected, their use is not as prevalent compared with alcohol-related harm and smoking. In addition, the evidence indicates that effective prevention needs to be multi-faceted and undertaken across the life course. At this point there is little workforce capacity specifically dedicated to other drugs apart from continuing drug education in schools and services and ensuring awareness of treatment services and making appropriate referrals. However, some of the recommended strategies mentioned above take a broad approach and reflect work being done already, particularly in working with vulnerable families and young people.

The Plan From Here

The integrated planning process for MPHWPs and the PCP Strategic Plan has resulted in alcohol and tobacco being included as priorities.

The shared goal, objectives and strategies are as follows:

Goal: Build informed leadership on building the prevention system for alcohol and tobacco.

Objectives	Strategies
Build a shared understanding about harmful alcohol consumption and tobacco use, our local experience and effective approaches.	Identify local data on the impact of harmful alcohol consumption and tobacco. Identify evidence-based prevention approaches for workplace interventions (including the Achievement Program) and agencies which can provide expertise and support.
Develop our capacity and leadership to "walk the talk" on responsible alcohol consumption using a workplace settings approach.	Identify and engage people with influence to act as champions within partner agency workplaces. Present the data & interventions evidence to champions and partners who are potential leaders in the alcohol and tobacco prevention work.
Develop our capacity and leadership on tobacco prevention initiatives and reducing tobacco use, using a workplace settings approach.	Implement the alcohol and tobacco components of the Achievement Program (or workplace programs) in key potential leaders' and partners' workplaces. Establish a steering and support structure to provide guidance and support to workplace champions implementing the alcohol and tobacco components of the Achievement Program (or workplace programs).

Appendix 1 List of Key Stakeholders consulted

Aspire

Brophy Family & Youth Services

Casterton Memorial Hospital

Dhauward-Wurrung Elderly & Community Health Service

Glenelg Shire

Glenelg Southern Grampians Drug Treatment Service

Glenelg Youth Network

Heywood Rural Health

Portland District Health

Southern Grampians Shire

Southern Grampians Youth Network

Victoria Police

Western District Health Service