

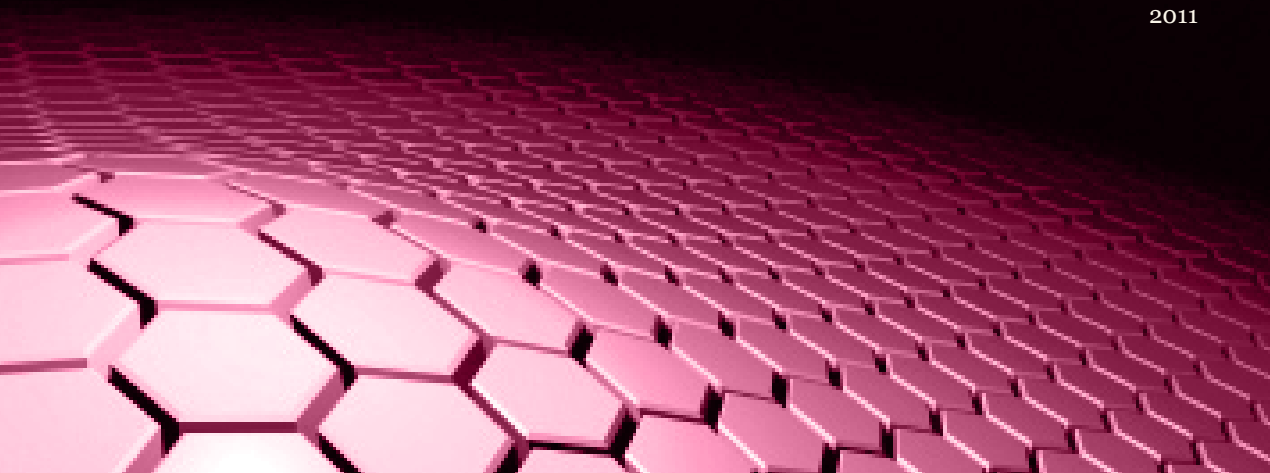


Australian Government
Department of Defence

The Use of Alcohol in the Australian Defence Force

Report of the Independent Advisory Panel on Alcohol

Reviews into aspects of Defence and
Australian Defence Force Culture
2011



Independent Advisory Panel on Alcohol

Report to Minister for Defence and Chief of Defence Force

19 August 2011

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Author: Professor Margaret Hamilton AO

Sponsor: Vice Chief of Defence Force

Contact: For further information please write to:

Mental Health, Psychology and Rehabilitation Branch
Joint Health Command
CP2-7-002
Campbell Park Offices
Northcott Drive
CANBERRA ACT 2600

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The Hon Stephen Smith MP
Minister for Defence
Parliament House
Canberra ACT 2600 Australia

General David Hurley, AC, DSC
Chief of the Defence Force (CDF)
Department of Defence
Canberra ACT 2600 Australia

Dear Minister Smith and General Hurley

I am pleased to present you with the report from the Independent Advisory Panel on Alcohol in the Australian Defence Force.

The Panel has welcomed this opportunity to provide advice to the Government and the ADF on the range of challenges which alcohol presents to the Defence community.

In undertaking this Review the Panel has drawn upon the input of key ADF personnel and stakeholders, a review of current policies and practices relating to alcohol in the ADF, available data and evidence regarding alcohol use and its harmful impacts and costs within the ADF, and intelligence from other important and relevant fields such as drug and alcohol prevention and workplace health and safety. The Panel has sought to carefully and respectfully balance the views and expectations of those consulted in providing its own perspective on the issues as detailed in the attached report.

Using the above approach, the Panel has given particular consideration to addressing the questions implicit in its terms of reference, including:

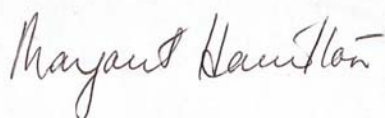
- what are the key influences on drinking attitudes and behaviours in the ADF?
- what represents best practice in workplace alcohol management?
- how does the ADF compare with best practice and what are the priority areas for the ADF in which to adopt best practice?
- what are the areas of good and promising performance that might warrant additional attention and support in the short, medium and long term, and who are potential internal leaders and external partners?
- what will be required to support the implementation and sustainability of organisational change?

The Panel has had a privileged opportunity to access members of the ADF at all levels and to hear diverse views and experience. Panel members have prepared this report to contribute to the clear commitment by Government and the Defence Senior Leadership Group to address alcohol.

We see the ADF as an action focussed organisation. The Panel members trust that the advice contained in this report will provide some prompts to act, some suggestions of directions to go and ways of getting there as well as broader advice across the whole organisation.

The Panel commends its recommendations to the Government and the ADF and urges a timely response. It is our intention that these will provide a foundation for sustainable cultural changes regarding alcohol in the ADF.

Yours sincerely

A handwritten signature in dark ink, reading "Margaret Hamilton". The signature is written in a cursive style with a large, stylized 'M' and 'H'.

Professor Margaret Hamilton AO
Chair
Independent Advisory Panel on Alcohol

19th August 2011

Independent Advisory Panel on Alcohol

Professor Margaret Hamilton AO — currently an Executive member of Australian National Council on Drugs (ANCD). (Chair)

Professor Hamilton has forty years experience in this field including clinical work, education and research. She has a background in social work and public health and has conducted research in epidemiology, policy, evaluation (prevention and treatment), young people and drugs, women and alcohol, alcohol problems in remote Australia and evaluation of many treatment programmes. She was the founding Director of Turning Point Alcohol and Drug Centre in Victoria. She was formerly Chair of the Multiple and Complex Needs Panel in Victoria and currently serves on various alcohol and drug related boards and policy advisory groups including the Advisory Group to the Drug Policy Modelling Programme. She is a member of the Prime Ministers Council on Homelessness, Vice President of the Cancer Council Victoria and a member of the Board of VicHealth Promotion Foundation and is a Professorial Associate of the School of Population Health at the University of Melbourne. She is the lead editor of two alcohol and drug textbooks and the author of many other publications in this area.

Professor Steve Allsop — Director, National Drug Research Institute (NDRI) (Member)

Professor Allsop is the Director of the National Drug Research Institute at Curtin University. With almost 30 year's experience he has been involved in prevention, policy and clinical research and professional development for health, police, education, welfare staff and community organisations. He has previously worked as the A/Executive Director, Drug and Alcohol Office, Western Australia. Professor Allsop's professional interests are in preventing and reducing alcohol-related harm, preventing and reducing harm associated with amphetamine use, preventing and reducing co-existing mental health and drug problems, responding to drug problems in the workplace and enhancing the capacity of human service providers to implement effective prevention and harm reduction strategies.

Associate Professor John Wiggers — Associate Director Centre for Health Advancement (Member)

Associate Professor Wiggers is currently leading the data team on the ADF Alcohol Management Strategy (ADFAMS) project and therefore is ideally situated to be the link between the Panel and the ADFAMS project teams. Associate Professor John Wiggers (Newcastle University) is currently the Associate Director Centre for Health Advancement (NSW Health) and Director of Hunter New England Population Health (NSW). With 20 years experience he is recognised as a leading 'research to practice' health promotion practitioner and has extensively researched and published in the areas of health promotion and disease prevention generally, with particular interests in the prevention of tobacco and alcohol-related harm, and the conduct of efficacy and implementation research trials. A key area of work John has led is the 'Police Alcohol Linking' project which centred on trials of a police surveillance and feedback system relating to alcohol-related harms associated with licensed premises, and a method of auditing the performance of licensed premises with respect to alcohol-related harms. The system has since been the subject of effectiveness studies and subsequent adoption by police in three jurisdictions (New South Wales, New Zealand, South Australia), with adoption in two of the jurisdictions being led by John and his team.

MAJGEN Paul Alexander, AO — Commander Joint Health/Surgeon General ADF (ADF Representative)

General Alexander is an experienced Army Medical Officer who has held a variety of Medical Officer positions across the ADF including a three-year posting to the Special Air Service Regiment. He has been deployed on various Australian and overseas operations and exercises in both Commanding Officer and Public Health Officer roles. He transferred to the Army reserve in 1998 and maintained his links with the Army as the Director Reserve Health Services for Army in Queensland. General Alexander is a General Practitioner who has maintained his clinical skills as a partner in a large group medical practice. His clinical specialities include sports and tropical medicine and he has a Master's in Legal Medicine. He has been active in primary health care policy development particularly during his tenure as the Chairman of the Redcliffe Division of General Practice. General Alexander has been actively involved in risk management and legal medicine and was the principle medico-legal advisor in Queensland for Australia's second largest medical indemnity organisation. In 2010 he was awarded a Fellowship in the Royal Australian College of Medical Administrators. In the 2011 Australia Day Honours, General Alexander was awarded an Officer of the Order of Australia – Military Division for distinguished service to Defence in the field of health and in particular as the inaugural Commander Joint Health Command.

Secretariat

Mr David Morton
Director General
Mental Health, Psychology and Rehabilitation Branch
Joint Health Command
Department of Defence

Ms Carole Windley
Director Clinical Programs and Standards
Mental Health, Psychology and Rehabilitation Branch
Joint Health Command
Department of Defence

Ms Jennifer Harland
Assistant Director Alcohol, Tobacco and Other Drugs Program
Directorate Clinical Programs and Standards
Mental Health, Psychology and Rehabilitation Branch
Joint Health Command
Department of Defence

Writing and research support:

Mr Brian Vandenberg
Manager – Alcohol, Tobacco and UV
Victorian Health Promotion Foundation (VicHealth)

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Professor Alexander McFarlane, Head-The Centre for Traumatic Stress Studies, University of Adelaide

COL Stephanie Hodson — Director Strategic and Operational Mental Health Programs, MHP&R Branch, JHC

LCDR Dee Williams — Director Navy Alcohol and Other Drugs Service, RAN

MAJ Michelle McInnis — AToD Program Senior Officer, MHP&R Branch, JHC

Leonie Clifford — National OATP Coordinator, MHP&R Branch, JHC

Ms Nicole Steele — Assistant Director Occupational Psychology and Health Analysis, MHP&R Branch, JHC

Dr Monique Crane — Research Officer, Strategic and Operational Mental Health Programs, MHP&R Branch, JHC

Ms Lyndall Moore — Chief of Staff Office of Commander Joint Health Command

Angela Price — Business Support Officer — Mental Health, Psychology and Rehabilitation Branch, JHC

Michelle Capper — Executive Assistant to Director General Mental Health, Psychology and Rehabilitation, JHC

The Chair of the Panel wishes to thank the Victorian Health Promotion Foundation (VicHealth) for allowing Mr Brian Vandenberg to work with Panel on this Review.

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Executive Summary

1. INTRODUCTION

This report reviews the nature **and extent of alcohol use and associated problems** in the Australian Defence Force (ADF) and provides recommendations for ways of supporting a proactive approach to preventing and reducing the **negative** impact of alcohol use in the ADF.

The Panel has intentionally undertaken a **high level appraisal** of the many elements that contribute to the way in which alcohol is used, and its impacts and the implications of this for the ADF. The Panel recognise that the ADF has already commenced a major review in commissioning the Alcohol Management Strategy (ADFAMS) project, and note a number of positive activities and appropriate responses to alcohol use in their examination of the place of alcohol in the ADF, some of which are highlighted in the report.

The Panel's conclusions are a mix of recommendations, advice and suggestions. Given the effort to make this a high level review, the Panel draws attention to areas for further attention, development or analysis and provides advice about broadening the focus for this extra work, along with some suggestions for ways of proceeding.

Review approach and addressing the Terms of Reference

The Panel has endeavoured to achieve a balance between building upon Defence's own concepts and understandings of alcohol management and related concepts (eg 'capability') with those from the civilian community.

With regards to the latter, the National Drug Strategy (covering alcohol, tobacco and other drugs) and its underpinning philosophy of harm minimisation is introduced here as a relevant framework for reviewing, preventing and responding to alcohol issues in the ADF. The framework does not proscribe alcohol, nor propose a 'zero tolerance' approach. Rather, it promotes three approaches: supply reduction, demand reduction and harm reduction.

Alcohol supply reduction is considered by the Panel to be an essential element in the ADF's response to alcohol as international evidence shows that the most effective responses to reducing alcohol related problems are price controls, access and availability controls and modifying the drinking context. Similarly, drink-driving controls and restrictions on alcohol marketing and promotions are suggested to be effective in reducing demand for alcohol. Early intervention and treatment services have been shown to be effective in mitigating the level of harm for those with an alcohol problem.

Sources of information and evidence used by the Panel for its review include international literature, consultations with ADF personnel and other experts on alcohol and drugs in the ADF, health and administrative data systems relating to alcohol, and polices and current practices, including examples of good practice, as well as submissions received by the Panel.

[See Appendix 8: Persons and organisations consulted by the Panel].

2. CONTEXT

Use of alcohol by ADF members

The Panel has found that **alcohol use is common among ADF personnel and while many drink in moderation, there is also a high prevalence of drinking at hazardous levels, at least on some occasions.** By all accounts, this situation has existed in the ADF for a considerable time, despite some commendable efforts to comprehensively address it over the years.

As with any community where alcohol is readily available and consumed, there are negative impacts including harms to the physical and mental health and wellbeing of individuals – along with their colleagues, friends and families. In the ADF this can also contribute to reduced unit and Service productivity and effectiveness, and all of these effects have a potential impact on Defence **capability**. Importantly, risky drinking by ADF members and the incidents that can ensue from this also do **collateral damage to the public image and reputation of the Services**, both within Australia and internationally.

Methodological differences between studies limit the ability to make direct comparisons between ADF data and that from other studies. However, data obtained from this review suggest that **26.4% of ADF members report consuming alcohol at hazardous or harmful levels.** The prevalence of at-risk alcohol consumption among ADF personnel is similar to or lower than Defence personnel in other countries. These estimates use the AUDIT **screening** instrument which detects early signs of possible alcohol problems that warrant further assessment and where early intervention can be successful in curbing ongoing risky alcohol use. The high prevalence of **risky drinking** in the ADF **is an important contributor to alcohol related harm** [see Page 84].

Australians expect our Defence Force members to respond to an increasing number and spread of operational requirements and roles, yet most Australians are only obliquely familiar with these. The Panel recognises that by far the **majority of Defence Force members effectively carry out these duties without blemish** and are held in exceptional high regard.

There are however some members with significant alcohol disorders that are likely to impact on their capacity. A diagnostic interview included as part of the recent Mental Health Prevalence and Wellbeing Survey (MHPWS) included use of a **diagnostic tool (CIDI)** to identify those likely to have later stage alcohol problems such that they have a significant **alcohol disorder** (usually alcohol dependence). This would usually only develop after some years of sustained high risk and/or heavy drinking. Here the health and other negative impacts are most significant and extended treatment is required. The prevalence of such alcohol disorders (indicating a likely need for treatment) among ADF personnel appear to be lower than among those who are employed in the community. (See further detailed explanation including note re those that leave Defence and are therefore not included in this study: Appendix 5).

Factors contributing to patterns of use

There are many **contributing factors** to a potentially **harmful drinking culture** within the ADF. These include the broader Australian **community context** within which the ADF exists and in which much of the drinking by ADF members occurs. Specific ADF factors that increase the probability of risky and potentially harmful alcohol use include the age and gender profile of the ADF, and particularly of recruits, **early shaping of drinking**

behaviours among recruits, the use of **alcohol in rituals and celebrations** and in **team bonding** activities; the use of alcohol in **response to the pressures, stress, trauma and grief** associated with Defence activities and/or the anticipation of this, especially among ADF members actively rotating through **deployments**. This increased probability of **risky alcohol use is enhanced by the relatively greater availability and affordability** of alcohol within some Defence workplaces and a **culture that accepts and sometimes expects higher levels of alcohol use**. Alcohol is not an ordinary commodity; it is a drug with psychoactive effects and a leading cause of preventable illness and injury.

Evidence from review of the relevant literature

The Panel reviewed the literature in two areas: (i) the international literature on the prevalence of alcohol use and harm in military populations; and (ii) the international literature on approaches to preventing and reducing harm associated with alcohol use within workplaces and other organisations, including the military. Highlights include:

- Alcohol use and related problems within military populations is **not a new phenomenon**.
- Large proportions of military populations in many countries consume alcohol at hazardous levels and several studies have found that **military personnel are heavier drinkers than civilians**, with associated higher levels of problems.
- Some studies show that **recruits drink more than civilians of the same age** before commencing in Defence forces, and that their drinking does not decrease after commencing.
- The prevalence of risky drinking is **highest among younger, lower ranked and male** personnel.
- Several studies have found **deployment to be a risk factor** for subsequent hazardous consumption.
- **Separation from home, family and friends** while on deployment might contribute to this risk factor, while the risk of hazardous drinking is heightened among personnel who perceive that they **might be killed or who experienced hostility** from civilians during deployment.
- **Length of deployment and frequency of deployment** may be a risk factor for risky drinking, but there are inconsistent findings among the studies.
- A major contributor to risky drinking is **alcohol availability**: in a physical (accessibility), economic (affordability) and social (perception of organisational and peer norms) sense. It follows that some of the **most potent levers to reduce risky drinking are those that control and reduce availability of alcohol**. Among these are **price, access and availability controls** (ie number of outlets; opening hours).
- There are likely to be significant **costs to Defence forces** as a result of alcohol use by their personnel, including productivity costs due to absenteeism and reduced capability.
- There is a range of interventions discussed in the international literature that are known to be effective or hold promise for reducing alcohol related problems in organisations, both in civilian and military environments. The provision of information and education alone is relatively ineffective.
- Substantial proportions of the estimated costs of hazardous and harmful alcohol use are attributable to low-risk drinkers and people who ‘infrequently drink heavily’ rather than the contribution from the small proportion of dependent drinkers in an organisation. It is the large number of people who occasionally drink in a risky manner (putting themselves at risk of injury from violence and/or vehicle accidents) who are likely to be a larger public health and safety concern, by virtue of their larger number.

- Studies of the negative impact of a person's drinking on others, especially family members and work colleagues, suggest that costing studies significantly underestimate this element.
- There are minimal studies assessing the extent and costs of alcohol-related safety or disciplinary matters in defence forces; though it is suggested that alcohol is a significant contributor to assaults.

3. FINDINGS

Alcohol in the ADF — Examination of drinking situations

As a way of examining the place of alcohol across all of the ADF, the Panel determined that it was most useful and efficient to focus on specific ADF situations or 'spotlights' through which to view the use and impact of alcohol in the ADF. These 'spotlights' address situations where alcohol is supplied and consumed or where alcohol harms are seen, screened or responded to.

The **five spotlights** include:

- (1) The time of **recruitment and early training** allowing a focus on who enters the ADF, their early induction and the culture in to which they come as well as the training and curriculum content;
- (2) **Common situations of drinking** (eg cadets' mess, officers' mess, Dining-In Nights) and specific situations of drinking (eg RAN at sea, alongside, ashore);
- (3) **The deployment cycle** including preparation; decompression; and post deployment and the stresses associated with sudden and dramatic transitions in relation to access to alcohol, together with the stress associated with these operational roles;
- (4) **Safety or disciplinary matters/incidents** where alcohol might be implicated; and
- (5) **Involvement with health** (especially indicators of possible alcohol implicated impediments to health) and responses including the support services available/used by ADF members (and some consideration of **family** members).

The 'spotlights' form the basis of the Panels observations and findings and are presented in Section 5 of the report (with further detail on each in Appendices 1–5).

Key findings of Spotlight 1: Recruitment and early training (see Section 5.1):

- Given the demographic pattern of risky alcohol drinking in the community, the age and gender profile of the ADF recruits presents particular challenges to the ADF in minimising alcohol related harms.
- Recruitment and early training is a formative time in the lives of ADF personnel and this includes the shaping of drinking behaviours.
- ADF recruits are motivated to use alcohol in ways similar to similar aged civilian populations but are also exposed to risk factors which are particular to ADF recruits such as relatively high disposable income and the use of alcohol in bonding and the release of stress coinciding with or after intense periods of abstinence.

- Available data suggest that ADF recruits and young personnel (aged less than 25 years) are more likely to consume alcohol at harmful levels, as do younger persons in the civilian population generally.

Key findings of Spotlight 2: Situations of drinking (see Section 5.2):

- Situations of drinking in the ADF include many of those typically found in civilian environments, but there are also particular situations that are distinctive to the ADF.
- The Panel considered the situation of Navy personnel as they go alongside as a particular example of transitions for Defence personnel that include changes to the access and context of alcohol availability, expectations and use. The Panel noted the development of a 5-step Navy alcohol harm reduction matrix to address the risk associated with alcohol use in specific locations. The strength of this matrix is that it encourages the commanding officer to assess every situation that includes alcohol in an objective and standardised way and then allows the CO to implement appropriate controls.
- Common across most of the drinking situations is the relatively high availability and accessibility of alcohol — both physically and economically.
- There is limited collated information available regarding the availability and accessibility of alcohol in terms of prices, hours, locations, and contexts of alcohol consumption in the ADF.

Key findings of Spotlight 3: Deployment including Preparation, Decompression and Post Deployment (see Section 5.3):

- Deployment is generally a time of limited access to alcohol but observers suggest the pre-deployment and especially post-deployment periods are times of particular vulnerability.
- The Panel was not able to obtain data describing alcohol issues during the pre-deployment phase, although this phase was considered by some to be a risky time.
- While alcohol is generally not permitted during deployment (except in special situations where it is approved by command), data obtained by the Panel reveals that around one third of deployment convictions are alcohol related.
- According to the international literature and ADF's own data, post-deployment appears to be a particularly high-risk time for alcohol problems.
- ADF's Post-Operational Psychological Screen (POPS) found that 18.1% of post-deployment personnel were consuming alcohol at risky or high-risk levels.
- It is unclear at this stage what impact the trialled decompression programs have upon alcohol use by ADF members.

Key findings of Spotlight 4: Safety and discipline (see Section 5.4):

- The ADF is a highly safety focused and discipline based organisation, but it is not immune to alcohol related transgressions by its members.
- There are limited analyses of how alcohol contributes to risk in the ADF, but studies of the impacts upon civilian contexts reveal substantial costs for workplaces, particularly reduced capacity and productivity. It is apparent that the ADF also incurs these costs.
- ADF data from reports on safety and discipline matters show significant numbers of alcohol related convictions such as being intoxicated on duty, being intoxicated whilst driving a vehicle, and assault.

Key findings of Spotlight 5: Involvement with health and support services (see Section 5.5).

- Whether ADF members attend health services for reasons unrelated to alcohol consumption or because of their alcohol consumption and/or issues related to this consumption, evidence consistently indicates this is an opportune time to intervene.
- ADF data on the health and wellbeing of members shows: more than one quarter of personnel (26.4%) consume alcohol at hazardous/harmful levels; women were less likely to have any alcohol disorder compared to males; and Navy personnel were more than three times more likely to have any alcohol disorder than Air Force personnel, and Army personnel were more than twice as likely as Air Force personnel to have an alcohol disorder.
- Many ADF personnel are reluctant to access health services for alcohol issues because of the perceived and sometimes real threat this poses to their career prospects.
- Pathways into alcohol related health and support services are not always clear for ADF members nor is there necessarily a comprehensive range of services available.
- There are a myriad of health and support services and organisations that can offer potential assistance and support for family members regarding alcohol, but these are not well integrated with services for members of the ADF.
- ADF is well placed to build upon existing services as well as innovate in ways that strengthen its capacity to address alcohol issues across the whole organisation.

4. RECOMMENDATIONS, ADVICE AND SUGGESTIONS

The Panel has aggregated its main recommendations, advice and suggestions into the following themes:

- An all of organisation approach.
- Policy and communication of culture.
- Information/Data for strategic planning as well as for care of individual members.
- Connectedness to the community.

An all of organisation approach

Over the past 20 years there has been significant development of attention to the health impacts of alcohol in the ADF. Most of the systemic responsibility for alcohol in the ADF appears to rest with health. While this is positive, consideration of alcohol in the **ADF requires considerably broader ‘ownership’** as alcohol related matters can have a direct and indirect impact on overall capability. Health could lead the prevention and treatment interventions, but such a uniquely health focussed response would be limited to addressing the need to reduce the *demand* for alcohol, but would fail to address the need to manage the supply and safety aspects of alcohol use.

A broader understanding of the range of alcohol issues is needed across the ADF, extending the current focus on the ‘few bad apples’ who might be alcohol dependent, to viewing the drinking of all members. **Much of the risk, costs and harms associated with alcohol for the organisation arise from the drinking of those who are not alcohol dependent;** rather, from those who participate in occasional episodes of intoxication and associated risk behaviours and regular, but not necessarily dependent drinkers.

To facilitate this broader view, the Panel suggests that further development and implementation of ADF policy and strategy on alcohol should be under the **joint leadership and responsibility of health (Joint Health Command) and personnel (People, Strategies and Policy).**

Policy and communication of culture

- ***Policy***

The Panel has been challenged by the **considerable density of policy**, within the ADF and the Single Services that relates to alcohol, and is **concerned about duplication** and the difficulty of coordinating and applying diverse policies **consistently**. The Panel has not reviewed all policies it has identified but has sought to offer broad advice on how existing approaches can be improved and where gaps exist, how these could be addressed. There is a need for a revised and updated overarching alcohol policy and subsequent review of the myriad of supplementary policies with the explicit intention of reducing duplication and potential confusion.

The Panel supports the more **proactive** approach to alcohol use that it observed among some leaders in the ADF and foreshadowed in many activities; rather than the historic and predominantly reactive approach.

The Panel therefore strongly supports and **encourages an overall preventative stance** with regard to alcohol use in the ADF.

Recommendation 1 [see Page 53]

Develop an overarching ADF wide alcohol policy to reflect evidence about effective practice, in conjunction with the current development of the ADF Alcohol Management Strategy.

This should be directed at reducing alcohol related harm and include an increase in the attention paid to:

- *Primary prevention, especially in relation to:*
 - *Communication and education about risks of alcohol consumption, ADF alcohol policy and regulations*
 - *Controls on the supply and availability of alcohol within the ADF.*
- *Secondary prevention, such as organisation wide screening to identify risk and respond with a broader range of opportunistic and brief interventions.*

There are many aspects to policy enhancement that are captured in other recommendations that follow and that might usefully be considered in conjunction with the development of such an overarching policy. The Panel recognises the work that has gone in to the development of the **drafted revised alcohol policy DI(G)15–1**, which was developed to replace the current policy dating from 1980, but urges further consideration of its emphasis [see Page 54]. A brief history of the other past and recent reviews of alcohol policies and programs in the ADF is presented in the report [see Section 4.2].

- ***Communication regarding the place of alcohol in the ADF***

Since expectations influence alcohol related behaviours, in the context of re-developing a policy on alcohol it is important to ensure that a clear message about the approach to alcohol within the ADF is understood by all personnel. This is likely to require the development and implementation of an internal alcohol communications strategy. This is necessary before development of any specific external communication strategy regarding the place of alcohol in the ADF.

Subsequently, attention could be given to an external communication strategy. It is evident that risky alcohol use within the ADF has had a significant impact on the organisation's reputation. For example, an analysis of the volume of **negative television, radio and press coverage of the ADF and its personnel** in relation to alcohol found that in 2010–2011 there were **2,666 such reports**, which reached a cumulative potential **audience of 81,159,239** and had an advertising space rate of **\$4,445,812**. This was a **347% increase** from 2009–2010 [see Page 57].

Any explicit communication strategy can be readily undermined by adverse counter messages and in this context the Panel advises the ADF to develop an organisation-wide policy on alcohol industry sponsorship and promotion of ADF people, units, and events that has a specific intent of reducing alcohol related harm [see Page 53].

In addition to explicit messages or communications there are ways of sending powerful **implicit messages about the intent and expectations of senior leaders in relation to alcohol**. Alcohol has great symbolic and cultural meaning in the Australian community; particularly in the ADF where alcohol linked stories contribute to defining identity and group membership. These meanings **currently serve to support the normalisation and even celebration of heavy, risky alcohol use in the ADF**.

One effective way to reduce the risks associated with alcohol use is by reducing the amount of alcohol consumed at ADF functions and on ADF premises. This can be done without interfering with the number or occasions when alcohol is available by **reducing the strength of alcoholic beverage products available**. For example, there is a range of reduced strength beer products available and wines can significantly vary in alcohol content. This could potentially reduce alcohol consumption on any one occasion by approximately 30%, assuming the same number of drinks. This would provide an **opportunity to send a strong message without interfering in the desire to gather together and share a drink**.

Recommendation 2 [see Page 70]

Reduce the supply and sale of higher strength alcohol products permitted to be sold or made available on ADF locations and at ADF functions.

The ADF is in a unique position compared to many workplaces and organisations with regard to responding to alcohol issues. There is a strong tradition and workplace culture of command responsibility, discipline and safety, and a focus on maintaining organisational capability. Further, the **ADF has available to it many of the most powerful levers that are known through international experiences and research to be key to reducing harmful patterns of alcohol use**.

The Panel noted that considerable thought currently goes into the occasions and situations where alcohol is banned. As an alternative approach, it suggests that this attention could usefully be turned to making decisions about when and where alcohol might be made available. That is, **turn the focus of careful decision making about alcohol availability in the ADF around such that it not be available *except* when a decision is made to allow it**.

Recommendation 3 [see Page 71]

Adopt a vision and a plan for implementation of alcohol harm reduction in the working environments of Defence by requiring Commanders to assess situations in which alcohol is proposed to be used informally or formally and where specific approval would then be required for the use and access to alcohol within ADF work location.

Information/Data for strategic planning as well as records for management and care of individual members

Strong indicators of alcohol related harm are how much alcohol is consumed, over what time and in what contexts. In order to inform effective prevention and other interventions, and in order to determine the impact of policy and related strategies, there is a **need to monitor alcohol consumption and related harm in various contexts using valid, reliable and up to date data** (See Section 4.4.4, p. 58).

The Panel accessed considerable information and data that are held in various places within the ADF. Where the **data** were available, it **was primarily found to be collected and used for the purposes of managing individual incidents or personnel, and not for policy or practice monitoring, evaluation or planning.**

The Panel was **not** able to easily **obtain some important information to enlighten its review**, such as accurate and reliable data on alcohol consumption among ADF members or comprehensive data on alcohol related health issues experienced by them, nor comprehensive information on the nature and extent of alcohol availability in the workplace. Whilst ADF senior leadership and other personnel were highly cooperative and supportive of the Panel's requests for information, often **the systems in place were not able to provide what was required, or the information was simply not collected or stored in a fashion that enabled ready retrieval.**

There are a number of references to the need to improve data collection and utilisation throughout the report. Information is vital to inform ongoing strategic planning and **requires data relating to:**

- the supply and availability of alcohol,
- alcohol in relation to health, and
- incidents linked to alcohol use.

The Panel noted that some information is available in all three of these areas; though it is more developed in the health arena. Comprehensive data about supply and availability appears not to have been systematically considered for strategic planning previously. Hence the following recommendations endeavour to utilise and enhance what data are collected now as well as suggest further specific data collection. Overall the Panel believes it **possible to use alcohol related data in a more strategic manner.** For these purposes, the Panel advises use of the Alcohol AUDIT screening instrument in all screening situations, including during recruitment testing for one element of data needs.

Recommendation 4 [see Page 58]

Develop an approach to collecting and responding to alcohol related data to enhance their value in terms of managing individuals and strategic planning; this will include alcohol screening of individuals at recruitment and across important career transition points, particularly post-deployment, and a whole of ADF Alcohol Incident Reporting System.

Given the strategic importance of monitoring the **supply and availability of alcohol** and the significant potential for greater control of these determinants of alcohol related harm by the ADF, the Panel recommends an initial audit of such information together with an audit of the policies and practices with regard to supply and availability of alcohol on ADF property and at ADF events.

Recommendation 5 [see Page 69]

The Panel recommends that:

- *An audit of the available data regarding the determinants of the supply and availability of alcohol be conducted.*
- *A valid and reliable reporting system for alcohol sales be established by the ADF; allowing for per capita calculations where possible.*

The current Strategic Reform Program (SRP) in the ADF may facilitate the identification, selection and analysis of data regarding the costs (and possible benefits) associated with alcohol available across Defence. Defence estimates that part of the cost of alcohol use in Defence (not accounting for the cost of alcohol itself) is approximately \$10m annually spent on amenities and related contracted staffing associated with the provision and sale of alcohol on Defence establishments. There are likely to be many other costs associated with alcohol for the ADF and a more comprehensive assessment of these costs might be important.

The Panel advises that for **health** surveillance and strategic planning, it will be important to review the ability of the proposed **Joint eHealth Data and Information System (JeDHI)** to facilitate the recording of patient diagnosis, alcohol consumption and harm status in both routine consultations and in mandated health assessments, and if necessary modify the system to provide this capacity.

The Panel notes that a **survey of alcohol consumption and related harms**, as collected in the MHPWS has value and suggests that this be conducted on a regular basis (eg every 3 years) to provide an ongoing capacity for the organisation to monitor and respond to such harms in a strategic fashion.

There are opportunities to more systematically collect and use health specific data to inform health planning and care for individual members including at recruitment, deployment and post deployment and in annual, biannual or other regular health assessments (eg AHA / PHE).

It appears to have been the reporting of **alcohol related incidents** that especially contributed to the drive for a review of the place of alcohol in the ADF in recent times. There are many ways in which such incidents come to the attention of commanding officers and the senior leadership group. However there is still a need to **more systematically record this**

information if it is to be useful in strategic planning. Based on the Panels experience in accessing these data and given the priority of monitoring this information, the Panel makes the following recommendation:

Recommendation 6 [see Page 80]

Develop a whole of Defence Alcohol Incident Reporting System so that it:

- *Ensures data are recorded and managed in a consistent manner organisation-wide, and entry/maintenance is mandatory.*
- *Ensures that the systems include the necessary information to identify priority sub-groups (eg service, age, gender, rank, operation) and is easily extracted for reporting and epidemiological purposes.*
- *Incorporates reports of incidents, convictions, alcohol involvement and place of purchase and consumption.*
- *Provides a system that monitors issues at both the individual (early identification of an issue) and the organisational (epidemiological) levels.*
- *Provides regular reports to Commanding Officers on incidents relating to their personnel.*

In this context it is suggested that further analysis of existing incident databases regarding information collected, data collection procedures, and data definitions and inclusion criteria be undertaken.

Recognising the ongoing examination and development of an alcohol management strategy under the ADFAMS project, the Panel suggests that some of the data that it gained access to warrants further analysis (eg POPS data and possibly further work with the results of the MHPWS). In addition, further analysis of alcohol consumption and alcohol related harm characteristics of recruits and young Defence personnel might be possible. This additional work could possibly be negotiated to be undertaken by the current ADFAMS project. [See Appendix 6 for a summary description of the ADF Alcohol Management Strategy project (ADFAMS)].

Connectedness to the community

While there is a tendency within the ADF to measure its own alcohol problems against those in the civilian community, the Panel discourages this as the principal frame of reference as it does not orient the organisation towards reform and change; nor does it provide impetus for taking up wider leadership that the broader community could benefit from; especially given the symbolic place of the Defence Force in Australia. **There is much to be gained by the ADF in aligning with, and ideally leading community standards in relation to evidence based alcohol prevention and harm reduction policies and practices; including good practice in workplace alcohol programs.**

- *Consider alignment with current community standards/requirements*

There are some areas where changes in general community requirements or approaches with regard to alcohol have moved further than is apparent in the ADF. The Panel suggests creating a standard for Defence where the **reduction of alcohol related harm is the primary object of alcohol related legislation, general orders and other policies**. This should start with alcohol legislative provisions. The Panel does note that alignment with the provisions across all Australian jurisdictions is not possible, but it draws attention to the inclusion now of a primary object of reducing alcohol related harm in all the various State/Territory liquor control Acts.

Recommendation 7 [see Page 67]

Working to a principle that Defence Laws with regard to alcohol need to operate in the context of State and Territory Laws in Australia, examine the consistency and interface between Defence and State/Territory laws regarding alcohol and related law enforcement practices.

In addition, specifically:

- *Review current legislation and instructions with a view to extending the powers of military law enforcement officers to use alcohol breath testing on ADF bases and to implement penalties, and*
- *Improve ADF Policing and Security Management System with regard to alcohol.*

The Panel noted significant reform and development in the ADF health area in response to the mental health review conducted in recent years. It agreed with the overall direction of these changes as they refer to alcohol specific health concerns and expect that many of them will significantly improve the responses to alcohol related health matters.

The Panel suggests that one way of further enhancing health care policies and practices with regard to alcohol is through the **application of appropriate accreditation and standards of health care**. This should include developing clinical practice guidelines based on Australian alcohol clinical treatment and Department of Veterans Affairs Guidelines.

The Panel further suggests that the ADF enhance alcohol related services and pathways to care through the development of a comprehensive plan to ensure that a range of alcohol related interventions are available, accessible and known about. In this context the Panel draws attention to work in the Department of Health and Ageing where a framework for this is being investigated [see Page 88].

Closer and more consistent collaboration with community-based services could help to develop a more coordinated approach through mutual understanding and agreed referral pathways, enhanced capacity and through this widen the options for treatment. Noting the development in coordinated care approach to rehabilitation, this could be extended to health care involving families.

While **tobacco use** was not part of the specific terms of reference of this Panel, the linkages of tobacco with alcohol use are well established. **Smokers are at increased risk of problematic alcohol and other drug use.** The Panel therefore advises the ADF to engage with the overall community effort with as much vigour as possible in addressing smoking. A focus on reducing the uptake of tobacco smoking among recruits (at least) should be a priority.

- *Engagement and opportunities for leadership in the broader community*

The Panel believes that the ADF has an opportunity to strengthen its capacity in relation to alcohol management through using its greater interconnectedness and interdependence with the broader community. This could include influencing community wide alcohol related policies and practices in localities in which Defence personnel purchase and consume alcohol; including, for example, liquor licensing decisions.

The ADF also has an **opportunity to develop internal capacity and links to external expertise for innovation, monitoring and evaluation of alcohol policy and practice.** While there are already pockets of alcohol specific expertise within the ADF these are somewhat isolated. The Panel recommends that the ADF draw on these interest and expertise together with a broad base of specialist knowledge available in the wider community.

Recommendation 8 [see Page 60]

Access expert input to policy and program development and implementation by forming alliances and partnerships with other organisations and individual experts on alcohol outside Defence.

The Panel notes an ongoing need for monitoring and review such as considering the outcomes of the Third Location Decompression Trial and provision of further advice regarding the vulnerability to alcohol risk for members post deployment [See Page 75].

The Panel suggests that some of the ADF's current alcohol programmes require reconsideration with a view to providing a more comprehensive menu of responses. In the treatment area, for example, the Panel notes that the AREP residential rehabilitation programme has been the subject of many previous reviews. There is an urgent need to re-engineer the resources and approach underlying this program to ensure it is incorporated into a broader Defence alcohol management strategy demonstrating the full spectrum of alcohol services and contemporary best practice matched to the needs of ADF personnel.

To facilitate and focus both internal and external advice and expertise, the **Panel strongly advises the establishment of a Centre on Alcohol and Capability.** This could be a virtual centre and where appropriate, draw on resources and members from across the ADF already committed to this area together with advice and experience from without. This could be the 'go to' place for alcohol related matters in the ADF [See Page 61].

5. CONCLUSIONS

The Panel believes that it **is timely** that the ADF is currently involved in the **ADFAMS project** that will facilitate development of an organisation wide **Alcohol Management Strategy**; together with supplementary further development of Alcohol Strategies for each of its three Services: the Australian Army, the Royal Australian Navy and the Royal Australian Air Force. There is an opportunity for some of the work started by this Panel to be taken up within the ADFAMS project that is underway.

Priorities for action

The Panel has identified priorities for action and included these as recommendations [above]. Other advice and suggestions are included throughout the report and referred to in this executive summary.

The Panel recognises that some of these recommendations warrant sequencing. In this regard, the Panel notes the parallel and ongoing development of the ADF Alcohol Management Strategy. It also notes the other concurrent cultural reviews and the potential for coordinated action and response to their findings.

In this context it is difficult for the Panel to nominate an appropriate sequence of recommendations for attention. However, in general the Panel expects that the recommendations relating to development of overreaching alcohol policy (**Rec. 1**) and data development and analysis (**Rec's. 4 and 6**) are needed in order to underpin adoption of an ADF Alcohol Management Strategy.

Adoption of **Rec. 2** (reducing the strength of alcohol products) would signal the ADF senior leadership group's commitment to change; while they pursue a longer-term vision and plan for implementation of **Rec. 3**.

Given the importance of monitoring the supply and availability of alcohol, implementation of **Rec. 5** (audit of alcohol in ADF) should occur in consultation with experts in this area. The Panel believes that an effort to audit the supply and availability of alcohol is likely to identify gaps in information. This is expected to prompt further development of an appropriate alcohol reporting system.

The Panel expects that legislative review (**Rec. 7**) would be a necessary priority since it sets the overall legal framework for policy and practices.

Finally, the Panel suggests the engagement with external experts in relation to **Rec. 8** and the potential development of a Centre could proceed immediately. This could then provide an all of organisation focus for consideration of the anticipated ADF Alcohol Management Strategy and the initial steps in building a stronger alliance with community based expertise.

The ADF will have its own ways of responding to this report. **It is vital that any response encourages engagement at all levels if it is to be successful and sustainable in developing a reputation and capability that will service Australia well into 2030 and beyond.** Alcohol, along with other risks, has the potential to derail this endeavour; but responding to this challenge also offers an opportunity for leadership. **Leadership** will need to come from the top and from other levels within the organisation if this is to be achieved.

1. Overview

1.1 The significance of this Review

The Independent Advisory Panel on Alcohol (hereafter referred to as “the Panel”) is one of five Reviews into aspects of Defence and ADF culture established by the Minister for Defence. The Panel undertook its work in conjunction and cooperation with the other independent reviews.

This Review has occurred at time when the ADF has reached several important junctures in its development, both organisationally and culturally.

- Increased operational tempo and demands on infrastructure and personnel.
- Increasing political scrutiny of its costs and resourcing levels (eg Strategic Reform Program).
- Sustained media coverage of incidents involving inappropriate behaviour by ADF personnel, including but not limited to the misuse of alcohol (eg HMAS SUCCESS incidents).
- Significant focus and energy on enhancing the ADF’s mental health strategy following the recommendations of the Review of Mental Health Care in the ADF and Transition through Discharge (Dunt 2009).
- Debate about the roles of women in the ADF.
- Vocal disapproval of drinking cultures in the ADF from the senior leadership group (eg Chief of Army’s message 2010).
- A period of significant change and transition among the ADF leadership positions.
- Efforts to undertake organisational change (eg New Generation Navy).

1.2 Terms of Reference

- Purpose of the Review Panel: The purpose of the Panel is to review the overall strategy for managing alcohol use in the ADF.
- Membership: The Panel members are Professor Margaret Hamilton (Chair), Professor Steve Allsop, Associate Professor John Wiggers and MAJGEN Paul Alexander.
- Areas that the review will cover:
 - i. Advise the ADF on current influences on organisational culture and individual attitudes towards alcohol.
 - ii. Provide an overview of evidence-based strategies and frameworks that might assist with minimising alcohol related harm and support cultural change within the ADF.
 - iii. Review the current ADF Alcohol Management Strategy against the frameworks.
 - iv. Identify short, medium and long term goals that will support a sustainable ADF Alcohol Management Strategy.
 - v. Make recommendations against the frameworks that will enhance the ADF’s ability to react and respond.

- Governance arrangements: The Panel reports directly to the CDF and the Minister for Defence with MAJGEN Paul Alexander, Commander Joint Health / Surgeon General ADF as the ADF representative.
- Administration and resourcing: Secretariat support to the Panel was provided by Joint Health Command staff.

2. Review Approach and Addressing the Terms of Reference

The following section describes the Panel's approach to its review of the management of alcohol use in the ADF and to address the terms of reference, within the constraints of time, resources and information in the three months available to it.

The Panel intentionally took a high level appraisal of the many elements that contribute to the way in which alcohol is used and the implications of this for individual ADF personnel and the organisation as a whole.

The Review Panel was keen to broaden the overall thinking about alcohol in the ADF to include both positive aspects of alcohol use as well as possible problematic aspects. To focus on one without the other is ultimately limiting. The Panel does not propose a ban on alcohol for the ADF. Rather, it proposes moving the thinking of the ADF to considered decision making about the availability of alcohol. That is, a practice of explicitly deciding if and when alcohol **can** be consumed rather than the more common situation currently of determining those times, locations or occasions when it **cannot** be. The Panel urges the ADF to ensure that access to alcohol occurs without unnecessary and undue costs to individual members, to the ADF or to the community more broadly. This means opening the practice and culture of alcohol consumption to scrutiny.

This is a vital first step that has already been taken by senior leadership and others in the ADF, as demonstrated by their willingness at all levels to actively and cooperatively support and facilitate the Panel's access to people and information for the purposes of this Review. The Panel has had a very limited opportunity to provide feedback to the ADF and seek its response to this report.

To manage the extent of information potentially able to be reviewed, the mix of Service efforts regarding health and safety in the ADF, and the specific differences between each of the Services, the Panel has focused on reviewing a range of situational contexts where alcohol is supplied and consumed, where harm related to alcohol is seen and responded to, and where the cultural meanings associated with its consumption are apparent.

To this end, the Panel chose an approach that put "spotlights" on such contexts to inform the review and its ultimate recommendations¹. The following spotlights/focus areas were selected:

Spotlight 1: The time of recruitment and early training;

Spotlight 2: Common situations of drinking (eg cadets' mess, officers' mess, dining-in nights) and specific situations of drinking (eg RAN at sea, alongside, ashore);

Spotlight 3: Deployment including Preparation; Decompression; and Post Deployment;

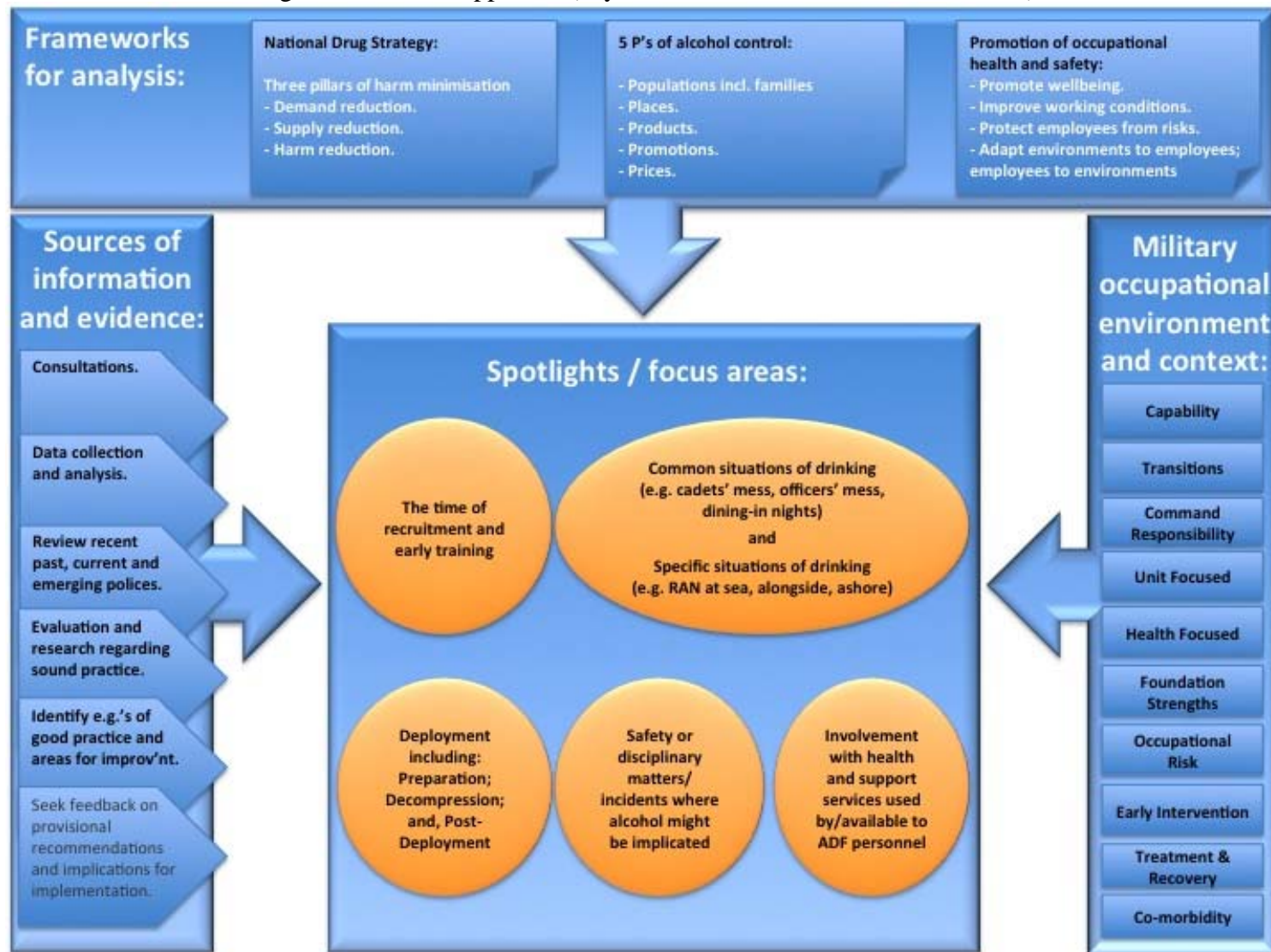
¹ Note Appendices are included in order to provide as much information as the Panel sourced (given that it will cease to exist at the end of this Review. It wished to make all information available to others who might use it. Generally there will be some repetition to provide context and more detailed data is included in these appendices).

Spotlight 4: Safety or disciplinary matters/incidents where alcohol might be implicated; and

Spotlight 5: Involvement with health (especially indicators of possible alcohol implicated impediments to health) and responses including the support services available/used by ADF members (and some consideration of family members).

For all of the above, a set of general questions were used to frame the review, and for each individual spotlight/focus area there were particular questions and issues the Panel examined (see Figure 1).

Figure 1: Review Approach (key frameworks and information sources)



2.1 Principles informing and guiding the review

It has been the Panel's intention that the review be consistent with international policy and practice in managing alcohol in the workplace and the broader community, bearing in mind:

- The primary importance of Defence '**capability**' in the way ADF plans and responds to issues in its internal and external environment, and that capability arises from the combination and application of several inputs ranging from personnel, training, and command and management.
- The significance of **transitions** in the operations of the ADF and in the lives of its people. These include transitions from community to recruitment and through the cycle of deployment.
- Australia's National Drug Strategy 2010–2015, which maintains a commitment to the philosophy of harm minimisation and the three pillars of: demand reduction; supply reduction; and harm reduction.
- The relevance of evidence-based approaches to preventing and managing adverse impacts of alcohol on the workplace and specific evidence of approaches to alcohol use within the Defence Force.
- The unique context and function of the ADF and the differences among each of the three Single Services within the ADF.
- Frameworks for prevention in both the safety and health fields.
- A desire and a commitment by the Panel that the review and recommendations will be practically oriented and feasible.
- The need to coordinate with the concurrent work of the ADF Alcohol Management Strategy (ADFAMS) project [November 2010–November 2011].

2.2 Frameworks for analysis

The following frameworks have assisted the Panel in reviewing the information and evidence pertaining to the five spotlights identified above.

2.2.1 National Drug Strategy

The current National Drug Strategy (2010–2015) is underpinned by the philosophy of harm minimisation, which, as applied to alcohol, encompasses the three pillars of:

- **demand reduction** to prevent the uptake and/or delay the onset of use of alcohol; reduce the misuse of alcohol in the community; and support people to recover from dependence and reintegrate with the community;
- **supply reduction** to control, manage and/or regulate the availability of legal drugs such as alcohol; and
- **harm reduction** to reduce the adverse health, social and economic risks and consequences arising from the use of alcohol.

2.2.2 Alcohol control

Alcohol is widely available and affordable and its use is commonplace in the Australian community; however, alcohol is not an ordinary commodity. It is a drug with psychoactive effects and a leading cause of preventable illness and injury in Australia. An effective approach to preventing and reducing harmful consumption of alcohol involves a complementary set of alcohol controls and policy interventions targeting (i) high-risk drinking populations, (ii) places where alcohol is supplied or consumed, (iii) particular products associated with harmful consumption, (iv) promotions that reinforce risky drinking

behaviours, and (v) prices that exacerbate both occasional and regular hazardous consumption. This can be described as a “five P’s” approach to alcohol control, and relates primarily to supply control and demand reduction (pers comm, VicHealth 2011).

There is now a considerable body of scientific literature on the effectiveness of various measures to prevent and reduce harm from alcohol. Drawing upon a recent World Health Organisation report (Babor *et al* 2010), these measures are summarised below.

Tax/Price

Price is a determinant of consumption and related harm. Taxation influences the price of alcohol over and above market forces (cost of production, supply etc.) and changes in taxation and other price changes (even small changes) affect alcohol consumption. Higher priced alcohol is associated with declines in consumption while lower priced alcohol is associated with increases in consumption. Particular subgroups, such as young people and heavy drinkers, are particularly sensitive to price changes.

Physical availability

The ease/difficulty of accessing alcohol affects levels of its consumption. Limitations may be imposed on the days and hours of sale and in some communities, there are restrictions on the nature of purchases (eg no bulk packaged liquor sales). Increases and decreases in the minimum purchase age have been associated with corresponding changes in consumption and related problems. Alcohol may be banned (eg in a specific community, as happens in some Australian Indigenous communities; and ‘alcohol free zones’). Controls may be placed on the type of alcohol available at certain times or events (eg at some sporting events there are controls on the types of alcohol, alcohol content, and/or limitations on how many drinks an individual can purchase at one time).

Drinking context

Not all drinking contexts have the same risk. For example, overcrowded, late night venues with poor crowd control techniques have a higher risk of a range of adverse outcomes (eg violence) than well-managed venues that comply with liquor licensing regulations.

Drink-driving

Random breath testing reduces drink driving, if there is a perceived high probability of detection. Certain individuals (eg repeat offenders; those who record very high blood alcohol levels; those who are alcohol dependent) who are resistant to these strategies might need additional approaches (eg diversion to treatment, installation of devices that prevent car activation if a breath test is ‘positive’).

Alcohol promotions

Alcohol promotions have become diverse and more sophisticated as electronic and other media have developed. Higher exposure to alcohol promotions has been associated with increased product recognition, more positive attitudes to alcohol and drinking and in some studies, heavy drinking, especially among young people. Unlike alcohol availability, promotions have largely been subject to voluntary as opposed to statutory regulation. There are criticisms (based on evidence) that self-regulation has been ineffective. On the other hand, the evidence regarding statutory controls is inconsistent.

Education and persuasion

These include mass media communication, communicating guidelines on low-risk drinking and school- and college-based programs (eg information about the risks of alcohol; resistance skills). While the acceptance of these programs appears high and some well-resourced programs show modest effects, often these do not persist, particularly if the programs are solely information-based and conducted in isolation of other strategies.

Early intervention and treatment

A range of treatments for alcohol problems, including opportunistic and brief interventions for hazardous drinkers (eg in GP surgeries and hospitals or through self-help programs) or intensive treatments for people who are alcohol dependent, have been shown to be effective. However, widespread adoption of such approaches in primary health care settings has not occurred.

2.2.3 Promotion of occupational health and safety

Alcohol can contribute to workplace risks. This is why many occupational safety and health approaches now include strategies to reduce their likelihood. These strategies include:

- Clear rules and regulations about alcohol use and impairment at work that are communicated to staff.
- Strong controls on alcohol's availability, where it is allowed at work.
- Health promotion strategies that reduce alcohol related risks.
- Quality supervision.
- Development of a workplace safety culture.
- Alcohol testing.
- Strategies to help individuals who experience alcohol related harm.

The International Labour Organisation (ILO) and the World Health Organisation (WHO) share a common view of occupational health and safety and state that the main focus in occupational health is on three objectives:

- (i) the maintenance and promotion of workers' health and working capacity;
- (ii) the improvement of working environment and work to become conducive to safety and health; and
- (iii) development of work organisations and working cultures supports health and safety at work and in doing so also promotes a positive social climate and may enhance productivity of the undertakings.

2.3 Sources of Information and Evidence

The time constraints for the Panel's review have meant that rather than undertake an extensive review of the literature, appraisal of data and conduct of consultations, its main purpose was to assess the scope of the available literature and Defence data and consult with key stakeholders, summarising the most salient points from these sources as the basis for future action and planning.

The following sources of information and evidence have assisted the Panel in understanding the involvement, impact and range of actual and potential responses to alcohol issues at critical times and situations in the Defence domain.

2.3.1 Literature

The review has concentrated on the most recent and directly relevant literature relating to the prevalence of alcohol use and related harm in military populations, and literature on the range of policy and programmatic responses.

2.3.2 Consultations

The Panel has consulted with a range of key ADF personnel, Departmental staff, experts and other stakeholders (including a DEFGRAM invitation opportunity for submissions). The Panel acknowledges the consultations already underway by the Australian Drug Foundation as part of the ADFAMS project. The Panel met with key personnel involved in this project, and were briefed on their consultations to date. A list of those consulted by the Panel directly is provided in Appendix 8.

2.3.3 Data collection and analysis

The Panel reviewed the published literature, existing Defence data, and existing Defence data systems and processes to develop an understanding of:

- the extent and nature of alcohol related harm across and within the ADF and other defence forces; and
- the capacity of existing ADF data systems and processes to identify and respond to alcohol related harms from both an individual and organisational perspective

Based on accepted indicators of alcohol-related harm, the following data were sought:

- patterns of alcohol consumption including non-drinkers/drinkers and quantities and frequencies of consumption by gender and age, specific services and key situations within Defence practice (eg post deployment);
- prevalence of alcohol related harm based upon accepted measures, such as the AUDIT screening instrument; and
- prevalence of other forms of harm such as alcohol-related disciplinary incidents.

Such data were sought and assessed from the following data sources:

- Army Incident Management System (AIMS).
- ADF Policing and Security Management System.
- HealthKEYS.
- MIMI.
- Post-Operational Psychological Screen (POPS)².
- Mental Health Prevalence and Wellbeing Survey (MHPWS)³.
- LASER study of recruits.
- Data from the other current ADF cultural Reviews, reports and studies.

In addition, data were sought regarding other possible indicators of harm for the ADF (eg absenteeism; retention; incident management). Finally, data were sought regarding the availability of alcohol (eg number of outlets, trading hours, and prices). The Panel has not attempted to undertake analyses of such data, with the exception of requesting simple descriptive analyses of key data sets (eg POPS).

² POPS data are included in summary throughout the report where relevant to particular topics. Detail of these data can be found at Appendix 5).

³ MHPWS: since the Panel's report was completed prior to the finalisation of the report of this study, all calculations using these data should be regarded as preliminary only and subject to possible changes.

2.3.4 Review recent past, current and emerging policies.

The Panel has identified a range of ADF policies, procedures, programs and projects that relate directly and indirectly to alcohol management and use. This includes policies relating to:

- Provision of alcohol including pricing and circumstances of availability/permission to use alcohol.
- Problematic alcohol use and possible responses (including early identification efforts and interventions offered and policies regarding implications for the persons Defence career).

A list of the policies identified by the Panel is provided in Appendix 7.

The Panel has not attempted to provide a detailed analysis and reviews of all of the policies identified, but rather, provide some brief commentary on the main overarching policies perceived to have relevance for the ADF.

2.3.5 Review evidence regarding sound practice

To identify good practice approaches to preventing and reducing alcohol related harm in the workplace and specifically in defence forces. The Panel has reviewed and summarised the key findings from the most recent and available literature reviews, including where available those with a focus on the military safety and health literature.

2.3.6 Identify examples of good practice within the ADF.

This has included identifying strategies to address the use of alcohol with a particular interest in any efforts to reduce hazardous consumption. Some of these are highlighted throughout the report and are sub-titled “Good News stories” rather than good or best practice since these are only the Panel’s impressions and are not based upon an evaluation of these strategies).

3. Literature Review

3.1 Prevalence of alcohol use and harm

The follow literature review addresses two main issues: (i) international literature on the prevalence of alcohol use and harm in military populations; and (ii) international literature on approaches to preventing and reducing harm associated with alcohol use within workplaces and other organisations, including the military.

Summary highlights of the literature review on the prevalence of alcohol use and harm in military populations are provided below.

Highlights of the literature review:

- Alcohol use and related problems within military populations is not a new phenomenon.
- Large proportions of military populations in many countries consume alcohol at hazardous levels and several studies have found that military personnel are heavier drinkers than civilians, with associated higher levels of problems.
- Some studies show that recruits drink more than civilians of the same age before commencing in defence forces, and that their drinking does not decrease after commencing.
- The prevalence of risky drinking is highest among younger, lower ranked and male personnel.
- Several studies have found deployment to be a risk factor for hazardous consumption.
- Separation from home, family and friends while on deployment might contribute to this risk factor, while the risk of hazardous drinking is heightened among personnel who perceive that they might be killed or who experienced hostility from civilians during deployment.
- Length of deployment and frequency of deployment may be a risk factor for risky drinking, but there are inconsistent findings among the studies.
- A major contributor to risky drinking is alcohol availability: in a physical (accessibility), economic (affordability) and social (perception of organisational and peer norms) sense.
- There are likely to be significant costs to defence forces as a result of alcohol use by military personnel, including productivity costs due to absenteeism and reduced capability.
- There is a range of interventions discussed in the international literature that are known to be effective or hold promise for reducing alcohol related problems in organisations, both in civilian and military environments. The provision of information and education alone is relatively ineffective.

- Substantial proportions of the estimated costs of hazardous and harmful alcohol use are attributable to low-risk drinkers and people who ‘infrequently drink heavily’ rather than the contribution from the small proportion of dependent drinkers in an organisation. It is the large number of people who occasionally drink in a risky manner (putting themselves at risk of injury from violence and/or vehicle accidents) who are likely to be a larger public health and safety concern, by virtue of their larger number.
- Studies of the negative impact of a person’s drinking on others, especially family members and work colleagues, suggest that costing studies significantly underestimate this element.
- There are minimal studies assessing the extent and costs of alcohol-related safety or disciplinary matters in defence forces; though it is suggested that alcohol is a significant contributor to assaults.

Alcohol use in military populations: an historical and international perspective

The use of alcohol, and related problems within military services, is not a new phenomenon. As noted in a recent review:

“Soldiers about to go over the top during World War One were issued a drink of rum. Indeed, the very term ‘Dutch Courage’ derives from gin taken by English troops in the Low Countries to stiffen their resolve during the Thirty Years War” (Jones and Fear, 2011, p. 166).

Similarly, these reviewers noted the use of alcohol as a treatment for shell shock and anxiety, sleep aid and fortification before and during continuous combat during WW1 and before. The authors noted the propensity for commentators around WW2 to observe that properly selected, trained and led troops would resist alcohol problems, and that those who succumbed probably had a predisposition (eg parental alcohol dependence).

By the time of the Vietnam war, illicit drug use was perceived by many to be the key concern, despite observations that nearly 20% of psychiatric patients in one study were diagnosed with alcohol dependence compared to just under 1% who were diagnosed with ‘drug abuse’ (Huffman 1970, cf Jones and Fear 2011). As noted by Ikin and colleagues (2004) in a study involving over 1400 Australian veterans of the 1991 Gulf War ten years after the event, ‘alcohol abuse’ was the most common psychological disorder.

Hooper *et al* 2008 examined alcohol consumption in UK forces among a random sample of service personnel in 2002, of whom 61.5% responded via a questionnaire about drinking and smoking. Follow up approximately 3 years later involved a 69.2% response rate of the 1382 who originally responded. The study found that alcohol consumption and binge-drinking increased over the follow up period, with increase being associated with deployment, and highest in those who thought they might be killed or experienced hostility.

A study by Debon *et al* (2011) of a large military cohort (31,000 men and women) found that 38% of all active duty recruits reported ‘binge drinking’ (i.e., defined as 5 or more drinks on a single occasion) at least one time in the previous 30 days. They also identified some adverse outcomes, noting that 3% of those who drank reported driving after consuming five or more drinks, and 9% had been a passenger with a driver who had been drinking heavily. In the US, Stahre and colleagues (2009) reported that more than 40% of their sample reported past-month ‘binge drinking’, most commonly among 17-25 year old recruits (noting the higher legal alcohol purchase age in the U.S). Those who reported such drinking were more likely to

report poorer job performance, including presenting at work intoxicated. US forces tend to drink more than civilians (heavy drinkers: 20% and 14% respectively) even when adjusting for socio-demographic differences (eg Bray *et al* 2009).

Risk factors

As with studies of alcohol and the workplace, alcohol consumption is not randomly distributed among personnel. A study of UK military personnel noted that heavier drinking was associated with lower rank, younger age, being single and deployment in the first phase (2003) of the war in Iraq (Fear *et al.*, 2003) and more common among the Army and Navy than among Air Force personnel (Fear *et al.* 2007). Rates of heavy drinking were higher than within the general population, even when controlling for age and gender. Other studies of UK troops deployed to Iraq have found that alcohol consumption and ‘binge drinking’ increased over time, but increased the most among those who thought they might be killed or were exposed to civilian hostility (Hooper *et al.*, 2008).

Other related studies found that problems at home during and after deployment and poor unit leadership also contributed to risk (Browne *et al.*, 2008) as did being single (which included never married, separated, divorced) being a member of lower ranks (eg McKenzie *et al.*, 2006) being deployed to a conflict zone (Bosnia), being a smoker (Fear *et al.*, 2007; McKenzie *et al.*, 2006), having a depression diagnosis (McKenzie *et al.*, 2006) and poorer subjective physical and mental health (Iversen *et al.*, 2007). On the other hand, as noted by McKenzie and colleagues study of Australian naval personnel who had served in the 1991 Gulf War, being a non-smoker, being married and higher military rank were protective. Spera *et al* 2011, using a large random sample (selected 135,225 active duty U.S. Air Force personnel but only had a 52% response rate) found a relationship with deployment. Recency of deployment was not related to drinking (using AUDIT) but total number of deployments was related and cumulative time spent deployed was predictive of higher AUDIT scores. The authors concluded:

“...we found that the aspect of deployment that had the biggest effect on the likelihood of problem drinking, when controlling for the recency of deployment as well as the deployment exposure variables, was the aggregate length of time deployed. This suggests that, for some individuals, the deployment stress of being away from home and family for long periods can lead to maladaptive ways of coping, such as turning to alcohol use” (Spera *et al.* 2011: 13).

It is important to note deployment was not just to war zones. It included overseas postings (eg Asia; Europe), suggesting that the impact was more likely related to general separation from the normal environment and family. This is consistent with other reports of civilian populations that have also indicated that being separated from home and family has been identified as a risk factor (Allsop *et al.* 2001). Spera and colleagues pointed to a critical finding in their sample, concluding that the evidence:

“... denotes a potential ‘additive’ impact of deployment as it relates to alcohol use, indicating that, over time, increased length and frequency of deployments can accumulate and therefore have an impact on problem behaviours such as drinking. ...for each increase in the deployment-frequency category, the odds that an Air Force member was a problem drinker increased by 14% and for each additional year in deployed time, the odds increased by 23%” (Spera *et al.* 2011) p.13).

Ames and Cunradi (2004/2005) also observed that some Defence personnel are more at risk than others. For example, they found that:

“Rates of heavy alcohol use among 18- to 25-year old military personnel differ significantly by service branch and by gender ...” (p. 252)

Their study found that males in the U.S. Marines Corps have highest rate of heavy use (38.6%) compared to 24.5% among males in Air Force, while 12.9% of female Marine corps compared to 6.3% of female Air Force personnel reported heavy drinking. In their commentary about risk, the authors observed that a key risk factor was that alcohol sold in military stores is sold below prices in civilian stores. Other risk factors they identified included: cultural factors that might influence drinking (such as drinking rituals and celebrations); expectations about drinking norms after work and while on leave; drinking to cope and as a recreational activity; and the physical and social availability of alcohol.

Ames, Cunradi and Moore (2007) undertook detailed interviews with 81 staff and a survey of 2,922 (response rate of 61.7% from total of 4732 possible respondents/personnel who had service of at least 7 years in US Navy). Among current drinkers, 28.2% men and 15.1% women met DSM-IV criteria for past 12-month alcohol abuse. They noted that high risk drinking appeared to be a part of deployment liberty. They noted a barrier to effective prevention was that many senior personnel, medical staff and counsellors saw drinking problems:

“...in the context of individual personality, personal family circumstances, character weakness, or exuberance of youth rather than attributable to factors of the Navy work environment and traditions. Clearly, explanations that point to causes outside the realm of the work environment are convenient, because it is much easier to regard problem drinking as an individual choice issue than it is to rearrange normative behavioural patterns, including activities for a shipload of sailors in a foreign port (Ames *et al.* 2007: 344).

A study by Bray *et al* 2005 involved a sample of over 17,000 (US) personnel in different services and different regions (Asia, Europe, Hawaii and mainland US) Heavy use was defined as five or more drinks a day at least once a week in the 30 days before the survey. These authors found regional influences on drinking; for example, being based in Asia was associated with heavier drinking:

“Differences in military culture may also help explain our findings. Our post hoc analyses showed that personnel based in Asia were more likely to perceive a strong connection between their installation’s culture and drinking and were more likely than personnel in the other regions to report drinking more now than before entering the military. ...military norms were more favourable toward drinking in Asia than in the other regions. ... These findings suggest that the military culture in Asia has become more accepting of heavy alcohol use and may tolerate and even encourage it” (page 237).

“At a minimum, our findings suggest that military alcohol use prevention and early intervention programs need to be tailored, to take account of regional differences that exist among locations of military personnel. These may include local culture, military culture, norms and specific environmental influences...” (page 237).

Recruitment and Early Training

In 2009/10 the Australian Defence Force Academy (ADFA, 2010) conducted surveys with cadets and graduates. It was found that:

- 24.5% reported having had problems or arguments with friends/peers after drinking too much (13.9% for ADFA graduates)
- 29.5% reported not remembering or feeling unwell the morning after drinking alcohol (46.6% for ADFA graduates)
- 15.6% reported having trouble resisting the influence of friends/peers to continue drinking alcohol on social outings or social events (28.8% for ADFA graduates)

Similarly, in a study of ‘alcohol abuse’ among U.S. Navy recruits, Trent *et al* (2007) reported that 85% of new recruits consumed alcohol and 69% reported consuming alcohol in the 30 days prior to entry. Almost 49% reported that they usually consumed until intoxication, and reported an average of 3 ‘binge drinking’ episodes (5+ drinks) in the 2 weeks prior to the survey. Thirty-three per cent of drinkers were classified as ‘alcoholics’ and a further 8% were possible ‘alcoholics’ (as measured by MAST). Debon *et al* (2011) reported that, from a cohort of over 38000 US Air Force recruits, 53% reported alcohol use in the month before starting basic military training, including 45% that were under the legal minimum age for drinking (21yrs). In addition 38% of all active duty recruits reported binge drinking at least once in the 30 days prior to the survey, with 23% reporting 1 to 3 episodes of binge drinking.

A U.S. study by Ames *et al* (2002) tracked high school students into the military, and found that those who entered the military were more likely to be heavy drinkers. Another study of U.S. Navy recruits found that 26% reported heavy drinking prior to entering the Navy and this remained relatively unchanged at 2 years follow-up (23%) (Ames *et al* 2002).

The results of a Canadian Forces survey indicated that the proportion of personnel exceeding the weekly Low-Risk Drinking Guideline was highest amongst the 18 to 29 year olds (24.5%), NCMs (19.5%) and singles (29.1%). In addition, 28.2% of 18 to 29 year olds exceeded the AUDIT cut-off for hazardous/ harmful drinking. It was also reported that 27% reported drinking more since joining the force (Canadian Forces, 2010). In 2004, a similar survey of reservists was conducted in which 34% reported consuming alcohol 2 to 3 times a week, 51% exceeded the guidelines, 46% had engaged in binge drinking in the last month and 25% scored above 8 on the AUDIT (CF, 2006).

Generally the evidence suggests that in other countries, a significant proportion of new recruits drink at risky levels.

Access to alcohol

There is limited literature available outlining the locations and contexts of alcohol consumption in the military, however, it is clear that alcohol is readily available.

Moore et al (2007) conducted 50 semi-structured interviews and 713 surveys with U.S. Navy personnel to shed light on alcohol availability. It was found that 63% of underage personnel reported that obtaining alcohol after work on the military base was easy (81% for personnel aged over 21 years). Further to this, 80% reported that alcohol was easy to obtain off-base. The factors commonly associated with increased physical and social availability of alcohol include low alcohol prices in military stores, frequent barrack parties, drink promotions in bars surrounding bases, and multiple opportunities for underage drinking. Respondents found that alcohol and opportunities to drink were overwhelmingly available in both on-base and off-base settings (Moore 2007).

Similarly, Ames et al (2007) reported that a major risk factor of consumption and harm is alcohol availability. It was found that Navy personnel reported easy access in both foreign ports and U.S. naval bases. Underage personnel reported easy access to alcohol in bars, barracks or hotel rooms near bases.

Pre-deployment preparation

Very few studies have looked at alcohol consumption in the immediate lead up to deployment; however there is some evidence to suggest that consumption increases in the two weeks prior to deployment. Blume *et al* (2010) found that 20.5% of US soldiers surveyed reported episodes of binge drinking in the 2 weeks prior to deployment. The proportion of personnel reporting binge drinking prior to deployment was slightly higher than that at the end of deployment (16.6%). There was no significant difference between pre-deployment and end of deployment reports of drinking frequency and total drinks within a 14 day period; however the mean number of drinks per day was significantly higher at pre-deployment.

Deployment

There is a wealth of research studying the relationship of deployment and combat to mental health issues, including excessive alcohol consumption. According to Jacobson *et al* (2008), personnel reporting combat exposures where their life was threatened were at higher risk for heavy weekly drinking (OR 1.12)⁴, binge drinking (OR 1.13) and other alcohol-related problems (OR 1.03).

Browne *et al* (2008) found that personnel who reported 4 or more occasions where they thought they might be killed were at higher risk of being classified as heavy drinkers, as measured by the Alcohol AUDIT even after adjusting for all other combat experiences, psychological distress, comradeship, leadership and demographic characteristics (OR 1.35). Killing in combat has also been identified as a significant predictor of alcohol abuse, after controlling for combat deployment, number of deployments, mental health issues and demographic characteristics (Maguen *et al*, 2010).

Studies of UK troops deployed to Iraq have found that alcohol consumption and ‘binge drinking’ increased over time, but increased the most amongst those who thought they might be killed or were exposed to civilian hostility (Hooper et al. 2008). Other related studies found that problems at home during and after deployment and poor unit leadership also contributed to the risk (Browne et al. 2008) as did being single, being a member of lower ranks (McKenzie *et al.*, 2006), being deployed to a conflict zone (Bosnia), isolation of assignments (Bray 2005), stress associated with relocation to unfamiliar countries (Bray 2005), being a smoker (Fear et al. 2007; McKenzie et al. 2006), having a diagnosis of

⁴ OR: Odds ratio

depression (McKenzie et al. 2006) and poorer subjective physical and mental health (Iversen et al. 2007). In addition, it has been reported that alcohol consumption patterns of deployed Defence personnel is often influenced by the culture of the deployment location (Bray 2005).

Research has reported that the length of deployment is associated with increases in frequency and quantity of alcohol consumption. Allison-Aipa *et al* (2010) reported that the more time personnel are deployed in combat situations, the greater the levels of mental health issues including excessive alcohol consumption. Deployments of 12 months or more are associated with an increase in distress scores and alcohol consumption (Allison-Aipa *et al* 2010). In addition, Spera *et al* 2011 found that the total number of deployments was related of excessive consumption (as measured by the AUDIT), and cumulative time spent deployed was predictive of higher AUDIT scores.

However, recent studies have contradicted these findings. The Canadian Forces (2010) found that personnel exceeding the AUDIT cut-off (8) didn't vary between personnel who had been recently deployed and those that hadn't. Likewise, the prevalence of binge drinking (6 or more drinks on one occasion) did not vary significantly between those that had been deployed and those that hadn't. This study, did however report high levels of alcohol consumption amongst personnel on home-leave following deployment. Amongst personnel who had been on home-leave in the previous 3 years, 8.7% consumed 5 or more drinks on a daily basis, 5.4% consumed at this level 'every other day' and 24.4% did so 3 to 4 times during their leave. It was, however, reported that 50.2% of personnel thought that their drinking hadn't changed since pre-deployment, 33.2% said that their drinking was similar, and 16.6 said that it was different. Of those who reported a change, 26.9% were aged 18 to 29 years, 18.3% were NCMs and 22.1% were in the Army.

A survey of ADF families found that, over time, increased length and frequency of deployments can accumulate and have an impact on problem behaviours such as drinking. In fact, for each increase in the deployment-frequency category, the odds that a member was a problem drinker increased by 14%, and for each additional year in deployed time, the odds increased by 23%. It was also found that the aspect of deployment that had the biggest effect on the likelihood of problem drinking, when controlling for the recency of deployment as well as the deployment exposure variables, was the aggregated length of time deployed. This suggests that, for some individuals, the deployment stress of being away from home and family for long periods can lead to maladaptive ways of coping, such as turning to alcohol use (ADF 2009).

Decompression

A decompression period immediately following a deployment operation is standard practice in many armed forces, where combat troops are given a short period of leave and psychological support following deployment. However, it is well known that alcohol continues to play a significant role in this process (Fossey 2010).

The Australian Defence Force is in the process of trialling Third Location Decompression (TLD), thus the impact on alcohol consumption is unclear at this stage. It has, however, been part of the US military end-of-deployment policies since the Vietnam War and it is viewed as a stress management exercise to transition personnel back into their home life and ensure they are prepared for their next deployment. In Canada and the UK third location decompression (or normalisation as it is referred to in the UK) is an optional exercise at the end of deployment activities, and aims to reintroduce personnel to drinking in a responsible manner (ADF 2011).

Minimal evaluation of the impact of TLD on alcohol consumption has been undertaken. However, a study by Hacker-Hughes *et al* (2008) that involved post hoc analysis of data on personnel who spent one week or less in decompression were 1.13 times more likely [adjusted Odds Ratio] to drink heavily than those that went straight home; those that spent 1 to 2 weeks in decompression were 1.2 times more likely to drink heavily; and those that spent more than 2 weeks in decompression were 1.17 times more likely to consume heavily. Thus, personnel involved in decompression were more likely to drink heavily compared to those that returned home immediately following deployment.

A briefing from the ADF Joint Health Command (5 April 2011) reported some satisfaction data from the UK and Canada. In the UK study on decompression in Cyprus, it was found that approximately 80% of personnel did not want to participate in TLD or were ambivalent about participation prior to their arrival. However, the majority (91%) reported having found TLD useful upon completion and 80% of TLD activities were seen as being generally helpful. About 70% of decompressing troops thought that the briefings would be helpful in easing their transition home and the three groups of personnel least likely to perceive TLD as being helpful were NCOs/SNCOs, troops serving in the Combat Arms and those who reported low levels of adjustment concerns.

The UK decompression program currently limits personnel to five cans of beer per person, per day, after Day 1 (ACDMH 2009). Anecdotally, there is evidence that following controlled drinking during decompression, there was a drop in alcohol-fuelled assaults/injuries on return to the UK, though it was stated that there were incidents during decompression. A study of the program found that 5.1% of respondents commented on alcohol consumption: 44% of these responses were requests for greater alcohol availability both in quantity and choice, and 22% were requests for less alcohol.

In the Canadian study on decompression (also in Cyprus), it was reported that the majority of respondents (96%) reported that they “Agree” or “Strongly Agree” that some form of TLD was a good idea; 86% of respondents reported that they “Agree” or “Strongly Agree” that the TLD experience was valuable; and 90% of respondents recommended it for future rotations to Afghanistan. At 6 months post-decompression, 86% agreed that TLD was valuable and 83% felt that the program made the reintegration process easier for them. In addition, in an evaluation of a Canadian decompression program in Guam, it was reported that many participants reported appreciation of the extra effort and expense which the Canadian Forces invested in order to ensure that they were properly cared for and followed-up. Many participants commented about the need for downtime, and how much they had enjoyed the chance just to have a beer and unwind in a North American type of atmosphere. Their spouses also noted the positive effect a few days of down time before the troops got home had on their readiness to rejoin their families, and many participants had positive comments about the lectures that were provided during the TLD.

The Canadian Forces reported a small number of alcohol-related medical problems during the early stages of TLD (seven trauma incidents, mostly involving fights, and three cases of alcohol poisoning). Recurring events were successfully remedied by introducing a number of counter measures, including an orientation brief and a buffet lunch.

Post-deployment

The U.S. Military conduct a Post-Deployment Health Assessment (PDHA) upon return and a Post-Deployment Health Re-Assessment (PDHRA) approximately six months post-deployment, with alcohol use being measured in the PDHRA only. This self-administered assessment includes the TICS screen for alcohol misuse (Two-Item Conjoint Screen). A study by Milliken (2007) reported the mental health outcomes of 88,235 U.S. soldiers who completed both the PDHA and PDHRA. Almost 12% of 'active' soldiers and 15% of 'National Guard and reservists' reported alcohol misuse via the PDHRA, with only 0.4 subsequently being referred for specialty care.

Santiago *et al* (2010), in studying 6527 U.S. Army soldiers returning from Iraq reported that 27% screened positive for alcohol misuse using the TICS. Those who screened positive were more likely to have recently engaged in: drink driving (OR 4.99); riding with a driver who had been drinking (OR 5.87); reported being late or missing work because of a hangover (OR 9.24), using illicit drugs (OR 4.97); and being convicted of driving under the influence (OR 4.84)(Santiago et al, 2010). Santiago et al also reported that 27% of the soldiers reported hazardous/harmful consumption (AUDIT ≥ 8).

A study by Maguen (2010) assessed the mental health impact of reported exposure to direct and indirect killing amongst 2,797 U.S. Operation Iraqi Freedom soldiers during routine post-deployment mental health screening. Based on the AUDIT, 25% reported hazardous or harmful consumption (AUDIT ≥ 8). In contrast, Duma (2010) reported that only 8% of US soldiers after returning from deployment and again before the next deployment (Iraq and Afghanistan) reported hazardous or harmful alcohol consumption (AUDIT ≥ 8).

Similarly, a recent UK study of troops returning from Afghanistan and Iraq noted that 'alcohol misuse' was high among UK service personnel (13% of a sample of almost 10,000), more common than among non-deployed colleagues (Fear *et al* 2010). A study of US marines also noted high rates of 'intense drinking' (Schuckit *et al.* 2001), and a study by Wilk *et al* 2010 reported that deployment to combat zones was associated with higher alcohol related risk (Wilk et al., 2010). A study of nearly 1600 Royal Navy personnel reported that almost all (92%) were identified as hazardous drinkers (using AUDIT-C) with 40% meeting the criteria for 'heavy drinking' and 15% were classified as problem drinkers (Henderson *et al.*, 2009).

Hooper *et al* 2008 examined alcohol consumption in UK forces (random sample of 2246 service personnel with 61.5% responding to a questionnaire about drinking and smoking). This provided baseline data in 2002 and was followed-up approximately 3 year's later (69.2% response rate of the 1382 who originally responded). It was reported that both alcohol consumption and binge-drinking in the UK Armed Forces increased during the study period. It was found that the change in drinking was associated with deployment, highest in those who thought they might be killed or experienced hostility from civilians. The latter added an average of 6.1 units a week to alcohol consumption on exiting theatre, but with each year that passed this was reduced by 2.8 units a week. Thus, it was concluded that alcohol use in the UK military increased following traumatic exposures, though this increase was not maintained over time.

The ADF Annual Mental Health Surveillance Report (ADF, 2009) reported that 20% of Army personnel, 12.6% of Navy personnel and 7.3% of Air Force personnel consumed alcohol at risky levels (AUDIT score ≥ 8). The study also demonstrated significant differences between operations in 2009, with operation Krugar and Astute showing the highest proportion of post-operational personnel reporting drinking at risky levels (19.4% and 18.9% respectively).

Thus, in reviewing the evidence, it appears that separation from home and family increases the risk of subsequent hazardous drinking and perceived threat and exposure to traumatic events on deployment also increases this risk. Increasing deployments may be associated with increasing risk. The period immediately post deployment may be a particularly risky time for adverse outcomes of drinking.

Impact on individual and organisational health and safety

There are limited systematic analyses of how alcohol contributes to risk in the ADF. However, some insight may be gained from evidence accumulated in the broad community. It is pertinent to note that costs can arise from a number of sources eg costs from the acute effects of alcohol misuse such as injury, intoxication and hangover, costs from regular use, and costs associated with dependence. Collins and Lapsely (2008) calculated the costs that arise from alcohol use in Australia overall, including health costs, costs to policing, and costs to workplace productivity to be A\$3.5 billion. Alcohol-attributable reductions in the male labour force accounted for approximately 77% of this total, indicating the potential scale of negative impact for workplaces such as the ADF.

Pidd *et al* (2006b), estimated that alcohol-related absenteeism cost Australia between A\$437 million (calculated on the basis of 2.5 million work days missed) and A\$1.2 billion (calculated on the basis of 7.5 million work days missed) annually. Alcohol-attributable fractions correspond to the proportion of a population's chronic and acute medical conditions as well as deaths that can be attributed, either wholly (as in the case of alcoholic liver cirrhosis) or in part (eg liver cancer or injuries) to a particular drinking level (eg low-risk, risky, high-risk). Pidd *et al* (2006) observed that a substantial proportion of estimated costs were attributable to low-risk drinkers and people who 'infrequently drink heavily'. In contrast, many people focus their attention on the harm that arises from the small proportion of very heavy drinkers in a community or organisation. However, the large number of people who occasionally drink in a risky manner (putting themselves at risk of injury from violence and/or vehicle accidents) can be a larger public health and safety concern by virtue of their larger number.

Many of the estimates above do not include the effect of consumption on others. In a recent study, seventy per cent of Australians report having been affected by strangers' drinking (Laslett *et al*, 2010: xviii). These harms range from minor annoyances, such as, those who report being kept awake, to more severe harms such as physical violence. Just over 40% of respondents reported that they had been threatened, physically assaulted, or had their property or belongings damaged as the result of a stranger's drinking (Laslett *et al*. 2010: xviii). Another recent study by Dale and Livingston (2010) investigated the impact that an individual's alcohol consumption imparts on co-workers. They found that just under one-third of all respondents reported working with co-workers who drank heavily, 8 per cent reported being negatively affected by a co-worker's drinking, and 3.5 per cent reported having to work extra hours as a consequence of the alcohol-consumption habits of co-workers. Further, they estimated that the annual cost of additional hours worked as a consequence of having a heavy-drinking colleague was A\$453 million.

In terms of research assessing the extent of alcohol-related safety or disciplinary concerns in defence forces, minimal studies were located. Scheckel (2005), however, reported that alcohol contributes to 50% of alleged assaults in the U.S. military, and that the U.S. Department of Defence estimated that in 2002/3, the loss in personnel readiness due to alcohol-related incidents was 1764 members. The Canadian Force (2010) found that 7% of males and 3% of females reported they had been a passenger in a vehicle with a driver who had consumed too

much alcohol; 6% of males and 2% of females reported driving a vehicle after consuming too much alcohol; and 3% of males and 1% of females had driven or been a passenger in a water vehicle after the operator had consumed too much alcohol.

In December 2010, Lieutenant General Gillespie (Chief of Army) stated that:

“As part of my daily briefing process, I am advised of incidents involving non-operational casualties, safety and irresponsible behaviour. For example, in the period January to September 2010 there was a total of 372 alcohol-related incidents reported to Army Headquarters. Be aware that these were only the reported incidents and many of them involved multiple individuals. In one 72 hour period there were 12 incidents involving alcohol. These incidents often impact adversely on careers, and can result in injury and even death. As you might imagine these incidents can keep me awake at night. In my view they are NOT accidents, they are people-made incidents. Our most alarming statistic is that in 2009, we lost more people in alcohol-related incidents than to war”.

and

“In 2009, we had 140 driving under the influence charges around the country and over 80 injuries to my people where alcohol was a contributing factor — and these are just the more serious ones, those that are caught and then lead to some sort of report! Some of the injuries will be life lasting and will affect families and the individual for the whole of their lives. When you start to tally the cost to the people, to their families and the organisation, it’s a cost that we can no longer ignore”.

3.2 Approaches to alcohol within workplaces and other organisations

It takes more than a person to produce alcohol related trouble. The substance itself, one of Australia’s most popular psychoactive drugs, and the environments in which it is consumed plays an important part in the mix. If an individual works in a setting where alcohol is readily available, where work is stressful and/or boring and there is a cultural norm of heavy drinking, there may be an increased prevalence of alcohol related harm. To simply focus on the individual (eg education strategies urging individuals to resist temptation; treatment programs to help those with problems to cut down/stop; discipline for those whose drinking interferes with work performance) and not address the environmental conditions and availability of alcohol that contribute to harm, is likely to have limited impact.

The traditional focus of responses to alcohol problems in the workplace, including armed forces, has been on providing treatment for staff who develop problems. Preventive effort has largely relied on regulations about alcohol use while on duty and identification of affected individuals.

The evidence regarding alcohol problems in the workplace indicates a range of internal and external factors that influence alcohol use. These factors include (Cercarelli 2011):

- workplace alcohol availability and availability in the broad community (more easily available alcohol associated with increased use and harm);
- clarity of regulations about alcohol use and related harm — this includes ensuring regulations are understood and supported by all segments of personnel;
- quality of supervision — low or unsupervised occupations carry higher risk than others;

- work culture - cultures that tolerate or encourage risky alcohol use are associated with increased risks;
- occupational safety and health culture — work cultures that strongly support safety are likely to have lower risk;
- separation from family and social networks; and
- experience of stress and alienation.

3.2.1 Approaches in civilian contexts⁵

It is apparent that alcohol use and related harm in the workplace are not randomly distributed among workplaces, with some workplaces being associated with higher rates of use and harm than others. This may be influenced by workplace factors, such as recruitment practices and working conditions, and factors that drive consumption and harm in the broad community.

A variety of views were expressed to the Panel regarding the existence of alcohol problems in the ADF. While many acknowledged the ADF had such problems, others did not, or indicated that if they existed, they were no different to the broader community. For some, the problems were defined in public health or safety terms, whilst for others, they were expressed in terms of impact on operations and capability. This diversity of views will have an impact on the response of the organisation to this report and its recommendations, and hence on the strategies adopted for implementation.

An example of different perspectives can be seen in the types of views expressed to the Panel across a range of rank levels. The following is representation of comments and views:

“Restricting availability of alcohol will make no difference here. It will only drive our members outwards. It will be resented”:

While the views of others included:

“Get rid of all boozers”

Tailored responses

Individual, community and workplace factors can increase and decrease alcohol risk. Responses to alcohol problems in the workplace will therefore need to be tailored and multifaceted. For example, approaches to prevent intoxication may be distinct from, but complement, those that aim to reduce absenteeism related to regular heavy use. Responding to problems in remote or specific areas where work is safety-sensitive, where the workforce is dominated by young males who regularly celebrate the end of the working day by drinking, may have different characteristics to strategies used for lower risk office environment with an older age group who are more regular heavy drinkers

⁵ This summary of good practice approaches to the management of alcohol issues in the workplace is derived from a forthcoming report by the Victorian Health Promotion Foundation (see Cercarelli *et al.* 2011).

Multifaceted strategies

The multifaceted nature of alcohol use and related harm and evidence from outside and within the workplace suggest that diverse and multifaceted interventions will be needed. A focus on a single approach, such as relying on educational approaches or peer support programmes will be insufficient. If the risk of alcohol-related harm is increased by a context where alcohol is easily available, where work is stressful and boring, where supervision is poor and there is a cultural norm of heavy use, an effective response requires all of these issues to be addressed.

Accessible interventions

Sometimes people will resist seeking help, especially if they perceive there will be negative consequences of doing so. Web-based interventions are increasingly being adopted as an effective response to this barrier. They can be disseminated to any location at low cost. Stigmatisation concerns are reduced through the use of such programs because there is no need for face-to-face contact and in many cases the recipient retains anonymity. Automation assures the treatment is consistently delivered as intended.

Good practice in policy

Alcohol policies can help clarify procedures related to alcohol consumption in the workplace as well as the management of such a practice, and in these terms can be useful to workplaces. Allsop and colleagues (2001) suggest that the process of developing effective policies is critical, requiring consultation with the workforce and other key stakeholders, with policies purchased ‘off-the-shelf’ less likely to be effective. The requirements for an effective alcohol policy are suggested to include:

- being written in explicit terms, describing the procedures to be followed in responding to hazardous use;
- identifying the responsibilities of the broad workforce and individual officers;
- ensuring that the workforce is informed about and supportive of the rationale for the policy and implementation procedures;
- ensuring universal and equitable application;
- ensuring that the consequences of any breach are agreed, reasonably graduated (i.e. consistent with the seriousness of the breach), explicit and clearly communicated;
- being consistent with relevant legislation; and
- including evaluation and review.

Implementing and embedding policy

Effective implementation is likely to involve an approach that attracts employees to change, not simply having to accept an unpopular imposition. This means explaining, providing a rationale for action and responding to concerns expressed by staff. It may be useful, or more attractive, to integrate an alcohol policy into an overall approach to manage other safety and health issues, such as sedentary behaviour, stress management and workplace safety. Social marketing approaches can help create a context for policy development and program implementation.

Individual, structural, community focus

As described previously, while interventions focussed on individuals have a place (such as health education and rehabilitation responses) it is important to address the structural factors (actual and perceived availability; degree of management and peer acceptability of drinking and alcohol affected behaviour; working conditions; visibility and quality of supervision) that might contribute to low and high-risk drinking.

Finally, it is arguable that an effective response will not just focus on an organisation such as the ADF. If community alcohol consumption and related harms increase (as indeed they appear to be in Australia (see Chikritzhs et al. 2010), it is reasonable to propose that this could translate to increased costs. Employer and employee organisations have previously brought influence to bear on governments to address alcohol availability, use and harm in the broad community. Such considerations in the UK during the First World War resulted in action to reduce the hours of sale of alcohol (see, for example, Higgs 1984).

3.2.2 Approaches in military contexts

The following section examines the more limited literature relating to alcohol interventions in defence forces. Moore et al 2007 reported, in a study of 50 U.S. Navy personnel and a mail survey of over 700 enlisted males and females, the influence of the physical and economic availability of alcohol on drinking risks (eg price of alcohol at Navy Exchange base stores, parties at barracks and the promotion of alcohol in surrounding, off-base bars). They suggested that it was important to raise alcohol prices in base stores and also to enforce policies regarding underage drinking, particularly in relation to secondary supply (ie the provision of alcohol to underage drinkers by people who have attained the legal purchase age, and by bars in and around bases [noting mostly 21 years in USA]. They observed that as the Navy tried to address concerns about alcohol, for example by strengthening controls on the base, off-base provision grew in prominence. This influenced their conclusion that prevention strategies should not just target bases, but the surrounding suppliers. One suggestion was to focus on meaningful changes in alcohol availability in base surrounds, for example by liaising with external suppliers, and using as a motivator the threat to declare off-limits those venues that do not comply with the spirit and letter of liquor licensing.

Interestingly Spera *et al* (2010) reported on the effectiveness of such an intervention to reduce drinking among young Air Force personnel. The intervention consisted of enforcement of legal purchase/drinking age, related compliance checks at local, off-base outlets (including controlled underage purchases) enforcement of DUI legislation, community education and peer intervention (referred to as a “shoulder tap” for risky drinking). The intervention was associated with a greater decline in drinking relative to control sites.

While physical and economic availability (eg hours of sale, number of outlets; price; age restrictions) of alcohol clearly affect consumption, as already noted, so too does social availability (eg the perception that ones peers drink and/or drink heavily). Ames et al. 2002 noted that normative beliefs about drinking (eg believing your peers are drinkers/heavy drinkers) was associated with drinking levels at pre-enlistment. They noted that pre-enlistment ‘underage’ drinking was also a predictor of risk.

Such beliefs, or social norms, are amenable to influence and may mediate changes in drinking behaviour. For example, Williams and colleagues (2008) reported on a web-based intervention in a sample of U.S. military personnel. Participants either received the Drinker's Check-Up (N= 1483), Alcohol Savvy (N= 688), or served as controls (N= 919). Participants were followed up at one and six months. The researchers noted that web-based interventions were effective in lowering perceived norms about the frequency and quantity of drinking and this was associated with declines in the individual's own drinking.

4. Military and the broader community context

4.1 Military context and frames of reference

While many aspects of alcohol use among the ADF population are likely to be influenced by similar factors to those that influence the wider community, there is an additional range of ADF specific occupational, environmental and contextual factors that need to be considered. The Panel recognises that these factors present both challenges and opportunities to the ADF. For instance, there is an expectation of many ADF personnel to be deployed to and from high intensity and often remote working environments (involving sudden transitions) and to perform demanding roles at a consistently high level over sustained periods. These factors may contribute to a greater risk of hazardous alcohol use and related problems. However, there are also factors that present specific opportunities to the ADF in managing alcohol, such as the focus on command responsibility, managing occupational risk, and others factors aimed at ensuring occupational wellbeing of personnel.

4.2 History — previous reviews of policy and programs

The main piece of legislation relating to alcohol control in the ADF is S.123A of the Defence Act 1903. The ADF's main policy statement on alcohol, known as DI(G) 15–1, was adopted in 1980 and although recent work has been undertaken towards adoption of an updated version, it remains the formal policy in place.

Despite a long history, a limitation of the alcohol management programs across the ADF is that they have not been comprehensively reviewed. However, there have been some more localised reviews and evaluations of components, including:

- 2010: Evaluation of the ADF Outpatient Treatment Program (Bull)
- 2009: Review of Mental Health Care in the ADF and Transition through Discharge (Dunt)
- 2008: Report on Alcohol Consumption in the ADF (SQNLDR S Maloney)
- 2007: Evaluation of group counselling at AREP (Roberts)
- 2005: Evaluation of the ADF Alcohol, Tobacco and other Dugs Services Program (Berends et al)
A Survey of ADF Health Professionals: Summary Report and Analysis (J Swann and A Toomey)
- 2004: Preliminary Outcomes of a Correspondence Intervention for Veteran and Members of the Defence Force with Alcohol Misuse (Cavanaugh, Morton, O'Connor, Wheeler – DVA)
Alcohol Brief Intervention Program for ADF Members within the NT Region. (CAPT A Kaine)
- 2003: Review of Alcohol Rehabilitation and Education Program (Pead ACPMH)
- 2002: Evaluation of the Royal Australian Navy Alcohol and other Drug Program (Currie, Directorate of Mental Health)
- 2001: Management of Substance Abuse in the Australian Defence Force (Bull)
- 2000: Sobering Facts; Options for an ADF Alcohol Management Program (ADF Tri-Service Working Party)

In addition, the ADF is also currently reviewing the Keep Your Mates Safe program.

4.3 ADF Alcohol Management Strategy project (ADFAMS)

As previously noted, it is important to acknowledge the significant steps being taken through the Alcohol Management Strategy project (ADFAMS) that predated the establishment of this Review Panel. The Panel has sought to coordinate and collaborate with the ADFAMS project. This project commenced in November 2010 as a component of the ADF's Mental Health Reform Process and is conducted by the Australian Drug Foundation as a component of Joint Health Command's Alcohol and Other Drug (AToD) Program. The objective of the ADFAMS project is to deliver an updated ADF Alcohol Management Strategy by November 2011 with specific requirements for each Service as follows:

- Army: creation of an Australian Army Alcohol Management Strategy (Now to be 'Australian Army Force Protection — Alcohol').
- Navy: build evidence to enhance Navy's existing alcohol management strategy
- Air Force: recommendations for future strategy development.

Parts of the methodology for the ADFAMS project involve consulting with personnel across the ADF, conducting policy to practice reviews, and appraisals of Defence data. The Panel has aimed to utilise information available from these ADFAMS activities to inform its own approach, conclusions and recommendations.

4.4 Observations of the military context

As the Panel began to examine the place of alcohol in the ADF it became more familiar with the complex organisational structure of the ADF. This complexity arises from its mix of many cultures, three proud and distinctive services and their histories, values, rituals and operational focus; its size, mix of views and experience, range of activity, contractual arrangements and the challenges inherently associated with the important relationships between civilian and uniformed elements, and with the Department of Defence.

The Panel acknowledges the specific stress and grief associated with the loss of life of a number of ADF members, especially over the past year. The impact of this, in an organisation that trains to a standard where the imperative is to "look after your mates" is evident. Australians expect our Defence Force members to respond to an increasing number and spread of operational requirements and roles, yet most Australians are only obliquely familiar with these. The Panel recognises that by far the majority of Defence Force members effectively carry out these duties without blemish and are held in exceptional high regard. From the development of this understanding the following review principles emerged that underpin the specific recommendations relating to alcohol in the ADF that follow later in the report. These principles include a need for:

- An all of organisation approach.
- A broader evidence-based prevention approach that links with the broad directions of the ADF.
- Recognition of alcohol as key factor in ensuring capability.
- Recognition of alcohol's role in ADF culture.
- Quality information/data that will enhance individual management and organisational strategic planning and responses.
- Connectedness to community wide alcohol policy, programmes and practices (with recognition of possible adaption and addition of ADF specific elements where relevant).

4.4.1 An all of organisation view is needed

Currently there is a significant administrative and ‘mind-set’ divide between a health focus and broader alcohol management focus in the ADF. While alcohol was **historically** seen as an ‘administrative’ issue; over the past 20 years there has been increased attention on the health impacts of alcohol in the ADF to a point where it appears that most of the **systemic** responsibility for alcohol now rests with health.

This apparent implicit expectation that the Joint Health Command is responsible for alcohol matters, in part, reflects a prevalent focus among ADF personnel of the need to identify individuals with alcohol related problems and refer them to care and health/rehabilitation/recovery services. While command at various levels sees a responsibility to respond to day-to-day alcohol related incidents, too often the solution sought is to have the individual “treated” by the health services. Health has taken leadership in developing some alternative and complementary responses to individual personnel (such as alcohol awareness training, OATP 4 day courses, direct treatment and counselling and residential treatment and rehabilitation). However, their focus is, by necessity and trade, mainly on individual attitudes and behaviours.

While the move to identify a health response is positive, consideration of alcohol in the ADF requires considerably broader ‘ownership’ as alcohol related matters have a direct and indirect impact on overall capability. Health alone cannot ‘deal with’ all that is required to ensure that capability is not reduced due to alcohol misuse and that responses to alcohol are adequate, appropriate, integrated and comprehensive. . There is no doubt that health can lead the prevention and treatment interventions, but a uniquely health focussed response limits access to the broad range of influences and largely addresses reduction of *demand* for alcohol, not necessarily supply, safety or capability. The support from the Chief of the Defence Force (CDF, April/May 2010) in establishing the Panel suggests recognition that the overall strategic responsibility for thinking about alcohol cannot remain solely or primarily the responsibility of health.

To facilitate this broader view, the Panel suggests that further development and implementation of ADF policy and strategy on alcohol should be under the **joint leadership and responsibility of health (Joint Health Command) and personnel (People, Strategies and Policy)**.

It is also essential to extend the understanding among members of what constitutes the range of alcohol issues in the ADF, especially among Commanding Officers at various levels. It is apparent that some leaders in the ADF have a rhetorical focus on the ‘few bad apples’ who might be alcohol dependent; not seeing that the drinking by all members needs to be in view. In fact most of the alcohol risk, costs, and harms for the organisation are more associated with those who are not dependent; those who participate in occasional episodes of intoxication and associated risk behaviours and those who are regular but not dependent drinkers (See Pidd et al, 2006). This is likely to require the development and implementation of an internal alcohol communications strategy. Subsequently, attention could be given to an external communication strategy.

Any explicit communication strategy can be readily undermined by adverse counter messages and in this context the Panel advises the ADF to develop an organisation-wide policy on alcohol industry sponsorship and promotion of ADF people, units, and events that has a specific intent of reducing alcohol related harm.

In addition to explicit messages or communications there are ways of sending powerful implicit messages about the intent and expectations of senior leaders in relation to alcohol. Alcohol has great symbolic and cultural meaning in the Australian community; particularly in the ADF where alcohol linked stories contribute to defining identity and group membership. These meanings currently serve to support the normalisation and even celebration of heavy, risky alcohol use in the ADF.

In general, there is intent to be responsive and comprehensive across the range of alcohol issues within the ADF. However, it is not clear to the Panel if there are consolidated policies that bring this together. Indeed, the Panel heard conflicting perspectives on this situation with some ADF personnel advising that the complexity is necessary and even desirable while others cautioned that it potentially poses risk for the ADF. A number of people at all levels frequently informally asked us not to suggest “any more policy” suggesting that the sheer quantity/number is already overwhelming and possibly dysfunctional.

For policy users, the number and spread of policies could be difficult to be aware of and utilise. Also, it is not clear how policies are formally developed, communicated, implemented, reviewed, and updated across the ADF. In addition, the multiplier effect of tri-Service and Single Service policies contributes to the volume and complexity of policy in the ADF. The Panel selected a limited number of key alcohol policies and assess these, rather than attempt to map and review all policies relating to alcohol throughout the ADF.

The Panel concluded that the ADF is an organisation of many policies; including many that relate to alcohol. There is a need to reduce these and in future, avoid duplication of alcohol policies.

Recommendation 1

Develop an overarching ADF wide alcohol policy to reflect evidence about effective practice, in conjunction with the current development of the ADF Alcohol Management Strategy.

This should be directed at reducing alcohol related harm and include an increase in the attention paid to:

- *Primary prevention, especially in relation to:*
 - *Communication and education about risks of alcohol consumption, ADF alcohol policy and regulations*
 - *Controls on the supply and availability of alcohol within the ADF.*
- *Secondary prevention, such as organisation wide screening to identify risk and respond with a broader range of opportunistic and brief interventions.*

The Panel believes it is time to develop a comprehensive policy statement on alcohol that sets the scene for a fresh approach. This would allow a framework for review of the many existing policies with the aim of reducing the overall number and existing inconsistencies. The ADF has available to it many of the most potent levers to reduce alcohol related harms if applied systematically and strategically. Like other capability and safety responses, this should include a thorough assessment of risks across the organisation, which may vary in different contexts, and the development of organisation wide and context specific responses to all factors that contribute to alcohol related risk. This broader focus:

- is required to focus on the three key areas, supply, demand and harm reduction. This means including examination of the economic (price/fees and related items especially in context of disposable incomes), physical (places where alcohol is available including density of outlets), cultural (attitudes and the broad historic and 'membership' practices), social (including group norms, expectations, peers and social opportunities together with promotion, sponsorship and coupling of alcohol with social activities), temporal (times of opening and availability) and situational availability of alcohol; and
- includes the way in which alcohol related harms and incidents are dealt with: the administrative, clinical and disciplinary response measures available and applied; their consistency and importantly the understanding and beliefs of members regarding their application.

The Panel is aware that the overarching policy on the management of alcohol in the Australian Defence Force [DI(G) PERS 15–1] has recently been reviewed and updated through extensive internal consultations. However, this updated version has not yet been formally endorsed and until then the substantive policy is that which was introduced in 1980. It is well out of date in terms of its framework and scope, connection to current evidence based practice, and in terms of the context of alcohol use in the ADF today.

The Panel had hoped to endorse this revised policy but found two reasons to pause. The commendable initiative of the ADFAMS project that is systematically working toward a whole of Defence alcohol management strategy and specific advice for each of the Single Services is due to report toward the end of this calendar year. This is a critical parallel element in clarifying the needs and directions for revising and implementing any alcohol policy in the ADF and given the central importance of DI(G) PERS 15–1, it would be somewhat unwise to insist on its adoption mid stream. Secondly, the Panel found that it still lacked the focus that this Panel is recommending overall. So, while it is a substantial and greatly enhanced policy in comparison with the one that it would replace, there remain some issues that require further attention. One concern with the revised policy is that it is based on the premise that education is the most effective approach to preventing and reducing hazardous drinking and alcohol related harm; a view which is not supported by scientific evidence.

The overarching alcohol policy should be developed according to the following best practice principles (eg Allsop *et al.* 2001):

- Consultation is important during developmental stages.
- Universal application is required across the whole organisation.
- Policies must be organisation and context specific.
- Policies must be comprehensive.
- Clear instructions and procedures for responding to non-compliance.
- Publicise the policy in an appropriate and equitable way.
- Engender employee compliance through definition of roles and responsibilities. education and training.
- Evaluate the implementation process.

4.4.2 Prevention — the need for enhancement and linkage (including thinking safety)

The Panel understands that the ADF is ready to adopt a more preventative approach to alcohol. A useful frame for considering prevention is the 5 P's framework: populations, products, prices, places and promotions (pers comm, VicHealth 2011). The ADF appears ready to take up the challenge to shift its thinking to incorporate all of these elements. This coincides with calls in the broader community for a greater emphasis on the prevention of alcohol related harm.

As noted earlier, a key preventative approach involves controlling alcohol availability. Evidence from the broad community indicates that the strongest influence on alcohol consumption and harm is the availability of alcohol (price, hours of sale, number of locations, controls on who alcohol can be served to) so any preventative effort needs to include attention to these drivers. Much of the detailed information about these aspects of alcohol in the ADF is contained in more detailed commentary in Section 5.2 and Appendix 2 — Situations of drinking; where the Panel provides some analysis of the aspects of physical, economic and social availability of alcohol in the ADF.

In addition to overall consideration of the availability of alcohol, the specific contexts of alcohol use will be important with particular attention needed to assess situations of increased risk and harm. Low risk drinking can become high risk in some contexts, such as driving. Safety sensitive situations usually have more demanding rules about consumption than others (eg 0.02 BAC for probationer drivers and heavy goods drivers; 0.0 BAC for pilots). There is sound experience of identifying safety critical areas and events. For these, relevant rules and regulations are usually developed and communicated to all relevant personnel. Similarly, other conditions may increase risk. For example, risky drinking is associated with mental health diagnoses and these problems often co-occur.

4.4.3 Culture and Capability

For some people, both in the ADF and in the wider community, alcohol has great symbolic and cultural meaning. There is a strong ADF specific set of alcohol stories that contribute to mythology, tradition, rituals and practices. These appear to contribute to defining elements in the identity and membership of Defence personnel. The ongoing use of such Defence imagery and stories in association with alcohol consumption serves to support and further entrench both the imagery itself and the ongoing normalisation and even celebration of heavy, risky alcohol use.

“It seems that every day the emailed “Daily news summary” contains advertisements for alcohol. It is done through advertising social activities, and wineries are using mess functions to get advertising rights in Defence through the back door”.

Submission to Panel

This perceived association of Defence personnel and Defence work with heavy alcohol consumption is reflected powerfully in the community in the form of alcohol marketing and promotions such as the use of alcohol in the recent Fosters promotion for Victoria Bitter around the time of ANZAC Day (the “Raise a Glass Appeal”).

“My concern is more around the fact that Army has handed our most decorated soldier to Fosters to sell their product”.

Submission to Panel

The use of stereotypical Defence imagery in association with alcohol consolidates assumptions of the central place of alcohol in team bonding and mateship and in promoting the notion of ADF personnel being — “real men” (usually gendered) and paired with heroism and bravery. The Australian community thus is conditioned to ‘expect’ that its soldiers, sailors and Air Force members will use alcohol. Recruits who aim to ‘belong’ are very familiar with this expectation.

There is clearly some inherent conflict and ambivalence in the community regarding the place of alcohol and this is mirrored in the ADF. On the one hand there is a strong connection between alcohol and being an ‘Aussie’ and being a ‘real man’. As in the community generally, these perceptions may be considered to be beneficial for the ADF. That is, there are times and situations where alcohol use can be seen to facilitate conviviality, recreation, team building and to relieve stress. On the other hand there are strong ADF rules about occasions when using alcohol is prohibited; such as in safety critical situations or when needing to be fully capable and ready to face adversity and to take action.

Ambivalence toward alcohol use was reflected in comments to the Panel. It became apparent that while there are those in the ADF who want radical change regarding alcohol use, many others see alcohol as part of their heritage and with this, as being an aspect of their entitlement.

Effective responses will need to acknowledge this place of alcohol while simultaneously reducing risk for individual personnel and the whole ADF. It is relevant to note that community’s and cultures that have a high ambivalence about the place of alcohol are suggested to be at increased risk of the harm from alcohol (Room and Makela 2000). In this context the mixture of strong endorsement of alcohol use in some situations in the ADF and prohibition in others may be a particular contributor to risk of alcohol related harm in the ADF.

“The consumption of alcohol within the ADF is driven in part by the supply of cheap alcohol (through the messes/wardrooms), the lack of alternative entertainment and distraction for young members living-in on base, and by the lack of any 'real' example as to the correct behaviours by the middle rank officers and NCOs”.

Submission to Panel

As a part of reflection on the cultural place of alcohol in the ADF, it will be necessary for the organisation, while recognising the benefits of alcohol, to accurately assess the true costs of alcohol. This could be undertaken in the context of the current and ongoing strategic review process (SRP).

Risky drinking by ADF members and the incidents involving alcohol also do collateral damage to the public image and reputation of the Services, both within Australia and internationally, particularly when it is reported in the media. While many in the ADF celebrate their traditions with the use of alcohol, the media reporting of alcohol fuelled incidents or the death of members of the ADF in accidents associated with alcohol consumption has a significant negative impact on the ADF's reputation. The two-sided symbolic association of alcohol with the ADF has the potential to impact on the willingness of families to have children entering the ADF, on general community support for Defence expenditure, and ultimately on governments' willingness to continue to look to Defence for leadership.

The Panel commissioned an analysis of the volume of television, radio and press coverage of the Australian Defence Force (ADF) and its personnel in relation to alcohol, covering the year 2009/10 and 2010/11. The analysis focused only on negative media reports⁶. The analysis found:

- The total volume of coverage in 2010–2011 was **2,666 reports**, which reached a cumulative potential **audience of 81,159,239** and had an advertising space rate of **\$4,445,812**.
- This is a **347% increase** from 2009–2010, when a total of 596 reports mentioned the ADF in relation to alcohol. These reached a potential cumulative audience of 52,029,815 and had an advertising space rate of \$1,797,788.
- Television stations had the most coverage of the ADF and alcohol in 2010–2011, with 1,288 reports (including syndication). This contrasts with 2009–2010, when television outlets had the lowest volume of coverage (160 reports).
- The major news stories that contributed the increase in media coverage of ADF and alcohol in 2010/11 were the report into Navy culture and HMAS SUCCESS incidents, the fatal car accident at Crib Point that killed two Navy recruits from the HMAS Cerberus base, the proposal by the Defence Minister to allow women to undertake combat roles, the plans to charge soldiers for beer at Christmas celebrations in Afghanistan, and most significantly, the Skype incident at ADFA.

This could be interpreted as representing the equivalent of \$4.5million worth of negative publicity for the ADF. It is unknown what impact this negative publicity has on ADF recruitment and more broadly.

⁶ The terms used in the search include 'alcohol', 'drunk', 'binge' and 'intoxicated'. Results were also filtered manually to remove any irrelevant or benign mentions (eg news stories about Fosters fund raising for Legacy or RSL). News reports about the proposal by the Defence Minister to allow women to undertake combat roles were included where they also made negative references to alcohol in the ADF.

4.4.4 Information/data: extending usefulness for both individual management and strategic planning

Strong indicators of alcohol related harm are how much alcohol is consumed, over what time and in what contexts. In order to inform effective prevention and other interventions, and in order to determine the impact of policy and related strategies, there is a need to monitor alcohol consumption and related harm in various contexts using valid, reliable and up to date data.

Alcohol consumption can be measured through a variety of means. Firstly, alcohol sales and supply within the Defence Force are one source of data indicating risk and the impact of policy and other responses to alcohol related harm. Secondly, not all alcohol consumed is supplied on Defence sites. Some is purchased and consumed in the broad community. Therefore, sales/supply data should be supplemented by regular surveys of consumption by service personnel, including assessment of the context of consumption and incidents of harm. As well as identifying overall levels of consumption, it is appropriate to gather information about the harms associated with alcohol consumption. The AUDIT is now widely used across different countries to assess individual and community wide risk of such harm. In addition, the AUDIT has become established as a key instrument to screen for risk in defence forces in a number of countries (eg US, UK, Canada) to identify absolute risk for Defence personnel and comparative risk (eg with similar aged general community members).

The Panel accessed considerable information and data that are held in various places within the ADF. Overall, the Panel found that in some instances such information was incomplete and/or difficult to access. Where the data were available, it was primarily found to be collected and used for the purposes of managing individual incidents or personnel, and not for policy or practice monitoring, evaluation or planning. The Panel believes that a more strategic approach to collecting and responding to alcohol related data across many areas of the ADF is required, one that includes alcohol screening of individuals across all important career transition points, and the development of a whole of ADF Incident Reporting System that facilitates monitoring of incidents at both the individual (early identification of an issue) and the organisational (epidemiological) levels.

Recommendation 4

*Develop an approach to collecting and responding to alcohol related data to enhance their value in terms of managing individuals **and** strategic planning; this will include alcohol screening of individuals at recruitment and across important career transition points, particularly post-deployment, and a whole of ADF Alcohol Incident Reporting System.*

See Section 5 and appendices 1–5 for details of data used in this report.

4.4.5 Connectedness to the community

The ADF is a distinctive and complex organisation sitting within the Australian community. Its members are citizens as well as ADF members. Organisationally and administratively the differentiation between Defence members and community is diminishing (eg increased contracting in of community based services and the increase in the proportion of personnel living off-bases). Nevertheless there remains a sense that in many respects the ADF is a *separate and special organisation*. It has its own rules and laws, has an emphasis on specific

values, is very hierarchically organised and is reported to be slow to change; at least in part since it depends for some of its modus operandi on tight structures, clear lines of command and responsibility, certainty and decisiveness. It is expected to attract people who will confront danger and take extreme risks and work in diverse situations that most in the community would not be willing or able to do; yet generally want done.

The Panel understands that the operational requirements in different Defence settings are diverse such that while on field operations, especially on deployment, the requirements for constant work might be extreme but on return and on base, much time is taken with necessary training and other activities that some personnel describe, for example, as “boring” and “playing at being soldiers”. Alcohol use is likely to increase where and when boredom occurs concurrently with ready availability of alcohol.

The stance and actions taken to reduce alcohol related harm by the ADF has the potential to be a powerful contributor to improvements in the Australian way of drinking. The community needs champions in this arena.

Good news story

ADF Sponsorship of National Drug and Alcohol Awards

The ADF has demonstrated a commitment to the responsible use of alcohol by sponsoring an award at the 2012 National Drug and Alcohol Awards in the category of Excellence in Prevention and Community Education. This provides a clear message that the ADF is committed to change and are willing to invest in community and National initiatives and this has already been favourably commented on by many who are working in the alcohol and other drug sector.

It is acknowledged that the ADF has taken steps to develop more effective responses to alcohol, including the recent investment in ADFAMS. However there are areas where a stronger systematic approach is indicated. Some support may be found in developments that exist in the broader Australian community. These include:

- The system wide and multifaceted approach of the National Drug Strategy.
- Liquor control laws and regulations, especially their recent focus on public health and reducing alcohol related harm.
- Development of evidence based clinical guidelines for people affected by alcohol problems.
- Development of organisation and community wide integrated rather than isolated responses (eg coordinating law enforcement, health and housing responses).
- Recognition of the role and needs of families and their involvement in responding to alcohol and other drug problems.
- Development of partnerships and alliances with local community groups advocating for safer alcohol use.

See also Section 5.2: Situations of drinking, where consistency with other Australian legislation regarding alcohol is discussed and also Section 5.5: Involvement with health and support services, where consistency with accreditation standards is discussed.

Innovation, Monitoring and Evaluation

The Panel emphasises the importance of innovation, monitoring and evaluation of policy and practice, and notes the ongoing development of such capacity within the ADF; including identification of necessary knowledge and skills needed to support the initiatives that are already underway.

There are current projects and programmes that appear to be innovative and constructive in reducing adverse outcomes of alcohol use in the ADF. However, impressions are not a sufficient measure of effectiveness. The Panel has identified a need for a more systematic approach to the review and evaluation of alcohol-related policies and innovations; for example, monitoring outcomes of the Third Location Decompression Trial and evaluation of the Alcohol KYMS programme.

Overall, strategic planning and lines of accountability need to be aligned with current best practice approaches to managing alcohol related issues. Not all capacity that might be needed to implement a comprehensive strategy has to come from within the ADF. The Panel suggests identifying potential strategic partnerships and alliances to enhance existing internal capacity. Enhancement of the diverse skill sets needed by the ADF to achieve its alcohol harm reduction objectives could also be achieved through a consolidation of existing capacity, virtual or otherwise. This could support and extend the somewhat isolated pockets of alcohol specific expertise that currently exists within the ADF, and provide a basis for stronger connection with other alcohol expertise in the community.

Recommendation 8

Access expert input to policy and program development and implementation by forming alliances and partnerships with other organisations and individual experts on alcohol outside Defence.

Currently the ADF is largely depending on the knowledge, skills and capacity of those already involved in the Joint Health Command for advice and development in these areas. The Panel has been impressed with the interest, knowledge and experience that is available but notes that higher level planning, strategic population planning, surveillance and expert addiction specialist advice is apparently not readily available. There will always be a need to bring diverse disciplines and knowledge together in tackling alcohol in a large and complex organisation like the ADF. The alcohol domain requires more than health and more than any specific single discipline. The knowledge in this field is also constantly changing and where therapeutic developments, for example, occur that can significantly change current best-practice.

Given the suggested shift in thinking that is away from health being predominantly responsible for alcohol issues, towards health being one important contributor to furthering the response to alcohol use in the ADF, the Panel believes there is a need to create structures and processes that allow ready access to broad expertise and experience. The Panel's advice is to create a 'centre with or without walls' and suggest it focus on how alcohol impacts on capability; thus the development of a (virtual) Centre for Alcohol and Capability.

Establishment of a Centre on Alcohol and Capability

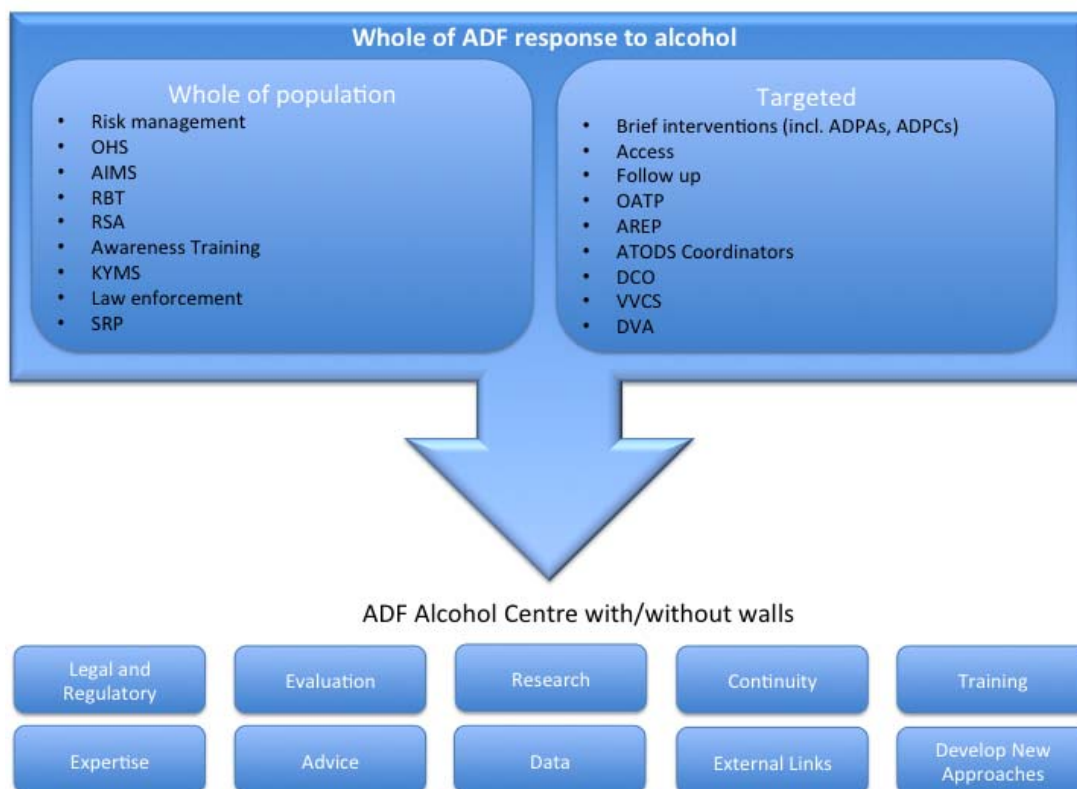
Such a Centre could include capacity for the range of responses necessary for any large organisation with the complexity of the ADF. For example this could include capacity for secondary consultation at every level from policy development and advice regarding alcohol, situational alcohol risk assessment, advice to CO's in responding to alcohol related matters including planning events where alcohol is involved to management of incidents and liaison with external stakeholders. It could be a repository of information and advice on clinical diagnoses, treatment and possible referral including use of external as well as internal treatment responses services. It could include an intranet web based presence that houses self-screening and assessments with a capacity for grouped, anonymous data analysis for strategic understanding in addition to the individual respondent specific, planning and evaluation of impact of policies and programmes or situations and changes in external environment. It could be the 'go to' place within the ADF for alcohol related expertise (see for example, Figure 2).

The Centre could provide leadership for the implementation of the upcoming ADF alcohol management strategy as well as housing a strategic surveillance unit for monitoring and evaluation of change; providing early warning on any shifts in the indicators of possible alcohol related data as well as feedback on implementation of policies and programmes. It could support the development of capacity for population wide analysis and utilisation of these data for planning purposes at various levels and contribute to other strategic planning such as the current development of strategic transitional plans after deployment and before reaching home.

While it would be important for such a centre to have links with mental health developments in the ADF, it is equally important that it not be seen as a sub-set of the mental health initiatives or a sub-center of the ADF Centre for Mental Health. Given the emphasis in this review on the need for a whole of organisation ownership of alcohol planning, policy and responses and the crucial including of the supply related elements in any comprehensive alcohol policy, the Panel is concerned that if it were to be subsumed under a mental health umbrella it would lose the most potent levers needed for an integrated strategic approach to alcohol in the ADF.

While noting the effort that is being applied to broadly consider alcohol related matters within the ADF, the Panel believes that there is a need for a high level Advisory Group to help connect to current best practice, significant national alcohol policy and various more specific areas of expertise and experience that cannot reasonably be available within the ADF. Such a group could comprise a small number of people with qualifications and expertise in alcohol policy programs and implementation of national standing including, for example, a recognised medical Addictions specialist, researchers and alcohol policy advisors who are involved with other national, leadership organisations.

Figure 2. Example of ADF Centre on Alcohol and Capability



5. Alcohol in the ADF

This section of the report summarises the detailed findings on each of the spotlights chosen for the Panel's attention and analysis and includes the context for the remaining recommendations. The following spotlights/focus areas were selected:

Spotlight 1: The time of recruitment and early training.

Spotlight 2: Common situations of drinking (eg cadets' mess, officers' mess, dining-in nights) and specific situations of drinking (eg RAN at sea, alongside, ashore).

Spotlight 3: Deployment including Preparation; Decompression; and Post Deployment.

Spotlight 4: Safety or disciplinary matters/incidents where alcohol might be implicated.

Spotlight 5: Involvement with health (especially indicators of possible alcohol implicated impediments to health) and responses including the support services available/used by ADF members (and some consideration of family members).

Further details of each of the spotlight analyses are provided in Appendices 1–5.

5.1 Recruitment and early training

Recruitment and early training is a formative time in the lives of ADF personnel. It is a period which shapes individual values, attitudes, and behaviours that can last a life-time. It is also a time that introduces a collective culture that defines the workplace and much of their life outside of it. This is also a time when drinking behaviours can become established. At the time of recruitment and early training, many are aged less than 18 years and for many it is their first time living away from home; and for young women it can be their first experience of a male-dominated environment. They have a high level of disposable income, and once 18 years of age, this is coupled with the legal right to drink and enter a world where there are competing pressures of newfound independence and the challenges and demands of being a member of the Defence Force. The early phases of training are highly structured and supervised, and there is limited free time available to socialise in ways that the civilian community take for granted.

"It's sometimes like being the parent of a thousand teenagers"
Commanding Officer at a recruit training facility

At the same time, many are adolescents who are seeking and gaining typical experiences of this life stage such as reaching physical and emotional maturity, loosening ties to their family, developing a wider social circle and friendship network, having sexual relationships, and experimenting with drugs including alcohol and tobacco.

The Panel consulted with ADF personnel, including senior command and cadets, at some of the main training bases where ADF recruits are located, including ADFA and HMAS CERBERUS. In general there was acknowledgement of a culture of binge drinking within the young training population, although this was sometimes defended as typical of the age group in the wider community. However, the Panel observed many distinctive aspects to the alcohol situation within the ADF, such as the relatively low price of alcohol on base in the context of their relatively high disposable income, the use of alcohol in bonding and the release of stress after periods of intense training, and the peer pressure to drink regularly and

heavily within a mostly male dominated environment. Similar observations have been made by family members of ADF recruits, as reported in a recent study of the effects of Defence life on families:

“As a parent, I am particularly concerned about the drinking culture within the ADF. My son is particularly young and I feel the on base presence of extremely cheap alcohol (particularly spirits) encourages excessive drinking at all levels. If the ADF was serious about implementing changes in relation to binge drinking and/or the perceived drinking culture within the ADF, this would be a particularly good place to start” (Defence Families of Australia 2011, p.27).

Below is a sample of quotes from focus group meetings with Recruit Trainees in the early weeks of training:

“On weekend leave from training a lot of us go to the Casino because that’s what the group ahead of us said we should do. The tradition is handed down to the new recruits”

“We go to XXXXX because of a lot of us are new to [city] and they advertise deals for ADF people. Lots of places offer cheap drinks and strip clubs offer free entry to us”

“We spend \$600 to \$800 in one night out at XXXXX. A lot of people shout rounds of drinks. Its about \$100 a round. We get paid well while we’re training but the money just sits there until we have a weekend off and can go out”

“We drink the most on nights we get paid — Thursday. 10, 15, or 20 drinks is normal for us”

“I spent about \$4,000 in that first weekend”.

Image 1. Example of alcohol promotion offered to ADF personnel at a civilian venue.

Enlargement:

MILITARY PERSONNEL

As most of you would be aware, [redacted] and the Defence Forces have had a great relationship over the years. So much so, that now you only need to show your current Military ID which will work as a [redacted]. If you are serving your country then let the [redacted] Serve You. A current military id can add to the [redacted] benefits.

Added Bonus
Priority Entry to cardholder only

Defence Force Fridays
Every Friday Menu Pizza or Schnitzel and [redacted] Drink for \$10
Live Music from 6pm - 9pm
Discounts given to Military until 12Midnight
This kind of value is too good to be true.

SPECIALS
EVERY FRIDAY (WELCOME TO EVERYONE) Apr - Oct 2016
\$3.00 Schmeers of Top Beer
\$3.00 Champagne Cocktail
\$3.00 Basic Gin
\$4.00 Bacardi Breeze

Basic Spirits are
Jim Beam Bourbon, Tsarevitch Vodka, Roundhead Rum, Famous Grouse Scotch, Liqueur Gin

MILITARY PERSONNEL
As most of you would be aware, Mooseheads and the Defence Forces have had a great relationship over the years. So much so, that now you only need to show your current Military ID which will work as a [redacted]. If you are serving your country then let the [redacted] Serve You. A current military id can add to the [redacted] benefits.

Added Bonus
Priority Entry to cardholder only

Defence Force Fridays
Every Friday Menu Pizza or Schnitzel and Moosehead Drink for \$10
Live Music from 6pm - 9pm
Discounts given to Military until 12Midnight
This kind of value is too good to be true.

Source: <http://www.mooseheads.com.au/mCard.html>

Overseas studies have shown that military recruits are at risk of binge drinking and are more likely to be heavy drinkers. There is limited data available concerning the alcohol consumption of ADF recruits. Subsequent data on longer established members using POPS and LASER datasets provided information that suggests that recruits and personnel who are younger (aged less than 25 years) are more likely to consume alcohol at harmful levels, as do younger persons in the civilian population generally. Given such findings, the limited availability of data regarding the alcohol consumption and harm characteristics of recruits limits the ADF's capacity to effectively respond to and manage the alcohol-related risks of this high-risk group. Further analysis of the MHPWS by recruit and age status would be of benefit in developing a better understanding of such risks. Similarly, analysis of alcohol-related data and possible 'risk' or vulnerability characteristics obtained from the recruitment process could be of benefit. The finding from POPS data of a possible reduction in the prevalence of hazardous or harmful consumption among personnel less than 25 years of age over the last four years is encouraging. Further analysis is required of this and other datasets to develop a better understanding of the determinants of such a reduction, including changes in the characteristics of recruits, in ADF selection procedures and/or changes in ADF alcohol risk management practices.

As part of the ADF's pre-recruitment selection and screening processes, the Panel suggests:

- That the ADF establish alcohol specific screening at the time of recruitment and review the induction environment to identify and reduce risk.
- That the ADF consider reviewing all recruitment and screening criteria and mechanisms to ensure that alcohol screening is included and potentially develop a system to monitor alcohol consumption at both the individual (ie for referral and treatment) and the population levels (eg monitoring of excessive consumption).
- That the Alcohol AUDIT screening instrument should be used in place of the existing psychological screen items used by the ADF regarding alcohol during recruitment testing.
- Further analysis of existing datasets to obtain a better understanding of alcohol consumption and alcohol related harm characteristics of recruits and young Defence personnel is also suggested by the Panel.

With regards to the early induction and training curriculum, the Panel suggests that the ADF review current Alcohol and Drug Training modules (including those used for initial induction) and alcohol components of other training curricula and redevelop these, if necessary, to ensure that they are consistent with alcohol and drug training for other community post-secondary education institutions and workplaces. The ADF should also encourage the use of a range of techniques for ways of thinking about 'own alcohol use' among recruits. This could include, for example: web based self-assessment tools to facilitate the capacity to self-monitor.

Given the links between use of tobacco and the increased likelihood of smokers also being more vulnerable to problematic alcohol use (and other drugs), the Panel advises the ADF to maintain all efforts to reduce the uptake of tobacco smoking among recruits (at least) utilising advice from expert groups to develop an 'all of organisation' approach and set prevalence targets for sub-groups to help monitor implementation and utilise the inherent competitive element present in the ADF.

Good news story

Online AToD training

The AToD online awareness brief was developed as an alternate pathway to face-to-face presentations, and aims to increase mental health literacy in the area of AToD for those who are not able to access a face-to-face session. However, Defence sees that it is still preferable for ADF members to attend the face-to-face sessions, which are conducted at the start of each year. The package was developed within Defence as collaboration between Joint Health Command and the Directorate of Training, Educational Services and Forces Entertainment. The package is available to all ADF members who can access the Defence Restricted Network. The aim of the AToD online brief is to promote awareness of Alcohol, Tobacco and other Drugs, in an engaging and accessible way.

5.2 Situations of drinking

Situations of drinking in the ADF include many of those typically found in civilian environments, but also particular situations that are distinctive to the ADF. These range from formal situations such as Dining-In Nights and disbursement of rations aboard Navy fleet (ie "two cans per day, per man, perhaps"), to less formal situations such as 'end of day' or 'end of week drinks' at officers' messes, to very informal situations such as an afternoon barbeque at an Army unit's "boozier". Within this diversity of drinking situations, the Panel has

reviewed information regarding a variety of drinking times and opening hours, methods of procurement and supply of alcohol, selling practices and pricing arrangements, product types, serving rules and regulations, and drinking styles. All of these are influenced by distinguishable social, economic and cultural factors, and the particular Service context.

Such information demonstrates that the place of alcohol in the ADF environment is complex and multifaceted and not easily comprehended by those outside the ADF. However, what appears to be common across most of the drinking situations is the relatively high availability and accessibility of alcohol; both physically and economically. Availability spans from that which is accessed and purchased from retail sources (eg mess bar, canteen, boozier) to that which is obtained through social sources (eg commanding officers, colleagues).

Compared to civilian settings in Australia where there are strict legislative controls over alcohol access and accompanying law enforcement activities, alcohol control in the ADF is mostly devolved to the level of the local command.

There are some areas where changes in general community requirements or approaches with regard to alcohol have moved further than is apparent in the ADF. The Panel suggests creating a standard for Defence where the reduction of alcohol related harm is the primary object of alcohol related legislation, general orders and other policies. This should start with alcohol legislative provisions. The Panel does note that alignment with the provisions across all Australian jurisdictions is not possible, but it draws attention to the inclusion now of a primary object of reducing alcohol related harm in all the various State/Territory liquor control Acts.

(See further details and rationale in Section 5.4: Safety and Discipline)

Recommendation 7

Working to a principle that Defence Laws with regard to alcohol need to operate in the context of State and Territory Laws in Australia, examine the consistency and interface between Defence and State/Territory laws regarding alcohol and related law enforcement practices.

In addition, specifically:

- *Review current legislation and instructions with a view to extending the powers of military law enforcement officers to use alcohol breath testing on ADF bases and to implement penalties, and.*
- *Improve ADF Policing and Security Management System with regard to alcohol.*

In the context of managing aggression and alcohol related incidents and injuries, there is a need to enhance enforcement of liquor laws and an opportunity to use strategic proactive policing; including targeted policing and enforcement of the legal liability of alcohol servers, and the managers and owners of businesses where alcohol is sold or served.

It is clear that ADF personnel are governed by the Commonwealth legislation and general orders, and that the Defence Act 1903 over-rides the State/Territory laws. However, the latter remain important for the ADF as they reflect general community standards and expectations with regards to alcohol. ADF personnel are subject to jurisdictional laws when in civilian environments but due to differences in laws and enforcement provisions in the DFDA community laws intended to reduce risks associated with alcohol use and driving are not included. ADF personnel on base are not subject to the laws relating to driving with a BAC >0.05 when on bases. The charge available is the much more difficult to sustain driving while intoxicated. The Panel understands that the Domestic Policing Unit on Army bases within Australia, for example, do not have powers to conduct the equivalent random breath tests on drivers within the base as they cannot follow this with appropriate, equivalent charges.

The Panel notes that liaison with local police is common and was made aware of “Project Fulcom”. It understands that this includes elements of law enforcement of alcohol matters, although there was insufficient time to receive a detailed briefing on it. Other brief descriptions of partnerships between military and civilian police to address local alcohol issues were also described, including the Darwin Safe Precinct Initiative.

In the policy domain, some ADF statements direct personnel to not “encourage” or “coerce” members to drink [DI(G) PERS 15-1, Pt 1, 14] nor to “popularise” drinking [DI(N) PERS 31-9, Pt 1, 8)]. Consultations with members suggest that the strong pro-drinking culture within ADF, at least in some situations, especially when using the comparison of former practices and experience of senior personnel (the “good bad old days” as one termed this) makes judgements of interpretation of these policies mixed at best. This is further reflected in the availability of alcohol in ADF environments, where any suggestion that it might be more restricted is generally met with incredulity.

The economic availability of alcohol in the ADF is shaped by the relatively low selling price of alcohol at ADF outlets compared to those at civilian outlets, the subsidisation by the ADF of labour and other costs related to the serving of alcohol to its personnel, the overall affordability of alcohol for ADF personnel relative to other commodities and the remuneration of ADF personnel.

The Panel recognises that the availability of alcohol within the ADF stems partly from its perceived utility in maintaining aspects of operational capability. That is, drinking is seen to serve an important function in building team spirit, celebrating unit tradition, fostering Service ethos, and supporting leisure/recreation time for those who live on base. In this regard it is not desirable or feasible to prohibit access to alcohol for ADF personnel. However, as the scientific evidence indicates that the availability of alcohol is a major determinant of levels and patterns of alcohol consumption in a population, and in turn a major determinant of alcohol problems, greater consideration of the accessibility of alcohol is required.

There is limited information available outlining the locations and contexts of alcohol consumption in the ADF. Some information obtained by the Panel indicates that alcohol is sold cheaper in many ADF environments compared to civilian environments. While it appears that the density and opening hours of alcohol outlets within ADF working environments are similar to the civilian community, the Panel noted that it is unusual today for civilian workplaces to contain alcohol outlets.

Analysis of alcohol consumption in the ADF via alcohol purchase and sales figures are limited since data for the Air Force and the Army are apparently not readily available, or there is only limited capacity to extract the required information (eg alcohol sales only). Limited data regarding alcohol availability within the Royal Australian Navy were identified. For example, in the period 2009–2011 there was almost 20 Navy Fleets that purchased alcohol for consumption by crew. In 2010, the total sales of alcohol in Navy mess halls (including soft drinks and snacks) were \$1,914,064. This is included here only as an example of these data [see Appendix 2].

Hence, the Panel believes that the information regarding the availability of alcohol in the ADF warrants considerable additional work. The current Strategic Reform Programme (SRP) in the ADF may facilitate the identification, collection and analysis of data regarding the costs (and possible benefits) associated with alcohol availability across Defence.

“Defence spends around \$2.8 billion per year on the acquisition of non-military goods and services from external suppliers. These suppliers include airlines, accommodation providers, cleaning contractors, stationery providers and healthcare providers, to name a few. There are significant opportunities to make the purchase of these non-military goods and services more efficient”. (Department of Defence 2010: 10)

Recommendation 5

The Panel recommends that:

- *An audit of the available data regarding the determinants of the supply and availability of alcohol be conducted.*
- *A valid and reliable reporting system for alcohol sales be established by the ADF; allowing for per capita calculations where possible.*

The Panel considers an audit of the supply and availability of alcohol in the ADF is warranted to identify the various aspects of alcohol availability.

The audit should be informed by the factors that international research has shown have a significant influence on the patterns of drinking of the population: sources of alcohol sold or made available, pricing, physical availability including the number and density of liquor outlets (including all bars, canteens, “boozers”, stores and Messes); trading hours and serving arrangements including relevant requirements for staff and management training (including the responsible service of alcohol training).

The systematic collection and analysis of data to determine a realistic measure of the total cost of alcohol to the ADF should be undertaken. Both the expenditure and costing elements need to be considered in such work and could usefully parallel the cost of alcohol studies undertaken in the broad Australian community. These include costs to health, amenity, and alcohol’s contribution to crime and policing as well as loss of productivity. Other important costs are difficult to assess but emerging work relating to the harm to others such as family members is now also available as a guide. (Laslett *et al.* 2010)

The Panel also considers that where data are collected regarding alcohol incidents or harms, additional information is collected regarding the context of alcohol consumption preceding the incident (eg location, time, intoxication level) to identify at-risk drinking situations. Australian studies have found that the addition of data fields of this sort in incident reporting

systems has been most valuable in identifying problem places, times and situations as the focus for subsequent intervention.

In terms of the previously recommended development of an over-arching policy, it is suggested that the policy address the following aspects of access to alcohol relevant to specific situations and contexts of alcohol consumption:

- Pricing eg increased prices; standard minimum price at all bases/barracks; bans on alcohol promotions, sponsorships and discounts; and differential pricing for different alcoholic drinks (with incentives favouring lower alcohol content beverages).
- Regulating physical availability eg banning drinking in areas other than licensed premises; restricting the days and hours of alcohol sales on-base; restricting the density of liquor outlets on-base; restricting the sale of high-strength alcoholic drinks during peak drinking times; ensuring that the Australian minimum purchase age is applied in all situations including when on operations including deployment; rationing of alcohol; ensuring that non alcoholic drinks and food are available at all times; restrictions on the number of drinks purchased at one time.
- Modifying the drinking environment eg mandatory RSA and aggression training for all alcohol servers and security personnel and trained security staff to monitor service, consumption and intoxication.

One effective way to reduce the risks associated with alcohol use is by reducing the amount of alcohol consumed at ADF functions and on ADF premises. This can be done without interfering with the number or occasions when alcohol is available by reducing the strength of alcoholic beverage products available. For example, there is a range of reduced strength beer products available and wines can significantly vary in alcohol content. This could potentially reduce alcohol consumption on any one occasion by approximately 30%, assuming the same number of drinks. This would provide an opportunity to send a strong message without interfering in the desire to gather together and share a drink.

Recommendation 2

Reduce the supply and sale of higher strength alcohol products permitted to be sold or made available on ADF locations and at ADF functions.

In this context, the Panel also believes that it is appropriate to recommend a longer-term goal regarding alcohol availability. The Panel noted that considerable thought currently goes into the occasions and situations where alcohol is banned. As an alternative approach, it suggests that this attention could usefully be turned to making decisions about when and where alcohol might be made available. That is, turn the focus of careful decision making about alcohol availability in the ADF around such that it not be available *except* when a decision is made to allow it.

Recommendation 3

Adopt a vision and a plan for implementation of alcohol harm reduction in the working environments of Defence by requiring Commanders to assess situations in which alcohol is proposed to be used informally or formally and where specific approval would then be required for the use and access to alcohol within ADF work location.

Based on a strategies developed by community bodies and also in the Navy with regard to events management and situational strategies, including responsible hosting of events, there would be a place for the development of ‘decision rules’ that require deliberate consideration of various risk factors and plans to ameliorate these. This would require a specific plan for each event with consideration of the location, the members involved, the source of supply and circumstances of serving and any other plans for risk/harm reduction. Such an approach would allow alcohol at ceremonial events and particular situations where it was thought appropriate. The decision making currently regarding the exclusion of alcohol or declaring ‘dry’ certain locations/operations would instead be decisions about allowing access to alcohol. These decisions should not be limited to orders regarding base availability.

It is perhaps not surprising that the Navy was the first of the Single Services to develop specific policy and programs regarding alcohol some 30 years ago; albeit in response to alcohol as a contributing risk factor to high profile incidents. In the context of frequent changes to access and the context of alcohol availability, expectations and use the Panel noted the development of the Navy Harm Reduction Matrix for assessment of alcohol risk in different situations and locations.

Comment from senior RAN personnel:

“The alcohol restrictions placed on our people while at sea tend to exacerbate the binge drinking culture when they go alongside and the restrictions are temporarily removed”

Good News story

Navy Alcohol Harm Reduction Matrix

The purpose of the harm reduction matrix is to address the risk associated with alcohol use in specific locations. It uses a five-step approach that includes:

- Step 1 Determine the context relating to the consumption of alcohol
- Step 2 Assess the consequences of alcohol-related unacceptable behaviour
- Step 3 Assess the likelihood of alcohol-related unacceptable behaviour
- Step 4 Determine level of risk using Hazard Risk Index calculator
- Step 5 Implement controls according to level of risk.

The strength of this hazard risk index is that it encourages the Commanding Officers to assess every situation that includes alcohol in an objective and standardised way. The Commanding Officers can then implement appropriate controls based on the level of risk.

The Panel suggests that the ADF explore the development of risk assessment tools for safety critical areas, situations, contexts and events where alcohol may pose a particular risk.

A supplement to these recommendations, there are opportunities to further influence the way alcohol is promoted and/or made available in the many situations where ADF members live and work off base, including participation in the broader community's decision making about alcohol availability; for example, through involvement in community consultation processes, by submission or other means, when Liquor Control/Licensing applications are being considered. This could include responding to applications for extended opening hours. Given the value of the military customer base for licensed premises in some locations, this could be a significant role. The Panel therefore urges the ADF to identify opportunities for ADF leadership to influence community wide alcohol related practices in the broader locality in which Defence personnel purchase and consume alcohol; including, for example, liquor licensing decisions.

5.3 Deployment including Preparation, Decompression, and Post Deployment

This spotlight was selected to allow a focus on the transitions that many members of the ADF undergo and the possible increased risks associated with the place of alcohol in these transitions. The Panel recognised the high importance and value of operational deployment as a key feature of Defence life and strategic purpose, and the increasing acknowledgement by the ADF of the impact of deployment upon the organisation. The recent Defence White paper, *Defending Australia in the Asia Pacific Century: Force 2030*, states:

“The pressure of the higher operational tempo that Defence has experienced since 2000 has put stress on Defence's capabilities, from wear and tear on equipment to the sustained higher activity levels faced by Defence's people. Too often the tempo of current operations has taken precedence over proper planning for our personnel and capability needs in the future. We need strategies to ensure that our capabilities, and especially our people, can sustain that which we ask of them” (pp.16-17).

In this context, it is important to examine the way in which alcohol availability and use plays out in a range of contemporary operational situations. Deployment is generally a time of extremely limited access to alcohol (mostly 'dry' situations) but observers suggest that the pre-deployment and post-deployment period is a time of a particular vulnerability to trouble with alcohol. The Panel is also aware of the Third Location Decompression trial that is underway in providing some planned transition time for members existing specific operations and returning home to family, friends and community. The Panel therefore aimed to focus on deployment to the extent possible in the time and resources available.

Pre-deployment preparation

The period of pre-deployment preparation is an intense time for many ADF members and one that involves heavy training, planning and team building. The latter can involve alcohol use, although the Panel was unable to access precise details of this. There are very few studies that have looked at alcohol consumption in the immediate lead up to deployment; however there is some evidence to suggest that consumption increases in the two weeks prior to deployment. However a number of people the Panel spoke with indicated that this is a time of focussed preparation and not so concerning with respect to alcohol related incidents. The Panel did not have data to verify this impression.

There are programmes that have been developed to encourage alcohol related considerations in the context of broader preparatory thinking. This includes the Keep Your Mates Safe / Alcohol Peer Support Program. This appears to be soundly based, appeals to members and is consistent with the overall ethos of the ADF services. It could be a vital element in any re-

alignment of the ADF with regard to alcohol; especially if it was used strategically and it was developed to extend its reach to thinking about non-work situations (such as when on leave or off-base, in a local bar or at a barbeque for example).

Good News story:

Keep Your Mates Safe – Alcohol - Peer Support Program

In mid-2010, 17 Combat Support Services Brigade piloted a program as a way to trial the provision of peer supported alcohol training to personnel and to share an important message Army-wide. The trial was being delivered in the form of workshops called Keep Your Mates Safe (KYMS), which aimed to build an awareness of the effects of alcohol use and misuse and a familiarisation among personnel of their limits. Selected 17 CSS Bde unit SNCOs and officers were trained by Joint Health Command staff, allowing them to deliver the workshops to their members under the supervision of the Regional Alcohol Tobacco and Other Drugs Coordinator. Since the program's commencement, the workshop had been delivered to more than 100 1 HSB personnel and 30 17 Sig Regt members across a range of ranks, trades and age groups. The two-year pilot course will end in May 2012 and it will be evaluated by the 17CSS Bde RSM and the Director of Mental Health.

“We now include the K.Y.M.S. program as part of pre-deployment training. ... We also provide pre-deployment briefings for members and their partners/spouses and families and provide contact information for DCO and VVCS. We try to de-stigmatise asking for help. We are also providing [pre-return briefings] for families of those returning from deployment”.

BGDR Paul McLaughlin, July 2011.

“The only problem with KYMS is that it was designed to be delivered to a small group and facilitate discussion but it (often) ends up being delivered to 200–300 sometimes all at once; that partly defeats the purpose”

ATODS Co-Coordinator, June 2011

It will be important to reinforce the positive use of programmes such as these pre-deployment briefings and training courses and to establish their value, including the context in which they occur; along with consideration of broader education and training initiatives and courses.

Deployment

In general, it is ADF policy that alcohol is not to be supplied to or consumed by personnel on deployment. Officially, the only exception to this is limited access (usually 2 standard drinks per person) on special days (eg ANZAC Day or Christmas) where authorised by the Commanding Officer (CO).

These policies, however, are reported to not necessarily be adhered to by all personnel on deployment in all situations and do not avert all alcohol related trouble. Preliminary analysis of the ADF Policing and Security Management System dataset indicates that 31.6% of deployment convictions in 2010 were alcohol-related. This compared to 28.4% in 2008 and 38.5% in 2009.

Interpretation of the ADF Policing and Security Management System data is however subject to a number of caveats:

- Potential for under-reporting due to the self-reported nature of the conviction.
- The system is not currently in a format that allows for the easy extraction of specific crime categories (eg assaults) or personnel characteristics (eg age, gender, and rank).

There is a wealth of international research studying the relationship of deployment experience and mental health issues, including excessive alcohol consumption. According to Jacobson *et al* (2008), personnel reporting combat exposures where their life was threatened were at higher risk for heavy weekly drinking (OR 1.12), binge drinking (OR 1.13) and other alcohol-related problems (OR 1.03). Some studies have found that the length of deployment and number of deployments was related to risky alcohol use (Allison-Aipa *et al* 2010; Spera *et al* 2011), although another study has contradicted these findings (Canadian Forces 2010).

A survey of ADF Families found that, over time, increased length and frequency of deployments can accumulate and have an impact on problem behaviours such as drinking. In fact, for each increase in the deployment-frequency category, the odds that a member was a problem drinker increased by 14%, and for each additional year in deployed time, the odds increased by 23%.

Post deployment

A review of the international literature generally shows that there is a relationship between deployment and risky alcohol consumption at some point during the period after deployment.

Analysis of data from the ADF's Post-Operational Psychological Screen (POPS) is presented in detail in Appendix 5 with other summary data in Sections 5.5.

The POPS analysis found that of the 18,000 post-deployment personnel who completed the screen in the years 2007 to 2010:

- 18.1% of personnel were found to be consuming alcohol at risky or high-risk levels (*Hazardous or harmful consumption*)
- 31.3% were consuming alcohol at risky levels (*Alcohol Consumption Score*)
- 0.8% were possibly dependent (*Dependency Score*)
- 22.5% were at-risk of alcohol-related problems (*Alcohol-Related Problems Score*)

Research by Saunders and Lee (2000) reported that, in developed countries, the proportion of the population reporting hazardous or harmful consumption (AUDIT ≥ 8) was 20%, dependency is typically under 5%; hazardous or harmful drinking is 5 to 15%; and low-risk drinking is 50 to 75%.

A comment made by family members of ADF personnel as reported in a recent study of the effects of deployment on families illustrate the occurrence of risky and possibly harmful alcohol use post deployment:

“He is binge drinking to extreme. Along with the mates he was deployed with. Some have separated from wives and girlfriends. Others have put in discharge papers” (Defence Families of Australia 2011, p.27).

Whilst the POPS dataset provides valuable information regarding the alcohol consumption and harm status of post-deployed ADF personnel it should be noted that as approximately 7,000 of 50,000 personnel are deployed each year (13%), the POPS data are not representative of all ADF personnel. There are a number of other limitations regarding interpretation of such data including:

- Double counting of individual personnel due to multiple deployments.
- Possible respondent fatigue/response bias/habituation due to multiple surveying after multiple deployments.
- Disincentive to report alcohol problems due to perceived risk to career progress, future deployments, etc.

Decompression

A decompression period immediately following a deployment operation is standard practice in many armed forces, where combat troops are given a short period of leave and psychological support following deployment. However, it is well known that alcohol continues to play a significant role in this process (Fossey 2010). The Australian Defence Force is in the process of trialling Third Location Decompression (TLD), thus the impact on alcohol consumption is unclear at this stage.

Access to alcohol would seem to be an important element in this trial; even though it is likely to contribute to some incidents where alcohol use and intoxication, in particular, contributes to potential trouble. This is a situation that requires a harm minimisation plan that recognises this risk and attempts to ameliorate it. Location, access and context of drinking are likely to be important elements to any such plan; including planning for management of intoxication among members.

The Panel notes an ongoing need for monitoring and review such as considering the outcomes of the Third Location Decompression Trial and provision of further advice regarding the vulnerability to alcohol risk for members post deployment.

Information and Data:

The analyses of data relating to deployment indicated that there are opportunities for enhancements in data use. In this context, the Panel suggests collection of ***alcohol consumption data during the pre and post-deployment stages to enhance*** understanding of the impact and implications of deployment in the ADF.

The full AUDIT could be used with measurement at specified intervals during the deployment process. This could be important for monitoring the drinking behaviours of individuals, sub-groups (eg specific operations, locations, services) and ADF personnel as a group.

For example this could occur at the following times:

- **Deployment selection:** All personnel could be screened during the deployment selection process. However, individual results should be interpreted carefully because personnel are likely to provide the ‘desirable’ responses rather than the ‘actual’ responses to ensure that they are deployable. Therefore, measures should be developed to help counteract this anomaly.
- **Start of deployment:** Personnel could be screened in the first few days of deployment to capture information on alcohol consumption in the weeks leading up to deployment, often a time to socialise with family and friends.

- **3 to 6 months post-deployment:** This interval is currently covered by POPS (Post-Operational Psychological Screen), however, it would be more useful if the current version of the POPS survey was reviewed and revised, including review of the personal and service characteristics (eg operation, ship/TG on deployment) collected.
- **12 months post-deployment.**

The Panel notes that the Australian National Audit Office (2010)⁷ recommends that consideration be given to adopting a risk-based approach in preference to annual individual readiness medical checks for all personnel. If this is to occur, it will be important to have broad risk definitions/categories for possible alcohol risk given that the risks and costs of high-risk alcohol use go beyond consideration of individual member's health. This Panel's advice is that the AHA (PHE or equivalent) be applied to all deployed personnel 12 months post deployment, and include the full AUDIT. The Panel's advice is that all such surveys be completed by ADF personnel, followed by an interview with a mental health professional (if required) to allow for adequate support and referral.

The preliminary analyses of available datasets suggests that further more detailed analyses are required to ensure accurate interpretation of POPS and other data to allow for appropriate comparison with other studies, and in better understanding the apparent reduction in the prevalence of alcohol related harm.

Further detail is contained in the Appendix 3: Deployment including Preparation; Decompression; and Post Deployment.

5.4 Safety and discipline

In an era where recruitment requires significant resources in a competitive market place, where training is needed and costly and therefore where every effort goes in to retention of workers, organisations such as those in the mining and building industries are increasingly including alcohol policy and programme development in their strategic planning. This is usually after having recognised the potential of alcohol use to impact negatively on organisational imperatives.

The ADF is an organisation with similar specific personnel needs where alcohol use can be an impediment to organisational capacity and hence to capability.

There are limited systematic analyses of how alcohol contributes to risk in the ADF. However, some insight may be gained from evidence accumulated in the Australian community. Collins and Lapsely (2008) calculated that approximately 77% of the \$3.5 billion cost of alcohol harm in the Australian community arises from alcohol-attributable reduction in the male labour force. This is made up of absenteeism (due to alcohol-attributable illness or injury resulting in an absence from work) and workforce attrition (due to illness, injury, death and early retirement). While it is not known what the equivalent cost is to the ADF, given the significant investment in developing skills and expertise of members, this warrants attention.

⁷ ANAO (2010) Audit Report No. 49 2009-10. Performance Audit. 37, Rec No. 6, Par 4.67.

It is clear that alcohol can contribute to significant costs in the workplace, not just to the drinker but to their colleagues, and members of the broader community. The range of impacts suggests that there are potential safety and health, capability and reputational gains to be had by preventing and reducing alcohol-related harm in the ADF.

Many of the estimates above do not include the negative effect of consumption use on others (i.e. persons affected by somebody else drinking), which are also substantial and can include domestic violence and other family related harm.

In recent years, management of alcohol issues in the ADF has been seen as “health business”, however, various sources have led the Panel to identify safety and discipline, and thus capability, as being highly relevant to the way alcohol issues in the ADF are viewed, understood and addressed. It is recognised that alcohol often comes to the attention of leaders in the ADF through negative publicity, incidents involving alcohol (often in the community setting), impact on safety of members. Despite verbal reports indicating such events, the Panel found it generally difficult to access clear, consistent information on the impact of alcohol use upon safety and discipline in the ADF.

Safety

Safety and discipline are key issues for the ADF. Safety is integral to the military and has a significant impact on organisational viability, productivity, efficiency and operational readiness. However, safety in the military has to be considered in a different context to civilian organisations due to the high-risk nature of their role. Thorough risk assessment and management are integral to the ADF functioning, and it is evident that alcohol should be approached in the same manner. This approach is consistent with the way in which civilian occupational safety and health bodies are addressing the issue (eg See WA Commission for Occupational Health and Safety 2008).

The safety risks associated with alcohol are implicitly and explicitly noted in a variety of ADF policy documents and guidelines. Under the Occupational Health and Safety Act 1991, the ADF’s duty of care encompasses all Defence personnel, Australian Defence Force Cadets, contractors and those affected by ADF activities.

General orders relating to alcohol within the ADF, such as Defence Instructions (General) as well as those for each of the Single Services, explicitly identify requirements around alcohol. Such instructions include:

- DI(G) PERS 15–1—*Misuse of Alcohol in the Defence Force.*
- DI(G) PERS 15–4—*Alcohol testing in the Australian Defence Force.*

In addition, the ADF 2007 to 2012 Defence Occupational Health and Safety Strategy has 9 main strategic outcomes that have the potential to address alcohol related harms:

- Further develop and implement the elements of the Defence-wide OHSMS.
- Develop and implement a Defence OHS.
- Management Information System to improve the quality of OHS information available to decision-makers at all levels.
- Reduce the frequency and severity of risks to people’s health and safety.
- Improve prevention of occupational injury, illness and disease.
- Reduce the impact of occupational injury, illness and disease.
- Train, support and motivate personnel to identify and manage hazards effectively.

- Improve and embed a systematic capability to identify, eliminate or manage hazards in the design and planning stages of Defence activities.
- Enable Defence personnel to manage the OHS performance of third parties, consistent with Defence policies and practices (Department of Defence, 2007).

Discipline

Military discipline refers to the regulation of personnel and involves rules that govern orientation and behaviour, inside and outside of the military. Safety and discipline are not only cultural attributes of the ADF, they are enshrined in legislation, policies, procedures, training, and operational protocols. The ADF places strict demands on its personnel to maintain the high standards that are expected of a professional military. This is accompanied by very high public expectations of Defence Force personnel regarding their personal conduct and behaviour, both on and off-duty.

In addition to the controls demanded by occupational safety and health considerations, ADF policy and procedures relating to discipline are implicitly and explicitly relevant to preventing and reducing alcohol-related harm.

Instructions relevant to disciplinary action include:

- DI(G) PERS 35–3—*Management and Reporting of Unacceptable Behaviour*
- DI(G) PERS 35–4—*Management and Reporting of Sexual Offences*
- DI(G) PERS 35–6—*Formal Warnings and Censures in the Australian Defence Force*

In addition to general legislation, military personnel are subject to the provisions of the Defence Act 1903. The sections directly relating to alcohol include Section 123A (Intoxicating Liquor) and Section 123AA (Intoxicating liquor not to be supplied to cadets). Defence personnel are also subject to the Defence Force Discipline Act 1982. There are three sections which relate specifically to alcohol: S.32 – Person on guard or on watch; S.37-Intoxicated while on duty; and S.40 – Driving while intoxicated. (See Appendix 3 for further DFDA detail).

In addition to the above, the DFDA also provides powers for the creation of general orders and it is through these that detailed rules and the procedure for their application are typically described. These may include Defence Instructions (General or Single Service), and any order emanating from the ADF or a general standing, routine or daily order.

There is a range of possible disciplinary actions that can be taken against a member, depending upon the severity of the matter and the judgement of the commanding officer. Considerable discretion rests with CO's who can take administrative action after reviewing an incident or decide on the nature of disciplinary action for summary offences. For more serious offences, the member is referred to one of the policing units or the Investigate Service (ADFIS) [see Appendix 3 for more detail].

ADF Policing and Security Management System

There are limited ADF data that reports on the involvement of alcohol in safety and discipline matters. The data that are available, however, indicate that a significant number of incidents and convictions involve excessive alcohol consumption. There is the possibility that these may underestimate risk, given the motivations to not report or underreport alcohol's contribution to any given incident. The existing ADF Policing and Security Management System should be enhanced to include the collection of data regarding alcohol involvement

(consumption, purchase and consumption context) for all incidents. Similarly, these data from the system should be routinely utilised in an ADF-wide alcohol surveillance system.

Analysis of data from the ADF Policing and Security Management System indicates that there were 8,101 convictions⁸ between 2008 and 2010. Of these approximately 12% (961) were reported as alcohol-related, and this figure remained constant over the three year period (11.3% in 2008, 13% in 2009 and 11.5% in 2010). The proportion of convictions that are alcohol-related over this period is highest for the Navy (17.4%), compared to 8.9% for the Army and 11.9% for the Air Force.

Over the 2008 to 2010 period there were 174 reported incidents of ‘being intoxicated on duty’ (s37). Of these, 93 (53%) were from the Navy, 77 (44%) were from the Army and the remaining 4 (3%) were from the Air Force. Similarly, over this period, there were 107 reports of ‘being intoxicated whilst driving an ADF vehicle’ (s40). Of these, 77 (72%) were from the Army, compared to 15 (14%) for both the Navy and the Air Force.

In addition, over this period, there were reported:

- 801 civil jurisdiction *driving offences* for ‘driving under the influence of alcohol’ (DUI) (582 for the Army, 160 for the Navy and 69 for the Air Force).
- 378 civil jurisdiction drivers *licence suspensions* for DUI (288 for the Army, 58 for the Navy and 32 for the Air Force).
- 589 civil jurisdiction *finest* for DUI (438 for the Army, 95 for the Navy and 56 for the Air Force).

It should be noted that the above figures may not be mutually exclusive because some offenders receive multiple punishments (eg licence suspension and a fine).

Army Incident Management System

Analysis of data from the Army Incident Management System indicated that over the 2008 to 2010 period, there were 8148 reported incidents. Of these, approximately 12.2% (991) were recorded as involving alcohol. The number of incidents reports as alcohol-involved increased from 5.4% (125) in 2008 to 8.5% (236) in 2009, to 20.7% (630) in 2010.

Examination of reports relating to both ADF and civil jurisdictions found that:

- Of 358 reported assaults (ADF jurisdiction), 134 (37%) were reported as alcohol-involved and 114 of the alcohol-involved assaults resulted in administrative or disciplinary action.
- Of 317 reported assaults (civil jurisdiction), 104 (33%) were reported as alcohol-involved and 90 of the alcohol-involved assaults resulted in administrative or disciplinary action.
- There were 261 reported drunk and disorderly incidents, with 241 resulting in administrative or disciplinary action.
- There were 446 reported DUI incidents, with 443 resulting in administrative or disciplinary action.

Overall, there was an increase in alcohol-related assaults (ADF jurisdiction) from 14.7% (16) in 2008 to 25% (31) in 2009, and 87 (69%) in 2010. Whilst the number of reported civil jurisdiction assaults remained stable, the proportion of alcohol-involved increased from 16% (18) in 2008 to 59% (59) in 2010. The number of drunk and disorderly incidents remained stable over the years, and the number of DUI incidents increased from 106 in 2008 to 161 in

⁸ Note: these have not been weighted for the relative numbers in the different Services where Army have many more than the other two.

2010. The apparent increase in the number of alcohol-related incidents may be due to a greater vigilance in recording of such information.

Whilst the data sources access by the Panel provide some information regarding the involvement of alcohol in incidents, the utility of the data is less than optimal because:

- The systems are not currently in a format that allows for the easy extraction of detailed information (eg offence type, age, gender, rank)
- Whilst it is mandatory to report convictions, there is potential under-reporting due to limited communication between the state police forces and the ADF.
- The definitions of what constitutes alcohol involvement in an incident vary between databases and sources. Similarly, place of purchase and consumption are not recorded. Information regarding the place of purchase and consumption of alcohol prior to an incident is of benefit in targeting harm reduction strategies.
- Some systems are service specific, and hence cannot provide across service comparisons.

Recommendation 6

Develop a whole of Defence Alcohol Incident Reporting System so that it:

- Ensures data are recorded and managed in a consistent manner organisation-wide, and entry/maintenance is mandatory.
- Ensures that the systems include the necessary information to identify priority sub-groups (eg, service, age, gender, rank, operation) and is easily extracted for reporting and epidemiological purposes.
- Incorporates reports of incidents, convictions, alcohol involvement and place of purchase and consumption.
- Provides a system that monitors issues at both the individual (early identification of an issue) and the organisational (epidemiological) levels.
- Provides regular reports to Commanding Officers on incidents relating to their personnel.

In this context it is suggested that further analysis of existing incident databases regarding information collected, data collection procedures, and data definitions and inclusion criteria be undertaken.

Risk Taking and Safety

The ADF is an organisation that requires risk taking; that is what is expected of its members and this is captured in a statement from a Senior Commanding Officer: “We take alcohol issues very seriously and respond quickly. Our approach is to appeal to a soldier’s innate sense of self-discipline. We are talking about people who are trusted with weapons”.

The ADF is also an organisation experienced with the development of ways of assessing risk and making decisions in the context of risk; together with the development of drills and exercises, such as “Battle Smart”, in preparing for uncertainty and risky situations. There might be potential for development of alcohol specific tools that utilise military training approaches in managing alcohol for both individual member decisions making and planning at senior levels. The development of such tools is likely to come best from those with direct day-to-day experience and responsibility for operational units because their experience is most relevant in operational planning and also because the engagement of these people in any change of approach to alcohol will be critical to success.

Comments from a Commander Officer: “Canberra doesn’t think anything is being done unless they direct it ... the senior ADF hierarchy only hear the bad news about alcohol, not the good news about the majority who do the right thing...” July 2011.

5.5 Involvement with health and support services

This spotlight was chosen to explore the way in which the ADF manages the health aspects of alcohol problems including the care and treatment provided to those adversely affected by their alcohol use. It considers the following:

- Health information
- Health Services
 - Policies and standards
 - Programmes and pathways to care
 - Linkage with families and other services in the community
- Innovation, integration and advice

Personnel may attend health services for reasons unrelated to alcohol consumption or because of their alcohol consumption and/or issues related to this consumption. Evidence consistently indicates this is an opportune time to intervene with staff to reduce risks associated with alcohol use where this is identified. Personnel are more likely to be receptive to health messages at this time from credible sources; that is, health staff.

The involvement of ADF personnel with these services is seen by the Panel as an important opportunity not only for assisting and supporting people experiencing alcohol related problems, but also as an opportunity for preventive interventions that may include identifying early signs of a problem and provide a timely response to reduce the risk of problems developing further.

This health and support service context is also an important setting for appropriate recording and storing of information about individuals (de-identified where appropriate), their alcohol consumption, and their health and support needs and issues. This enables monitoring the overall extent of problematic alcohol consumption and related harm in the ADF, which in turn can be used to inform service planning and evaluation and the development of preventative policies and programs.

The Panel observed that there appears to be some confusion about who has access to medical records among members of the ADF and what the purposes of the records are. This confusion adds to the possible reluctance by some members in seeking health support for alcohol related issues. There also appears to have been dysfunctional policies in place preventing some health and other appropriate professionally qualified health personnel accessing important health related information; though the Panel understands that this is currently being addressed by Health Directive 603 titled *Introduction of a Combined Medical and Mental Health Record*, which is currently going through the ADF policy development and approval process.

Alcohol has a range of potential impacts on the health and wellbeing of individuals who drink – in the short term and long term, and also on those affected by others' drinking, including co-workers, family members and friends. Thus health and support services need to be available to all of those affected by alcohol. There are varying degrees of harmful consumption of alcohol ranging from one-off occasions of risky drinking through to regular heavy drinking by alcohol dependent individuals. Accordingly, there is a need to provide a varied range of responses depending on the drinker, their patterns of consumption, and the context.

5.5.1 Health Information

A full description and analysis of health related data related to alcohol in the ADF that the Panel has been able to obtain is contained in Appendix 5: Health and Support Services. This includes a review of the literature relating to health data, overseas comparisons where available details of ADF data review and relevant details regarding recommended further development.

Review of data on alcohol use and health issues in the Australian Defence Force

The following presents a summary of the datasets obtained by the Panel. The Panel identified and attempted to interrogate three general sources of health data regarding the extent and nature of alcohol consumption and related harms among Australian Defence personnel. The main findings are summarised as follows:

Medical record data:

1. **Primary care presentations.** Data Issues: alcohol consumption or harm information is not routinely recorded. Assessment: not useful for analysis.
2. **In-patient admissions.** Data issues: Small number of in-patient admissions and diagnosis code not routinely recorded. Assessment: not useful for analysis.

Health status screening/assessment data:

3. **Comprehensive Preventive Health Examination (CPHE).** Data issues: Lack of representativeness of the electronically stored data. Assessment: not useful for analysis.
4. **Annual Health Assessment (AHA).** Data issues: Did not include the AUDIT or any other valid measure of alcohol-related harm. Assessment: not useful for analysis.
5. **Post-Operational Psychological Screen (POPS).** While the POPS data are not representative of all ADF personnel (representing only 7,000 (13%) of deployed personnel out of 50,000), it does nonetheless include AUDIT results. Therefore, the Panel requested and considered POPS data for the 2007 to 2010 period regarding AUDIT and demographic data.

Health survey data:

The Mental Health Prevalence Study (MHPWS) is currently being finalised, for which data was collected in two formats:

6. **Mental Health Prevalence and Wellbeing Survey (MHPWS)** The survey focused on personal and service characteristics, health status, lifestyle behaviours (including alcohol), past experiences (eg combat, PTSD, suicide ideation), social support networks, and recent health problems.
7. **Composite International Diagnostic Interview (CIDI).** The CIDI is a structured interview designed to assess mental disorder according to the definitions and criteria of ICD-10 and DSM-IV including ICD10 Alcohol Disorders. A sample of 1,798 personnel who completed the MHPWS were invited to participate in the interview. Summary data from the survey and interview were obtained for inclusion in this report.

From the Post Operational Psychological Screen (POPS) that were completed on over 18,000 post-deployment personnel in the years 2007 to 2010 [see Appendix 5]. The following characteristics associated with hazardous or harmful consumption (AUDIT ≥ 8) were:

- male (19.2% compared to 7.8% for females);
- aged less than 25 years (26.9% compared to 18.1% for the 25-34 year age group);
- a member of the Australian Regular Army (23.6% compared to 7.4% for the Air Force);
- deployed on Operation Herrick (23.6%) or Operation Astute (23.2%), compared to 13.6% for Operation Anode;
- deployed for a period of greater than 8 months (34% compared to 14% for those that were deployed for less than 4 months);
- a member suffering from very high levels of distress (44.4% compared to 14.8% for low levels); and suffering from high levels of PTSD (51.4% compared to 16.3% for low levels).

[Note: Detail of POPS data analysis is in Appendix 5 and other summary data is in Section 5.3 above].

Of those sampled for the MHPWS survey, 24,481 (or 48.9%) ADF personnel participated. Preliminary results of the survey found that:

- 40% of personnel consumed alcohol at least twice per week, with 11% consuming four or more times a week.
- Men consumed more often (11.6% four or more times per week) compared to women (7.8%).
- Army personnel were more likely to consume alcohol four or more times per week compared to the other services. Almost 17% of commissioned officers (eg Commanders, Lieutenant Colonels, Majors) consumed alcohol at this frequency, compared to 10.7% of non-commissioned officers (Petty Officers, Sergeants).
- Almost one third (29.2%) consumed over 5 standard drinks on a typical day, with Army personnel consuming greater amounts (14.6% consumed 7 or more on a typical day; 10.7% for the Navy and 7% for the Air Force (MHPWS 2011).

In terms of the AUDIT scores:

- 26.4% (13,201) reported consuming alcohol at hazardous/harmful levels (AUDIT ≥ 8).
 - 22.7% scored between 8 and 15 points (22.7% of total).
 - 3.7% scored in the high-risk category indicating an increasing likelihood of a need for treatment (and these are also most likely to have a diagnosable alcohol disorder).
 - Men were more likely to consume at these levels than women (28.1% compared to 15.1%).
 - Air Force personnel were more likely to score lower on the AUDIT than Army or Navy personnel (MHPWS 2011)

Of the people who completed the MHPWS survey, 1,798 also completed the interview-administered diagnostic CIDI. The prevalence of CIDI diagnosed alcohol disorders in the last twelve months (harmful use and alcohol disorder) was 5.2% compared to 8.3% for those who were employed in the community. There were no differences in prevalence of alcohol disorders by rank or deployment history. However, women were less likely to have any alcohol disorder compared to males. Navy personnel were more than three times more likely to have any alcohol disorder than Air Force personnel and Army personnel were more than twice as likely as Air Force personnel to have an alcohol disorder (Alexander 2011).

The difference in percentages between those 26.4% screened as drinking at risky levels and the 5.2% with diagnosed alcohol disorders is readily explained. These relate to two different measures and they are measuring two different things. The first (using AUDIT) is a **screening tool** designed to identify whether an individual is at risk of having an alcohol-related problem. The Second, arising from the CIDI (using ICD-10 criteria) relates to a **diagnostic tool** designed to identify the existence of a clinically defined/diagnosable condition in an individual. These differences refer to different possible stages in the development of alcohol related problems.

Those engaged in hazardous or harmful drinking (Scores on AUDIT >8) can respond to interventions designed to assist them to curb ongoing risky alcohol use. The CIDI, on the other hand identifies someone with later stages of alcohol problems such that they have a significant alcohol disorder (usually alcohol dependence). There are also differences between potential harm in the short term and long term. Short term harms arise from accidents and injuries in association with an episode of heavy drinking often involving intoxication. The risks of harmful longer-term consequences include the multiple impacts on health associated with long periods of harmful or dependent drinking, usually over some years.

The lower prevalence of diagnosable alcohol disorders compared to the general community does not mean that there are fewer problems or less need for action. The context of the ADF provides some ‘protection’ against the establishment and expression of alcohol disorders while people remain in Defence with required periods of abstinence and the likelihood that those with significant alcohol disorders leave the ADF and are thus not captured in surveys of this sort.

There are thus good reasons for developing screening for earlier identification of those at risk of alcohol harm including disorders since earlier interventions can be successful and are usually less intensive and less costly. The negative impact on children and families is likely to be significantly reduced by earlier responses and early interventions can interrupt what would otherwise be a high likelihood of the person leaving the ADF.

Methodological differences between studies limit the ability to make direct comparisons between ADF data and that from other studies. However, data obtained from this review suggest that 26.4% of ADF members report consuming alcohol at **hazardous or harmful** levels. The prevalence of at-risk alcohol consumption among ADF personnel is similar to or lower than Defence personnel in other countries.

Some limitations of the datasets available should be considered when interpreting this result, as discussed in further detail in Appendix 5.

Notwithstanding the limitations in data collection and quality observed by the Panel, there are promising developments that should be encouraged as these may address some of the data issues discussed. One of these is the proposed JeDHI System which will aim to provide health data from recruitment to discharge for each member of the Defence Force by December 2013. It will focus on four core functions:

- Records management and reporting eg health surveillance, force readiness, information architecture.
- Governance and standards eg unique health identifiers, clinical terms.

- Delivery enablement eg consultations, procedures, referrals, health assessments, referrals, diagnostic reporting.
- Delivery management eg appointments, attendance, case management, record tracking, eHealth record.

As such, the proposed JeDHI system has the potential to address the data system limitations described above. A review of its functionality specific to the collection, storage and retrieval of alcohol-related clinical information is required to confirm this potential. It will need to facilitate the recording of patient diagnosis and alcohol consumption and harm status in both routine consultations and in mandated health assessments and it will depend on the clinical and recording practices of clinical staff.

To ensure that the potential of the system to provide alcohol harm reduction benefits is achieved, deployment of the new system will require the implementation of a complementary clinical practice change program to ensure the provision and recording of preventive care according to recommended guidelines. Such a program will need to be reflected in the contractual arrangements and supervision of health contractors, revised Health Directives and Bulletins, and in JHC effectiveness KPI's, in keeping with the recommendations of the ANAO performance audit of Defence Management of Health Services to the Australian Defence Force Personnel in Australia (2010).

The Panel notes that a survey of alcohol consumption and related harms, as collected in the MHPWS has value and suggests that this be conducted on a regular basis (eg every 3 years) to provide an ongoing capacity for the organisation to monitor and respond to such harms in a strategic fashion.

5.5.2 Health Services

The Panel recognises that Joint Health Command is still developing after the integration of the former Single Service specific health services. The Panel notes the attention being paid to the evolution of structures, lines of accountability and programmes, and capacity of personnel in this arena. This offers an exciting opportunity to align alcohol specific responsiveness to these overall changes. Appropriately, there is considerable effort being directed to development of capacity in the mental health services domain. However, alcohol-specific responses remain patchy; with some services such as the residential rehabilitation services (AREP) only moving under this central command very recently.

Health Policies

The Panel has identified the need for the ADF to review and align health services to current, evidence based practices and procedures, consistent with Australian community standards. The Panel suggests that one way of further enhancing health care policies and practices with regard to alcohol is through the application of appropriate accreditation and standards of health care. This should include developing clinical practice guidelines based on Australian alcohol clinical treatment and Department of Veterans Affairs Guidelines. This should be addressed over the next the next five years.

This should also be reflected in requirements within contracts with service providers to ensure appropriate, updated education and training in relation to alcohol and other drug practices (through requirements for specific CPD/CPE units) and the accreditation of health specific services.

Health Programmes

The ADF's Alcohol, Tobacco and other Drugs (AToD) program was launched in 2002, as an initiative of the ADF Mental Health Strategy. This is an important and valuable development. The AToD Program oversees education and treatment across Defence to ensure interventions are evidence based and capacity building. The program comprises:

- Education: AToD education sessions; Alcohol and Other Drug Annual Awareness Course (40 minutes); Keep Your Mates Safe (KYMS) — Alcohol.
- Treatment: Brief interventions are conducted by health providers and professionals; Outpatient Alcohol Treatment Program (OATP); Alcohol Rehabilitation Education Program (AREP); Regional AToD Coordinators.

As part of the Mental Health reform process, eight Regional AToD Coordinators are to be appointed, with most having commenced from 2010. This is increasing capacity and the delivery of AToD education and treatment programs across Defence.

There have been numerous reviews of AToD program areas. Some of these reviews have produced changes in programmes; for others this does not appear to have been the case. Perhaps the most striking has been the number of reviews of the residential rehabilitation programme AREP. This appears to be a somewhat isolated pocket of intense activity with limited connection to the overall approach and developments of the health response in the wider AToDs programme area. In some respects it is like an 'orphan' of the changes that have taken place over the past decade; yet continues to have a number of very committed staff working to support those who are referred or, in some cases, 'sent' for treatment. The Panel understands that although it has been available to all three services for some time, its organisational accountability had previously been with the RAAF. The Panel understand that it is currently in the process of moving under the control of Joint Health command. There is an urgent need to re-engineer the resources and approach underlying this program to ensure it is incorporated into a broader Defence alcohol management strategy demonstrating the full spectrum of alcohol services and contemporary best practice matched to the needs of ADF personnel.

Extract from AREP client essay:

"I have been given the chance to reclaim my life back. Reclaim my life back from a disease that I knew nothing about before AREP. I now know that being an alcoholic is OK. Being an alcoholic doesn't mean my life is over; it means that alcohol can't handle me, so I need to leave him alone. Being here at AREP has shown me that I am not alone with my struggles."

Sex: Male

Marital Status: Single

Age: 24 y/o

Service History: Army. 4 years service, including 8-month overseas deployment.

Reason for referral: Significant history of binge drinking. Several civilian charges for alcohol related offences. Assessment conducted and deemed alcohol dependent and consequently referred to AREP program.

Previous interventions: Outpatient counselling. Despite this, attempts to reduce his alcohol consumption to more moderate levels had been unsuccessful.

Family history: alcohol/drug/gambling issues, violence.

The Chair of the Panel visited this facility and was welcomed by staff who explained the approach, training available for staff and escorted her on a tour of the building. There is no doubt that it serves some small number of service members well and a 'graduating essay' forwarded to the Panel attests to this. However, there is an urgent need to bring this facility in to the development of a spectrum of alcohol services in the ADF, under Joint Health Command. There may be a place for a residential service but in its current form, the AREP is too isolated to be properly used and developed as one among many responses to ADF members with alcohol specific problems. Like other services it would benefit from opportunities to ensure that it is abreast with community treatment options and the people who provide these services are properly educated, trained and supervised. The Panel did not conduct a review of this service; rather the visit helped to inform the findings more broadly regarding health responses to people with alcohol problems.

Pathways to care

One of the complexities for any ADF member with alcohol concerns is how to access help without jeopardising their future career prospects in the Service. In discussion with members this hesitation was often raised and it is likely that it acts as an impediment to accessing early interventions that have been found to be effective. It is vital to act to prevent early signs of alcohol trouble becoming more serious or eventuating in alcohol disorders. While ADF members are able to attend community based services including local general medical practitioners (GP's) or specialist medical services, it is noted that ADF members expect and are expected to have their health care provided by the ADF. ADF members do not ordinarily pay the Medicare levy that other Australian citizens are expected to pay and thus must pay full fees if they choose to attend community based GP's who are not a part of the contracted ADF health service.

There would be benefit in examining the ways that ADF members currently access services and what might be optimal pathways in the future. This could include examining the impediments to help-seeking together with expectations of care.

There are opportunities to develop innovative approaches to the provision of information, advice, self-assessments and appropriate directed interventions now available as web based options that warrant consideration. This could include development of an anonymous on-line screening tool and diversion to a brief intervention depending on scores (eg and educational update for personnel with no or low risk scores; brief intervention for low to moderate risk/dependence scores; brief intervention and recommendation to more intensive treatment options for more severe risk and dependence). The changes that are occurring in pathways to mental health care currently might provide lessons of value to alcohol specific service provision in the longer term.

In summary, there is a need for a stock take of current ADF service provision against a model of the full range of services that could potentially be included in a comprehensive and contemporary suite of alcohol (and other drug) services together with some analysis of pathways to care. Services need to be available, accessible and known about.

A contemporary model of care could include health promotion, prevention, early and brief interventions and more intensive treatment interventions for those requiring it. The latter could range from residential and out-patient detoxification, counseling using cognitive behavioral and other evidence based approaches, pharmacotherapies; rehabilitation programmes (both residential and community based and linked) to a range of community programmes including self help groups. In developing an appropriate programme profile the

ADF will need to assess the spectrum of services appropriate to the needs of ADF members and which of these services should be provided from within and which will be sourced from the community service sector.

The timing of consideration of an appropriate spectrum of services for the ADF could fit well with current related projects of the Department of Health and Ageing: (i) Funding Model and Quality Framework for Alcohol and Drug Services; and (ii) Patient Pathways. Another national project: National Drug and Alcohol Clinical Care and Prevention (DA-CCP) Modeling Project, could also be informative for planning for the ADF.

Joint Health Command should ensure that the care coordination approach as evidence in the ADF Rehabilitation Program is extended and replicated across its primary health care services to deliver greater integration of services that will respond to people who experience alcohol problems, allowing access and involvement of family, a variety of health, social, welfare and financial services in an intense and coordinated wrap around manner to facilitate integrated rehabilitation of those who might be at higher risk of dysfunctional alcohol use.

Linkage with families and other services in the community

Alcohol work requires strong connections. Families in particular can be an important resource for enhancing resilience of members and in setting standards, provision of support and solace and also in direct roles in treatment of alcohol related problems. They can also contribute to difficulties that increase the risks of problems associated with the use of alcohol. In this sense families can be both contributors to alcohol problems but they can also provoke help seeking of a member and facilitate engagement through provision of support in treatment; if they are engaged and included.

A recent report on families of ADF personnel reported that among the negative perceptions of Defence's support for families were: condoning of excessive drinking in many units and compulsory social events after normal work hours, especially when cheap alcohol is supplied (p. 54). The report also highlighted the harmful consumption of alcohol by family members of ADF personnel, particularly by spouses or partners when left alone during periods of their spouse's/partner's deployment; eg maladaptive strategies reported by spouses that had been employed to help them cope when their spouse or partner was away on deployment included 'excessive (binge drinking) while out with friends, drinking alcohol to aid sleep and reduce stress, smoking cigarettes, and taking sedatives to aid sleep' (Atkins 2009: 78). Those members on deployment also reported some maladaptive behaviours because of their absence from family: some reporting that smoking and binge drinking were used to cope with absence from their children (Atkins 2009: 82).

It will be important to establish the impediments and facilitators to the inclusion of partners/families in alcohol related responses given the interactive impact of alcohol use in families. The Panel recognises the potential, perceived impediment to an ADF member approaching internal health services for alcohol related help, including possible implications for their service career. Unfortunately many of the structures of health care provision in the ADF *appear to* act against the inclusion of families in treatment responses.

The degree to which structural, financial and possibly geographic barriers that were often mentioned as though they were fact/policy were as impenetrable as they seem or whether this is generally an historic, attitudinal matter where practice has become entrenched to the point where it is believed to be policy was unclear. The Panel does however draw attention to the increasing need for alcohol responsive health services to identify the opportunities for family members to be included in the unit of attention to achieve effective outcomes.

The Panel became aware of a myriad of services, associations and organisations working to care for ADF personnel and their families. However, it was not possible, in the time available, to untangle who can and who does attend which services for alcohol specific concerns. There are complex eligibility rules and/or pathways between internal services under JHC, the Department of Veterans Affairs and complex and confusing expectations about who can access and at what times or stages in their Defence career use other services such as the Veterans and Veterans Families Counselling Service (VVCS) and the Defence Community Organisation. Some of these services were consulted briefly and the Panel also considered some written materials from these organisations. All appear to have a commitment to integration of services. They also express some focus, including resources, on trying to achieve this in an extremely complex environment of eligibilities, systems of payment, communication and classifications along with historic expectations amidst their planning, strategic directions for the future and other imperatives.

The Panel did not spend sufficient time in this area to have a view about the complex division of responsibilities. It does however note the statement of a senior health director: “We create the injured veterans and then pass them on to another lot to take care of them.”

Sometimes other ‘carers’ are already or potentially involved. This includes Chaplains in the ADF who appear to serve a vital role in absorbing distress, supporting and responding to members who talk to and sometimes confide in them. They are in a unique place in the ADF. They do not and are not expected to keep records. They are usually embedded in operational units and so readily available to both members and CO’s. They are seen as ‘one of us’ by members and recognised as someone you can go to where matters can be shared in confidence. They are a part of the team who respond to alcohol related concerns.

“The Chaplains are more trustworthy; they’re like one of us”
RAN Recruit School trainee

The Panel suggests that closer and more consistent collaboration with community-based services could help to develop a more coordinated approach through mutual understanding and agreed referral pathways, enhanced capacity and through this widen the options for treatment. Noting the development in coordinated care approach to rehabilitation, this could be extended to health care involving families.

5.5.3 Innovation, integration and advice

The Panel is aware of a number of initiatives currently being implemented or planned by health personnel within the ADF. Many of these show promise and are using current evidence based understandings of effective interventions. The appointment of the regional ATOD coordinators provides an opportunity for coordination and consolidation of some of these. The development and programs such as the four day OATP and motivational interviewing training are appropriate and useful elements of any comprehensive menu of options to address the individual therapeutic needs of people already experience significant alcohol related problems.

In addition, there are significant facilities and a strong, committed ethos of care among many health service providers the Panel met with. Health personnel are appropriately contributing to a broad population health systems approach within the ADF. Further development of this is required and involvement of other domains is suggested including Command, garrison support/catering, and regulatory areas of Defence in order that the approach of the ADF is comprehensive.

Health is not the only area developing innovative approaches but needs to be central to ongoing attention to alcohol related developments in the ADF. The Panel has strongly recommended an all of organisation approach and believes that there would be significant advantages to all areas with an interest in and responsibility for alcohol related policies and programmes in being connected. This would be facilitated by the development of a virtual (or otherwise) centre that could support growth of the necessary multi-pronged development of innovation, integration and the provision of advice. (See discussion Section 4.4.5).

6. Summary and Conclusions (See summary: Executive Summary)

The Panel believes that it **is timely** that the ADF is currently involved in the **ADFAMS project** that will facilitate development of an organisation wide **Alcohol Management Strategy**; together with supplementary further development of Alcohol Strategies for each of its three Services: the Australian Army, the Royal Australian Navy and the Royal Australian Air Force. There is an opportunity for some of the work started by this Panel to be taken up within the ADFAMS project that is underway.

Priorities for action

The Panel has identified priorities for action and included these as recommendations [above]. Other advice and suggestions are included throughout the report and referred to in this executive summary.

The Panel recognises that some of these recommendations warrant sequencing. In this regard, the Panel notes the parallel and ongoing development of the ADF Alcohol Management Strategy. It also notes the other concurrent cultural reviews and the potential for coordinated action and response to their findings.

In this context it is difficult for the Panel to nominate an appropriate sequence of recommendations for attention. However, in general the Panel expects that the recommendations relating to development of overarching alcohol policy (**Rec. 1**) and data development and analysis (**Rec. 4 and 6**) are needed in order to underpin adoption of an ADF Alcohol Management Strategy.

Adoption of **Rec. 2** (reducing the strength of alcohol products) would signal the ADF senior leadership group's commitment to change; while they pursue a longer-term vision and plan for implementation (**Rec. 3**).

Given the importance of monitoring the supply and availability of alcohol, implementation of **Rec. 5** (audit of alcohol in ADF) should occur in consultation with experts in this area. The Panel believes that an effort to audit the supply and availability of alcohol is likely to identify gaps in information. This is expected to prompt further development of an appropriate alcohol reporting system.

The Panel expects that legislative review (**Rec. 7**) would be a necessary priority since it sets the overall legal framework for policy and practices.

Finally, the Panel suggests the engagement with external experts in relation to **Rec. 8** and the potential development of a Centre could proceed immediately. This could then provide an all of organisation focus for consideration of the anticipated ADF Alcohol Management Strategy and the initial steps in building a stronger alliance with community based expertise.

The ADF will have its own ways of responding to this report. It is vital that any response encourages engagement at all levels if it is to be successful and sustainable in developing a reputation and capability that will service Australia well into 2030 and beyond. Alcohol, along with other risks, has the potential to derail this endeavour; but responding to this challenge also offers an opportunity for leadership. Leadership will need to come from the top and from other levels within the organisation if this is to be achieved.

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Mooseheads Pub and Nightclub, Moosecard Image, retrieved 15 August 2011, from <http://www.mooseheads.com.au/mCard.html>

Appendix 1:

Recruitment and early training

Overview

Recruitment and early training is a formative time in the lives of ADF personnel. It is a period which shapes individual values, attitudes, and behaviours that can last a life time, and also reproduces a collective culture that defines the workplace and much of their life outside of it. This is also a time when drinking behaviours can become established.

At the time of recruitment and early training, many are aged under 18 years and for many it is their first time living away from home; and for young women it can be their first experience of a male-dominated environment.

“The cadets of ADFA form a unique constituency within the ADF (some [1 ½ % of its full time personnel). They include some of its most intelligent members, they remain on location and in communal residence for at least three years and, by the nature of their studies and military programs (as well as the need to allow them to develop fully into adults through the requirement to make and be responsible for their own choices) have significant free time within an environment away from their parents with which they become increasingly familiar and in which they have many friends. Unlike other ADF personnel of equivalent length of service, they are required to live in if they are not in a recognised relationship” (RADM James Goldrick, Commandant of ADFA)

Many are still developing life skills and experiences to deal with a range of developmental challenges and occupational issues that will arise. They will have a high level of disposable income relative to many other students and trainees in the community, coupled with the legal right to drink and they enter a world where there are competing pressures of new found independence and the challenges and demands of being a member of the Defence Force. However, the early phases of their training are highly structured and supervised, with limited free-time available to socialise in ways that the civilian community take for granted.

At the same time, many are adolescents who are seeking and gaining typical experiences of this life stage such as reaching physical and emotional maturity, loosening ties to their family, developing a wider social circle and friendship network, having sexual relationships, and experimenting with identity and behaviours including the use of alcohol, tobacco and other drugs.

Review of ADF data regarding alcohol consumption and harm

The data review identified four potential datasets for describing alcohol consumption and harm during the recruitment/early training stage of the military career. These include:

1. Mental Health Prevalence Study

The Mental Health Prevalence Study (MHPWS) was a survey conducted by the Mental Health Outcomes Program (MillHOP) that aimed to:

- Establish baseline prevalence rates of mental health disorder in order to target mental health services and identify high risk groups.
- Determine the ADF-specific clinical scores on the mental health screening instruments to ensure the maximum number of personnel are identified for early intervention.

- Identify cultural and organisational factors in the ADF that have detrimental effects on mental health and reduce care-seeking behaviours.

The data were collected in two formats:

a. Health and Wellbeing Survey

All regular ADF staff (not part-time or reservists) were invited to participate in an on-line survey conducted by an independent organisation (Centre for Military and Veteran's Health – CMVH, University of Adelaide). The survey focused on personal and service characteristics, health status, lifestyle behaviours (including alcohol), past experiences (eg combat, PTSD, suicide ideation), social support networks, and recent health problems. The survey included information on age, rank and time in service thus allowing the analysis of sub-group data including recruits and those in early training.

b. Composite International Diagnostic Interview (CIDI)

The CIDI is a structured interview designed to assess mental disorder according to the definitions and criteria of ICD-10 and DSM-IV including ICD10 Alcohol Disorders. A sample of 1,798 personnel who completed the MHPWS were invited to participate in the interview. Similar to the Health and Wellbeing Survey, sub-group analysis was possible.

The Panel was provided with preliminary and summary data prior to the study's final report being available. However, data by age group as an indicator of alcohol consumption among younger recruits was not available at the time of this report's preparation.

2. *Post-Operational Psychological Screen (POPS)*

It is mandatory that all personnel complete a POPS in the 3 to 6 months following return to Australia from deployment. The screen consists of basic demographic information including age, service, rank and deployment information; the AUDIT; the K10 (depression) and the PCL-C (Post-Traumatic Stress Disorder). Whilst the survey is self-administered, it is reviewed during an interview with a mental health professional. The survey and interview allows for the clinical diagnosis of alcohol-related problems. As such the POPS data provide comprehensive information on alcohol consumption amongst post-deployed personnel.

As approximately 7,000 of 50,000 personnel are deployed each year (13%), the POPS data are not representative of all ADF personnel. Nonetheless, POPS data were requested for the 2007 to 2010 period regarding AUDIT and demographic data. The data were analysed by age as an indicator of alcohol consumption among recruits and those in early training.

3. *ADF LASER- Resilience Study*

LASER is a longitudinal survey that involves surveying new enlistees and appointees entering the ADF from November 2009. Data collection is repeated every year for the first 4 years of their ADF career. To-date, approximately 3000 personnel have been surveyed at the time of enlistment, and 1000 of these members have completed the year one repeat survey. Measurement of alcohol use is included in the survey.

Recruitment process

The process of applying for and being assessed to become a member of the ADF involves completion of a number of selection processes that include completion of screening surveys, interviews and assessments. With regard to alcohol use, direct screening occurs via a limited number of items in a screening tool, with a focus on alcohol dependency. Alcohol use is also indirectly assessed in the context of a broader lifestyle assessment. No data regarding the alcohol consumption and harm characteristics of recruits were available for the preparation of this report.

Prevalence of alcohol consumption and harm

1. *Post-Operational Psychological Screen (POPS)*

POPS were completed on over 18,000 post-deployment personnel in the years 2007 to 2010. In regards to newer recruits, it was found that significantly more personnel aged 25 years of less consumed at hazardous or harmful levels (AUDIT ≥ 8) (26.9%) compared to 18.1% for the 25 to 34 year group, 12.5% for the 35 to 44 year group, and 9.4% for those over 45 years of age. The results suggest a possible reduction over time in the prevalence of such consumption for personnel aged under 25 years (34.3% in 2007 to 25.1% in 2010).

The prevalence of risky alcohol consumption on the AUDIT sub scales also suggests a greater prevalence among younger personnel.

- *Alcohol Consumption Score* (Total score of questions 1 to 3 ≥ 6)
 - 32.7% of personnel aged under 25 years were found to be consuming alcohol at risky levels (compared to 30.8% for the 25 to 34yr age group, 24.5% for the 35 to 44 year age group, and 20.4% for the over 45yr age group).
- *Dependency Score* (Total score of questions 4 to 6 ≥ 4 -12)
 - 1.3% of personnel aged under 25 years were found to be possibly alcohol dependent (compared to 0.8% for the 25 to 34yr age group, 0.5% for the 35 to 44 year age group, and 0.2% for the over 45yr age group).
- *Alcohol-Related Problems Score* (Total score of questions 7 to 10 ≥ 1 -16)
 - 31.9% of personnel aged under 25 years were found to be at risk of alcohol-related problems (compared to 24% for the 25 to 34yr age group, 15.5% for the 35 to 44 year age group, and 9.8% for the over 45yr age group).

Analysis of POPS data against the 2009 Australian Drinking Guidelines (no more than 2 standard drinks on any day) (NHMRC 2009) found that 79.8% of personnel aged less than 25 years exceeded this guideline (68.2% for the 25 to 34yr ages group, 55% for the 35 to 44 year age group, and 47.4% for the over 45 year age group). Further analysis of POPS data by age and other characteristics is warranted.

2. *ADF LASER- Resilience Study*

Preliminary analysis of the LASER study has found that 31% of male officers and 40% of female officers reported at-risk alcohol consumption at entry into the ADF. At the end of initial training, these figures had increased to 43% for males and 57% for females. When assessed against the male criterion (AUDIT-C >6), the proportions of female officers reporting drinking at this level were 14% and 29% before and after training, respectively.

Conclusion of data analysis

Overseas studies have shown that military recruits are at risk of binge drinking and are more likely to be heavy drinkers. Regarding ADF recruits, there is limited data available concerning their alcohol consumption and harm characteristics. The ADF's POPS and LASER datasets provided information that suggests that recruits and personnel who are younger (aged less than 25 years) are more likely to consume alcohol at harmful levels, as do younger persons in the civilian population generally. Given such findings, the limited availability of data regarding the alcohol consumption and harm characteristics of recruits limits the ADF capacity to effectively respond to and manage the alcohol-related risks of this high-risk group. Further analysis of the Mental Health Prevalence survey by recruit and age status would be of benefit in developing a better understanding of such risks. Similarly, analysis of alcohol-related data obtained from the recruitment process would be of benefit in developing a better understanding of the alcohol-consumption and harm characteristics of recruits. The finding from POPS data of a possible reduction in the prevalence of hazardous or harmful consumption among personnel less than 25 years of age over the last four years is encouraging. Further analysis is required of this and other datasets to develop a better understanding of the determinants of such a reduction, including changes in the characteristics of recruits, in ADF selection procedures and/or changes in ADF alcohol risk management practices.

Review of current ADF policies relating to new recruits and those in early training

For most of what follows in this section, the information relates most especially to the Australian Defence Force Academy. Although the Panel visited and spent time with trainees at HMAS CERBERUS, detailed written orders, policy documents and curriculum was not analysed. Therefore written policy relating to ADFA is used as an example.

a. ADFA Standing Orders

The Australian Defence Force Academy Standing Orders (2010) set out rules and orders under which all military staff, Defence civilian staff and contractors are to operate whilst posted to, or employed at, the Academy. The Standing Orders include several rules relating to alcohol, as follows:

- 1.1 It is Defence policy to encourage members to maintain a responsible attitude to the consumption of alcohol. The Australian Defence Force Academy (ADFA) will not retain members who repeatedly misuse alcohol, refuse treatment for alcohol misuse, or fail to complete an alcohol counselling or rehabilitation program when ordered.
- 1.2 Alcohol is not to be consumed within the ADFA precinct, except:
 - a. within that area of a mess, canteen or club set aside for the consumption of alcohol, or
 - b. at a place authorised by the DCOMDT ADFA.
- 1.3 Alcohol is not to be consumed or stored in Midshipman or Officer Cadet Accommodation buildings.
- 1.4 Midshipman and Officer Cadets under the age of 18 years are not to consume alcohol. Midshipman and Officer Cadets are not to purchase or provide alcohol for/to members under 18.

- 1.5 Alcohol is not to be consumed on Defence transport, or transport associated with ADFA, this includes academic field trips.
- 1.6 Alcohol is not to be consumed whilst on duty, except where written authorisation has been granted by the DCOMDT or COMDT prior to the event.
- 1.7 ADF prescribed Blood Alcohol Level Whilst on Duty, subject to the discretionary powers of COMDT or DCOMDT, all ADF members are to maintain a zero Blood Alcohol Level (BAL). However, for testing purposes, BAL readings below 0.02 per cent will not be considered as a positive reading.

The Standing Orders also prohibit consumption by cadets under the age of 18 whilst on local leave (s.5.40), and duty staff who are over 18 must not have consumed alcohol within eight hours prior to the commencement of duty (s.5.28). The consumption and sale of alcohol at sporting events within the Academy is also prohibited (s.5.45).

b. ADFA Cadet's Mess Rules

The ADFA Cadet's Mess Rules generally reflect the above, with some additional rules. For example, a maximum of two drinks per person per visit to the bar (i.e. per transaction) is to be adhered to, and "shouting" is not an Officers Mess custom and will not be tolerated in the ADFA Cadets' Mess (s.3.14). It is notable that the description of the Bar Manager's responsibilities does not include any reference to maintaining compliance with liquor control laws or responsible service of alcohol practices (Annex K).

c. Other relevant policies and rules

Other relevant policies and rules regarding alcohol need to be reviewed and redeveloped to ensure that they are comprehensive, widely and regularly disseminated, include regular reviews, actions for non-compliance, and monitoring of implementation.

3. Review of current Alcohol and Drug Training modules used in early basic and officer cadet training

All ADFA trainees are provided with alcohol and drug awareness training as part of their curriculum. In first year, 8 hours of training are provided including a mandatory briefing on the ADF drug and alcohol policies delivered by Joint Health Command, the Keep Your Mates Safe (KYMS) program, PSPT and alcohol testing, and ASO and ACM briefs. Refresher courses (1 period) are also provided in Year 2 and Year 3.

In addition, all recruits who undertake the Initial Entry Course at the Navy Recruit School at HMAS Cerberus will receive a training module in alcohol and drug awareness. The module covers: what is alcohol; metabolism and blood alcohol content; physical effects, pathways to addition; sobering up; acting responsibly; public expectations; and expected Navy behaviours.

There are opportunities to locate alcohol related training more widely across the formal and informal curriculum for ADF members; especially important for recruits and those in the early, formative years of adult life. One off modules that can be completed rapidly but are not connected to other curricula and not seen to be relevant in a range of situations, environments and linked are likely to be less effective in shaping attitudes, expectations and behaviour around alcohol. Curriculum ‘infiltration’ where planned, strategic location of alcohol examples and related inputs in the overall curriculum as far as possible (including the creative development of elements used in military specific subjects and activities) could enhance the effectiveness of the specific alcohol content modules.

Alcohol examples offer very positive integrated teaching/learning experience; usually allowing for both simple messaging and more complex thinking, decisions making rehearsal techniques, problem solving by individuals or groups; strategic risk assessment/management and could fit well with other embedded messages already being used in the ADF such as KYMS.

Other opportunities exist for more systematic step-wise rehearsal of decision-making and action could be developed in relating to alcohol akin to the ‘Battle-Smart’ systematic exercise that requires cognitive input toward sensible behavioural outcomes. The Panel notes that this has now been adopted by the Defence Community Organisation in developing a ‘Family-Smart’ programme. Alcohol policy could also be an element in the advanced teaching and training of those going in to leadership positions.

All Drug and Alcohol training would benefit from review and redeveloped to ensure that consistent, regular information is provided during these formative years with the military. Training modules not only provide the necessary information on alcohol and its related harms (eg health issues, associated risks, legal issues, recommended consumption levels), but they can also include information to assist with the development of resilience eg peer pressure, motivation, support systems etc. It is important that these developments are consistent with the ADF policies and expectations and consistent with approaches that challenge expectations and social norms about drinking.

4. *Review of the recruitment/selection criteria*

New recruits are typically action-oriented, outgoing and social, and are likely to be risk takers (Orme 2011). The traditional recruitment grounds for military personnel are often areas that are of a lower socio-demographic status, and the standards for entry academically are not high (Fossey 2009). These are all risk factors for high alcohol use.

Given this, it is suggested that all recruitment and screening criteria and mechanisms be reviewed to ensure that alcohol screening is included. Currently, all applicants are screened for medical issues, fitness requirement, aptitude and psychological issues. It would be recommended that the Alcohol AUDIT be included in the psychological screen.

5. *Ongoing health and psychological assessments for recruits*

Given the endemic nature of excessive alcohol consumption amongst ADF personnel, it would be advisable that assessments of health and psychological status be undertaken at periodic intervals (eg at 1yr, 2yr, 3yr). Such assessments should include the Alcohol AUDIT, and an interview/consultation with a medical officer. It would be recommended that the categories of care outlined in the Alcohol AUDIT Manual (Babor 2001) be followed:

- Zone I (AUDIT 0–7): Alcohol education
- Zone II (AUDIT 8–15): Brief advice
- Zone III (AUDIT 16–19): Brief advice plus brief counselling and continued monitoring
- Zone IV (AUDIT 20–40): Referral to a Specialist for Diagnostics Evaluation and Treatment

A system needs to be developed to monitor alcohol consumption at both the individual (ie for referral and treatment) and the population levels (eg monitoring of excessive consumption).

6. *Utilise other programmes and opportunities to influence the patterns of alcohol consumption of recruits.*

New ADF recruits have a substantially higher income when compared to their peers in the civilian community. For example, ADF recruits undertaking a year of basic training are paid a base salary of \$31,358. This is more than double the maximum level of Austudy and Rent Assistance paid to civilian students, and is also exclusive of other allowances and benefits such as accommodation, clothing and meals. Given this high level of income and fewer expenses, recruits have a high disposable income, and might be more likely to spend more money on social activities, including alcohol.

Cadets in a group interview reported spending between \$2,000 and \$4,500.00 on their first weekend leave following the period of four weeks initial training when they must stay on base and have no access to alcohol. Their reported “special deals” from city based venues makes this expenditure even more ‘impressive’. The venue that approximately two-thirds of them stayed at is a high profile venue that includes significant gambling options and extended opening hours for the sale of alcohol.

Reasons given for this choice included: special deals offered to cadets; recommendations of other cadets; nearness to public transport route from the base; lack of familiarity with options (given that most of them were from many other locations all around Australia and many had little or no knowledge of the city they were based near) and national TV advertising of the venue that they had seen so they “knew about it”. 29th June, 2011

Elsewhere in this report (Section 3: Literature review and Sections 5.2 and 5.2) reference is made to other measures that hold promise and warrant consideration given that economic availability of alcohol and the ways in which this can affect alcohol consumption.

Thus, it is suggested that the ADF:

- ensure that there are adequate financial services and advice to new recruits in the hope of assisting them with saving and investments for the future; and
- develop opportunities to prompt thinking about the cash available at different points using messages akin to those already included in some on-line ADF modules for members.

Two examples of ADF using \$ considerations to deliver health related messages:

The alcohol, tobacco and other drugs Awareness on-line training module includes information such as: “Smoking can cost you \$44,000 over 10 years”. This is likely to resonate with members more than a message telling young people not to smoke.

The observation of one of the senior staff who deliver the OATP course for alcohol (see later) where member participants are invited to estimate/calculate how much alcohol has cost them in the past year, suggests that this has ranged from \$2,000 to \$70,000 (sometimes including fines related to alcohol linked behaviours).

Social availability (eg the perception that ones peers drink and/or drink heavily) also affects drinking patterns. Ames et al. 2002 noted that normative beliefs about drinking (eg believing your peers are drinkers/heavy drinkers) was associated with drinking levels at pre-enlistment. Among secondary school students considerable work is now being done to ensure that they are better informed about the actual drinking (and other drug using) practices of their peers; rather than relying on commercial or social media sources alone.

Researchers (Williams and colleagues, 2008) note that web-based interventions were effective with a sample of U.S. military personnel in lowering perceived norms about the frequency and quantity of drinking and this was associated with declines in individual participants own drinking. Beliefs, or social norms, are amenable to influence and may mediate changes in drinking behaviour.

In this context, it is suggested that the ADF:

- encourage the use of web based self assessment tools to be developed and allocate specific curriculum time for these to be completed from time to time.

Other approaches that warrant consideration include:

- exploration of the potential for use of diaries. Since these are an important tool for support, resilience, self-management and used in situations later in military roles including especially on deployment (deployment diaries) there is value in examining their use to facilitate self-assessment and reflection in the early induction phase of life in Defence — including recording of amounts and situations of drinking, for example;
- provision of information about local options, sites and visitors guides for those in the ADF in new locations (such as Cadets and also for others such as RAN members prior to on shore leave)> This was thought to be provided but was asked for by members suggesting that this is not usual.

The Panel encourages the use of a range of techniques for ways of thinking about ‘own alcohol use’ among recruits. This could include, for example: web based self assessment tools to facilitate the capacity to self monitor

Although the Terms of Reference for this Review Panel did not include direct consideration of tobacco, the Panel recognises that there are clear links between tobacco and alcohol (and other drugs) use, and there was sufficient mention of this and direct observation to draw attention to it. For this reason the Panel advises the ADF to engage with the overall community effort with as much vigour as possible in addressing smoking. A focus on reducing the uptake of tobacco smoking among recruits (at least) should be a priority.

Appendix 2:

Situations of drinking

Overview

This section focuses on the range of situations when ADF personnel consume alcohol. The purpose of this section is to provide a description of those situations and the nature and extent of risky and harmful drinking occurring during specific situations, identify the contributing factors, and propose how some of the issues might be addressed.

Situations of drinking in the ADF do include many of those typically found in civilian environments, but also particular situations that are distinctive to the ADF. These range from formal situations such as dining-in nights and disbursement of rations aboard Navy fleet (ie “two cans per day, per man”), to less formal situations such as ‘end of day’ or ‘end of week drinks’ at officers’ messes, to very informal situations such as an afternoon barbeque at an Army unit’s “boozer”. Within this diversity of drinking situations, the Panel has observed a variety of: drinking times and opening hours; methods of procurement and supply of alcohol; selling practices and pricing arrangements; product types; serving rules and regulations; and drinking styles. All of these are influenced by distinguishable social, economic and cultural factors particular the Service context.

Hence, the place of alcohol in the ADF environment is complex and multifaceted and not easily comprehended by those outside the ADF in a short period. However, what appears to be common across most of the drinking situations in the ADF is the relatively high availability and accessibility of alcohol; both physically and economically. Availability spans from that which is accessed and purchased from retail sources (eg mess bar, canteen, boozer) to that which is obtained through social sources (commanding officers, colleagues, friends, etc.).

There are diverging perspectives on the availability and consumption of alcohol in the ADF. Some formal policy statements direct personnel to not “encourage” or “coerce” members to drink [DI(G) PERS 15–1, Pt 1, 14] nor to “popularise” drinking [DI(N) PERS 31–9, Pt 1, 8)]. However, consultations with members suggest that there is strong pro-drinking culture within ADF, at least in some situations, and this further evidenced by the availability of alcohol in ADF environments. The economic availability of alcohol in the ADF is shaped by the relatively low selling price of alcohol at ADF outlets compared to those at civilian outlets, the subsidisation by the ADF of labour costs related to the serving of alcohol to its personnel, and the overall affordability of alcohol for ADF personnel relative to other commodities and taking into consideration the remuneration of ADF personnel.

The Panel recognises that the availability of alcohol within the ADF stems partly from its perceived utility in maintaining aspects of operational capability. That is, drinking is seen to serve an important function in building team spirit, celebrating unit tradition, fostering Service ethos, and supporting leisure/recreation time for those who live on base. In this regard it may not be seen as desirable or feasible to restrict access to alcohol for ADF personnel. However, as will be discussed further below, this issue goes to the heart of the debate about managing alcohol in the ADF because, as the scientific evidence indicates, the availability of alcohol is a major determinant of levels and patterns of alcohol consumption in a population, and in turn a major determinant of alcohol related problems.

Review of ADF alcohol availability data

The aim of this review was to assess the capacity of existing ADF datasets to provide useful information regarding the availability of alcohol. The following section describes the results of the review of data availability and utility for assessing the prevalence of alcohol misuse and/or harm among Defence personnel.

No comprehensive data sources describing alcohol availability and/or location of consumption within the Australian Army and Air Force were identified. Limited data regarding alcohol availability within the Royal Australian Navy were identified. Two datasets were accessed and reviewed:

- *Navy mess sales 2010 and 2011 (to-date)*
- *Navy fleet alcohol purchases 2010 and 2011 (to-date)*

In addition, information relating to trading hours (Navy) were received as were data relating to drink prices (ADFA), and trading hours at outlets at one Army base.

a. Navy mess sales 2010 and 2011 (to-date)

Alcohol is served or sold on 19 of the 20 Navy fleet ships. In the Navy, of the 14 bases, 11 have the facilities to sell alcohol. It is mandatory that all alcohol sales are recorded. The Navy has recorded all alcohol sales for: Wardroom, Junior Sailors Mess, Seniors Sailors Mess and 'others' Mess.

Whilst the data provides an indication of the dollar value being spent on alcohol by Navy personnel, the dataset has a number of limitations:

- The sales figures include the purchasing of non-alcoholic items such as soft drinks and snack foods.
- The figures can capture non-ADF patrons that visit the base and consume alcohol (eg friends and family).

b. Navy fleet alcohol purchases 2010 and 2011 (to-date)

In the period 2009 to 2011, there were almost 20 Navy Fleets that purchased alcohol for consumption by crew. The dataset included crew numbers, volume of alcohol purchased for general consumption, volume purchased for specific functions and the cost of purchase.

Whilst the data provides an indication of the dollar value being purchased by the Navy fleets, the dataset has a number of limitations:

- The figures are based on buy-in figures rather than consumption figures, thus may over-estimate consumption.
- The data doesn't appear to be available for consistent time periods across the Fleets.

The World Health Organisation (2000) recommends that public health monitoring of alcohol use should include credible estimates of per capita alcohol consumption derived from alcohol sales data. Hall (2008) stated that without sales data, policy makers would lack essential information to monitor trends in per capita alcohol use and the effectiveness of strategies in changing the way that certain groups drink, including military personnel. To collect per capita information, accurate information pertaining to the number of personnel residing on each base would be necessary.

However, in relation to the criteria of assessment, the only criterion that this data may meet is the routine recording of data.

c. Drink prices

The Panel did not access price lists for all ADF alcohol outlets but observed and recorded posted prices during visits to facilities. They are therefore only indicative and used as such here.

A price list of alcoholic drinks was obtained from one of the Australian Defence Force Academy bars (Beersheba Bar) and a liquor outlet at HMAS Cerberus. Whilst the information provides an indication of the price of alcohol for ADF personnel, the utilisation of the information is limited without more data for comparison.

d. Trading hours of bars

The trading hours of alcohol service at the Army Gallipoli Barracks (Enoggera) were obtained.

ADF alcohol sales, pricing and trading hours - Examples

1. Navy mess sales 2010 and 2011 (to-date)

In 2010, the total sales of alcohol in Navy Mess Halls (including soft drink and snacks) was \$1,914,064, including \$390K for wardrooms, \$352K for Senior Sailor Mess Halls, \$1 million for Junior Sailor Mess halls, and \$170K for other Mess Halls. In 2011 to-date, the total sales of alcohol in Navy Mess Halls (including soft drinks and snacks) was \$1,789,859, including \$347K for wardrooms, \$359K for Senior Sailor Mess Halls, \$910K for Junior Sailor Mess Halls, and \$135K for other Mess Halls.

2. Navy fleet alcohol purchases 2010 and 2011 (to-date)

The alcohol cost for 19 Navy Fleet Ships was \$276,333.70 (2009–2011). This represents 3082 crew members, over 86000 units of alcohol plus 8000 litres of alcohol. Alcohol for special functions cost \$19,000.

3. Drink prices

Drink prices were obtained from 2 ADF bars:

- ADFA ‘Beersheba Bar’ (Canberra, ACT): local beers averaged at \$2.30; light beer was \$1.80; imported beers averaged at \$2.90; ‘Ready-to-drink’ drinks averaged at \$3.80; and shots averaged at \$2.20.
- HMAS Cerberus (Mornington Peninsula, Victoria): local beers averaged at \$3.50; ‘Ready-to-drink’ drinks averaged at \$5.00; and shots averaged at \$3.80.

4. Trading hours

The posted trading hours of the officer's mess at one Army Barracks was obtained (Gallipoli – Enoggera, Brisbane):

- Monday: 12pm to 1pm; 4pm to 8pm (5hrs)
- Tuesday: 12pm to 1pm; 4pm to 11pm (Reservist night) (8hrs)
- Wednesday: 12pm to 1pm; 4pm to 8pm (5hrs)
- Thursday: 12pm to 1pm; 4pm to 8pm (5hrs)
- Friday: 12pm to 1pm; 4pm to 11pm (8hrs)
- Saturday: 12pm to 10pm (10hrs)
- Sunday: 12pm to 10pm (10hrs)

TOTAL hrs trading per week: 51hrs

The standard trading hours for commercial premises operating in Queensland are 10am to midnight Monday to Sunday.

Conclusion of data analysis:

Analysis of alcohol consumption via alcohol purchase and sales figures are limited due to:

- The unavailability of data for the Air Force and the Army.
- The limited capacity to extract the required information (eg alcohol sales only)
- *Conduct an audit – supply and availability*

This recommendation follows from the complexity of the current sources of information that are hard to access and held at various levels by different people but with no clear, consistent purpose for overall use in analysis of the potential impact or implications of changes to these potent levers. The Panel therefore concluded that an audit of these elements is warranted to draw attention to the various aspects of alcohol availability and use in the ADF.

This audit should be informed by the factors that international research has shown have a significant influence on the patterns of drinking of the population; in this case the ADF members. This should at least include the following: Sources of alcohol sold or made available, pricing, physical availability including the number and density of liquor outlets (including all bars, canteens, "boozers", stores and Messes); trading hours and serving arrangements including staff and management training (including the responsible service of alcohol training (RSA)).

The additional collection and analysis of costing data to determine a more realistic measure of the total cost of alcohol to the ADF should receive attention. This is likely to require expertise to help establish the parameters for such a costing to include at least the cost of labour in serving alcohol and the cost of the provision of physical facilities where alcohol is served and/or consumed. These elements however are only the tip of an iceberg when considering costs and some work could be commissioned to develop a more thorough costing study that parallels the cost of alcohol work done in the broad Australian community. Collins and Lapsely (2008) describe the adverse outcomes that arise from alcohol, including health costs, costs to policing, and costs to workplace productivity. This study includes the costs of the negative impact on health, amenity, crime and policing, loss of productivity and other costs.

- *Establish a valid and reliable reporting system for alcohol sales per capita*

It is recommended that further investigation is required into the maintenance of alcohol purchase and/or sales records by the Air Force and the Army. A reporting system should be established that records all sales in a consistent manner, and allows for the easy extraction and analysis of such data. Ideally, a per capita rate of alcohol consumption should be calculated.

- *Develop a policy addressing each of the supply determinants discussed in the literature review.*

The comprehensive policy needs to address the following:

- Pricing eg increased prices; standard minimum price at all bases/barracks; bans on alcohol promotions and discounts; and differential pricing for different alcoholic drinks.
- Regulating physical availability eg banning drinking in areas other than licensed premises; restricting the days and hours of alcohol sales on-base; restricting the density of liquor outlets on-base; restricting the sale of high-strength alcoholic drinks during peak drinking times; ensuring that the Australian minimum purchase age is applied when on deployment; rationing of alcohol; ensuring that non alcoholic drinks and food are available at all times; restrictions on the number of drinks purchased at one time.
- Modifying the drinking environment eg mandatory RSA and aggression training for all alcohol servers and security; trained security to monitor service, consumption and intoxication; alignment of the Defence liquor legislation to the state legislation; increased enforcement of ADF licensed premises; and the implementation of targeted policing based on crime/harm associated with high-risk premises.
- The incorporation of data collection on alcohol consumption context (eg location, time, intoxication level) into all routinely collected ADF data systems to identify at-risk drinking situations (eg POPS, primary care presentations, policing/security and incident management systems). It is recommended that the data collected be utilised in responding to harm associated with consumption at ADF premises.

The Panel notes the importance of Mess fees and the work that Mess Committees do in providing services and facilities beyond usual Defence provisions. It has been suggested that alcohol sales form a significant component of the available sources of revenue for these activities. The Panel does not believe that changes in pricing policy would necessarily have to mean a reduction in resources available for these additional services, which, the Panel understands can include purchase of play equipment for children and other valued family oriented services and a contribution to informal events.

- *Create a single standard/Align Defence liquor legislation to the state/territory legislation.*

The Panel recognises that it is not possible to directly align Defence Law with the number and specific provisions of all States and Territories (nor does it expect that this should apply to overseas locations). However there is a need to retain strong connections with community sentiment as expressed in changes to legislation. The Panel therefore believes that it is timely to review the legislative provisions regarding alcohol in this context.

All Australian jurisdictions now have as one of their primary purposes the reduction of alcohol related harm. This is in contrast to the historic focus on industry control; especially the historic place of hotels. Liquor control Acts (variously named) include laws governing the sale, supply and serving of alcohol.

Associated instructions and orders should similarly align with these laws and mechanisms of enforcement should also be reviewed.

- *Advertising, promotion and sponsorship*

The Panel is very aware of the significant value associated with the promotion of any product associated with the ADF; especially in context of iconic national symbolic events, people, days or operations such as “Anzac” associations, and strongly urges extreme care with allowing this to be used by a voracious /rapacious industry that is extremely experienced in positioning alcohol products with high status, Australian icons in promoting their products.

- *Active participation in community decisions about alcohol availability*

Greater consideration and development of proactive responses to the supply factors that influence alcohol availability in the general community is needed across all locations. While some are actively involved in local community activities, there is significant space to identify partnerships (such as with local government, local police and resident groups) in responding to the environmental context of alcohol provision, the response to alcohol related problems and with other organisations and services working to reduce harm associated with the production of major events as well as usual community practices and venues. This does not appear to have been a priority for all base commanders.

It is clear that many ADF members (perhaps the majority) now source their alcohol outside the Defence precincts. While some suggested that this means that the ADF has no role in this context, the Panel believes that there is both an opportunity and a responsibility to be involved in the efforts of Australian communities to reduce the negative impact of alcohol use. This is a necessary aspect of any comprehensive response to alcohol problems in the ADF and provides a clear opportunity for the ADF to provide significant leadership in local communities.

The Panel had an opportunity to informally visit and drink at a community based bar/nightclub in a location where it also participated in a formal Dining-In-Night. As expected, the manner of drinking, quantities consumed, behaviours and appearance of similar people drinking in these different venues/occasions was vastly different. Many are young and they, together with their families/parents, might reasonably expect that there is some shared responsibility between the young person and the institution in which they have placed their trust. It is in this context that there is a particular duty of care on the ADF to be involved “beyond the base”.

The Panel has not been able to extend its enquiries to explore these connections further but recognise that this context of the ADF in the broader community and enhanced connections with community efforts in relation to alcohol.

On enquiring about sources of alcohol for Defence base liquor outlets responses varied from “don’t know” (even from some senior officers) to more direct verbal examples provided of diverse sources. Some of the alcohol consumed by ADF members on ADF bases is purchased from local hotels, clubs and other liquor outlets.

The Panel received submissions and heard directly from members of the ADF who take advantage of “special deals” offered to Defence personnel in many venues and localities. The incentives offered to Defence members are clearly widespread and it is recognised that in some locations, the presence of a Defence base is possibly critical to the economic viability of many businesses. These factors give the ADF a strong lever to work with to reduce the likelihood that members will be involved in reputational, physical or mental health or social harm or embarrassment. In this context it is important to recognise the association between extended hour liquor outlets and the significant increase in alcohol related community based harmful incidents and accidents. Most jurisdictions provide opportunities for community groups to make submissions when a licensed venue is seeking an extension to their hours. The Panel believes that the ADF should be active in this regard. Opportunities could include the involvement of relevant commanding officers responsible for ADF bases liaising with local groups, local government, local police, licensed venues as well as health and other relevant services.

Perhaps the most significant action that could be taken, and probably the most difficult, would be to modify the supply and availability of alcohol at ADF events and on ADF premises. The Panel recognises that this would take considerable leadership, courage and resilience on the part of the ADF leaders. There are likely to be many who find this an affront to the cultural norms associated with life in the ADF. The Panel has nevertheless recommended these measures as they are the most likely to contribute to cultural change and a reduction in alcohol related harm in the medium and longer term. This judgement is based on international, scientific evaluation research across many countries; reducing supply and availability is the most effective way of moving toward less alcohol related harm. Hence the two recommendations related to this.

Reduce the supply and sale of higher strength alcohol products permitted to be sold or made available on ADF locations and at ADF functions. A change in the alcohol content of beverages available and served at ADF events and on ADF premises would potentially have the effect of reducing alcohol consumption on any one occasion by approximately 30%. Research suggests that very few people detect a significant difference between full and medium strength beer. In addition, it is worth noting the range of wine products now available and the differences in their alcohol content (as evidenced by the standard drink labels now required, for example). These too should be the subject of increased scrutiny and decision-making.

In the longer term, the Panel believes that the current climate of reform and planning for a future Defence Force provides the appropriate context to propose a shift in the way alcohol is viewed and planned for in the ADF. In this context it sets the following challenge for the Defence leadership group(s): *Adopt a vision and a plan for implementation of alcohol harm reduction in the working environments of Defence, by requiring Commanders to assess situations in which alcohol is proposed to be used informally or formally and where specific approval is required for the use and access to alcohol within all ADF work location.*

Appendix 3:

Deployment including Preparation, Decompression and Post Deployment

Overview

In the event of major hostilities, all personnel face the possibility of deploying to, or near, a war zone. Personnel can be deployed to other areas in Australia or overseas on planned exercises, peacekeeping missions or in response to natural disasters. Some missions require the engagement of offensive or defensive action, and the risk of violence is often high. Some missions require personnel to relocate at short notice, so it is pertinent that operational staff are physically and mentally ready at all times. Because of this, a major proportion of ADF resources in terms of labour, time and infrastructure are dedicated to the cycle of deployment, beginning with pre-deployment training and ending in post-deployment recovery.

Deployment provides many opportunities for individuals, including application of their skills and knowledge from training; performance in high-risk and high-pressure situations; achievement of tangible results; gaining of new skills and knowledge; participation in team work as well as leadership roles; and gaining a meaningful experience of being part of a national Service. Deployment can also be highly valued by many Defence personnel because it provides other benefits such as opportunities to travel outside of Australia; opportunities for career advancement; status and recognition from the ADF and government (eg medals) and from their family, friends, and general public; and significant increased remuneration.

Notwithstanding the fulfilling experience that deployment provides to the majority of ADF personnel that are deployed, it can also have significant negative effects on the health and wellbeing of members. These include but are not limited to physical injuries and psychological damage from traumatic experiences, as well as separation from family and friends for long periods of time, often repeatedly. The length of deployment and frequency of deployment are increasingly recognised as factors that may be increasing the risks to the health and wellbeing of ADF personnel.

From the Dunt review (p.90):

“The high operational tempo of recent years was frequently noted by members in relation to the stress it imposed on members. This was so for several reasons. First, it imposes on members with long periods of separation from their families. The land-based deployment cycle has been until recently six months in every two year period, but is now changing to eight months in every three years forming a pre-deployment, deployment and post-deployment cycle. In fact, the periods of separation are longer with pre-deployment preparation and periods of military exercises and training that many follow deployment”.

The recent Defence White paper, *Defending Australia in the Asia Pacific Century: Force 2030*, states:

“The pressure of the higher operational tempo that Defence has experienced since 2000 has put stress on Defence's capabilities, from wear and tear on equipment to the sustained higher activity levels faced by Defence's people. Too often the tempo of current operations has taken precedence over proper planning for our personnel and capability needs in the future. We need strategies to ensure that our capabilities, and especially our people, can sustain that which we ask of them” (pp.16–17).

Given the high necessity for operational readiness and the well publicised negative consequences of deployment and the link with excessive alcohol consumption, the deployment cycle has been a priority for the Panel. Whilst alcohol consumption by members on deployment is not permitted, or at least in very limited amounts in exceptional situations, it is suggested that some level of risky consumption still sometimes occurs. Alcohol consumption during deployment poses particular risks to the ADF because it can undermine capability, and in particular, can threaten the health and safety of personnel. Alcohol-related incidents on deployment can also cause significant reputational and potential diplomatic damage to the ADF and threaten the safety of the member(s) involved, especially when they occur in an overseas location.

Risky alcohol use is more likely to occur following deployment, sometimes as part of group social activities upon returning to Australia, or as part of an individual's response to the pressures, stressors and traumatic experiences of their recent deployment experience.

Decompression

A decompression period immediately following a deployment operation is standard practice in many armed forces, where combat troops are given a short period of leave and psychological support following deployment. However, it is well known that alcohol continues to play a significant role in this process (Fossey 2010).

The Australian Defence Force is in the process of trialling Third Location Decompression (TLD), thus the impact on alcohol consumption is unclear at this stage. It has, however, been part of the US military end-of-deployment policies since the Vietnam War and it is viewed as a stress management exercise to transition personnel back into their home life and ensure they are prepared for their next deployment. In Canada and the UK third location decompression (or normalisation as it is referred to in the UK) is an optional exercise at the end of deployment activities, and aims to reintroduce personnel to drinking in a responsible manner (ADF 2011).

Minimal evaluation of the impact of TLD on alcohol consumption has been undertaken. However, a study by Hacker-Hughes *et al* (2008) reported that personnel who spent one week or less in decompression were 1.13 times more likely to drink heavily than those that went straight home; those that spent one to two weeks in decompression were 1.2 times more likely to drink heavily; and those that spent more than two weeks in decompression were 1.17 times more likely to consume heavily. Thus, personnel involved in decompression were more likely to drink heavily compared to those that returned home immediately following deployment.

A briefing from the ADF Joint Health Command (5 April 2011) reported some satisfaction data from the UK and Canada. In the UK study on decompression in Cyprus, it was found that approximately 80% of personnel did not want to participate in TLD or were ambivalent about participation prior to their arrival. However, the majority (91%) reported having found TLD useful upon completion and 80% of TLD activities were seen as being generally helpful. About 70% of decompressing troops thought that the briefings would be helpful in easing their transition home and the three groups of personnel least likely to perceive TLD as being helpful were NCOs/SNCOs, troops serving in the Combat Arms and those who reported low levels of adjustment concerns.

The UK decompression program currently limits personnel to five cans of beer per person, per day, after Day 1 (ACDMH 2009). Anecdotally, there is evidence that following controlled drinking during decompression, there was a drop in alcohol-fuelled assaults/injuries on return to the UK, though it was stated that there were incidents during decompression. A study of the program found that 5.1% of respondents commented on alcohol consumption: 44% of these responses were requests for greater alcohol availability both in quantity and choice, and 22% were requests for less alcohol.

In the Canadian study on decompression (also in Cyprus), it was reported that the majority of respondents (96%) reported that they “Agree” or “Strongly Agree” that some form of TLD was a good idea; 86% of respondents reported that they “Agree” or “Strongly Agree” that the TLD experience was valuable; and 90% of respondents recommended it for future rotations to Afghanistan. At 6 months post-decompression, 86% agreed that TLD was valuable and 83% felt that the program made the reintegration process easier for them. In addition, in an evaluation of a Canadian decompression program in Guam, it was reported that many participants reported appreciation of the extra effort and expense which the Canadian Forces invested in order to ensure that they were properly cared for and followed-up. Many participants commented about the need for downtime, and how much they had enjoyed the chance just to have a beer and unwind in a North American type of atmosphere. Their spouses also noted the positive effect a few days of down time before the troops got home had on their readiness to rejoin their families, and many participants had positive comments about the lectures that were provided during the TLD.

The Canadian Forces reported a small number of alcohol-related medical problems during the early stages of TLD (seven trauma incidents, mostly involving fights, and three cases of alcohol poisoning). Recurring events were successfully remedied by introducing a number of counter measures, including an orientation brief and a buffet lunch.

Review of ADF data regarding alcohol consumption and harm

The data review identified two potential datasets for describing alcohol consumption and harm during the deployment cycle, however, all of them focussed on the deployment and post-deployment stage rather than the pre-deployment or decompression.

1. Post-Operational Psychological Screen (POPS)

It is mandatory that all personnel complete a POPS in the three to six months following return to Australia from deployment. The screen consists of basic demographic information including age, service, rank and deployment information; the AUDIT; the K10 (depression) and the PCL-C (Post-Traumatic Stress Disorder). Whilst the survey is self-administered, it is reviewed during an interview with a mental health professional. The survey and interview allows for the clinical diagnosis of alcohol-related problems. As such the POPS data provide comprehensive information on alcohol consumption amongst post-deployed personnel.

As approximately 7,000 of 50,000 personnel are deployed each year (13%), the POPS data are not representative of all ADF personnel. Nonetheless, POPS data were requested for the 2007 to 2010 period regarding AUDIT and demographic data.

2. *ADF Policing and Securities Management System*

It is mandatory for all ADF personnel to report any convictions, that is, any incidents that resulted in legislative or disciplinary action within the ADF or the civil jurisdictions). This reporting system records information on all convictions. It provides information on the total number of convictions and the number recorded as alcohol-related for each service. It should be noted that alcohol involvement is somewhat subjective based on the details of the incident. This dataset captures alcohol-related harm data that is not captured by any other datasets (with the exception of AIMS), and can report on alcohol-involved convictions whilst on deployment.

However, there is potential for under-reporting due to the self-reported nature of the conviction. Also, whilst personal and conviction characteristic data are included in the system, it is currently not in format that allows for easy extraction of such information. For example, the system is unable to easily extract information on offence categories (eg assaults, offensive conduct) and certain sub-populations (eg younger personnel, rank, gender).

3. *Research study into the adjustment and reintegration experience of Australian Army Reserve Personnel following full-time service*

This study is an independent study aimed at evaluating whether the participation of Army Reservists in fulltime military activity including a deployment overseas on operations will lead to longer adjustment and re-integration for Reservists than their Regular Army counterparts⁹. This study involved the development of an ADF Members Questionnaire that focussed on mental health and alcohol consumption. Two groups were followed over time:

- Group A (Timor L'Este): **Reservists** deployed for seven months in war-like service.
- Group B (Timor L'Este): **Regular** personnel deployed for 7 months in war-like service (same deployment and battalion was Group A).

All participants completed a mental health survey at a number of intervals, including mandatory ADF screens (RtAPS and POPS).

Group A (Reservists)

- Time 1: Concentration weekend pre-deployment
- Time 2: End of deployment concurrent with RtAPS (Return to Australia Psychological Screen)
- RtAPS: Capture of RtAPS data from ADF
- Time 3: Six months post deployment (mail-out)
- POPS: Capture of POPS data from ADF
- Time 4: One year post deployment (mail-out)
- Time 5: Two year post deployment (mail-out)

Group B (Regular Army)

- RtAPS: Capture of RtAPS data from ADF
- POPS: Capture of POPS data from ADF
- Time 5: Two year post deployment (mail-out)

⁹ Orme, G (Unpublished thesis Title: to be inserted when available)

The screening instruments included a number of mental health measures (eg Kessler 10, Post-Traumatic Stress [PCL-C], the Depression, Anxiety and Stress Scale [DASS21]). The Alcohol AUDIT was included at all intervals, with the exception of the RtAPS.

Prevalence of alcohol consumption and harm

1. Post-Operational Psychological Screen (POPS)

POPS were completed on over 18,000 post-deployment personnel in the years 2007 to 2010

- *Hazardous or harmful consumption* (AUDIT ≥ 8)
 - 18.1% of personnel were found to be consuming alcohol at risky or high-risk levels
- *Alcohol Consumption Score* (Total score of questions 1 to 3 ≥ 6)
 - 31.3% were consuming alcohol at risky levels
- *Dependency Score* (Total score of questions 4 to 6 $\geq 4-12$)
 - 0.8% were possibly dependent
- *Alcohol-Related Problems Score* (Total score of questions 7 to 10 $\geq 1-16$)
 - 22.5% were at-risk of alcohol-related problems

The main characteristics associated with hazardous or harmful consumption (AUDIT ≥ 8) were: being male (19.2% compared to 7.8% for females); being aged less than 25 years (26.9% compared to 18.1% for the 25-34 year age group); being a member of the Australian Regular Army (23.6% compared to 7.4% for the Air Force); being deployed on Operation Herrick (23.6%) or Operation Astute (23.2%)(compared to 13.6% for Operation Anode); being deployed for a period of greater than 8 months (34% compared to 14% for those that were deployed for less than 4 months); suffering from very high levels of distress (44.4% compared to 14.8% for low levels); and suffering from high levels of PTSD (51.4% compared to 16.3% for low levels).

Research by Saunders and Lee (2000) reported that, in developed countries, the proportion of the population reporting dependency using the AUDIT is typically under 5%; hazardous or harmful drinking is 5 to 15%; and low-risk drinking is 50 to 75%.

2. ADF Policing and Security Management System

Preliminary analysis of the dataset indicates that 28.4% of deployment convictions in 2008 were alcohol-related. This compared to 38.5% in 2009 and 31.6% in 2010.

3. Research study into the adjustment and reintegration experience of Australian Army Reserve Personnel following full-time service

This study reported that the proportion of reservists (Group A) reporting hazardous/harmful alcohol consumption (AUDIT ≥ 8) was:

- 7.5% at Time 1 (pre-deployment screening)
- 41.9% at Time 2 (post-deployment survey)
- 22.5% at Time 3 (6 mths post-deployment survey)
- 29.2% at POPS
- 40.4% at Time 4 (12 mths post-deployment survey)
- 29.4% at Time 5 (2 year post-deployment survey)

In comparison, the proportion of regular personnel (Group B*) reporting hazardous/harmful alcohol consumption (AUDIT ≥ 8) was:

- 62% at POPS
- 50% at Time 5 (2 year post-deployment survey)

The study also showed that, at the POPS, 30% of the reservists were consuming at hazardous/harmful levels (AUDIT ≥ 8) compared with just over 60% for the regular personnel. Thus, the regular personnel were consuming at substantially higher rates compared with the reservists at these two occasions.

* To be interpreted with caution due to small sample size (13% response rate for Time 5 N=14 compared to 66% for POPS N=72).

Conclusion of data analysis

Notwithstanding differences in the age and gender characteristics of POPS participants and community level data, the POPS reported prevalence of post-deployment alcohol-related as measured by the AUDIT appears broadly consistent with, or below that reported in community studies. There is a suggestion that this prevalence may be reducing.

Whilst the POPS dataset provides valuable information regarding the alcohol consumption and harm status of post-deployed ADF personnel, there are a number of limitations regarding interpretation of such data including:

- Double counting of individual personnel due to multiple deployments.
- Possible respondent fatigue/response bias/habituation due to multiple surveying after multiple deployments.
- Disincentive to report alcohol problems due to perceived risk to career progress, future deployments, etc.

Interpretation of the ADF Policing and Security Management System data is also subject to a number of caveats:

- Potential for under-reporting due to the self-reported nature of the conviction.
- The system is not currently in a format that allows for the easy extraction of specific crime categories (eg assaults) or personnel characteristics (eg age, gender, and rank).

1. Analysis of POPS and other data sets

The preliminary analyses of available datasets suggests that further more detailed analyses are required to ensure accurate interpretation of POPS and other data with respect to comparison with other studies, and suggested changes in the prevalence of alcohol related harm. It is recommended that the conduct of such analyses be referred to the current ADFAMS project for consideration.

2. Collection of alcohol consumption data during the pre and post-deployment stages

Defence personnel were required to undertake the Comprehensive Preventive Health Examination (PHE) every five years. The PHE includes the AUDIT tool. It is understood that this will replace the AHA that was mandatory for all ADF personnel to complete on an annual basis. The AHA did not include the AUDIT or any other valid measure of alcohol-related harm. Completion rates of these assessments are low.

The Panel notes that the Australian National Audit Office (2010) recommends that consideration be given to adopting a risk-based approach in preference to annual individual readiness medical checks for all personnel. If this is to occur, it will be important to have broad risk definitions/categories for possible alcohol risk given that the risks and costs of high-risk alcohol use go beyond consideration of individual member's health. This Panel's advice is that the AHA (PHE or equivalent) be applied to all deployed personnel 12 months post deployment, and include the full AUDIT. It is recommended that all such surveys be completed by ADF personnel, followed by an interview with a mental health professional (if required) to allow for adequate support and referral.

3. *Entry and storage of data in a central repository*

The proposed JeDHI System has the capacity for health staff to enter the responses of the screening surveys and assessments directly into the system. This will allow for the storage of data in a central repository for effective management and surveillance of alcohol issues.

4. *Review of current ADF policies relating to all stages of deployment and alcohol consumption*

A briefing provided by the ADF Joint Health Command dated 3 February 2011 states that

“ADF members deployed on operations do not have regular access to alcohol, although limited access (usually two standard drinks per person) may be permitted on special days (eg ANZAC Day or Christmas) where authorised by the Commanding Officer (CO). Members' access to alcohol during Relief out of Country Leave (ROCL) is not monitored by the ADF. In a planned trial of decompression, ADF members will be re-introduced to alcohol, in limited quantities, in a controlled setting. Policy regarding access to alcohol by deployed Special Forces (SF) is very similar to other ADF members whilst on deployment (eg could be authorised for special occasions at the discretion of the CO)”.

In comparison, the U.S. Department of Defence policy is similar to that of the ADF's, whilst the UK does not allow alcohol to be consumed on deployment. Alcohol is re-introduced to personnel during the decompression period. Similarly, the New Zealand Defence Force does not allow consumption on deployment, although some 'specialised' groups have unlimited access. In contrast, the Canada Force policies vary depending on the deployment/location and are set by the chain of command. For example, no alcohol is permitted in Kandahar, whilst personnel located in Kabul and on 'quieter peacekeeping missions' are allowed a limit of two drinks per day.

5. *Review of the Medical Employment Classification System*¹⁰

The tri-service MEC (Medical Employment Classification) system is used to inform the employability, deployability and rehabilitation of the member. Because deployment offers personnel with a range of career and material opportunities, maintaining one's status as “medically fit for employment in a deployed or seagoing environment without restriction” (ie MEC 1) is a continuing priority for many in the ADF. However, while on the one hand the MEC system encourages ADF personnel to maintain good health and wellbeing, it also potentially:

¹⁰ Please note in Addendum.

“encourages members to conceal their mental, and for that matter, physical health problems. These members run the risk of their health breaking down or necessary treatment not being able to be accessed while on deployment. This may require medical extraction imposing a considerable cost burden on the ADF” (p.108, Dent Review).

In its recent review of the MEC system the ADF have developed a periodic health examination (PHE) process as a means to assess health issues pertinent to employment and deployment, including medical conditions, occupational exposures, and/or clinical risk factors that may impact on a member’s fitness and safety in a given working environment. The Panel acknowledges and support the inclusion of the AUDIT alcohol screening tool as part of the PHE.

Appendix 4:

Safety and discipline

Overview

Safety and discipline are key issues for the ADF. Safety is integral to the military and has a significant impact on organisational viability, productivity, efficiency and operational readiness. However, safety in the military has to be considered in a different context to civilian organisations due to the high-risk nature of their role. Thorough risk assessment and management are integral to the ADF functioning, and it is evident that alcohol should be approached in the same manner. This approach is consistent with the way in which civilian occupational safety and health bodies are addressing the issue (WA Worksafe Alcohol Guidance Note).

Military discipline refers to the regulation of personnel involving rules that govern orientation and behaviour, inside and outside of the military. Safety and discipline are not only cultural attributes of the ADF, they are enshrined in legislation, policies, procedures, training, and operational protocols. The ADF places strict demands on its personnel to maintain the high standards that are expected of a professional military. This is accompanied by very high public expectations of Defence Force personnel regarding their personal conduct and behaviour, both on and off-duty.

Indiscretions involving alcohol are particularly damaging to the ADF's reputation and public image because they can be perceived as a lack of discipline and undermine community trust in the Defence Force. Public reaction to such incidents is perhaps heightened because of recent increased community-wide concern about alcohol, and the range of harms that can occur from risky drinking, especially incidents involving young people. In recent years there has been an increased media focus on the conduct and behaviour of ADF personnel whilst based in Australia or deployed overseas, particularly regarding incidents where alcohol has been involved. Newspaper articles have included headlines such as "Australian general blasts Army of drunks" (The Age, 16 February 2010) and "Australian Army warns soldiers against 'irresponsible stupidity'" (news.com.au, 27 May 2009).

Whether or not the tone of these news reports is justified will not be considered here. However, the Panel acknowledges that these do contribute to the external, and some internal, perceptions that ADF is facing considerable challenges with regards to with alcohol, yet at the same time, has heard from some ADF members that "we are no worse than the general community". It is possible, of course, for these two apparently distinct views to sit side by side. The rates of alcohol use and related harm may be no worse than the general community (and some data appear to support this contention). However, many argue that rates of alcohol-related harm in the general community are unacceptably high, and the policies, public statements of the ADF leadership and public commentary suggest that higher standards are expected of ADF personnel. Also, even a small number of adverse alcohol related incidents can be very costly in human and reputational terms. It is relevant to note that some commentators observed that risk management and "looking after your mates" was integral to Defence Force activity, but this did not always extend to after hours behaviour:

“There is a paradox that exists in Army where we seek to develop a capacity in our soldiers, based on robust training and strong leadership that enables them to keep themselves and their mates safe in extremely dangerous and volatile environments. The paradox is — while my people are very good at keeping themselves and their mates safe when engaging in training exercises or on the battlefield, some soldiers demonstrate the exact opposite as a result of alcohol misuse after hours and in their private lives” (LTGEN Gillespie, Chief of Army, 14 December 2010).

Risky drinking by ADF members and the incidents involving alcohol appear to do collateral damage to the public image and reputation of the Services, both within Australia and internationally, particularly when it is reported in the media. The Panel commissioned an analysis of the volume of television, radio and press coverage of the Australian Defence Force (ADF) and its personnel in relation to alcohol, covering the year 2009/10 and 2010/11. The analysis focused only on negative media reports¹¹. The analysis found:

- The total volume of coverage in 2010–2011 was **2,666 reports**, which reached a cumulative potential **audience of 81,159,239** and had an advertising space rate of **\$4,445,812**.
- This is a **347% increase** from 2009–2010, when a total of 596 reports mentioned the ADF in relation to alcohol. These reached a potential cumulative audience of 52,029,815 and had an advertising space rate of \$1,797,788.
- Television stations had the most coverage of the ADF and alcohol in 2010–2011, with 1,288 reports (including syndication). This contrasts with 2009–2010, when television outlets had the lowest volume of coverage (160 reports).
- The major news stories that contributed the increase in media coverage of ADF and alcohol in 2010/11 were the report into Navy culture and HMAS SUCCESS incidents, the fatal car accident at Crib Point that killed two Navy recruits from the HMAS Cerberus base, the proposal by the Defence Minister to allow women to undertake combat roles, the plans to charge soldiers for beer at Christmas celebrations in Afghanistan, and most significantly, the Skype incident at ADFA.

This could be interpreted as representing the equivalent of \$4.5million worth of negative publicity for the ADF. It is unknown what impact this negative publicity has on ADF recruitment and more broadly.

The above report has only been obtained by the Panel in recent days and hence there has not yet been an opportunity to brief the senior leadership group of the ADF.

Review of ADF data regarding alcohol involvement

The aim of this review was to assess the capacity of existing ADF data to provide useful information regarding alcohol-involvement in safety and disciplinary incidents. The sources of data identified were:

¹¹ The terms used in the search include 'alcohol', 'drunk', 'binge' and 'intoxicated'. Results were also filtered manually to remove any irrelevant or benign mentions (eg news stories about Fosters fund raising for Legacy or RSL). News reports about the proposal by the Defence Minister to allow women to undertake combat roles were included where they also made negative references to alcohol in the ADF.

1. *ADF Policing and Security Management System*

It is mandatory for all ADF personnel to report any convictions, that is, any incidents that resulted in legislative or disciplinary action within the ADF or the civil jurisdictions). This reporting system records information on all convictions. It provides information on the total number of convictions and the number recorded as alcohol-related for each service. It should be noted that alcohol involvement is somewhat subjective based on the details of the incident. This dataset captures alcohol-related harm data that is not captured by any other datasets (with the exception of AIMS), and can report on alcohol-involved convictions whilst on deployment.

However, there is potential for under-reporting due to the self-reported nature of the conviction. Also, whilst personal and conviction characteristic data are included in the system, it is currently not in format that allows for easy extraction of such information. For example, the system is unable to easily extract information on offence categories (eg assaults, offensive conduct) and certain sub-populations (eg younger personnel, rank, gender).

2. *Army Incident Management System (AIMS)*

AIMS is a similar dataset to the Policing and Security Management System, but is based on incidents rather than convictions. Like the ADF Policing and Security Management System, it is mandatory for personnel to report all incidents of safety, security and unacceptable behaviour incidents to the Army. Again, this is often under-reported. The report template includes personal and service characteristics, thus potentially the possibility of analysing data for sub-populations. Alcohol-involvement is also recorded, but is highly subjective. However, on advice from AIMS, crude results are relatively easy to extract, but detailed analysis would require a significant amount of time and resources. The database is currently only implemented by the Army, and is 'fluid' in that personnel can continuously enter and update information about an incident.

On advice from the Army Incident Manager, this system does not capture all incidents because it only covers personnel operating in the Army Group (estimated 80% coverage). Alcohol involvement was not recorded until the end of 2007, and not all incidents coded as 'alcohol involved' will actually include alcohol (eg an assault on licensed premises may be recorded as alcohol-related because it occurred in a licensing environment).

3. *Inspector General Australian Defence Force Military Justice Statistics Catalogue*

Since 2008 the Inspector General Australian Defence Force has released an annual catalogue of military justice statistics. The catalogue compiles information from a number of sources including: routinely conducted ADF-wide surveys (eg Defence Attitudes Survey); databases such as Conduct Reporting and Tracking System; ADF Administrative Enquiry Tracking System; and Fairness and Resolution Branch Complaint Management, Tracking and Reporting System; IGADF audits, focus groups and surveys; and data from other agencies eg ADF Policing and Security Management System. In a number of instances within the data reported, information regarding alcohol involvement in incidents is reported. However, given its role as a summary of data available from a variety of sources, the catalogue consists primarily of data tables and figures, with limited information regarding data recording procedures and definitions for each data source. Further appraisal of such information with regard to the alcohol-related information available is required to confirm the utility of the data reported.

Prevalence of alcohol-related incidents

1. ADF Policing and Security Management System

Analysis of the data indicates that there were 8,101 convictions¹² between 2008 and 2010. Of these approximately 12% (961) were reported as alcohol-related, and this figure remained constant over the 3 year period (11.3% in 2008, 13% in 2009 and 11.5% in 2010). The proportion of convictions that are alcohol-related over this period is highest for the Navy (17.4%), compared to 8.9% for the Army and 11.9% for the Air Force.

Over the 2008 to 2010 period there were 174 reported incidents of ‘being intoxicated on duty’ (s39). Of these, 93 (53%) were from the Navy, 77 (44%) were from the Army and the remaining 4 (3%) were from the Air Force. Similarly, over this period, there were 107 reports of ‘being intoxicated whilst driving an ADF vehicle’ (s40). Of these, 77 (72%) were from the Army, compared to 15 (14%) for both the Navy and the Air Force.

In addition, over this period, there were:

- 801 civil jurisdiction *driving offences* for ‘driving under the influence of alcohol’ (DUI) (582 for the Army, 160 for the Navy and 69 for the Air Force).
- 378 civil jurisdiction drivers *licence suspensions* for DUI (288 for the Army, 58 for the Navy and 32 for the Air Force).
- 589 civil jurisdiction *finest* for DUI (438 for the Army, 95 for the Navy and 56 for the Air Force).

It should be considered that the above figures may not be mutually exclusive because some offenders receive multiple punishments (eg licence suspension and a fine).

2. Army Incident Management System (AIMS)

Analysis of the data indicated that over the 2008 to 2010 period, there were 8,148 reported incidents. Of these, approximately 12.2% (991) were recorded as involving alcohol. The number of incidents reports as alcohol-involved increased from 5.4% (125) in 2008 to 8.5% (236) in 2009, to 20.7% (630) in 2010.

It was also found that:

- Of 358 reported assaults (ADF jurisdiction), 134 (37%) were reported as alcohol-involved and 114 of the alcohol-involved assaults resulted in administrative or disciplinary action.
- Of 317 reported assaults (civil jurisdiction), 104 (33%) were reported as alcohol-involved and 90 of the alcohol-involved assaults resulted in administrative or disciplinary action.
- There were 261 reported drunk and disorderly incidents, with 241 resulting in administrative or disciplinary action.
- There were 446 reported DUI incidents, with 443 resulting in administrative or disciplinary action.

¹² Convictions are incidents that result in either disciplinary or administrative actions

Overall, there was an increase in alcohol-related assaults (ADF jurisdiction) from 14.7% (16) in 2008 to 25% (31) in 2009, and 87 (69%) in 2010. Whilst the number of reported civil jurisdiction assaults remained stable, the proportion of alcohol-involved increased from 16% (18) in 2008 to 59% (59) in 2010. The number of drunk and disorderly incidents remained stable over the years, and the number of DUI incidents increased from 106 in 2008 to 161 in 2010. The apparent increase in the number of alcohol-related incidents may be due to a greater vigilance in recording of such information.

3. *Inspector General Australian Defence Force Military Justice Statistics Catalogue*

The following information reported from the 2011 statistics catalogue may include information inclusive of that reported above. Similarly, as an incident may be recorded in multiple databases, the potential exists for the information reported from multiple below to involve the same incidents. Bearing this caveat in mind, the catalogue indicates that there were 55 convictions in 2010 for being intoxicated while on duty (s37), with Army accounting for 29 of such incidents. Data from the Conduct Reporting and Tracking System suggests that in 2010 there were a total of 191 convictions in the Navy that ‘involved alcohol’, with 148 and 28 of such convictions occurring in the Army and Air Force respectively. In 2010, there were 247 adverse administrative actions recorded that involved the ‘misuse of alcohol’, with 159 of these being attributed to Navy personnel. Two hundred and twenty civil convictions were recorded with a large proportion of these being DUI. In addition to incidents that are defined in terms of alcohol involvement, the prevalence of other forms of incidents that are known to be strongly associated with alcohol are also reported. For example, the catalogue indicates that there were 90 incidents of assault/disturbance/obscene conduct/insulting words recorded in 2010, with 56 of such incidents being attributed to Army personnel.

Conclusion

There are limited ADF data that reports on the involvement of alcohol in safety and discipline matters. The data that are available, however, indicate that a significant number of incidents and convictions involve excessive alcohol consumption.

Whilst the data sources provide some information regarding the involvement of alcohol in incidents, the utility of the data is less than optimal because:

- The systems are not currently in a format that allows for the easy extraction of detailed information (eg offence type, age, gender, rank).
- Whilst it is mandatory to report convictions, there is potential under-reporting due to limited communication between the state police forces and the ADF.
- The definitions of what constitutes alcohol involvement in an incident vary between databases and sources. Similarly, place of purchase and consumption are not recorded. Information regarding the place of purchase and consumption of alcohol consumed prior to an incident is of benefit in targeting harm reduction strategies.
- Some systems are service specific, and hence cannot provide across service comparisons.

As an element of the recommended Review of ADF Alcohol policy, the ADF should also review and revise the Defence Occupational Health and Safety Strategy to incorporate alcohol as a risk to Defence capability.

The ADF currently have a 2007 to 2012 Defence Occupational Health and Safety Strategy that has nine main outcomes:

- Further develop and implement the elements of the Defence-wide OHSMS.
- Develop and implement a Defence OHS.
- Management Information System to improve the quality of OHS information available to decision-makers at all levels.
- Reduce the frequency and severity of risks to people's health and safety.
- Improve prevention of occupational injury, illness and disease.
- Reduce the impact of occupational injury, illness and disease.
- Train, support and motivate personnel to identify and manage hazards effectively.
- Improve and embed a systematic capability to identify, eliminate or manage hazards in the design and planning stages of Defence activities.
- Enable Defence personnel to manage the OHS performance of third parties, consistent with Defence policies and practices (Department of Defence, 2007).

As this policy ends in 2012, it is recommended that the revision ensure that the risks related to excessive alcohol consumption be incorporated, as well as the reporting of incidents in a manner as described above.

3. *Review existing ADF policies and guidelines that address safety and/or discipline to ensure they adequately address reporting and addressing alcohol-related incidents*

a. *Safety*

The risks associated with alcohol are implicitly and explicitly noted in a variety of ADF policy documents and guidelines. For example, under the Occupational Health and Safety Act 1991, the ADF's duty of care encompasses all Defence personnel, Australian Defence Force Cadets, contractors and those affected by ADF activities.

General orders relating to alcohol within the ADF, such as Defence Instructions (General) as well as those for each of the single Services, explicitly identify requirements around alcohol. Such instructions include:

- DI(G) PERS 15-1—*Misuse of Alcohol in the Defence Force*; and
- DI(G) PERS 15-4—*Alcohol testing in the Australian Defence Force*.

It is recommended that these instructions be reviewed and updated as per the recommendations of the Panel.

b. *Discipline*

In addition to the controls demanded by occupational safety and health considerations, ADF policy and procedures relating to discipline are implicitly and explicitly relevant to preventing and reducing alcohol-related harm.

Instructions relevant to disciplinary action include:

- DI(G) PERS 35-3—*Management and Reporting of Unacceptable Behaviour*;
- DI(G) PERS 35-4—*Management and Reporting of Sexual Offences*; and
- DI(G) PERS 35-6—*Formal Warnings and Censures in the Australian Defence Force*.

It is recommended that these instructions be reviewed and updated as per the Panel's recommendations.

In addition to general legislation, military personnel are also subject to the provisions of the Defence Act 1903, which is a Commonwealth law and thus overrides State/Territory laws. The sections directly relating to alcohol include Section 123A (Intoxicating Liquor) and Section 123AA (Intoxicating liquor not to be supplied to cadets).

Defence personnel are also subject to the Defence Force Discipline Act 1982. There are three sections which relate specifically to alcohol:

- s32 — Person on guard or on watch:

A Defence member is guilty of an offence if the member is on guard duty or on watch and the member is intoxicated (max punishment: 12 years imprisonment). For the purposes of this section, a person is intoxicated if, and only if, the person's faculties are, because of the person being under the influence of intoxicating liquor or a drug (other than a drug administered by, or taken in accordance with the directions of, a person lawfully authorised to administer the drug), so impaired that the person is unfit to be entrusted with the person's duty or with any duty that the person may be called on to perform.

- s37 — Intoxicated while on duty:

A Defence member is guilty of an offence if the member is on duty, or reports or should report for duty, and the member is intoxicated (maximum punishment: six months imprisonment).

- s40 — Driving while intoxicated:

A person who is a Defence member of a Defence civilian is guilty of an offence if:

- a) The person drives a service vehicle in any place (whether public or not) AND the person is under the influence of intoxicating liquor or a drug to such an extent as to be incapable of having proper control of the vehicle (maximum punishment: 12 months imprisonment).
- b) The person drives a vehicle on service land AND the person is under the influence of intoxicating liquor or a drug to such an extent as to be incapable of having proper control of the vehicle (maximum punishment: 12 months imprisonment).

In addition to the above, the DFDA also provides powers for the creation of general orders, which is typically where, detailed rules and the procedure for their application is described. These may include:

- Defence Instruction (General), a Defence Instruction (Navy), a Defence Instruction (Army) or a Defence Instruction (Air Force);
- any other order, instruction or directive issued by, or under the authority of, the Chief of the Defence Force or a service chief; or
- a general, standing, routine or daily order in force with respect to a part of the Defence Force.

Under the DFDA, it is an offence for failing to comply with any of the provisions contained in general orders such as those described above. However, it is a defence if the member proves that he or she neither knew, nor could reasonably be expected to have known, of the order. This may be pertinent given the considerable volume of general orders in existence in the ADF.

If a member is found to have been non-compliant with the provisions of the Defence Act 1903, the Defence Force Discipline Act 1982, or general orders, they are liable for disciplinary action from the ADF. There are a range of possible disciplinary actions that can be taken against a member, depending upon the severity of the matter and the judgement of the commanding officer. Options include:

- *Administrative Action:* Commanding Officer may choose to review the incident/behaviour and use their discretion to address the matter.
- *Take action pursuant to the DFDA:* In cases of summary offences (ie minor offences), a Commanding Officer may choose to review the incident/behaviour in relation to the DFDA and determine the appropriate disciplinary action.
- *Referral:* Referring the matter to the single service policing units or the Australian Defence Force Investigative Service (ADFIS) which is a tri-service unit responsible for complex and major investigations. This service may provide a further opportunity for data collection on alcohol involved incidents.

The discipline system is seen to be necessary for ADF operational capability by dealing with offences that affect military discipline. This includes offences that are uniquely military and other offences that occur in a military environment. Offences by ADF members are prosecuted under the DFDA, within the military justice system, when the offence substantially affects the maintenance and ability to enforce Service discipline in the ADF. Otherwise, criminal offences or other illegal conduct are referred to civil authorities, such as the police.

The military justice system provides the ADF with an Australian legal framework able to be applied on operations anywhere in the world. This is essential because the ADF may conduct operations in countries where the civil system has broken down and no law applies. The military justice system applies to all ADF members in times of peace and war, whether in Australia or overseas. ADF members must maintain the high level of discipline required on operations, at all times.

The discipline system includes processes for the investigation of alleged offences, preferring of charges and conduct of fair and reasonable trials. All ADF members have access to free legal advice in the internal discipline system. This is unique to the military. The discipline system includes safeguards such as automatic review of convictions and punishments and the right to an internal and external appeal. These safeguards are more extensive and rigorous than those available in the civilian criminal system. (Source: <http://www.defence.gov.au/mjs/mjs.htm>)

Risk Taking and Safety

The ADF is an organisation that requires risk taking; that is what is expected of its members and this is captured in a statement from a Senior Commanding Officer: “We take alcohol issues very seriously and respond quickly. Our approach is to appeal to a soldier’s innate sense of self-discipline. We are talking about people who are trusted with weapons”.

The ADF is also an organisation experienced with the development of ways of assessing risk and making decisions in the context of risk; together with the development of drills and exercises to prepare for uncertainty and risky situations such as “Battle Smart”. The Panel thinks that there is potential for some development of alcohol specific tools that might utilise these approaches in managing alcohol for both individual members decision making and planning at senior levels. The development of such tools might well come from those with direct day-to-day experience and responsibility for those units going and returning from deployment. It is possible that their experience is most relevant in operational planning and development of tools of this sort and their engagement will be critical.

Comments from a Commanding Officer: “Canberra doesn’t think anything is being done unless they direct it ... the senior ADF hierarchy only hear the bad news about alcohol, not the good news about the majority who do the right thing...” (July 2011).

The Panel considered the situation of Navy personnel as they go alongside (ie arrive ashore) from time to time as another example of transitions for Defence personnel; with frequently changing access and context of alcohol availability, expectations and use. It is perhaps not surprising that the Navy was the first of the single Services to develop specific policy and programs regarding alcohol; albeit in response to alcohol as a contributing risk factor to high profile incidents. The Panel recognises that this is usually the provocation for any organisation to take alcohol seriously and to address its place in the day-to-day operations, culture and requirements for capability. The Panel noted the development of the Navy Harm Reduction Matrix for such situations.

Good news example

Navy Alcohol Harm Reduction Matrix

The purpose of the harm reduction matrix is to address the risk associated with alcohol use in specific locations. It uses a five-step approach that includes:

- Step 1 — Determine the context relating to the consumption of alcohol;
- Step 2 — Assess the consequences of alcohol-related unacceptable behaviour;
- Step 3 — Assess the likelihood of alcohol-related unacceptable behaviour;
- Step 4 — Determine level of risk using Hazard Risk Index calculator; and
- Step 5 — Implement controls according to level of risk.

The strength of this hazard risk index is that it encourages the Commanding Officers to assess every situation that includes alcohol in an objective and standardised way. The Commanding Officers can then implement appropriate controls based on the level of risk.

Comment from senior RAN personnel:

“The alcohol restrictions placed on our people while at sea tend to exacerbate the binge drinking culture when they go alongside and the restrictions are temporarily removed”.

Appendix 5:

Involvement with health and support services

Overview

This spotlight was chosen to explore the way in which the ADF manages the health aspects of alcohol problems including the care and treatment provided to those adversely affected by their alcohol use.

It considers the following:

- Health information
- Health Services
 - Policies and standards
 - Programmes and pathways to care
 - Linkage with families and other services in the community
- Innovation, integration and advice

Personnel may attend for reasons unrelated to alcohol consumption or because of their alcohol consumption and/or issues related to this consumption. Evidence consistently indicates this is an opportune time to intervene with staff to reduce risks associated with alcohol use, where this is identified — personnel are more likely to be receptive to health messages at this time from credible sources — that is, health staff.

The involvement of ADF personnel with these services is seen by the Panel as an important opportunity not only for assisting and supporting people experiencing alcohol related problems, but also as an opportunity for preventive interventions that may include identifying early signs of a problem and provide a timely response to reduce the risk of problems developing further.

This health and support service context is also an important setting for appropriate recording and storing of information about individuals (de-identified where appropriate), their alcohol consumption, and their health and support needs and issues. This enables monitoring the overall extent of problematic alcohol consumption and related harm in the ADF, which in turn can be used to inform service planning and evaluation and the development of preventative policies and programs.

Alcohol has a range of potential impacts on the health and wellbeing of individuals who drink — in the short term and long term, and also on those affected by others' drinking, including co-workers, family members and friends. Thus health and support services need to be available to all of those affected by alcohol. It is also important to recognise that there are varying degrees of harmful consumption of alcohol ranging from one-off occasions of risky drinking through to regular heavy drinking by alcohol dependent individuals. Accordingly, there is a need to provide a varied range of responses depending on the drinker, their patterns of consumption, and the context.

Health information

Within the Australian Defence Force, three primary sources of health data have the potential to provide an understanding of the extent and nature of alcohol consumption and related harms among Defence personnel. First, as assessment and recording in the medical or related record of a patient's alcohol consumption status and related treatment is a recommended

component of health care, analysis of such records represents one potential source of such information. Second, given that the health and fitness of Defence personnel is central to Defence Force capability, regular assessment of the health and fitness of Defence personnel, including assessment of alcohol-related harms, provides a further potential source of such information. Third, Australian Defence Force has recently undertaken a health survey of Defence personnel that has assessed the alcohol consumption and related harms status of Defence personnel.

- **Literature review**

- a) *Medical record data*

A limited number of studies report the prevalence of alcohol-related harms experienced by military personnel based upon analysis of medical record data. In one study by Howland et al (2007), the relationship between alcohol use and the cause, type and severity of hospitalised Army soldiers in the U.S between 1980 and 2002 was assessed. Of the 211,790 hospitalisations, 4% had a secondary alcohol diagnosis with 72% indicating acute intoxication. Alcohol co-morbidity was positively associated with injuries from violence and falls; and with cases of head injury, open wounds and poisoning.

Robinson (2004) reported that The Office of the U.S. Air Force Surgeon General found that in the U.S. Department of Defence, alcohol contributed to 50% of alleged sexual assaults, 29% of completed suicides and 25% of motor vehicle crash fatalities. Tien (2010) conducted a retrospective review of Canadian Force death records (autopsy reports, death certificates, coroner reports, hospital records and military reports). It found that alcohol potentially caused 186 (11%) deaths in the period 1983-2007, including 32% of drowning deaths, 20% of motor vehicle crashes and 24% of suicides.

A study by Gahm et al (2007) analysed data from the routine screening of personnel seeking assistance from an outpatient Behavioural Health Clinic on a large U.S. Military Base. Twenty-three per cent of patients scored 8 or more on the AUDIT, with such scores being more prevalent among male patients. More than 60% presented with multiple mental disorders (including depression, anxiety, PTSD, panic and alcohol use), with PTSD, depression and alcohol use being the most prevalent.

- b) *Health status screening/assessment*

Screening of alcohol consumption and related harms among Defence Force personnel is most commonly reported as a component of mental health screening, with the majority of reported studies relating to routine post-operational mental health screening. The U.S. Military conduct a Post-Deployment Health Assessment (PDHA) upon return and a Post-Deployment Health Re-Assessment (PDHRA) approximately 6 months post-deployment, with alcohol use being measured in the PDHRA only. This self-administered assessment includes the TICS screen for alcohol misuse (Two-Item Conjoint Screen). A study by Milliken (2007) reported the mental health outcomes of 88,235 U.S. soldiers who completed both the PDHA and PDHRA. Almost 12% of 'active' soldiers and 15% of 'National Guard and reservists' reported alcohol misuse via the PDHRA, with only 0.4 subsequently being referred for specialty care.

Santiago et al (2010), in studying 6527 U.S. Army soldiers returning from Iraq reported that 27% screened positive for alcohol misuse using the TICS. Those who screened positive were more likely to have recently engaged in: drink driving (OR 4.99); riding with a driver who had been drinking (OR 5.87); reported being late or missing work because of a hangover (OR 9.24), using illicit drugs (OR 4.97); and being convicted of driving under the influence (OR 4.84)(Santiago et al, 2010). Santiago et al also reported that 27% of the soldiers reported hazardous/harmful consumption (AUDIT ≥ 8).

A study by Maguen (2010) assessed the mental health impact of reported exposure to direct and indirect killing amongst 2,797 U.S. Operation Iraqi Freedom soldiers during routine post-deployment mental health screening. Based on the AUDIT, 25% reported hazardous or harmful consumption (AUDIT ≥ 8). In contrast, Duma (2010) reported that only 8% of post-deployed soldiers (Iraq and Afghanistan) reported hazardous or harmful alcohol consumption (AUDIT ≥ 8).

A study of UK armed forces found that approximately 17% of men that consumed at high risk/harmful levels (AUDIT ≥ 16) had been deployed. It also reported that 48% of men and 32% of women who reported binge drinking (6 or more drinks on one occasion on at least a weekly basis) had been deployed (Fear 2007).

c) Health survey data

Health surveys are a common method of collecting information regarding the health of populations. The Canadian Force conducted the Health and Lifestyle Information Survey (HLIS) in 2008/9 using a stratified random sample of Defence personnel. The survey was mailed to Defence personnel (52.8% consent rate). Forty-eight per cent reported consuming more than the recommended daily maximum of 2 drinks; 20% were consuming at hazardous/harmful levels (AUDIT ≥ 8). In addition, 24.6% reported binge drinking monthly or more often (more than 6 drinks on one occasion) (Canadian Forces, 2010).

Fear et al (2007) conducted a random cross-sectional postal survey of UK Armed Forces personnel in 2003 (8686 personnel). Sixty-seven per cent of men and 49% of women reported consuming alcohol at hazardous/harmful levels (AUDIT ≥ 8), compared to 38% of men and 16% of women in the general population.

A web-based survey of 56137 active duty Air Force personnel worldwide found that 9% of personnel reported consuming alcohol at hazardous/harmful levels (AUDIT ≥ 8) (Spera 2011).

A study of Australian Royal Navy veterans of the 1991 Gulf War (1232 personnel) reported that 25.7% consumed alcohol at hazardous/harmful levels (AUDIT ≥ 10 revised cut-point for this study)(McKenzie et al 2006).

Review of ADF health data regarding alcohol consumption and harm

To assess the capacity of existing ADF health care data to provide an insight into the prevalence of alcohol misuse and/or harm among Defence personnel, seven datasets were reviewed:

- *Medical record data*
 - Primary care presentations
 - Inpatient hospital admissions

- *Health status screening/assessment data*
 - Comprehensive Preventive Health Examination (PHE)
 - Annual Health Assessment (AHA)
 - Post-Operational Psychological Screen (POPS)
- *Health survey data*
 - Health and Wellbeing Survey (MillHOP)
 - Composite International Diagnostic Interviews (Health and Wellbeing Survey - MillHOP)

Each data set was reviewed against the following criteria:

1. Includes a valid and reliable measure of alcohol consumption and/or alcohol-related harm.
2. Routinely and systematically collected and recorded.
3. Representative of the ADF population.
4. Has the ability to identify sub-populations at risk.
5. Can be linked to other datasets.
6. Adequate retrospective data to identify trends over time.

The following section describes the results of the review of data availability and utility for assessing the prevalence of alcohol misuse and/or harm among Defence personnel.

1. Medical record data

a. Primary care presentations

Within the ADF there are approximately 50 barracks/bases, most of which have primary care health facilities.

As the majority of the general community alcohol-related presentations for medical treatment generally involve management of trauma, and occur at particular times (evenings), the majority of ADF member presentations might be expected to occur at a local non-ADF health facilities as ADF health care facilities are not resourced to provide emergency care at such times. These events are therefore not likely to be captured by the ADF health record system.

It is mandatory for a record to be generated for every presentation to an ADF Health Facility. Information from such records was requested regarding alcohol-related primary care presentation information recorded in either HealthKEYS or the Medical Information Management Index (MIMI). The recording of a patient diagnosis is however not mandated, thereby precluding an analysis of diagnoses known to be fully or partially related to alcohol. Whilst the medical record includes personal and service characteristics, alcohol consumption or harm information is not routinely recorded. As a consequence, primary care medical record data were not sought for analysis.

b. In-patient admissions

Only a small number of the ADF health facilities provide in-patient admission services. The majority of personnel are referred to a non-ADF public or private hospital for in-patient care.

Information was requested regarding alcohol-related in-patient admission information recorded in either HealthKEYS or MIMI: number of admissions for known alcohol-related diagnoses, acute alcohol effects (eg alcohol poisoning), and night-time admissions for assault and injury/poisoning for the period 2007 to 2010 as well as demographic data.

As the number of in-patient admissions to ADF health facilities was found to be small and the diagnosis code not routinely recorded, hospital admission medical record data were not sought for analysis.

2. *Health status screening/assessment data*

a. *Comprehensive Preventive Health Examination (CPHE)*

It is mandatory for all ADF personnel to complete a CPHE every five years.

The CPHE examination is completed by a health professional. The examination obtains information regarding the health facility, name, rank, age, gender, current illness/ injuries, family history of disease, smoking status, alcohol consumption, deployment history, medications, allergies and stress; as well as clinical tests (eg blood tests, vaccinations and hearing tests). The CPHE includes the AUDIT tool to measure possible alcohol-related problems.

Information was requested regarding alcohol AUDIT information obtained from the CPHE and recorded in HealthKEYS.

Only 17% of completed CPHE's were reported to be entered into either HealthKEYS or MIMI, with such data being available from 2007 to present. The remaining CPHE's are stored in hard copy form only. Given time constraints and the lack of representativeness of the electronically stored data, such data were not requested for analysis.

b. *Periodic Health Examination (introduced from 31 July, 2011)*

The overall aims of the ADF PHE program are to:

- A. *Identify risk factors arising from an individual's lifestyle, health history and occupational exposures.*
 - B. *Act in accordance with legislated OH&S requirements for occupational health screening.*
 - C. *Maintain the ADF's duty of care by measuring and reporting individual members' fitness for employment and deployment.*
-
1. **Routine screening intervals.** The routine PHE screening interval in otherwise healthy members is five years for Navy and Air Force and three years for Army. This will vary according to the following:
 - A. ***Service and service-type.*** *The member's service and service-type are one component for determining screening intervals.*
 - B. ***Age.*** *In otherwise healthy members, the PHE is to be conducted biennially from age 40 and annually from age 50 (table 1).*

- C. ***Specific occupational requirements.*** Identification of workplace hazards during the PHE may trigger the requirement to complete further screening activities and may alter the screening interval. and/or,
- d. ***Scheduled MEC review.*** The PHE interval may be reduced at the discretion of the CCAHP to allow follow up of MEC/SPEC. The interval **may not** be extended beyond the standard age-specific screening period.

The PHE replaces the AHA which did not include the AUDIT or any other valid measure of alcohol-related harm. However it is understood that the PHE will include the use of the AUDIT as a tool applied during the assessment.

c. *Post-Operational Psychological Screen (POPS)*

It is mandatory that all personnel complete a POPS in the 3 to 6 months following return to Australia from deployment. The screen consists of basic demographic information including age, service, rank and deployment information; the AUDIT; the K10 (depression) and the PCL-C (Post-Traumatic Stress Disorder). Whilst the survey is self-administered, it is reviewed during an interview with a mental health professional. The survey and interview allows for the clinical diagnosis of alcohol-related problems. As such the POPS data provide comprehensive information on alcohol consumption amongst post-deployed personnel.

As approximately 7,000 of 50,000 personnel are deployed each year (13%), the POPS data are not representative of all ADF personnel. Nonetheless, POPS data were requested for the 2007 to 2010 period regarding AUDIT and demographic data.

3. *Health survey data*

The Mental Health Prevalence and Wellbeing Study (MHPWS) was a survey conducted by the Mental Health Outcomes Program (MillHOP) that aimed to:

- Establish baseline prevalence rates of mental health disorder in order to target mental health services and identify high risk groups;
- Determine the ADF-specific clinical scores on the mental health screening instruments to ensure the maximum number of personnel are identified for early intervention; and
- Identify cultural and organisational factors in the ADF that have detrimental effects on mental health and reduce care-seeking behaviours.

The data was collected in two formats:

a. *Mental Health Prevalence and Wellbeing Survey (MHPWS)*¹³

All regular ADF staff (not part-time or reservists) were invited to participate in an on-line survey conducted by an independent organisation (Centre for Military and Veteran's Health — CMVH, University of Adelaide). The survey focused on personal and service characteristics, health status, lifestyle behaviours (including alcohol), past experiences (eg combat, PTSD, suicide ideation), social support networks, and recent health problems.

¹³ MHPWS: since the Panel's report was completed prior to the finalisation of the report of this study, all calculations using this data should be regarded as preliminary only and subject to possible changes.

b. Composite International Diagnostic Interview (CIDI)

The CIDI is a structured interview designed to assess mental disorder according to the definitions and criteria of ICD-10 and DSM-IV including ICD10 Alcohol Disorders. A sample of 1798 personnel who completed the MHPWS was invited to participate in the interview.

Summary data from the survey and interview were obtained for inclusion in this report.

• Prevalence of alcohol consumption and harm

1. *Post-Operational Psychological Screen (POPS)*

POPS were completed on over 18,000 post-deployment personnel in the years 2007 to 2010

- *Hazardous or harmful consumption (AUDIT ≥ 8)*
 - 18.1% of personnel were found to be consuming alcohol at risky or high-risk levels
- *Alcohol Consumption Score (Total score of questions 1 to 3 ≥ 6)*
 - 31.3% were consuming alcohol at risky levels
- *Dependency Score (Total score of questions 4 to 6 ≥ 4 -12)*
 - 0.8% were possibly dependent
- *Alcohol-Related Problems Score (Total score of questions 7 to 10 ≥ 1 -16)*
 - 22.5% were at-risk of alcohol-related problems

The main characteristics associated with hazardous or harmful consumption (AUDIT ≥ 8) were being:

- male (19.2% compared to 7.8% for females);
- aged less than 25 years (26.9% compared to 18.1% for the 25-34 year age group);
- a member of the Australian Regular Army (23.6% compared to 7.4% for the Air Force);
- deployed on Operation Herrick (23.6%) or Operation Astute (23.2%)(compared to 13.6% for Operation Anode);
- deployed for a period of greater than 8 months (34% compared to 14% for those that were deployed for less than 4 months);
- a member suffering from very high levels of distress (44.4% compared to 14.8% for low levels); and suffering from high levels of PTSD (51.4% compared to 16.3% for low levels).

Research by Saunders and Lee (2000) reported that, in developed countries, the proportion of the population reporting hazardous or harmful consumption (AUDIT ≥ 8) was 20%, dependency is typically under 5%; hazardous or harmful drinking is 5 to 15%; and low-risk drinking is 50 to 75%.

2. *The Mental Health Prevalence and Wellbeing Survey (MHPWS)*

In total, 24 481 (or 48.9%) ADF personnel participated in the Mental Health Prevalence and Wellbeing Survey (MHPWS), with 1,798 participating in the CIDI. Preliminary results of the survey found that:

- 40% of personnel consumed alcohol at least twice per week, with 11% consuming four or more times a week.

- Men consumed more often (11.6% four or more times per week) compared to women (7.8%).
- Army personnel were more likely to consume alcohol four or more times per week compared to the other services. Almost 17% of commissioned officers (eg Commanders, Lieutenant Colonels, Majors) consumed alcohol at this frequency, compared to 10.7% of non-commissioned officers (Petty Officers, Sergeants).
- Almost one third (29.2%) consumed over 5 standard drinks on a typical day, with Army personnel consuming greater amounts (14.6% consumed 7 or more on a typical day; 10.7% for the Navy and 7% for the Air Force (MHPWS 2011).

In terms of the AUDIT scores:

- 26.4% (13,201) reported consuming alcohol at hazardous/harmful levels (AUDIT ≥ 8).
 - 22.7% scored between 8 and 15 points (22.7% of total).
 - 3.7% scored in the high-risk category indicating an increasing likelihood of a need for treatment (and these are also most likely to have a diagnosable alcohol disorder).
 - Men were more likely to consume at these levels than women (28.1% compared to 15.1%).
 - Air Force personnel were more likely to score lower on the AUDIT than Army or Navy personnel (MHPWS 2011).

The prevalence of CIDI diagnosed alcohol disorders in the last twelve months (harmful use and alcohol disorder) was 5.2% compared to 8.3% for those who were employed in the community. There were no differences in prevalence of alcohol disorders by rank or deployment history. However, women were less likely to have any alcohol disorder compared to males. Navy personnel were more than three times more likely to have any alcohol disorder than Air Force personnel and Army personnel were more than twice as likely as Air Force personnel to have an alcohol disorder (Alexander 2011)

The difference in percentages between those 26.4% screened as drinking at risky levels and the 5.2% with diagnosed alcohol disorders is readily explained. These relate to two different measures and they are measuring two different things. The first (using AUDIT) is a screening tool designed to identify whether an individual is at risk of having an alcohol-related problem. The Second, arising from the CIDI (using ICD-10 criteria) relates to a tool designed to identify the existence of a clinically defined/diagnosable condition in an individual.

The differences can in part be understood in terms of the different stages of development of alcohol related problems. The AUDIT **screening** instrument detects early signs of possible alcohol problems that warrant further assessment (once the score is ≥ 8) and where early intervention can be successful in curbing ongoing risky alcohol use. The CIDI, on the other hand, is a **diagnostic tool** used to identify someone with later stages of alcohol problems such that they have a significant alcohol disorder (usually alcohol dependence). The criteria for diagnosis of a disorder are more strict and less likely to be present until a significant time of sustained high risk or heavy drinking has occurred (usually over some years). One would therefore expect that the prevalence of **disorders** would be lower than those identified as 'at risk' due to their drinking at hazardous or harmful levels.

Further, there are differences between potential harm in the short term and long term. Short term harm arises from accidents and injuries in association with an episode of heavy drinking, often involving intoxication. The risk of harmful longer-term consequences, include the multiple impacts on health associated with long periods of harmful or dependent drinking, usually over some years where there is an extensive impact on various systems of the body along with significant impacts on other aspects of a person life including relationships.

It is important that the ADF appreciate these differences and not be lulled in to thinking that the lower prevalence of diagnosable alcohol dependence than in the general community means that there are fewer problems or less need for action. The context of the ADF provides some 'protection' against the establishment and expression of alcohol disorders while people remain in Defence.

There might be reasons for the lower rate of disorders that are not about member's greater resilience to these but about the circumstances of ADF life. The intermittent periods of abstinence from alcohol required in certain situations and at specific times, such as on deployment, would provide some 'protection' against the development of alcohol dependence where sustained use is usual. In addition, the average length of time for a career in the military in Australia, currently approximately eight years, means that it is possible that many in this category leave the ADF and are thereby removed from ADF surveys and analysis. Since it generally takes some years for an alcohol disorder to manifest it is likely that they then contribute to the significant burden of disease in the broader community and require other services including family and other Defence-linked services and the Department of Veterans Affairs.

There are thus good reasons for developing screening for earlier identification of those at risk of alcohol harm including disorders since earlier interventions can be successful and are usually less intensive and less costly. The negative impact on children and families is likely to be significantly reduced by earlier responses and early interventions can interrupt what would otherwise be a high likelihood of leaving the ADF.

- **Summary – Health information**

Analysis of alcohol consumption and harm status as recorded in the medical records of Defence personnel, for both routine presentations and structured health assessments was unable to be undertaken due to: the recording of relevant information not occurring on a sufficiently consistent basis; the limited accessibility of such data due to its not being systematically stored in electronic form; and the limited staff capacity to extract such information.

Comparison of the prevalence of alcohol-related harm as obtained from the POPS and MHPWS datasets with estimates from the literature is constrained by differences in the sample characteristics of the various studies. ADF and previous studies suggest that a number of factors including age, gender and service type are predictors of alcohol risk. Further analysis of the POPS and MHPWS datasets adjusting for such factors is required.

Methodological differences between studies limit the ability to make direct comparisons between ADF data and that from other studies. However, data obtained from this review suggest that 26.4% of ADF members report consuming alcohol at **hazardous or harmful** levels. The prevalence of at-risk alcohol consumption among ADF personnel is similar to or lower than Defence personnel in other countries.

Whilst the POPS dataset provides valuable information regarding the alcohol consumption and harm status of post-deployed ADF personnel, there are a number of limitations regarding interpretation of such data including:

- Double counting of individual personnel due to multiple deployments
- Possible respondent fatigue/habituation/response bias due to multiple surveying
- Disincentive to report alcohol problems due to perceived risk to career progress, future deployments, etc.

The data obtained from the Mental Health Prevalence and Wellbeing Study provides comprehensive data regarding alcohol consumption and harm. Limitations of such data that need to be considered in its interpretation including that the data is based on self-report, and hence subjected to recall-related biases.

5.5.2 Health Services

The Panel recognises that Joint Health Command is still developing after the integration of the former Single service specific health services. The Panel noted the attention being paid to the evolution of structures, lines of accountability and programmes and capacity of personnel in this arena. This offers an exciting opportunity to align alcohol specific responsiveness to these overall changes. Appropriately, considerable effort is going in to development of capacity in the mental health domain. Alcohol responsiveness remains patchy; with some services such as the residential rehabilitation services (AREP) only moving under this command at 31st July 2011.

Policies

In general, there appears to be intent to be responsive and comprehensive across the range of alcohol issues within the ADF. However, it is not clear to the Panel if there are consolidated policies which bring all of the above together. Indeed, the Panel heard conflicting perspectives on this situation with some ADF personnel advising that the complexity is necessary and even desirable while others cautioned that it potentially poses risk for the ADF. A number of people at all levels frequently informally asked us not to suggest “any more policy” suggesting that the sheer quantity/number is already overwhelming and possibly dysfunctional.

For policy users, the number and spread of policies could be difficult to be aware of and utilise. Also, it is not clear how policies are formally developed, communicated, implemented, reviewed, and updated, across the ADF. In addition, the multiplier effect of tri-Service and single Service policies contributes to the volume and complexity of policy in the ADF. For the Panel’s purposes, it has been appropriate to select a limited number of key alcohol policies and assess these, rather than attempt to map and review all policies relating to alcohol throughout the ADF.

The Panel is aware that the overarching policy on the management of alcohol in the Australian Defence Force [DI(G) PERS 15–1] has recently been reviewed and updated through extensive internal consultations. However, this updated version has not yet been formally endorsed and until then the substantive policy is that which was introduced in 1980 and is well out of date in its focus and framing; connection to current evidence based practice and in terms of the context of alcohol use in the ADF today.

While the Panel hoped to endorse this carefully developed policy platform, there are two reasons for pausing. The commendable initiative of the ADFAMS programme that is systematically working toward an all of Defence alcohol management strategy and specific advice for each of the three services is due to report toward the end of this calendar year. This is a critical parallel element in clarifying the needs and directions for implementation of any policy and given the central importance of this overarching document, it would be somewhat foolish to insist on its adoption mid stream. Secondly, the Panel found that it still lacked the focus that this Panel is recommending overall. So, while it is a substantial and greatly enhanced policy in comparison with the one that it would replace, there remain some issues that require further attention. The significant concern with the revised policy is that it is based on the premise that education is the most effective approach to preventing and reducing hazardous drinking and alcohol related harm; a view which is not supported by scientific evidence.

Health policies and practices: Accreditation and standards of health care

Over the next (say) 5 years, the Panels advice is to review and align health services to current, evidence based practices and procedures, consistent with Australian community standards. This should be reflected in clinical/practice guidelines specific to the ADF; requirements in contracts for service providers to ensure appropriate, updated education and training in relation to alcohol and other drug practices (through requirements for specific CPD/CPE units) and the accreditation of health specific services. (Noting also ANAO Audit report recommendation No. 3 Para 3.63 (d), 2010).

Programmes

The Alcohol, Tobacco and other Drugs (AToD) program was launched in 2002, as an initiative of the ADF Mental Health Strategy. This is an important and valuable development. AToD Program oversees education and treatment across Defence to ensure interventions are evidence based and capacity building. The program comprises:

- Education: AToD education sessions; Alcohol and Other Drug Annual Awareness Course (40 minutes); Keep Your Mates Safe (KYMS) — Alcohol.
- Treatment: Brief interventions are conducted by health providers and professionals; Outpatient Alcohol Treatment Program (OATP); Alcohol Rehabilitation Education Program (AREP); Regional AToD Coordinators

As part of the Mental Health reform process, eight Regional AToD Coordinators are to be appointed, with some having commenced from 2010. This will increase capacity and delivery of education and treatment programs across Defence.

There have been numerous reviews. Some of these reviews produced changes in programmes; for others this does not appear to have been the case. Perhaps the most striking has been the number of reviews of the residential rehabilitation programme, AREP. Despite numerous reviews it appears to be a somewhat pocket of intense activity with limited connection to the overall approach and developments of the health response. In some respects it is like an ‘orphan’ of the changes that have taken place over the past decade; yet continues to have a number of very committed staff working to support those who are referred or, in some cases ‘sent’ for treatment. The Panel understands that although it has been available to all three services for some time, its organisational accountability has previously been with the Air Force. It is in the process of moving under the control of Joint Health command.

The Chair of the Panel visited this facility and was welcomed by staff who explained the approach, training available for staff and escorted her on a tour of the building. There is no doubt that it serves some small number of service members well and a 'graduating essay' forwarded to the Panel attests to this. However, there is an urgent need to bring this facility in to the development of a spectrum of alcohol services in the ADF, under Joint Health Command.

There may be a place for a residential service but in its current form, the AREP is too isolated to be properly used and developed as one among many responses to ADF members with alcohol specific problems. Like other services it would benefit from opportunities to ensure that it is abreast with community treatment options and the people who provide these services are properly supported through advanced education and training as well as the current emphasis on direct supervision. An intense residential service also requires overnight supervision by appropriate staff. The Panel did not conduct a review of this service; rather the visit helped to inform the findings more broadly regarding health responses to people with alcohol problems.

Pathways to care

One of the complexities for any ADF member with alcohol concerns is how to access help without jeopardising their future career prospects in the Service. In discussion with members this hesitation was often raised and it is likely that it acts as an impediment to the use of early interventions that have been found to be effective in many cases; preventing early signs of alcohol trouble becoming more serious or eventuating in alcohol dependence.

While ADF members can go to community based services including local general medical practitioners (GP's) or specialist medical services, it is noted that ADF members expect and are expected to have their health cared for by the ADF so they do not pay the Medicare levy that other Australian citizens are obliged to pay and thus must pay full fees if they go to a community based GP who is not a part of the contracted ADF health service. (Some might carry private health or other related insurance).

Overall, the Panel became aware of a myriad of services, associations and organisations working to care for ADF personnel. It was not possible, however, in the time available to untangle who can and who does go to what services for alcohol specific concerns. There are complex eligibility rules between internal services under JHC, the Department of Veterans Affairs, the Veterans and Veterans Families Counselling Service (VVCS) and the Defence Community Organisation and there are implications for integration of care, building an individual's profile that might allow identification of problems and earlier interventions and for dissipation and duplication of effort that is both costly and likely to be less effective.

In addition to the need to clarify ways that ADF members might best access services, there are opportunities to develop innovative approaches to the provision of information, advice, self-assessments and appropriate directed interventions now available as web based options that warrant consideration. One option would be to develop and provide an anonymous on-line screening tool and diversion to a brief intervention depending on scores (eg and educational update for personnel with no or low risk scores; brief intervention for low to moderate risk/dependence scores; brief intervention and recommendation to more intensive treatment options for more severe risk and dependence). The changes that are occurring in pathways to mental health care currently might provide lessons of value to alcohol specific servicing in the longer term.

In summary, there is a need for a stock take against a model of the range of services that might be included in a comprehensive, contemporary set of alcohol (and other drug) services. This plan can include health promotion, prevention, early and brief interventions and more intensive treatment interventions for those requiring it (from residential and out-patient detoxification, counseling using cognitive behavioral and other evidence based approaches, pharmacotherapies; rehabilitation programmes — both residential and community based and linkage to a range of community programmes including self help groups. In developing an appropriate programme profile the ADF will assess which of these services should be provided from within and which will be sourced from the community service sector. The timing of such an exercise in the ADF could fit well with current project of the Department of Health and Ageing and the outcomes of this project could be used as a guide for such planning for the ADF.

Linkage with families and other services in the community

Alcohol work requires strong connections. Families in particular can be an important resource for enhancing resilience of members and in setting standards, provision of support and solace and also in direct roles in treatment of alcohol related problems. They can also contribute to difficulties that increase the risks of problems associated with the use of alcohol. In this sense families can be both contributors to alcohol problems but they can also provoke help seeking of a member and facilitate engagement through provision of support in treatment; if they are engaged and included.

A recent report on families of ADF personnel reported that among the negative perceptions of Defence's support for families, relating to leadership at senior Defence and regional levels were: Condoning of excessive drinking in many units; Compulsory social events after normal work hours, especially when cheap alcohol is supplied (p. 54). The report also highlighted the harmful consumption of alcohol by family members of ADF personnel, particularly by spouses or partners when left alone during periods of their spouse's/partner's deployment. For example, respondents were asked to report the strategies that they had employed to help them cope when their spouse or partner was away on deployment. Among the strategies reported by the respondents likely to have been maladaptive during the absence of their spouse or partner in the short and/or long term, was 'excessive (binge drinking) while out with friends, drinking alcohol to aid sleep and reduce stress, smoking cigarettes, and taking sedatives to aid sleep' (Atkins 2009: 78). Those on deployment also reported some maladaptive behaviours because of their absence from family: some respondents reported that smoking, and binge drinking were used to cope with absence from their children (Atkins 2009: 82).

It will be important to establish the impediments and facilitators to the inclusion of partners/families in these interventions given the interactive impact of alcohol use on these folk. The Panel recognises the complexity of this involvement with the different Departments and services that ADF members and their families have access to, the potential impediment to an ADF member approaching internal responses with (at least — perceived and in fact probably realistic) implications for their service career including their opportunities for deployment if they are known to be in difficulty with alcohol.

Others need to be involved including families and sometimes there will be occasions when other 'carers' are already or potentially involved. This includes Chaplains in the ADF who appear to service a vital role in absorbing distress, supporting and responding to members who talk to and sometimes confide in them. They are in a unique place in the ADF. They do not and are not expected to keep records. They are usually embedded in operational units and

so readily available to both members and CO's. They are seen as 'one of us' by members and recognised as someone you can go to where matters can be shared in confidence. They are a part of the team who respond to alcohol related concerns.

Unfortunately many of the structures of health care provision in the ADF *appear to* act against the inclusion of families in alcohol related interventions. Having enquired about this, it was not possible for the Panel to independently assess how real these structural, financial and possibly geographic barriers often mentioned as though they were fact/policy were as impenetrable as they seem or whether this is generally an historic, attitudinal matter where practice has become entrenched to the point where it is believed to be policy. The Panel does however draw attention to the increasing need for alcohol responsive health services to identify the opportunities for family members to be included in the unit of attention to achieve effective outcomes.

The Panel draws attention to the complexity and possible overlap or lack of appropriate and necessary connection to family members in particular and to broader community based services providing for members and their families. The Panel did not have sufficient opportunity nor was it seen as central to the terms of reference to examine in detail the connections between services provided by ADF Health, the Defence Community Organisation (DCO) and the Department of Veterans Affairs. It is aware that there is a long history of evolution of these services and the complex interrelatedness of them. The division of their responsibilities is complex. The Panel is not in a position to make any firm recommendation in this area but notes the statement of a senior health director: "We create the injured veterans and then pass them on to another lot to take care of them"

5.5.2 Innovation, integration and advice¹⁴

While the focus of attention regarding alcohol has involved many leaders and others across the ADF, over the past decade (at least) most of the responsibility and development of programmes or activity appears to have been referred to health; certainly at CO's level where individuals identified with alcohol problems (either through illness and health concerns or through disciplinary needs) have been referred to health for attention. This is sound where there is a strategic and coordinated purpose and where all involved understand this.

It is often necessary to provide a health response; especially where health personnel properly fulfil their role in health promotion and in the prevention of alcohol problems as well as treatment. For these referrals to have maximum value, common understanding of purpose and expected outcomes with appropriate coordination and follow up is necessary. In this context there is a need for broader responsibility and clarity about avenues of address in response to alcohol concern. It is not sensible to have doctors providing one off leave certificates for people where alcohol might have been a stimulant in an incident. This could make sense if the doctor uses their role and authority to engage in appropriate assessment and a brief intervention but where alcohol has not been identified by the member or the CO seeking a certificate, this can be a waste of resources and even worse, a deflection from the need to provide an administrative or disciplinary response. These routes of responses require greater clarity such that expectations of all in the system are more consistent. Thus rather is a need to link policies and practices in the macro ADF environment such as those to do with the supply and availability of alcohol, and also in the micro individual member management area.

¹⁴ This section combines material found in the main body of the report in Section 4.4.5 and Section 5.5.3

Health professionals within ADF may well take a leadership role given that they have been recently developing an enhanced capacity with breadth and depth of qualifications across the spread of requirements relating to individuals with alcohol and other drug problems.

The Panel is aware of a number of other initiatives that show promise and that use current evidence base understandings of effective interventions, in particular the appointment of the regional ATOD coordinators. The development and emergence of a range of programs such as the four day OATP and motivational interviewing training are appropriate and useful elements of any comprehensive menu of options to address the individual therapeutic needs of people already experience significant alcohol related problems. There are significant facilities and a strong, committed ethos of care among many health service providers the Panel met with. In addition, health personnel are appropriately contributing to a broad population health systems approach within the ADF. Further development of this is required and involvement of other domains is suggested including safety, OHS, regulatory, garrison support / catering in order to address the three main pillars akin to the national drug strategy (demand, supply, and harm reduction).

Currently the ADF is largely depending on the knowledge, skills and capacity of those already involved in the Joint Health Command for advice and development in these areas. The Panel has been impressed with the interest, knowledge and experience that is available but notes that higher level planning, strategic population planning, surveillance and expert addiction specialist advice is apparently not readily available. There will always be a need to bring diverse disciplines and knowledge together in tackling alcohol in a large and complex organisation like the ADF. The alcohol domain requires more than health and more than any specific single discipline. The knowledge in this field is also constantly changing and where therapeutic developments, for example, occur that can significantly change current best-practice.

One example is the development of rapid assessment approaches that might have particular resonance for the ADF. Rapid assessment methods are increasingly used to assist identification of risk and subsequent decision-making on appropriate interventions. The approach uses multiple indicators and data sources, especially existing data sources, and often combines qualitative and quantitative methods. Rapid assessment is intended to be cost effective and practically orientated (Stimpson et al. 1997, for early articulation)

Given the suggested shift in thinking that is away from health being predominantly responsible for alcohol issues, towards health being one important contributor in taking particular responsibility for individual members with regard to their alcohol use and possible needs for interventions the Panel believes there is a need to create structures and processes that allow ready access to broad expertise and experience. The Panel's advice is to create a body that can deal with a broader range of alcohol issues. Its advice is to establish a 'centre with or without walls' and suggest it focus on how alcohol impacts on capability; thus the development of a (virtual) Centre for Alcohol and Capability.

Such a Centre could include capacity for a range of responses necessary for any large sub-population and in an organisation with the complexity of the ADF. For example this could include capacity for secondary consultation at every level from policy development and advice re alcohol, situational alcohol risk assessment, advice to CO's re responding to alcohol related matters from planning events where alcohol is involved to management of incidents

and liaison with external stakeholders. It could be a repository of information and advice on clinical diagnoses, treatment and possible referral including use of external as well as internal treatment responses services. It could include an intranet web based presence that houses self-screening and assessments with a capacity for grouped, anonymous data analysis for strategic understanding including early warning signals in addition to the individual respondent specific, planning and evaluation of impact of policies and programmes or situations and changes in external environment. The 'go to' place within the ADF regarding alcohol.

The Centre could provide leadership for the implementing of the upcoming ADF alcohol management strategy as well as housing a strategic surveillance unit for monitoring and evaluation of change; providing early warning on any shifts in the indicators of possible alcohol related data as well as feedback on implementation of policies and programmes (refer to Figure 2 below as an example of some of the elements that could be included in such a Centre). It could support the development of capacity for population wide analysis and utilisation of these data for planning purposes at various levels and contribute to other strategic planning such as the current development of strategic transitional plans after deployment and before reaching home.

While it would be important for such a center to have links with mental health developments in the ADF, it is equally important that it not be seen as a sub-set of the mental health initiatives or a sub-center of the Centre for Defense Mental Health. Given the emphasis in this review on the need for a whole of organisation ownership of alcohol planning, policy and responses and the crucial including of the supply related elements in any comprehensive alcohol policy, the Panel is concerned that if it were to be subsumed under a mental health umbrella it would lose the most potent levers needed for an integrated strategic approach to alcohol in the ADF.

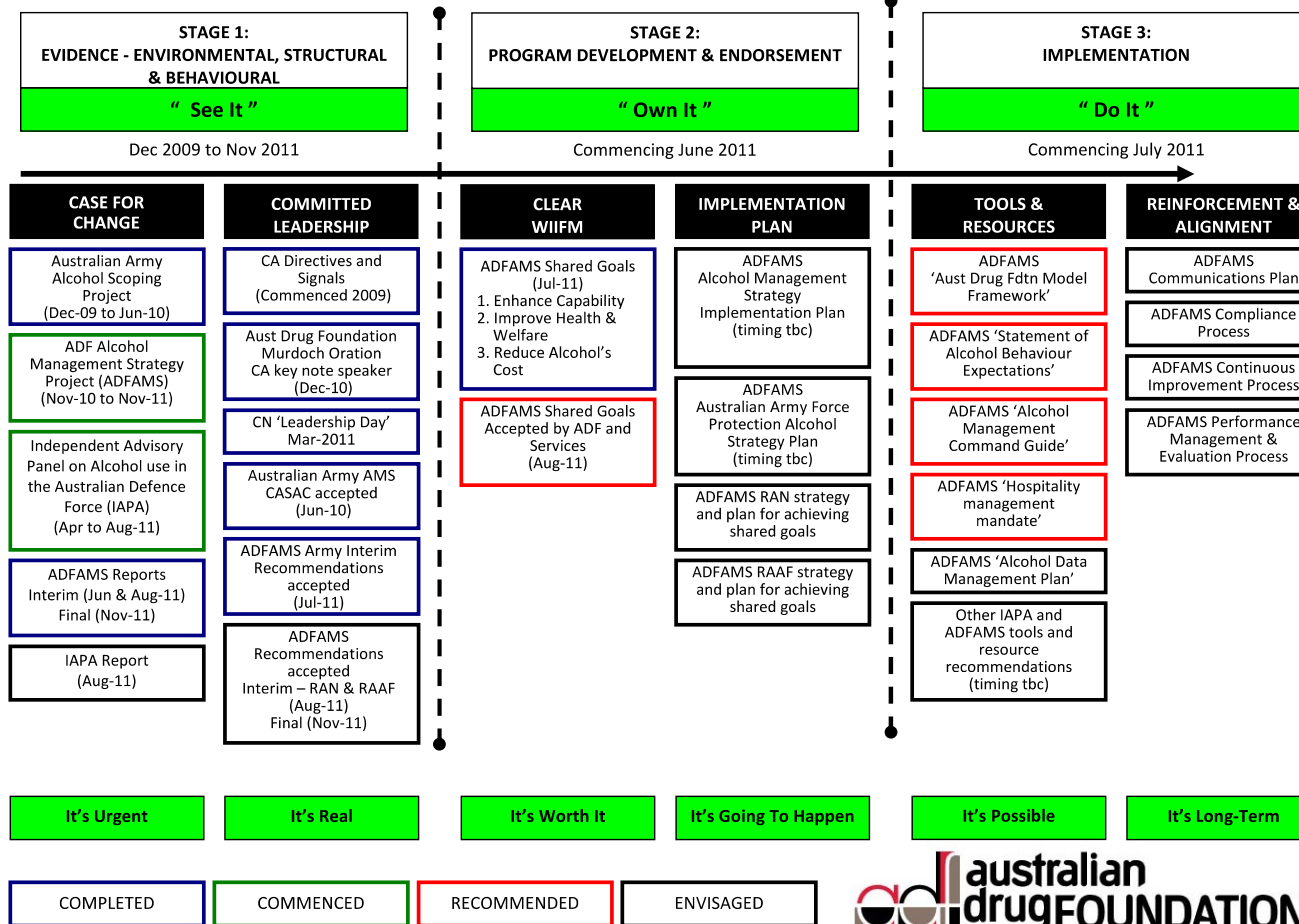
While noting the effort that is being applied to broadly consider alcohol related matters within the ADF, the Panel believes that there is a need for a high level Advisory Group to help connect to current best practice, significant national alcohol policy and various more specific areas of expertise and experience that cannot reasonably be available within the ADF. Such a group could comprise a small number of people with qualifications and expertise in alcohol policy programs and implementation of national standing including, for example, a recognised medical Addictions specialist, researchers and alcohol policy advisors who are involved with other national leadership organisations. To ensure appropriate connectedness both within and without the ADF, the Panel considers it appropriate for responsibility for alcohol policy across the ADF to be broad; while including health.

Appendix 6:

ADF Alcohol Management Strategy project summary

AUSTRALIAN DEFENCE FORCE ALCOHOL MANAGEMENT STRATEGY – Status at 31st July 2011

Diagram summary using the Australian Drug Foundation's 'Model for Alcohol & other drug Culture Change'



Appendix 7:

List of ADF policy documents related to alcohol identified by the Panel

1. Relevant sections of Commonwealth legislation

Defence Act 1903:

- Section 123A Intoxicating liquor;
- Section 123AA Intoxicating liquor not to be supplied to cadets; and
- Section 124 Regulations.

Defence Force Discipline Act 1982:

- Section 32 Person on guard or on watch;
- Section 37 Intoxicated while on duty etc; and
- Section 40 Driving while intoxicated.

Naval Defence Act 1910:

- Section 44E Intoxicating liquor not to be supplied to Australian Navy Cadets.

Army and Air Force Canteen Service Regulations 1959:

- Section 27 Exemption from State or Territory liquor control laws.

2. Relevant ADF Strategic Plans and Frameworks

Defending Australia in the Asia Pacific Century: Force 2030
Department of Defence. Canberra. 2009

The Strategic Reform Program: Delivering Force 2030
Department of Defence. Canberra. 2009

The Strategic Reform Program: Making it happen.
Department of Defence. Canberra. 2010

Annual People Plan 2010–11: Implementing the Vision of People in Defence.
Department of Defence. Canberra. 2010

People in Defence: Creating the Capability for the Future Force.
Defence Strategic People Communications. November 2009

3. Tri-Service health and alcohol related policies:

DI(G) Pers 15–1— *Misuse of Alcohol in the Defence Force*
(Currently being reviewed and rewritten)

Provides Defence policy on the use of alcohol within the Services. (Defence Instruction (Navy) Pers 31–9, Manual of Personnel Administration (Army) chapter 95, Defence Instruction (Air Force) Pers 4–14.

DI(G) Pers 15-4 Alcohol testing in the Australian Defence Force

Provides instructions for the testing of Defence personnel for alcohol use.
(Navy Pers 31–50, Army Pers 66–4, Air Force 4–24)

DI(G) Admin 45–2—*Reporting and Investigation of Alleged Offences within the Australian Defence Organisation.*

Outlines procedure for reporting on Notifiable Incidents including all drug related incidents (filed as Navy Admin 35–26, Army Admin 23–3, Air Force 9–29)

DI(G) PERS 33–4—*Recruitment and employment of members under 18 years in the Australian Defence Force* (22 Apr 08). This relates to the non-consumption of alcohol for members under 18 years of age.

HB 03/2005—*Treatment of problematic alcohol use in the Australian Defence Force*
Provides guidance and referral options in relation to problematic alcohol use.

HB 15/2003—*Alcohol use Disorders Identification Test*
Advises when the AUDIT should be used in the Australian Defence Force (ADF) and explains the questions and scoring method of the test.

HB 10/2005—*Australian Defence Force Outpatients Alcohol Treatment Program*
(Currently being reviewed and rewritten)
Gives a description of the pilot Outpatient Alcohol Treatment Program (OATP) and the referral pathways for this program.

PERS 16–27 *Defence Health Services Division philosophy and instruments of control*
Policy on the Health Services philosophy and instruments of control for health care, policy, planning and advice within the ADF.

PERS 16–18—*Australian Defence Force policy for the Health Promotion Program*
Establishes a tri-Service approach to the provision of health care to ensure that all personnel are aware of their individual risk factors and the means to combat these factors in order to achieve a healthy ADF population.

PERS 16–1—*Health care of Australia Defence Force personnel*
Policy on requirements to maintain a comprehensive health record and to undertake health surveillance and preventive health measures in order to monitor and maintain medical and dental fitness.

Note:

- i. Defence Road Transport Instructions have numerous refs to consumption of alcohol
- ii. The Alcohol, Rehabilitation and Education Program (AREP) have program specific policies available on request.

4. Army Policies:

DI(A) Pers 66–1—*Alcohol use and the management of misuse in the Army*
Advises on the misuse of alcohol consumption in the Army as well as the sale and correct storage of alcohol on service land.

DI(A) PERS 66–7—*Alcohol testing in the Australian Army*

Provides policy on the procedure for testing members for the presence of alcohol and lists a guide to safety critical areas.

DI(A) Pers 116–3 (*annex B attached*)—*Guidelines for the employment of drivers deprived of civil driving licenses.*

DCA Directive 11/05

Provides instructions on the implementation of random breath tests on Army bases. The contents of this directive could be amalgamated into CA Directive 07/06.

CA OH&S Policy Statement — 15 Jun 09

5. Royal Australian Air Force Policies:

DI(AF) Pers 04–25—*Alcohol testing in Air Force*

Provides policy for alcohol testing with the 37SQN and lists actions to be taken as a result of a positive alcohol testing.

DI(AF) Pers 04–14—*The use and abuse of alcohol in the RAAF*

Advises the dangers of alcohol abuse and states RAAF policy regarding use and abuse of alcohol.

IRTU Standing Instruction PERS 35–2—Alcohol, Smoking and Drugs

Identifies the restrictions of alcohol consumption and the use of cigarettes whilst at IRTU.

6. Royal Australian Navy Policies:

NADPC Z4P/WAT/W2N 100105Z April 2007—Drug and Alcohol Reporting

Provides advice on the relocation of NADPC and PSTP coordinator to Canberra and authorises pen amendments to references below with respect to signal reporting and contact details.

DI(N) PERS 31–9—*Management of alcohol and the prevention and management of alcohol*

Provides policy on consumption and sale of alcohol on service property, details the RANAODP, prevention and management of alcohol abuse.

AF Memo 43/09—Administrative Consequences for Unacceptable Alcohol Related Behaviour

Outlines options available to Fleet Command Commanding Officers in terms of possible administrative consequences following unacceptable alcohol-related behaviour and situations where members test positive to alcohol in Safety Critical Areas.

DI(N) PERS 13-1—*Illegal use of drugs and drug education in the Royal Australian Navy*

Contains information on definitions, RAN policy, education, detection and deterrence, investigations, disciplinary action, administrative action and self-referral provisions.

DI(N) PERS 31-51—*Alcohol testing in the Royal Australian Navy*

Contains information on education, testing, Safety Critical Areas (SCA), management and reporting of test failures, and responsibilities of Commanding Officers, testing staff and individual members.

DI(G) PERS 15-5—*Testing for prohibited substances in the ADF under Part VIIIA of the Defence Act 1903*

Contains ADF policy (with Navy supplement) with regard to definitions, authorisation and conduct of testing, privacy and confidentiality, and procedures for screening and laboratory tests.

DGNPT WAT/WNC 150446Z MAY 06 — *Continued Positive Alcohol Testing Results*

Provides guidance and instruction for the imposition of administrative consequences of failure of Safe Spirit testing and other alcohol-related incidents.

AFTP 1(B) (MARORDS) Chapter 305 Personnel Administration

Paragraphs 305.61 to 305

Contains guidance on regulation of alcohol and other drugs within Fleet Command.

Appendix 8:

List of persons and organisations consulted

Date	Location	Reason	Name	Position
15 Apr	Canberra	Project planning	Major General Paul Alexander	Commander Joint Health
			Mr David Morton	Director General Mental Health Psychology and Rehabilitation
			Ms Carole Windley	Director Mental Health Clinical Programs and Standards
			Ms Jen Harland	Assistant Director Alcohol Tobacco and Other Drugs Program
19 May	Melbourne	Consultation by telephone	Professor David Dunt	University of Melbourne
20 May	Canberra	Consultation with Professor Margaret Hamilton	Ms Elizabeth Broderick	Federal Sex Discrimination Commissioner
2 Jun	Canberra	Consultation	Minister Snowdon	Minister for Defence Science and Personnel and Minister for Veterans' Affairs
			Major General Paul Symons	Deputy Chief of Army
			Captain Jonathan Mead -Navy	Director Navy Personnel Policy
			Lieutenant Commander Dee Williams	Director Navy Alcohol and Other Drugs
			Major Michelle McInnes	Staff Officer Alcohol, Tobacco and Other Drugs
3 Jun	Canberra	Brief to IAPA Meeting	Air Marshal Geoff Brown	Chief of Air Force
			Major General Craig Orme	(Then) Head of People Capability, People Strategies and Policy
			Major General Gerard Fogarty	(Then) Director General Personnel - Army
			Mr John Rogerson	CEO The Australian Drug Foundation
			Mr Richard Colbran	Innovation and Sector Support Director The Australian Drug Foundation
			Mr Nick Tolhurst	Project Officer The Australian Drug Foundation
			Ms Di Morgan	Culture and Services Director The Australian Drug Foundation
			Ms Gail Johnson	Project Officer Forces Protection - Alcohol
9 Jun	Melbourne	Consultation	Mr Andrew Dare	Senior Researcher, Australian Drug Foundation
16 Jun	Melbourne	Consultation	Professor Robin Room	AER Centre for Alcohol Social Research

Date	Location	Reason	Name	Position
22 Jun	Canberra	Brief on outcomes of the Mental Health Prevalence Study with Assoc. Prof. John Wiggers	Professor Sandy McFarlane	Centre for Traumatic Stress Studies, University of Adelaide
			Colonel Stephanie Hodson	Director Strategy and Operational Mental Health
23 Jun	Richmond	Visit to Alcohol Education and Rehabilitation Program by Professor Margaret Hamilton, Mr Brian Vandenberg	Dr Luke Wolfenden	Post Doctoral Research Fellow University of Newcastle
			Squadron Leader Jen Roe	Officer in Charge Alcohol Education and Rehabilitation Program
			Flight Lieutenant Warwick Chate	Counsellor Alcohol Education and Rehabilitation Program
			Flight Sergeant Ian Waddell	Counsellor Alcohol Education and Rehabilitation Program
			Ms Crystal Lockard	Senior Counsellor Alcohol Education and Rehabilitation Program
			Mr Michael Sargent	Counsellor Alcohol Education and Rehabilitation Program
			Wing Commander Nick Clarke	Commanding Officer 1 st Combat Communication Squadron
24 Jun	Sydney	Consultation with Professor Margaret Hamilton	Flying Officer Emma Stones	Administration Officer 1 st Combat Communication Squadron
			Mr David Pirie	Regional Mental Health Team Alcohol Tobacco and Other Drugs Coordinator South Queensland
			Mr Mark Trewella	Regional Mental Health Team Alcohol Tobacco and Other Drugs Coordinator Victoria / Tasmania
			Ms Leonie Clifford	National Outpatient Alcohol Treatment Program
			Ms Carole Windley	Director Mental Health Clinical Programs and Standards
24 Jun	Sydney	Consultation with Professor Margaret Hamilton, Mr Brian Vandenberg	Ms Jen Harland	Assistant Director Alcohol Tobacco and Other Drugs Program
			Chaplain Rob Sutherland	Chaplain 1 st Intelligence Battalion
28 Jun	Canberra	Consultation with Professor Margaret Hamilton, Mr Brian Vandenberg	Rear Admiral James Goldrick	Acting Commandant Australian Defence Force Academy
			Commodore Bruce Kafer	Commandant Australian Defence Force Academy
			Colonel Paul Petersen	Deputy Commandant Australian Defence Force Academy
			Warrant Officer Dave Devlin - Navy	Academy Sergeant Major Australian Defence Force Academy
			Wing Commander Steve Edwards	Executive Officer of Cadets Australian Defence Force Academy
			Squadron Leader David Brewer	Staff Officer Executive Officer of Cadets Australian Defence Force Academy
			Ms Anne Goyne	Senior Psychologist Australian Defence Force Academy
			Chaplain Bill Phillips	Chaplain Australian Defence Force Academy
			Chaplain Andrew Lewis	Chaplain Australian Defence Force Academy

Date	Location	Reason	Name	Position
			Chaplain Anthony Doyle	Chaplain Australian Defence Force Academy
			Captain Steve Trewin -Army	Staff Officer Cadets Mess Australian Defence Force Academy
29 Jun	HMAS Cerberus	Consultation with Professor Margaret Hamilton, Mr Brian Vandenberg	Captain Mark Hill (Navy)	Commanding Officer HMAS Cerberus
			Commander Shane Glasscock,	Executive Officer HMAS Cerberus
			Chief Petty Officer Dave Leeming,	Discipline Coxswain Naval Police Coxswains HMAS Cerberus
			Commander Meg Ford	Head Health Care - Cerberus
			Mr Chris Harrison	Command Equity Advisor HMAS Cerberus
			Lieutenant Commander Tristan Skousgaard	(Then) Command Legal Officer HMAS Cerberus
			Lieutenant Commander Brian Cook	Command Legal Officer HMAS Cerberus
			Warrant Officer Vaughan King	Complex Case Officer Victoria / Tasmania
			Lieutenant Commander Matthew Fergusson	Executive Officer RAN Recruit School HMAS Cerberus
			Commander Paul O'Grady	Commanding Officer RAN Recruit School HMAS Cerberus
			RAN Recruit School students – Week 9 level.	RAN Recruit School HMAS Cerberus
			Lieutenant Kel Nagle	Alcohol and other Drug Program Coordinator Southern Region Drug and Alcohol Program HMAS Cerberus
			Chief Petty Officer Holger van Geelen	Alcohol and other Drug Program Advisor HMAS Cerberus
			Warrant Officer Peter Beaumont	Alcohol and other Drug Program Advisor HMAS Cerberus
			Petty Officer Kimberley Slater	Alcohol and other Drug Program Advisor HMAS Cerberus
			Petty Officer Gillian Bryant	Alcohol and other Drug Program Advisor HMAS Cerberus
			Petty Officer Andrew Buckingham	Alcohol and other Drug Program Advisor HMAS Cerberus
1 Jul	Canberra	Brief on outcomes of the Mental Health Prevalence Study with Assoc. Prof. John Wiggers	Professor Sandy McFarlane	Centre for Traumatic Stress Studies, University of Adelaide
			Colonel Stephanie Hodson	Director Strategy and Operational Mental Health
12 Jul	Melbourne	Consultation with Mr Brian Vandenberg	Mr Dean Herbert	(Then) Senior Project Officer Australian Army Alcohol Management Strategy
6 Jul	Melbourne	Consultation with Professor Margaret Hamilton, Mr Brian Vandenberg,	Dr Ros Blakley	Regional Health Director, Regional Health Services VIC/TAS
			Mr Ross Hawkins	Director Strategic Reform Team, Chief Operating Division
			Professor Alexander McFarlane	Centre for Traumatic Stress Studies, University of Adelaide
			Colonel Stephanie Hodson	Director Strategy and Operational Mental Health
15 Jul	Brisbane	Consultation with Professor Margaret Hamilton, Mr Brian	Brigadier Paul McLachlan,	Commander 7th Brigade

Date	Location	Reason	Name	Position
		Vandenberg,		
			Warrant Officer Class One Robert Thompson	Regimental Sergeant Major 7th Brigade
			Major James Burchmore	Mental Health and Psychology Section - Gallipoli
			Major Margaret Goodman	Officer Commanding 1 Psychology Unit Brisbane Det
			Mr Tony Sherlock	Regional Rehabilitation Coordinator South Queensland
			Warrant Officer Class 2 Kirsty James	Section Commander Domestic Policing Unit Enoggera
			Mr David Pirie	Regional Mental Health Team Alcohol Tobacco and Other Drugs Coordinator South Queensland
			Ms Jo Wardle	Regional Mental Health Team Coordinator South Queensland
			Mr Greg Curry	Regional Mental Health Team Clinical Psychologist South Queensland
20 Jul	Canberra	Consultation with Professor Margaret Hamilton, Mr Brian Vandenberg	Mr David Lloyd	Defence Legal Counsel
			Mr Shane Carlson	Senior Legal Officer Directorate of Military Justice
22 Jul	Canberra	Consultation with Professor Margaret Hamilton by telephone	Mr Phil Minns	Deputy Secretary People Strategies and Policy
28 Jul	Tele-conference	Consultation with Mr Brian Vandenberg	Lieutenant Colonel Murray Heron	Provost Marshal - Army
			Major Shannon Smith	Deputy Provost Marshal - Army
			Wing Commander David Turner	Provost Marshal – Air Force
			Pilot Officer Craig Steer	Deputy Provost Marshal – Air Force
			Warrant Officer	
			Lieutenant Commander Jeff Duke	Deputy Provost Marshal - Navy
			Chief Petty Officer Richard Spence	Quality Assurance Manager Directorate of Policing and Security – Navy
21 Jul	Canberra	Consultation with Professor Steve Allsop, Associate Professor John Wiggers, Major General Paul Alexander, Mr Brian Vandenberg	Air Commodore Henrik Ehlers	Director General Defence Force Recruiting
			Mr Geoff Gallas	Director Occupational Psychology and Health Analysis
21 Jul	Canberra	Meeting with Professor Margaret Hamilton	Rob Hudson	George Patterson Y&R
27 Jul	Canberra	Consultation with Professor Margaret Hamilton, Mr Brian	CMDR Vicki McConachie	Acting Head Navy People and Reputation

Date	Location	Reason	Name	Position
		Vandenberg		
			Mr Mick Callan	Director General Defence Community Organisation
		Regional Health Directors Meeting with Professor Margaret Hamilton	Air Commodore Tracy Smart	Director General Garrison Health Operations
			Dr Roslyn Blakley	Regional Health Director Victoria / Tasmania
			Dr Danielle Klar	Regional Health Director Southern New South Wales
			Dr Daryl Duncan	Regional Health Director Northern New South Wales
			Dr Mark Norman	Regional Health Director Queensland
			Commander David Parry	Regional Health Director Western Australian
			Ms Julie Wilson	Assistant Director Quality Assurance and Clinical

