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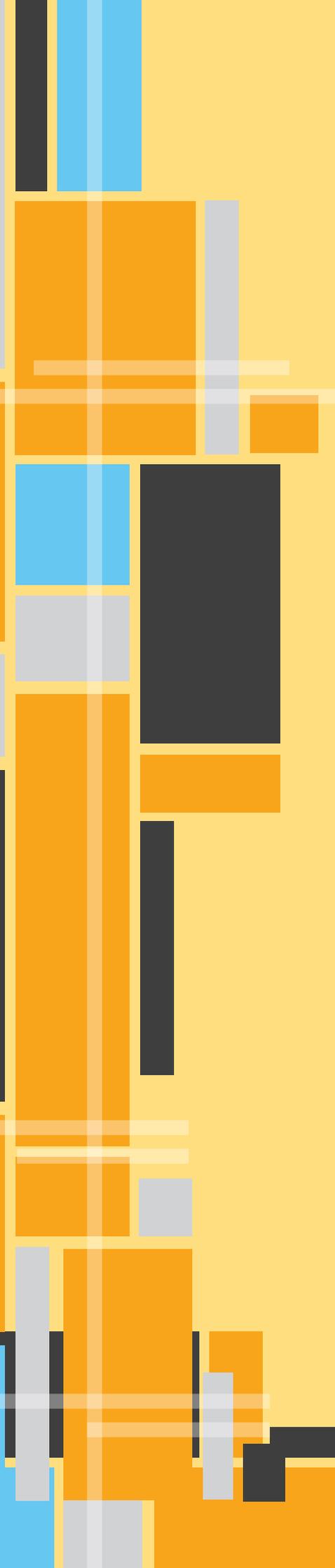
Australian Institute of Health and Welfare

Trends in **alcohol** availability, use and treatment

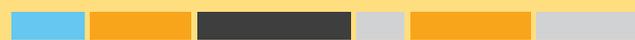


2003–04 to 2014–15

Drug treatment series no. 28



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Contents

Acknowledgments	v
Abbreviations	vi
Summary	vii
1 Introduction	1
About this report	1
2 Policy context	2
The National Drug Strategy	2
The National Alcohol Strategy	2
The National Binge Drinking Strategy	3
3 Alcohol availability	4
Total volume of pure alcohol; per capita consumption—alcohol sales and tax	4
Restricting alcohol availability	7
Taxation and pricing of alcohol	7
Hours and days of sale for licensed premises	8
Liquor licensing and outlet density	8
4 Alcohol use	9
Who is drinking alcohol	10
5 Alcohol treatment	15
Who receives treatment for alcohol use?	15
Clients in AOD Treatment, 2012–13 to 2014–15	19
6 Trends from 2003–04 to 2014–15	20
7 Conclusions and Policy implications	22
8 Data sources	23
AODTS NMDS	24
NDSHS	24
Estimating the number of Alcohol users	24
Apparent consumption of Alcohol, Australia, 2013–14	24
NASDP	25
Glossary	26
References	28

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Abbreviations

ABS	Australian Bureau of Statistics
AOD	Alcohol and Other drugs
AODTS NMDS	Alcohol and other drug treatment services national minimum dataset
AIHW	Australian Institute of Health and Welfare
NAS	National Alcohol Strategy
NASDP	National Alcohol Sales Data Project
NBDS	National Binge Drinking Strategy
NDRI	National Drug Research Institute
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
PCC	Per capita consumption
RTD	Read-to-drink beverage
WHO	World Health Organization

Summary

Drinking alcohol is widely accepted in Australia. However, it is also understood that excessive alcohol use presents many risks of short- and long-term harm to the drinker and those around them.

In 2011 alcohol dependence was responsible for 1.5% of the total burden of disease in Australia, and alcohol was the third highest risk factor for disease (AIHW 2016b). While some positive patterns in drinking have emerged in recent years, alcohol has consistently accounted for the largest proportion of treatment episodes for people receiving specialist alcohol and other drug treatment services over time.

■ ■ ■ **Nationally, the population rate of pure alcohol available for consumption has steadily declined since 2008–09—although mixed trends were apparent by jurisdiction.**

The total volume of pure alcohol available for consumption in Australia has increased from around 160 million litres of pure alcohol in 2004–05 to over 180 million litres in 2013–14. Once population growth was accounted for, apparent per capita consumption decreased from 10.8 litres per person in 2008–09 to 9.7 in 2013–14—this trend varied by jurisdiction.

■ ■ ■ **Research shows increasing the price of alcohol, restricting trading hours and reducing outlet density can have positive outcomes in reducing consumption and harms related to alcohol use.**

Reviews into the effectiveness of different strategies to reduce alcohol consumption and the negative consequences of drinking alcohol have found strong evidence for the effectiveness of restrictions on economic availability (such as increased taxes and minimum pricing) and physical availability (such as restricting the days and hours of sale).

■ ■ ■ **Across the Australian population the rate of alcohol use has decreased across several measures from 2004 to 2013 and the rate of treatment for alcohol has increased.**

The biggest decreases in rates were reported for Australians drinking at risky levels on a single occasion (11%) and over a lifetime (13%). From 2003–04 to 2013–14, the rate of service usage for clients receiving alcohol treatment has increased by 20%, from 25 treatment episodes per 10,000 people to 30 episodes per 10,000 people.

■ ■ ■ **Remote and very remote areas had higher rates than other areas for people drinking at risky levels and receiving treatment for alcohol in 2013; this was consistent over time.**

Rates for those living in *Remote and very remote areas* increased across several measures of risk from 2004 to 2013, including single occasion risk; lifetime risk and monthly drinking at very high levels. Rates of alcohol treatment also increased for this group, from 13 episodes per 1,000 in 2007–08 to 16 in 2013–14.

■ ■ ■ **Australians aged 18 to 24 were more likely than any other age group to drink at risky levels, but clients receiving treatment for alcohol were more likely to be aged over 40.**

In 2013, most Australians who reported single occasion risky drinking (47%), yearly drinking at very high levels (33%) and monthly drinking at very high levels (18%) were aged 18 to 24. Those who reported lifetime risky drinking were most likely to be aged 40–49 (23%); similarly, the largest group of clients in treatment for alcohol were aged 40–49 (49%).

1 Introduction

Drinking alcohol is widely accepted in Australia. However, it is also understood that alcohol use also presents many risks of short- and long-term harm to drinkers and those around them. In the short term, risks associated with drinking alcohol include anti-social behaviour, exposure to violence, including domestic and family violence, accidents and injury (Laslett et al. 2011). In the long term, risks range from chronic health conditions, such as cardiovascular diseases and cancer, and alcohol dependence (AIHW 2014a).

In 2011 in Australia, alcohol dependence has been reported as responsible for 1.5% of the total burden of disease, and alcohol was the third highest risk factor for disease (AIHW 2016b). Overall, alcohol was found to be the leading contributor to burden of disease for ages 0–44 in Australia in 2011; this has been the case for at least a decade.

Although alcohol consumption is a significant contributor to burden of disease in Australia, some positive trends have emerged. In 2013, more Australians abstained from alcohol, particularly young people aged 12–17, than in 2010 and those aged over 14 reported lower levels of drinking at risky levels compared with previous years (AIHW 2014a).

Despite these positive recent trends, some evidence suggests that very heavy episodic drinking has increased over time (Livingston 2015). Indeed, alcohol has consistently accounted for the largest proportion of treatment episodes for people receiving specialist alcohol and other drug (AOD) treatment, services that play a crucial role in reducing this burden over time (AIHW 2016a).

This report aims to identify the patterns that have emerged over time in the availability, use and treatment for alcohol. The results presented in this report provide insights that may assist policymakers and practitioners to tailor intervention strategies and services to reduce the harms associated with alcohol. They also indicate areas for further, more targeted research.

About this report

This report analyses the trends of 3 key aspects relating to alcohol in Australia: availability (including, trends from national data sources and a summary of the key findings from the literature); use; and treatment. The report also provides a summary of the key trends across these subjects from 2003–04 to 2014–15.

Several data sources have been used in this report; see the 'Data sources' section of this report for descriptions of each data source. Data used in this report are not exhaustive. None of these data sources are without limitations, and, although they represent significant proportions of the Australian population, there are some gaps in the scope of what they cover.

The National Drug Strategy Household Survey (NDSHS) is the leading national survey of licit and illicit drug use in Australia and one of the main sources for data on alcohol use at the national-level. *The Apparent consumption of alcohol, Australia, 2013–14* report by the Australia Bureau of Statistics (ABS 2015) is another leading source of information on alcohol consumption and the availability of alcohol in Australia (alcohol that is available for consumption in Australia). The Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS NMDS) is a comprehensive administrative dataset of people receiving services for their drug and alcohol-related issues.

Supplementary tables referred to in this report (tables with the prefix 'S') are available for download from <www.aihw.gov.au/publication-detail/?id=60129557147>.

2 Policy context

An individual's alcohol and other drug use is affected by a variety of factors, such as their social, cultural, economic and physical environment (Spooner & Hetherington 2005). As such, policy targeted at reducing drug use in the community sits within broader economic, social and welfare policy (Ritter et al. 2011). Government policies in different spaces will influence and contribute to the patterns of drug use observed in the Australian population.

This section provides a broad overview of the policies and strategies during the period 2003–04 to 2014–15 that were relevant to reducing the prevalence of risky drinking and the harms associated with alcohol use in Australia.

The National Drug Strategy

Since 1985, the National Drug Strategy (NDS) has provided the overarching framework for a consistent and coordinated approach to address licit and illicit drug use in Australia. Although the strategy has been regularly updated, there has been no change to the overarching approach, which focuses on harm minimisation.

Two iterations of the NDS, 2004–2009 and 2010–2015, cover most of the time period considered in this report. The principle of harm minimisation underpins these strategies. Harm minimisation encompasses 3 aspects (pillars): demand reduction, supply reduction and harm reduction.

Together, these aspects aim to: reduce misuse of drugs in the community; control and manage the supply of alcohol; and, reduce harms to communities, families and individuals. The NDS 2010–15 identified the significant harms that risky drinking, drinking to intoxication and alcohol-related disease continue to cause the community among its main challenges.

A draft Strategy has also been developed for the period 2016–2025. This strategy is once again underpinned by harm minimisation and its three pillars of demand reduction, supply reduction and harm reduction. It is anticipated that the 2016–2025 Strategy will seek to be more flexible in responding to changing priorities of the sector over time. Note that this is currently in draft form and certain details may change prior to the release of the final strategy.

The National Alcohol Strategy

The National Alcohol Strategy (NAS) 2006–2011 was developed in response to the patterns in the prevalence of high-risk alcohol consumption in Australia, and the harms and costs associated with high-risk consumption. The NAS had the broad goal and challenge of developing Australia's drinking cultures to produce healthier and safer outcomes. The strategy's 4 priority areas were: intoxication; public safety and amenity; health impacts; and cultural place and availability.

The NAS identified the many areas of influence that state, territory and local governments also had in reducing the harms associated with alcohol. For example, state and territory governments are involved in the development and implementation of strategies to reduce alcohol-related harm (such as trading-hour restrictions), as well as liquor-licensing review. While local governments support both national and state and territory government strategies, they also work with businesses, industry and community groups at a local-level, and deliver harm-minimisation programs through service delivery, land-use planning and co-enforcement with other regulatory agencies.

The National Binge Drinking Strategy

The Department of Health was initially responsible for the funding of the National Binge Drinking Strategy (NBDS) from 2008–09 to 2011–12. In 2010, the Australian Government provided further funding to expand the strategy, and the Australian National Preventive Health Agency became responsible for the strategy's implementation. The NBDS aimed to address Australia's harmful binge-drinking culture, especially among young people. The strategy aimed to affect the binge drinking culture at the local-level, by strengthening partnerships between local governments, sporting organisations, police and the non-government sector.

The key projects funded under the Department of Health's responsibility were:

- rounds 1 and 2 of the community-level initiatives to confront the culture of binge drinking
- an early-intervention program to act earlier to assist young people and ensure that they assume personal responsibility for their binge drinking
- an advertising campaign that confronted young people with the costs and consequences of binge drinking—the Don't Turn a Night Out into a Nightmare campaign.

The Australian National Preventative Health Agency was responsible for the expansion of the NBDS and this included the following:

- the third round of the community-level initiative grants and Australian Drug Foundation's Good Sports program
- Implementing the Be the Influence—Tackling Binge Drinking initiative.
- The National Preventative Health Agency was disbanded on 30 June 2014 and the Department of Health became responsible for the NBDS.

3 Alcohol availability

Compared with other drugs, particularly those that are controlled or illegal to possess or use, alcohol is readily available to people aged 18 and over. It is not only a legal substance, but its use is widely accepted amongst the Australian community. As such, availability of alcohol is a complex concept to explore, particularly in considering how it applies to problematic use.

Despite this, there are many reports and research articles exploring the availability of alcohol. These have generally focused on a range of measures aimed at reducing or restricting the supply of alcohol, with the ultimate goal of reducing the harms associated with its use.

Total volume of pure alcohol; per capita consumption—alcohol sales and tax

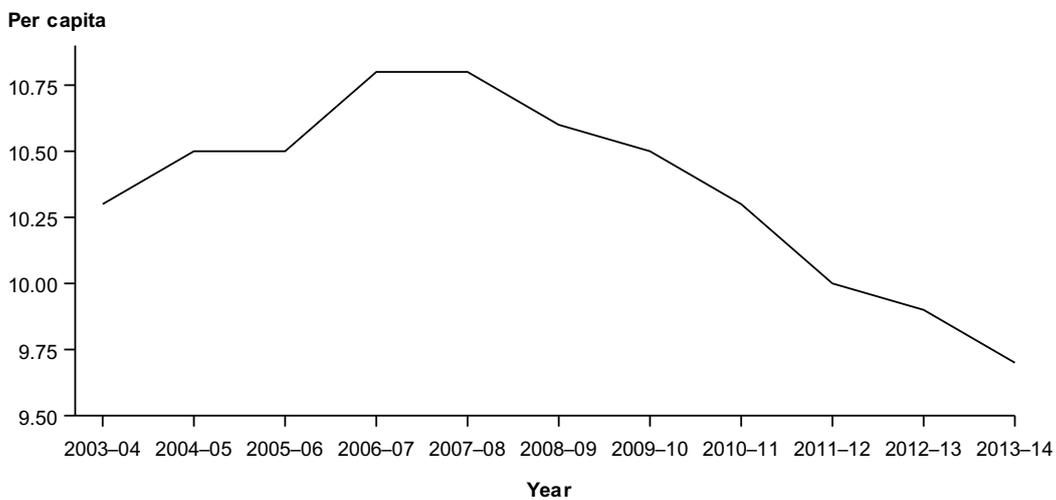
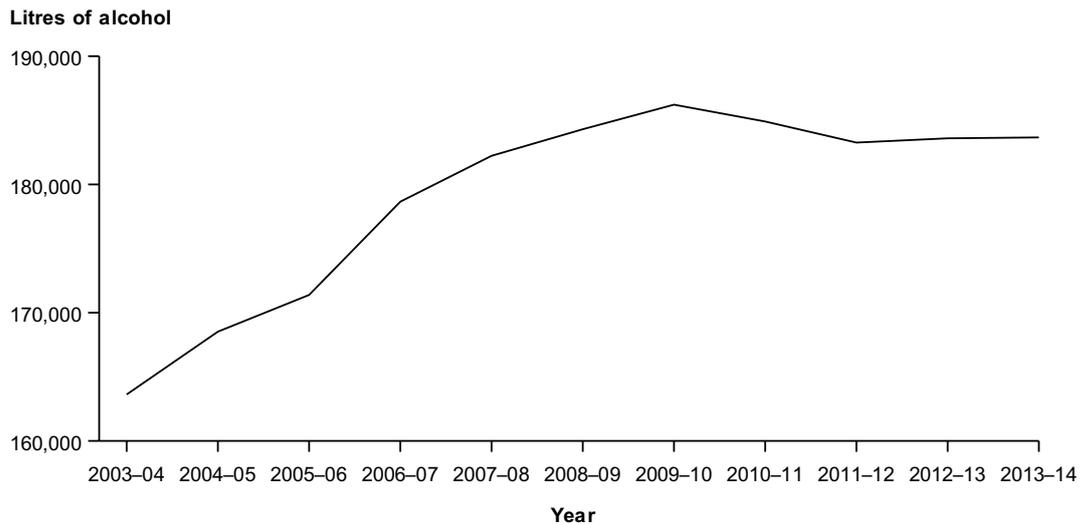
Measuring the total volume of pure alcohol available in Australia needs to be considered in the context of consumption as a rate per population (total volume of pure alcohol as a rate of the Australian population), as the majority of alcohol available for consumption is assumed to be consumed. This section presents both total volume of pure alcohol available and per capita consumption (PCC).

The reports of the Australian Bureau of Statistics (ABS) on *Apparent consumption of alcohol, Australia* include information from a range of sources to estimate both the total volume of alcohol available and the PCC in Australia. Similarly, the National Alcohol Sales Data Project (NASDP) reports on both of these measures using sales data from several jurisdictions. See 'Data sources' section for further details on these reports.

■ ■ ■ Nationally, the per capita rate of pure alcohol available for consumption steadily declined from 2008–09 to 2013–14—although there were mixed trends across jurisdictions.

The total volume of pure alcohol available for consumption in Australia increased by 12% from around 160 million litres of pure alcohol in 2004–05 to over 180 million litres in 2013–14 (Figure 1). Although the total volume of pure alcohol available for consumption increased over this time, apparent consumption declined from 10.8 litres per person in 2008–09 to 9.7 litres per person in 2013–14 (Figure 1). Note that this assumes alcohol is consumed equally across all people in Australia.

The latest NASDP report found that apparent consumption varied within different states and territories. In 2010–11, while trends in per capita consumption (PCC) in the Northern Territory and Queensland had both declined, in Western Australia PCC has steadily increased (from 11.23 litres in 2005–06 to 13.24 in 2010–11). Note, 2010–11 is the latest available data from the NASDP, and it currently collects information from, Queensland, Western Australia, Northern Territory and Australian Capital Territory only. PCC was not available for the Australian Capital Territory (Loxley et al. 2014).

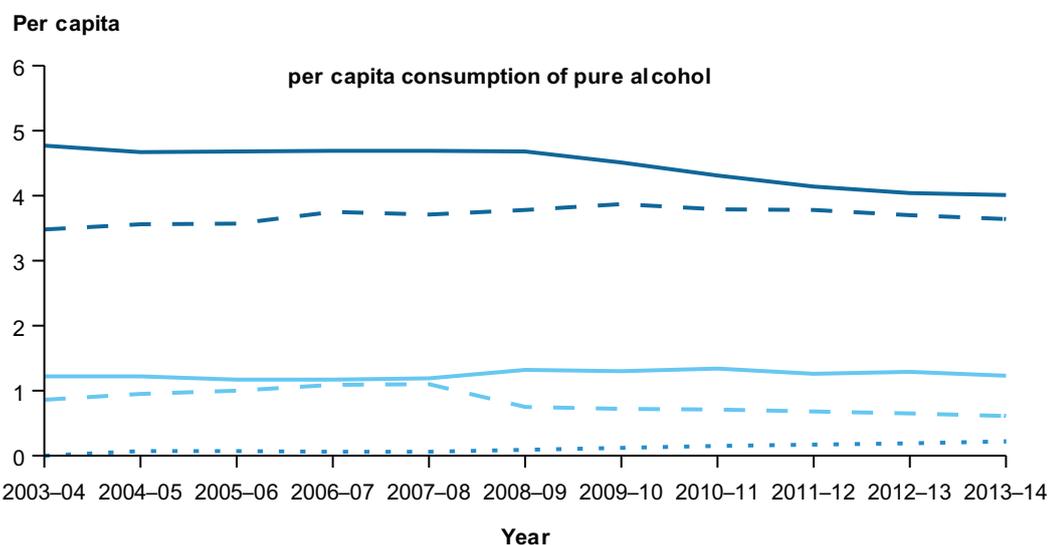
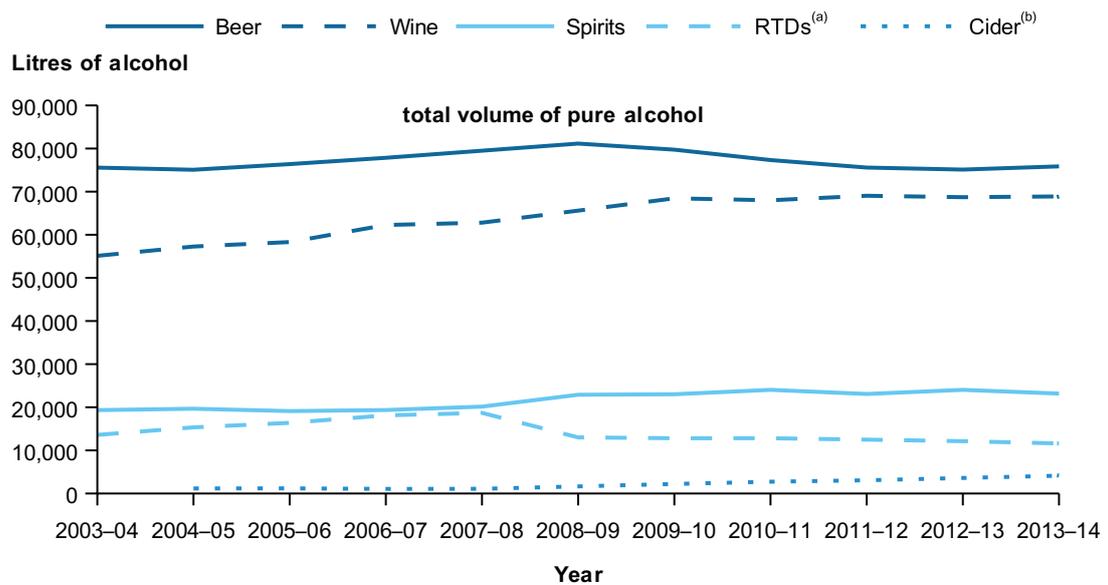


Source: Apparent consumption of alcohol, Australia, 2013–14 (ABS 2015).

Figure 1: Total volume of pure alcohol available for consumption and per capita consumption of pure alcohol in Australia, 2003–04 to 2013–14

Recent trends in the types of alcohol consumed have also varied. Nationally, beer and wine have remained the most available types of alcohol in the last 11 years, although PCC of beer has continually decreased since 2008–09 (see Figure 2 and ABS 2015).

While the PCC of most types of alcohol decreased from 2003–04 to 2013–14, it increased slightly for cider, from 0.07% to 0.22%—although it remained at relatively low-levels. Ready-to-drink (RTD) beverages were the only type of alcohol to decrease in the volume available over the full period, by around 15 per cent (Figure 2).



(a) Ready-to-drink (pre-mixed) beverages.

(b) See Apparent consumption of Alcohol, Australia, 2013–14 (ABS 2015) for measurements of total volume for cider.

Source: Apparent consumption of alcohol, Australia, 2013–14 (ABS 2015).

Figure 2: Alcohol available for consumption and per capita consumption of pure alcohol, by type of alcohol, 2003–04 to 2013–14

These findings highlight the difficulty in measuring availability and consumption nationally, and the importance of analysing different population groups—see ‘Alcohol use’ section below for analyses of different population groups. Rankin and Livingston (2016) argued that transaction-level data, including price, volume and standardised retail outlet-level data, can provide more reliable and detailed data at more detailed levels of geography. The inclusion of more jurisdictions and sub-jurisdictional data in future reporting will help improve reporting on alcohol availability and consumption.

Restricting alcohol availability

While the information above helps to set the context of alcohol in Australia, measures that aim to reduce the harms associated with alcohol by restricting alcohol availability are equally important to policymakers. This section summarises some of the key areas in the recent literature dealing with these measures.

The measures taken to reduce the supply, or availability, of alcohol cover 2 broad areas; physical availability, and economic availability. Physical availability refers to the ease or convenience of obtaining alcohol for drinking purposes, while economic availability of alcohol refers to the effective or full price of alcoholic beverages (Table 1).

Table 1: Common measures used to reduce alcohol availability

Type of availability	Measures
Physical availability	<p>The licensing, of on- or off-premise retail sales of alcohol, including factors such as government monopolies of off-premise retail sales outlets</p> <p>General or special limits on opening hours and days for alcohol sales</p> <p>Regulations covering the placement, location and sales practices (for example, self-service or over-the-counter) of alcohol retail sale outlets</p> <p>Rules on maximum size or number of drinks to be served to a customer at 1 time</p> <p>Legal age limits for selling, buying, possessing or drinking alcoholic beverages</p> <p>Restrictions on sales of alcohol, such as sales of certain alcohol types, sales to intoxicated persons or people of certain religious or ethnic groups, or specific rules according to age and sex</p>
Economic availability	<p>Any measures that affect alcohol prices, such as tax and excise arrangements</p> <p>Rules on minimum and maximum prices of alcohol</p> <p>Rules on profit margins on retailing alcohol</p>

Research shows increasing the price of alcohol, restricting trading hours and reducing outlet density can have positive outcomes in reducing consumption and harms related to alcohol use.

In 2007, the National Drug Research Institute (NDRI) conducted a review of the different measures on restricting the availability of alcohol (NDRI 2007). In the review, the NDRI considered 2 measures to have the most consistent and strongest evidence base for restricting alcohol supply and reducing negative outcomes from alcohol use:

- restrictions on the economic availability of alcohol, namely through taxation and pricing
- restrictions on hours and days of sale for licensed premises.

The NDRI review also noted there is a large body of research that shows evidence for restricting the outlet density of licensed premises and reductions in harms associated with alcohol (see the 'Liquor licensing and outlet density' section below).

Taxation and pricing of alcohol

The theory behind taxation and pricing of alcohol is that consumers respond to changes in the price of alcohol as they do with other products. In their analysis of the evidence, Gilmore and others (2016) found that reducing the affordability of alcohol had the strongest evidence of any intervention for reducing the alcohol-related harms at the population level. In a similar review, Anderson and others (2009) found several positive outcomes from increasing the price of alcohol. Significantly, the studies they reviewed found that increased taxes on alcohol reduced the consumption of and harm related to alcohol. They found that price increases reduced overall consumption, harms caused by alcohol, alcohol dependence and reductions in heavy drinking among young people (Anderson et al. 2009). They also found that heavy drinkers generally preferred cheaper drinks and that setting a minimum price per unit gram of alcohol alongside price increases would have a much greater effect on heavier drinkers.

Hours and days of sale for licensed premises

Several reviews have found positive outcomes resulting from restricting the hours and days of sale for alcohol (see Gilmore et al. 2016 and Anderson et al. 2009). For example, Anderson and others (2009) found that a reduction of the hours or days of sale of alcoholic beverages were associated with fewer alcohol-related problems, including homicides and assaults. In contrast, extending the times of sale often led to overall increases in consumption and associated problems. A review by Popova and others (2009) also found extended trading hours to be associated with increases in monthly assaults, and later trading hours to significantly correspond to an increase in monthly crash rates.

Liquor licensing and outlet density

Outlet density generally refers to the number of premises located within a certain geographical area—for example, a square kilometre road network (Kavanagh et al. 2011). What constitutes an outlet generally comes under 2 main categories: on-site and off-site. An on-site outlet is one where the alcohol is consumed on the premises, and an off-site outlet is one where the alcohol is taken away for consumption—off-site outlets are generally categorised as either liquor chains or independent stores.

Generally, research into outlet density has found a positive association with lower outlet density and alcohol-related harm (MDCH et al. 2011). Morrison and Smith (2015) found that the number of chain outlets was strongly associated with trauma risk. They found each additional chain outlet was associated with a 35% increase in intentional injuries and a 22% increase in unintentional injuries to individuals.

Livingston (2011) found an important difference in the types of harm associated with different outlets. Outlet density was positively associated with violence—specifically, assault-related hospital admissions—which much of the literature confirms. Livingston (2011) also found that off-site outlet density was related to long-term harms, such as alcohol use disorders. Corresponding to Livingston's findings, Liang and Chikritzhs (2011) argued that it may be more appropriate to apply different measures to different types of outlets.

While there is a large body of research analysing the effectiveness of outlet density, there is some debate among researchers on the strength of this evidence. Gmel and others (2016) argue that much of the evidence is too diverse and with a great risk of bias to generalise the results for policy. In response to this, Morrison and others (2016) argued that Gmel and others (2016) did not adequately assess each study on its own merits and overstated the potential for bias in the literature.

4 Alcohol use

While alcohol is consumed widely in Australia, it is the harms associated with alcohol use that are of most concern to individuals and the community. Drinking at harmful levels is associated with increased risk of chronic disease, injury and premature death (AIHW 2014a).

Harms associated with alcohol can include short-term and long-term health effects. Short-term harm is associated with violence, anti-social behaviours and accidents, whereas long-term harm is usually associated with dependence and other chronic conditions, such as cardiovascular diseases and mental illness (AIHW 2014a). As such, harmful drinking is usually measured through drinking habits associated with a single occasion or over a lifetime.

Given that risks of short- and long-term harms are usually associated with different drinking patterns, this report uses several measures to show trends in use associated with harmful effects, particularly those that are likely to result in people needing treatment. See Box 1 for the different types of use reported here. All data in this section are from the National Drug Strategy Household Survey (NDSHS).

Box 1: Types of alcohol use

There are several measures of harmful drinking habits:

- **Single occasion risk (monthly)***—drinking more than 4 standard drinks on a single occasion on at least a monthly basis.
- **Lifetime risk***—drinking more than 2 standard drinks a day, on average.
- **Very high risk (yearly, monthly or weekly)**—had consumed 11 or more standard drinks on a single occasion at least yearly, at least monthly or at least weekly in the past 12 months.

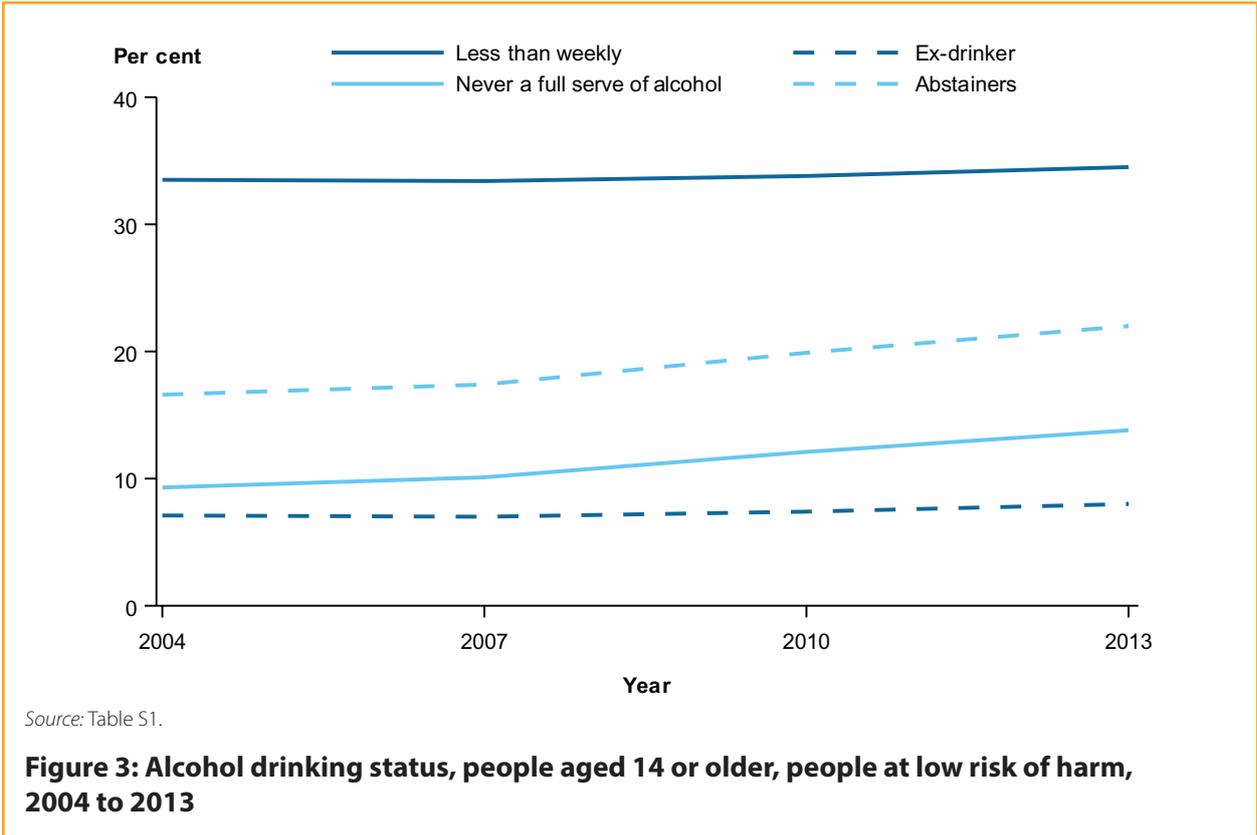
To put the above measures in the context of the broader population, additional measures are reported:

- **Weekly**—consumed an alcohol drink of any kind on a weekly basis.
- **Daily**—consumed an alcoholic drink of any kind on at least a daily basis.
- **Low-risk**—drinking 4 or fewer drinks in a single occasion on a monthly basis.
- **Abstainers**—people who have never consumed alcohol.
- **Ex-drinkers**—people who have not consumed alcohol in the past 12 months.

* These measures of risk are based on the Australian guidelines to reduce health risks from drinking alcohol (NHMRC 2009); all remaining measures are based on those used in the National Drug Strategy Household Survey detailed report, 2013 (AIHW 2014b). See Glossary for further details.

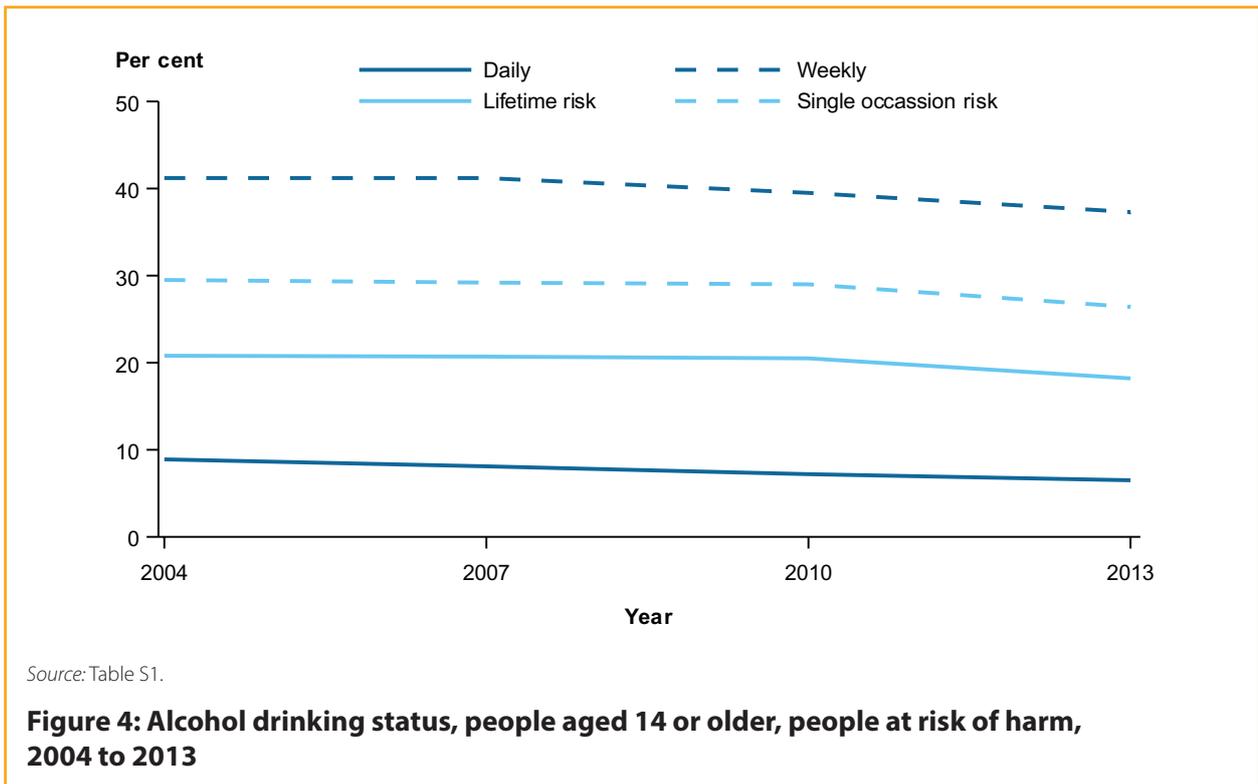
Who is drinking alcohol?

In 2013, just over 15 million Australians (around 78% of the population) had consumed alcohol in the previous 12 months, while 22% had not consumed any alcohol (AIHW 2014b). Although a substantial proportion of Australians reported drinking alcohol, across most measures of drinking (especially those measuring risk) there were positive signs in the recent trends in different drinking habits. Noticeably, there were increases in the rate of Australians who had never had a full serving of alcohol (see glossary for definition), from 9.3% in 2004 to 14% in 2013; in the rate of ex-drinkers, from 7.1% to 8%; and in the rate of people abstaining from alcohol, from 17% to 22% (Figure 3).



In 2013, around 5 million Australians reported drinking alcohol at risky-levels on a single occasion, and just under 3.5 million Australians reported drinking at lifetime risky levels. Similar to other drinking patterns, from 2010 to 2013 there were decreases seen across a range of measures of alcohol consumption in Australia. Reductions were reported for; daily drinkers (7.2% to 6.5%), weekly drinkers (40% to 37%); single-occasion risky drinkers (29% to 26%) and lifetime risky drinkers (21% to 18%) (Figure 4).



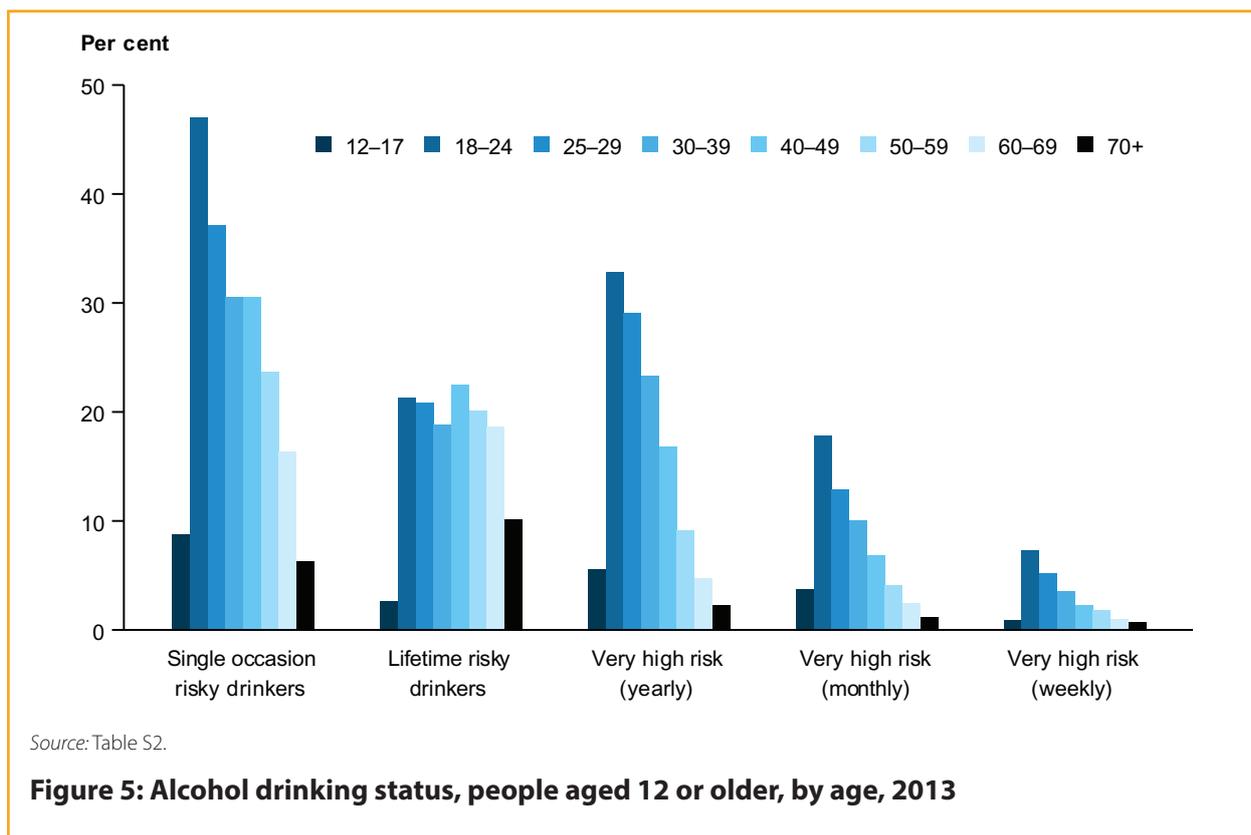


In 2013, over 3 million Australians reported drinking 11 or more standard drinks in a single occasion at least yearly—in other words, they drank at very high levels of risk. As with other groups, there was a decrease in Australians drinking at very high levels of risk. From 2010 to 2013, Australians drinking yearly at very high levels of risk decreased (17% to 16%); monthly at very high levels (8.7% to 7.5%); and weekly at very high levels (4.1% to 2.9%).

Australians aged 18–24 were more likely than any other age group to drink at risky levels for all but one measure of risky drinking.

Australians aged 18–24 were most likely to report single occasion risky drinking (47%), yearly drinking at very high levels (33%) and monthly drinking at very high levels (18%) (Figure 5). Lifetime risky drinking was the only exception to this pattern—Australians aged 40–49 were the most likely to report this form of risky drinking (23%). However, Australians aged 18–24 were still the next most likely age group to report this type of drinking (21%) (Table S2).

The patterns of drinking among different age groups in the Australian population differ slightly to those in treatment for alcohol use, where most clients were aged 40–49 (see ‘Treatment’ section below). Although the age patterns of Australians drinking at lifetime risk levels were similar to those in treatment. While the age patterns of other risky drinking habits were not aligned to those seen in AOD treatment services, it is possible that problems associated with drinking do not develop until later stages of life, or people do not seek treatment for these problems until later stages of life.



Higher rates of risky drinking were reported among people living in *Remote and very remote* areas who were single and without children, or homosexual/bisexual*.

People living in *Remote and very remote* areas were more likely to report risky drinking than people living in *Major cities*—across all measures of risk. In 2013, the rate of people living in *Remote and very remote* areas reporting risky drinking over a lifetime, and monthly and weekly at very high levels was over twice that of people living in *Major cities* (Table S5). For example, 7.0% of people in *Remote and very remote* areas reported drinking weekly at very high levels, whereas 2.7% of people in *Major cities* reported this level of drinking. People living in *Inner regional* areas (54%) and *Major cities* (52%) were more likely to report drinking at low-risk levels than people in *Remote and very remote* areas (40%).

People who identified as homosexual or bisexual (LGB) were also more likely to report risky drinking across all measures and this increased as risk increased. In 2013, the proportion of people who identified as LGB and drinking monthly and weekly at very high levels was double that of people who identified as heterosexual. For example, 15% of people who identified as LGB reported drinking monthly at very high levels compared with 7% of people who identified as heterosexual (Table S3).

* The characteristics of alcohol users described here are not mutually exclusive and often overlap with other characteristics. For example, people with low SES are often unemployed, and/or do not have educational qualifications. In addition, people within disadvantaged groups may experience different levels of disadvantage and belong to 1 or multiple groups.

Higher proportions of single people without children reported drinking across all very high risk measures than any other group of people in 2013; whereas they were the second least likely to report drinking at low-levels of risk (Table S3).

While for most measures there were higher proportions of employed people reporting risky drinking, there were higher rates of unemployed people who reported drinking monthly at very high levels (11.9% compared with 9.5%) and weekly at very high levels (5.9% compared with 3.3%) (Table S4).

People drinking at very high levels were twice as likely as low-risk drinkers to drink at licensed premises. The price of a usual drink in 2013 was less likely to cause people to reduce drinking than in 2010.

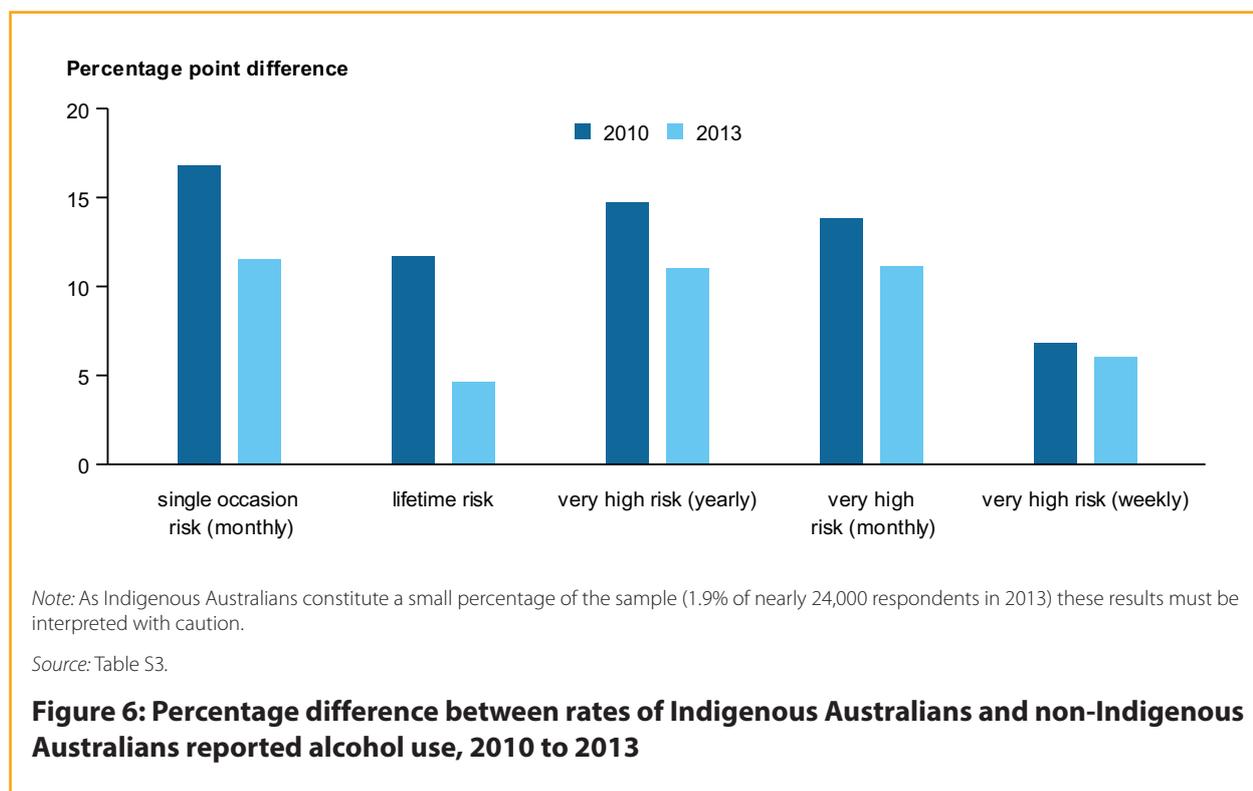
The rate of people reporting the price of a usual drink as their reason for reducing their alcohol intake decreased across all risk measures. The rate decreased the most for those drinking weekly at very high levels (14% in 2010 to 4.9% in 2013) (Table S7).

People drinking at all levels of risk were more likely to usually consume alcohol in their own home. The rate was highest (90%) for people who reported lifetime risky drinking—an increase from 73% in 2004. The rate of people usually drinking at licensed premises increased as risk increased (31% for low-risk drinkers, compared with 62% of people drinking weekly at very high levels) (Table S6).

Although higher rates of risky drinking were reported for Indigenous Australians than non-Indigenous Australians the gap between these 2 groups has decreased.

Indigenous Australians were more likely than non-Indigenous Australians to report risky drinking on a single occasion (38% compared with 26%). However, the proportion of Indigenous Australians who reported drinking weekly at very high levels was over 3 times that reported by non-Indigenous Australians: (8.8% compared with 2.8%) (Table S3).

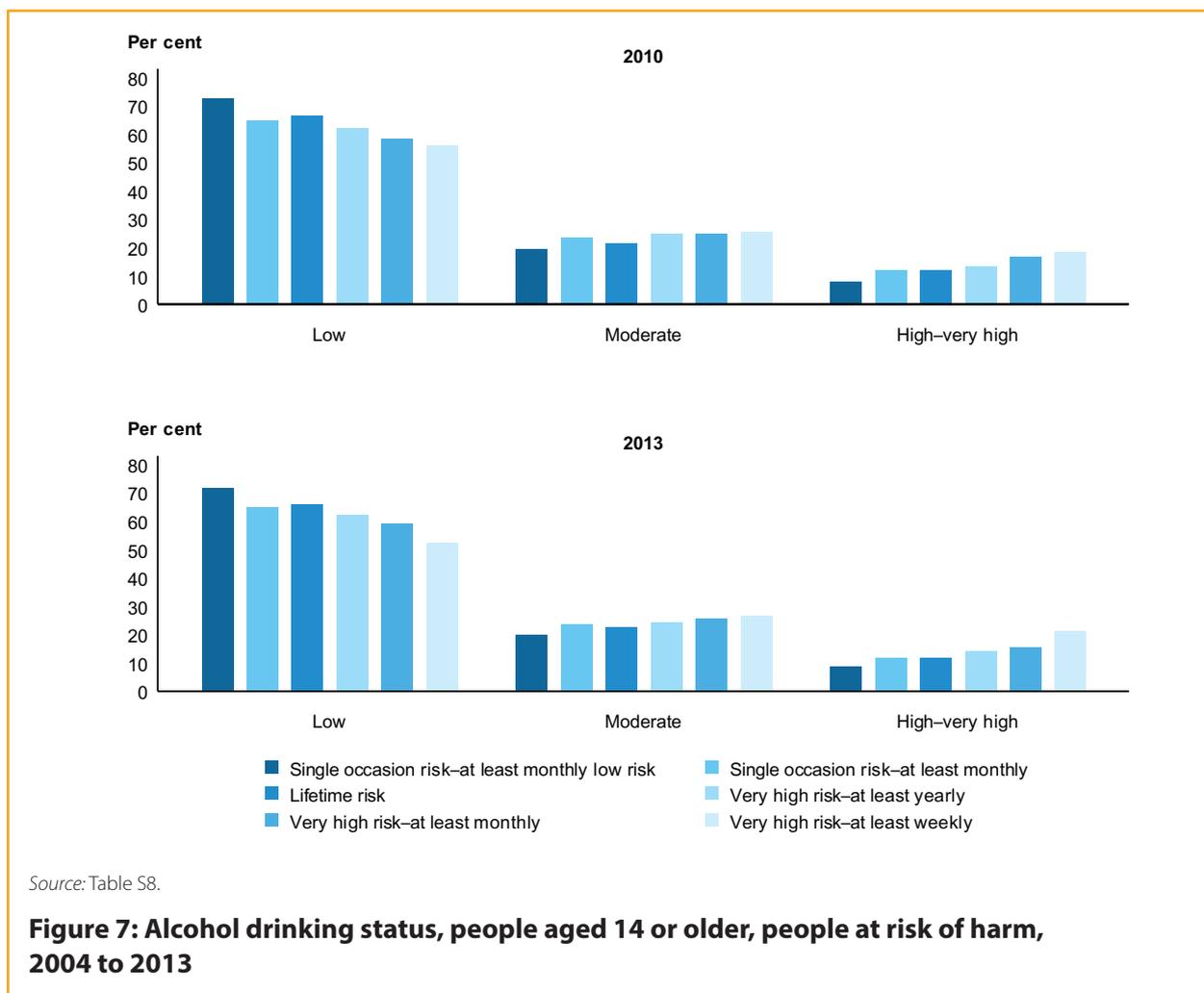
However, across all risky drinking measures, the gap in rates reported between these 2 groups has decreased over time. From 2010 to 2013, the biggest decrease was reported for lifetime risk: 32% for Indigenous Australians compared with 20% for non-Indigenous Australians in 2010, and 23% compared with 18% in 2013 (Figure 6).



Higher rates of all people drinking at very high levels reported experiencing high levels of psychological distress; 1.6 times as likely as low-risk drinkers.

In 2013, higher rates of people drinking at very high levels (yearly, monthly or weekly) also reported high or very high levels of psychological distress. People drinking weekly at very high levels were more than twice as likely as low-risk drinkers to report high or very high levels of psychological distress (21% compared with 8.6%) (Figure 7 and Table S8).

Furthermore, while there was little change in the proportion of adults who reported low-risk drinking and high levels of psychological distress (from 8.0% in 2010 to 8.6% in 2013); there was an increase in the proportion of people who reported both drinking at very high levels and high levels of psychological distress. For example, 18% in 2010 compared with 21% in 2013 drank weekly at very high levels and also reported high psychological distress (Figure 7).

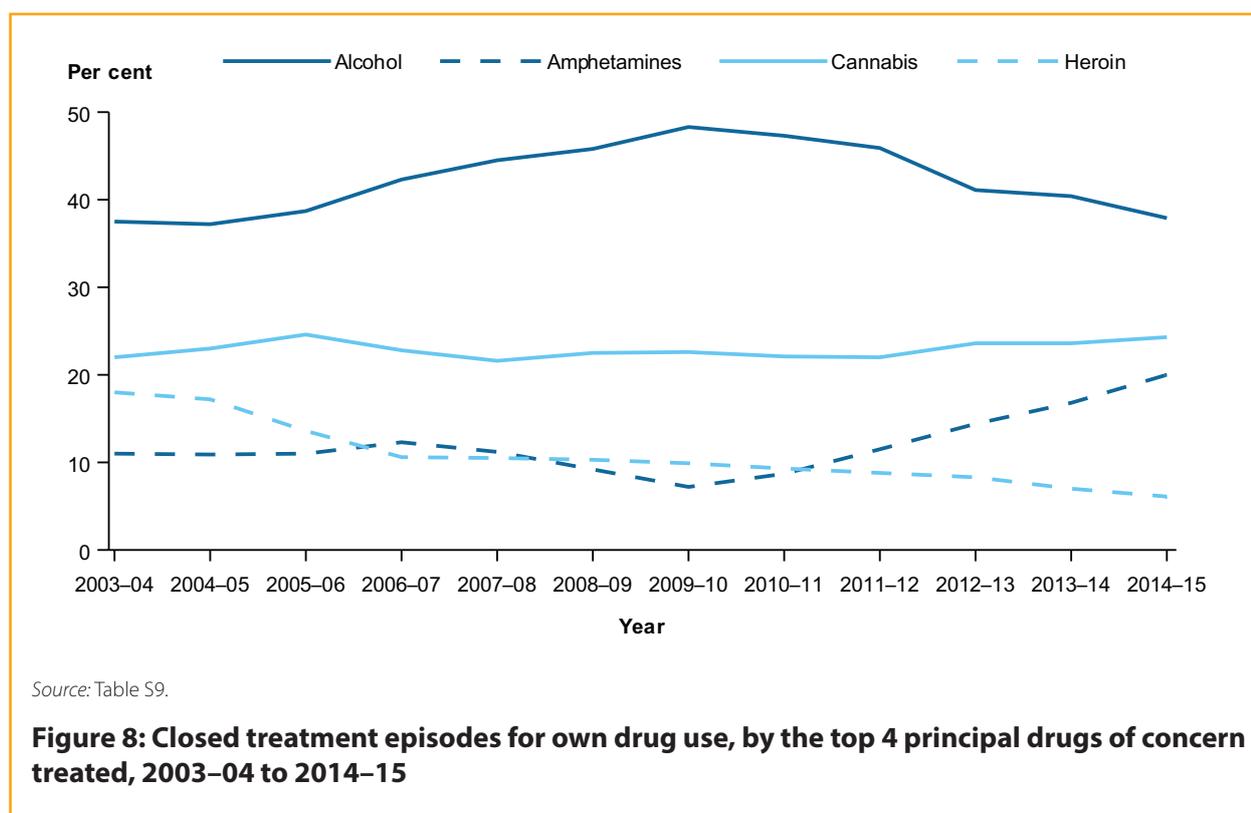


For people drinking at all levels of risk, health reasons were the most commonly reported reason for reducing alcohol intake—higher for low-risk drinkers than all other measures of risk. These rates increased across all measures of risk from 2004 to 2013, except for low-risk drinking (Table S7). The largest increase over this time was for people drinking weekly at very high levels (45% in 2010 to 56% in 2013).

5 Alcohol treatment

A range of treatment types are available in Australia through alcohol and other drug (AOD) treatment services to assist people with problematic drug use. Most services aim to reduce the harm of drug use, for example, through counselling and diversion programs, while others use a structured drug-free setting with abstinence-oriented interventions. This section presents information on treatment episodes delivered by publicly-funded treatment services for alcohol use from the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) (see 'Data gaps and limitations' section).

In 2014–15, AOD treatment services provided a total of 170,367 closed treatment episodes, an increase of 24% since 2003–04 (136,869 episodes). While there are many different drugs people receive treatment for, the most common principal drugs of concern (the primary drug leading someone to seek treatment)—alcohol, cannabis, heroin and amphetamines—have accounted for the majority of services over time (Figure 8).



Who receives treatment for alcohol use?

Since 2003–04, alcohol has been the most common principal drug of concern for which people received alcohol and other drug treatment. While steadily increasing from 38% of closed treatment episodes in 2003–04 to a peak of 48% in 2009–10, this proportion has subsequently declined, returning to its lowest proportion seen since 2003–04 (38%) (Table S9).

In over two-thirds (69%) of episodes with a principal drug of concern of alcohol, the client reported additional drugs of concern. These were most commonly cannabis (23%), nicotine (21%) and amphetamines (11%) (Table S9).

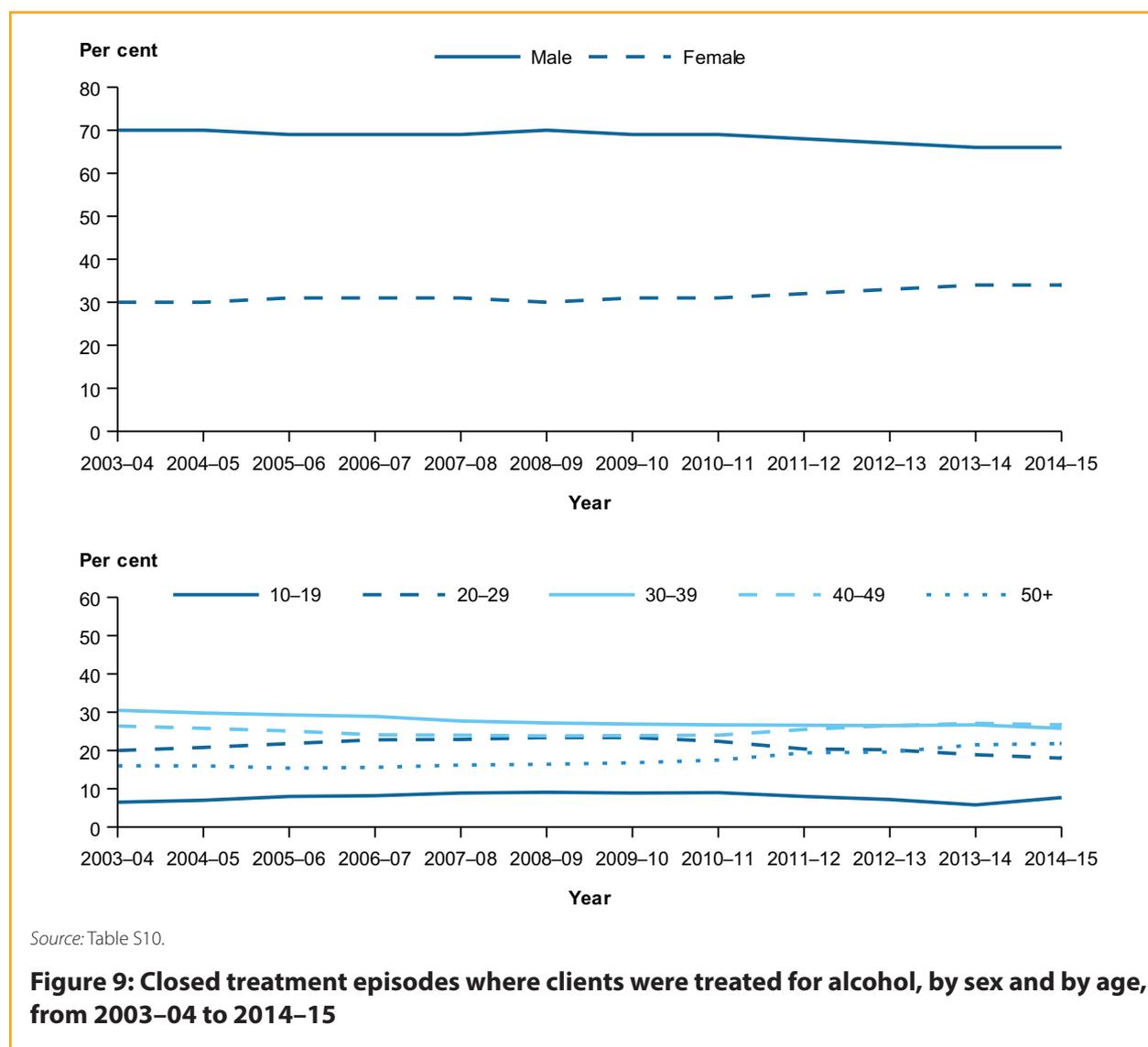
In 2014–15, alcohol was the most commonly reported additional drug of concern for clients who received treatment for ecstasy (33%), cocaine (30%), nicotine (28%), benzodiazepines (25%) and codeine (20%) (Table S9).

In 2014–15, clients receiving treatment episodes for alcohol were most likely to be males and aged over 40.

In 2014–15, in two-thirds of treatment episodes for clients drinking alcohol, the clients were male (66%). This proportion had declined slightly compared with 2003–04 (70% of episodes), meaning the proportion of females has risen from 30% to 34% of episodes in 2014–15 (Figure 9).

While the majority of clients were aged between 20 and 49 years over this period, the proportion in this age range decreased slightly from 2003–04 to 2014–15 (77% of episodes to 71%) (Figure 9). This decrease appears to equate to an ageing of clients who have received treatment for alcohol use, with the proportion of clients aged 40 and over increasing from 42% of episodes in 2003–04 to 49% in 2014–15 (Table S10).

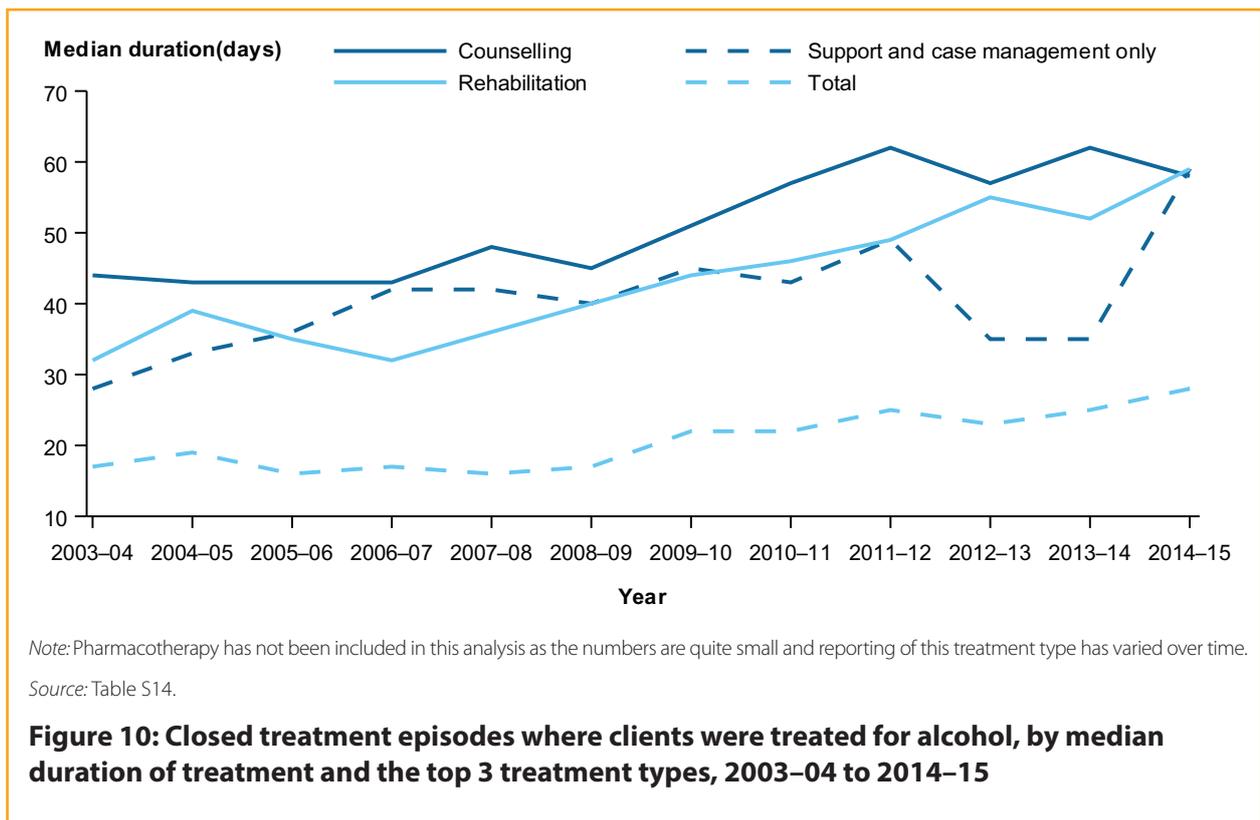
In 2014–15, Indigenous Australians received treatment for alcohol in almost one-fifth (18%) of closed treatment episodes. This proportion almost doubled from 2003–04 to 2014–15, with an 84% increase in the number of episodes for Indigenous Australians receiving treatment for alcohol (Table S11). It is important to note when interpreting results of Indigenous Australians that this is likely an undercount, as not all services catering for Indigenous Australians are covered in the AODTS NMDS (see ‘Data sources’ for more details).



Counselling was the most common service for clients using alcohol and they spent a median duration in treatment of 4 weeks.

In 2014–15, the most common main treatment type (the primary activity used to treat the client’s AOD problem) for episodes where alcohol was the principal drug of concern was counselling (43%), followed by assessment only (17%) and withdrawal management (17%) (Table S12). This distribution is similar to treatment episodes for other commonly reported drugs, especially for counselling, which is consistently the highest reported treatment type. While the proportion of episodes where counselling was the main treatment type has fluctuated somewhat since 2003–04, it has remained fairly consistent at around 40% of treatment episodes; being highest at 45% in 2012–13 and lowest at 39% in 2008–09 (Table S12). For Indigenous clients, counselling was also the main treatment type received (44% of episodes in 2014–15) and this has increased since 2003–04 (from 35% to 44% of episodes) (Table S13).

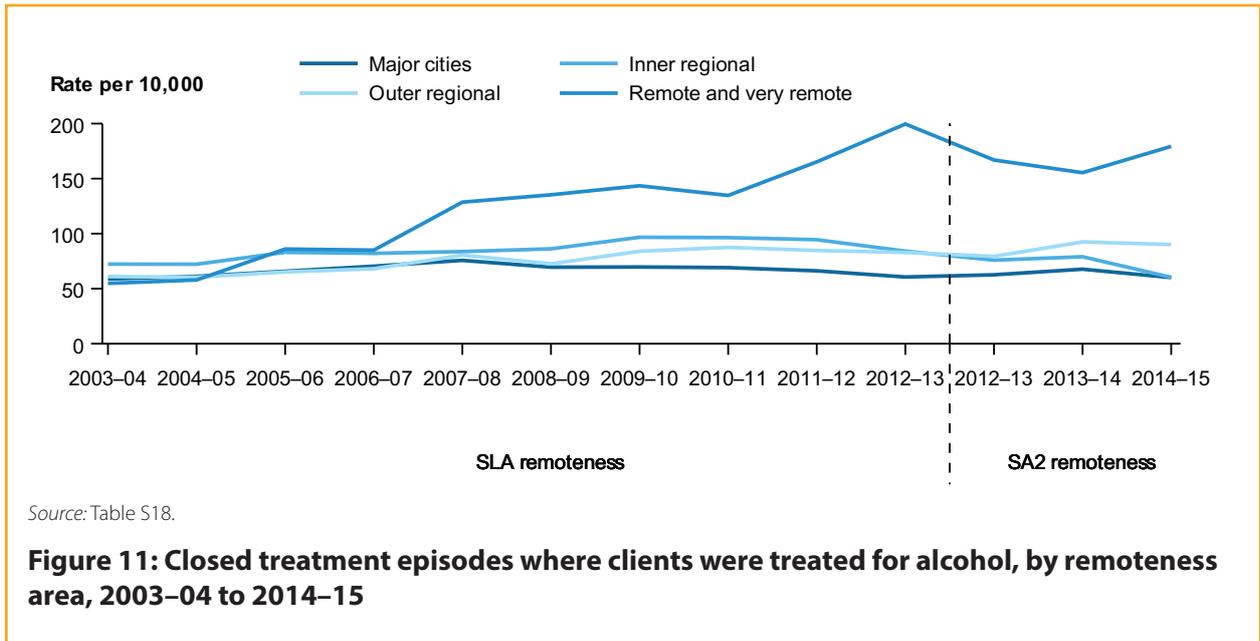
Treatment for alcohol was most likely to take place in a non-residential treatment facility (62%) and last a median duration of 4 weeks (28 days)—longer when compared to all treatment episodes in 2014–15 (22 days) (Table S14). However, episode duration varied by the main treatment type—episodes for rehabilitation, support and case management only, and counselling had a median duration of just over 8 weeks (58–59 days) (Figure 10). Typical episodes with withdrawal management ended just after 1 week (8 days) and information and education only lasted a median duration of 1 day. The median days spent in treatment was higher for Indigenous clients, with a median duration of 34 days overall, compared with 26 days for non-Indigenous clients.



For most treatment episodes where alcohol was the principal drug of concern the referral source was self/family (42%), followed by health services (32%). Over three-fifths (62%) of episodes ended with an expected cessation and just over one-fifth (22%) of episodes ended with an unexpected cessation (Table S15), with the remainder of episodes ending due to either a treatment change, or other reasons, see ‘Glossary’ for definition of cessation reason.

Most people in treatment for alcohol were in *Major cities*, but the rate of service usage in the population for alcohol treatment in *Remote and very remote areas* has increased significantly compared with other regions.

From 2003–04 to 2014–15 the majority of clients have received treatment for alcohol in *Major cities*, from 66% of treatment episodes in 2003–04 to 65% in 2014–15. However, the rate of service usage in the population has increased substantially for *Remote and very remote areas*—from 55 episodes per 10,000 people in 2003–04 to 180 per 10,000 in 2014–15). Service usage has been greatest in *Remote and very remote areas* since 2007–08, consistently increasing to 2012–13 (Figure 11). Over this time, the next highest rate of service usage was in *Inner regional areas*, ranging from 72 episodes per 10,000 in 2003–04, to 84 in 2012–13. Note that in 2012–13 there was a major change in geographical classifications, comparisons between these 2 classifications should be made with caution.



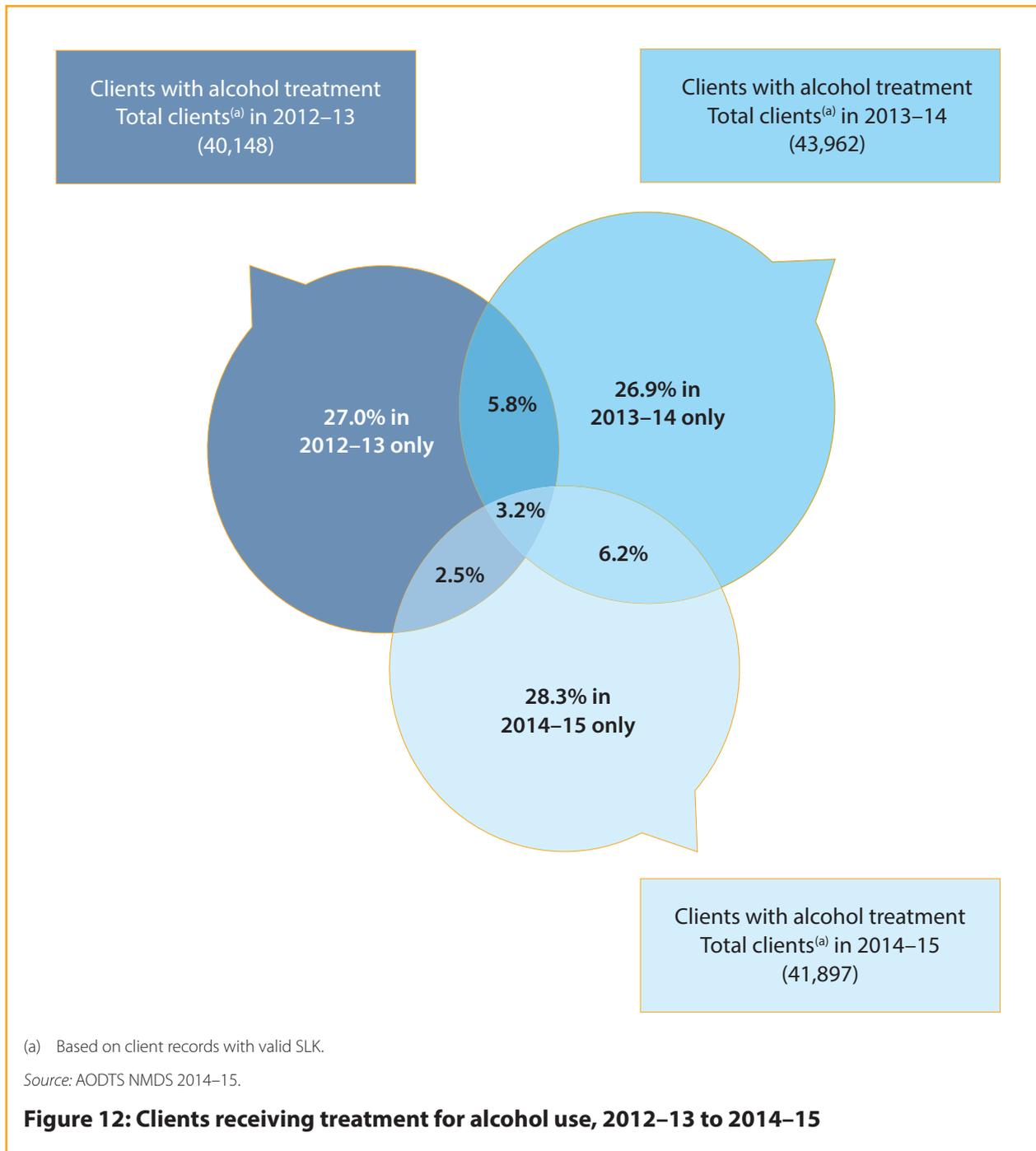
Clients in AOD Treatment, 2012–13 to 2014–15

Information at client-level in the AODTS NMDS has been available since 2012–13. Client-level analysis was made possible from the introduction of linkage key (SLK-581) in this reporting period, see *Alcohol and other drug treatment services in Australia 2014–15*, for more details.

Over the 3 year period from 2012–13 and 2014–15, almost one-fifth (18%) of clients receiving treatment for alcohol had received support in more than 1 reporting year (Figure 12). A small proportion of these clients (3.2%) had received support in all 3 years.

This was lower than all clients receiving AOD treatment; a third (33%) of whom received treatment in more than 1 reporting year, and 3.9% in all 3 years.

This is interesting given treatment of alcohol consistently accounts for the largest proportion of treatment episodes. This suggests that more new people are commencing treatment for alcohol than the same people returning for treatment.



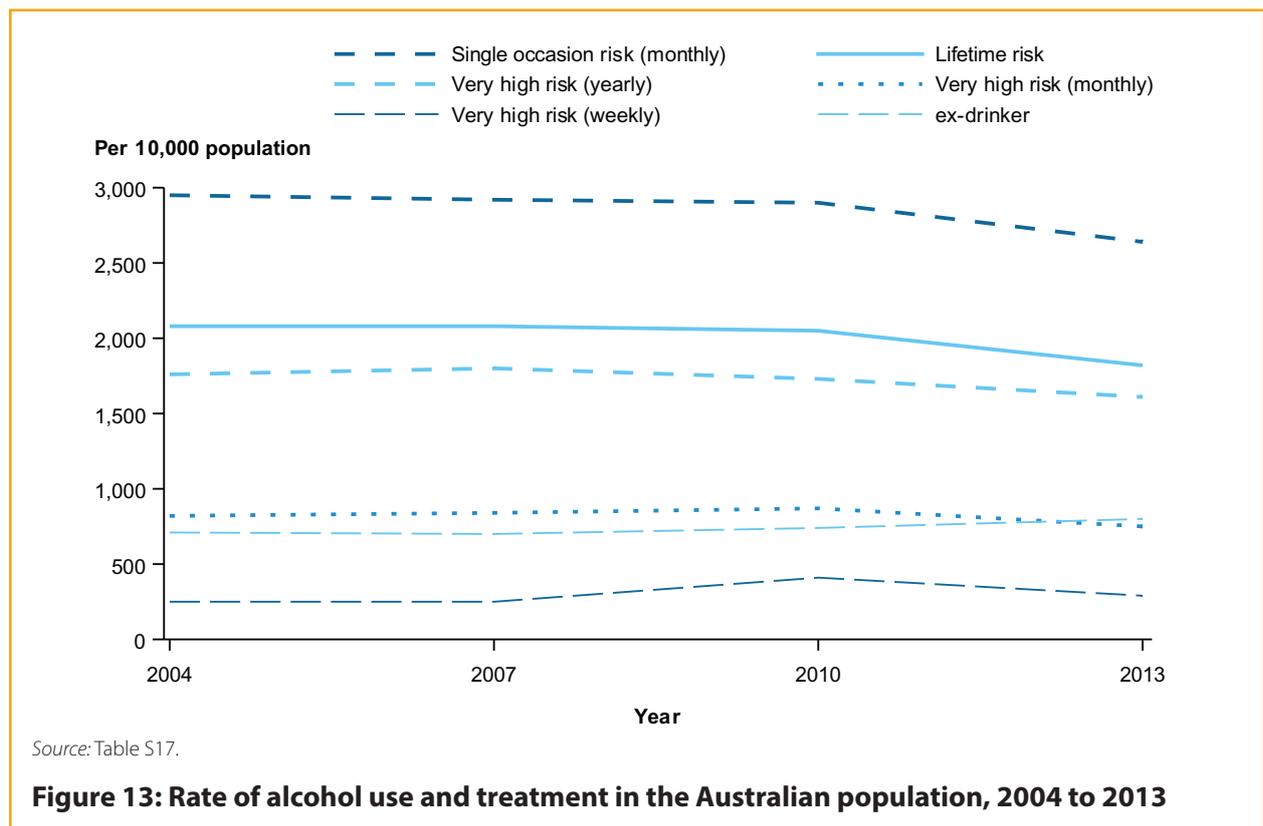
6 Trends from 2003–04 to 2014–15

Analysis of the trends in the availability, use and treatment of Alcohol can provide useful insights into the full extent of the impacts of its use in the population. In turn, it can also provide researchers and policy makers with indications of where to focus their efforts in future strategies and interventions to reduce the associated harms related to alcohol use.

■ ■ ■ **Across the Australian population, while the rate of alcohol use has decreased across several measures, the rate of treatment for alcohol has increased.**

From 2004 to 2013, there were decreases in the rates of Australians drinking alcohol across all measures of risky drinking (Figure 13). The biggest decreases were reported for Australians drinking at risky levels in a single occasion, at least monthly (decreasing by 310 people per 10,000, or 11%) and over a lifetime (decreasing by 260 people per 10,000, or 13%). Coinciding with these decreases, there were also increases seen in the number and rate of people who had not drunk in the previous 12 months, but had drunk in the past (ex-drinkers) (by 90 people per 10,000, or 13%).

Over the same time period as the decreases in drinking has occurred, service usage for clients receiving alcohol treatment has increased—overall, and as a rate of the population. In 2003–04, there were over 48,000 treatment episodes for people receiving treatment for alcohol, a rate of 25 treatment episodes per 10,000 people (Table S17). However, in 2013–14, this had increased to almost 70,000 episodes and a rate of 30 episodes per 10,000 people (an increase in the rate of 20%).

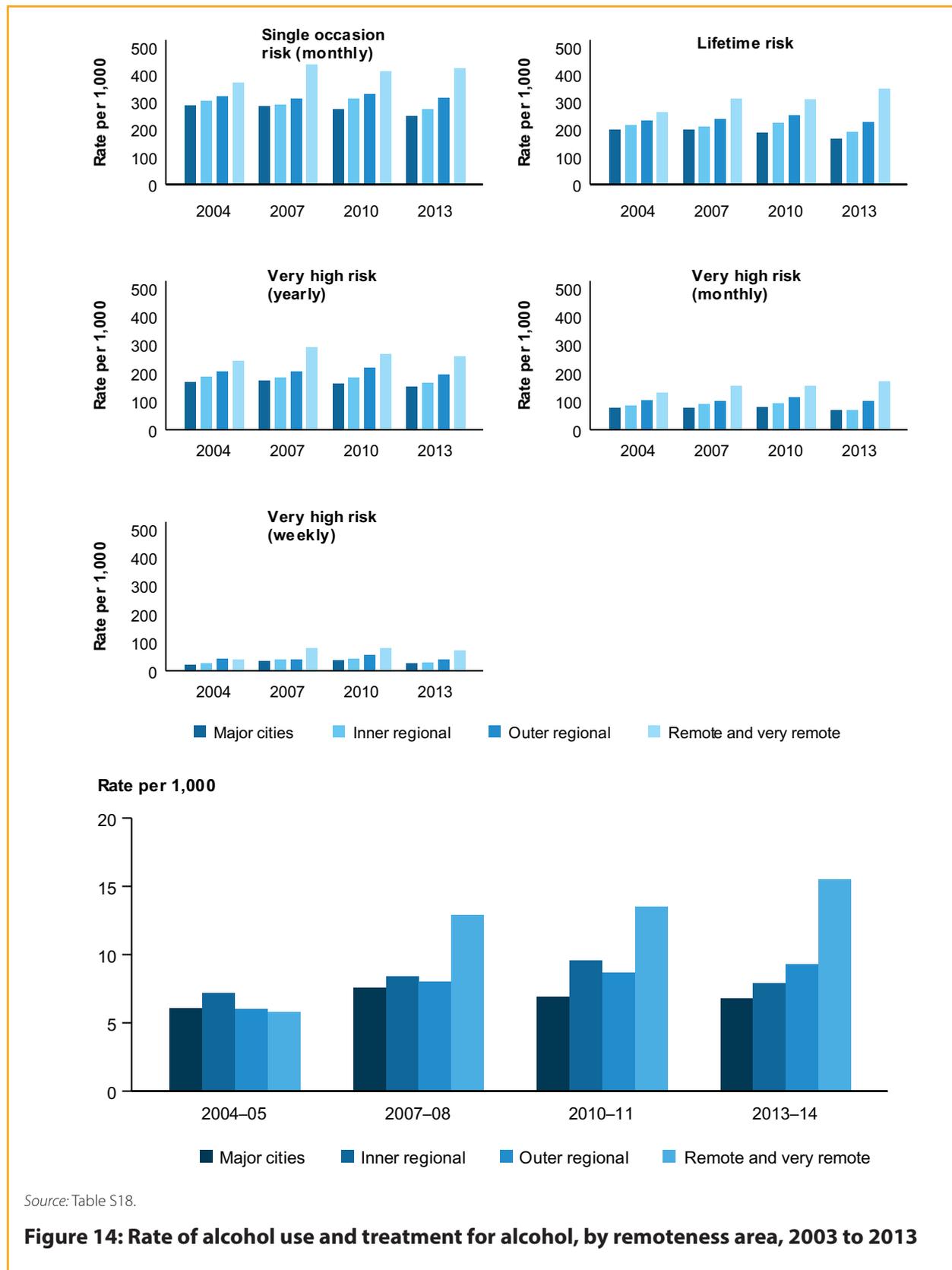


■ ■ ■ **Higher rates of people drinking at risky levels and higher rates of treatment for alcohol are reported in *Remote and very remote areas*; this was consistent over time.**

From 2004 to 2013, there were higher rates of drinking alcohol for people in *Remote and very remote areas* for all measures of risk (Figure 14). These rates have increased from 2010 to 2013 for 3 of the measures of risk, single occasion risk (413 per 1,000 to 422 per 1,000), lifetime risk (310 per 1,000 to 349 per 1,000); and monthly drinking at very high levels (154 per 1,000 to 170 per 1,000).

From 2007 to 2013 people receiving treatment for alcohol were also more likely to receive treatment in *Remote and very remote areas* (Figure 14). Since 2007, treatment episodes for alcohol also increased, by around 2013 this increased substantially, from 13 to 16 episodes per 1,000.

It is possible that the greater rate of treatment in these areas reflects an increase in people needing treatment for alcohol. But given the consistently high rates of people drinking at risky levels in these areas, it is also possible that access to services in these areas has also increased, or reporting in these areas has improved.



7 Conclusions and Policy implications

From 2003 to 2013, some interesting patterns can be seen for the availability, use and treatment of alcohol in Australia. While high-level analyses are presented here, they highlight the complexity of trying to gain insight into the connections between these 3 domains.

Further research and analysis into understanding national-level trends in increased service use, despite decreased trends in several measures of risky alcohol use, can help to inform policies and interventions aiming to reduce the issues with alcohol harm in Australia. This could start with further exploration into whether there are levels of drinking at the population-level that follow the same trends as treatment. For example, Livingston's (2015) research identified relatively stable trends in people drinking 20 or more drinks in Australia from 2001 to 2013. Continued research such as this may help to determine measures of alcohol use that more accurately predict trends in subsequent treatment. In turn, this can help policymakers more accurately identify policies and interventions that make positive impacts on the number of people receiving AOD treatment.

Similarly, a greater understanding in why risky drinkers at the population-level are younger than those in treatment may also help to identify or tailor policies and strategies for early intervention of subsequent alcohol dependence issues.

Trends in both risky drinking and treatment received suggest that people in *Remote and very remote areas* are disproportionately affected by issues with alcohol use. Further research is required to try and understand what can help reduce the use and subsequent treatment of alcohol in these areas specifically.

Finally, despite a clear association between availability of alcohol (particularly as it relates to outlet density and the sale of alcohol) and harms associated with alcohol, reporting against this kind of information at the national-level is limited (see also Rankin & Livingston 2016). National and consistent reporting of information on sales data, liquor licences, and on-site and off-site density will be vital in understanding the relationships of availability with use and treatment for alcohol in Australia.

8 Data sources

The data sources examined in the report differ in their purpose, population, scope and counting units. Differences across these factors affect the representativeness of each data source and their comparability to other data sources. The patterns presented across data sources in this report are intended to give a broad picture of the different aspects of alcohol use in Australia, both supplementing existing research and indicating a need for further research.

It is important to note that the data sources presented here are not exhaustive of the information available on this subject. The data sources used here were considered to have the broadest coverage nationally, and relate most directly to treatment.

Table 2: Detailed information of data sources

Data Source	Reference Period	Sample/Scope	Counting Units
NDSHS	Conducted every 3 years since 1985	Sample survey of Australian residents aged either 12–14 or over (depending on state or territory) Sample size: around 24,000 in 2013 Residential household, excluding institutional settings, hostels, motels and homeless people. Foreign language interviews not conducted Households are selected in a multistage, stratified area random sample	People
AODTS NMDS	Every financial year from 2003–04 onwards	AODTS that are publicly-funded—either by state and territory governments (the majority of AODTS), or by the Australian Government under the Non-Government Organisation Treatment Program (NGOTGP) 843 agencies in 2014–15 Includes clients aged over 10	Closed treatment episodes
Apparent Consumption of Alcohol, Australia	Every financial year from 2002–03 onwards (from 2004–05 only for cider)	Beer, wine, spirits, Ready-to-drink beverages and cider available for consumption in Australia	Quantity of pure alcohol available Total volume of alcohol available Per capita consumption of alcohol
<i>NASDP</i>	Financial years from 2005–06 to 2010–11	Alcohol sales data, collected for tax purposes or by wholesaler or retailer record keeping. Available for Queensland, Western Australia, Northern Territory and Australian Capital Territory (ACT data is for 2012–13 only)	Total volume of pure alcohol available Per capita consumption of alcohol

AODTS NMDS

It is difficult to fully quantify the scope of AOD services in Australia. There are a variety of settings in which people receive treatment for AOD-related issues that are not in scope for this collection. These include agencies that: do not receive any public funding; primarily provide accommodation (for example, sobering-up shelters); are based in correctional institutions; provide services primarily concerned with health promotion; are located in acute care/psychiatric hospitals and only provide treatment to admitted patients; or have the sole function of prescribing or providing dosing services for opioid pharmacotherapy. These data are captured in the AIHW's National Opioid Pharmacotherapy Statistics Annual Data Collection (NOPSAD).

The AODTS NMDS does not cover all agencies providing substance-use services to Indigenous Australians. These agencies provide data to Online Services Report Collection.

Data from the AODTS NMDS presented in this report are based on information about closed treatment episodes and are therefore not directly comparable to data presented on people, as a person may have multiple treatment episodes in a reference period.

NDSHS

The NDSHS is the leading national survey of licit and illicit drug use in Australia. While data cover a significant range of people, they do not represent all of the population. For example, people in institutional settings, hostels, motels and homeless people are not included. Foreign language interviews are not conducted. The information completed in the survey is self-reported.

Questions relating to information on the quantity and frequency of alcohol consumed in the Survey have remained consistent since 2001. While alcohol drinking guidelines have changed over the time period reported here, all measures of alcohol risk that are based on the NHMRC guidelines have been calculated using the 2009 guidelines.

Estimating the number of Alcohol users

Further to the limitations in coverage in the survey overall, it is known from past studies of alcohol consumption that respondents tend to underestimate actual consumption levels (Stockwell et al. 2004). As such, it is likely that estimates of the levels of alcohol use provided in this report are an undercount.

Apparent consumption of Alcohol, Australia, 2013–14

The scope of this collection covers beer, wine, spirits, Ready-to-drink (RTD; pre-mixed) beverages, and cider available for consumption in Australia. Noting that data for cider are only available from 2004–05 onwards.

Data are collected from a range of sources.

Type of alcohol	Source
Beer, Wine, spirits and RTDs	Import clearances via the Australian Customs and Border protection service (ACBPS) Excise tariff data from the Australian Taxation Office (ATO) (which only applies to alcohol sold in Australia and is collected for beer and spirits only) Domestic sales of Australian produced wine from winemakers Data for beer and wine also contains an estimated component for home production Derived indirectly from ABS National Health Surveys
Cider	Derived indirectly from ABS National Health Surveys

Apparent consumption estimates are derived using information relating to supply (that is, based on data from the above sources), and therefore assumed to have been consumed in that year, no adjustments are made for:

- changes in stocks
- duty-free alcohol imported by overseas travellers
- alcohol imported into Australia, cleared through a bonded warehouse and then re-exported
- alcohol that has been stored or cellared, used in food preparation or discarded.

NASDP

The overall objective of the NASPD is to construct an ongoing, regularly updated, national database of standardised alcohol sales data which includes all Australian states and territories. Jurisdictions supply the project with electronic copies of their alcohol sales records conforming to a minimum set of specifications.

The NASDP uses the sales data and alcohol conversion factors from the ABS to calculate pure volume of alcohol. Pure volume of alcohol can then be used to compare against population numbers to calculate per capita consumption.

Queensland, Western Australia, Northern Territory and the Australian Capital Territory all provided de-identified data for the fourth NASDP report. Although the ACT data covered 90% of wholesalers and this was found to affect the per capita consumption results, as such these were not reported.

Glossary

abstainer: Never consumed a full serve of alcohol.

additional drugs: Clients receiving treatment for their own drug use nominate a principal drug of concern that has led them to seek treatment and additional drugs of concern, of which up to 5 are recorded in the AODTS NMDS. Clients receiving treatment for someone else's drug use do not nominate drugs of concern.

administrative cessation: Includes episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

alcohol: A central nervous system depressant made from fermented starches. Alcohol inhibits brain functions, dampens the motor and sensory centres and makes judgement, coordination and balance more difficult.

Australian Standard Geographical Classification (ASGC): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGC was implemented in 1984 and the final release was in 2011. It has been replaced by the Australian Statistical Geography Standard (ASGS).

Australian Statistical Geography Standard (ASGS): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGS replaced the Australian Standard Geographical Classification (ASGC) in July 2011.

closed treatment episode: A period of contact between a client and a treatment provider or team of providers. An episode is closed when treatment is completed, there has been no further contact between the client and the treatment provider for 3 months or when treatment is ceased (see reason for cessation).

ex-drinker: A person who has consumed a full serve of alcohol in his or her lifetime, but not in the previous 12 months.

expected cessation: Includes episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement.

lifetime risk: Defined as the accumulated risk from drinking either on many drinking occasions, or on a regular (for example, daily) bases over a lifetime. The lifetime risk of harm from alcohol-related disease injury increases with the amount consumed.

main treatment type: The principal activity that is determined at assessment by the treatment provider to treat the client's alcohol or other drug problem for the principal drug of concern.

median: The midpoint of a list of observations ranked from the smallest to the largest.

principal drug of concern: The main substance that the client stated led them to seek treatment from an alcohol and drug treatment agency.

reason for cessation: The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service:

- **ceased to participate against advice:** Where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest
- **ceased to participate at expiation:** Where the client has fulfilled their obligation to satisfy expiation requirements (for example, participation in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment

- **ceased to participate by mutual agreement:** Where the client ceases participation by mutual agreement with the service provider, even though the treatment plan has not been completed. This may include situations where the client has moved out of the area
- **ceased to participate involuntarily:** Where the service provider stops the treatment due to non-compliance with the rules or conditions of the program
- **ceased to participate without notice**
- **change in the delivery setting**
- **change in the principal drug of concern**
- **change in the main treatment type**
- **death**
- **drug court or sanctioned by court diversion service:** Where the client is returned to court or jail due to non-compliance with the program
- **imprisoned** (other than sanctioned by a drug court or diversion service)
- **treatment completed:** Where the treatment was completed as planned
- **transferred to another service provider:** This includes situations where the service provider is no longer the most appropriate and the client is transferred or referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital. This excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment.

standard drink: Contains 10 g of alcohol (equivalent to 12.5 mL of alcohol). Also referred to as a full serve.

treatment type: The type of activity that is used to treat the client's alcohol or other drug problem:

- **assessment only:** Where only assessment is provided to the client. Note that service providers would normally include an assessment component in all treatment types
- **counselling:** Is the most common treatment for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing
- **information and education only**
- **pharmacotherapy, where the client receives another type of treatment in the same treatment episode:** Includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who are addicted to certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy
- **rehabilitation:** Focuses on supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways, including residential treatment services, therapeutic communities and community-based rehabilitation services
- **support and case management only:** Support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs including general welfare needs, and it includes assessment, planning, linking, monitoring and advocacy

- **withdrawal management (detoxification):** Includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern.

single occasion risk: A single occasion is defined as a consequence of drinks taken without the blood alcohol concentration reaching zero in between. The risk of an alcohol-related injury arising from a single occasion of drinking increases with the amount consumed.

treatment episode: The period of contact between a client and a treatment provider or a team of providers. Each treatment episode has 1 principal drug of concern and 1 main treatment type. If the principal drug or main treatment changes, then a new episode is recorded.

unexpected cessation: Includes episodes where the client ceased to participate against advice, without notice or due to non-compliance.

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From 2003–04 to 2014–15 the rate of treatment for alcohol in Australia has increased. From 2004 to 2013 however, there was a decrease in the rate of Australians drinking alcohol and this was seen across a range of risk measures. Similarly, the apparent consumption of alcohol (as determined through sales and taxation data) has decreased nationally from 2003–04 to 2013–14.

Analyses at lower geographical areas found higher rates of people in remote and very remote areas reporting risky drinking than people in other areas—and this was across all measures of risk—and treatment for alcohol was also highest in remote and very remote areas.

