
NATIONAL HEALTH POLICY ON ALCOHOL IN AUSTRALIA

and Examples of strategies for implementation

Copyright Commonwealth of Australia 1990

Foreword

NATIONAL HEALTH POLICY ON ALCOHOL IN AUSTRALIA

EXAMPLES OF STRATEGIES FOR IMPLEMENTATION

Foreword

The Ministerial Council on Drug Strategy (MCDS), which comprises Commonwealth, State and Territory Ministers responsible for health and law enforcement, oversees the National Campaign Against Drug Abuse. The campaign is a major national effort to minimise the harmful effects of drugs both legal and illegal on Australian society.

The 'National Health Policy on Alcohol in Australia' was adopted by MCDS on 23 March 1989. At the same time, MCDS also endorsed 'Examples of strategies for implementation of the National Health Policy on Alcohol in Australia'. The two documents, although separate, need to be read together and it is for this reason that they have been published under the one cover.

The strategies contained in the document, 'Examples of strategies for implementation of the National Health Policy on Alcohol in Australia', are suggestions for ways in which the policy might be implemented. They are not exhaustive and it will be a matter for the Commonwealth and individual States and Territories to determine whether they are appropriate for their jurisdictions.

NATIONAL HEALTH POLICY ON ALCOHOL IN AUSTRALIA

**Prepared by The Ministerial Council on Drug Strategy Sub-Committee (Chaired by
The Honourable F T Blevins, Minister for Health, SA)**

Adopted by The Ministerial Council on Drug Strategy 23 March 1989

Overview

Background

The aim of the national policy

Policies

References

Overview

The overall objective of this National Health Policy on Alcohol in Australia is the minimisation of the harm associated with the use of alcohol. Achieving this objective will require that comprehensive programs for public education and health promotion be implemented together with enhanced professional training and education and access to early forms of treatment. Such initiatives will not, however, be successful unless control policies which address availability, pricing, and advertising and marketing are at a level which is congruent with and supportive of strategies designed to minimise harm by public education, professional training, early intervention and treatment of established problems.(1)(1) Underpinning these initiatives there will need to be an increased commitment to research and improved administrative arrangements ensuring that alcohol related problems receive the attention their seriousness warrants.

Background

Alcohol use and the problems associated with it do not occur in isolation from the use and problems associated with other drugs, from other social behaviours and factors, or from government initiatives. For such reasons there is a need for a National Health Policy on Alcohol in Australia. This need can be readily justified by reference to earlier enquiries as well as recent trends. The Senate Standing Committee on Social Welfare, reporting in 1977, described alcohol problems in Australia as having reached epidemic proportions, the neglect of which would represent gross national irresponsibility.(2)(2) The National Health and Medical Research Council has identified problems related to alcohol as the fourth most serious health problem in Australia.(3)(3) The Special Premiers' Conference on Drugs held in 1985 (the Drug Summit), while concentrating on the use of illicit drugs, acknowledged that the total harm associated with alcohol greatly exceeded that identified with illicit drugs.(4)(4) The World Health Organization has long recommended the need to formulate comprehensive national

plans with respect to alcohol.(5)(5)

The consumption of alcohol in Australia expressed in per capita terms has stabilised and even fallen slightly in recent years.(6)(6) However, current levels of injury, illness, disability and death, family disruption and crime associated with alcohol remain at a level requiring a concerted, comprehensive policy for their amelioration. While the moderation of Australia's alcohol consumption is to be welcomed, the fact that Australians drink on average more alcohol per year than any other English speaking population and rank thirteenth in the world in terms of per capita consumption must remain a matter for concern. Of the deaths caused by drug use in 1985, 16 per cent were attributed to alcohol and it is estimated that one in every five admissions to general hospitals in Australia are due to alcohol related problems.(6)(7)

Within the broad perspective of harm minimisation, there are a number of issues that are of particular concern to both governments and the general public. These include underage drinking, binge drinking and drink-driving. Each of these causes enormous loss to the community, the family and the individuals concerned in health, social and economic terms.

A number of surveys have been conducted in recent years to establish levels of alcohol and other drug use among school students. Results from recent surveys indicate that a disturbingly high proportion of students drink on average at least weekly (7% 19% at age 12, rising to 36% 51% at age 16).(6)(8) Even more worrying is that many of these young people consume more than five drinks in a row and as a consequence reach the stage of being drunk, sick, or even passing out.(7,8)(9)

The consequences of this alcohol abuse are particularly evident when mortality statistics are examined. Between 1980 and 1986, alcohol was the most significant cause of death among young people aged 15-34 years, and three-quarters of these deaths were due to alcohol related motor vehicle crashes.(9)(10) It is apparent that urgent action is necessary to combat these problems.

Personal choices about lifestyle behaviour must be made in an environment free from undue pressure. Such pressure is of particular importance where it is exerted on young people by their close association of alcohol with success, social and sexual prowess and good health.

While there is a need to direct attention to the specific issues discussed above and to develop campaigns to alleviate the social harm they cause, it is also important that they be placed in perspective, and it be recognised that there is a place in Australian society for the responsible and moderate consumption of alcohol.

The aim of the national policy

The aim of a National Health Policy on Alcohol in Australia should be the minimisation of the harm associated with alcohol use while interfering as little as possible with the freedom of individuals to exercise personal responsibility for the use or non-use of alcoholic beverages.

Because there is no universally safe level of drinking, and because most alcohol related problems occur in persons who would be regarded by most Australians as social drinkers, it is not sufficient to direct all efforts at reducing alcohol related problems to those whose drinking is habitually irresponsible. Accordingly, although a targeted approach is appropriate in some instances, relating either to habitual heavy drinkers or to specific problems such as road crashes, in general efforts to minimise alcohol related problems need to be broadly based. However, no single initiative itself is likely to effect the significant improvement sought.

Policies

1. Educational policies
2. Control policies
3. Legal policies
4. Role of the non-government sector and the community
5. Research policies
6. Treatment policies

1. Educational policies

- 1.1 Public education and health promotion
- 1.2 Professional training and education

1.1 Public education and health promotion

Public education in the area of alcohol use is of vital importance. If the present levels of harm associated with alcohol are to be reduced it will require a more responsible attitude towards the use of alcohol on the part of the Australian public at large.(10)(11) Equally, if the various other policies advocated in this document are to receive support, the majority of the population will need to accept that alcohol is a special sort of commodity, the use of which requires the exercise of particular responsibility. The objective of such public education must therefore be a better informed public and one prepared to exercise discernment in the use of alcohol. The role of community groups in such education cannot be overestimated.

Objectives

1. To assist all sections of the community and in particular young people to develop understanding, attitudes and behaviour which will enable them to minimise and avoid the

harmful consequences of alcohol use.

2. To assist people to recognise the legal, health, social and employment implications of their own alcohol use, including its different effects and its significance for others.

3. To assist people to recognise when they or those they know require help to cope with problems related to alcohol use and to provide information about where such help can be obtained.

4. To encourage and support initiatives in the non-government sector aimed at preventing the development of alcohol related problems.

5. To foster a community attitude which reduces the pressure placed on young people to be seen to be successful, attractive and healthy by consuming alcohol.

1.2 Professional training and education

Despite widespread and official recognition that alcohol problems constitute a major health risk in Australia, the training of health professionals and allied workers in this field has received very low priority. As a consequence, people having alcohol related problems can receive services through a variety of institutions, both health and welfare, without the relevance of alcohol to their problems being recognised or, if recognised, competently dealt with.

Training programs must include reference to the wide range of personnel and of community resources available and of the value of an interdisciplinary team approach.

Objectives

1. To encourage the infusion into the undergraduate courses of all health related disciplines of material related to alcohol and other drug use which is up to date, comprehensive and coordinated.

2. To encourage the development of in-service and postgraduate training programs that:

- are suitable for those working specifically in the field of alcohol and other drug use;

- provide guidance to all of those whose work places them in contact with clients presenting with these problems or with problems secondary to the drinking of others; and

- equip persons who can exercise a preventive role to do so effectively.

2. Control policies

2.1 Price and taxation

2.2 Availability

2.3 Advertising and marketing

2.1 Price and taxation

Alcoholic beverages behave like other commodities in the sense that price increases reduce consumption although the elasticities for beer, wine and spirits are different.(11,12,13)(12) Therefore influencing the price of alcohol through excise and other taxes is regarded as one of the means available to governments to influence consumption, whilst acknowledging that other factors influence price.

Objectives

1. To carefully assess the practical effect of any proposed changes to pricing, taxation and excise policies on the incidence and prevalence of alcohol related problems prior to their implementation.

2.2 Availability

The availability of alcohol in Australian society is a reflection of a number of considerations, including the attitudes and values of Australians towards alcohol, which themselves determine such things as the legal minimum drinking age, hours of trading and the number and type of outlets all of which fall within the jurisdiction of States and Territories.

Even though there is no single invariable relationship between alcohol availability and alcohol problems, in every situation where it is proposed to increase availability, the real possibility of increasing problems should be considered. Similarly, the possibility of decreasing problems by reducing availability should also be given serious consideration.

Objectives

1. To ensure that current policies on availability do not aggravate the incidence and prevalence of alcohol related problems.
2. To consider practical ways in which any changes to policy can be implemented without negative impact on the responsible use of alcohol.
3. To ensure the effective policing of existing laws relating to availability.

2.3 Advertising and marketing

A policy of minimising the harm associated with alcohol necessitates that attention be given to the way alcohol is used, which in turn requires that attention be paid to the ways in which

alcohol is marketed and, in particular, the ways in which alcohol is promoted in the media. The objectives expressed for this National Health Policy on Alcohol in Australia will require action be taken to ensure that these activities do not promote practices which are potentially harmful, do not undermine attitudes and practices which are potentially beneficial and do not minimise the effectiveness of educational programs. It is clear that some current marketing and advertising practices do not conform to these requirements.

The aim should be to establish a firm but workable voluntary code of practice. The existing system of industry self regulation of advertising is not working uniformly in a way calculated to protect the health interests of the population and is currently being reviewed. Although existing voluntary constraints on advertising and marketing are not perceived to be adequate, there is insufficient justification at this time for banning all forms of advertising of alcohol.

While it is preferable that a voluntary code be maintained, should this prove unsatisfactory, consideration may need to be given to some mandatory form of regulatory control.

Objectives

1. To ensure that marketing and advertising of alcoholic beverages is consistent with the aim of encouraging responsibility in its use.
2. To ensure that the advertising of alcohol is subject to the provisions of a code of practice which adequately addresses health issues, which does not place unfair pressure on young people and which is subject to effective mechanisms of review and monitoring of its administration.

3. Legal policies

Alcohol problems impinge on the legal system in a variety of ways, notably in the areas of drinking and driving, under age drinking, public drunkenness, alcohol related crime and family law. In general, this policy document upholds the principle that individuals are responsible for their drinking behaviour and the consequences, under the criminal justice system, of offences attributable at least in part to the effects of alcohol. However, this policy document also recognises the appropriateness of a range of responses within the legal system for responding to these issues.

Objectives

1. To ensure that legislation and administrative practices in all areas relevant to alcohol operate in a manner consistent with the objective of reducing the level of alcohol related problems in Australian society.

4. Role of the non-government sector and the community

The problems presented by alcohol use in Australian society are too numerous to be

responded to only by government agencies. The action of these agencies or a small group of professionals alone will not bring about the changes in attitudes and practices which must occur if alcohol related problems are to be reduced. Widespread activity using the resources of the community as a whole needs to be initiated. Nonetheless, governments have an essential role in supporting and, where necessary, stimulating the non-government sector and community action in this area.

Government and non-government activities should be complementary in ways which maximise their effectiveness in the areas in which it is considered they have most to offer.

Objectives

1. To support initiatives in the non-government sector aimed at preventing the development of alcohol related problems or assisting people and communities experiencing such problems.
2. To stimulate such initiatives where they are not forthcoming and to ensure that all such activities are undertaken in a way which allows the government and non-government sectors to complement one another.

5. Research policies

Although important initiatives have been taken in the context of the National Campaign Against Drug Abuse, the quality and quantity of research conducted into the prevention, nature, extent and treatment of alcohol dependence and alcohol related problems in Australia has not historically been commensurate with the scale of these problems.

Objectives

1. To encourage a recognition of the importance of research, as a basis for policy development.
2. To encourage the further development of quality research which will provide the basis for an integrated, systematic and comprehensive approach to alcohol dependence and alcohol related problems.

6. Treatment policies

Treatment has a limited but vital role in a comprehensive policy aimed at the reduction of alcohol problems. The development of treatment facilities should not, however, lead to the neglect of prevention.

In recognition of recent research indicating that minimal intervention may be as effective as intensive treatment(14,15,16)(13), and of the fact that resources for specialist services will never be adequate to meet the needs, treatment should be provided by both generalists and specialists in such a way that the number of individuals receiving some form of intervention is

maximised.

Much of the intervention offered should take place on an outpatient basis although there remains a need for some inpatient facilities. For heavily dependent people, treatment will need to be on an ongoing basis.

The services available to assist in the identification and management of people suffering from alcohol related problems should maintain a high profile in both the professional and general community and their nature and role should evolve over time to reflect changes in knowledge based on scientific research.

All health and welfare professionals should accept some responsibility for the identification of, and intervention with, people with alcohol related problems. Specialist units should operate within a consultation liaison model in relation to generalists as well as providing direct services.

As there is no single form of treatment which is effective for all individuals, a range of interventions should be available and the person with the problem should be actively involved in defining the goals of treatment and the most appropriate methods of achieving them.

Objectives

1. To ensure that individuals with alcohol related problems of any nature are identified as early as possible.
2. To ensure that all individuals in whom an alcohol related problem has been identified have access to comprehensive assessment.
3. To ensure that an appropriate range of interventions is available for, and offered to, those individuals in whom an alcohol related problem has been identified.
4. To ensure that adequate information and support is available for the families of people with alcohol related problems.
5. To ensure that the type and extent of interventions offered reflects current knowledge related to the efficacy of intervention programs.
6. To ensure that the programs offered provide a high quality of care.
7. To ensure that the interventions offered are accessible to all in need irrespective of socioeconomic, cultural, racial or religious background, and of geographic or physical location.
8. To ensure that health funding arrangements facilitate universal access to appropriate treatment including that provided by the non-government sector.

9. To create an environment which recognises the capacity of individuals with alcohol related problems to help themselves and assist society in general to respond to the individual's excessive drinking in a helpful way.

10. To ensure that services for the treatment of alcohol related problems maintain a high profile in the professional and general community.

11. To encourage all members of the professional community to accept a responsibility to contribute to a reduction in the level of alcohol related problems in the community.

References

1. Rootman, I. & Moser, J. 1984, Community response to alcohol-related problems, National Institute on Alcohol Abuse and Alcoholism, Washington DC.

2. Senate Standing Committee on Social Welfare 1977, Drug problems in Australia: an intoxicated society? AGPS, Canberra.

3. Standing Committee on the Health Problems of Alcohol 1975, Report. Approved at the eightieth session of the National Health and Medical Research Council (appendix XXI), April, Brisbane, AGPS, Canberra.

4. Prime Minister 1985, Communique, Special Premiers' Conference on Drugs, 2 April, Canberra.

5. World Health Organization Expert Committee 1980, Problems related to alcohol consumption, Technical Report, Series no. 650, WHO, Geneva.

6. Commonwealth Department of Community Services and Health 1987, Alcohol the facts, AGPS, Canberra.

7. Cormack, S., Kalenink, Z., Smith, H. & Bungey, J. 1987, Survey of alcohol, tobacco and other drug use by South Australian school children, Drug and Alcohol Services Council, Adelaide.

8. Baker, W., Hornel, P., Flaherty, B. & Trebilco, P. 1987, The 1986 survey of drug use by secondary school students in New South Wales, New South Wales Drug and Alcohol Authority, Sydney.

9. Commonwealth Department of Community Services and Health 1988, National drug abuse data system: statistical update, National Drug Abuse Information Centre, Canberra.

10. National Drug Education Program Assessment Team of the Drug Education

Subcommittee, Health Committee on Drugs of Dependence 1984, Final report, Commonwealth Department of Health, Canberra.

11. Single, E. 1984, 'International perspectives on alcohol as a public issue', Journal on Public Health Policy, vol. 5, pp. 238-56.

12. Levy, D. & Stephen, N. 1983, 'New evidence on controlling alcohol use through price', Studies on Alcohol, vol. 44, pp. 929-37.

13. Ornstein, S I. 1980, 'Control of alcohol consumption through price increases', Journal of Studies on Alcohol, vol. 41, pp. 807-18.

14. Edwards, G. 1982, The treatment of drinking problems, Grant McIntyre, London.

15. Orford, J & Edwards, G. 1977, Alcoholism, Maudsley Monograph no. 26. Oxford University Press, London.

16. Chick, J. Lloyd, G & Crombie, E. 1985, 'Counselling problem drinkers in medical wards: a controlled study', British Medical Journal, vol. 290, 965-67.

EXAMPLES OF STRATEGIES FOR IMPLEMENTATION of the National Health Policy on Alcohol in Australia

Prepared by The Ministerial Council on Drug Strategy Sub-Committee
(Chaired by The Honourable F T Blevins, Minister for Health, SA).

Endorsed by The Ministerial Council on Drug Strategy 23 March 1989.

CONTENTS

Background

The policy

Examples of strategies for implementation

References

Background

This strategies paper is a supplement to the National Health Policy on Alcohol in Australia and should be read in conjunction with that document.

The policy

The overall objective of the National Health Policy on Alcohol in Australia is the minimisation of the harm associated with the use of alcohol.

The policy document covers the areas of education (i.e. public education and health promotion, professional training and education), control issues (i.e. price and taxation, availability, advertising and marketing), legal issues, role of the non-government sector and the community, research and treatment.

Examples of strategies for implementation

1. Educational policies
2. Control policies
3. Legal policies
4. Role of the non-government sector and the community
5. Research policies
6. Treatment policies
7. Implementation

In order to facilitate the effective implementation of the National Health Policy on Alcohol in Australia, and to ensure that the positive momentum of the National Campaign Against Drug Abuse in Australia is maintained and enhanced, it is essential that strategies be identified to provide a direction for the future.

There are many means by which the objectives in the National Health Policy on Alcohol in Australia can be achieved. For each section of the policy, set out below are examples of strategies for implementation. It should be stressed that they are only examples, they are not exhaustive, and it will be a matter for the Commonwealth and individual States and Territories to determine whether they are appropriate for their jurisdictions.

1. Educational policies

1.1 Public education and health promotion

Strategies

1. The provision of public information services (as laid down by the national guidelines(2)(14)), covering a variety of printed, televised, audio, visual and face to face presentations, based on the researched information needs of specific target groups.
2. The provision of assistance to the media to encourage the effective presentation of the medical and social aspects of alcohol use both in advertising and program/editorial content.
3. The attention of the media should be drawn to the impact of role models in popular television productions.
4. The provision of alcohol education programs at all levels of the educational system within a general framework of health and lifestyle education.
5. The provision of information by doctors and other health and welfare workers covering risk levels of alcohol use and other issues.
6. The undertaking of mass media campaigns designed to encourage consumers of alcohol to do so responsibly.
7. The widespread dissemination of the National Health and Medical Research Council (NHMRC) recommendations regarding responsible drinking.
8. The provision of an appropriate medium through which the alcohol industry can participate in programs designed to assist the Australian community to adopt a more responsible attitude toward the use of alcohol.
9. The encouragement of alcohol free social events, particularly for young people.

1.2 Professional training and education

Strategies

1. The designation, where appropriate, of training positions in the staff complement of all alcohol services and programs.
2. The provision of working conditions within such services that allow for the development of in-service programs for staff of various disciplines.
3. Counsellors within alcohol services to be given opportunities to attend workshops and conferences.
4. Specific allocations for training to be made within budgets of agencies providing services in this area.
5. Tertiary institutions providing courses in the area of alcohol use, be encouraged to include a

practical component of experience in an alcohol unit as part of that course.

6. Appropriate professional bodies be encouraged to develop courses related to alcohol use for interns, residents, general practitioners and specialists as well as other relevant health and welfare staff, preferably within a multidisciplinary context.

7. Continued liaison between appropriate professional bodies be encouraged with a view to increasing the input into the curriculum of each professional school of matters relating to alcohol use.

8. The promotion within hospitals that have alcohol units, of the participation, on a rotating basis, of interns, residents and other staff.

9. The promotion of the concept that Family Medicine Programmes should encourage trainees to spend time working in alcohol units.

10. The provision of training in health education for all teacher education students and the provision of in-service training in alcohol in the education of all teachers.

11. The provision of appropriate training to people employed or seeking employment in the hospitality industry with particular reference to the responsible serving of alcohol.

2. Control policies

2.1 Price and taxation

Strategies

1. The regular adjustment of excise, import duty, and licence fees to assist in maintaining the real price of the various alcoholic beverages.
2. While recognising the difficulty that governments face in regulating prices, certain practices which tend to promote immoderate use such as excessive discounting should be actively discouraged.

2.2 Availability

Strategies

1. Laws and regulations affecting the availability of alcohol should be formulated to take account of their effects on the health and welfare of the people of Australia.
2. The impact of any proposed change in availability on health and welfare should be documented and be given high priority in determining policies.

3. Existing laws and regulations, including licensing laws, affecting the availability of alcohol, should be reviewed with a view to rendering them consistent with the objectives of this National Health Policy on Alcohol in Australia.
4. The introduction of programs designed to promote responsible serving as a condition of holding a licence.
5. The introduction of some form of positive identification to establish the age of drinkers.
6. The promotion of non-alcoholic alternatives and food in licensed premises.

2.3 Advertising and marketing

Strategies

1. The depiction of alcoholic beverages in all forms of advertising and marketing as a beverage to be consumed in moderation and responsibility.
2. Comprehensive voluntary codes should be developed with the alcohol industry to cover issues related to both the content of advertising and marketing strategies generally (e.g. it should address issues such as the size and design of containers that clearly distinguish them from non-alcoholic products).
3. The Standing Committee of Officials to the Ministerial Council on Drug Strategy should monitor the effectiveness of those codes.
4. The depiction of the alcohol content of beverages on all containers of alcoholic beverages in a way readily understandable by the public.
5. The encouragement of sponsorship of sporting, cultural and other recreational activities by bodies other than alcohol companies.
6. The avoidance of messages which may counter educational programs. In particular, limiting the image of products being based on success, social and sexual prowess, and good health.

3. Legal policies

Strategies

1. The promulgation by governments of a policy that the law in general will be written and administered in such a way as to support the goal of reducing the level of alcohol related problems in Australian society.
2. The establishment by governments of mechanisms for reviewing existing legislation and legislation proposed in the future, with a view to such legislation supporting, or at least not

being inimical to, efforts aimed at reducing alcohol related problems.

3. The provision of facilities for people in conflict with the law who have alcohol related problems, to be diverted from the criminal justice system, or otherwise be provided with services which will address their alcohol related problems.

4. The decriminalisation of the act of being intoxicated in a public place and the provision of facilities for the humane care of people found intoxicated in public.

5. The introduction of legislation giving police and other persons power to remove under age persons drinking or intoxicated in a public place and not under the supervision of a parent or a guardian, to a place of safety (e.g. their home or shelter) and the confiscation of liquor in their possession.

6. The introduction of drink-driving legislation that will, amongst other things, facilitate the identification of 'at risk' people with alcohol related problems and assist them to recognise and overcome such problems.

7. The introduction of a graduated licensing system whereby learner and probationary drivers are precluded for a period of up to 3 years from drinking and driving (i.e. the introduction of a zero blood alcohol level for such drivers).

8. As a long term goal and in consultation with the Federal Department of Transport and Communications, the adoption of uniform blood alcohol level legislation based on the establishment of the lowest acceptable blood alcohol level consistent with minimising the harm caused by drink-driving in the States and Territories; and the adoption of random breath-testing.

9. The provision, to those detainees in corrective institutions who have alcohol related problems, of treatment services consistent with their incarceration, and of a quality no lower than those provided to people in the community at large.

10. The introduction of some form of positive identification for the purpose of establishing age.

4. Role of the non-government sector and the community

Strategies

1. The provision of support to services provided by non-government agencies in a manner which will encourage initiative and flexibility but which includes a condition in respect of those funded agencies that such services be regularly evaluated.

2. The listing and monitoring of services provided by all treatment agencies in the non-government sector.

3. The provision of appropriate training opportunities for the staff, including volunteers, of non-government treatment agencies and the provision of funds to provide employee replacement.
4. The establishment of conditions of employment which ensure that high quality staff will be attracted into the non-government sector.
5. The establishment of a means of coordinating the activities of the government and non-government sectors with a view to ensuring their complementary nature.
6. The adoption of an uniform set of standards to apply to government and non-government services to ensure a high standard of service delivery is maintained.
7. The encouragement of alcohol free social events, particularly for young people.

5. Research policies

Strategies

1. To ensure the increased relevance and accessibility of research to policy making and planning.
2. The further development of a national research base, with appropriate emphasis given to epidemiological studies.
3. The promotion of training in research techniques for staff of alcohol prevention and treatment programs.
4. The development of research information services to include:
 - a comprehensive data collection system, where possible using a standardised format;
 - a national information system;
 - the systematic monitoring of alcohol related problems;
 - the coordination of national research efforts; and
 - the conduct, on a regular basis, of alcohol consumption surveys and the development of methodologically sound survey techniques.
5. The development of collaborative projects.

6. The establishment of appropriate mechanisms for giving consideration to the ethical implications of research in this area where such mechanisms do not already exist.
7. The further development and coordination of specialist libraries.
8. The sponsorship of research workshops and conferences.

6. Treatment policies

Strategies

1. Services should be planned for defined populations and should take account of the prevalence of alcohol related problems among that population. Reasonable access should be ensured.
2. A designated mechanism should exist in each geographical location for the planning and review of treatment services.
3. All relevant health and welfare professions should examine the role which their members can play in the treatment of drinking problems, and should ensure that appropriate training to reinforce these responsibilities is instituted.
4. All organisations, departments and agencies at which people with alcohol related problems may present should ensure that their staff have adequate training to identify and appropriately manage such clients. This includes health, welfare and corrective service organisations. The recording of alcohol consumption should become routine in all clinical settings.
5. All professionals and the general public should have access to an appropriate Education and Information Resource Unit which can conduct courses and provide current information.
6. Standards of service to persons with alcohol related problems should be developed in consultation with the agencies concerned.
7. All hospitals and health care facilities which do not have specialist alcohol services should have a specified mechanism for the identification, assessment and referral of people with alcohol related problems.
8. A range of programs for early intervention should exist (e.g. employee assistance programs, screening at antenatal clinics, involvement of general practitioners and drink-driving diversionary programs).
9. The development of culturally relevant policies and the employment of multilingual workers in alcohol services.
10. Treatment of alcohol related disabilities, including adequate follow up, should be provided

both by generalists and by specialist units incorporating the following services:

- sobering up services;
- detoxification facilities;
- access to a 24 hour telephone advisory service;
- a 24 hour emergency service;
- effective medical care as indicated for those with physical and psychological illness;
- an organisational network of health and welfare agencies providing services such as support services to individuals and families;
- an appropriate level of outpatient, residential and rehabilitation services; and;
- appropriate follow up mechanisms.

11.The provision of diagnosis, assessment, treatment and rehabilitation for those with alcohol related brain damage.

12.The removal, on the grounds of alcohol abuse alone, of those powers providing for compulsory admission to psychiatric hospitals.

7. Implementation

Strategies

1. The formation at Commonwealth, State and Territory levels of cabinet or interdepartmental committees concerned with the implementation of a National Health Policy on Alcohol in Australia.
2. The development at Commonwealth, State and Territory levels of consultative mechanisms involving industry representatives with a view to fostering discussions of those matters referred to in this document.
3. The establishment of a system of annual monitoring and reporting of progress on implementation of the National Health Policy on Alcohol in Australia by each jurisdiction to the Ministerial Council on Drug Strategy (MCDS) through the Standing Committee of Officials of MCDS.

1. Ministerial Council on Drug Strategy Sub-Committee 1989, 'National Health Policy on Alcohol in Australia', Canberra.

2. Commonwealth Department of Health 1987, Drug education programs in Australia, AGPS, Canberra.

Endnotes

1 (Popup)

1. Rootman, I. & Moser, J. 1984, Community response to alcohol-related problems, National Institute on Alcohol Abuse and Alcoholism, Washington DC.

2 (Popup)

2. Senate Standing Committee on Social Welfare 1977, Drug problems in Australia: an intoxicated society? AGPS, Canberra.

3 (Popup)

3. Standing Committee on the Health Problems of Alcohol 1975, Report. Approved at the eightieth session of the National Health and Medical Research Council (appendix XXI), April, Brisbane, AGPS, Canberra.

4 (Popup)

4. Prime Minister 1985, Communique, Special Premiers' Conference on Drugs, 2 April, Canberra.

5 (Popup)

5. World Health Organization Expert Committee 1980, Problems related to alcohol consumption, Technical Report, Series no. 650, WHO, Geneva.

6 (Popup)

6. Commonwealth Department of Community Services and Health 1987, Alcohol the facts, AGPS, Canberra.

7 (Popup)

6. Commonwealth Department of Community Services and Health 1987, Alcohol the facts, AGPS, Canberra.

8 (Popup)

6. Commonwealth Department of Community Services and Health 1987, Alcohol the facts, AGPS, Canberra.

9 (Popup)

7. Cormack, S., Kalenink, Z., Smith, H. & Bungey, J. 1987, Survey of alcohol, tobacco and other drug use by South Australian school children, Drug and Alcohol Services Council, Adelaide.

8. Baker. W., Hornel, P., Flaherty, B. & Trebilco, P. 1987, The 1986 survey of drug use by secondary school students in New South Wales, New South Wales Drug and Alcohol Authority, Sydney.

10 (Popup)

9. Commonwealth Department of Community Services and Health 1988, National drug abuse data system: statistical update, National Drug Abuse Information Centre, Canberra.

11 (Popup)

10. National Drug Education Program Assessment Team of the Drug Education Subcommittee, Health Committee on Drugs of Dependence 1984, Final report, Commonwealth Department of Health, Canberra.

12 (Popup)

11. Single, E. 1984, 'International perspectives on alcohol as a public issue', Journal on Public Health Policy, vol. 5, pp. 238-56.

12. Levy, D. & Stephen, N. 1983, 'New evidence on controlling alcohol use through price', Studies on Alcohol, vol. 44, pp. 929-37.

13. Ornstein, S I. 1980, 'Control of alcohol consumption through price increases', Journal of Studies on Alcohol, vol. 41, pp. 807-18.

13 (Popup)

14. Edwards, G. 1982, The treatment of drinking problems, Grant McIntyre, London.

15. Orford, J & Edwards, G. 1977, Alcoholism, Maudsley Monograph no. 26. Oxford University Press, London.

16. Chick, J. Lloyd, G & Crombie, E. 1985, 'Counselling problem drinkers in medical wards: a controlled study', British Medical Journal, vol. 290, 965-67.

14 (Popup)

2. Commonwealth Department of Health 1987, Drug education programs in Australia, AGPS, Canberra.