SENATE STANDING COMMITTEE ON COMMUNITY AFFAIRS

COMMUNITY AFFAIRS REFERENCE COMMITTEE

INQUIRY ON EFFECTIVE APPROACHES TO PREVENTION, DIAGNOSIS AND SUPPORT FOR FETAL ALCOHOL SPECTRUM DISORDER

RESPONSE TO QUESTIONS ON NOTICE

NATIONAL DRUG RESEARCH INSTITUTE (NDRI)

Response provided by Associate Professor Nyanda McBride, Prevention and Early Intervention Program Leader; Anna Stearne and David Tucker NDRI PhD Students.

Focus: Prevention

On notice: Senator Urquhart asked how many of the 19 recommendations from the 2012 House of Representatives Inquiry are relevant today.

OVERVIEW COMMENT AND RECOMMENDATION

Australia's focus on the prevention of FASD is relatively new and has yet to develop to a stage where proof of behavioural impact (reducing alcohol-exposed pregnancies, reducing incidence of FASD) is occurring. Previous NDRI submissions to this inquiry highlight the importance of 1) developing prevention around a prevention framework, 2) using a systematic approach for strategy/program development, and 3) identifying impact by ensuring that evaluation is incorporated at the time of strategy/program conception. These three core elements will assist in identifying and optimising impact into the future.

The 2012 prevention-focused recommendations range from specific to broad. Developing a conceptual plan around a framework, for example, the Prevention Framework (1), will assist in identifying the relevance of these recommendations, the appropriateness of modifications to these recommendations, and the development of new recommendations that can inform future action plans. Future action plans should be informed by the current FASD Action Plan and the National Alcohol Strategy Action Plan and incorporate a full range of possible mechanisms for change to assist in developing clear and justifiable prioritisation of actions based on potential for impact.

For example, one mechanism for change is through policies, laws and regulations (1-3). Within the prevention of FASD context this may include evidence-based policies such as reducing alcohol affordability (evidence of impact in the general population*); earmarked alcohol taxes to pay for prevention programs (evidence of impact in the general population by reducing harm while generating revenue*) (4, 5); combing taxation*; restricting discounts*; reducing physical availability*; restricting trading hours*; limiting density outlets*; restricting alcohol marketing (evidence of effectiveness with women), total or partial bans on marketing and counter advertising (effective with smoking)* (5). Of note, there is replicated research evidence that self-regulation of alcohol advertising is ineffective (5).

- additional evidence required around reducing alcohol-exposed pregnancies

Other mechanisms for change will include, for example, actions around individuals/family behaviour change, service providers and models of service etc. and are best advised to begin with by existing evidence of impact (and when this is not available through research evidence in related fields) and from a range of experts, service providers and women (including their partner, family and social networks). Building evidence of impact around those aspect that currently lack evidence, will be an important development for the future and may require specific targeted research.

There are multiple mechanisms for change with a prevention framework including the above examples. Identifying other mechanisms for change, and engaging in multiple actions is likely to have the greatest impact on reducing FASD. However, there are likely to be some mechanisms for change that have more impact on reducing alcohol-exposed pregnancies and FASD. Once identified these mechanisms for change should be given priority.

In addition to the use of research evidence, mechanisms for change and actions around a FASD prevention framework will need to be developed with critical stakeholders and experts (academic and professional) to ensure comprehensiveness and applicability. A plan based on a prevention framework should note where evidence of impact currently exists and where future program development and research is required to build a comprehensive picture for future action.

Recommendation:
Use a prevention framework, evidence if impact in this and related fields, expert, consumer group and stakeholder input to identify all mechanisms for reducing alcohol-exposed pregnancies and FASD, and actions around these mechanisms. Adopt multiple mechanisms for change, prioritizing those with most potential for impact.

SPECIFIC COMMENTS ABOUT SELECTED 2012 RECOMMENDATIONS.

Recommendations 1-3.

It is appropriate and relevant to have a national plan of action for preventing FASD and this is as relevant today as it was in 2012. There will be a continuing need for a national plan of action as new cohorts enter childbearing age.

It is appropriate and relevant to have a FASD reference group to oversee and advise on the national plan of action.

Given that only four of the 19 2012 recommendations have been implemented, additional stages of reporting may assist with maintaining a timetable of achieving future recommendations.

Given that only four of the 19 2012 recommendations have been implemented there is scope for positioning an enabling group (and supportive funding) with a priority focus on actioning the national plan. Composition of the enabling group should be determined by ability to provide action.

Recommendations 4-14
FASD awareness and prevention. Response to selected recommendations.

Recommendation 4
This recommendation is highly relevant as the majority of women interact with a health professional during child bearing age and/or during pregnancy and the advice provided can potentially impact on alcohol use during current and future pregnancies. This recommendation may also, eventually, assist with culture change in attitudes towards drinking during pregnancy. There are current gaps in knowledge on how to effectively engage health professionals to undertake FASD prevention.

Recommendation 6
Nation-wide public awareness campaigns have a place in a prevention framework and it is relevant and appropriate to maintain as part of the national action plan as an awareness raising strategy. Awareness raising strategies need to be teamed with targeted strategies and based on a systematic development process.

Recommendation 8 (response provided by Anna Stearne and David Tucker)
This recommendation is still very relevant, and is complex.

Commonwealth legislation needs to be supportive of locally developed initiatives. There are currently barriers in particular jurisdictions (for example, Northern Territory) which prevent locally developed initiatives from being approved and implemented. While the evidenced-based reforms of alcohol policy in the Northern Territory are having a positive impact, the Commonwealth level legislation remains, hindering and delaying Aboriginal community-led initiatives (6).

Self-determination is supported in communities and important for creating change/a top-down approach can limit Aboriginal community-led initiatives. Federal government legislation, enabled a community led initiative and intervention in the Northern Territory to be replaced by a similar top-down intervention. Even though the interventions were similar, the top-down directive reversed and undermined the considered efforts implemented by Aboriginal communities. Governments need to recognize and support the efforts of communities, as their right to be safe and healthy, and protect their children. This can best be done by working with Aboriginal communities to address community priorities.

A shared approach can be effective. A community near Port Hedland worked with the local Police to consider how to best enforce the alcohol ban in the community, which was being breached by some. Both the Police and community realised that having the rules and penalties developed by the community was likely to be more effective than the Police intervening when breaches occurred. This model of self-determination around alcohol use was something the community were very proud of, however, no formal evaluation was associated with the initiative. Health service with a focus on self-determination in Aboriginal communities have been shown to be successful (7) and it is an approach that is culturally appropriate and desirable in Pilbara communities.

Social and structural determinants of health provide guidance in addressing the symptoms and issues of alcohol-related harms. Patterns of alcohol consumption will change if the social and structural determinants of health are addressed. Social and structural

determinant models emphasize the importance of decision-making power over one's life as a key element of health and wellbeing.

Structural determinants such as liquor outlet opening hours and density have an impact on when and how people drink. For example, research reports that Aboriginal people in Port Hedland were generally supportive of liquor restrictions (61.9%) (8) with a desire for less top down approaches and community involvement in decision making. Almost all Aboriginal people surveyed drank in large social groups and shared alcohol (9) therefore limits on take away quantities were likely have little impact. Most people reported that they buy only what they want or need to drink that day. The days when liquor outlets are closed provide relief for the whole community, including drinkers and non-drinkers. This finding is reported elsewhere (10).

Knowledge of the harms associated with alcohol during pregnancy is widespread. A recent research study with Aboriginal people in the Pilbara reported that most (91%) knew that drinking alcohol during pregnancy could harm the baby (8). While health promotion focusing on awareness broadly might keep this front and centre, this awareness-raising approach should not be the centrepiece of strategies moving forward but should support other strategies that impact behaviour.

Protection of dry remote communities. Dry remote communities offer safety and protection to people struggling with alcohol as well as those affected by others alcohol use. Focus group participants in remote communities in the Pilbara (11) reported that those with a genuine need to come into the regional centres (shopping, maternal services, medical appointments) experience transport issues which can limit autonomy and increase drinking occasions . Many people do not have licenses or reliable vehicles and rely on getting a lift into town which results in extended visits and extended period with friends or family members who are drinkers. People have indicated that in these situations they often end up drinking to excess for a period of time until they can return to community.

Recommendation 9

The development of strategies for pregnant women with alcohol dependence or misuse is appropriate. However, recent systematic literature reviews report that there are no current strategies/programs that successfully reduce alcohol-exposed pregnancies with this group (12).

Using a systematic approach for strategy development, incorporating pertinent literature, relevant theory, expert advice, and most importantly consumer group engagement, will help to develop strategies most likely to have a behavioural impact on women who consume to risky levels. Multiple strategies are likely to be required. There may be existing data that can help build understandings about factors associated with high risk alcohol consumption during pregnancy which can inform future strategies.

Strategies developed to reduce risky drinking in high risk women require well developed evaluation methodology at the time of strategy inception to enable the reliable and valid identification of behavioural impacts.

Recommendations 10-11

NDRI provided a submission to the FSANZ proposal P1050 Pregnancy warning labels on alcohol beverages (available on request). The alcohol industry (specifically Drinkwise) involvement in the development of alcohol warning labels was noted as a major conflict of interest.

Recommendation 12

There are some promising results from NDRI research that pricing and availability can impact consumption levels (see above Overview Comment and Recommendation particularly Gilmore et al 2016 reference, and the National Alcohol Indicators Project at http://ndri.curtin.edu.au/publications-resources/project-reports-and-bulletins/national-alcohol-indicators-bulletins). Existing research may reduce the need to conduct additional studies.

Recommendation 13

The new draft NHMRC alcohol guideline (13) state:

'Guideline Two

To reduce the risk of injury and other harms to health, children and young people under 18 years of age should not drink alcohol.

Key messages

There is no clear 'safe' or 'no-risk' level of alcohol consumption for children and young people under 18 years. This is because of the increased risks of harm from alcohol for young people, including from injury and potential adverse effects on brain development.

Beginning alcohol use at an early age may also put young people at greater risk of longer-term alcohol-related harms, including alcohol use disorders that tend to appear later in life.

To minimise these risks children and young people under 18 years of age should not drink alcohol' (13):pp39).

The development of Australian alcohol guidelines are based on expert committee review and review of evidence. Given this background and that the advice is nonuse, it is questionable that any 'current alcohol marketing strategies' are appropriate.

Existing research by others may reduce the need for an independent study on the impact of alcohol advertising on youth. For example, see the following Young Australians Alcohol Reporting System (YAARS) bulletins on young people and advertising:

http://ndri.curtin.edu.au/NDRI/media/documents/yaars/yaars03.pdf

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