Australian Government
Australian Institute of Health and Welfare

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Committee Secretary
House of Representatives Standing Committee on Indigenous Affairs
PO Box 6021
Parliament House
Canberra ACT 2600

Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities

Dear Sir/Madam

The Australian Institute of Health and Welfare (AIHW) welcomes the opportunity to make 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. This submission highlights a number of projects, reports and data available from AIHW that may be of relevance to this inquiry.

The AIHW is a major national agency set up by the Australian Government in 1987 as an independent statutory authority within the Health portfolio. Our mission is to provide authoritative information and statistics to promote better health and wellbeing. We provide timely, reliable and relevant information and statistics on health, aged care services, child care services, services for people with disabilities, housing assistance, child welfare services and other community services.

We collect data and manage national data collections in these areas, producing over 100 public reports each year. Our work is frequently referenced by the media. We also provide information to other government bodies, such as the COAG Reform Council, the Productivity Commission and cross-jurisdictional councils, to external researchers and also directly back to data providers. We report in formats that suit their purposes and allow them to place their service provision in a wider context.

We also develop, maintain and promote data standards to ensure that data collected are nationally consistent. In all these activities we enable governments and the community to make better informed decisions to improve the health and wellbeing of Australians.

The health and welfare of Indigenous Australians is an important part of the AIHW's work. AIHW collects and reports data about Indigenous-specific health services and comparing access to need. The AIHW develops and reports against national key performance indicators for Indigenous specific primary health care services, reports against the Aboriginal and Torres Strait Islander Health Performance Framework and provides crucial analysis for determining the burden of disease.

AIHW hosts the Indigenous Observatory (www.aihw.gov.au/indigenous-observatory/), an online repository of information on the health and welfare of Aboriginal and Torres Strait Islander people. The AIHW manages the Closing the Gap Clearinghouse (www.aihw.gov.au/closingthegap/) in collaboration with the Australian Institute of Family Studies. A brief summary of relevant Clearinghouse reports is provided at Appendix A.

A number of our published reports from these and other projects contain data relating to the use or effects of alcohol by Aboriginal and Torres Strait Islander people. A list is provided at Appendix B. Data included in these reports are drawn from a variety of sources.

The AIHW manages a number of data collections on the use of alcohol and other drugs and treatment of alcohol use relating to Aboriginal and Torres Strait Islander people. Descriptions of these collections and findings relating to harmful use of alcohol in Aboriginal and Torres Strait Islander communities are set out below. Some published data on harmful use of alcohol in Aboriginal and Torres Strait Islander communities in Australia is provided in Appendix C.

Appendix D contains more detailed information on fetal alcohol syndrome disorders (FASD).

Relevant data collections managed by the AIHW

The AIHW manages and is the national repository and data custodian of the following national collections that inform the issue of alcohol consumption among Aboriginal and Torres Strait Islander people:

- OATSIH Services Reporting (OSR) data collection
- The Healthy for Life collection
- The National Drug Strategy Household Survey (NDSHS)
- The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS)
- The national Key Performance Indicators (nKPIs) for Indigenous–specific primary health care services

Ownership of some of these collections remains with the relevant jurisdictions and service providers.

Online Services Reporting data collection

The OSR collection is an ongoing collection that was established in 2008–09 to combine three separate data collections that receive funding from the Australian Government: Aboriginal and Torres Strait Islander primary health care data collection, substance use services data collection and Bringing Them Home and Link Up counselling services data collection. The focus of the OSR data collection is on activities provided to clients of these services and covers episodes of care, work force and service profile including governance structures. In 2008 COAG endorsed the establishment of the nKPIs for Indigenous-specific primary health care services, which include both outcome and level of care indicators. The nKPIs and the OSR information are collected through the web-based system OCHREStreams.

The OSR data collection is used to support accountability for, and quality improvement in, the Australian Government's investment in primary health care for Indigenous Australians. In 2011–12, data were received from 290 services from across Australia that received funding from the Australian Government: 224 primary health care services, 67 substance use services and 88 Bringing Them Home and Link Up counselling services.

Healthy for Life and nKPIs collections

Healthy for Life was an Australian Government program announced in the 2005–06 Budget with funding of $103 million over 4 years to improve the health of Aboriginal and Torres Strait Islander mothers and children, improve the early detection and management of chronic disease and reduce the incidence of adult chronic disease. It focused on primary health-care services providing care to Aboriginal and Torres Strait Islander people.

The Healthy for Life program was available to established primary health-care providers in Aboriginal Community Controlled Health Services (ACCHSs), state and territory health

services and Divisions of General Practice. ACCHSs comprised more than 70% of the participating services. About 100 primary health-care services participated in the program through 57 sites and 80% were in regional and remote areas. Services submitted data to the AIHW on 10 essential indicators, which included alcohol use during pregnancy.

The Healthy for Life collection ceased in 2011, with services transferring to reporting on the nKPIs. The nKPIs include indicators relating to alcohol consumption and risk of long-term harm for all clients.

National Drug Strategy Household Survey

The NDSHS is the leading survey of licit and illicit drug use in Australia. The 2010 survey was the 10th conducted under the auspices of the National Drug Strategy. Previous surveys were conducted in 1985, 1988, 1991, 1993, 1995, 1998, 2001, 2004 and 2007. The data collected through these surveys have contributed to the development of policies for Australia's response to drug-related issues.

In 2010, more than 26,000 people aged 12 years or older provided information on their drug use patterns, attitudes and behaviours. The sample was based on households, so homeless and institutionalised people were not included in the survey (consistent with the approach in previous years).

The 2010 NDSHS was designed to provide reliable estimates at the national level. The survey was not specifically designed to obtain reliable national estimates for Aboriginal and Torres Strait Islander people. In 2010, 1.7% of the sample (or approximately 460 respondents) identified as being of Aboriginal or Torres Strait Islander origin. The sample size for Indigenous Australians was smaller than anticipated based on population estimates, and so estimates based on this population group should be interpreted with caution.

Fieldwork for the 2013 NDSHS was completed in early-December 2013 and early analysis of the results has just begun. The report on the survey is expected to be published in October 2014.

Alcohol and Other Drug Treatment Services National Minimum Data Set

The AODTS NMDS is a collection of data from publicly funded treatment services in all states and territories, including those directly funded by the Australian Government Department of Health (DoH). Included are all publicly funded government and non-government agencies that provide one or more specialist alcohol and/or other drug treatment services and all clients who have completed one or more treatment episodes at an alcohol and other drug treatment service. To date, information solely on closed treatment episodes (a period of treatment with defined dates of commencement and cessation) have been included. From 2012–13, data on the number of clients these episodes represent will also be available.

Information on substance use services by Indigenous Australians is limited. Data relating to Indigenous substance use services in the AODTS NMDS collection are drawn primarily from treatment episodes where clients identifying as Indigenous have accessed services that are available to all people in Australia (mainstream services) and/or services that receive funding from state and territory governments.

Indigenous substance use–specific services that are funded solely by DoH generally do not report to the AODTS NMDS because they report through the OSR data collection.

Other related collections

A number of other collections managed by the AIHW may also be of interest to the Committee. These include:

- The **National Hospital Morbidity Database** which contains data on hospitalisation at almost all public and private hospitals across Australia. Data items of relevance include

principal and additional diagnoses, treatments provided, Indigenous status and other patient demographics, and geographical location. Relevant diagnoses may include mental and behavioural disorders due to use of alcohol, fetal alcohol syndrome and other effects of maternal alcohol use on the fetus or newborn, and evidence of alcohol involvement in hospitalisations for injury and poisoning.

- The **National Prisoner Health Data Collection** contains data on prisoners' use of alcohol, tobacco and illicit drugs in the 12 months before entry into prison and while in prison. Data collected includes Indigenous status.
- The **Specialist Homelessness Services collection** contains information about clients of and services provided by specialist homelessness agencies. Data collected includes: client characteristics (including Indigenous status); reasons for seeking assistance (including drug and alcohol related reasons); and types of assistance required and provided (including drug and alcohol counselling and referrals for drug and alcohol treatment).
- The **National Perinatal Data Collection** contains information on all births in Australia, both live births and stillbirths, of at least 20 weeks gestation or 400 grams birth weight. Data include the Indigenous status of the mother and (from 1 July 2012) the baby. Collection of data on alcohol use in pregnancy by the states and territories providing this information to the AIHW is being pursued.

Key findings drawn from AIHW reports

Attitudes to drinking

Less than half (43.9%) of Aboriginal and Torres Strait Islander people aged 14 years or over approved of the regular use of alcohol by an adult in 2010. Just over one-third of Aboriginal and Torres Strait Islander people (35.3%) identified excess consumption of alcohol as the most serious concern for the community out of all drug types (AIHW 2008).

Alcohol-related problems

In the 2008 Australian Bureau of Statistics National Aboriginal and Torres Strait Islander Social Survey (NATSISS), nearly 1 in 4 Indigenous people aged 18 years or over reported that they, a family member or close friend had experienced alcohol-related problems in the previous 12 months (AIHW 2013, p.1161). More than 40% of Indigenous people aged 15 years or over reported that they thought alcohol was a problem in their community (AIHW 2013, p.1178). This was more common in remote areas (AIHW 2013, p.1181).

Alcohol abuse was managed at 15 of every 1,000 GP-patient encounters during the period April 2006 to March 2011. After adjusting for difference in age structure, management of alcohol abuse was almost 4 times as likely among Indigenous patients as among other Australian patients (AIHW 2013, p.657).

Prevalence of alcohol consumption and risk

The majority of data in this section are sourced from the 2008 NATSISS, as reported in *Drugs in Australia 2010: tobacco, alcohol and other drugs*. Definitions of alcohol-related consumption risk are based on the 2001 National Health and Medical Research Council's *Australian Alcohol Guidelines* which applied at the time data were collected. Calculation of risk differs somewhat between sources. Please see the relevant source publications for more information.

Eight in ten Aboriginal and Torres Strait Islander people were non-drinkers or drank at levels that did not place them at risk in 2008 (Table 1). More than one-third (35%) had never consumed alcohol or had not done so in the 12 months before the 2008 survey, and almost half drank at levels defined as low risk. Around 11% drank at medium-risk levels and just over 6% at high-risk levels.

Table 1: Alcohol consumption risk level for Aboriginal and Torres Strait Islander people in the last 12 months, 2002 and 2008, per cent

Alcohol consumption risk level	Total 2002	Total 2008
Low risk	46.1	46.3
Medium risk	9.6	10.9
High risk	5.6	6.3
Never consumed/has not consumed in the last 12 months	38.0	35.1

Sources: ABS 2002, 2009.

Risk levels were based on the reported amount of alcohol consumed on a usual drinking day together with consumption frequency during the year before the survey. These risk levels are often described as long-term risk and differ from risk results presented for the general population.

When drinking behaviour in the past two weeks (or short-term risk) is the focus, almost two-fifths of people aged 15 years or over drank risky or high-risk amounts of alcohol (ABS 2009).

Trends

Between 2002 and 2008, there was a small decrease in the proportion of Aboriginal and Torres Strait Islander people who had either never consumed alcohol or had not consumed alcohol in the 12 months before the surveys (Table 1). There was a correspondingly small increase in the proportion of people drinking at medium or high levels of risk for long-term harm.

Age and sex

Among all age groups for both sexes, Aboriginal and Torres Strait Islander people aged 35–44 years were most likely to drink at long-term risky/high risk levels (22%) (ABS 2010). The age group most commonly drinking at those levels for non-Indigenous people was 25–34 years.

Indigenous men were more likely than Indigenous women to drink at chronic risky/high-risk levels (20% compared with 14%) in 2008. This pattern was observed in all year age groups from 15–24 years to 55 years and over (ABS 2009). Similarly, Indigenous men were more likely to drink at risky and high-risk levels (46%) than Indigenous women (28%) (AIHW 2011).

More detail about risky and high-risk drinking is provided in Table 2. More than half of Indigenous males aged 25–44 years drank at risky or high-risk levels in 2008. For females in the same age group, the proportion was closer to one-third.

Table 2: Short-term risky and high-risk consumption of alcohol, Aboriginal and Torres Strait Islander people aged 15 years or older, 2008 (per cent)

Age group (years)	Males	Females
15–24	43.1	31.9
25–34	53.8	32.4
35–44	53.2	32.8
45–54	45.5	24.3
55 and over	30.8	10.9

Source: ABS 2009.

Indigenous and non-Indigenous comparisons

When differences in the age structures of Indigenous and non-Indigenous populations are taken into account, the proportion of people drinking at risky or high-risk levels for long-term harm was similar for both groups (in 2004–05, 15% and 14% for Indigenous and non-Indigenous people respectively) (AIHW 2009).

Twice as many Aboriginal and Torres Strait Islander people as non-Indigenous people drank at risky/high-risk levels for short-term harm in 2004–05 (AIHW 2009). (These data are different from those in Table 1 due to different data sources.)

Alcohol use in pregnancy

Use of alcohol during pregnancy can have serious effects on the unborn baby. Fetal Alcohol Syndrome Disorders (FASD) is a term that encompasses 4 conditions that are considered to be the result of exposure of an unborn baby to alcohol during pregnancy. These disorders are separated into Fetal Alcohol Syndrome (FAS), partial FAS (pFAS), alcohol-related neurodevelopmental disorders (ARND) and alcohol-related birth defects (ARBD). The birth defects and developmental disabilities that result from FASD are preventable by avoiding alcohol during pregnancy. A summary of currently available information relating to FASD in Australia is included at Appendix D.

The 2008 NATSISS found that 3.3% of mothers of Indigenous children aged 0–3 years drank more or the same amount of alcohol during pregnancy, and a further 16.3% drank less (AIHW 2013, p.1525).

Reduction in alcohol consumption

In 2010, many Aboriginal and Torres Strait Islander people took steps to moderate or reduce their drinking. Just over one-third limited the amount of alcohol consumed at any one time (38.0%) and/or reduced the number of times they drank (36.1%). Lifestyle and health reasons were the most common reasons cited for a reduction in drinking (46.9% and 35.1%, respectively) (AIHW 2011).

Alcohol and other drug treatment services

In 2011–12, specialist alcohol and other drug treatment services provided 146,948 treatment episodes to people seeking treatment for their own drug use, of those 46% (67,370) were for those where the client's principal drug of concern was alcohol (Table C1). Of those episodes, 14% (9,738) were for Aboriginal and Torres Strait Islander people (Table C2). Those clients were more likely to be younger than other Australians receiving treatment for alcohol (Table C2).

Indigenous clients receiving treatment for alcohol were less likely than other Australians to have been self-referred (or referred by a family member) to alcohol and other drug treatment (29% compared to 45%) and more likely to have been referred to treatment through a corrections or diversion program (24% compared to 16%) (Table C3). Similar to other Australians, Indigenous Australians were most likely to receive counselling treatment for their alcohol issue (44% and 43%) whereas they were less likely than other Australians to receive withdrawal management treatment for their alcohol use (10% compared to 20%) (Table C4).

In 2011–12, over 200 Aboriginal and Torres Strait Islander primary health-care services also provided treatment or assistance to clients for a range of substance use issues. Most services that offered treatment or assistance for substance use issues to individual clients did so for alcohol (92% or 189), tobacco and nicotine (92% or 189), and cannabis and marijuana (88% or 180).

In addition, treatment and assistance for substance use issues were provided to about 32,600 clients by Aboriginal and Torres Strait Islander substance use services and 83% of these clients (27,000) were Indigenous. The most common substances for which treatment or assistance was provided for were alcohol (94% of services); tobacco and nicotine (88%); cannabis and marijuana (88%) and multiple drug use (79%) (Table C5).

Just over 2,000 Indigenous clients (72% males and 28% females) received residential treatment and rehabilitation for substance use in 2011–12 (Table C6). Over half (53%) of these

clients were aged between 19 and 35, and one-third (35%) were aged 36 or over. Just over 12% were aged 18 or less.

About 7,000 Indigenous clients also received overnight or up to 1 week residential care for sobering-up or respite but this type of did not involve formal rehabilitation. Most of these clients were males (62%) (Table C6).

Alcohol-related morbidity and mortality

Hospitalisations

Over the period July 2008 to June 2010, for New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory combined, 7,763 Indigenous Australians were hospitalised with a principal diagnosis related to alcohol use (9.3 per 1,000 persons). The most common principal diagnosis was acute intoxication, accounting for almost half of the total. Indigenous Australians were hospitalised for alcohol use at 4 times the rate of non-Indigenous Australians (AIHW 2013, p.1400–1401). The difference was greater in *Outer Regional* and *Remote* areas.

Deaths

Over the period 2006–2010, in New South Wales, Queensland, Western Australian, South Australian and the Northern Territory, there were 382 Indigenous deaths reported as being directly related to alcohol use (25.6 per 100,000 persons). This was almost 6 times the rate among non-Indigenous persons (4.3 per 100,000). The majority of these deaths were caused by liver disease due to alcohol consumption (AIHW 2013, p.1397)

Should the Committee have any queries about the information I have provided or wish to seek additional data from the AIHW, please contact Dr Fadwa Al-Yaman, Head of the Indigenous and Children's Group, on (02) 6244 1146.

Yours sincerely

David Kalisch
Director

April 2014

References

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ABS 2010. The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2010. ABS cat. no. 4704.0. Canberra: ABS.

AIHW (Australian Institute of Health and Welfare) 2008. 2007 National Drug Strategy Household Survey: detailed findings. Drug statistics series no. 22. Cat. no. PHE 107. Canberra: AIHW.

AIHW 2009. Aboriginal and Torres Strait Islander Health Performance Framework 2008: detailed analyses. Cat. no. IHW 22. Canberra: AIHW.

http://www.aihw.gov.au/publication-detail/?id=6442468199

AIHW 2011. Drugs in Australia 2010: tobacco, alcohol and other drugs. Drug statistics series. Cat. no. PHE 154. Canberra: AIHW.

http://www.aihw.gov.au/publication-detail/?id=10737420497

AIHW 2013. Aboriginal and Torres Strait Islander health services report 2011–12: Online Services Report – key results (published 1 October 2013).

http://www.aihw.gov.au/publication-detail/?id=60129544671

Appendix A: Relevant Closing the Gap Clearinghouse reports

Reducing alcohol and other drug related harm

Resource sheet no. 3 (December 2010)

This paper summarises patterns of alcohol use and alcohol-related harm in Aboriginal and Torres Strait Islander people, and examines some of the strategies used to address this, including supply reduction, demand reduction and harm reduction strategies. The paper outlines the evidence for effectiveness of the various strategies and also describes some of the facilitators and barriers to success.

What works? A review of actions addressing the social and economic determinants of Indigenous health

Issues paper no. 7 (December 2013)

This paper reviews evidence relating to improving Indigenous outcomes and 'closing the gap' across a range of key social and economic determinants of health and wellbeing, including alcohol use. It shows that there are initiatives that can address the social determinants of Indigenous health to improve outcomes, such as:

- For housing—focusing on improving health hardware, such as physical infrastructure relating to sanitation, food preparation and water supply
- For education—having high expectations of students and promoting a positive Indigenous identity
- For health behaviours—restricting the supply of harmful substances.

Appendix B: List of other relevant AIHW publications

Substance use among Aboriginal and Torres Strait Islander people (published 8 February 2011)

http://www.aihw.gov.au/publication-detail/?id=10737418268

Housing and homelessness services: access for Aboriginal and Torres Strait Islander people (published 13 May 2011)

http://www.aihw.gov.au/publication-detail/?id=10737419006

Healthy for Life: results for July 2007–June 2011 (published 1 March 2013)

http://www.aihw.gov.au/publication-detail/?id=60129542715

Aboriginal and Torres Strait Islander Health Performance Framework 2012: detailed analyses (published 16 July 2013)

http://www.aihw.gov.au/publication-detail/?id=60129543821

Expenditure on health for Aboriginal and Torres Strait Islander people 2010–11: an analysis by remoteness and disease (published 23 August 2013)

http://www.aihw.gov.au/publication-detail/?id=60129544367

Alcohol and other drug treatment services in Australia 2011–12 (published 28 August 2013)

http://www.aihw.gov.au/publication-detail/?id=60129544486

Specialist homelessness services 2012–13 (published 17 December 2013)

http://www.aihw.gov.au/publication-detail/?id=60129545629

2010 National Drug Strategy Household Survey report (published 27 July 2011)

http://www.aihw.gov.au/publication-detail/?id=32212254712

Appendix C: Additional tables

Table C1: Closed episodes provided to clients for their own drug use by principal drug of concern, Australia, 2003–04 to 2011–12

Principal drug of concern	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12
Codeine	318	376	438	497	628	851	981	922	978
Morphine	1,461	1,389	1,292	1,299	1,390	1,877	1,730	1,794	1,927
Buprenorphine	271	245	403	418	415	695	671	725	823
Heroin	23,326	23,193	19,776	14,870	15,571	14,222	13,882	13,354	12,918
Methadone	2,408	2,737	2,804	2,804	2,946	2,851	2,895	2,445	2,632
Paracetamol	17	23	36	45	62	66	38	45	11
Other analgesics	859	973	1,043	1,110	1,265	1,417	1,477	1,589	2,145
Alcohol	48,500	50,324	56,076	59,480	65,702	63,272	67,450	68,167	67,370
Ketamine	2	2	3	5	2	1	9	2	2
Nitrous oxide	1	3	1	2	1	1	1	1	1
Barbiturates	4	16	7	6	3	10	14	24	15
Benzodiazepines	2,711	2,538	2,583	2,298	2,487	2,080	2,238	2,488	2,524
Other sedatives and hypnotics	43	76	47	57	54	162	175	203	234
Amphetamines	14,208	14,780	15,935	17,292	16,588	12,739	10,027	12,563	16,875
Cannabis	28,427	31,044	35,637	31,980	31,864	31,100	31,558	31,762	32,321
Ecstasy	508	580	897	1,010	1,321	1,397	1,105	708	550
Volatile nitrates	11	7	12	6	5	14	13	7	16
Cocaine	272	400	434	448	457	479	595	501	417
Nicotine	2,001	2,478	2,618	2,450	2,548	2,461	2,553	1,849	1,722
Other stimulants and hallucinogens	86	118	176	187	240	236	229	287	348
Anabolic agents and selected hormones	5	10	6	14	33	19	30	28	27
Antidepressants and antipsychotics	35	41	24	22	29	53	39	45	43
Volatile solvents	463	698	612	383	341	589	602	553	602
Other	2,420	2,353	3,124	3,124	2,977	1,061	1,296	1,914	2,323
Not stated	974	798	979	668	792	374	5	2,026	124
Total	129,331	135,202	144,963	140,475	147,721	138,027	139,613	144,002	146,948

Source: AIHW 2013. *Alcohol and other drug treatment services in Australia 2011–12: Report on the national minimum data set, Supplementary tables*.

Table C2: Closed episodes provided to clients for their own drug use where alcohol was a principal drug of concern by age group, sex and Indigenous status, Australia, 2011–12

		Age group (years)							
Sex	**Indigenous status**	**10–19**	**20–29**	**30–39**	**40–49**	**50–59**	**60+**	**Unknown**	**Total**
Male	Indigenous	816	1,811	1,895	1,373	469	79	7	6,450
	Non-Indigenous	2,448	7,754	9,565	9,177	5,186	2,482	19	36,631
	Not stated	339	632	602	541	304	130	19	2,567
	Total	*3,603*	*10,197*	*12,062*	*11,091*	*5,959*	*2,691*	*45*	*45,648*
Female	Indigenous	445	833	991	761	228	23	3	3,284
	Non-Indigenous	1,125	2,502	4,636	5,050	2,880	1,121	13	17,327
	Not stated	178	185	240	285	130	30	5	1,053
	Total	1,748	3,520	5,867	6,096	3,238	1,174	21	21,664
Not stated	Indigenous	—	—	4	_	_	_	_	4
	Non-Indigenous	2	8	11	8	4	4	_	37
	Not stated	—	5	6	4	2	_	_	17
	Total	2	13	21	12	6	4	_	58
Total	Indigenous	1,261	2,644	2,890	2,134	697	102	10	9,738
	Non-Indigenous	3,575	10,264	14,212	14,235	8,070	3,607	32	53,995
	Not stated	517	822	848	830	436	160	24	3,637
	Total	5,353	13,730	17,950	17,199	9,203	3,869	66	67,370

Source: AIHW 2013. *Alcohol and other drug treatment services in Australia 2011–12: Report on the national minimum data set, Supplementary tables*.

Table C3: Closed episodes provided to clients for their own drug use where alcohol was a principal drug of concern by age group, referral source and Indigenous status, Australia, 2011–12

		10–19	20–29	30–39	40–49	50–59	60+	Unknown	Total
Self/family	Indigenous	222	713	885	733	258	31	3	2,845
	Non-Indigenous	1,009	4,105	6,866	7,019	3,953	1,355	11	24,318
	Not stated	91	260	307	355	192	63	9	1,277
	Total	**1,322**	**5,078**	**8,058**	**8,107**	**4,403**	**1,449**	**23**	**28,440**
Health service	Indigenous	299	720	974	795	293	43	3	3,127
	Non-Indigenous	838	2,437	4,171	4,632	3,007	1,794	14	16,893
	Not stated	68	141	214	244	143	67	5	882
	Total	**1,205**	**3,298**	**5,359**	**5,671**	**3,443**	**1,904**	**22**	**20,902**
Corrections	Indigenous	150	494	387	180	40	5	1	1,257
	Non-Indigenous	438	1,441	1,020	778	245	75	3	4,000
	Not stated	75	168	131	76	27	4	1	482
	Total	**663**	**2,103**	**1,538**	**1,034**	**312**	**84**	**5**	**5,739**
Diversion	Indigenous	366	339	221	156	34	3	-	1,119
	Non-Indigenous	779	1,507	1,107	773	265	50	1	4,482
	Not stated	68	182	106	80	23	7	5	471
	Total	**1,213**	**2,028**	**1,434**	**1,009**	**322**	**60**	**6**	**6,072**
Other	Indigenous	224	378	423	270	72	20	3	1,390
	Non-Indigenous	511	774	1,048	1,033	600	333	3	4,302
	Not stated	215	71	90	75	51	19	4	525
	Total	**950**	**1,223**	**1,561**	**1,378**	**723**	**372**	**10**	**6,217**
Total	Indigenous	1,261	2,644	2,890	2,134	697	102	10	9,738
	Non-Indigenous	3,575	10,264	14,212	14,235	8,070	3,607	32	53,995
	Not stated	517	822	848	830	436	160	24	3,637
	Total	**5,353**	**13,730**	**17,950**	**17,199**	**9,203**	**3,869**	**66**	**67,370**

Source: AIHW 2013. *Alcohol and other drug treatment services in Australia 2011–12: Report on the national minimum data set, Supplementary tables*.

Table C4: Closed episodes provided to clients for their own drug use where alcohol was a principal drug of concern by age group, main treatment type and Indigenous status, Australia, 2011–12

		10–19	20–29	30–39	40–49	50–59	60+	Unknown	Total
Counselling	Indigenous	487	1,341	1,276	861	268	30	6	4,269
	Non-Indigenous	1,357	4,965	6,411	6,137	3,312	1,284	16	23,482
	Not stated	273	415	398	404	182	45	5	1,722
	Total	**2,117**	**6,721**	**8,085**	**7,402**	**3,762**	**1,359**	**27**	**29,473**
Withdrawal management	Indigenous	52	190	326	311	87	11	-	977
	Non-Indigenous	210	1,419	3,028	3,483	2,083	833	8	11,064
	Not stated	12	61	145	176	122	57	1	574
	Total	**274**	**1,670**	**3,499**	**3,970**	**2,292**	**901**	**9**	**12,615**
Assessment only	Indigenous	117	509	555	347	116	26	1	1,671
	Non-Indigenous	307	1,921	2,177	1,984	1,040	448	1	7,878
	Not stated	35	98	130	112	39	14	-	428
	Total	**459**	**2,528**	**2,862**	**2,443**	**1,195**	**488**	**2**	**9,977**
Support and case management only	Indigenous	206	162	183	186	53	6	3	799
	Non-Indigenous	956	647	679	632	359	118	3	3,394
	Not stated	91	59	32	32	18	10	-	242
	Total	1,253	868	894	850	430	134	6	4,435
Rehabilitation	Indigenous	71	213	259	138	24	5	-	710
	Non-Indigenous	92	633	977	949	430	136	3	3,220
	Not stated	10	40	17	18	11	5	7	108
	Total	**173**	**886**	**1,253**	**1,105**	**465**	**146**	**10**	**4,038**
Information and education only	Indigenous	97	122	160	142	86	3	-	610
	Non-Indigenous	361	252	206	181	97	45	-	1,142
	Not stated	68	109	70	51	25	6	11	340
	Total	**526**	**483**	**436**	**374**	**208**	**54**	**11**	**2,092**
Pharmacotherapy	Indigenous	-	2	2	1	1	-	-	6
	Non-Indigenous	1	1	9	3	8	2	-	24
	Not stated	-	-	-	1	-	-	-	1
	Total	**1**	**3**	**11**	**5**	**9**	**2**	**-**	**31**
Other	Indigenous	231	105	129	148	62	21	-	696
	Non-Indigenous	291	426	725	866	741	741	1	3,791
	Not stated	28	40	56	36	39	23	-	222
	Total	**550**	**571**	**910**	**1,050**	**842**	**785**	**1**	**4,709**
Total	Indigenous	1,261	2,644	2,890	2,134	697	102	10	9,738
	Non-Indigenous	3,575	10,264	14,212	14,235	8,070	3,607	32	53,995
	Not stated	517	822	848	830	436	160	24	3,637
	Total	**5,353**	**13,730**	**17,950**	**17,199**	**9,203**	**3,869**	**66**	**67,370**

Source: AIHW 2013. *Alcohol and other drug treatment services in Australia 2011–12: Report on the national minimum data set, Supplementary tables*.

Table C5: Aboriginal and Torres Strait Islander substance use services providing individual and targeted programs, by type of substance, 2008–09 to 2011–12

	2008–09		2009–10		2010–11		2011–12	
Substance use issue	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
				On an individual basis				
Alcohol	40	88.9	43	89.6	48	98.0	63	94.0
Tobacco/nicotine	34	75.6	35	72.9	39	79.6	59	88.1
Cannabis/marijuana	39	86.7	42	87.5	48	98.0	59	88.1
Multiple drug use	34	75.6	33	68.8	39	79.6	53	79.1
Benzodiazepines	25	55.6	28	58.3	31	63.3	39	58.2
Amphetamines	27	60.0	27	56.3	28	57.1	35	52.2
Ecstasy/MDMA[(a)]	18	40.0	16	33.3	17	34.7	33	49.3
Petrol	24	53.3	24	50.0	26	53.1	29	43.3
Other solvents/inhalants	26	57.8	27	56.3	24	49.0	33	49.3
Heroin	21	46.7	22	45.8	19	38.8	25	37.3
Methadone	18	40.0	16	33.3	17	34.7	28	41.8
Morphine	19	42.2	15	31.3	17	34.7	25	37.3
Barbiturates	19	42.2	12	25.0	13	26.5	20	29.9
Cocaine	15	33.3	10	20.8	14	28.6	21	31.3
Lysergic acid diethylamide	8	17.8	12	25.0	12	24.5	17	25.4
Other drugs	3	6.7	4	8.3	3	6.1	15	22.4
Steroids/anabolic agents	6	13.3	7	14.6	6	12.2	8	11.9
Kava	5	11.1	2	4.2	6	12.2	5	7.5

(a) MDMA: methylenedioxymethamphetamine.

Source: AIHW analyses of the OATSIH Services Reporting data collection.

Table C6: Estimated number of Aboriginal and Torres Strait Islander clients of substance use services by residential treatment type and sex, 2011–12

Treatment type	**Male Indigenous clients**	**Female Indigenous clients**	**Total Indigenous clients**	**All clients[(a)]**	**Total[(b)] (per cent)**
Residential treatment and rehabilitation	1,560	592	2,152	2,726	**78.9**
Residential care for sobering-up or respite	4,346	2,711	7,057	7,177	**98.3**

(a) Includes non-Aboriginal and Torres Strait Islander clients.

(b) Aboriginal and Torres Strait Islander clients as a proportion of all clients.

Source: AIHW analyses of the OATSIH Services Reporting data collection.

Appendix D: Australian information about Fetal Alcohol Syndrome Disorders

Background

FASD is a term that encompasses 4 conditions that are considered to be the result of exposure of an unborn baby to alcohol during pregnancy. These disorders are separated into Fetal Alcohol Syndrome (FAS), partial FAS (pFAS), alcohol-related neurodevelopmental disorders (ARND) and alcohol-related birth defects (ARBD). The birth defects and developmental disabilities that result from FASD are preventable by avoiding alcohol during pregnancy.

Current data on alcohol use in pregnancy

Based on results from the 2010 National Drug Strategy Household Survey (NDSHS), the majority of pregnant women either reduced their alcohol consumption while pregnant (48.7%) or abstained (48.9%) (Table D1). The proportion of pregnant women abstaining during pregnancy increased in 2010 (statistically significantly from 40.0% in 2007 to 48.9% in 2010), as did the proportion of breastfeeding women abstaining (statistically significantly from 25.1% to 34.4%). The AIHW is currently finalising the 2013 NDSHS with preliminary results expected to be available in June 2014 and publically available in October 2014.

Table D1: Pregnant women who drank more, less or the same amount of alcohol compared with when they were neither pregnant nor breastfeeding, 2007 and 2010 (per cent)

Drinking alcohol while pregnant	While pregnant[a]			While breastfeeding[b]		
	2007	2010		2007	2010	
More	**0.6	**0.5		**0.2	**0.1	
Less	56.6	45.5	↓	70.2	62.4	↓
Same	*2.8	*2.1		4.5	3.7	
Didn't drink alcohol	40.0	52.0	↑	25.1	33.8	↑

(a) Base is only pregnant women or women pregnant and breastfeeding.

(b) Base is women who were only breastfeeding or pregnant and breastfeeding.

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Source: AIHW 2010 National Drug Strategy Household Survey report.

In Western Australia, it has been reported that nearly 50% of all live births are unplanned. When considering the high level of alcohol use in the three months prior to pregnancy it is highly likely that pregnancies will be exposed to alcohol before pregnancy is confirmed[1].

Prevalence[2] of FASD

There is limited information about the prevalence of FASD in Australia and the available statistics relate almost exclusively to FAS. There are no national Australian population estimates of the prevalence of FASD.

It is believed that the prevalence of FASD in Australia is difficult to determine and what is known is likely to be an under-count. Currently in Australia there are no screening, diagnostic or treatment services for FASD and no national guidelines for screening and diagnosing FASD. Doctors may miss or lack knowledge of key clinical criteria to make a FASD diagnosis. No national collection of FASD related data exists.

[1] Department of Health, Western Australia. Fetal Alcohol Spectrum Disorder Model of Care. Perth: Health Networks Branch, Department of Health, Western Australia; 2010.

[2] Prevalence refers to the total number he total number of cases of a disease in a given population at a specific time.

In Western Australia, FAS prevalence has been estimated as 0.18 per 1,000 children[3], in the Northern Territory 0.68 per 1,000 children[4] and 0.01 to 0.03 per 1,000 children in Victoria[5].

For Indigenous children, the reported prevalence of FAS was 2 to 3 times higher than non-Indigenous children[4, 5]. The published rates in Australia are lower than those reported in the United States where between 1 and 1.5 per 1,000 children have been estimated to be FAS affected, with rates 5 times higher than reported among African American and rates 16 times higher than reported among American Indian children[6].

International responses to FASD

Resources, interventions, and supports are generally concentrated in North America. Both Canada[7]and the United States[8] have expert guidelines on FAS and are considered to be the world leaders in the response to FASD. The Centres for Disease Control and its partners are currently working to develop diagnostic criteria for other FASDs, such as ARND (www.cdc.gov/ncbddd/fasd/diagnosis.html).

Services/Education

Both Canada and the United States also have government funded FAS-dedicated websites which provide information and linkages to clinical and family services (e.g. the Substance Abuse and Mental Health Services Administration Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence Web site (www.fasdcenter.samhsa.gov) in the U.S. and the Public Health Agency of Canada's FAS website (www.phac-aspc.gc.ca/fasd-etcaf/index-eng.php)). These, and other sites, also provide links to both online and face-to-face support groups for families and carers.

North America also has numerous specialised FAS multidisciplinary diagnostic and treatment centres. For example, the state of New Jersey has 6 FAS/ARND Diagnostic and Education Service Centres, where they evaluate "children's physical growth and intellectual and emotional development and make recommendations. Evaluation is done by an experienced team of professionals consisting of a developmental paediatrician, nurse, psychologist, physical and occupational therapists, speech pathologist, social worker and/or family counsellor (accessed through www.nofas.org/resource)." These centres concentrate expertise into single locations, where evidence-based diagnosis and intervention plans can be created.

Canada also provides a wide range of services and support for diagnosis and care funded through FASD multidisciplinary clinics across the country. The clinics offer education, support and services to expectant mothers in addition to providing services and support for children and adults diagnosed with FASD. For example in the region of Alberta, 12 FASD service networks operate to provide community based coordinated assessment and

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3 Bower C, Silva D, Henderson T, Ryan A & Rudy E 2000. Ascertainment of birth defects: the effect on completeness of adding a new source of data. Journal of Paediatrics and Child Health 36:574–6.

4 Harris K & Bucens I 2003. Prevalence of fetal alcohol syndrome in the Top End of the Northern Territory. Journal of Paediatrics and Child Health 39:528–33.

5 Allen K, Riley M, Goldfeld S & Halliday J 2007. Estimating the prevalence of fetal alcohol syndrome in Victoria using routinely collected administrative data. Australian and New Zealand Journal of Public Health 31:62–6.

6 Sokol R, Delaney-Black V & Nordstrom B 2003. Fetal alcohol spectrum disorder. JAMA: the journal of the American Medical Association 290:2996–9.

7 Chudley A 2008.

8 Bertrand J, Floyd RL, Weber MK, O'Connor ML, Riley EP, Johnson KA & Cohen DE 2004. National Task Force on fetal alcohol syndrome and fetal alcohol effect: Fetal Alcohol Syndrome: guidelines for referral and diagnosis. Atlanta: Centres for Disease Control and Prevention.

diagnosis; targeted and indicated prevention, and support services for people affected by FASD and their caregivers. Examples of education programs offered are the Parent-Child Assistance Program (PCAP) – a program which provides targeted prevention of FASD to mothers at risk; the FASD Learning Series which aims to increase community and individual capacity to support individuals with FASD and their carers.

Support is also available through the centers to provide information; service coordination/case management; supports for daily living; rehabilitation/behavioural; opportunities for meaningful activities; and respite services. Additionally, throughout Canada, teachers have also been provided with training in strategies in teaching children with FASD and other pilot programs exist to help people with FASD into employment[9].

National Prevalence Plan for FASD in Canada

It is estimated that FASD is the leading known cause of developmental disability in Canada. The cost for Canada (population nearly 35 million) is estimated at $4 billion a year based on a rate of one FASD case in 100 pregnancies[10]. In response, Canada has developed a *Framework for Action*[11] in regards to FASD which provides a comprehensive and consistent approach to FASD prevention and support.

Canada is continuing to work on a *National Prevalence Plan for FASD* as it has been determined that (as outlined above) that diagnosis alone is not sufficient for measuring prevalence. Four key areas have been identified as being key to the National Prevalence Plan for FASD.

1. Screening should be conducted on: children and adults for FASD; women at risk of consuming alcohol during pregnancy; and alcohol consumption by all women of childbearing age.
2. Diagnosis: A standard definition of diagnosis of FASD must be determined; diagnostic capacity of clinicians must be increased; and a register of diagnosis should be created at a regional or national level (with the capacity for data linkage).
3. Routine, longitudinal data collection: national infrastructure should be created and developed to support FASD prevalence data collection, possibly including maternal drinking during pregnancy and new and existing diagnoses of FASD.
4. Knowledge exchange: establish a national FASD prevalence system to collect, analyse and distribute information in a timely fashion to direct policy, create evidence based programs and prevention and intervention strategies, and inform public perception; and ensure that prevalence data for FASD informs a national strategy for FASD prevention and intervention.

Australia's response to FASD

Services available to those diagnosed with FASD and their families are limited, and Australia has only one dedicated FASD diagnostic clinic, which is funded by the Foundation for Alcohol Research & Education (FARE). This clinic opens fortnightly and is based at the Children's Development Unit, within The Children's Hospital at Westmead in Sydney.

Screening tools for alcohol consumption in pregnancy have been reviewed in Australia and there are strong arguments for their introduction into routine antenatal care. Monitoring patterns of alcohol consumption in pregnancy using validated screening tools provides an indirect view of the extent of FASD and is a requirement for diagnosis of FASD conditions.

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[9] FARE 2013.

[10] Canada FASD. http://www.canfasd.ca/wp-content/uploads/2013/02/2012_Annual_Report_Final_e.pdf

[11] Public Health Agency of Canada. http://www.phac-aspc.gc.ca/publicat/fasd-fw-etcaf-ca/index-eng.php#toc

The previous Australian Government announced on 6 August 2013 an investment of $20 million over four years towards a FASD Action Plan, commencing in 2013–14. The FASD Action Plan has been informed by the report of the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into FASD and an Inter Departmental Committee which developed the whole of government FASD Action Plan.

The Commonwealth investment is aimed to support 5 priorities:

- Prevention with a focus on primary care
- Secondary prevention to support intervention among for pregnant women with problematic alcohol use, or who have a child with FASD
- Diagnosis and management to support the finalisation of FASD diagnostic tool and the development of associated resources for professions to support early management and advice to families
- Prevention of FASD in Indigenous communities through additional support for existing mothers and babies services
- Coordination and workforce to support joint efforts to prevent and reduce the impact of FASD, including the establishment of a collaborative network of FASD experts.

It should be noted that FASD is not currently recognised within the framework of financial support for carers or under the *National Disability Insurance Scheme* despite it being a lifelong condition that cannot be cured[12]. Education is currently underway but is set within the wider context of reducing alcohol related harm and not specific to pregnant women (or even women of child bearing age)[11].

The AIHW has undertaken some work considering the information gaps in FASD and determined that the use of jurisdictional congenital conditions/anomalies registries to accommodate notifications for FASD would make use of existing resources and infrastructure. However, work would be required by the AIHW to develop the jurisdictional congenital anomalies registers to accommodate FASD once it becomes notifiable.

A FASD register embedded into jurisdictional congenital anomalies/conditions registers would support the research still required in this field and could provide a platform for assessment during the testing and implementation phases of the introduction of the diagnostic and screening instrument. Further research facilitated by data linkage to other data collections such as disability services could provide information on outcomes for FASD-affected children and provide information on long term management. The issue of collecting alcohol use during pregnancy as part of routine collection as well as using the existing Congenital Anomalies Register to collect information on FASD have not been addressed in the Action Plan.

[12] FARE 2013. The Australian Fetal Alcohol Spectrum Disorders Action Plan. Retrieved from: http://www.fare.org.au/wp-content/uploads/2011/07/FARE-FASD-Plan.pdf