



INQUIRY INTO THE HARMFUL USE OF ALCOHOL IN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

April 2014

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1. AUSTRALIAN DRUG FOUNDATION

The Australian Drug Foundation (ADF) is a charitable, non-government, not-for-profit organisation and is widely regarded as one of Australia's leading alcohol and other drugs prevention agencies. For over 50 years the ADF has worked with communities to prevent alcohol and other drug problems. Our focus is prevention and early intervention and our strategies include community action, health promotion, education, information, policy, advocacy, and research. Our vision is an Australia that is composed of 'Healthy People, Strong Communities'.

The Australian Drug Foundation is pleased to address the Terms of Reference for the inquiry by the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities

2. SUMMARY OF RECOMMENDATIONS

The Australian Drug Foundation responds to the Terms of Reference with the following recommendations

Re THE SOCIAL AND ECONOMIC DETERMINANTS OF HARMFUL ALCOHOL USE ACROSS ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

- i. The social and economic determinants of health must be addressed simultaneously with concerted action to reduce excessive and problematic drinking in Aboriginal and Torres Strait Islander communities.

Re TRENDS AND PREVALENCE OF ALCOHOL RELATED HARM, INCLUDING ALCOHOL-FUELLED VIOLENCE AND IMPACTS ON NEWBORNS, E.G. FAS AND FASDS

- i. Alcohol misuse and related problems, harms, disorders and dependence is destructive of Aboriginal and Torres Strait Islander communities and resolution of this is required to for a major improvement in health, quality of life and life expectancy for Aboriginal and Torres Strait Islander people.
- ii. The future implementation of the Commonwealth Action Plan to reduce the impact of Fetal Alcohol Spectrum Disorder should take account of the Australian Fetal Alcohol Spectrum Disorder Action Plan 2013-2016 as developed by the Foundation for Alcohol Research and Education.

Re BEST PRACTICE TREATMENTS AND SUPPORT FOR MINIMISING ALCOHOL MISUSE AND ALCOHOL-RELATED HARM:

- i. Indigenous people and communities deserve access to the full suite of treatments for alcohol disorders and, whenever appropriate, those treatments must be adapted for delivery in ways that are culturally sensitive.

Re BEST PRACTICE STRATEGIES TO MINIMISE ALCOHOL MISUSE AND ALCOHOL-RELATED HARM

- i. **Priority for primary prevention:** That priority should be given to primary prevention as a cost-effective way to reduce the development of harmful patterns of alcohol use.
- ii. **Controlling the supply of alcohol:** That Aboriginal and Torres Strait Islander communities are empowered to control or end the supply of alcohol if they so choose and that the support includes scope for monitoring and evaluation of the strategies so that communities can learn from their own and from other communities' experience.
- iii. **Alcohol taxation:** That alcohol products should be taxed according to their alcohol content so that equivalent tax rates apply to different beverages with the same alcoholic content.
- iv. **Minimum pricing:** That a minimum price per standard drink for all alcohol products should be established in order to prevent the retailing of artificially cheap alcohol.
- v. **Health warning labels on alcohol containers:** That health warning and information labels for alcohol products should be mandatory, to protect consumers and enable them to make informed decisions about consumption

3. DETAILED RESPONSE TO THE TERMS OF REFERENCE

3.1. PATTERNS OF SUPPLY OF, AND DEMAND FOR ALCOHOL IN DIFFERENT ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

The prevalence of harm caused to the Aboriginal and Torres Strait Islander peoples by the excessive use of alcohol requires urgent and sustained action. Aboriginal and Torres Strait Islander people should not be stigmatised as excessive drinking is a universal problem in Australia. While there are drivers behind Aboriginal and Torres Strait Islander drinking that require special attention, it is also true that most measures will be equally effective in reducing alcohol harm in both Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander populations. The challenge for Australian governments is to ensure that those most effective measures are implemented.

For the Australian Drug Foundation (ADF) the prevalence of harm caused to the Aboriginal and Torres Strait Islander peoples by the excessive use of alcohol requires urgent and sustained action. The ADF is concerned that the necessary work to reduce harmful drinking and its effects among Aboriginal and Torres Strait Islander people does not single out or stigmatise Aboriginal and Torres Strait Islander people. We emphasise excessive drinking is a major problem among non-Aboriginal and Torres Strait Islander Australians, and that to some extent non-Aboriginal and Torres Strait Islander drinking reflects norms transmitted for generations by Australia's European population. While there are additional specific drivers behind Aboriginal and Torres Strait Islander drinking that require special attention, it is also true that some measures will be equally effective in reducing alcohol related harm in both Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander populations. The challenge for Australian governments is to ensure that those most effective measures are implemented.

Inequality in health is a major issue for Australia: as an example of the discrepancy in health within the whole population, the age-standardised mortality rate for Aboriginal and Torres Strait Islander people is 1.9 times greater than the mortality rate for non-Aboriginal and Torres Strait Islander people (MacRae et al., 2013). The impact of alcohol on Aboriginal and Torres Strait Islander health is recognised by the *National Drug Strategy 2010-15* for one of its seven sub-strategies is the National Aboriginal and Torres Strait Islander People Drug Strategy (NATSIDS). In addition there are several other strategies that are designed to make sustainable improvements to health and wellbeing of Aboriginal and Torres Strait Islander people. They include the Closing the Gap strategy that aims to extend the life expectancy of Aboriginal and Torres Strait Islander people, the National Aboriginal

and Torres Strait Islander Health Plan and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. The ADF believes a response by government to the present investigation must as far as is possible, be consistent with and support the work of those existing plans and strategies.

3.2. THE SOCIAL AND ECONOMIC DETERMINANTS OF HARMFUL ALCOHOL USE ACROSS ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

Many distal social and environmental influences help to determine the health of individuals in addition to the more proximate influences such as diet and exercise (Keleher & McDougall, 2011). Health status is correlated closely with social status because the quality of health improves as an individual ascends the social ladder and declines as their social status wanes – this is known as the ‘social gradient’ of health (Wilkinson & Marmot, 2003). These factors include the impact of early life, stress, work, unemployment, social support, food, transport and addiction (Wilkinson & Marmot, 2003). However they are not independent factors but operate synergistically so that, for example, excessive drinking of alcohol may reduce an individual’s capacity to work, and the consequential lack of employment may precipitate other problematic behaviours including poor diet and mental stress, both of which independently depress health status.

It is notable that 54% of Aboriginal and Torres Strait Islander people are employed compared to 76% of non-Aboriginal and Torres Strait Islander Australians and have lower rates of school retention and lower literacy levels: that reduces health literacy and capacity for employment (DHA 2012). More optimistically, young Aboriginal and Torres Strait Islander people who remain in school use fewer psychoactive substances – they are less likely to smoke tobacco and drink alcohol, which improves their health prospects and reduces risk of chronic disease (DHA, 2012).

The health and wellbeing of Aboriginal and Torres Strait Islander people cannot be divorced from history. Following their dispossession by European settlers from the eighteenth century, and the consequent loss of cultures, traditional roles, communities and family and kinship relationships, many Aboriginal and Torres Strait Islander people have used alcohol to assuage their loss of identity, cultural anguish and trauma. High rates of problematic substance use and addiction are common responses to cultural alienation (Alexander, 2008): this process is evident among the colonised aboriginal peoples of the New World in North America, South America, Australia and New Zealand. According to Alexander, addiction to a substance or to another non-adaptive behavior, is a way of coping with ‘psychosocial dislocation’, which occurs when people live without a clear role or purpose in a stable, established community. ‘Psychosocial dislocation’ is a common experience of

marginalised persons who are subjected to chronic unemployment, physical or emotional abuse, neglect or mental illness (Alexander, 2008).

The health of Aboriginal and Torres Strait Islander Australians and reductions in problematic use of alcohol (and other substances) specifically is unlikely to improve until the lives of Aboriginal and Torres Strait Islander people are founded more securely. This includes access to employment, education and training, appropriate housing in safe communities (Development of a National Aboriginal and Torres Strait Islander Health Plan 2012). Such communities will have tighter controls on access to alcohol and demonstrate less tolerance for problematic use of alcohol. It will also be important that policies, programs and measures to improve the health and wellbeing of Aboriginal and Torres Strait Islander people rest as much responsibility as is possible in Aboriginal and Torres Strait Islander peoples and their appropriate organisations.

Recommendation

The social and economic determinants of health must be addressed simultaneously with concerted action to reduce excessive and problematic drinking in Aboriginal and Torres Strait Islander communities.

3.3. TRENDS AND PREVALENCE OF ALCOHOL RELATED HARM, INCLUDING ALCOHOL-FUELLED VIOLENCE AND IMPACTS ON NEWBORNS, E.G. FAS AND FASDS:

Alcohol is Australia's most commonly used recreational psychoactive drug and its misuse is a significant public health problem, across the entire population, costing at least \$15 billion per annum (Collins & Lapsley, 2008). Overall, alcohol accounts for an estimated 3.2% of the burden of injury and disease in Australia (Begg et al., 2007). According to the 2010 National Drug Strategy Household Survey risky drinking is common; around 20% of people drank at levels that put them at risk of alcohol related injury or disease over their lifetime and 40% drank, at least once in the previous 12 months, in a pattern that placed them at risk of an alcohol-related injury from a single drinking occasion (AIHW, 2011).

It is important to acknowledge that Aboriginal and Torres Strait Islander people are more likely than non-Aboriginal and Torres Strait Islander people to abstain from alcohol (24.5% compared to 19.0%) but it is equally important that those Aboriginal and Torres Strait Islander people who do drink alcohol are more likely to do so at risky or high risk levels for both short term harm (52%: 40%) and long term harm (31.0%: 20%) (AIHW 2011).

Aboriginal and Torres Strait Islander people do not have an homogenous drinking pattern: more adults in remote areas abstain from alcohol consumption than adults in non-remote areas (38% compared with 19%) (NATSIHS 2006). Of the adult drinkers, those living in remote areas were more likely than those in non-remote areas to report drinking at risky or high risk levels in the short term (23% compared with 18%) (NATSIHS 2006). Similar proportions of Aboriginal and Torres Strait Islander Australians in remote and non-remote areas reported drinking at risky or high risk levels in the long term (15% and 17% respectively) (NATSIHS 2006).

The impact of alcohol upon Aboriginal and Torres Strait Islander populations has been documented many times: excessive consumption of alcohol is directly and indirectly responsible for high rates of mortality and morbidity. It is implicated in a multitude of acute harms such as injury, motor vehicle accidents, and antisocial behaviours including assault, street violence, domestic violence, homicide and suicide and is a contributor to family breakdown (DAH, 2012, 20) DHA reports Aboriginal and Torres Strait Islander people are four times more likely to be hospitalised for alcohol use and leading to family breakdown. Alcohol is the fifth leading cause of disease among Aboriginal and Torres Strait Islander Australians and the burden of disease that is attributable to alcohol among Aboriginal and Torres Strait Islander people is twice the level of non-Aboriginal and Torres Strait Islander Australians (MacRae et al., 2013).

Major contributors to the burden of disease for Aboriginal and Torres Strait Islander people are 'injury, mental disorders and cancer' (MacRae et al., 2013). Excessive acute or chronic alcohol use is implicated in each one of those factors. The gap in life expectancy between Aboriginal and Torres Strait Islander people and non-Aboriginal and Torres Strait Islander people highlights the inequity of health outcomes in Australia. Aboriginal and Torres Strait Islander men can expect to live for 67.2 years and Aboriginal and Torres Strait Islander women for 72.9 years, which in each case is a decade less than the average for non-Aboriginal and Torres Strait Islander Australian men and women (ABS, 2010). The impact of alcohol is evident among young Aboriginal and Torres Strait Islander people as the percentage of alcohol related deaths among Aboriginal and Torres Strait Islander youth aged 15–24 years is estimated to be almost three times higher than for non-Aboriginal and Torres Strait Islander youth [9].

According to Aboriginal leader Noel Pearson, the high rate of alcohol (and other drug) dependence within Aboriginal and Torres Strait Islander communities is doubly disabling because it prevents Aboriginal people from acting to improve themselves and their community, and to organize

themselves politically (Pearson, 2002). Pearson described alcohol dependence as ‘a psychosocially contagious epidemic’ which draws in functional Aboriginal people due to traditional Aboriginal kinship obligations to share food and drink or to contribute money to allow drink to be bought. In Pearson’s view alcohol use is the most pressing issue facing Aboriginals and Aboriginal communities because the prevalence of addiction to alcohol destroys Aboriginal values and stands in the way of their progress (Pearson, 2002).

Recommendation

Alcohol misuse and related problems, harms, disorders and dependence is destructive of Aboriginal and Torres Strait Islander communities and resolution of this matter is required to for a major improvement in health, quality of life and life expectancy for Aboriginal and Torres Strait Islander people.

3.3.1. Foetal Alcohol Spectrum Disorders

Foetal Alcohol Spectrum Disorders (FASD) refers to a range of adverse effects in a pregnant women’s unborn baby caused by prenatal alcohol exposure. Four separate diagnoses are embraced under FASD umbrella: ‘foetal alcohol syndrome’ (FAS), ‘partial foetal alcohol syndrome’ (PFAS), ‘alcohol related neuro-developmental disorders’ (ARND) and ‘alcohol related birth defects’ (ARBD) (Australian Drug Foundation, 2013). FAS is the most severe disorder as it represents physical, cognitive, and behavioural abnormalities and is likely caused by excessive and/or regular alcohol intake throughout pregnancy (Australian Drug Foundation, 2014). It is not known if there is a threshold level for the consumption of alcohol during pregnancy (State Government of Victoria, 2013). However, drinking a large quantity, particularly during the first trimester of pregnancy, increases the risk of Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorders (FASDs) (Burd et al., 2003). The current Australian guidelines to reduce health risks from drinking alcohol recommend not drinking is the safest option for women who are pregnant, breastfeeding, or planning a pregnancy (National Health and Medical Research Council, 2009). Children with FASD present primary disabilities in development, learning and behaviour since birth (National Aboriginal and Torres Strait Islander Drug and Alcohol Committee, 2012). As they grow into adulthood, most develop secondary disabilities such as mental health problems, disrupted school experience, trouble with the law and inability to live independently (Kellerman, 2003). FASD is a lifelong disorder and cannot be cured, but is entirely preventable by not drinking alcohol throughout pregnancy (State Government of Victoria, 2013).

Factors that influence alcohol intake by pregnant women include their mental health, quality of life and socio-economic status (Education and Health Standing Committee, 2012). A high proportion of women who give birth to children with FASD experience extreme stress, depression and anxiety, relationship problems, domestic violence, poor nutrition and lack of social support (Education and Health Standing Committee, 2012).

Reports suggest a relatively high prevalence of FAS and FASDs in Aboriginal and Torres Strait Islander populations (FARE, 2013). Further research into the incidence of FAS and FASD and the mechanisms by which it occurs within Aboriginal and Torres Strait Islander communities is required. The Lililwan Project, which commenced in 2009, is the first population-based study of FASD in Aboriginal and Torres Strait Islander Australian populations (Fitzpatrick, Elliott, Latimer, Carter & Oscar, 2012). It aims to address the prevalence of FASD in the Fitzroy Valley, Western Australia, which is currently unknown although the researchers estimated 50% of pregnant women in the Fitzroy Valley drink at dangerous levels (Wilson, 2014).

Aboriginal and Torres Strait Islander Australian women's knowledge of risks associated with alcohol consumption during pregnancy appears to be limited and is rarely obtained from a medical source (O'Leary, 2002). A South Australian study of Aboriginal and Torres Strait Islander women found no evidence that available information or advice had been received, internalised and acted upon (Burd *et al.*, 2003).

Health professionals appear to be reluctant to ask women about their alcohol consumption during pregnancy, despite current national alcohol guidelines stating that avoiding alcohol is the safest approach (Elliott *et al.*, 2005). Moreover, few health professionals are familiar with the clinical features of FAS possibly because there is not a standardised Australian diagnostic instrument or clinical guidelines for diagnosis (FARE, 2013). It is imperative that the prevalence of FASD in Aboriginal and Torres Strait Islander communities is accurately measured in order to inform policy, resource and service development in areas of health, education, justice and community.

Recommendation

The ADF supports the Commonwealth Action Plan to reduce the impact of FASD in 2013-14 and 2016-17 (The Department of Health, 2013). However, as of April 2014, the delivery of the plan has not commenced. The ADF recommends the implementation of the plan takes account of the Australian Fetal Alcohol Spectrum Disorder Action Plan 2013-2016 as developed by the Foundation

for Alcohol Research and Education (FARE) (2013). The major themes of the Australian FASD Action Plan are summarized as follows.

- Increase awareness of FASD among the general population, in particular women during pregnancy. A supportive environment to prevent prenatal alcohol exposure should be built through public campaigns, mandatory health warning labels on alcohol products, specialist support services to pregnant women who have alcohol-related disorders and training health professionals to routinely intervene with all women for alcohol use.
- Improve diagnostic capacity for FASD in Australia through developing an Australian FASD diagnostic instrument, establishing FASD specific diagnostic clinics across Australia and providing training to health professionals on the use of diagnostic instrument.
- Improve the quality of life for people with FASD by recognizing FASD as a disability and providing funding to custodians and career organizations to support the care of people with FASD.
- Improve data collection to clearly address the prevalence of FASD in Australia. Key strategies include routinely record alcohol use by pregnant women, establishing a FASD diagnosis register and requiring the Australian Pediatric Surveillance Unit to monitor the prevalence of FASD periodically.
- Reduce the prevalence of FASD among Aboriginal and Torres Strait Islander Australians by providing specialized, culturally specific and accessible diagnostic and treatment services. Education to reduce alcohol misuse, improving Aboriginal and Torres Strait Islander Australians' accessibility to resources on FASD as well as obtaining and understanding the community's responses to FASD are key strategies.

3.4. BEST PRACTICE TREATMENTS AND SUPPORT FOR MINIMISING ALCOHOL MISUSE AND ALCOHOL-RELATED HARM:

Aboriginal and Torres Strait Islander people need access to a full range of culturally appropriate interventions which enable individuals, families and communities to address harmful alcohol use. Furthermore, it is important that Aboriginal and Torres Strait Islander people have the capacity to take control of their own needs. Aboriginal and Torres Strait Islander organisations and communities have the unique knowledge and expertise to provide contributions to holistic and culturally appropriate AOD services (NATSIPDS, 2013). AOD organisations and associated sectors need to

promote their services that support those living within these communities. Interventions should also be culturally appropriate and, where possible, locally referenced.

Aboriginal and Torres Strait Islander communities are diverse and their needs vary greatly across Australia. Accordingly, the solutions that are generic and do not consider this diversity will often be ineffectual in their approach to the treatment of alcohol misuse. Aboriginal community ownership supports place-based solutions, and locally designed initiatives have a greater likelihood of success.

Alcohol treatment interventions that are effective in non-Aboriginal and Torres Strait Islander populations, such as brief intervention, may not be culturally appropriate for Aboriginal and Torres Strait Islander people. Adapting strategies to the cultural needs of Aboriginal and Torres Strait Islander people is important given differences of worldview, literacy and language (Jayaraj *et al.*, 2012). A reputable study in the Northern Territory found an approach known as Motivational Care Planning was found to be effective in addressing alcohol use, mental health and comorbidity. Motivational Care Planning was developed with the support of Aboriginal Mental Health Workers in three separate communities and utilises an approach, tools and metaphors that resonate with Aboriginal and Torres Strait Islander people (Jayaraj *et al.*, 2012).

Recommendation

That Aboriginal and Torres Strait Islander people and communities deserve access to the full suite of treatments for alcohol disorders and where appropriate those treatments must be adapted for delivery in ways that are culturally sensitive.

3.5. BEST PRACTICE STRATEGIES TO MINIMISE ALCOHOL MISUSE AND ALCOHOL-RELATED HARM:

3.5.1. Priority for primary prevention

The ADF believes more resources should be allocated to primary prevention and early intervention to reduce the demand for more intensive and expensive subsequent treatment of alcohol disorders. Primary prevention is a cost-effective way to reduce the development of harmful patterns of alcohol use. Prevention programs that target whole communities and consist of a range of evidence based interventions applied in concert are likely to be more effective than interventions applied piecemeal and in isolation from each other.

3.5.2. Controlling the supply of alcohol

Research evidence suggests a causal relationship between alcohol-related harms and the physical availability of alcohol. That relationship influences decisions around what, when and where alcohol is consumed. In broad terms, when the availability of alcohol increases so does consumption and consequently the prevalence of alcohol-related harm; conversely, when alcohol is less available consumption decreases, as does alcohol-related harm (Babor et al., 2010). This suggests that in order to reduce alcohol-related harms and the social impacts of alcohol on public safety and amenity, physical and economic alcohol availability should be restricted and regulated (NDRI, 2007).

Strong action to control and regulate the availability of alcohol in Aboriginal and Torres Strait Islander communities is essential to reduce the prevalence and incidence of acute and chronic alcohol related problems, including dependence or addiction. Approaches that are effective include:

- price controls
- restrictions on trading hours
- fewer outlets
- community alcohol management plans (see below).

3.5.2.1 Alcohol Management Plans

Alcohol Management Plans have been adopted by some local Aboriginal communities in regional and remote locations in Queensland and the Northern Territory to control the supply of alcohol. They have the additional value of enabling local communities to develop solutions best fitted for the local environment. At least 24 Aboriginal communities have implemented AMPs and tried a number of specific strategies to reduce harmful levels of drinking and the level of harm experienced by people in those communities (Smith et al., 2013). Although there is much variation between AMPs they essentially address the supply of alcohol, demand for alcohol, and harm associated with drinking. Evaluations of AMPs has shown variable results but in some cases they have recorded impressive results: AMPs have reduced alcohol consumption by a significant amount at Alice Springs, reduced alcohol related injury rates in Cape York, and reduced alcohol related violence at Groote Eyelandt and Bickerton (Smith et al., 2013). A review of AMPs concluded that they were most effective when they were established with a high level of involvement of local people; that the

interventions adopted by AMPs were generally soundly based, and the AMP approach was worthy of support and further research and evaluation (Smith et al., 2013).

Recommendation

That Aboriginal and Torres Strait Islander communities are empowered to control or end the supply of alcohol if they so choose and that the support includes scope for monitoring and evaluation of the strategies so that communities can learn from their own and from other communities' experience.

3.5.3. Alcohol taxation

An effective way of reducing alcohol related harm is to reduce the availability of cheap alcohol. Cheap alcohol tends to be purchased by harmful drinkers rather than by moderate drinkers, and is particularly attractive to people on low incomes: however, both groups are sensitive to alcohol pricing and consume less alcohol as the price increases (Babor et al, 2010). Alcohol taxation can be used to moderate drinking as well as to raise revenue to prevent and recover the costs of excessive consumption.

One economically efficient and fair method of taxation is to tax all alcohol products according to their alcoholic content (i.e. alcohol-by-volume or ABV) as this treats all alcohol, whether wine spirits or beer, in the same way. The recent comprehensive review of Australia's tax system, known colloquially as the Henry Review, noted the existing system of alcohol taxation was incoherent and recommended the introduction of a volumetric tax on alcohol (Henry, 2010).

Under the present system wine, spirits, beer, ciders and fortified wines - are taxed differently. The Excise tax, which applies to beer and spirits, is based on the volume of alcohol the product contains, while the Wine Equalization Tax (WET) is an ad valorem tax that is based on the value of the product. From a public health perspective, some of the results are desirable, for the reduced tax on low-strength beer encourages production and consumption of a low alcohol product. However, other results are unwelcome as they encourage the production and consumption of higher strength products. A most relevant example is the tax break provided to cheap wine. The tax payable per standard drink for cheap cask wine with an alcohol content of 12.5% is only \$0.05, while the tax payable per standard drink of mid-strength beer with an alcohol content of 3% is \$0.26. (Gray et al 2000).

International studies and reviews have shown that alcohol taxation is effective in reducing consumption and related harm (Wagenar et al., 2009; Chaplounka et al., 2002; Markowitz 1999). An Australian study reported that taxation measures could reduce social costs of alcohol in Australia by between 14% and 39% (or between \$2.19 and \$5.94 billion in 2004-05 dollars) (Collins and Lapsley 2008). A second Australian study found that alcohol taxation based on alcohol content was the most cost-effective intervention and provided the greatest benefit when measured in terms of health and wellbeing (Doran, 2008).

Recommendation

Alcohol products should be taxed according to their alcohol content so that equivalent tax rates apply to different beverages with the same alcoholic content.

3.5.4. Minimum pricing

Setting a minimum price (or floor price) for alcohol is another potentially effective way of reducing excessive consumption and subsequent harms and disorders. Some products are inherently cheaper to produce and distribute than others, and are sold at significantly cheaper prices, irrespective of alcohol content. Second, retailers discount particular alcohol products below the cost of production and use them as loss-leaders to attract customers. This retail tactic depresses the price of alcohol artificially and encourages consumers to purchase larger quantities of alcohol than they would otherwise, and consequently, to consume more alcohol than otherwise. That is a disturbing effect because a study by researchers at Sheffield University found low prices for alcohol was associated with drinking to intoxication, which in turn is associated with the highest levels of acute harm (Meier et al, 2008).

Setting a minimum price for alcohol would reduce the capacity for retailers to artificially reduce the prices, which would act to discourage some consumption by heavy drinkers, including heavy drinkers among Aboriginal and Torres Strait Islander populations. A minimum price for alcohol has been introduced in several countries including Canada, the Ukraine, Russia, the Republic of Moldova and Uzbekistan (Carragher & Chalmers, 2011). In May 2012, Scotland passed *The Alcohol (Minimum Pricing) (Scotland) Act 2012*, setting a 50p minimum unit price as part of an effort to tackle alcohol misuse. This legislation has been challenged by the alcohol industry so delaying implementation of a floor price.

Recommendation

A minimum price per standard drink for all alcohol products should be established in order to prevent the retailing of artificially cheap alcohol.

3.5.5. Health warnings on alcohol containers

Health warning labels can be effective in raising consumers' awareness of health risks at critical decision points of purchase of the product and its consumption. The introduction of health information labels on all alcohol products should be a component of a comprehensive approach to minimising alcohol related harm in Aboriginal and Torres Strait Islander communities. Such labels should inform consumers of risks associated with drinking alcohol, nutritional information and standard drink size. Currently alcohol is regulated as a food product, under Food Standards Australia and New Zealand (FSANZ). While alcoholic beverages must be labelled with information on alcohol content, their packaging, unlike that of other beverages, does not need to display a list of ingredients or nutritional information. This discrepancy is not sensible (Wilkinson and Room, 2009).

The example of tobacco labelling offers strong evidence that health information and warning labels can not only improve understanding of health risks and alter attitudes, but contribute to changing behaviour (Hammond et al., 2003). Tobacco packages have been required to carry graphic health warning information labels since 2006, including rotating, picture and text warnings. Were alcohol health information and warning labels displayed on alcohol beverage labels the outcomes could be similar. The cost of introducing such labels will be low and Australian wine that is exported to the USA and France already carries health warnings that are necessary to meet the regulatory requirements in those countries.

A study of the US warning labels showed they had an effect on stages necessary for behavioural change, such as intention to change drinking patterns, having conversations about drinking and willingness to intervene with others who are seen as hazardous drinkers (Babor et al, 2010). Other studies have shown that warning labels have the potential to influence behaviour depending on their design, the content of the message, and how well they are targeted at their intended audience (Agostinelli, & Grube, 2002).

Evidence suggests the Australian population would support health information labelling of alcohol products. According to the 2010 National Drug Strategy Household Survey 66% of respondents supported adding information from the national drinking guidelines on to alcohol containers (AIHW

2011). Drink and alcohol content information should be mandated to enable easy recognition and understanding. Format, font, and colours of the message, as well as location on the container, should be standardised to maximise recognition and legibility.

Recommendation

Health warning and information labels for alcohol products should be mandatory, to protect consumers and enable them to make informed decisions about their consumption. The current voluntary scheme is inappropriate. These warning labels should:

- be based on sound evidence of effective communication on alcohol risks;
- be graphic and attention-getting
- be of sufficient size in relation to the size of the package
- involve rotating messages, and
- target the general population as well as specific groups such as Aboriginal and Torres Strait Islander people, pregnant women and young people.

4. THE GOOD SPORTS PROGRAM IN THE NORTHERN TERRITORY

ADF draws to the attention of the parliamentary committee to a pilot program which is working with specific aboriginal communities in the northern territory to reduce harmful use of alcohol via the sports setting. This is the ADF's remote Aboriginal and Torres Strait Islander Good Sports pilot program in central Australia.

Since mid-2012 the ADF has been working with two central Australian remote Aboriginal communities to adapt its award winning *Good Sports* accreditation program to suit the needs and contexts of remote Aboriginal and Torres Strait Islander communities. One community has been accredited at Level One of the new AOD harm reduction program and the second) is making appropriate progress towards this. ADF has also visited two other communities in the region, both of which are implementing Alcohol Management Plans. Individual community stakeholders in both these communities have expressed interest in joining the new *Good Sports* program.

Typically communities have insufficient community sports governance and administration and the prevailing "football culture" usually makes it extremely difficult for leaders to implement and then sustain measures to encourage safe consumption of alcohol by players and officials, let alone

supporters, especially when matches occur in regional towns like Alice Springs or Tennant Creek. Remote Aboriginal and Torres Strait Islander *Good Sports* provides a structure (the accreditation framework) and practical support (project worker) to encourage this and links leaders and sports groups with other complementary local or regional supply, demand and harm reduction measures.

Significant stakeholders in all four communities visited by the ADF reported their concerns about alcohol (as well as cannabis and, with prompting from the project consultant, tobacco) linked to community sports, especially competitions involving adults in regional townships. There have been innumerable cases reported in remote Australia of road deaths, other trouble and health issues directly related to alcohol consumption by certain sports players or at – or after – particular events.

The Program's capacity relies on its voluntary uptake by community leaders. *Good Sports* is presented as a tool which may be useful in addressing leaders' own stated concerns about the strong linkages between alcohol consumption and community sports, especially football. Aboriginal and Torres Strait Islander leaders choose whether to join Good Sports and they and their nominees determine how the program is implemented within their community.

Good Sports for remote Aboriginal and Torres Strait Islander communities is in its early stages of development. In the one accredited community it has shown signs of promise in an environment notorious for its levels of complexity. For instance the community now has an authorised and established group meeting regularly to coordinate community sports

- their sports committee auspiced by a reputable local Aboriginal Corporation representing all clan groups in the community
- developed a conduct code for all its members and players clearly including safe alcohol consumption requirements
- provided additional sports activities within the community to supplement those provided by paid staff from other organisations in the community
- hosted a successful, if protracted, annual community sports carnival which attracted a record crowd and number of teams competing in both women's and men's tournaments, opportunities for broader family groups to socialise in a positive environment and which remained alcohol and fight free.

Having a more formalised community sports organising group has also provided an avenue in which unintended outcomes from major community events like the annual sports carnival or "weekend"

such as their impact upon education, employment and training have increased potential to be addressed. Because the group and its auspice are from within the community there is greater potential to implement community sanctioned measures aligned with both leaders' and all levels of government's aspirations for improvements in areas such as school attendance as well as their desires for active, healthy members with strong cultural roots and families, and their enjoyment of sports, all of which are linked to overcoming Aboriginal and Torres Strait Islander disadvantage.

Good Sports will require ongoing implementation within current trial sites along with targeted expansion over time in order to have an accurate measure of the program's effectiveness in addressing harmful levels of alcohol use linked to sport in remote Aboriginal and Torres Strait Islander Australia. It is presented as an example of a program which clearly meets the principles of effective programs to address disadvantage, including alcohol related concerns, in remote Aboriginal and Torres Strait Islander Australia. (AIHW, AIFS, 2013.) The ADF would be pleased to provide the Inquiry with more information about this emerging program.

Note: Good Sports is the largest and longest-running prevention program for sporting clubs in Australia. The program provides free support for community sporting clubs to help make them healthier, safer and more family friendly places.

Good Sports clubs progress through three levels of accreditation over three to five years, increasing their commitment to changing practices and policies around alcohol and smoking management as they advance. Level one accreditation focuses on ensuring clubs abide by liquor licensing laws and Responsible Service of Alcohol (RSA) training of bar staff; level two accreditation focuses on the provision of alternative food, drink and revenue-raising; and level three focuses on policy development, review and enforcement. The staged approach takes into account the club's readiness to change and enables progressive improvements to be embedded within the club before setting greater expectations at the next level.

Good Sports has been thoroughly evaluated, and has shown positive results. Early research suggests that rates of risky alcohol use decrease as clubs move through the program (Rowland et al., 2012). The clubs experience many other positive changes including an increase in membership, particularly among females, young people and non-players (Crundall, 2012).

Good Sports is also cost-effective. A recent economic analysis undertaken by KPMG demonstrated that in 2011 to 2012 alone Good Sports is estimated to have averted well over 1,300 alcohol related

falls, assaults and road accidents (combined) and saved the economy almost \$14 million (KPMG Health Economics Group, 2013). Very few community-driven, community-owned alcohol management initiatives have achieved this magnitude of success.

Good Sports is an example of the positive benefits that can come from implementing a simple yet effective program. For this reason Good Sports has now been adopted by over 6,500 clubs around Australia. It is often incorporated into wider community initiatives such as Liquor Accords and local Alcohol Management Plans as a key way of tackling alcohol problems in the important setting of sporting clubs.

5. OTHER COMMENTS ON FAS AND FASDS WITHIN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

The ADF believes it is important that health promotion interventions do not raise unnecessary fears in Aboriginal and Torres Strait Islander communities nor guilt amongst women who have consumed alcohol whilst pregnant. Such outcomes would be counterproductive and lessen the likelihood of future success.

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