QUEENSLAND COALITION FOR ACTION ON ALCOHOL

ACTION ON ALCOHOL

WORKING TOGETHER TO REDUCE ALCOHOL RELATED HARM

QCAA Submission to the Discussion Paper: Reducing alcohol and other drug impacts in Queensland

October 2015

About the Queensland Coalition for Action on Alcohol

The Queensland Coalition for Action on Alcohol (QCAA) is a coalition of like-minded health and community organisations in Queensland committed to reducing alcohol-related harm.

QCAA's aim is to identify and prioritise what needs to be done to achieve change that will reduce alcohol harms and improve the health and wellbeing of Queenslanders.

The QCAA comprises of a number of organisations within Queensland who have an interest in alcohol harm reduction and/or public health.

The founding members of QCAA are Healthy Options Australia, the Australian Medical Association Queensland (AMAQ), Queensland Alcohol and Drug Research and Education Centre (QADREC), the Foundation for Alcohol Research and Education (FARE) and Lives Lived Well.

QCAA has 12 member organisations:

- Australian Medical Association Queensland
- Collaboration for Alcohol Related Developmental Disorders
- Drug and Alcohol Nurses Australasia
- Drug ARM Australasia
- Foundation for Alcohol Research and Education (FARE)
- Healthy Options Australia
- Lives Lived Well
- Royal Australian College of Surgeons (Queensland)
- Safe Streets Association Inc
- Queensland Alcohol and Drug Research and Education Centre
- Queensland Homicide Victims Support Group
- Queensland Network of Alcohol and other Drug Agencies

This broad-based Queensland alliance has come together to pool collective expertise and knowledge around what strategies are needed to reduce the harms associated with drinking in Queensland.

To find out more about QCAA, visit http://www.qcaa.org.au/

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Introduction

The Queensland Coalition for Action on Alcohol (QCAA) welcomes the opportunity to provide a submission to the discussion paper, *Reducing alcohol and other drug impacts in Queensland* for the *Queensland Drug and Alcohol Action Plan 2015-17* (Action Plan).

QCAA's aim is to reduce alcohol related harm in the Queensland community. Not surprisingly therefore, its priority is to take action to address harmful levels of alcohol consumption.

Alcohol, because of its potential to cause harms, is not like other products. The World Health Organization (WHO) recognises that the consumption of alcohol is one of the main risk factors for poor health globally[1] and that it can "ruin the lives of individuals, devastate families and damage the fabric of communities." Its sale and access should therefore be treated with due care and consideration.

The way that people consume alcohol is influenced by a range of circumstances such as age, gender, cultural background and place of residence. Alcohol consumption can lead to poor living conditions and lack of employment, but it can also occur as a result of these circumstances occurring. Alcohol, therefore, can be both a contributor to, and consequence of, poor health and inequity.

Preventing harm from alcohol must be a priority for the Action Plan. In order to achieve this, action is needed to address the circumstances that contribute to harmful use. The harms from alcohol do not just impact the health system. They also impact emergency services, the justice system and family and children's services. In Queensland alone there are more than 1,000 deaths and 35,000 hospitalisations each year. More than one third of Queensland adults have experienced violence as a result of alcohol. It is therefore essential that the health sector works across government portfolios to ensure that the impact on health is considered when government decisions are made.

In the case of alcohol, it has never been so easy to buy. Prices are low, there are licensed venues on just about every corner and alcohol advertising is ubiquitous. This is a concern because increases in the availability, affordability and promotion of alcohol have consistently been associated with an increase in alcohol consumption and social and health harms.[2]

A long-term commitment is needed to reduce alcohol harms. Such a commitment needs to include a range of evidence-based solutions. This means tackling both the drivers of demand to prevent harm from occurring and addressing supply. Targeted activities on the ground are also important to meet local needs. Success will be limited if the underlying causes of harmful consumption and drivers of demand are not addressed in a strategic and sustained approach.

The government should target the most effective demand, supply and harm reduction strategies to reduce risky alcohol consumption and prevent alcohol-related harm.

The discussion paper

The purpose of the Discussion Paper is to seek views from Queenslanders and key stakeholders on actions that should be taken as part of the whole-of-government *Queensland Drug and Alcohol Action Plan 2015-17* (the Action Plan). The Action Plan is being developed in support of the *Queensland*

Mental Health, Drug and Alcohol Strategic Plan 2014–2019 (the Strategic Plan) which aims to prevent and reduce the adverse impact of drugs and alcohol on the health and wellbeing of Queenslanders. The Action Plan supports a range of other initiatives taken to support implementation of the Strategic Plan, such as actions to improve consumer, family and carer engagement and leadership, a new mental health, drug and alcohol services plan and the Queensland Aboriginal and Torres Strait Islander Action Plan.

The Discussion Paper outlines themes arising from consultations held in the lead up to the development of the paper and invites consideration of a number of questions outlined below.

Overarching questions

1. What priorities should the Action Plan address?
2. What actions are currently being taken that would support preventing and reducing the adverse impact of drugs and alcohol and how might they be improved?
3. What other actions should be taken?

Demand reduction

4. What improvements could be made on the current mix of demand reduction activities in Queensland?
5. What are some innovative ways that prevention and early intervention activities can be promoted and access improved?
6. Are there any examples of good practice in demand reduction?

Supply reduction

7. Are there improvements that could be made on the current supply reduction activities in Queensland?
8. Are there any examples of good practice in supply reduction?

Harm reduction

9. Are there improvements that could be made to harm reduction strategies in Queensland?
10. Are there any examples of good practice in harm reduction that you can identify in Queensland and elsewhere?

Vulnerable population groups

11. How can people experiencing problematic alcohol and drug use be supported to participate in the economy through education, training and employment and in the community?
12. What should be the main priorities to prevent and reduce the adverse impact of drugs and alcohol for groups who are at greater risk of alcohol and drug related harms including:
    - people experiencing disadvantage such as unemployment and homelessness
    - Aboriginal and Torres Strait Islander peoples

- people living in rural and remote communities
- children and young people
- pregnant and parenting women
- people living with co-occurring problematic drug use and mental health issues
- people from culturally and linguistically diverse backgrounds
- people in contact with the criminal justice and youth justice systems
- lesbian, gay, bisexual and transgender people.

This submission

This submission responds to the Discussion Paper on Reducing alcohol and other drug impacts in Queensland in the context of the priorities of the Queensland Coalition for Action on Alcohol (QCAA).

QCAA's submission focuses on alcohol and the key priorities for action to prevent alcohol harms. The submission looks at the environment in which alcohol consumption occurs, identifies alcohol as the number one priority for the Plan and then discusses the key priorities to address alcohol harm. The submission closes with a final section on other matters that should be considered in the development of the Action Plan.

List of recommendations

1. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 adopts prevention as a guiding principle.
2. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to promote a 'health in all policies' approach across all government agencies.
3. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 actively supports the legislation for 3am last drinks and 1am lockout be introduced as soon as possible to prevent further alcohol harm from occurring.
4. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 actively supports the reintroduction of the moratorium on late night trading.
5. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to liaise with the Department of Justice and Attorney General to remove exemptions on 10pm close for off-licence venues.
6. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action for the development of a framework to manage outlet density through the introduction of measures such as cluster control policies and saturation zones, which takes into consideration police data related to crime, including domestic and non-domestic assault.

7. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action that the government evaluate the 3am last drinks and 1am lockout measures once they are introduced.

8. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to advocate for the introduction of a minimum price for alcohol of at least one dollar per standard drink to stop the extreme discounting of alcohol.

9. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to reduce community exposure to alcohol related promotions that normalise problematic drinking in social situations and promote excessive consumption of alcohol

10. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to advocate for the prohibition for point of sale promotional materials for liquor (such as 'happy hours', free gifts with purchase, prominent signage, competitions, price discounts for bulk purchases, and sale prices) from being displayed on and around licensed premises where minors are likely to be present.

11. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to reduce young people's exposure to alcohol advertising by working with the Australian Government and other state and territory governments to ensure alcohol products are not targeted at people younger than 18 years

12. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to ban the redemption of alcohol 'shopper docket' promotions, which promote discounted alcohol on supermarket receipts.

13. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to ban alcohol promotions on state property, including public transport.

14. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an evidence-based education and awareness campaign that is based on social learning theory designed and is supported by other interventions aimed at supply, demand and harm reduction.

15. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 addresses the need for the Queensland Government to provide adequate and secure funding for the AODs sector to enable them to provide quality services that can meet the needs of individuals and respond to changes in these needs.

16. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes measures to address gaps in service delivery and creates funded mechanisms that enable collaboration between different sectors.

17. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to implement routine collection and annual reporting on alcohol harms to inform the development of alcohol policy and the evaluation of programs and services.

18. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action for the use of screening and brief interventions by health practitioners in primary health care and emergency department settings to identify people at risk from alcohol and provide a brief intervention or referral as required.

19. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 supports the use of *The Common Approach* as a tool to identify early children and families in need of support from alcohol harm and to prevent a crisis situation from developing and people being at risk of much greater harm.

20. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to promote the *Women Want to Know* campaign that encourages and supports health professionals to talk to their clients about alcohol use during pregnancy to reduce the harm from alcohol during pregnancy and breastfeeding and prevent Fetal Alcohol Spectrum Disorders.

21. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 establishes additional Fetal Alcohol Spectrum Disorders diagnostic services to be delivered to people in Queensland and particularly those living in rural and remote locations.

22. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 seeks access to early intervention services for children with Fetal Alcohol Spectrum Disorder and funds these accordingly.

23. That in addressing the particular needs of Aboriginal and Torres Strait Islander people, the Queensland Alcohol and Other Drug Action Plan 2015-2017 is informed by previous work such as the *National Aboriginal and Torres Strait Islander People's Drug Strategy 2014-2019* and the report of the *Inquiry into the harmful consumption of alcohol in Aboriginal and Torres Strait Islander communities*.

24. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to establish sobering-up shelters to provide support, care and monitoring for those who are intoxicated. These should be independent of law enforcement activities.

25. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to establish community patrols in urban, regional and remote locations where these do not exist and a need is identified, to improve community safety and reduce harm in Aboriginal and Torres Strait Islander people.

What priorities should the Action Plan address?

The Discussion Paper outlines the three priorities of the Queensland Alcohol and other Drug Action Plan 2015-2017 (Action Plan) which reflect the three pillars of harm minimisation of the *National Drug Strategy: demand, supply and harm reduction*. These strategies recognise that the most important activity that should be taken to reduce alcohol harm from alcohol and other drugs is prevention and that a comprehensive strategy is critical to achieving success.

Early intervention and treatment activities are also important to assist those who are at risk of or already engaging in behaviours that contribute to alcohol and other drug related harm. These activities are important to prevent further harm from occurring. Early intervention and treatment services are discussed later in the submission.

In focusing on prevention, QCAA believes that the most important priority for the Action Plan should be to address alcohol consumption, since alcohol is the most widely used drug in Queensland[3] and it is the primary drug of concern for most people seeking treatment.

This section will discuss why it is important to focus on prevention and alcohol and recommends actions for inclusion in the Action Plan.

Prevention

Prevention should be a key priority for any government with a genuine interest in improving the health and wellbeing of their community. Promoting good health and preventing disease provides a benefit not only to the individual but to the community as a whole by improving health, quality of life and increased productivity. The health system also benefits from reduced cost pressures as illness is reduced and the health and wellbeing of individuals and the community improves.

There are a number of factors that can impact on a person's health, however which can counter prevention activities. For example, a person's age, gender, cultural background and place of residence can all influence the way in which that person consumes alcohol. This means that some population groups, such as young people and Aboriginal and Torres Strait Islander peoples, experience disproportionate levels of alcohol-related harms when compared to the rest of the population.

The problems is compounded by the fact that some harmful behaviours can be a both a contributor to and consequence of poor health and inequity.[4] Risky alcohol consumption, for example, can lead to poor living conditions and lack of employment, but it can also occur as a result of these circumstances occurring.

The challenge for the health sector in trying to address alcohol harms is that decisions made outside the health portfolio can have an impact on the health of an individual or community. Liquor licensing is managed by the Department of Justice and Attorney General (JAG) which regulates the sale of alcohol through the *Liquor Act 1992* (the Act). While JAG is concerned about minimising alcohol harm and includes this in the main purposes of the Act, it is also concerned about developing the alcohol, tourism and hospitality industries.[5] This creates a clear tension of priorities in the Act and limits government's ability to reduce harm. Government action in areas such as homelessness, domestic violence, competition and deregulation can also have an impact on alcohol consumption and associated harm.

To successfully prevent health harms from occurring, we need to look at health in broader terms. The World Health Organization (WHO) defines health as a "state of complete physical, mental and social wellbeing and not merely the absences of disease or infirmity".[6] This means that it is essential for consideration to be given to the social factors that have an impact on people's health. These are the the circumstances in which people are born, live, work and grow which contribute to their health. They often fall outside of the traditional health portfolio and have a great impact on the inequities that exist between countries, within countries and even within local communities.

A range of factors can mitigate or prevent risky alcohol consumption. Known as protective factors, these include higher levels of income, employment and participation in education. Safe and supportive families and communities are also protective by promoting a range of positive outcomes. Protective factors emphasise the need to address the underlying social determinants as well as targeting alcohol consumption itself.[7] Improvements in health status and outcomes will occur only when people are able to live healthier lives and have access to high quality health services when needed.

The impact of government policy on people's health needs to be considered across all government policy and decision making. In January 2014, the WHO published a framework for implementing a 'health in all policies' approach. It takes into account the impact on health of decisions taken across government portfolios, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity.[8] It recognises that the determinants of health have social, environmental, and economic origins that extend beyond the direct influence of the health sector and health policies, and that public policies in all sectors and at different levels of government can have a significant impact on population health and health equity.[9]

The 'health in all policies' approach has been developed and implemented in a number of countries including Canada and Sweden[10] and all European Union policies.[11] It assists leaders and policy makers to integrate considerations of health, wellbeing and equity during the development, implementation and evaluation of policies and services.[12] A 'health in all policies' approach is relatively new, however a preliminary evaluation in South Australia demonstrated a willingness and acceptance of the approach.[13]

By focusing on the social determinants of people's health, governments can improve outcomes across a range of portfolios including homelessness, education, employment and social services. This provides a win-win situation for government.

Recommendations

1. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 adopts prevention as a guiding principle.
2. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to promote a 'health in all policies' approach across all government agencies.

Alcohol

As the Discussion Paper says, alcohol is the most widely used drug in Queensland with more Queenslanders (80.4 per cent) consuming alcohol than the national average (78.2 per cent) and more consuming alcohol on a daily basis (7.4 per cent) compared to daily consumption nationally (6.5 per cent).[14]

Table one below, which is drawn for the Discussion Paper, shows that alcohol had the highest number of treatment episodes compared to cannabis, amphetamines, nicotine and heroin in 2013-14. This is a change from 2003-04 when the highest number of treatment episodes were for cannabis.

The table also shows that in spite of the action already taken by the Queensland Government to reduce alcohol harm, treatment for alcohol increased by 180 per cent over the ten years to 2013-14. This increase was higher than for any other drug examined, including amphetamines.

Table 1. Number of closed episodes for own drug use by principal drug of concern, Queensland 2003-04 to 2013-14.[15]

	2003-04	2013-14	% change
Alcohol	4,716	13,188	180
Cannabis	7,079	11,796	67
Amphetamines	1,844	4,362	136
Nicotine	795	1,065	34
Heroin	1,367	1,198	12

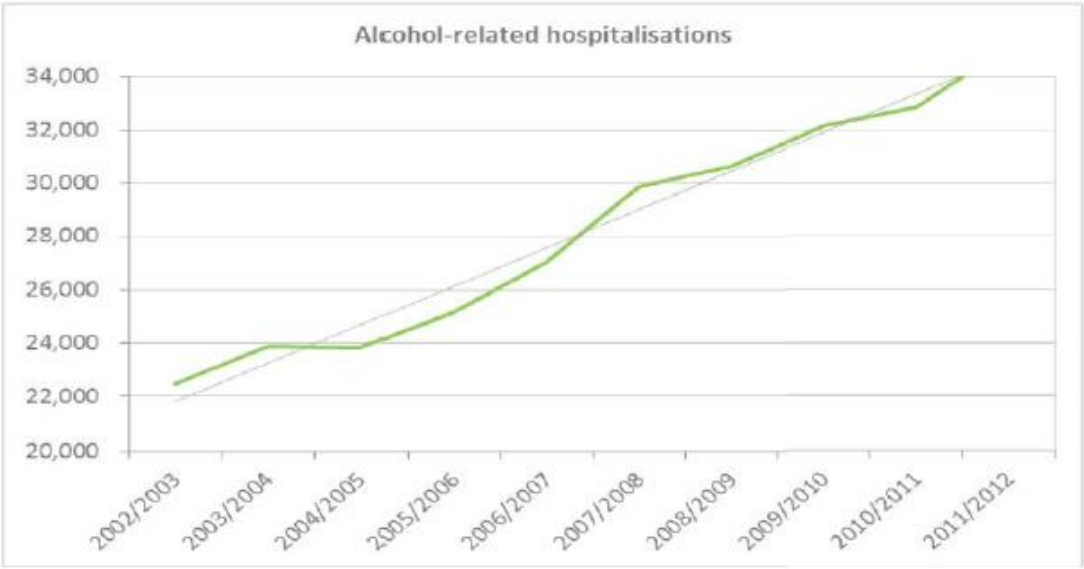
Prioritising alcohol harm will contribute to strategies addressing a number of other health issues. Alcohol is an addictive substance that is responsible for considerable health harms. It is a contributing factor in more than 200 health conditions, including major non-communicable or chronic diseases such as liver cirrhosis, some cancers, heart disease or failure, stroke, chronic kidney disease, lung disease and type 2 diabetes, as well as injuries resulting from violence and road crashes.[16] Chronic diseases are responsible for 83 per cent of all premature deaths[17] in Australia and 85 per cent of the burden of disease.[18] Alcohol is also associated with comorbidity or co-occurrence with mental health disorders[19] and pregnancy complications including miscarriages, birth defects and Fetal Alcohol Spectrum Disorder and is second only to tobacco as a leading preventable cause of death and hospitalisations in Australia.[20,21]

In light of the heightened awareness around domestic violence, it is worth noting that alcohol is a significant contributor to family violence and child maltreatment.[22] However, despite its involvement in up to 67 per cent of family violence incidents reported to police and up to 47 per cent of child abuse cases in Australia, alcohol's role has not been adequately addressed in national or state and territory plans to address family violence.

The social cost of harm from alcohol in Australia has been estimated at $36 billion annually. This figure includes the cost of harm to the drinker and to others.[23]

Each year, alcohol is responsible for 1,143 deaths in Queensland, equating to three deaths per day. It is also responsible for 35,159 alcohol-related hospitalisations each year, an increase of 57 per cent since 2002.[24] Figure 1 shows the change in the number of hospitalisations in Queensland due to alcohol between 2002-03 and 2011-12.

Figure 1. Number of alcohol-related hospitalisations in Queensland between 2002-03 and 2011-12



Two thirds (66 per cent) of Queenslanders have been adversely affected by someone else's drinking.[25] More than one third (35 per cent) of Queenslanders have experienced alcohol-related violence and two thirds (66 per cent) consider that the city or centre of town is unsafe on a Saturday night.[26] Clearly more needs to be done to reduce alcohol related harm.

The most effective measures to reduce alcohol harm are population wide measures that address the price, advertising and availability. In the last 20 years, alcohol has become increasingly available due to an expanding range of retailers, longer trading hours, cheaper prices and heavier advertising. It is now more affordable, more accessible and more promoted than ever before.

Strategies that address price, availability and advertising of alcohol should be prioritised in the Action Plan to reduce alcohol harm. The case for addressing these activities is outlined below.

Availability

There are nearly 7,200 venues in Queensland licensed to serve alcohol on the premises[i]. Standard trading hours for on-licence premises are 10am to midnight, however licensees can apply to extend their trading hours until later. Over 700 venues were approved for late night trading at September 2014 and this number has increased following the lifting of the moratorium on late night trading last year. In Queensland, alcohol can be purchased seven days a week from as early as 4am until as late as 5am.[27] Some venues trade 24 hours a day.[28]

Nearly 800 venues are licensed to sell alcohol for consumption off the premises. Standard trading hours for off-licence premises are from 10am to 10pm, with extended trading hours allowing trade from 9am until midnight.

[i] Based on numbers from the Queensland Office of Liquor and Gaming Regulation at 30 June 2014

There are 7,971 on- and off-licensed venues in Queensland, representing roughly one liquor licence for every 604 people in Queensland.[29,30] This is an increase of 347 licences since 2010.

The number and density of liquor licences has continued to increase over the past ten to 15 years.[31] This is despite the fact that research overwhelmingly demonstrates that as alcohol becomes more available, consumption and alcohol-related problems increase,[32] and that to reduce alcohol-related harms, a reduction in access and availability are effective measures.[33]

Research in Melbourne has found that there is a strong association between domestic violence (involving family members, not just partners) and the concentration of take-away liquor outlets in an area, in that a ten per cent increase in off-licence (take-away) liquor outlets is associated with a 3.3 per cent increase in domestic violence. Increases in domestic violence were also apparent with the increase in general (pub) licences and on-premise licences.[34] Recently in Western Australia, a study was undertaken examining the links between licensed outlets and violence. The study concluded that for every 10,000 additional litres of pure alcohol sold at a packaged liquor outlet, the risk of violence experienced in a residential setting increased by 26 per cent.[35]

Policy solutions

According to The National Drug Law Enforcement Research Fund "[Restricting] trading hours is the most effective and cost-effective measure available to policymakers to reduce alcohol-related harm. If the availability of alcohol is reduced, for example by reducing the trading hours of licensed venues or reducing outlet density, the number of alcohol-related assaults can be reduced.

Research has consistently shown that an increase in trading hours is associated with an increase in harms.[36] Extended trading hours increase the availability of alcohol which results in increased rates of violence and road crashes.[37,38] Australian and international research demonstrates that for every additional hour of trading, there is a 16-20 per cent increase in assaults and conversely, for every hour of reduced trading there is a 20 per cent reduction in assaults.[39,40]

Reducing trading hours of off-licence premises will contribute to an overall reduction in alcohol harm, as demonstrated by research in Switzerland and Germany. A reduction in off-licence trading hours in Geneva, combined with a reduction in availability by banning sales from gas stations and video stores, had a significant effect on hospital admission rates among adolescents and young adults. Depending on the age group, a reduction in availability resulted in a decrease in alcohol-related hospital admissions of 25-40 per cent.[41] In Germany, a reduction in trading hours of off-licence premises in Baden-Wurttemberg resulted in a nine per cent fall in alcohol-related hospitalisations among adolescents and young adults.[42]

Restrictions on late night trading for premises that sell alcohol for consumption on the premises are particularly important since alcohol-related assaults increase significantly after midnight.[43,44] Research by the Bureau of Crime Statistic and Research (BOCSAR) in New South Wales (NSW) looked at the relationship between alcohol and crime using NSW Police records. The study found that the percentage of alcohol-related assaults increased substantially between 6pm to 3am, with the highest rates of alcohol-related assaults occurring between midnight and 3am.[45]

The current government has announced its intention to introduce measures to reduce alcohol-related harm. These measures include last drinks at 3am and a 1am lockout. The government should introduce the legislation for these measures to the Queensland Parliament as a matter of urgency. These

measures have been proven to be effective in reducing alcohol related harm in three locations in NSW; Newcastle, Sydney Central Business District (CBD) and Kings Cross.

In Newcastle, modest restrictions to 14 hotels were introduced, including a 3am close time and 1am lockout, later amended to 3.30am and 1.30am. Other measures were also introduced such as having a supervisor on the premise from 11pm until closing time and introducing restrictions on the types of drinks that could be sold after 10pm.

An evaluation of these restrictions found that there was a 37 per cent reduction in night time assaults between the hours of 10pm and 6am after 18 months.[46] Five years after the restrictions were introduced, a further evaluation found a sustained reduction in alcohol-related assaults with an average of a 21 per cent decrease in assaults per hour.[47] This compares closely with research in Norway where an average 20 per cent decrease in assaults per hour of restriction was observed in 15 cities where trading hours were restricted.[48]

The Newcastle restrictions have been opposed by members of the alcohol industry who claim that the measures caused businesses to close and harmed Newcastle's nightlife.[49] However, evidence suggests that the measures led to a diversification of the night time economy. A study commissioned by the Australian National Local Government Drug and Alcohol Advisory Committee found that between 2009 and 2011 there was a 9.6 per cent decline in 'drink' sales revenue in Newcastle which was offset by a 10.3 per cent increase in 'food' sales revenue.[50]

Reductions in alcohol related harm were found in the Sydney CBD and Kings Cross when similar restrictions were introduced. An independent evaluation of the restrictions by the BOCSAR found that the January 2014 reforms were associated with a reduction in non-domestic assaults of 32 per cent in Kings Cross and 26 per cent in the Sydney CBD precinct as well as no evidence of displacement of these types of assaults to adjacent areas. In one area of the Sydney CBD, there was a 40 per cent reduction in non-domestic assaults.

The experiences of Newcastle and Sydney demonstrate that even modest reductions in trading hours can result in a significant reduction in harms. QCAA supports the introduction of these measures and in addition, the reintroduction of the moratorium on late trading hours.

The Foundation for Alcohol Research and Education (FARE) recently conducted an analysis of the impact of lifting the moratorium in Queensland on late night trading hours in the first six months. The analysis showed that licensees are keen to increase their late night trading hours and even though only a small percentage of licensees sought to extend their hours, this amounted to a large increase in the number of additional trading hours. This increase in hours leads to a significant increase in the risk of harm.

The analysis found that 107 applications were made to extend late night trading hours of which 40 were approved at 28 February 2015. Of the 40 applications approved, 491 extra trading hours per week were approved, equating to 25,532 additional late night trading hours per year.[51] At September 2015, over 120 applications for late night trading had been approved. Based on the average number of extra trading hours per week observed up until February 2015 (12 hours per week), this amounts to a total of 1,473 extra hours per week and roughly 76,500 extra hours per year.

Another way to control availability is to restrict the density of alcohol venues (both on-and off-premises). Research has consistently found an association between alcohol outlet density (that is, the

number of active liquor licences in an area) and negative alcohol-related outcomes such as assaults, adolescent drinking, domestic violence, drink driving, homicide, suicide, and child maltreatment.[52,53,54] An Australian study from Melbourne has found that there is a strong association between domestic violence and the concentration of off-licence liquor outlets in an area, with a ten per cent increase in off-licence liquor outlets associated with a 3.3 per cent increase in domestic violence. Increases in domestic violence were also apparent with the increase in general (pub) licences and on-premise licences. A study in Western Australia, found that for every 10,000 additional litres of pure alcohol sold at a packaged liquor outlet, the risk of violence experienced in a residential setting increased by 26 per cent.

Currently, there is no requirement for consideration to be given to the number and concentration of active licensed premises in the relevant local area when assessing new liquor licensing applications or applications to extend late night trading. This is a serious oversight that needs to be addressed in light of the evidence on the relationship between outlet density and alcohol harm.

Two policies that have been introduced elsewhere to control the number of liquor licences are saturation zones and cluster controls. Saturation zones are established at the discretion of the individual local authority in the United Kingdom who impose limits on the provision of new licences in areas where there are a high density of licences. Crime data and domestic violence statistics[55] [56] are also considered in declaring an area saturated.

Cluster controls prohibit new liquor licences for premises within a specified distance of existing licensed premises or other amenities (such as schools, hospitals, churches or places of religious worship).[57] They are found in England, Wales, Paris and New York. New York has enacted these through their *Alcohol Beverage Control Act*. Introduced in 1993, the legislation includes the '500 foot' (150 metres) rule which prohibits new on-premises licences being issued within a 500 foot radius of three or more existing licences.[58] In Paris, under the *Code de La Sante Publique* (public health legislation), there are protected areas within which new liquor licences are prohibited if they are within 75 metres of a licensed premise of the same category.[59]

Policies that support authorities to manage the density of liquor outlets and prioritise the health and safety of the community should be implemented to reduce alcohol related harm.

Queenslanders strongly support action to reduce availability of alcohol with 82 per cent supporting a closing time for pubs, clubs and bars of no later than 3am and 61 per cent supporting a 1am lockout. Other measures supported by Queenslanders include stopping the sale of alcohol 30 minutes before closing time (76 per cent), placing a limit of four drinks on the number of drinks a person can purchase at one time after 10pm (59 per cent), stopping the sale of alcohol and energy drinks after midnight (58 per cent) and stopping the sale of shots after 10pm (52 per cent).[60]

Recommendations

3. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 actively supports the legislation for 3am last drinks and 1am lockout be introduced as soon as possible to prevent further alcohol harm from occurring.

4. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 actively supports the reintroduction of the moratorium on late night trading.

5. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to liaise with the Department of Justice and Attorney General to remove exemptions on 10pm close for off-licence venues.

6. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action for the development of a framework to manage outlet density through the introduction of measures such as cluster control policies and saturation zones, which takes into consideration police data related to crime, including domestic and non-domestic assault.

7. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action that the government evaluate the 3am last drinks and 1am lockout measures once they are introduced.

Pricing

Alcohol has become increasingly affordable with wine available for as little as 29 cents per standard drink in 2015.[61] A study of the Australian alcohol industry by The Australia Institute shows that over the last two decades, the cost of alcohol has increased by 15 per cent relative to other consumer prices in Australia however Australian incomes have increased by 46 per cent over the same period.[62]

The increased affordability of alcohol is a concern in light of evidence which shows that the lower the price of alcohol, the higher the levels of consumption[63] and higher the risk to the individual, and others, of alcohol-related harms. There are many studies that have indicated that when the price of alcohol is increased, levels of consumption are reduced at a population level.[64]

Policy solution

One way for state and territory governments to address pricing is through the introduction of a minimum price for alcohol.

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

A minimum price has been shown to be effective in reducing alcohol consumption. A 10 per cent increase in minimum price in two Canadian provinces, British Columbia and Saskatchewan, was associated with a 3.4 per cent reduction[65] in overall consumption in British Columbia and an 8.4 per cent reduction in Saskatchewan.[66] In both contexts, minimum pricing was shown to reduce alcohol consumption overall and for all beverage types. The difference in results is due to the different circumstances in which they were implemented. In British Columbia, only spirits and liqueur wine prices were maintained at a level consistent with increases in cost of living and the cost per minimum drink of other beverages was relatively low[67] whereas Saskatchewan set per litre prices for beverages in different strength bands. Furthermore, the cost per standard drink varied between the two provinces.[68]

The extent of reduction in consumption varied depending on beverage type. British Columbia saw consumption fall by 13.9 per cent for alcoholic sodas and ciders, 8.0 per cent for wine, 6.8 per cent for

spirits and liqueurs and 1.5 per cent for beer whereas Saskatchewan saw consumption fall by 21 per cent for premixed cocktails, 10.6 per cent for beer, 5.9 per cent for spirits and 4.6 per cent for wine.

Minimum pricing policies are an important mechanism available for the Queensland Government to implement to reduce demand for alcohol. There is good support for a minimum price among Queenslanders with 65 per cent supporting the sale of alcohol at no less than $1 per standard drink.[69]

Recommendation

8. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to advocate for the introduction of a minimum price for alcohol of at least one dollar per standard drink to stop the extreme discounting of alcohol.

Advertising and promotion

Queenslanders are exposed to alcohol advertising through a range of sources including advertising on television, radio, online, print media, product placement, point of sale and other promotions, and sponsorship of sports and cultural events. While the evolution of social media and smart phones has seen an explosion in the amount of advertising and the way in which alcohol products are advertised,[70] there has been an increasing prominence of alcohol retailers in print media.[71] The product's design, packaging, name and use of logos are also marketing devices.

The Act currently allows for the Minister to prohibit the sale of a product that inappropriately targets young people, increases intoxication at rapid rates and/or encourages irresponsible use of alcohol. [72] The Act also prohibits promotional activities which encourage the rapid consumption of alcohol such as free drinks or drinks available at discounted prices.

Licensees are held responsible for advertising on licensed premises. At on licences where alcohol is consumed on the premises, the Act prohibits advertising of happy hours, free alcohol or offers such as two drinks for the price of one unless this occurs within the relevant premises and is not visible or audible to any person outside the premises.

While there are some restrictions on advertising at licensed venues, the exposure to other forms of marketing continues with point of sale (POS) promotions including happy hours, special promotions, free gifts with purchase, prominent signage, competitions, price discounts for bulk purchases, and sale prices that do not contravene the Act.

The promotion and marketing activities associated with the sale and supply of alcohol can have a significant influence on the way that alcohol is consumed and the behaviour of those who consume it. [73,74,75] International and Australian research has consistently demonstrated that the volume of alcohol advertising that children and young people are exposed to predicts future consumption patterns, including initiation of alcohol consumption and heavier consumption among people who already consume alcohol.[76]

Regulation of alcohol advertising is currently a mix of government regulation and industry self-regulation which is flawed and fails to protect children and young people.[ii,77] The failure to protect young people has been recognised by several government reviews.[78,79]

High levels of consumption are likely to continue since we are bombarded with messages about alcohol being a normal, everyday part of people's lives not just through traditional and online sources but also through billboards and signs. While the Queensland Government is concerned about reducing alcohol related harm, it is unwittingly promoting consumption by allowing alcohol promotions on public transport such as buses and trains and at bus and train stops.

At licensed venues, many promotions encourage rapid and excessive consumption which increases the risk of alcohol related harm for the individual and others. Price-based liquor promotions are particularly concerning as there is an inverse relationship between the price of alcoholic beverages and levels of consumption and harms.[80] The cheaper the alcohol, the greater the volume of alcohol consumed.

POS promotions are also problematic since research has shown that they are likely to affect overall consumption by underage drinkers, as well as the consumption patterns of harmful drinkers, and regular drinkers.[81]

Current controls in Queensland to regulate promotions focus predominantly on on-licence premises, with little or no regard for the reckless promotions occurring at off-licence premises. This is concerning given that 80 per cent of alcohol is purchased from off-licence premises.

Television, radio and newspaper advertisements are some of the more obvious forms of advertising and promotion but the less obvious activities that act to normalise alcohol as an everyday product are neglected in state and territory alcohol regulations. The use of shopper dockets is one such example.

Shopper dockets are coupons or vouchers for free or discounted products such as petrol, accommodation and alcohol which are printed either on the bottom or the back of supermarket receipts. These dockets are often used to promote alcohol discounts such as two-for-one offers. They normalise alcohol consumption by advertising discounted alcohol in the same fashion as other products. Both of the big retailers (Woolworths and Coles) use shopper dockets to promote alcohol.

Following complaints in 2013, the NSW Office of Liquor Gaming and Racing (NSW OLGR) conducted an investigation into the use of shopper dockets to offer alcohol discounts. After a six month investigation into the practice involving public health experts, NSW OLGR concluded that that "there is sufficient evidence to support a preliminary view that the activity is likely to encourage the misuse and abuse of liquor as contemplated by section 102A of the Act". NSW OLGR proposed imposing "a condition that licensee does not engage in the activity promoted" and a "condition to prohibit redemption in the individual licensees' premises".

[ii] Government regulates the broadcast of alcohol advertising on television and all other components of alcohol advertising are governed by industry codes. The main industry code is the Alcohol Beverages Advertising (and Packaging) Code (ABAC), administered and governed by members of the alcohol industry. The ABAC has responsibility for the 'content' of alcohol advertisements. Other industry codes attempt to cover the 'placement' of alcohol advertising such as outdoors, on radio, television, and in cinemas.

Policy solutions

While the ubiquitous promotion of alcohol continues regulation of advertising and promotion of alcohol by state and territory governments is critical. Alcohol marketing is prolific and measures need to be taken to reduce exposure to alcohol marketing, particularly to children and young people. Reducing exposure to alcohol through the regulation of advertising and promotions has been shown to be one of the most effective strategies to reduce alcohol harm.

The Act should be strengthened to address harmful promotional activities on both on-and off-licence premises and should be appropriately enforced to ensure that reckless promotions do not continue to occur. The Act covers advertising that occurs by signage, in print, orally or electronically however it does not mention responsibility for comments made by third parties on social media nor for advertisements and promotions made by promoters engaged by the licensee. This needs to be rectified.

Shopper dockets should be addressed in light of recent findings that one in six (16 per cent) Australian drinkers bought a particular alcohol product because of a shopper docket promotion in 2015, an increase from 12 per cent of drinkers in 2014.[82] Queensland should introduce a ban on shopper dockets to ensure that alcohol does not continue to be further normalised through its promotion alongside everyday grocery items.

In addition, alcohol advertisements from state property such as at train and bus stations, and on public transport should be prohibited.

The community is aware of and concerned about the impact of alcohol advertising on young people. 71 per cent of Queenslanders believe that alcohol advertising and promotions influence the behaviour of people under 18 years[83] and 59 per cent support a ban on alcohol advertising on television before 8.30pm.[84]

Recommendations

9. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to reduce community exposure to alcohol related promotions that normalise problematic drinking in social situations and promote excessive consumption of alcohol

10. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to advocate for the prohibition for point of sale promotional materials for liquor (such as 'happy hours', free gifts with purchase, prominent signage, competitions, price discounts for bulk purchases, and sale prices) from being displayed on and around licensed premises where minors are likely to be present.

11. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to reduce young people's exposure to alcohol advertising by working with the Australian Government and other state and territory governments to ensure alcohol products are not targeted at people younger than 18 years

12. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to ban the redemption of alcohol 'shopper docket' promotions, which promote discounted alcohol on supermarket receipts.

13. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to ban alcohol promotions on state property, including public transport.

Other policies to consider

Education and awareness programs

Under the *Safe Night Out Strategy* developed by the previous government, school-based alcohol and other drug education programs were introduced in Queensland schools for students in years seven to 12. The *Alcohol and other drugs education program* is available to all Queensland schools to develop greater awareness and understanding in young people about the impact of binge drinking and illicit drug use and how they can respond to situations where alcohol and other drugs are available.[85]

The current government has committed to the development of a multimedia education and awareness campaign targeted at young male drinkers about safe drinking practices, the impacts of alcohol-related violence, the changes to alcohol service times and the increased enforcement of existing regulations.86

Most alcohol and other drug (AOD) education programs in Australia have been implemented in school-based settings. The advantages of school-based settings are that educators can deliver the lessons, materials and interact with large audiences while keeping costs low.[87] School-based AOD education interventions should start before harmful patterns of alcohol use are established among young people. Such pre-emptive action is important to reduce the occurrence and costs associated with alcohol use and misuse by young people in the short-term and long-term.[88]

However, research has shown that education and awareness raising activities may increase knowledge and change attitudes towards alcohol but they are one of the least effective strategies to achieve behavioural change.[89]

AOD school-based programs in particular often face many challenges including that they are not always supported by the evidence, poorly implemented, funded in an ad hoc manner that jeopardises the sustainability of the project, or never evaluated to assess the effectiveness of the program and areas for future improvement.[90]

Policy solutions

Education and awareness campaigns can be effective when they are part of a broader comprehensive strategy to reduce alcohol harm. The most effective strategies to minimise alcohol harm to young people are multi-dimensional and where each component is applied together in a balanced way.

There is the need to provide young people with opportunities to reflect on the drinking culture they are exposed to and the reasons and risks behind alcohol consumption behaviours. The World Health Organization supports alcohol education strategies as worthwhile pursuits based on the principle that the population "should know about and understand harmful alcohol use and associated health risks".[91] WHO also states that:

… To be effective, education about alcohol needs to go beyond providing information about the risks of harmful use of alcohol to promoting the availability of effective interventions and mobilizing public opinion and support for effective alcohol policies.[92]

Effective AOD education programs for young people have inclusive, interactive teaching strategies that actively engage students in the learning process.[93,94] Such programs are comprehensive and involve whole of school and community support for classroom drug education messages. AOD education programs should be also based on the experiences and interests of the students it is designed to influence, and should be timed such that the intervention starts before AOD experimentation begins and continues as young people mature.

An example of an effective school-based education program is the Drug Education in Victorian Schools (DEVS). A trial of this program commenced in 2008 and ran for three years in 21 high schools in Victoria.[95] The classroom AOD education program addressed issues around the use of alcohol, tobacco and illicit drugs (mainly cannabis). At the heart of the DEVS program is its grounding in social learning theory, which posits that human learning – including AOD use – occurs in a social context and is socially learned through modelling, imitating and reinforcing behaviours.[96] This "social cognitive approach" aims to teach young people to avoid using AODs by resisting external pressure from peers, family and the media, and by increasing coping skills.[97,98]

The program was delivered to year eight and nine students and included up to 12 classes.[99] As part of the program students also completed three self-completion questionnaires: before the program, after the program (in 2008), and the year following the program (2009). The information collected was used to collect information on knowledge, patterns and context of use, attitudes and harms experienced in relation to alcohol, tobacco, cannabis and other illicit drug use.

Students who participated in the intervention were no less likely to have tried alcohol, however the trial evaluation found that after the program they were more knowledgeable about drug use issues, communicated more with their parents about alcohol, drank less and got drunk less, experienced fewer alcohol related harms, and remembered receiving more alcohol lessons.[100]

In light of the positive trial results, the Victorian Government has committed to roll-out the DEVS program in all secondary schools across Victoria.[101]

Recommendation

14. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an evidence-based education and awareness campaign that is based on social learning theory designed and is supported by other interventions aimed at supply, demand and harm reduction.

Treatment services

Alcohol and other drug organisations provide specialist services for people in need of support as a result of their AOD use. They play an important role in preventing alcohol harm and where such harm has already occurred, supporting the individual and preventing further harm. A range of activities is needed to meet the differing needs of those seeking support. To be effective, services need to address the individual needs of clients.

Currently there are insufficient services to meet the needs of those seeking support. Clients face long waiting lists and often lost interest in receiving treatment by the time a place becomes available. Traditionally, services have provided support to the individual seeking help with their AOD use, however increasingly clients are seeking to include families and friends in their program planning and delivery.

Policy solutions

New services are needed to support families and friends and those exposed to long-term alcohol harm. For example, services that provide family therapy and residential facilities that will enable families to stay together during treatment are needed. The latter is particularly important for single parents where non-residential treatment is no longer viable.

These services need security of funding through sustained funding commitments. This is important for both the planning and availability of services, building service capacity, development of new services and also to attract and retain staff.

Lack of funding security ultimately risks the quality and quantity of services provided which ultimately has an impact on client outcomes. It also makes it difficult to recruit and retain staff which affects not just to the organisation but the sector as a whole.[102]

Gaps in service provision also need addressing, either for the type of service available or general access and availability of services. This is particularly relevant in rural and remote and Aboriginal and Torres Strait Islander communities where services are scarce. Services also need adequate funding to enable them to work with other sectors to provide support for clients with multiple needs.

Queensland needs a strong and sustainable sector that can continue to provide the quality and quantity of services that are needed to support those in need and be flexible and responsive to changing needs.

Recommendations

15. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 addresses the need for the Queensland Government to provide adequate and secure funding for the AODs sector to enable them to provide quality services that can meet the needs of individuals and respond to changes in these needs.

16. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes measures to address gaps in service delivery and creates funded mechanisms that enable collaboration between different sectors.

Data collection and reporting

Good evidence-based policy requires good data to inform its development. Evidence-based policy leads to better outcomes for policy since the solutions have been tried and tested and proven to be effective. Currently, the Queensland Government collects a range of data including alcohol sales, alcohol-related hospitalisation, emergency department presentations and alcohol-related violence.

Queensland is one of five jurisdictions to collect alcohol sales data. Sales data is important as it provides the most accurate picture of Queenslander's alcohol consumption patterns, which in turn

enables researchers, policy makers and the government to develop, implement and track the progress of evidence-based alcohol policies.[103] It is important that Queensland continues to collect this information and provides it for use in research.

Data collected by Queensland Health on alcohol-related hospitalisations and emergency department presentations is not consistently reported across all locations with 27 facilities collecting and reporting alcohol-related emergency presentations at June 2014.

Alcohol related ambulance data is available on request but the data is limited and it is not clear if and how alcohol related ambulance data would be reported.

The 2010 Queensland Legislative Assembly Inquiry into alcohol-related violence recognised that there is a need for collecting and reporting alcohol-related violence data, recommending that "the Government develop a comprehensive and consistent scheme involving all relevant departments for the collection and evaluation of data regarding alcohol related violence."[104]

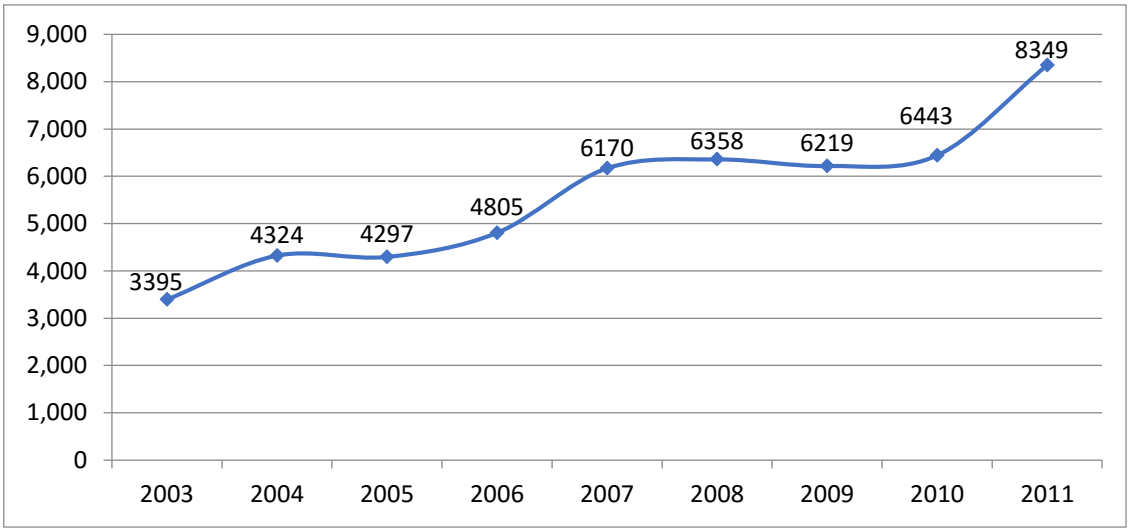
Policy solutions

Alcohol-related police data, including both domestic and non-domestic assaults, alcohol-related hospitalisations and emergency presentations and alcohol-related ambulance attendances, should be routinely collected and publically reported on an annual basis. This data is important because it contributes to our knowledge about the extent of the harm from alcohol and can inform the development of policies in reducing alcohol consumption and alcohol harms.

Collecting and reporting on a range of harms indicators is important to ensure a more complete picture of the harm that is occurring. Hospital and police data can be influenced by different approaches to data collection including types of data collected and in the case of police data, by the number of police visible in a location and how they respond. Ambulance data is likely to be more consistent and provide information on the location of event.

Ambulance Victoria data demonstrates the type of information that could be available to Queensland, including trends. In 2011 there were 8,349 ambulance attendances where alcohol was identified as a contributing factor in metropolitan Melbourne.[105] This figure has more than doubled since 2003, increasing by 146 per cent from 3,395.[106] The graph overleaf provides an overview of alcohol-related ambulance attendances in metropolitan Melbourne from 2003 to 2011.

Figure 2. Alcohol-related ambulance attendances in metropolitan Melbourne.



While alcohol consumption and alcohol-related harm data are essential elements in alcohol policy development, there is also a need for the collection and reporting of compliance data.

Recommendation

17. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to implement routine collection and annual reporting on alcohol harms to inform the development of alcohol policy and the evaluation of programs and services.

Screening and brief interventions

Health professionals have a key role in raising awareness of the risks associated with alcohol consumption. When consumers visit a health professional this provides a 'window of opportunity' to discuss a variety of health issues and provide information relevant to the individual. This approach, known as screening and brief intervention, consists of 'screening' individuals to determine if they are at risk of harms (such as smoking, alcohol consumption, diet and lack of physical activity) and a 'brief intervention' which is the provision of information to the individual about ways to reduce the risks associated with their current behaviours. The brief intervention may involve goal setting, discussion of relapse prevention and problem solving.[107] Despite the evidence supporting the effectiveness of screening and brief interventions,[108,109] only 17 per cent of Queensland adults had been asked by their doctor about their alcohol use in the past 12 months.[110]

Policy solutions

Screening and brief interventions are an effective, evidence-based approach that can reduce harm and prevent further harm from occurring. Screening can identify whether a person's alcohol consumption is placing them or others at risk and identify individuals who may be developing alcohol-related problems and issues. Screening and brief interventions have been shown to reduce the quantity of alcohol consumed per week by individuals and have been proven effective in different

settings such as General Practice and Emergency Departments as well as across different age groups.[111]

Recommendation

18. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action for the use of screening and brief interventions by health practitioners in primary health care and emergency department settings to identify people at risk from alcohol and provide a brief intervention or referral as required.

The Common Approach

Known previously as The Common Approach to Assessment, Referral and Support (CAARS), The Common Approach[112] is a prevention tool that is designed to identify children and families that are in need of support. It recognises that prevention is everybody's business. The strength of The Common Approach lies in its flexibility to be used in different situations by a range of practitioners such as school teachers, psychologists, nurses, counsellors and AOD workers to recognise the early warning signs and start conversations to determine whether a child or family needs support. By addressing problems early, we can prevent situations from developing into a crisis resulting in more functional families and improved health and wellbeing.

Recommendation

19. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 supports the use of *The Common Approach* as a tool to identify early children and families in need of support from alcohol harm and to prevent a crisis situation from developing and people being at risk of much greater harm.

Pregnant women

Alcohol consumption during pregnancy can harm the developing foetus and breastfeeding baby. The *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* (the Guidelines) clearly say that for women who are pregnant or planning pregnancy, the safest option is not to drink to reduce the risk of harm to the mother and their baby.

Alcohol can cross the placenta and the developing foetus can have levels of alcohol in their system which are nearly the same as the mother. High levels of and/or frequent consumption of alcohol increases the risk of miscarriage, premature and still birth and low birth weight. Alcohol can interfere with the developing foetus and cause congenital abnormalities resulting in physical, mental and/or behavioural problems. Fetal Alcohol Spectrum Disorders (FASD) are lifelong conditions that have an impact on the baby, their family and the community at large.

Many health professionals are reluctant to talk about alcohol with their clients during pregnancy. They face a range of personal and situational barriers such as lack of knowledge of risk and specific consequences, preconceived ideas about who is at risk, fear of a negative reaction, lack of skills and tools to intervene, and other priorities and therefore did not engage in these conversations. A survey of 300 health professionals found that over half (56 per cent) found it difficult to undertake conversations about alcohol in pregnancy and only 33 per cent were familiar with the Guidelines.

Policy solutions

Health professionals said that they were more likely to initiate discussions about alcohol if they are aware that women expected them to raise the topic and that women trusted the advice they receive from health professionals.

In 2014, the *Women Want to Know* project was launched by the Foundation for Alcohol Research and Education (FARE) to raise awareness among health professionals about the alcohol guideline for pregnancy and breastfeeding and to provide them with resources to support them to initiate discussions about alcohol consumption and pregnancy with women. These resources were developed since a lack of resources is often cited as a barrier by health practitioners.[113,114] The Royal College of Obstetricians and Gynecologists (RANZCOG), Royal Australian College of General Practitioners (RACGP), Australian College of Midwives (ACM), Australian Medical Association (AMA), and the Maternity Coalition oversaw the development of the resources and accredited online training courses have been developed through the ACM, RACGP and RANZCOG. Some discussions have been held with the Queensland Department of Health about the *Women Want to Know* program.

People who have FASD and their families and carers need support to manage this lifelong condition. For the person with FASD, their everyday life is affected as they struggle with relationships and encounter difficulties at school and work. The families and carers of people with FASD often face considerable financial and emotional hardships. In addition there is a range of social and emotional impacts associated with the stigma that comes with a FASD diagnosis.

A concerted effort is needed to facilitate diagnosis and provide access to early intervention and specialised services for people living in metropolitan, rural and remote locations. More diagnostic services are needed which are supported by a range of health professionals such as paediatricians, clinical or neuro psychologists, occupational therapists, speech and language therapists, physiotherapists and social workers. The health professionals are needed to help diagnose the condition and support the individual and their family to manage the condition and maximise the potential of the person affected. Data is needed to support greater understanding of the prevalence and impact of FASD.

Recommendations

20. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to promote the *Women Want to Know* campaign that encourages and supports health professionals to talk to their clients about alcohol use during pregnancy to reduce the harm from alcohol during pregnancy and breastfeeding and prevent Fetal Alcohol Spectrum Disorders.

21. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 establishes additional Fetal Alcohol Spectrum Disorders diagnostic services to be delivered to people in Queensland and particularly those living in rural and remote locations.

22. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 seeks access to early intervention services for children with Fetal Alcohol Spectrum Disorder and funds these accordingly.

Aboriginal and Torres Strait Islander people

The Discussion Paper recognises the disproportionate nature by which Aboriginal and Torres Strait Islander people are affected by alcohol harm such as alcohol-related violence, domestic violence, a range of health conditions and death. For alcohol-related health conditions, Aboriginal and Torres Strait Islander men are hospitalised at rates between 1.2 and 6.2 times than other Australian men, and Aboriginal and Torres Strait Islander women at rates between 1.3 and 33.0 times greater.[115] Deaths from alcohol-related causes are overall 7.5 times greater than those of other Australians.[116]

This harm has long been recognised and much has been done to reduce the extent to which Aboriginal and Torres Strait Islander people are affected by alcohol. Two recent pieces of work at a national level include the *National Aboriginal and Torres Strait Islander People's Drug Strategy 2014-2019* (NATSIPDS) and the *Inquiry into harmful use of alcohol in Aboriginal and Torres Strait Islander communities* (the Inquiry).

The *Queensland Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033*[117] acknowledges the risk to health of AOD use in Aboriginal and Torres Strait Islander communities and the need for a different approach for Aboriginal and Torres Strait Islander people. This framework is designed to develop the capacity of Queensland Health to respond appropriately and in a way that is respectful of Aboriginal and Torres Strait Islander culture. The *Queensland AOD Treatment Service Delivery Framework*[118] developed in 2015 reaffirms the principles underpinning the *National Drug Strategy Aboriginal and Torres Strait Islander People's Complementary Action Plan 2003-2009*[119] which highlights the need for enhanced capacity of and improved access to treatment services, a whole-of-government commitment, holistic approaches, workforce initiatives and sustainable partnerships.

In 2002-03, the Queensland Government introduced alcohol restrictions to either ban or limit the amount and type of alcohol that can be taken into a community to reduce the harm from alcohol among Aboriginal and Torres Strait Islander people. Some communities in Queensland have restrictions placed on when and what alcohol can be purchased or what can be taken into the community, while in others alcohol is completely banned.

Despite these efforts, Aboriginal and Torres Strait Islander people continue to be disproportionately affected and communities continue to be devastated by the harm from alcohol. They face significant disadvantage in income, employment, educational attainment and health compared to other Australians. Education and income levels are estimated to account for between one third and one half of the gap between Aboriginal and Torres Strait Islander people's and non-Indigenous people's health status.

Many of the alcohol restrictions were introduced into Queensland without providing support to the community to ensure their success. The design of the alcohol management plans (AMPs) varied between communities and implementation appears to have been piecemeal, with success observed in some communities but not in others.[120] In Mount Isa, the impact of restrictions were mixed with an evaluation surmising that the lack of a sustained positive effect was possibly due to a focus on supply measures without providing adequate support or input from local agencies.

The Newman Government announced a review of AMPs in Aboriginal and Torres Strait Islander communities in light of opposition to the restrictions. If AMPs are removed from any of the

communities, alcohol availability will increase which will further increase the risks of alcohol harm for individuals and families within those communities.

Policy solutions

It is vital that the government commits to reducing alcohol harms among Aboriginal and Torres Strait Islander people. Significant work has already been done to identify what works and what doesn't to reduce alcohol harm among Aboriginal and Torres Strait Islander people which can inform the development of the Action Plan.

The overarching approach of the NATSIPDS follows the three pillars of the National Drug Strategy of supply, demand and harm reduction and is underpinned by four principles:

- Aboriginal and Torres Strait Islander ownership of the solutions
- holistic approaches that are culturally safe, competent and respectful
- whole-of-government effort and partnerships
- resourcing on the basis of need.[121]

Four priority areas were established:

- Build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander-controlled services and its workforce, as part of a cross-sectoral approach with the mainstream AOD services to address harmful AOD use.
- Increase access to a full range of culturally responsive and appropriate programs, including prevention and interventions aimed at the local needs of individuals, families and communities to address harmful AOD use.
- Strengthen partnerships based on respect both within and between Aboriginal and Torres Strait Islander peoples, government and mainstream service providers, including in law enforcement and health organisations, at all levels of planning, delivery and evaluation.
- Establish meaningful performance measures with effective data systems that support community-led monitoring and evaluation.

A recent federal government *Inquiry into the harmful consumption of alcohol in Aboriginal and Torres Strait Islander communities* tabled its report in June 2015. This report made 23 recommendations relating to social and economic determinants of harmful alcohol use, the need for a public awareness campaign highlighting the risks of alcohol consumption, best practice strategies to minimise harmful use of alcohol and related harm, best practice treatments and support, FAS and FASD, and supply and demand issues. It recognised the range of impacts that alcohol has on children in communities such as FASD, incarceration of parents, violence, neglect, out of home care, missed schooling, and use of substances themselves, and like the Strategy, it recognised that community led flexible solutions are the key to success.

Importantly, the report acknowledged that without addressing the drivers of alcohol consumption, it would be difficult to achieve significant change and therefore recommended that action should be taken on price, availability and advertising.

The report made a number of recommendations on prevention, best practice treatments and support including:

- repeated public health messages about the risks of consuming alcohol with some targeted at particular audiences
- implementation of justice reinvestment in states and territories to reduce the number of Aboriginal and Torres Strait Islander people incarcerated as a result of harmful alcohol use.
- the need for a range of treatment options to be available to meet the different needs of individuals, families, communities and age groups
- development of a protocol for sharing of effective evidence-based practices in Aboriginal and Torres Strait Islander communities
- longer funding cycles to allow organisations and health care providers to be viable, build relationships, attract and retain suitably trained staff, training and support for the health workforce and allow collaboration and sharing of effective practice.

The findings of the Inquiry are aligned with previous work which identified successful strategies in reducing supply, demand and harm reduction strategies for Aboriginal and Torres Strait Islander people:[122]

- effective supply reduction strategies include price controls, restrictions on trading hours, fewer alcohol outlets, dry community declarations, and culturally sensitive enforcement of existing laws
- effective demand reduction strategies include early intervention, provision of alternatives to AOD use, various treatment modalities, and ongoing care to reduce relapse rates
- effective harm reduction strategies include provision of community patrols, sobering-up shelters, and needle and syringe exchange programs.

Gray and Wilkes[123] also identified what doesn't work in addressing AOD harm in Aboriginal and Torres Strait Islander communities, including:

- interventions that are designed for the non-Aboriginal and Torres Strait Islander population which are imposed without local Aboriginal and Torres Strait Islander community control and culturally appropriate adaptation
- local dry area bans (ie location-specific as opposed to community-wide bans) simply shift alcohol and other drug use to other areas, often where there is greater risk of harm
- voluntary alcohol accords
- education and persuasion programs that are implemented without other interventions to support communities
- interventions which stigmatise alcohol and other drug users since these are counter-productive
- interventions which focus upon dependent users and ignore episodic 'binge' users
- short-term one-off funding, provision of services in isolation and failure to develop Aboriginal and Torres Strait Islander capacity to provide services Barriers to effective service provision.

The government should not disregard the potential of AMPs. These can be effective in reducing alcohol harm within a community however in order to do so they need to be culturally appropriate, community owned and implemented, with support from the government where needed to build capacity locally to develop the plans, and adopt a holistic approach to their implementation. This means that not only are restrictions put in place to reduce the availability of alcohol, other strategies need to be included to address the underlying social factors which predispose people to harmful use, provide ongoing support to people to reduce their need for alcohol and provide treatment where necessary. Community support is essential and while it may take time for sufficient support to be achieved, it will be a significant factor in determining the success of the intervention.

Recommendations

23. That in addressing the particular needs of Aboriginal and Torres Strait Islander people, the Queensland Alcohol and Other Drug Action Plan 2015-2017 is informed by previous work such as the National Aboriginal and Torres Strait Islander People's Drug Strategy 2014-2019 and the report of the Inquiry into the harmful consumption of alcohol in Aboriginal and Torres Strait Islander communities.

24. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to establish sobering-up shelters to provide support, care and monitoring for those who are intoxicated. These should be independent of law enforcement activities.

25. That the Queensland Alcohol and Other Drug Action Plan 2015-2017 includes an action to establish community patrols in urban, regional and remote locations where these do not exist and a need is identified, to improve community safety and reduce harm in Aboriginal and Torres Strait Islander people.[124]

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