Foundation for Alcohol Research & Education

FARE's Submission to the Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander Communities

House of Representatives' Standing Committee on Indigenous Affairs

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About the Foundation for Alcohol Research and Education

The Foundation for Alcohol Research and Education (FARE) is an independent organisation working to stop the harms caused by alcohol in Australia. Our mission is to help Australia change the way it drinks by:

- helping communities to prevent and reduce alcohol-related harms;
- building the case for alcohol policy reform; and
- engaging Australians in conversations about our drinking culture.

FARE is guided by the World Health Organization's *Global Strategy to Reduce the Harmful Use of Alcohol*[i] for addressing alcohol-related harms through population-based strategies, problem-directed policies, and direct interventions.

[i] World Health Organization (2010). *Global strategy to reduce the harmful use of alcohol.* Geneva: World Health Organization.

Contents

Summary

The Foundation for Alcohol Research and Education (FARE) welcomes the opportunity to provide a submission to the House of Representatives' Standing Committee on Indigenous Affairs, *Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander Communities*.

Alcohol use leads to substantial harms across Australia, both to the drinker and people affected by others drinking. Alcohol-related harms disproportionately affect Aboriginal and Torres Strait Islander peoples, who are impacted by alcohol-related violence, domestic violence, health conditions and death. For example, for alcohol-related health conditions, Aboriginal and Torres Strait Islander men are hospitalised at rates between 1.2 and 6.2 times than other Australian men, and Aboriginal and Torres Strait Islander women at rates between 1.3 and 33.0 times greater.[1] Deaths from alcohol-related causes are overall 7.5 times greater than those of other Australians.[2]

The greater impacts of alcohol-related harms on Aboriginal and Torres Strait Islander peoples, has been examined and acknowledged by innumerable Government Reviews and Inquiries.[i] It has been the focus of media attention for more than 50 years. Hundreds of programs and billions of dollars have been spent in well-intentioned efforts to address this national shame.

Previous Reviews and Inquiries have understood the problem and emphasised the need to address the social determinants of risky alcohol consumption and the need for population-wide measures to target alcohol consumption as well as targeted strategies to prevent and treat alcohol-related harms. These processes have also acknowledged the need for community engagement and ownership of strategies, the need to adopt culturally sensitive approaches and the need for supply, demand and harm reduction strategies.

Despite this, the harms from alcohol continue to devastate many Aboriginal and Torres Strait Islander communities across Australia. This is in part because Governments have been unable to successfully translate the problem diagnosis into effective and sustainable action that prevents alcohol-related harms. Failure has led to frustration and further policy change in the pursuit of the elusive solution, which often exacerbates the problems.

This is evidenced by the recent moves of some Australian Governments to focus on punitive measures to address alcohol-related harms among Aboriginal and Torres Strait Islander peoples; rather than preventive or harm minimisation measures. These measures include the Northern Territory Government's alcohol mandatory treatment program and their examination of options to *"either to prosecute or alternatively to restrain [pregnant women] from engaging in conduct which harms their unborn child."*[3] These efforts will only serve to contribute to the continued inequalities among Aboriginal and Torres Strait Islander peoples and their overrepresentation in the criminal justice system. Recourse to punitive measures reflects an unwillingness to stay the course and focus on strategies that will reduce alcohol-related harms.

[i] For example, 2012 the former Australian Government Department of Families Housing Community Services and Indigenous Affairs (FaHCSIA) consultation on the *Draft Minimum Standards for Alcohol Management Plans (AMPs) in the Northern Territory;* 2011 House of Representatives Inquiry into Fetal Alcohol Spectrum Disorders; 2009 House of Representatives Inquiry into the impact of violence on young Australians; 2009 House of Representatives Inquiry into the high level of involvement of Indigenous juveniles and young adults in the criminal justice system; 2008 Senate Select Committee on Regional and Remote Indigenous Communities; 2000 House of Representatives Inquiry into substance abuse in Australian communities; 2000 House of Representatives Inquiry into the needs of urban dwelling Aboriginal and Torres Strait Islander peoples; Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse 2007 – Ampe Akelyernemane Meke Mekarle *Little Children are sacred* report.

Some Australian Governments have also rescinded or threatened to rescind policies and programs that have been implemented to reduce alcohol-related harms. In 2012, the new Northern Territory Government dismantled the Banned Drinkers Register (BDR) and removed the associated requirement for scanning IDs before purchase.[4] In 2012 in Queensland, the Liberal National Party (LNP) announced their intention to review Alcohol Management Plans (AMP) if they were elected at the forthcoming state election noting *"in the long run we would want to review and get rid of Alcohol Management Plans so Indigenous Queenslanders can enjoy the same rights, opportunities and obligations as other Queenslanders, but we have a lot of work to do to provide more opportunity first."*[5] AMPs had been introduced to reduce alcohol-related violence, particularly against women and children.[6] The LNP was elected and announced an immediate review of AMPs in 19 Aboriginal and Torres Strait Islander communities.[7]

The examination of this historical policy landscape also reveals a switching of focus between the role of government and responsibilities of drinkers. The third leg of any understanding about reducing these harms has been repeatedly overlooked. The role of the supply of alcohol and those who are responsible rarely rates a mention and is given little attention. In fact some political leaders deem it advantageous to praise the liquor industry for its contribution to the drinking culture.

Little is also known about the alcohol supply chain from alcohol producers, distributors, wholesalers and retailers to Aboriginal and Torres Strait Islander communities or regional areas near these communities. The Standing Committee on Indigenous Affairs should examine the alcohol industry's role in supplying alcohol to Aboriginal and Torres Strait Islander communities where alcohol-related harms are significant. This Inquiry should seek to request data from the alcohol industry on their supply practices. This data should be made publically available and an approach to the continual collection and reporting of this data should be recommended.

About this submission

This submission addresses each of the Terms of Reference for the Inquiry. In this submission FARE has focused on areas where it has experience or expertise, this includes the prevention of alcohol-related harms and the evidence on effective strategies to reduce alcohol-related harms. Areas outside of this remit such as housing and education have not been addressed in this submission. FARE nevertheless supports a social determinants approach to addressing alcohol-related harms among Aboriginal and Torres Strait Islander communities and understands that in order to do this, factors outside of the health system need to be considered and addressed.

FARE has made 32 recommendations to the Inquiry.

The Challenge

This is not a problem without solutions. And it is a challenge that is surmountable.

Years of media attention. Too many Inquiries to mention. Hundreds of Government, non-government and community programs. Nothing seems to have made a significance difference. At least this is what the public at large is led to believe.

So what is missing? Where are we going wrong?

There are many policies and programs that can reduce alcohol-related harms among Aboriginal and Torres Strait Islander peoples. After years of Inquiries, Reviews and policy development in this area, there are examples of strategies that have been successfully implemented by communities and government across Australia to reduce alcohol-related harms.

Despite this, the success of policies and programs are often short lived. Often the implementation challenge is too great to allow these policies to produce meaningful change and reduce the inequalities experienced by Aboriginal and Torres Strait Islander peoples over the longer term.

Governments at all levels (national, state, territory and local) have a responsibility to address alcohol-related harms experienced by Aboriginal and Torres Strait Islander peoples. However, the actions of government is rarely coordinated, each has independent policy goals and measures to determine progress. These programs are often short term or changed or weakened before their implementation. This creates a situation where we are trying to address disadvantage in a constantly changing policy environment, which is exhausting and never-ending.

Governments also change. When they change, so do the policy settings. This creates an unstable and inconsistent policy environment – a key ingredient needed to reduce systemic and intergenerational disadvantage. A recent example of this is in the Northern Territory where the BDR was scrapped without careful consideration or evaluation as the result of an ill-informed election promise.

A further challenge in addressing alcohol-related harms is the vast difference in the needs of Aboriginal and Torres Strait Islander communities. 'Communities' should not be referred to in the singular. There are very different social worlds covered by drinking among Aboriginal and Torres Strait Islander peoples. There are often different needs within communities (e.g. gender differences) and differences between communities. Communities can be groups of people that are not necessarily co-located. There are urban and remote communities. The challenge for policy makers is to develop and implement policies for these different communities.

Unfortunately, even when the intentions for policy reform and the reasons behind the reform are noble, the implementation challenge can be too great. When this occurs policy makers should 'go back to basics,' examine the evidence, identify the problems, agree the needs of the community and develop the solutions needs to address these. Measures to determine success should also be developed. These policies must be targeted and must adapt as the community adapts to ensure that they are continuing to achieve their desired goals.

Lastly it must not be forgotten that there is an industry that profits from the consumption of alcohol by Australians, including Aboriginal and Torres Strait Islander peoples. Too often the role of the alcohol industry in contributing to the considerable harms in Aboriginal and Torres Strait Islander communities and their culpability is not explored.

This Inquiry presents a real opportunity to gather information from the alcohol industry about the supply alcohol to Aboriginal and Torres Strait communities. This information will contribute to a better understanding of the problems surrounding the supply of alcohol and contribute to better policy making and allow appropriate policy measures to be developed that address the flow of alcohol into areas that are significantly affected by harms.

This Inquiry must go beyond rhetoric and principles, it must instead focus on addressing the implementation challenges that have plagued the introduction and management of programs and policies to address alcohol-related harm. This is a significant challenge but one that can have lasting impact.

The Inquiry must be prepared to make tough recommendations that are in the long term interests of Aboriginal and Torres Strait Islander peoples. It should recognise that in many communities too much alcohol is overwhelming community and government efforts to address significant social and economic disadvantage. These communities need relief from the chaos. Supply restrictions including dry communities, should be considered to allow communities to be stabilised for the long journey towards restoration and rehabilitation.

FARE's submission has suggested tangible and practical recommendations that will assist overcoming these challenges and lead to enduring change.

Recommendations

1. That the Inquiry recommends that addressing alcohol-related harms be a priority for the Council of Australian Governments (COAG). As part of this, COAG should establish minimum standards for alcohol-related legislation and policies for all states and territories.
2. That the Inquiry recommends that state and territory governments reduce trading hours for all new and existing liquor licences to the following:
   - All existing 24 hour liquor licences should be abolished and no new 24 hour licences should be granted;
   - Opening times for all licensed premises (including packaged licences) should be no earlier than 10.00am;
   - Standard closing times for all on-licence premises from Monday to Saturday should be midnight, with extended trading venues limited to 3.00am and lockouts (preventing entry for patrons) no later than 1.00am. Standard closing time for Sundays should remain at 10.00pm; and
   - Closing times for packaged licensed premises should be no later than 10pm.
   - For communities where trading hours are shorter than these, there should be the capacity to reduce trading hours further, for example through the introduction of Alcohol Management Plans.
3. That the Inquiry recommends the introduction of Alcohol Management Plans (AMPs) that control the availability of alcohol in communities where a need has been identified and agreed. These AMPs should also be targeted at the needs of the particular community, introduced in association with supportive structures designed to build capacity within the community, prevent risky consumption and support people who need assistance to reduce their alcohol consumption.
4. That the Inquiry recommends that states and territory governments introduce cluster control policies for the determination of new liquor licenses and establish saturation zones in areas that are identified as already having large numbers of liquor licenses.
5. That the Inquiry requests information from alcohol producers, distributors and retailers on the supply chain of alcohol to Aboriginal and Torres Strait Islander communities, including:
   - What is the supply chain of alcohol from producers, distributors, wholesalers and retailers to Aboriginal and Torres Strait Islander communities? How does this differ for communities with limited restrictions, when compared to those that are dry?
   - How much alcohol and what type of alcohol is being supplied?
   - How frequently is alcohol being supplied to these communities and what is the timing of the provision of alcohol?
   - How is the alcohol priced and promoted in and around these communities?
   - What role is the alcohol industry adopting in mitigating the risk of harms that result from the consumption of alcohol?
6. That the Inquiry recommends that all states and territory governments mandate the collection and reporting of alcohol sales data at least annually. At a minimum, wholesale producers and licensees should provide sales data on beer, wine (including bottled and cask), spirits (including premix spirits) and cider separately. Postcode data should be provided by all producers and licensees to enable mapping of per capita consumption. A system should be established for nationally consistent collection and management of alcohol wholesale sales data to inform key alcohol policy developments and evaluations. As part of this, alcohol sales data should be made publically available in a format which can be easily accessed, used and analysed by policy makers and researchers.

7. That the Inquiry recommends that a new National Alcohol Strategy be developed and implemented and informed by the World Health Organisation's *Global strategy to reduce the harmful use of alcohol.*
8. That the Inquiry recommends that all governments adopt a 'health in all policies' approach to public policy which includes the establishment of health benchmarks and monitoring structures to ensure cross government action is being implemented and targets are being achieved.
9. That the Inquiry recommends that all state and territory governments elevate harm minimisation as the primary object of their respective liquor acts.
10. That the Inquiry recommends that public health considerations be assessed in the Commonwealth Government's deregulation agenda prior to action being taken.
11. That the Inquiry recommends that a national data repository for alcohol-related harms be established. All states and territories should be required to routinely collect standardised data on alcohol-related harms that is mandatory, consistent, reliable, and reported so that it is publicly available. The following harm indicators should be included in the collection of alcohol harms data:
    - Alcohol-related ambulance attendances;
    - Alcohol-related emergency department presentations for harms incurred to self (e.g. alcohol poisoning, injuries) and others (e.g. Injuries from alcohol-related violence);
    - Alcohol-related hospitalisations;
    - Alcohol-related assaults, including non-domestic assaults, domestic assaults and assaults on police; and
    - Alcohol-related child protection cases.
12. That the Inquiry recommends that the standardised national diagnostic tool commissioned by the then Department of Health and Ageing is tested and implemented to facilitate diagnosis of Fetal Alcohol Spectrum Disorders (FASD) in Australia and that services are provided to diagnose, treat and manage FASD.
13. That the Inquiry recommends that FASD is recognised as a disability and eligibility criteria for disability services are modified to support people with a FASD condition, their families and their carers. FASD should be recognised as a cognitive impairment to allow access to support services and should be included in the Impairment Tables for Disability Support Pensions, acknowledged in the National Disability Insurance Scheme and included in the List of Recognised Disabilities for Carer Payments.
14. That the Inquiry recommends that a National FASD Action Plan is introduced that specifies the Commonwealth, State and Territory Government's responsibilities in addressing FASD and includes actions, targets and outcomes. The Plan should include the five key areas outlined in *FARE's Australian Fetal Alcohol Spectrum Disorders Action Plan 2013-2016* outlined below.
    I. Increase community awareness of FASD and prevent prenatal exposure to alcohol
        - Conduct an ongoing national public education campaign about the harms resulting from alcohol consumption during pregnancy.
        - Implement mandatory health warning labels on all alcohol products available for sale in Australia.
        - Provide specialist support services to pregnant women who have alcohol-related disorders.
        - Educate health professionals on FASD and enable them to routinely ask and advise all women about their alcohol consumption.

II. Improve diagnostic capacity for FASD in Australia
   - Publish, implement and evaluate the Australian FASD diagnostic instrument.
   - Establish FASD diagnostic services.
   - Implement training for health professionals on the use of the Australian FASD diagnostic instrument.

III. Enable people with FASD to achieve their full potential
   - Support people with FASD, their families and carers - economic modelling is required to determine accurate funding estimates.
   - Improve early intervention options for people with FASD, their families and carers - Expand the current *Better Start for Children with Disability* initiative to include FASD and provide funding support to parent and carer organisations to support those who care for people with FASD.
   - Treat people with FASD in a socially inclusive manner upon entry into education, employment and if in contact with the criminal justice system.

IV. Improve data collection to understand the extent of FASD in Australia
   - Routinely record women's alcohol consumption during pregnancy and include standardised questions about alcohol consumption during pregnancy, as part of the Perinatal National Minimum Data Set – link this data to related collections.
   - Standardise data collection on FASD diagnosis and monitor prevalence, *referral, treatment and support.*
   - Monitor FASD prevalence through the Australian Paediatric Surveillance Unit.

V. Address the high prevalence of FASD among Aboriginal and Torres Strait Islander peoples
   - Provide support to Aboriginal and Torres Strait Islander peoples to develop community-driven solutions to address alcohol misuse.
   - Publish resources on FASD that are culturally appropriate and tailored to different cultural groups within Aboriginal and Torres Strait Islander communities.
   - Develop comprehensive community responses to FASD in remote and isolated Aboriginal and Torres Strait Islander communities.

15. That the Inquiry recommends that all people diagnosed with FASD are provided with a treatment and management plan that is designed to meet *individual* needs.
16. That the Inquiry recommends that equitable life-long services are provided when developing management and care systems for people with FASD, their families and carers, and that transitions from child to adult services are pre-planned and coordinated to ensure that people do not 'fall between the cracks.'
17. That the Inquiry recommends that processes are developed to ensure that people who are considered to be at-risk of having FASD are screened when they come into contact with government services including the criminal justice system, foster care system, child safety system and child and family centres and provide them with support throughout this time.
18. That the Inquiry examines sentencing options for people identified as having a FASD condition who comes into contact with the criminal justice system, similar to options provided to other people who have cognitive functioning disabilities.

19. That the Inquiry recommends an increase in funding and support for evidence informed treatment and rehabilitation services, including:
    - Psychosocial interventions - brief interventions and counselling, including general or problem solving counselling and motivational interviewing;
    - Pharmacotherapy; and
    - After care.
20. That the Inquiry recommends that Aboriginal and Torres Strait Islander peoples in urban, regional, rural and remote locations have access to at least the same range and quality of services as the rest of the population in Australia.
21. That the Inquiry recommends that Aboriginal and Torres Strait Islander controlled services, staffed with Aboriginal and Torres Strait Islander health workers, and mainstream services that have culturally appropriate support mechanisms in place are available.
22. That the Inquiry recommends that services are adequately resourced and funded for longer periods to offer stability, reduce staff uncertainty, provide staff training and development and to increase screening and brief interventions for alcohol. Equitable access to alcohol-related professional development is needed in rural and remote locations.
23. That the Inquiry recommends that families and friends of people consuming alcohol at risky levels and/or those suffering from alcohol-related harms are included in the treatment decision making and implementation process where appropriate and acceptable to the client.
24. That the Inquiry recommends that alcohol use and harm is treated as a health issue and, where appropriate, diversionary services are introduced and expanded to keep people out of prison for alcohol-related offences.
25. That the Inquiry recommends that the Commonwealth Government reform the alcohol taxation system in Australia to implement a volumetric tax on wine.
26. That the Inquiry recommends that the Commonwealth Government close the loophole that allows alcohol advertising on television before 8:30pm and introduce independent regulation of alcohol marketing.
27. That the Inquiry recommends a phase out of alcohol sponsorship of sport and cultural events.
28. That the Inquiry recommends that the Northern Territory Government re-introduce the Banned Drinkers Register and undertake a robust and independent evaluation of this measure.
29. That the Inquiry recommends that sobering up shelters be established to provide support, care and monitoring for those who are intoxicated. These should be independent of law enforcement activities.
30. That the Inquiry recommends that community patrols be established in urban, regional and remote locations where these do not exist and a need is identified, to improve community safety and reduce harm.
31. That the Inquiry recommends that state and territory governments introduce a minimum price for alcohol to stop the extreme discounting of alcohol.
32. That the Inquiry recommends that a comprehensive strategy based on the *Living With Alcohol Program* be introduced in regions or jurisdictions where there are substantial levels of alcohol-related harms among Aboriginal and Torres Strait Islander peoples.

FARE's response to the terms of reference

Patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders

Current situation

Supply of alcohol

There is limited information available in the public domain about the supply chain of alcohol. Little is known about how decisions are made by the alcohol industry in the supply of alcohol to or around Aboriginal and Torres Strait Islander communities. There is some evidence to suggest that there is substantial socioeconomic variation in the location of alcohol outlets, with a Victorian study showing a higher proportion of off-licence premises in lower socioeconomic areas.[8] However, the extent to which the alcohol industry, from producers to retailers, are knowingly providing alcohol to communities that are experiencing significant disadvantage, needs to be ascertained. The extent to which the alcohol industry is implementing meaningful harm mitigation strategies is also unknown.

Some data is available in some jurisdictions on wholesale alcohol sales. This data is collected in the Australian Capital Territory, Western Australia, Northern Territory, and Queensland. Alcohol sales data serve as a proxy measure for consumption and therefore it can be used to identify and monitor emerging trends in consumption and the effectiveness of strategies to minimise alcohol-related harms.

Availability of alcohol

Alcohol is more readily available than it ever has been in Australia. The number and density of liquor licenses has consistently increased over the past 10 to 15 years.[9] This is despite the fact that research overwhelmingly demonstrates that as alcohol becomes more available, consumption and alcohol-related problems increase, and that to reduce alcohol-related harms, a reduction in access and availability are effective measures.[10] Figure 1 below shows the growth in liquor licenses over a 10 to 15 year period in some Australian states and territories.

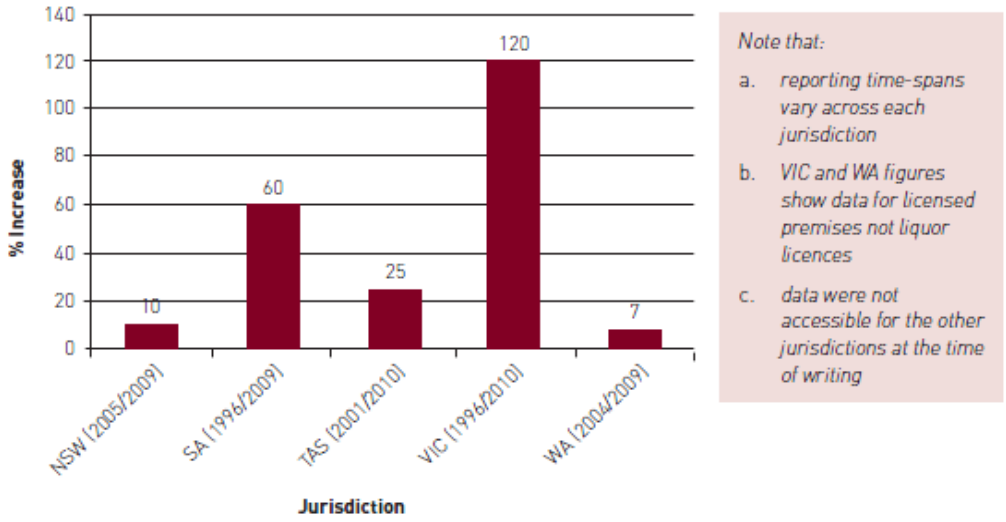

Figure 1: Percentage growth in liquor licenses in NSW, SA and TAS and licensed premises in Vic and WA[11]

Trading hours across the country have also been extended. Legislation relating to trading hours of licensed premises vary. However most state and territory liquor legislation includes trading hours for packaged or take-away alcohol of 10am until 10pm and allow for extended trading of on-licence alcohol sales until 5am, with some allowing 24 hour trading. The excessive availability of alcohol through extended trading hours contributes to increases in levels of alcohol-related harm.

In Aboriginal and Torres Strait Islander communities, there are significant variations in the way that alcohol is made available. Some remote communities, such as Aurukun[12] in Queensland and Anangu Pitjantjatjara Yankunytjatjara (APY) lands in South Australia are 'dry', which means that no alcohol is allowed in the community or region specified. Others have restrictions on when and what alcohol products can be purchased, such as Tennant Creek[13] in the Northern Territory and Karratha[14] in Western Australia. In Tennant Creek, for example, the restrictions are as follows:

1. Takeaway alcohol sales are only allowed on:
   - Weekdays, between 2.00pm - 8.00pm;
   - Saturday and public holidays, between 12noon - 8.00pm; and
   - Sunday (hotels and clubs only), between 2.00pm - 8.00pm.
2. Sales of cask and fortified wine are limited to one two litre cask or one bottle of fortified wine per person per day, between the hours of 4.00pm and 6.00pm.
3. Takeaway port in any container is prohibited.
4. Takeaway sale of beer in 750 ml and 800 ml bottles is prohibited.[15]

Many cities and regional cities also have declarations of Dry Zones. Dry zones are areas where the consumption of liquor in public areas is prohibited. For example, Ceduna and Adelaide city centre in South Australia and specific areas of Darwin and Katherine in the Northern Territory have Dry Zones.

Alcohol Management Plans

Some of these availability restrictions are articulated in Alcohol Management Plans (AMPs) which exist in South Australia, Western Australia, the Northern Territory, and Queensland. AMPs are agreements developed to reduce the harm caused by alcohol within a community. AMPs also have a focus on improving community safety, particularly among women and children. AMPs vary across states and territories.

AMPs can include supply reduction strategies, demand reduction strategies and harm reduction strategies. Supply reduction strategies reduce the availability of alcohol, such as reducing trading hours and placing restrictions on the sale of particular products. Demand and harm reduction strategies include health and education programs, improved service delivery, sport and recreation programs, night patrols and sobering up shelters.

AMPs in the Northern Territory are now required to meet minimum standards that include demand, supply and harm reduction strategies as well as requirements relating to consultation and engagement, governance, monitoring, reporting and evaluation, and defining geographical boundaries.[16]

Evidence

Trading hour restrictions and density controls

International and national evidence demonstrates that one of the most effective measures to reduce risky alcohol consumption is to reduce its availability.17 Meaningful restrictions on access to, number of and density of alcohol venues (both on and off-premises), have been shown to be effective in reducing alcohol consumption and related harm. This can be achieved through a number of mechanisms, the most effective of which includes a reduction in trading hours of licensed premises and reduction in the density of liquor outlets.

In Newcastle, pub closing times were wound back from 5am to 3am (later 3.30am after a legal challenge by the pubs) and a lockout introduced at 1am (later 1.30am; the lockout prevented new patrons from entering pubs after this time but if people were already in a venue, they could continue drinking). A 37% reduction in night time assaults, (between the hours of 10pm and 6.00am) was observed after 18 months.[18]

Five years after these conditions were introduced, a further evaluation was undertaken. This evaluation found that there was a sustained reduction in alcohol-related assaults in the Newcastle CBD with an average of a 21% decrease in assaults per hour.[19] This compares closely with research in Norway where an average 20% decrease in assaults per hour of restriction was observed in 15 cities where trading hours were restricted.[20] The Newcastle experience demonstrates how even modest reductions in trading hours can result in significant reductions in harms.

An analysis was undertaken in Victoria of the effects of licensed outlet density on several measures including assault, domestic violence, chronic harms and high risk drinking in young people. The analysis found there was a strong association between reported assaults and all three outlet types (general licenses, on-licence and off-licence).[21] A 10% density increase in general licence rates in an area increased assault rates by 0.6%, while a 10% increase in off-licence rates increased assault rates by 0.8%. There was also a strong association between domestic violence and the density of packaged liquor outlets. A 10% increase in off-licence liquor is associated with a 3.3% increase in domestic violence. Increases in domestic violence were also apparent within general (pub) licences and on-premise licenses, although the effect was more modest.[22]

There are a number of policies that can be implemented to control the number of liquor licenses. Two of these policies are introducing ‘saturation zones’ and ‘cluster controls’. Saturation zones impose limitations on the provision of new licenses in areas where it has been identified there are a high density of licenses. Cluster controls prohibit new liquor licenses for premises within a specified distance of existing licensed premises or other amenities (e.g. schools, hospitals, churches or places of religious worship).[23]

Targeted supply restrictions and AMPs

Restrictions on the availability of alcohol are not only effective for areas with late trading alcohol venues and a high density of outlets. In smaller communities, restrictions in drink types and hours of availability for alcohol, have resulted in reductions in harms. These restrictions include limiting access to high risk alcoholic beverages, restricting hours of sale and restricting the amount of alcohol that can be purchased. These restrictions have been introduced in various communities as stand-alone measures or as part of AMPs.

There are several evaluations of communities that have had alcohol restrictions in place, some of these are outlined below.

Norseman restrictions

In Norseman in Western Australia, alcohol restrictions were introduced in March 2008 and continue today. Restrictions include sales per person per day of no more than one five litre cask of red and white Lambrusco wine, one two litre cask of port wine, and one four litre cask of non-fortified wine between the hours of 12pm and 6pm, Monday to Sunday. An evaluation of the restrictions published in 2010 found:

- A 17.5% reduction in assaults and a 15.3% decrease in domestic violence incidents;
- A 60.5% decrease in the number of alcohol-related hospital admissions in the 12 months after the restrictions; and
- A decrease in per capita consumption of alcohol of 9.8% with the majority of the decrease observed in cask red wine, fortified wine and Ready-to-drink.[24]

Groote Eylandt and Bickerton Island Alcohol Management System

On 1 July 2005, with extensive community involvement, the Licensing Commission Alcohol Management System was implemented on Groote Eylandt and Bickerton Island. Under the decision, the whole of Groote Eylandt and Bickerton Island became a restricted area except for the two licensed clubs (Alyangula Recreation Club and the Alyangula Golf Club) and the Police Social Club.[25] The system is still in force today.[26]

Everyone on the islands, including visitors, requires a permit to buy takeaway alcohol. Permits can be revoked if any of the conditions of the permit are breached, although people can apply for new permits following revocation. At the time of implementation, applicants would have their permits recommended by a Permit Committee and issued by the Northern Territory Government.[27]

In 2007 an evaluation was undertaken into the Groote Eylandt and Bickerton Island Alcohol Management System, using both quantitative and qualitative data.[28] At the time of the evaluation, liquor permit conditions could be breached by doing the following:

- Disrupting community order and peace;
- Being involved in alcohol-related violence or traffic incidents;
- Illegally bringing, possessing or consuming alcohol or a dangerous drug in a restricted area;
- Supplying alcohol or drugs to a person who is not a permit holder or an invited guest of a permit holder; or
- Littering with alcohol within the restricted area, such as dumping cans or bottles.

Quantitative data showed that between 2004/2005 and 2005/2006 (pre and post intervention), there were reductions in aggravated assaults (67%), public drunkenness (75%) and property offences (52%). Qualitative interviews with community members and key stakeholders revealed that community functioning had improved, violence had decreased and workforce engagement had improved.

The success of the Groote Eylandt and Bickerton Island Alcohol Management System lies in the 'ownership and support of the system by Aboriginal communities and by key local service providers, employers and the licensed premises.'[29] The relative isolation of these regions may have also contributed to its success as there were fewer opportunities for people to be influenced by surrounding areas.

Mount Isa mandatory restrictions

On 1 August 2002, restrictions on alcohol sales were implemented for a 12 month trial period and applied to 14 (out of 45) licensed premises in the town. The restrictions were:

- No on-premise alcohol sales before 9am;
- No takeaway sales before 10am; and
- No sale of cask wine in containers greater than two litres.[30]

An evaluation of the Mount Isa restrictions was carried out by d'Abbs, Togni and Hollins (2003).[31] The evaluation found that total volume of absolute alcohol purchased declined by 8.8% from January to March 2002 (pre intervention) to the same period in 2003 (post intervention). This decline was partially offset by increased sales in the nearby town of Cloncurry.

In the first six months of the trial, there was a 16.7% decrease in alcohol-attributable assaults for Aboriginal and Torres Strait Islander peoples and no change to non-Indigenous admissions. However, in the first five months of the trial (five months because data for the latter part of the trial was considered unsuitable for analysis) emergency department presentations for causes likely to be related to alcohol increased by 39% for males and 47% for females compared to the equivalent period the previous year. The researchers postulated that this may have been due to an increase in broken glass from wine flagons being present in the area and this is reflected in the increase in glass being coded as a Major Injury Factor during the first six months of the trial period.[32] It is also important to note that study included small numbers of people.

There was no impact on the number of public order offences and drink-driving offences during the restrictions. The evaluation surmised that the lack of sustained positive effects may have been due to over-focus on supply measures, without adequate support or input from local agencies.

The Tennant Creek restrictions: 'Thirsty Thursday' 6-month trial (August 1995 to February 1996)

In August 1995, The Tennant Creek restrictions 'Thirsty Thursday' came into effect for a six-month trial. Two hotels and one bottle shop were affected by these restrictions, leaving four licensed clubs (members only), two restaurants and three private hotels unaffected.

Alcohol was restricted on Thursdays, to coincide with the timing of welfare payments. In Phase One of the trial (August 1995 to November 1995), takeaway sales and sales from front bars were prohibited on Thursdays. In Phase Two (November 1995 to February 1996) this was modified to allow takeaway and front bar sales between 3.00pm and 9.00pm on Thursdays. The remainder of the restrictions concerning days other than Thursday were consistent across both phases, and these included: wine only to be sold with meals from front bars, a ban on the sale of four and five litre casks of Riesling and Moselle and the sale of two litre cask wine being limited to one per person per day.[33]

An evaluation of the trial of the Tennant Creek restrictions was conducted by d'Abbs et al (1996).[34] Compared to the same period in 1994/95, the total number of incidents attended by police on Thursdays decreased by 55% in Phase One and by 13% during Phase Two (when the Thursday restrictions were relaxed).

d'Abbs et al also analysed weekly data (as opposed to Thursday data only) for other measures. Public drunkenness, breaches of the 'Two Kilometre Law'[ii] and disturbances increased from Phase One to Phase Two when the Thursday restrictions were relaxed.

During Phase One, presentations to the Tennant Creek emergency department that were attributed by staff to alcohol were 34% lower than the equivalent pre-trial period in 1994/95. In Phase Two, the total number of presentations increased from Phase One. This data indicates that the tighter the restrictions (Phase One compared to Phase Two), the greater the reduction in alcohol-related harms.

In April 1996, the Northern Territory Licensing Commission imposed the restrictions on a permanent basis. These restrictions aligned more closely to Phase One's total Thursday bans. Evaluations of these restrictions by Gray et al, 1998 [35] and by d'Abbs et al, 2000 [36] showed reductions in alcohol-related harms compared to before the restrictions, although there was evidence of a weakening effect over time. Several modifications to the restrictions have been made since April 1996. The most significant change was the abolition of the Thursday bans in July 2006.[37] However, other restrictions are still in place in Tennant Creek, including those targeting the hours of supply of alcohol.[38]

Summary of policy options

There are a number of policies that can limit the availability of alcohol included in the examples provided above. A summary of these is included in the table below. For each of these measures an effectiveness rating is provided using symbols that indicate the following:

- ✓ There is strong evidence that these policies will result in substantial reductions in alcohol-related harm.
- ✓/× These policies can be effective when certain conditions, such as community control or enforcement are present.
- × There is limited evidence that these policies will result in reductions in alcohol-related harm and may in some instances, increase alcohol-related harms.

Table 1: Effectiveness of policy options to reduce alcohol-related harm in Aboriginal and Torres Strait Islander communities

Policy option	Rating of effectiveness	Notes/comments
Trading hour restrictions on off-licence and on-licence premises	✓	Evidence has consistently demonstrated that increased trading hours are associated with increased levels of alcohol consumption and harm.
Outlet density controls	✓	Evidence consistently shows a strong relationship between increased numbers of licensed premise and increases in the levels of violence. Policy responses include implementing 'saturation zones' or 'cluster controls'.
Restrictions on access to high risk alcohol beverages	✓	Some beverage types are associated with specific problems for population groups or areas. While restricting access to these products can cause substitution, the effects of this are outweighed through the overall reductions in consumption and related harms.

[ii] The 'Two Kilometre Law' was introduced to deter public drunkenness in 1983 by the Northern Territory Government. This Law made it an offence to consume alcohol in a public place within two kilometres of a licensed premise, or to consume alcohol on unoccupied land without the owner's permission. This Law remains in place today.

Policy option	Rating of effectiveness	Notes/comments
Mandatory restrictions for remote and regional communities	✓/×	Can result in long-term change, particularly when supported by the general community, the Aboriginal and Torres Strait Islander community and Police. To be effective restrictions need to be adaptive to local needs and circumstance and be adequately resources and enforced. They should also be supported by harm and demand reduction strategies and long-term commitment to improving the underlying social determinants.
Alcohol Management Plans (AMP)	✓/×	AMPs are most effective when they are controlled by the local community and have adequate long-term resources to imbed supply reduction, demand and harm reduction strategies within an area.
Dry Community Declarations	✓/×	Key to dry area declarations is the combination of statutory and community control. However police enforcement is also of vital importance to the success of dry communities.
Local 'dry area' alcohol bans	×	Only restrict alcohol consumption in public places, usually imposed upon communities. This may lead to decreases in public order offences but not reductions in alcohol-related harm.

While there is some evidence on the effectiveness of various policies, there are many policies and programs that are not independently evaluated. It is critical to evaluate the effectiveness of any restrictions that are implemented on a regular basis. The National Drug Research Institute has outlined *"key points for decision makers to keep in mind when gauging expectations:*

- *Even modest changes in measurable outcomes, can in reality, bring welcome relief to communities beset with the burden of alcohol-related problems;*
- *Evidence of short-term improvements may be preferable to no improvement at all;*
- *Evidence of short-term change is typically easier to show than long-term change;*
- *To produce evidence of on-going change enduring but flexible evaluation strategies are necessary;*
- *Piece-meal strategies may be easier to implement than comprehensive strategies but are less likely to result in optimal and ongoing change;*
- *Restrictions that are politically attractive, met with little resistance and relatively easy to implement are not necessarily effective;*
- *Restrictions may require multiply transformation and adjustments to reach these optimal potential and should be monitored over time;*
- *A goal should be to sustain the impact of the restrictions; and*
- *Where possible it is preferable to err on the side of minimising – not continuing – harm."*[39]

FARE position

To gain further information on the supply of alcohol, FARE urges the Standing Committee on Indigenous Affairs to seek information on the supply of alcohol to Aboriginal and Torres Strait Islander communities (and surrounds) from alcohol producers, distributers, wholesalers and retailers as part of this Inquiry. This information should seek to answer the following questions:

- What is the supply chain of alcohol from producers, distributors, wholesalers and retailers to Aboriginal and Torres Strait Islander communities? How does this differ for communities with limited restrictions, when compared to those that are dry?
- How much alcohol and what type of alcohol is being provided to communities?
- How frequently is alcohol being supplied to these communities and what is the timing of the provision of alcohol?
- How is the alcohol priced and promoted to these communities?
- What role is the alcohol industry adopting in mitigating the risk of harms that result from the consumption of alcohol?

It is also important that sales data is collected and reported on nationally and that data is available for all states and territories. The collection of sales data is recommended by The World Health Organization (WHO).[40]

Reducing the availability of alcohol reduces alcohol-related harms. Governments have the ability to introduce restrictions to the availability of alcohol through state and territory liquor legislation and through the development of tools such as AMPs. The alcohol industry also has a role in making available data on their supply practices, particularly to Aboriginal and Torres Strait Islander communities and nearby regions given the disproportionate levels of harm evidenced.

A reduction in trading hours and controls on outlet density across all states and territories will result in reductions in alcohol-related harms. These measures are evidence-based and have proven their effectiveness in reducing alcohol-related harms in Australia and internationally. A reduction in trading hours for both on and off-licence premises is needed. There should be no 24 hour licenses, opening times for all licensed premises should be no earlier than 10am and licensed venues with extended hours should not operate beyond 3am.

The introduction of targeted, community driven AMPs that are adequately resourced is one strategy that has been found to be effective in reducing alcohol-related injuries, including serious injury.[41] AMPs can enable communities to implement local initiatives that are focused on reducing alcohol-related harms. However, to be effective they need to be driven and led by Aboriginal and Torres Strait Islander communities and by Aboriginal and Torres Strait Islander agencies, with support from Governments to build the capacity locally to develop the plans. AMPs that are not controlled by Aboriginal and Torres Strait Islander communities and do not have culturally appropriate adaptation will not reduce alcohol and other drug related harm and will not succeed.[42]

Governments should abandon any moves that would directly or indirectly increase the availability of alcohol. For example there is a high risk of increased alcohol-related harms if AMPs are revoked under the current review by the Queensland Government. Removing regulation of alcohol that controls its availability under the guise of deregulation is irresponsible and will result in further alcohol-related harms.

The recommendations outlined in this submission cross over the responsibilities of both the Commonwealth and state and territory governments. In the circumstances where changes are required by all state and territory governments, FARE recommends that a coordinated approach be adopted where addressing the harms from alcohol should be a priority of the Council of Australian Governments (COAG). As part of this approach, COAG should determine minimum standards for improvements to alcohol-related legislation and policies across all states and territories. These minimum standards should be based on the recommendations included throughout this report.

Recommendations

1. That the Inquiry recommends that addressing alcohol-related harms be a priority for the Council of Australian Governments (COAG). As part of this, COAG should establish minimum standards for alcohol-related legislation and policies for all states and territories.

2. That the Inquiry recommends that state and territory governments reduce trading hours for all new and existing liquor licences to the following:
   - All existing 24 hour liquor licences should be abolished and no new 24 hour licences should be granted;
   - Opening times for all licensed premises (including packaged licences) should be no earlier than 10.00am;
   - Standard closing times for all on-licence premises from Monday to Saturday should be midnight, with extended trading venues limited to 3.00am and lockouts (preventing entry for patrons) no later than 1.00am. Standard closing time for Sundays should remain at 10.00pm; and
   - Closing times for packaged licensed premises should be no later than 10.00pm.
   - For communities where trading hours are shorter than these, there should be the capacity to reduce trading hours further, for example through the introduction of Alcohol Management Plans.

3. That the Inquiry recommends the introduction of Alcohol Management Plans (AMPs) that control the availability of alcohol in communities where a need has been identified and agreed. These AMPs should also be targeted at the needs of the particular community, introduced in association with supportive structures designed to build capacity within the community, prevent risky consumption and support people who need assistance to reduce their alcohol consumption.

4. That the Inquiry recommends that states and territory governments introduce cluster control policies for the determination of new liquor licenses and establish saturation zones in areas that are identified as already having large numbers of liquor licenses.

5. That the Inquiry requests information from alcohol producers, distributors and retailers on the supply chain of alcohol to Aboriginal and Torres Strait Islander communities, including:
   - What is the supply chain of alcohol from producers, distributors, wholesalers and retailers to Aboriginal and Torres Strait Islander communities? How does this differ for communities with limited restrictions, when compared to those that are dry?
   - How much alcohol and what type of alcohol is being supplied?
   - How frequently is alcohol being supplied to these communities and what is the timing of the provision of alcohol?

- How is the alcohol priced and promoted in and around these communities?
- What role is the alcohol industry adopting in mitigating the risk of harms that result from the consumption of alcohol?

6. That the Inquiry recommends that all states and territory governments mandate the collection and reporting of alcohol sales data at least annually. At a minimum, wholesale producers and licensees should provide sales data on beer, wine (including bottled and cask), spirits (including premix spirits) and cider separately. Postcode data should be provided by all producers and licensees to enable mapping of per capita consumption. A system should be established for nationally consistent collection and management of alcohol wholesale sales data to inform key alcohol policy developments and evaluations. As part of this, alcohol sales data should be made publically available in a format which can be easily accessed, used and analysed by policy makers and researchers.

The social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities

Current situation

Over the last decade our understanding of the factors that contribute to positive health and life outcomes have improved significantly. This has culminated in the development of the World Health Organization (WHO) Commission on Social Determinants of Health in 2005.

Put simply the social determinants of health are the circumstances in which people are born, live, work and grow that contribute to their health. These circumstances often fall outside of the traditional health portfolio and have a great impact on the inequities that exist between countries, within countries and even within local communities.

The social determinants of health are relevant to alcohol policy because the way that people consume alcohol is influenced by a range of life circumstances. These include people's age, gender, cultural background and place of residence. This is why particular population groups within the broader Australian population experience disproportionate levels of alcohol-related harms when compared to the rest of the population; these include young people and Aboriginal and Torres Strait Islander peoples.

Alcohol can be both a consequence of and contributor to poor health and inequity.[43] For example, risky alcohol consumption can be as a result of poor living conditions and lack of employment, and can also lead to these circumstances (loss of housing or employment).

A social determinants approach requires that the impact on health is considered across all government policy and decision making. In January 2014, the WHO published a framework for implementing a 'health in all policies' approach. It takes into account the impact on health of decisions taken across government portfolios, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity.[44] It recognises that the determinants of health have social, environmental, and economic origins that extend beyond the direct influence of the health sector and health policies, and that public policies in all sectors and at different levels of government can have a significant impact on population health and health equity.[45]

An area where a 'health in all policies' approach should clearly be adopted is liquor licensing. Each state and territory has liquor legislation which regulates the sale and supply of alcohol. While several states and territories have now introduced the principle of harm minimisation within their legislation, the interests of business are often elevated above this principle. In New South Wales for example, the *Liquor Act 2007* does not include harm minimisation as a Primary Object.

"The Objects of the Act are as follows:

a) *To regulate and control the sale, supply and consumption of liquor in a way that is consistent with the expectations, needs and aspirations of the community;*
b) *To facilitate the balanced development, in the public interest, of the liquor industry, through a flexible and practical regulatory system with minimal formality and technicality; and*
c) *To contribute to the responsible development of related industries such as the live music, entertainment, tourism and hospitality industries.*[46]

Harm minimisation is included merely as a requirement to secure the Objects of the Act, stating that particular regard be given to:

a) *The need to minimise harm associated with misuse and abuse of liquor (including harm arising from violence and other anti-social behaviour);*
b) *The need to encourage responsible attitudes and practices towards the promotion, sale, supply, service and consumption of liquor; and*
c) *The need to ensure that the sale, supply and consumption of liquor contributes to, and does not detract from, the amenity of community life.*[47]*"*

The recent review of the *NSW Liquor Act 2007* considered proposed amendments to the Act but decided against taking the opportunity to prioritise harm minimisation. This places the interests of business ahead of the interests of the community and of public health.

A further example of an area where a 'health in all policies' approach should be taken is in the Commonwealth Government's deregulation agenda aimed at cutting red tape to 'build a strong and prosperous economy' and to 'improve our nation's competitiveness, help to create more jobs and lower household costs.'[48] The deregulation agenda conducted its first Repeal Day on 26 March 2014 where more than 10,000 pieces of legislation were repealed. It is important that this approach to 'deregulation' includes consideration of public health, including a determination of whether the changes to policy could result in unintended poor health outcomes.

Evidence

Aboriginal and Torres Strait Islander peoples face significant disadvantage in income, employment, educational attainment and health, when compared to other Australians. Education and income levels are estimated to account for between one-third and one-half of the gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous people's health status. Socioeconomic differences account for between one-third and two-thirds of the gap in early childhood outcomes.[49]

A range of factors can mitigate or prevent risky alcohol consumption. Known as protective factors, these include higher levels of income, employment and participation in education. Safe and supportive families and communities are also protective by promoting a range of positive outcomes. Protective factors emphasise the need to address the underlying social determinants as well as targeting alcohol and other drug (AOD) use itself.[50] Improvements in health status and outcomes will occur only as Aboriginal and

Torres Strait Islander peoples are able to live healthier lives and use high quality health services when needed.[51]

The 'health in all policies' approach has been developed and implemented in a number of countries including Canada and Sweden[52] and all European Union policies.[53] It assists leaders and policy-makers to integrate considerations of health, well-being and equity during the development, implementation and evaluation of policies and services.[54] A 'health in all policies' approach is a relatively new approach, however a preliminary evaluation in South Australia demonstrated a willingness and acceptance of the approach.[55]

FARE position

It is vital that the Commonwealth Government commits to actions to reduce alcohol-related harms in Australia and particularly among Aboriginal and Torres Strait Islander peoples. To do this, a comprehensive approach to reducing alcohol-related harms is needed across all levels of government. A new National Alcohol Strategy is needed which adopts a social determinants approach to health and outlines coordinated and planned strategies across Government portfolios to reduce alcohol-related harms.

A critical part of all policy development is assessing whether policies will detrimentally impact on a person's health or indeed result in poorer health outcomes. This means a 'whole of government' or 'health in all policies' approach to health[56] and in the context of this Inquiry, to the health of Aboriginal and Torres Strait Islander peoples. The National Alcohol Strategy should include information on how a 'health in all policies' approach will be used in regulating the activities of the alcohol industry.

Two areas where a 'health in all policies' approach is particularly relevant are the current deregulation agenda of the Commonwealth Government and the regulation of liquor licensing and related legislation. Economic imperatives should not override the duty of care that the governments have to ensure the health and safety of Australians. All governments have a role in ensuring this.

Improved health status and better outcomes will occur only once social indicators (ie social determinants) such as adequate housing, literacy levels, employment and income, community safety and healthy behaviours (such as risky levels of alcohol consumption) improve. Other factors needed include connection to family, community, country and culture, racism.[57]

Recommendations

7. That the Inquiry recommends that a new National Alcohol Strategy be developed and implemented and informed by the World Health Organization's *Global strategy to reduce the harmful use of alcohol.*

8. That the Inquiry recommends that all governments adopt a 'health in all policies' approach to public policy which includes the establishment of health benchmarks and monitoring structures to ensure cross government action is being implemented and targets are being achieved.

9. That the Inquiry recommends that all state and territory governments elevate harm minimisation as the primary object of their respective liquor acts.

10. That the Inquiry recommends that public health considerations be assessed in the Commonwealth Government's deregulation agenda prior to action being taken.

Trends and prevalence of alcohol related harms, including alcohol-fuelled violence and impacts on newborns e.g. Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders

Current situation

The degree of risk for harmful use of alcohol varies with age, gender and other biological characteristics as well as with the setting and context in which the alcohol consumption takes place. Alcohol accounts for 3.2% of the total burden of disease and injury each year in Australia[58] and on average contributes to over 3,000 deaths and more than 80,000 hospitalisations per year.[59]

Risky alcohol consumption has an impact not just on the drinker but also on the people around them. In 2005, harms from 'someone else's drinking' resulted in 367 deaths, 14,000 hospitalisations and 70,000 cases of alcohol-related violence, including 24,000 cases of domestic violence. Furthermore, in 2006/07 almost 20,000 children were victims of substantiated alcohol-related child abuse.[60]

Aboriginal and Torres Strait Islander peoples experience more significant levels of alcohol-related harms than the general population. For alcohol-related health conditions, Aboriginal and Torres Strait Islander men are hospitalised at rates between 1.2 and 6.2 times those of other Australian men, and Aboriginal and Torres Strait Islander women at rates between 1.3 and 33.0 times greater.[61] Deaths from alcohol-related causes are 7.5 times greater for Aboriginal and Torres Strait Islander peoples than those of other Australians.[62]

At the state and territory level, data from the Northern Territory provides insight into regional variation of the disproportionate nature of alcohol-related-harm among Aboriginal and Torres Strait Islander peoples. Death rates among Aboriginal and Torres Strait Islander peoples and other Australians in the Northern Territory in 2004/05 were 18.6 and 3.8 per 10,000 people respectively, with the Northern Territory alcohol-related death rate as a whole for 2004/05 at 7.2 per 10,000 people 15 years and over, almost 3.5 times higher the national estimate of 2.1 per 10 000 people.[63] The alcohol-attributable hospitalisation rate for Northern Territory Aboriginal and Torres Strait Islander peoples in 2005/06 was 379 per 10,000 people, approximately 6.5 times higher than for non-Aboriginal and Torres Strait Islanders at 57.6 per 10,000 people.[64] Overall, the age-adjusted Northern Territory alcohol-attributable hospitalisation rate in 2005/06 was 135.4 per 10,000 people 15 years and over,[65] which was more than twice the national rate of 62.2 per 10,000 people.[66]

As well as health problems, alcohol is the cause of a wide range of social problems in Aboriginal and Torres Strait Islander communities and contributes to high rates of unemployment and incarceration. It also has a significant impact on whole communities, with particular concern arising from violent antisocial behaviour, the impact of parental alcohol use on children (including those yet to be born) and the intergenerational ramifications of these.[67]

Police data from the Northern Territory demonstrates the concerning trends in alcohol-related harms. This data is outlined in Table 2 below.

Table 2: Alcohol-related assaults in the Northern Territory from 2008 to 2013[68]

	Alcohol-related domestic assaults	Offence rates per 100,000	Alcohol-related non-domestic assault	Offence rates per 100,000	All alcohol-related assaults	Offence rates per 100,000
2008	1,768	804.1	1,332	605.8	3,100	1,409.9
2009	2,181	964.9	1,515	670.3	3,696	1,635.2
2010	2,385	1,038.0	1,680	731.1	4,065	1,769.1
2011	2,398	1,036.8	1,517	655.9	3,915	1,692.7
2012	2,540	1,079.9	1,581	672.2	4,121	1,752.1
2013	3,137	1,309.8	1,582	660.5	4,719	1,970.3

In 2013 in the Northern Territory, there were 4,719 alcohol-related assaults, including 3,137 alcohol-related domestic assaults and 1,582 alcohol-related non-domestic assaults. Alcohol-related domestic assaults have increased by 77 per cent from 2008 to 2013, while all alcohol-related assaults have increased by 52 per cent over the same time period. Alcohol-related non-domestic assaults increased to 1,650 in 2010, declined in 2011 and have remained relatively stable since. It is important to note that this data is for all Northern Territory residents and is not restricted to Aboriginal and Torres Strait Islander peoples. The data is important however in helping us to understand the increasing trends in alcohol-related assaults.

The disadvantage experienced by Aboriginal and Torres Strait Islander peoples is a consequence of the historical and continuing impact of colonialism and dispossession.[69] In addition many people who use alcohol and other drugs fear having a child removed from their custody and this can be a deterrent to seeking antenatal care and support.[70]

Fetal Alcohol Spectrum Disorders (FASD) prevalence rates in Australia are largely unknown. The availability of a diagnostic tool would facilitate the identification of FASD and collection of standardised data on prevalence. However such a tool for FASD does not currently exist in Australia. Work has been undertaken to develop a national diagnostic tool which will raise awareness about FASD and make diagnosis easier. In 2010-11 the then Department of Health and Ageing (DoHA) commissioned a group of Australian FASD researchers to develop a Screening and Diagnostic Instrument for Australia. This collaborative group brought together clinicians, epidemiologists, policy makers, parents and carers, consumer advocates, researchers and public health personnel. A final report was submitted to government, but the results have not yet been made public.[71] The collaboration is now seeking further funding to produce Australian guidelines on how to use the diagnostic instrument in a clinical setting.

Current Australian data suggests that prevalence rates for Fetal Alcohol Syndrome (FAS), one of the conditions within the spectrum, are between 0.06 and 0.68 per 1,000 live births in the general population and 2.8 and 4.7 per 1,000 births in the Aboriginal and Torres Strait Islander population.[72] However it is likely that these figures are underestimates.

In Western Australia, the Lililwan Project was established at Fitzroy Crossing to conduct the first prevalence study of FASD in Australia through a partnership of experts in local Aboriginal culture, Aboriginal health, paediatrics, research, epidemiology and human rights. In addition to surveillance, the

project aimed to give each child with FASD a personalised management plan involving their families, doctors and teachers. The project also aimed to educate the Fitzroy Valley communities about the risks of consuming alcohol during pregnancy and about the challenges faced by children with FASD and their families.

The Lililwan Project is part of a broader strategy known as the Marulu Project. This project was established after alcohol restrictions were introduced in Fitzroy Crossing following a high number of deaths and suicides in the community. It aims to create a brighter future for their children by providing prevention, diagnosis and support services to children affected by FASD and early life trauma.

The Northern Territory Government has recently indicated that it is *"exploring the antenatal rights of the unborn child"*[73] and could introduce laws to prevent women drinking during pregnancy. This could include *"either to prosecute or alternatively to restrain [pregnant women] from engaging in conduct which harms their unborn child."*[74] However, John Elferink, Attorney General for the Northern Territory, says the Government is yet to explore these options. There are significant concerns that if such measures proceed, they will further stigmatise women who are pregnant and deter them from seeking assistance. This could have the perverse effect of creating even greater levels of harms.

Evidence

The health inequality that exists between Aboriginal and Torres Strait Islander peoples and other Australians is significant. Aboriginal and Torres Strait Islander peoples living in remote areas have the greatest health need compared to other Australians. However the three quarters of Aboriginal and Torres Strait Islander peoples living in urban areas collectively make the greatest contribution to the health gap between Aboriginal and Torres Strait Islander peoples and other Australians.[75]

The quality of the collection of alcohol-related data varies significantly between jurisdictions across all health and social indicators. For example, alcohol-related violence data is not available for all states and territories. While some states such as NSW have an agency dedicated to collecting data on crime (the Bureau of Crime Statistics and Research), including alcohol-related violence, others do not even record alcohol-related incidents separately (such as Queensland). The collection of robust data on alcohol-related harms is important to allow the identification of the extent of alcohol-related violence in different regions and identify patterns of harm. It is also important to collect data so that the effectiveness of policies and programs can be measured.

The prevalence rates for FASD in Australia are believed to be significantly underestimated, due in part to the lack of routine screening of women about their alcohol use during pregnancy but also because many health professionals are reluctant to ask about alcohol due to time pressures, feelings of discomfort about doing so, and fear of repercussions.[76] Adding to this is the social stigma associated with alcohol consumption during pregnancy and a reluctance to report consumption due to embarrassment, guilt, and fear of being judged by others.[77] The situation is exacerbated by the lack of national guidelines for the screening and diagnosis of FASD conditions.

Preliminary results from the Lililwan Project in Western Australia provided early indications that the majority of the 127 children in the study required some form of allied health assessment, management and follow-up for well-defined levels of impairment. For example, 53% were referred for occupational therapy, 53% for speech pathology, 50% for psychology and 31% for physiotherapy.[78]

Currently there is no instrument to screen and diagnose FASD in Australia which has meant that health professionals have had to rely on tools that have been developed internationally such as those found in Canada and the United States of America (USA). Canada has nationally consistent diagnostic guidelines that have facilitated consistent diagnostic practice across the country and allowed comparable data to be collected and monitored over time.[79,80] In the USA, diagnostic clinics (established since 1993) have helped to raise awareness of FASD among health professionals and the community. Diagnosis has improved with 61% to 90% of paediatricians in the USA now being able to correctly identify the essential diagnostic features of FAS.[81]

International studies indicate higher prevalence rates of FAS. For example in the USA, the prevalence of FAS is estimated at between 0.5 to 2.0 per 1,000 live births, while FASD prevalence rates amongst younger school children in the USA and some Western European countries may be as high as 2-5%.[82]

FARE Position

Improvements are required in the collection of alcohol-related harms data on a range of harm indicators to identify particularly hazardous patterns of consumption and trends. This data should include the following:

- Alcohol-related ambulance attendances;
- Alcohol-related emergency department presentations for harms incurred to self (e.g. alcohol poisoning, injuries) and others (e.g. Injuries from alcohol-related violence);
- Alcohol-related hospitalisations;
- Alcohol-related assaults, including non-domestic assaults, domestic assaults and assaults on police; and
- Alcohol-related child protection cases.

Likewise, reliable data on FASD is needed to get a true picture of prevalence. A standardised diagnostic tool is the first step in collecting such data and is needed urgently. While some work has been done to develop a diagnostic tool, further resources are required to ensure that when the tool is completed it is supported by health professionals and implemented consistently across the country. Training health professionals on how to use the diagnostic tool is of equal importance.

Women who are pregnant need the community's support to better understand the risks associated with consuming alcohol when pregnant and reduce consumption, especially those who already consume alcohol at risky levels. In addition, dependent drinkers need access to appropriate and accessible treatment.

Recommendations

11. That the Inquiry recommends that a national data repository for alcohol-related harms be established. All states and territories should be required to routinely collect standardised data on alcohol-related harms that is mandatory, consistent, reliable, and reported so that it is publicly available. The following harm indicators should be included in the collection of alcohol harms data:
    - Alcohol-related ambulance attendances;
    - Alcohol-related emergency department presentations for harms incurred to self (e.g. alcohol poisoning, injuries) and others (e.g. Injuries from alcohol-related violence);
    - Alcohol-related hospitalisations;

- Alcohol-related assaults, including non-domestic assaults, domestic assaults and assaults on police; and
- Alcohol-related child protection cases.

12. That the Inquiry recommends that the standardised national diagnostic tool commissioned by the then Department of Health and Ageing is tested and implemented to facilitate diagnosis of FASD in Australia and that services are provided to diagnose, treat and manage FASD.

The implications of Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders being declared disabilities

Current situation

Australia lags behind the rest of the world in preventing, diagnosing and managing FASD. The USA and Canada in particular have been undertaking initiatives associated with the recognition, diagnosis and response to FASD over the past 20 years. A parliamentary report on the problems of FASD was tabled in the Canadian Parliament in 1992, public awareness campaigns began in 1997 and a FASD Framework for Action was launched in 2002. In the USA, multi-disciplinary diagnostic clinics have been operating in Washington State since 1993.

In 2011, the Australian House of Representatives conducted an *Inquiry into the prevention, diagnosis and management of FASD* and recommended that a National Action Plan for FASD be established together with a FASD Reference Group, to provide advice on national initiatives to prevent, identify and manage FASD. As part of the Plan, the Committee recommended that the Commonwealth Government include FASD in the List of Recognised Disabilities and the Better Start for Children with a Disability Initiative.

In 2013, prior to the federal election, the Commonwealth Government committed $20 million over four years towards the *Australian Government Action Plan to reduce the impact of FASD 2013-14 to 2016-17: A Commonwealth Action Plan* (Action Plan). The plan had five key priorities:

1. Enhancing efforts to prevent FASD in the community – $5.0 million
2. Secondary prevention targeting women with alcohol dependency – $4.8 million
3. Better diagnosis and management of FASD – $0.5 million
4. Targeted measures to prevent and manage FASD within Indigenous communities and families in areas of social disadvantage – $5.9 million
5. National coordination, research and workforce support – $4.0 million

Due to the timing of the release of the Action Plan, no implementation occurred prior to the Commonwealth Government going into caretaker mode for the election. Unfortunately the fate of the Action Plan remains unknown and the current Government has not indicated whether it will progress the introduction of the Action Plan.

Other work to address FASD in Australia includes the development of a Model of Care for FASD by the West Australian Government in 2010 and the establishment of the first FASD diagnostic service in Australia at the Children's Hospital at Westmead in Sydney. In 2012 FARE released the *Australian FASD Action Plan 2013-2016* which aims to support people with FASD and prevent future generations from being affected by these conditions. The cost of the plan has been estimated at $37 million over three years.

Recognition of FASD as a disability would lead to greater awareness of the condition, as well as increased financial support for individuals with FASD and their families to access support services. It will also lead to further research into FASD and greater focus on developing strategies to support and manage FASD, including at school and if exposed to the criminal justice system. Early diagnosis of FASD is vital, providing the best opportunity to reduce and manage the disabilities associated with FASD and to provide counselling for primary prevention in future pregnancies.[83]

Evidence

Difficulties in achieving a diagnosis mean that people with FASD, their families and carers struggle to access disability support services and funding from social services, education and training, justice and health agencies. A 2005 a study of 1,143 health professionals in Western Australia found that only 12% correctly identified all four essential features of FAS, 95% had never diagnosed FAS and only 2% considered themselves properly skilled to manage an individual with FAS.[84] This research included Aboriginal Health Workers, allied health professionals, community nurses, GPs and obstetricians. When a similar study was conducted on paediatricians (n=132), it found that only 18.9% identified all essential diagnostic features for FAS, 76.5% had suspected but not diagnosed FAS and 12.1% had been convinced of it but not recorded the diagnosis.[85]

For children with FASD, little support is available. Autism Spectrum Disorders, which need similar attention to improve access to diagnosis, early intervention, specialised services and improved data collection as FASD, received substantial government investment of $190 million from 2008 to 2011 through the 'Helping Children with Autism' package. This allowed for the funding of individual assistance packages for children with autism or any other pervasive developmental disorder (excluding FASD), their families and carers. The *'Helping Children with Autism'* package involved cross government working with the former Department of Health and Ageing (DoHA), the former Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the former Department of Education, Employment and Workplace Relations (DEEWR) to deliver the program.

For people who care for children under 16 years who have a disability, support is available through carers payments. However, FASD is not currently included in the *'List of Registered Disabilities*' and is not adequately covered by any other disabilities on the list. FASD carers are therefore not eligible to receive assistance.

Adults are marginally better placed. Since January 2012, adults with FASD can be assessed under *Table 9: Intellectual Function* of the *Tables for the Assessment of Work Related Impairment* detailed in the Commonwealth's Social Security Act 1991. However, while FAS is associated with lower IQ, 75-80% of people with FASD have an IQ within the normal range.[86] Since FASD is a brain based disability, it is more appropriately listed as a condition under *Table 7: Brain Function*, alongside 'a person with Autism Spectrum Disorders who does not have a low IQ'.

It is also important that in order to prevent FASD, population-wide prevention measures are introduced. One such measure to raise awareness of FASD is the placement of health warning labels on alcohol products. This is a low-cost strategy which targets communicating a message to the drinker at the vital points of sale and consumption. Internationally, at least eighteen countries or territories have introduced laws requiring the compulsory use of health warning labels on alcohol products. These countries include France, South Africa, Brazil, Costa Rica, Ecuador, Honduras, Mexico, South Korea and the USA. These labels have been shown to be effective in communicating the harms of prenatal alcohol exposure, as well

as initiating discussions of the issue among pregnant women. These labels should be easily recognisable, even by those with limited literacy.

FARE position

There are significant gaps in awareness, knowledge, data, diagnosis and service delivery relating to FASD which need to be addressed. The Government should fully fund and implement FARE's three year Australian FASD Action Plan as a matter of urgency.

A national standardised diagnostic tool is needed to facilitate diagnosis and enable meaningful data to be collected. Finalisation and testing of the tool developed for Department of Health should be prioritised and guidelines developed on how to use the tool in a clinical setting. Training on the use of the diagnostic tool should also be provided to a range of health professionals including paediatricians, general practitioners, health workers, maternal and child health nurses, midwives, psychologists and psychiatrists.

FASD should be recognised as a disability and eligibility criteria for disability services modified to support people with FASD, their families and their carers. All people diagnosed with FASD should be provided with a treatment and management plan that is targeted at individual needs. A 'one size fits all' approach will not work for all people with FASD.

Mandatory health warning label about the risks of consuming alcohol while pregnant. The health warning labels should also be introduced:

- be mandatory so the label appears on all products;
- be applied consistently across all products so they are visible and recognisable;
- be developed by health behaviour and public health experts;
- be regulated and enforced by government; and
- be accompanied by a national public education campaign.

Recommendations

13. That the Inquiry recommends that FASD is recognised as a disability and eligibility criteria for disability services are modified to support people with a FASD condition, their families and their carers. FASD should be recognised as a cognitive impairment to allow access to support services and should be included in the Impairment Tables for Disability Support Pensions, acknowledged in the National Disability Insurance Scheme and included in the List of Recognised Disabilities for Carer Payments.

14. That the Inquiry recommends that a National FASD Action Plan is introduced that specifies the Commonwealth, State and Territory Government's responsibilities in addressing FASD and includes actions, targets and outcomes. The Plan should include the five key areas outlined in *FARE's Australian Fetal Alcohol Spectrum Disorders Action Plan 2013-2016* outlined below.
    I. Increase community awareness of FASD and prevent prenatal exposure to alcohol
        - Conduct an ongoing national public education campaign about the harms resulting from alcohol consumption during pregnancy.
        - Implement mandatory health warning labels on all alcohol products available for sale in Australia.
        - Provide specialist support services to pregnant women who have alcohol-related disorders.

- Educate health professionals on FASD and enable them to routinely ask and advise all women about their alcohol consumption.

II. Improve diagnostic capacity for FASD in Australia
   - Publish, implement and evaluate the Australian FASD diagnostic instrument.
   - Establish FASD diagnostic services.
   - Implement training for health professionals on the use of the Australian FASD diagnostic instrument.

III. Enable people with FASD to achieve their full potential
   - Support people with FASD, their families and carers - economic modelling is required to determine accurate funding estimates.
   - Improve early intervention options for people with FASD, their families and carers - Expand the current *Better Start for Children with Disability* initiative to include FASD and provide funding support to parent and carer organisations to support those who care for people with FASD.
   - Treat people with FASD in a socially inclusive manner upon entry into education, employment and if in contact with the criminal justice system.

IV. Improve data collection to understand the extent of FASD in Australia
   - Routinely record women's alcohol consumption during pregnancy and include standardised questions about alcohol consumption during pregnancy, as part of the Perinatal National Minimum Data Set – link this data to related collections.
   - Standardise data collection on FASD diagnosis and monitor prevalence, *referral, treatment and support.*
   - Monitor FASD prevalence through the Australian Paediatric Surveillance Unit.

V. Address the high prevalence of FASD among Aboriginal and Torres Strait Islander peoples
   - Provide support to Aboriginal and Torres Strait Islander peoples to develop community-driven solutions to address alcohol misuse.
   - Publish resources on FASD that are culturally appropriate and tailored to different cultural groups within Aboriginal and Torres Strait Islander communities.
   - Develop comprehensive community responses to FASD in remote and isolated Aboriginal and Torres Strait Islander communities.

15. That the Inquiry recommends that all people diagnosed with FASD are provided with a treatment and management plan that is designed to meet individual needs.

16. That the Inquiry recommends that equitable life-long services are provided when developing management and care systems for people with FASD, their families and carers, and that transitions from child to adult services are pre-planned and coordinated to ensure that people do not 'fall between the cracks.'

17. That the Inquiry recommends that processes are developed to ensure that people who are considered to be at-risk of having FASD are screened when they come into contact with government services including the criminal justice system, foster care system, child safety system and child and family centres and provide them with support throughout this time.

18. That the Inquiry examines sentencing options for people identified as having a FASD condition who comes into contact with the criminal justice system, similar to options provided to other people who have cognitive functioning disabilities.

Best practice treatments and support for minimising alcohol misuse and alcohol-related harm

Current situation

The term 'treatment' covers a broad range of interventions for alcohol and other drug-related problems. These include screening, brief interventions, detoxification, various counselling approaches including motivational interviewing and cognitive behavioural therapy, and other support such as self-help groups. Medical management is also important option for management and support once a person has finished withdrawal (detoxification).

Alcohol dependence is a chronic relapsing condition and therefore it is likely that relapse will occur. Ongoing care after treatment is important to support the individual at this critical stage and has been shown to reduce the frequency of relapse.[87]

Treatment programs are carried out in both community and residential settings, and focus on individuals and their families. Generally, residential treatment is not more effective than non-residential treatment[88] but evidence suggests that it is more effective for particular groups of clients including those *"… with more severe deterioration, less social stability and a high risk of relapse."*[89]

A range of treatment options and flexibility are needed to accommodate different needs. FARE has recently funded a project that will look at providing a home detoxification service for Aboriginal and Torres Strait Islander peoples in the Illawarra region of New South Wales, in response to a need identified in the area. The main alcohol treatment services used by Aboriginal and Torres Strait Islander dependent drinkers are residential. These are expensive and so have limited availability.[90] Other barriers such as stigma, transport and childcare needs also hamper access to treatment.[91] As a result many Aboriginal and Torres Strait Islander dependent drinkers continue to drink or risk un-medicated self-detox which can be life threatening in severe dependence. A diversity of treatment options should be developed for Aboriginal and Torres Strait Islander peoples and this FARE project is an example of this.

Treatment in Australia is voluntary in all states and territories unless a person is cognitively impaired and poses a risk to themselves or to others. However in the Northern Territory, mandatory treatment was introduced in 2013 for adults who are been taken into Police protective custody three or more times within a two month period for being intoxicated in public. These people are then referred by an independent tribunal to either a secure residential treatment facility, a community residential treatment facility or subject to another form of community management (including income management) for up to three months. Those people who abscond or are intentionally absent from a treatment service (on more than two occasions while the order is force) can be subject to imprisonment of three months.[92] There is no evidence to support the effectiveness of this approach in these circumstances.

Treatment can offer an alternative to entering the judicial system and provide substantial savings for courts and prisons. Diversion programs redirect people arrested and/or charged with drug or alcohol- related offences out of the judicial system and into the health system, with a view to minimising levels of contact with the formal criminal justice system.

All states and territories offer either drug, alcohol or both alcohol and other drug diversion programs. Research in 2008 found that Aboriginal people did utilise mainstream AOD services but that further improvement is required in treatment services for Aboriginal and Torres Strait Islander people to have access to Aboriginal and Torres Strait Islander staff, peer support groups and that treatment options that integrate the health care of the individual, the family and the community.[93] Overall more alcohol diversion programs are needed, particularly for Aboriginal and Torres Strait Islander peoples who are overrepresented in Australian prisons.

It is also acknowledged that Aboriginal Community Controlled Organisations (ACCHOs) and Aboriginal Community Controlled Health Services (ACCHS) have a role in the preventing and treating alcohol-related harms. ACCHOs and ACCHs operate across Australia in metropolitan, regional, rural and remote areas and are controlled by, and accountable to the Aboriginal and Torres Strait Islander people where they operate.[94] ACCHS provide a range of services that include general medical services as well as drug and alcohol services and health promotion programs. ACCHS aim to raise awareness within communities about particular health issues and tackle determinants of health at the community level, including advocating on behalf of the community on employment, and housing matters.[95]

A review of all AOD treatment services is currently underway by the Drug Policy Monitoring Program.[96] The *Review of the drug and alcohol prevention and treatment services sector* is looking at current and future service needs, the gap between met and unmet demand and planning and funding processes for the future. The expected completion date for this review is June 2014.

Evidence

A range of treatment options are available in Australia however access to treatment varies depending on level of remoteness. For Aboriginal and Torres Strait Islander peoples, access to culturally appropriate treatment services is limited. In 2009/10, there were 30 facilities providing residential drug and alcohol treatment to Aboriginal and Torres Strait Islander peoples, however nearly three-quarters of these had a waiting list.[97]

Mainstream services that have culturally appropriate support and services that are targeted at Aboriginal and Torres Strait Islander peoples are needed. Other gaps in service provision for Aboriginal and Torres Strait Islander peoples include the lack of ongoing care (also known as aftercare) for people completing treatment, treatment services for women and children, and services for people with co-occurring mental health problems.[98]

Aboriginal and Torres Strait Islander peoples appear to be under-represented in diversion programs that refer to alcohol treatment facilities.[99] In 2009/10, 13.7% of referrals to treatment as a result of court diversion were for Aboriginal and Torres Strait Islander peoples, much lower than the proportion of Aboriginal and Torres Strait Islander peoples who are incarcerated.[100]

Research to support compulsory treatment is limited. Based on current evidence, the best that can be said is that compulsory treatment can sometimes be effective in reducing AOD use and crime, for some people.[101] Unintended consequences of compulsory treatment include 'net widening' which increases the number of people subject to criminal justice proceedings due to the availability of a diversion option.

Other unintended consequences include reduced access to services for others (which can introduce the perverse incentive for people to access the criminal justice system to enable them to access treatment services earlier), greater sanctions associated with non-compliance that would ordinarily apply (particularly if treatment is referred from the criminal justice system), and discrimination against certain groups (such as Aboriginal and Torres Strait Islander peoples, young people, women, and people living in rural and remote locations).[102]

In 2004, the New South Wales Standing Committee on Social Issues conducted an extensive review of the *Inebriates Act 1912* (NSW) (*The Inebriates Act*). The Committee noted that the use of the Inebriates Act had declined between 2001 and 2004; 37 applications were made under the *Inebriates Act*, with 27 resulting in orders being made.[103] As a result of the review of the *Inebriates Act,* the Committee found that:

> *"In the absence of evidence to support the efficacy of compulsory treatment in addressing substance dependence in the longer term is a fundamental problem. This raises important questions about the cost effectiveness of the system that would be required to deliver compulsory treatment, and runs counter to the principle that encroachment on a person's autonomy, even in the community, cannot be justified unless there are substantial grounds for believing that the intervention will benefit the person."*[104]

FARE position

Equitable access to a range of evidence-based treatment options is required for Aboriginal and Torres Strait Islander peoples that are of the same quality and variety of those available to the others in the community. Culturally appropriate services are required, which include Aboriginal and Torres Strait Islander health workers. These services need to be adequately resourced to provide stability and security in the longer term to reduce uncertainty and high staff turnover.

FARE does not support mandatory treatment for risky alcohol use unless the person is cognitively impaired and at risk of harm to themselves or to others. In these circumstances, mandatory treatment should only continue for the period of impairment and risk of harm.

Mandatory treatment is not based on effective practice principles or evidence, discriminates against Aboriginal and Torres Strait Islander peoples, breaches human rights obligations, removes procedural fairness, criminalises public drunkenness, breaches an individual's right to self-determination and is unlikely to be effective.

Recommendations

19. That the Inquiry recommends an increase in funding and support for evidence informed treatment and rehabilitation services, including:
    - Psychosocial interventions - brief interventions and counselling, including general or problem solving counselling and motivational interviewing;
    - Pharmacotherapy; and
    - After care.

20. That the Inquiry recommends that Aboriginal and Torres Strait Islander peoples in urban, regional, rural and remote locations have access to at least the same range and quality of services as the rest of the population in Australia.

21. That the Inquiry recommends that Aboriginal and Torres Strait Islander controlled services, staffed with Aboriginal and Torres Strait Islander health workers, and mainstream services that have culturally appropriate support mechanisms in place are available.

22. That the Inquiry recommends that services are adequately resourced and funded for longer periods to offer stability, reduce staff uncertainty, provide staff training and development and to increase screening and brief interventions for alcohol. Equitable access to alcohol-related professional development is needed in rural and remote locations.

23. That the Inquiry recommends that families and friends of people consuming alcohol at risky levels and/or those suffering from alcohol-related harms are included in the treatment decision making and implementation process where appropriate and acceptable to the client.

24. That the Inquiry recommends that alcohol use and harm is treated as a health issue and, where appropriate, diversionary services are introduced and expanded to keep people out of prison for alcohol-related offences.

Best practice strategies to minimise alcohol misuse and alcohol-related harm

Current situation

It is well established that the increased availability, excessive promotion and lower price of alcohol all contribute to increased alcohol consumption and harms. Despite this, alcohol is more available than it has ever been in Australia. For example in New South Wales alone there are 17,010 liquor licenses[105] and in Victoria there are 20,000.[106] In addition, alcohol promotions are prolific, with the alcohol industry promoting messages through a range of media including television, social media, in store, on billboards and even on Government property. For example a New South Wales study found an average of 30.2 point of sale promotions per liquor outlet in NSW.[107] Alcohol is also more affordable than it has been for three decades with alcohol available for as little as 25 cents per standard drink.

A range of strategies are available to governments to minimise alcohol-related harm including population-wide strategies that act to reduce population consumption and targeted programs to address local needs. Broad-based, multidisciplinary and flexible strategies are needed to meet the varied needs of individuals and communities.[108]

Regulatory controls on the economic and physical availability of alcohol can be used to influence alcohol consumption and related harms. These include taxes and levies, restricting numbers, types and trading hours of outlets, restricting alcohol marketing and controls on the types of alcoholic beverages sold. Targeted strategies should aim to prevent or minimise the uptake of risky alcohol consumption, provide safe care for those who are intoxicated, provide treatment for those who are dependent, support those whose high risk consumption patterns have left them disabled or cognitively impaired, and support those whose lives are affected by others' harmful alcohol use.

A good example of how this can be applied is the experience at Fitzroy Crossing described earlier, where the community recognised the need to take action and worked together to effect change.

Evidence

Evidence shows that low alcohol prices result in higher consumption levels, including heavier drinking, occasional drinking, and underage drinking. If the price of alcohol increases, a reduction in overall consumption, and heavy consumption in particular, is observed.[109] In 2009, a meta-analysis was undertaken of 112 peer reviewed studies on the effects of alcohol price and taxation levels on alcohol-related harms found that there was 'overwhelming evidence of the effects of alcohol pricing on drinking'.[110] Even small increases in the price of alcohol can have a significant impact on consumption and harm.[111]

Australia's current alcohol taxation system is complex and inequitable. Alcohol products are taxed differently based upon their type, the way they are packaged, their alcohol content and their cost. The greatest discrepancy in the current alcohol taxation system is the wine equalisation tax or WET. The WET results in wine being taxed according to its retail price rather than its alcohol content. This means that cheaper wine attracts less tax. A volumetric tax (i.e. a tax based on the volume of alcohol in product) is applied to beer and spirits and would provide a fairer and more equitable approach to taxing wine. It would also result in an increase in the cheapest alcohol products and remove the incentive to produce cheap wine.

Alcohol marketing in Australia is pervasive and available in more formats than it has ever has been. A conservative estimate of total alcohol advertising expenditure in Australia in 2007 was $128 million.[112] However, this figure does not take into consideration the amount spent on alcohol sponsorship or merchandise. Use of social media and smart phones[113] presents challenges for regulators in monitoring and regulating marketing since social media is dependent on user creativity and interaction. Alcohol advertising has been shown to influence young people's attitudes and behaviours,[114] [115] [116] a particular concern because young people bear a disproportionate level of harm from alcohol-related accidents and injury.[117] Current regulatory activities in Australia are flawed, with alcohol advertising predominantly 'regulated' under a *voluntary* scheme which is funded and managed by the alcohol industry, the Alcohol Beverages Advertising Code.

Community-led interventions such as those found in Fitzroy Valley in Western Australia have also proven their effectiveness. Alcohol restrictions were established in the Fitzroy Valley after community members decided they needed to do something about the high number of deaths and suicides in the community of Fitzroy Crossing. With the support of community leaders, the *sale of packaged liquor, 'exceeding a concentration of ethanol in liquor of 2.7 per cent at 20 degrees Celsius', was prohibited to any person, other than a lodger (as defined in Section 3 of the Act)'* in October 2007[118].

A 12 month evaluation showed that following the restriction on the sale of take away alcohol there was an increase in the number of people seeking treatment and improvements to community safety, health, education and training, and cultural and community development.[119] The 24 month evaluation saw continuing benefits and found that when the volume of alcohol was reduced, there was an increase in health and social benefits.[120] It also found a slight reduction in the positive benefits which may be related to the initial absence of programs and services to support the community through these changes.

Other activities that have been shown to be effective include sobering up shelters and Community patrols. Sobering up shelters were established to keep intoxicated consumers safe. They have the added benefit of providing the opportunity to provide advice and referral if necessary. Community patrols[121,122] were established to prevent harm, and maintain community peace, security and safety. While evaluations of the effectiveness of sobering up shelters is limited, these are well supported in Aboriginal and Torres

Strait Islander communities and implemented widely because they have been shown to be effective in meeting their objectives.[123]

The Banned Drinkers Register (BDR) was introduced in 2011 as part of a range of measures to address alcohol-related harms in the Northern Territory. Key to the BDR was the use of identification scanners at all take-away outlets that were linked to the BDR. Every customer had to provide their identification when purchasing alcohol and those registered on the BDR were barred from buying alcohol at the point of sale. The BDR was subsequently removed in 2012 with a change in Government after the Northern Territory election amidst claims that the BDR had been ineffective in reducing hospital presentations. Yet an independent evaluation of the BDR had not been conducted.

However, the National Drug Research Institute recently analysed emergency department presentations and hospital admissions data from the Alice Springs Hospital following the introduction of the BDR. After accounting for a change in practice by police where all people in protective custody were automatically taken to the emergency department for a medical assessment following a recent death of an Aboriginal and Torres Strait Islander person whilst in custody, the analysis concluded that there was a reduction in alcohol-related harms at Alice Springs as a results of the BDR.[124]

FARE's position

The Government should target the most effective demand and harm reduction strategies to reduce risky alcohol consumption and alcohol-related harm. These include addressing the inequitable alcohol taxation system that allows for alcohol to be purchased for as little as 25 cents per standard drink. Countless reviews have recommended reforming the alcohol taxation system, including the most recent Final Report from the Australian National Preventive Health Agency which reported that the 'Agency finds that the current operation of the Wine Equalisation Tax is of concern and requires reappraisal by the Government.'[125]

Alcohol marketing is prolific and measures need to be taken to reduce exposure to of alcohol marketing, particularly to children and young people. The current regulatory approaches to alcohol marketing are flawed and the Government should move towards a system of independent regulation to improve this.

These population based strategies should be supported by interventions that are targeted at those at risk, including Aboriginal and Torres Strait Islander peoples, young people and women who are pregnant, and meet the needs of individual communities. Strategies should be developed in conjunction with the target group identified.

Community patrols and sobering up shelters should be introduced and/or retained in areas where a need has been identified. The BDR in the Northern Territory should be reintroduced to allow for a thorough and independent evaluation of its effectiveness. Alcohol interventions in Aboriginal and Torres Strait Islander communities should take into account the above principles for success when developing any strategies to reduce risky consumption and alcohol-related harms.

Recommendations

25. That the Inquiry recommends that the Commonwealth Government reform the alcohol taxation system in Australia to implement a volumetric tax on wine.

26. That the Inquiry recommends that the Commonwealth Government close the loophole that allows alcohol advertising on television before 8:30pm and introduce independent regulation of alcohol marketing.

27. That the Inquiry recommends a phase out of alcohol sponsorship of sport and cultural events.

28. That the Inquiry recommends that the Northern Territory Government re-introduce the Banned Drinkers Register and undertake a robust and independent evaluation of this measure.

29. That the Inquiry recommends that sobering up shelters be established to provide support, care and monitoring for those who are intoxicated. These should be independent of law enforcement activities.

30. That the Inquiry recommends that community patrols be established in urban, regional and remote locations where these do not exist and a need is identified, to improve community safety and reduce harm.

Best practice identification to include international and domestic comparisons

There are several examples of policies and programs both in Australia and internationally that have resulted in significant reductions in alcohol-related harms. Some examples of these are included in the sections below.

The Northern Territory's *Living With Alcohol Program*

The Northern Territory Government committed money to implement the *Living With Alcohol Program* as a whole of government approach to reduce alcohol-related harm, after estimates put the cost of alcohol-related problems to the Northern Territory community at more than $150 million a year.

A range of treatment, education, training, research and law enforcement activities were funded as part of the initiative. [126] Three main areas of action were:

- *Culture* – initiating change in both individual behaviour and the alcohol 'culture' of the NT by:
  - establishing awareness of the links between alcohol misuse and community, family and personal problems provide information about responsible drinking and the consequences of excessive consumption so that people can make informed choices;
  - creating an environment which actively encourages responsible drinking and discourages hazardous consumption; and
  - supporting individuals, families and communities in their careful drinking choices, including people and communities that choose not to use alcohol or to restrict the availability of alcohol.

- *Control* – making regulations and changes in the law and policies that affected the availability, promotion, serving and consumption of alcohol, such as:
  - restrictions on the number of cans of beer that can be purchased on any one day;
  - communities becoming 'dry' or having a licensed club; and
  - strict enforcement of laws about not serving intoxicated or underage people.

- *Care* – providing interventions, support, treatment and rehabilitation services for people who have alcohol-related problems or who are affected by someone else's drinking.

An evaluation of the program showed that there was a substantial reduction in alcohol-related harm following the introduction of the *Living With Alcohol program*.[127] Reductions were observed in the estimated alcohol-caused deaths from acute conditions (road deaths 34.5%, other 23.4%) and in road crash injuries requiring hospital treatment (28.3%). In addition there were substantial reductions in per capita alcohol consumption and self-reported hazardous and harmful consumption via surveys. These reductions were evident from the outset of the program and were largely sustained throughout the four years studied.

A further evaluation found that the key driver of reductions in alcohol-related harm was the implementation of the levy. This levy allowed for programs and services to be funded through its collection and this in turn helped to further reduce the alcohol-attributable injuries in the short term and reductions in chronic illness in the longer term.[128]

Alcohol minimum price

A minimum price or floor price for alcohol sets a minimum price per standard drink (or unit of alcohol) that alcoholic beverages must be sold for. Minimum pricing is not a taxation measure, but rather a regulatory measure used to increase the price of the cheapest alcohol products and decrease discounting of cheaper products. It can prevent retailers from using alcohol as a loss leader to attract customers into their stores and can guarantee that a product will not be discounted below a certain amount.

The introduction of a minimum price in two Canadian provinces, British Columbia and Saskatchewan, has demonstrated the impact of a minimum price on alcohol consumption. A 10% increase in minimum price in both provinces was associated with a 3.4%[129] reduction in overall consumption in British Columbia and an 8.4% reduction in Saskatchewan.[130] In both contexts, minimum pricing was shown to reduce alcohol consumption overall and for all beverage types.

The difference in results from introducing a minimum price is due to the different circumstances in which they were implemented. In British Columbia, only spirits and liqueur wine prices were maintained at a level consistent with increases in cost of living and the cost per minimum drink of other beverages was relatively low[131] whereas Saskatchewan set per litre prices for beverages in different strength bands. Furthermore, the cost per standard drink varied between the two provinces. In British Columbia, the price ranged from $0.56 Canadian per standard drink for fortified wine containing 22% alcohol to $1.35 Canadian per standard drink for spirits containing 40% alcohol, whereas the minimum price in Saskatchewan averaged between $1.04 and $1.49 Canadian per standard drink containing 17.05 ml of alcohol, depending on beverage type and strength.[132]

The extent of reduction in consumption varied depending on beverage type. British Columbia saw consumption fall by 13.9% for alcoholic sodas and ciders, 8.0% for wine, 6.8% for spirits and liqueurs and 1.5% for beer whereas Saskatchewan saw consumption fall by 21% for premixed cocktails, 10.6% for beer, 5.9% for spirits and 4.6% for wine.

FARE position

A long term commitment is needed to reducing alcohol-related harms. This needs to include a range of evidence-based solutions. This means tackling both the drivers of demand and supply as well as targeted activities on the ground. Success will be limited if the underlying causes of harmful consumption and drivers of demand are not addressed in a strategic and sustained approach.

Minimum pricing policies have proven to be effective in Canada when introduced at the regional level. Minimum pricing policies address the harmful discounting that results in the availability of alcohol for as cheap as 25 cents per standard drink. Minimum pricing policies should be considered for local communities or jurisdictions across Australia as a mechanism for harm reduction.

Recommendations

31. That the Inquiry recommends that state and territory governments introduce a minimum price for alcohol to stop the extreme discounting of alcohol.

32. That the Inquiry recommends that a comprehensive strategy based on the *Living With Alcohol Program* be introduced in regions or jurisdictions where there are substantial levels of alcohol-related harms among Aboriginal and Torres Strait Islander peoples.

References

1 Australian Institute for Health and Welfare [AIHW] and Australian Bureau of Statistics [ABS]. (2008). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008. Canberra: ABS & AIHW.

2 Steering Committee for the Review of Government Service Provision (2011). Overcoming Indigenous Disadvantage: Key Indicators 2011. Productivity Commission, Canberra

3 Alcohol research groups oppose Northern Territory proposal to criminalise drinking while pregnant, ABC News, Sat 15 Mar 2014, http://www.abc.net.au/news/2014-03-15/research-groups-oppose-nt-prosecuting-pregnant-women-drinking/5322814

4 Mills, T. (2012) Scrapping the scan Media Release downloaded on 1 May 2014 from http://newsroom.nt.gov.au/index.cfm?fuseaction=viewRelease&id=9782&d=5

5 Liberal National Party (2012) Responsible Alcohol Management – A Community Approach https://lnp.org.au/revitalise-front-line-services/responsible-alcohol-management-a-community-approach/

6 Department of Aboriginal and Torres Strait Islander and Multicultural Affairs (2012) Review of Alcohol Management Plans 2012

7 Minister for Aboriginal and Torres Strait Islander and Multicultural Affairs and Minister Assisting the Premier (2012) Alcohol Management Plan Review begins downloaded 1 May 2014 from http://statements.qld.gov.au/Statement/2012/10/3/alcohol-management-plan-review-begins

8 Livingston, M. (2011). Using geocoded liquor licensing data in Victoria–The socioeconomic distribution of alcohol availability in Victoria. Victorian Health Promotion Foundation (VicHealth), Carlton, Australia.

9 Trifonoff, A., Andrew, R., Steenson, T., Nicholas, R. and Roche, A.M. (2011). Liquor Licensing Legislation in Australia: An Overview. National Centre for Education and Training on Addiction (NCETA). Flinders University, Adelaide, SA.

10 Babor, T., Catalano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube., Hill, L., Holder, H., Homel. H., Livingston, M., Osterberg, E., Rehm, J., Room, R and Rossow, I. (2010) Alcohol: No Ordinary Commodity. Research and Public Policy 2nd Edition Oxford University Press

11 Trifonoff, A., Andrew, R., Steenson, T., Nicholas, R. and Roche, A.M. (2011). Liquor Licensing Legislation in Australia: An Overview. National Centre for Education and Training on Addiction (NCETA). Flinders University, Adelaide, SA.

12 Department of Aboriginal and Torres Strait Islander and Multicultural Affairs. Queensland Government (2014). Webpage: Aurukun alcohol limits. http://www.datsima.qld.gov.au/atsis/government/programs-and-initiatives/alcohol-reforms/community-alcohol-limits/aurukun-alcohol-limits

13 Department of Business. Northern Territory Government. Webpage: Barkly region: http://www.dob.nt.gov.au/gambling-licensing/liquor/liquor-restrictions/alcohol-measures/Pages/barkly.aspx

14 Department of Racing, Gaming and Liquor, West Australian Government (2012). Liquor restrictions Karratha. http://www.rgl.wa.gov.au/maps/Restrictions/Karratha.pdf

15 Department of Business. Northern Territory Government. Webpage: Barkly region: http://www.dob.nt.gov.au/gambling-licensing/liquor/liquor-restrictions/alcohol-measures/Pages/barkly.aspx

16 Australian Government Department of Social Services. (2014). Webpage: Tackling alcohol abuse: http://www.dss.gov.au/our-responsibilities/indigenous-australians/programs-services/tackling-alcohol-abuse

17 Livingston, M. (2008) A Longitudinal Analysis of Alcohol Outlet Density and Assault Alcoholism: Clinical and Experimental Research Vol. 32, No. 6

18 Kypri K, Jones C, McElduff P, Barker DJ. (2010). 'Effects of restricting pub closing times on night-time assaults in an Australian city', *Addiction, 106 303-310*

19 Kypri, K., McElduff, P. &Miller, P. (2014) Restrictions in pub closing times and lockouts in Newcastle, Australia five years on Drug and Alcohol Review (May 2014), 33, 323–326

20 Ingeborg Rossow, I. & Norström, T. (2011). The impact of small changes in bar closing hours on violence. The Norwegian experience from 18 cities Addiction Vol 107, Issue 3.

21 Livingston, M. (2008). A Longitudinal Analysis of Alcohol Outlet Density and Assault. Alcoholism: Clinical and Experimental Research, 32(6), 1074-1079.

22 Livingston, M. (2011). A longitudinal analysis of alcohol outlet density and domestic violence. Addiction, 106(5):919-925.

23 Matthews, S. (2010). To compare regulatory and planning models which reduce crime in the night time economy, Churchill Fellowship Report. Winston Churchill Memorial Trust, Australia.

24 Schineanu, A., Velander, F. and Saggers, S. (2010) "Don't wake up angry no more" The Evaluation of the Norseman Voluntary Liquor Agreement. National Drug Research Institute, Curtin University of Technology, Perth, Western Australia.

25 Conigrave, K., Proude, E. & d'Abbs, P. (2007). Evaluation of the Groote Eylandt and Bickerton Island Alcohol Management System. Northern Territory: Northern Territory Department of Justice.

26 Information for visitors to Groote Eylandt. Accessed: http://www.gebie.com.au/visitors.html

27 Conigrave, K., Proude, E. & d'Abbs, P. (2007). Evaluation of the Groote Eylandt and Bickerton Island Alcohol Management System. Northern Territory: Northern Territory Department of Justice.

28 Conigrave, K., Proude, E. & d'Abbs, P. (2007). Evaluation of the Groote Eylandt and Bickerton Island Alcohol Management System. Northern Territory: Northern Territory Department of Justice.
29 Conigrave, K., Proude, E. & d'Abbs, P. (2007). Evaluation of the Groote Eylandt and Bickerton Island Alcohol Management System. Northern Territory: Northern Territory Department of Justice. (pp. 58-59)
30 d'Abbs et al, 2003. Cited in: National Drug Research Institute. (2007). Restrictions on the sale and supply of alcohol: Evidence and outcomes. Perth: Curtin University of Technology.
31 d'Abbs, P. Smith, D. and Hollins, J. (2003). Evaluation of Mt Isa Liquor Restrictions: A report for the Liquor Licensing Division, Queensland Department of Tourism, Racing and Fair Trading. Queensland Health, James Cook University.
32 d'Abbs, P. Smith, D. and Hollins, J. (2003). Evaluation of Mt Isa Liquor Restrictions: A report for the Liquor Licensing Division, Queensland Department of Tourism, Racing and Fair Trading. Queensland Health, James Cook University.
33 National Drug Research Institute. (2007). Restrictions on the sale and supply of alcohol: Evidence and outcomes. Perth: Curtin University of Technology.
34 d'Abbs, P., Togni, S. & Crundall, I. (1996). The Tennant Creek Liquor Licensing Trial, August 1995 – February 1996: An Evaluation. Menzies Occasional Papers No. 2/96. Darwin: Menzies School of Health Research and NT Living With Alcohol Program.
35 Gray, D., Saggers, S. Atkinson, D., Sputore, B. & Bourbon, D. (1998). Evaluation of the Tennant Creek liquor licensing restrictions. Perth: National Centre for Research into the Prevention of Drug Abuse, Curtin University.
36 d'Abbs, P., Togni, S., Stacey, N., & Fitz, J. (2000). Alcohol restrictions in Tennant Creek: A review prepared for the Beat the Grog Committee, Tennant Creek, Northern Territory. Darwin: Menzies School of Health Research.
37 d'Abbs, P. What does the evidence show? Presentation to Aboriginal Peak Organisations Northern Territory. http://www.apont.org.au/attachments/article/62/Dr%20Peter%20D%27ABBS%20Presentation.pdf
38 Northern Territory Government Department of Business. Tennant Creek. http://www.dob.nt.gov.au/gambling-licensing/liquor/liquor-restrictions/tennant-creek/Pages/default.aspx
39 d'Abbs et al, 2003. Cited in: National Drug Research Institute. (2007). Restrictions on the sale and supply of alcohol: Evidence and outcomes. Perth: Curtin University of Technology. Pg xix-xx.
40 World Health Organization. (2000). International guide for monitoring alcohol consumption and related harm. Geneva: World Health Organization
41 Margolis, S.,Ypinazar, V., Muller, R. and Clough, A. (2011). Increasing alcohol restrictions and rates of serious injury in four remote Australian Indigenous communities. The Medical Journal of Australia 194 (10): 503-506.
42 Senior, K., Chenhall, R., Ivory, B., Stevenson, C. (2009). Moving beyond the restrictions: The evaluation of the Alice Springs Alcohol Management Plan. Menzies School of Health Research, Menzies University, NT.
43 Closing the Gap Clearinghouse (AIHW, AIFS) (2010). Reducing the harm from alcohol and other drug related harm: Resource Sheet no 3 produced for the Closing the Gap Clearinghouse – Gray D and Wilkes, E. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare, Australian Institute of Family Studies
44 World Health Organization (2012). Health in All Policies (HiAP) Framework for Country Action Geneva
45 ibid
46 Liquor Act 2007 (NSW), section 3(1).
47 Liquor Act 2007 (NSW), section 3(2).
48 Abbott, T. & Frydenberg, J., (2014) Reducing red tape to build a strong and prosperous economy Office of the Prime Minister of Australia 19 March 2014 downloaded from https://www.pm.gov.au/media/2014-03-19/reducing-red-tape-build-strong-and-prosperous-economy
49 Steering Committee for the Review of Government Service Provision. (2011)., Overcoming Indigenous Disadvantage: Key Indicators 2011, Productivity Commission, Canberra https://www.pm.gov.au/media/2014-03-19/reducing-red-tape-build-strong-and-prosperous-economy
50 ibid
51 Australian Health Ministers' Advisory Council. (2012). Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report. AHMAC, Canberra
52 Shankardass, K. (2013) Strengthening the use of impact assessment for Health in All Policies: Lessons Learned from Sweden, Quebec and South Australia Conference presentation at Realizing the Potential of HEIA: Lessons Learned November 26, 2013
53 European Commission. Webpage: Health in all policies: http://ec.europa.eu/health/health_policies/policy/index_en.htm,
54 World Health Organisation (2010) Adelaide statement on health in all policies: moving towards a shared governance for health and well-being.
55 South Australian Health. Government of South Australia. Webpage: Research and evaluation of Health in All Policies. http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/health+in+all+policies/research+and+evaluation+of+health+in+all+policies
56 World Health Organization (2012) Health in All Policies (HiAP) Framework for Country Action Geneva
57 Osborne, K., Baum, F. & Brown , L.. (2013). What works? A review of actions addressing the social and economic determinants of Indigenous health Issues Paper no. 7 Closing the Gap Clearinghouse

58 Begg S, Vos T, Barker DC, Stanley L and Lopez A. (2007) Burden of disease and injury in Australia in the new millennium: measuring health loss from diseases, injuries and risk factors. Medical Journal of Australia.188:36−40. www.mja.com.au/public/issues/188_01_070108/beg10596_fm.html
59 National Drug Research Institute. (2009) Trends in estimated alcohol-attributable deaths and hospitalisations in Australia, 1996-2005 , National Alcohol Indicators Bulletin No. 12.
60 Laslett, A-M., Catalano, P., Chikritzhs, T., Dale, C., Doran, C., Ferris, J., Jainullabudeen, T., Livingston, M., Matthews, S., Mugavin, J., Room, R., Scholtterlein, M. & Wilkinson, C. (2010) The Range and Magnistude of Alcohol's Harm to Others. Fitzroy, Victoria: Victoria, AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health.
61 Australian Institute for Health and Welfare [AIHW] and Australian Bureau of Statistics [ABS]. (2008). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008. Canberra: ABS & AIHW.
62 Steering Committee for the Review of Government Service Provision. (2011). Overcoming Indigenous Disadvantage: Key Indicators 2011, Productivity Commission, Canberra
63 Northern Territory Government (2012) Alcohol use in the Northern Territory Health Gains Planning Information Sheet, downloaded on 24 April 2014 from http://www.territorystories.nt.gov.au/bitstream/handle/10070/245741/Alcohol_use_in_the_Northern_Territory.pdf?sequence=1
64 ibid
65 ibid
66 Skov SJ, Chikritzhs TN, Li SQ, Pircher S, Whetton S (2010) How much is too much? Alcohol consumption and related harm in the Northern Territory. Medical Journal of Australia; Vol 193, Number 5: 1-4.
67 Closing the Gap Clearinghouse (AIHW, AIFS) (2010). Reducing the harm from alcohol and other drug related harm: Resource Sheet no 3 produced for the Closing the Gap Clearinghouse – Gray D and Wilkes, E. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare, Australian Institute of Family Studies
68 Northern Territory Department of the Attorney-General and Justice (2014). Northern Territory Crime Statistics. Data through December 2013. Available at: http://www.pfes.nt.gov.au/~/media/Files/Police/Crime-statistics/2013/NT%20crime%20statistics%20Dec%202013-pdf.ashx
69 Closing the Gap Clearinghouse (AIHW, AIFS) (2010). Reducing the harm from alcohol and other drug related harm: Resource Sheet no 3 produced for the Closing the Gap Clearinghouse – Gray D and Wilkes, E. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare, Australian Institute of Family Studies
70 Goodyear, P. (2014). Families torn apart: drugs and child protection. Of Substance, March Vol 12. No 1.
71 Telethon Institute for Child Health Research (2011). Alcohol, Pregnancy and FASD. http://alcoholpregnancy.childhealthresearch.org.au/
72 Peadon, E., Fremantle, E., Bower, C. and Elliott, E. (2008). 'International Survey of Diagnostic Services for Children with Foetal Alcohol Spectrum Disorders', BMC Pediatrics 2008, 8:12.
73 http://www.abc.net.au/news/2014-03-14/nt-government-considering-rights-of-unborn-child/5320016
74 Alcohol research groups oppose Northern Territory proposal to criminalise drinking while pregnant, ABC News, Sat 15 Mar 2014, http://www.abc.net.au/news/2014-03-15/research-groups-oppose-nt-prosecuting-pregnant-women-drinking/5322814
75 Boofer, J., Tilton, E., Legge, D. & Genat, B (2009) Reducing the harm from Alcohol, Tobacco and Obesity in Indigenous Communities Key Approaches and Actions, National Preventative Health Taskforce
76 Riley, E. Clarren, S., Weinberg, J. and Jonsson, E. (Eds) (2011). Fetal Alcohol Spectrum Disorder: management and policy perspectives of FASD. Wiley-Blackwell, Germany.
77 FASD ECD Curriculum Project (2007). Partnerships Project: Fetal Alcohol Spectrum Disorders: A Curriculum for Those Working with Young Children and their Families in Home and Community Settings. Public Health Agency of Canada
78 Lucas, B (2012) Submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Fetal Alcohol Spectrum Disorders (FASD), submission number 88 available from http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=spla/fasd/subs.htm
79 Badry, D. and Bradshaw, C. (2011). Assessment and Diagnosis of FASD Amongst Adults: A National and International Systematic Review. Public Health Agency of Canada ISBN 978-1-100-15348-3
80 Sterling, C. Lutke, J. and Sherbuck, M. (2011). The Canadian Guidelines and the interdisciplinary clinical capacity of Canada to diagnose Fetal Alcohol Spectrum Disorder. Journal of Population Therapeutics and Clinical Pharmacology Vol 18 (3) e494-e499
81 Elliott, E.J., Payne, J., Haan, E. and Bower, C. (2006). 'Diagnosis of foetal alcohol syndrome and alcohol use in pregnancy: A survey of paediatricians' knowledge, attitudes and practice.' Journal of Paediatrics and Child Health, 42, 698-703.
82 May, P., Gossage, J., Kalber W., Robinson, L., Buckley, D., Manning, M. and Hoyme, H. (2009). 'Prevalence and epidemiologic characteristics of FASD from various research methods with an emphasis on recent in school studies.' Developmental Disabilities Research Reviews Vol 15 (3): 176-92. http://www.ncbi.nlm.nih.gov/sites/entrez?db=pubmed&cmd=search&term=19731384
83 Bower, C & Elliott, E. (2011) Submission to House Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder, Australian FASD Collaboration

84 Payne J, Elliott E, D'Antoine H, O'Leary C, Mahony A, Haan E, et al. (2005). 'Health professionals' knowledge, practice and opinions about foetal alcohol syndrome and alcohol consumption in pregnancy.' ANZ Journal Public Health, 29(6), 558-64.
85 Elliott, E.J., Payne, J., Haan, E. and Bower, C. (2006). 'Diagnosis of foetal alcohol syndrome and alcohol use in pregnancy: A survey of paediatricians' knowledge, attitudes and practice.' Journal of Paediatrics and Child Health, 42, 698-703.
86 Streissguth, A., Barr, H., Kogan, J. and Bookstein. F. (1996). Understanding the Occurrence of Secondary Disabilities in Clients with Foetal Alcohol Syndrome and Foetal Alcohol Effects, Final Report to the Centers for Disease Control and Prevention. University of Washington, Fetal Alcohol and Drug Unit, Tech. Rep No 96-06
87 McDermott, F., Hamilton, M. & Lagay, B (1991) Evaluating treatments for alcohol and other Drugs Part one: Approaches to evaluation Part two: An annotated review of treatment evaluation literature Monograph Series No. 14 Commonwealth of Australia
88 Babor, T., Caetano, R. & Casswell, S.et al. (2003). Alcohol: No Ordinary Commodity. Research and Public Policy. Oxford: Oxford University Press
89 Shand F, Gates J, Fawcett & Mattick R (2003). The treatment of alcohol problems: a review of the evidence. Canberra: Australian Government Department of Health and Ageing (p.41).
90 Gray D et al. (2010). Indigenous specific alcohol and other drug interventions: continuities, changes, and areas of greatest need. ANCD research paper 20. Canberra
91 Conigrave K et al. The Alcohol Awareness project: community education and brief intervention in an urban Aboriginal setting. H Promot J Aust 2012;23: 219-25.
92 Department of Attorney General and Justice. (2014). Alcohol Mandatory Treatment Act. http://notes.nt.gov.au/dcm/legislat/legislat.nsf/linkreference/ALCOHOL%20MANDATORY%20TREATMENT%20ACT?opendocument
93 Teasdale KE, Conigrave KM, Kiel KA, Freeburn B, Long G & Becker K (2008). Improving services for prevention and treatment of substance misuse for Aboriginal communities in a Sydney Area Health Service. Drug and Alcohol Review, 27, 152-9.
94 Indigenous Studies Program, University of Melbourne webpage: http://www.atns.net.au/subcategory.asp?subcategoryID=109
95 Australian Medical Association [AMA] (2011). 2010-11 AMA Indigenous Health Report Card: Best Practice in Primary Health Care for Aboriginal Peoples and Torres Strait Islanders. AMA, Canberra. https://ama.com.au/aboriginal-reportcard2010-11
96 National Drug and Alcohol Research Centre (2013). Drug Policy Monitoring Program: Review of drug and alcohol prevention and treatment services. University of New South Wales. http://www.dpmp.unsw.edu.au/project/review
97 National Indigenous Drug and Alcohol Committee (2012) An economic analysis for Aboriginal and Torres Strait Islander offenders [electronic resource]: prison vs residential treatment, Deloitte Access Economics: A report prepared for the National Indigenous Drug and Alcohol Committee, Australian National Council on Drugs, downloaded on 29 April 2014 from http://www.nidac.org.au/images/PDFs/NIDACpublications/prison_vs_residential_treatment.pdf
98 Closing the Gap Clearinghouse (AIHW, AIFS) (2010). Reducing the harm from alcohol and other drug related harm: Resource Sheet no 3 produced for the Closing the Gap Clearinghouse – Gray D and Wilkes, E. Closing the Gap Clearinghouse, Australian Institute of Health and Welfare, Australian Institute of Family Studies
99 National Indigenous Drug and Alcohol Committee (2012) An economic analysis for Aboriginal and Torres Strait Islander offenders [electronic resource]: prison vs residential treatment, Deloitte Access Economics: A report prepared for the National Indigenous Drug and Alcohol Committee, Australian National Council on Drugs, downloaded on 29 April 2014 from http://www.nidac.org.au/images/PDFs/NIDACpublications/prison_vs_residential_treatment.pdf
100 ibid
101 Pritchard, E., Mugavin, J and Swan, (2007) A Compulsory treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs Australian National Council on Drugs, ANCD research paper 14.
102 ibid
103 Pritchard, E., Mugavin, J., and Swan, A. (2007) Compulsory treatment in Australia. Canberra: Australian National Council on Drugs.
104 NSW Legislative Council Standing Committee on Social Issues. (2004) Report 33: Report on the Inebriates Act 1912. Sydney: NSW Parliamentary Library.
105 Independent Liquor and Gaming Authority (ILGA). (2013). Unpublished data. 22 August 2013. Sydney: ILGA.
106 Victorian Commission for Gambling and Liquor Regulation (VCGLA) (2014) Victorian Liquor Licences as at 31 Mar 2014, downloaded from http://assets.justice.vic.gov.au/vcglr/resources/b48f5819-d4ef-4f8b-a9db-6c20471f0174/currentliquorlicences_31march2014.pdf
107 Independent Liquor and Gaming Authority (ILGA). (2013). Unpublished data. 22 August 2013. Sydney: ILGA.
108 ibid
109 Wagenaar AC, Salois MJ and Komro KA (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction 104: 179-190
110 ibid
111 Babor, T, et al. Alcohol: No Ordinary Commodity. Second Edition. New York: Oxford University Press. 2010
112 National Preventative Health Taskforce. (2009). Australia: the healthiest country by 2020. Technical Report No 3 Preventing alcohol–related harm in Australia: a window of opportunity. Commonwealth of Australia: Canberra.

113 Alcohol Policy Coalition Position Statement June 2011: Marketing and promotion of alcohol.
114 Winter, M.V., Donovan, R.J., Fielder, L.J. (2008). "Exposure of children and adolescents to alcohol advertising on television in Australia". Journal of Studies on Alcohol Drugs 69, pp.676–83.
115 Stacy, A.W., Zogg, J.B., Unger, J.B., Dent, C.W. (2004). "Exposure to televised alcohol ads and subsequent adolescent alcohol use". American Journal of Health Behaviour 28, pp.498–509.
116 Ellickson P, Collins R, Hambarsoomians K, and McCaffrey D. (2005). "Does alcohol advertising promote adolescent drinking? Results from a longitudinal assessment". Addiction 100, pp.235–46.
117 National Preventative Health Taskforce (2009). *Op.cit.*
118 Kinnane, S., Farringdon, F., Henderson-Yates, L., and Parker, H., (2009). *Fitzroy Valley Alcohol Restriction Report: An evaluation of the effects of a restriction on take-away alcohol relating to measurable health and social outcomes, community perceptions and behaviours after a 12 month period.*
119 ibid
120 Kinnane, S., Farringdon, F., Henderson-Yates, L., and Parker, H., (2010). Fitzroy Valley Alcohol Restriction Report: An evaluation of the effects of a restriction on take-away alcohol relating to measurable health and social outcomes, community perceptions and behaviours after a two year period.
121 Blagg, H. Valuri, G. (2003) *An Overview of Night Patrol Services in Australia* Attorney-General's Department, Canberra
122 Closing the Gap Clearinghouse (AIHW, AIFS) (2010). *Reducing the harm from alcohol and other drug related harm: Resource Sheet no 3 produced for the Closing the Gap Clearinghouse – Gray D and Wilkes, E.* Closing the Gap Clearinghouse, Australian Institute of Health and Welfare, Australian Institute of Family Studies
123 Loxley, W., Toumbourou, J. & Stockwell, T (2004) *Prevention of substance risk and harm in Australia; A review of the evidence: Monograph* Department of Health and Ageing
124 National Drug Research Institute (2014) *Alcohol Control Measures: Central Australia and Alice Springs*
125 Australian National Preventive Health Agency (2013). Exploring the Public Interest Case for a Minimum (floor) for Alcohol - Final Report May 2013. Canberra, Commonwealth of Australia.
http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/minimum-price-final-report
126 Northern Territory Department of Health (2007). Public health bush book volume 2: facts and approaches to three key public health issues. Darwin.
http://www.nt.gov.au/health/healthdev/health_promotion/bushbook/volume2/chap1/aodp.htm
127 Stockwell, T.R., Chikritzhs, T.N., Hendrie, D.V., Fordham, R.J., Ying, F., Phillips, M., Cronin, J. and O'Reilly, B. (2001). The public health and safety benefits of the Northern Territory's Living With Alcohol program. *Drug and Alcohol Review, 20,* (2), pp. 167-180.
128 Chrikritzh, T.N., Stockwell, T.R. and Pascall, R. (2005). The impact of the Northern Territory's Living With Alcohol program, 1999-2002: revisiting the evaluation. Addiction, 100. Pp 1625-1636.
129 Stockwell, T., Auld, M.C., Zhao, J. & Martin, G. (2012) Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. *Addiction 107*: 912-920.
130 Stockwell, T. Zhao, H., Giesbrecht, N., Macdonald, S., Thomas, G. & Wettlaufer, A. et al. (2012) The raising of minimum alcohol prices in Saskatchewan, Canada: impacts on consumption and implications for public health. *American Journal of Public Health* 102(12):e103-e110.
131 Stockwell, T., Auld, M.C., Zhao, J. & Martin, G. (2012) Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. *Addiction* 107: 912-920.
132 Stockwell, T. Zhao, H., Giesbrecht, N., Macdonald, S., Thomas, G. & Wettlaufer, A. et al. (2012) The raising of minimum alcohol prices in Saskatchewan, Canada: impacts on consumption and implications for public health. *American Journal of Public Health* (102)12:e103-e110.

Level 1
40 Thesiger Court
Deakin ACT 2600

PO Box 19
Deakin West
ACT 2600

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