

ALCOHOL USE IN RURAL AUSTRALIA

...good health and wellbeing in rural and remote Australia

Rural people experience disproportionately high levels of alcohol misuse and its associated burden of disease and injury. This is due to a range of factors characteristic of rural areas including lack of venues for recreation, stoic attitudes about help-seeking, economic and employment disadvantage, and less access to healthcare professionals and alcohol treatment services.



The AIHW reports that alcohol is consumed by more than 80 per cent of Australians, making it the most widely used drug in Australia. While the moderate intake of alcohol may have health benefits at middle and older ages, excessive consumption of alcohol can cause or contribute to chronic diseases including liver cirrhosis, several types of cancer, cardiovascular disease, foetal alcohol syndrome and mental illness. With its ability to impair judgement and coordination, excessive drinking also contributes to crime, violence, anti-social behaviours and accidents.

In 2010, about 20 per cent of Australians drank at levels that put them at risk of harm over their lifetime and 28 per cent drank at least once a month at levels that put them at risk of accident or injury. Alcohol misuse is estimated to cost \$36 billion annually in terms of productivity losses and healthcare, crime and child protection costs.

Overall, alcohol misuse is responsible for 3.2 per cent of the total burden of disease and injury in Australia.

About one-third of the Australian population (or 6.6 million people) live in rural and remote areas. In those areas, alcohol consumption and its associated harms are consistently higher than in urban areas. The 2010 National Drug Strategy Household Survey shows that the proportion of those drinking at risky levels increases with increasing remoteness with 19%, 22%, 25% and 31% of people consuming alcohol at risky levels for lifetime risk, and 15%, 17%, 19% and 26% at risky levels for single occasion risk in, respectively, Major cities, Inner regional, Outer regional and remote areas.

The AIHW has reported that among those living in rural areas, men and youths are particularly likely to drink at high-risk levels. Those working in the farming industry are also more likely to drink at risky levels. Among farming communities in rural Victoria, an estimated 54 per cent of men and 22 per cent of women reported drinking at high risk levels at least once a month compared to 20 per cent

for the general population. Compared to non-Indigenous people, Aboriginal and Torres Strait Islander people (two-thirds of whom live in rural and remote areas) are 1.5 times more likely to drink at risky levels for both lifetime and single-occasion harm. This is despite the fact that Indigenous Australians are also 1.4 times more likely to abstain from drinking alcohol.

Between 1990–2001, alcohol-attributable death rates were consistently higher for rural residents than urban residents (2.2 per 10,000 persons compared with 1.7). Similarly, rates of hospitalisation attributed to alcohol were higher for rural than urban residents (48 per 10,000 compared with 37). In rural areas, one-third of those aged 14–19 years and two-thirds of those aged 20–24 reported that they have been victims of alcohol-related physical abuse. In some mining communities in Queensland with neighbouring work camps housing ‘fly-in, fly-out’ workers, the rate of alcohol-fuelled violence is significantly higher than the state average.

Prevalence rates of risky alcohol consumption (AIHW 2011)

Proportion of population who drink at risky levels	Major cities	Inner regional	Outer regional	Remote/ Very remote
... for lifetime harm	19%	22%	25%	31%
... for single-occasion harm	15%	17%	19%	26%

Causes of alcohol misuse in rural areas

There is a strong drinking culture in Australian society and alcohol consumption is associated with pleasure, celebration and ‘rites of passage’. Some in rural Australia associate drinking with rural values such as ‘self-reliance’, ‘hardiness’ and ‘mateship’.

A limited range of venues for recreation and socialising could be a contributing factor to excessive drinking among rural residents, as local sports clubs (and the bars within) are among the few leisure and social venues in many rural areas. Some rural residents have expressed the view that social interaction is so important for people who are socially isolated that it is preferable for them to experience alcohol-related harms than the harms related to isolation. It has also been suggested that rural youth (especially males) experience high levels of boredom in leisure hours which leads them to drink excessively.

Studies show a lack of knowledge of alcohol guidelines and alcohol-related harms among rural residents, and a low level of community awareness of alcohol as a local problem. They also reveal a low awareness of existing alcohol interventions in the community.

Results from the 2007 National Drug Strategy Household Survey show a greater availability of alcohol in remote areas, with 44 per cent of those living in remote areas reporting fairly or very easy access to alcohol, compared with 29 per cent for the general population.

Strategies for reducing alcohol misuse

It is important to note that program strategies used successfully in urban settings are not necessarily transferrable to rural and remote settings. A combination of interventions, targeted particularly to meet the characteristics and needs of rural communities, will be the most effective means of reducing accidents and ill health arising from alcohol misuse.

The Ministerial Council on Drug Strategy 2011 www.nationaldrugstrategy.gov.au has recommended *demand reduction strategies* to prevent the uptake of excessive alcohol consumption, *supply reduction strategies* to control and manage the supply of alcohol, and *harm reduction strategies* to reduce alcohol-related harm for individuals, families and communities.

The National Preventative Health Taskforce www.preventativehealth.org.au recommended five priorities for action to reduce harmful consumption of alcohol:

1. reshape consumer demand towards safer drinking;
2. reshape supply towards lower-risk products;
3. strengthen, skill and support primary health care to help people in making healthy choices;
4. close the gap for disadvantaged communities; and
5. improve the evaluation of interventions.

The Australian National Preventive Health Agency www.health.gov.au is focusing on harmful alcohol consumption (as well as obesity and tobacco) as outlined in its strategic plans 2011–2015. The strategies for reducing alcohol misuse include the promotion of workplace programs that prevent and reduce alcohol-related harm and awareness of the NHMRC guidelines to minimise the misuse of alcohol www.nhmrc.gov.au/guidelines/publications/ds10

The National Alliance for Action on Alcohol (NAAA) www.phaa.net.au has identified the need for priority attention to alcohol pricing and taxation, alcohol marketing and promotion, and alcohol availability. The NAAA has

developed principles for reform of the alcohol taxation system in Australia.

Other effective interventions include partial or complete bans on promotion of alcohol, measures to reduce drink driving, and targeted advice in the primary care setting.

Effective interventions

Program managers will need to understand the underlying causes of alcohol misuse through consultation with the local community. Engaging the local community in program design will not only generate a program that meets local needs, but the process will also foster greater community support and ownership. For example, the National Drug Research Institute reports a review of past and existing alcohol restrictions applied throughout Australia that shows alcohol restrictions in Indigenous communities are only effective where community consultation is undertaken.

Program design should also address the barriers faced by rural residents in accessing treatment and care for alcohol problems. These barriers may include:

- lower socio-economic status which could translate into lower health literacy and lesser ability to afford health-related expenses;
- stoic attitudes which may lead to a delay in seeking treatment;
- less access to healthcare professionals including GPs and alcohol and other drugs specialist service workers;
- less access to alcohol treatment and rehabilitation services, such as alcohol counselling;
- greater distances to health services and lack of public transport; and
- the real and perceived lack of confidentiality as healthcare professionals are more likely to be personally known to the patient.

With limited resources in rural and remote areas, implementation of programs should ideally be done in partnership with local organisations so as to share resources and skills. Possible local partners include local governments (such as town planners and transport authorities) and healthcare and community service organisations (including alcohol treatment services, social welfare, income support and job services, housing and homelessness services, mental health care providers, child and family services) as well as Medicare Locals.

Given their greater health needs, people in rural and remote Australia, along with other disadvantaged groups, should be prioritised in the national strategies and programs to reduce alcohol misuse.

The National Alliance for Action on Alcohol (NAAA) is a national coalition of over 70 health and community organisations from across Australia, including the National Rural Health Alliance, that has been formed with the goal of reducing alcohol-related harm. For information on the work of the NAAA visit www.actiononalcohol.org.au

