Submission to the Inquiry into the health impacts of alcohol and other drugs in Australia

October 2024

fare
Foundation for Alcohol Research & Education

About FARE

The Foundation for Alcohol Research and Education (FARE) is the leading not-for-profit organisation working towards an Australia free from alcohol harms.

We approach this through developing evidence-informed policy, enabling people-powered advocacy and delivering health promotion programs.

Working with local communities, values-aligned organisations, health professionals and researchers across the country, we strive to improve the health and wellbeing of everyone in Australia.

To learn more about us and our work visit www.fare.org.au.

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FARE is a registered charity, and every dollar you give helps fund projects keeping our communities healthy and safe. You can make a tax-deductible donation at: www.fare.org.au/donate.

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Executive summary

All Australians should have the opportunity to be healthy, safe and free from the many ways that alcohol causes harm to people, families and communities. Alcohol contributes to harm, injustice and inequity for far too many people in Australia. This includes family and domestic violence, disability, chronic diseases like cancer, homelessness, self-harm and suicide.

These harmful impacts intersect and interact in complex ways requiring effective, evidence-informed policy measures and practices to address and reduce the harms. However, the state-based laws that exist to keep people safe and protect them from alcohol harm were developed many decades ago. These laws have not kept pace with the way that alcoholic products are marketed, sold and delivered. In addition, the services and programs needed to support people experiencing these harms are chronically under-resourced.

Alcohol is no ordinary commodity, it is a harmful product, requiring regulatory controls to minimise harm. Alcohol is reported as the most common drug of concern in alcohol and other drugs (AOD) treatment,[1] with Australia currently experiencing the highest number and rates of alcohol-induced deaths in over two decades.[2]

Communities expect that Governments will prioritise their wellbeing by implementing harm reduction measures based on evidence and on the experiences of people most impacted. Governments need to make meaningful changes to prevent the harmful impacts of alcohol on families and communities and ensure that people have equitable access to effective supports when and where they need them.

Policy responses must centre lived experience and First Nations voices, address systemic determinants, adopt harm reduction and public health approaches, prevent stigma and criminalisation and be evidence-informed. This will support the prevention of harms, and equitable access to services and support.

The Inquiry's Terms of Reference focus primarily on AOD services and programs. Examining equitable accessibility and effectiveness of program delivery is essential to address and prevent alcohol harms. Equally important is examining the systemic determinants of harms. Australian Governments have a responsibility to use both program funding and systemic harm reduction laws to prevent harm.

This submission addresses the following areas:

- **Human rights, justice and self-determination** - Centring lived expertise, preventing stigma and criminalisation and decolonising alcohol policy.
- **Gendered violence** - Preventing violence against women and children.
- **Systemic reforms** - Governance, model alcohol harm reduction laws, alcohol marketing reform and alcohol pricing.
- **Prevention** - Preventive health approaches and education campaigns.
- **Screening and supports** - Culturally responsive, trauma-informed, evidence-based, non-stigmatising, accessible screening and supports.
- **Fetal Alcohol Spectrum Disorder (FASD)** - Prevention, screening, diagnosis, supports and justice reforms.
- **Harmful industries** - Commercial determinants and preventing industry influence.

FARE thanks the Standing Committee on Health, Aged Care and Sport for the opportunity to make this submission to the '*Inquiry into the health impacts of alcohol and other drugs in Australia'*.

Recommendations

Recommendations are intended for the Australian Government, unless otherwise noted**.**

1. Human rights, justice and self-determination

Recommendation 1. Establish a national network of AOD lived experience advisory groups to ensure that policy and programs reflect people's experiences. This should comprise people from diverse communities with lived experience of harms, including domestic and family violence, mental ill-health, dependence, FASD and chronic diseases. (Commonwealth, and States and Territories)

Recommendation 2. Ensure alcohol policy reflects Australia's commitments under international human rights instruments to protect the rights of children when making legislative or regulatory changes to laws and policies relating to alcohol. (Commonwealth, and States and Territories)

Recommendation 3. Reduce stigmatisation by ensuring that adequate funding is provided for anti-stigma training and resources for all related workforces.

Recommendation 4. Develop guidelines for all government communications that avoids stigmatising and blaming language and promotes non-stigmatising language that centres people and acknowledges the social and commercial determinants of health. These guidelines should build on existing examples such as Mindframe's *'Guidelines for communicating about alcohol and other drugs',* and NADA's *'Language matters'.* (Commonwealth, and States and Territories)

Recommendation 5. Increase investment in accessible, trauma-informed mental health and AOD supports and treatment in criminal justice systems. Expand diversion programs, including Drug Courts, prioritising treatment over incarceration. (States and Territories)

Recommendation 6. Raise the Minimum Age of Criminal Responsibility to at least 14 years in all jurisdictions without exception, in line with Australia's International human rights obligations. (States and Territories)

Recommendation 7. Ensure that Aboriginal and Torres Strait Islander peoples and organisations are genuinely engaged in decision-making about alcohol programs, policies and laws.

2. Gendered violence

Recommendation 8. Fully implement the recommendations relating to alcohol in '*Unlocking the Prevention Potential: accelerating action to end domestic, family and sexual violence'* the report of the '*Rapid Review of Prevention Approaches to End Gender-Based Violence*'.

Recommendation 9. Ensure that each jurisdiction meets its National Cabinet commitment to review alcohol laws by establishing minimum principles, timeframes and transparent consultation processes for each for their reviews. This would include the primary objects prioritising the minimisation of harm and prevention of violence against women and children. (States and Territories)

3. Systemic reforms

Recommendation 10. Establish a national, AOD sector inclusive governance structure with the ability to support integrated planning between tiers of government and between relevant portfolios, implement national strategies and respond to both long-standing and emerging AOD sector priorities.

Recommendation 11. Commission the development of a framework for model alcohol legislation for Australia that prioritises alcohol harm reduction and uses a human rights and public health approach, by collaborating with experts and civil society organisations across the country and internationally. This should include provisions relating to the online promotion, sale and delivery of alcohol.

Recommendation 12. Develop and implement a regulatory framework with a legislative basis that effectively reduces community exposure to alcohol marketing. This must include effective administration, surveillance and deterrence systems for infringements of alcohol marketing.

Recommendation 13. Continue to index the excise on beer and spirits.

Recommendation 14. Replace the Wine Equalisation Tax (WET) with a volumetric tax rate.

Recommendation 15. Introduce a Minimum Unit Price (MUP) for alcohol in each state and territory, that is properly indexed to inflation.

4. Prevention

Recommendation 16. Fund the development and implementation of a national public education campaign on the NHMRC '*Australian guidelines to reduce health risks from drinking alcohol*' to increase the community's understanding of the risks associated with alcohol use.

Recommendation 17. Extend funding for the '*National Campaign on Alcohol, Pregnancy and Breastfeeding*', for at least five years.

5. Screening and supports

Recommendation 18. Prioritise resourcing equitable access to social services, including family support, and primary healthcare as sites for early identification of potential AOD issues. This should include community-led early intervention programs that use community development approaches.

Recommendation 19. Increase the capacity for cross-sector screening for AOD, by funding AOD, mental health, primary healthcare and family and domestic violence services to increase cross-sector collaboration and supports for screening, assessment, and treatment for AOD (including but not limited to psychosocial interventions, aftercare and postvention).

6. Fetal Alcohol Spectrum Disorder (FASD)

Recommendation 20. Provide secure, ongoing and indexed funding for National Organisation for Fetal Alcohol Spectrum Disorder (NOFASD) Australia, the FASDHub and the FASD Australian Register.

Recommendation 21. Implement fully the recommendations of the Senate Inquiry into Effective approaches to prevention, diagnosis and support for FASD, that reported in 2021.

Recommendation 22. Implement a National Partnership Agreement to adequately fund FASD assessment and diagnosis across Australia.

Recommendation 23. Implement FASD professional development for all health, education, child protection and community services professionals, within the broader disability context, to improve awareness, understanding and capacity. This must be culturally secure. (States and Territories)

Recommendation 24. Implement effective referral pathways to appropriate and adequately funded community services for people with FASD, their families and carers, including housing, healthcare, education, disability, employment, and other social services. (States and Territories)

Recommendation 25. Restore eligibility of people in criminal justice systems, (including people with FASD), to universal services, i.e. National Disability Insurance Scheme (NDIS), Disability Support Pension (DSP), Pharmaceutical Benefits Scheme (PBS) and Medicare.

Recommendation 26. Implement mandatory FASD professional development for all justice professionals, within the broader disability context, to improve awareness, understanding and capacity. (States and Territories)

Recommendation 27. Implement adequately funded, neuro-developmental (including FASD) assessment, diagnosis, and support, within the broader disability context, in all youth and adult justice systems by building capacity in community owned and managed organisations. (States and Territories)

Recommendation 28. Design and implement disability specialist courts, modelled on the FASD Court in Manitoba, Canada. These specialist courts would be culturally secure, disability-accommodating (including FASD), and provide diversionary alternatives. (States and Territories)

7. Harmful industries

Recommendation 29. Include addressing the commercial determinants of alcohol harms in all strategic documents (eg. National Alcohol Strategy), alongside social determinants of health and of alcohol harms.

Recommendation 30. Prohibit political donations from alcohol companies and their lobby groups.

Recommendation 31. Exclude alcohol companies and their lobby groups from the development of laws policies or programs related to alcohol harm reduction.

Alcohol harms

Alcohol contributes significantly to Australia's health burden (burden of disease) as well as costing billions of dollars each year in Australia in terms of healthcare and non-healthcare economic costs. Based on the findings of the Australian Burden of Disease Study 2018,[3] overall health burden attributable to alcohol as measured by disability-adjusted life years (DALYs) was 222,108 DALYs in 2018, or 4.46 per cent. The majority of this was fatal burden as measured by years of life lost (YLLs) at 132,845 YLLs.[4]

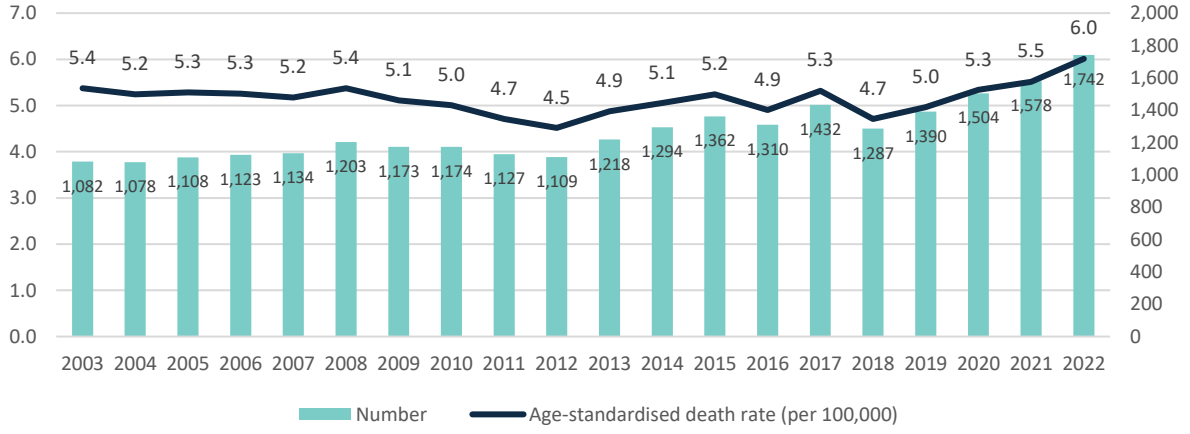
Physical impacts – injury, disease and disability

Health impacts of alcohol include hospitalisation and deaths from injury and other acute and chronic diseases, like cancer and mental ill-health. Alcohol is a carcinogen, causing causes at least seven types of cancer, including mouth, throat, oesophagus, liver, breast and bowel cancer.[5]

Alcohol also causes alcohol-related brain injury and Fetal Alcohol Spectrum Disorder (FASD). FASD is a lifelong disability describing a range of neuro-developmental impairments that impact on the brain and body of individuals prenatally exposed to alcohol.

Alcohol is the most common drug of concern in AOD treatment, (comprising 43 per cent of treatment episodes),[6] and causes 53 per cent of all AOD hospitalisations.[7] Tragically, Australia is currently experiencing the highest rates of alcohol-induced deaths in over 20 years.[8] Alcohol-induced deaths are those that are directly attributable to alcohol use. This may be because of a chronic (eg. alcoholic liver cirrhosis) or acute condition (eg. alcohol poisoning).

Alcohol induced deaths in Australia



Harms from alcohol are not equally distributed amongst Australians, with some people experiencing higher levels of harm. People experiencing socio-economic disadvantage, Aboriginal and Torres Strait Islander peoples, people living in a rural areas and people in prison all experience higher levels of alcohol related harms.[9] In Australia over half (54 per cent) of all alcohol is sold to 10 per cent of people who drink alcohol.[10]

Lived experience (in their own words): **I plan to shout about the link between alcohol and breast cancer … it might save a life - Corrine[11]**

"Since February 2022, I've battled breast cancer. I'd never joined the dots between this and my background of heavy drinking until I was undergoing chemotherapy and threw myself into the research. I'm well aware that my alcohol consumption when I was drinking would not have fit into Australia's Alcohol Guidelines. I am an alcoholic in recovery, and I've now been sober for eight years.

Eighteen months ago, I went for a routine mammogram, which was then followed by a whirlwind of 12 biopsies. I was swiftly diagnosed with Stage 2B breast cancer. I didn't know then that, according to the World Health Organization, alcohol is one of the biggest risk factors for breast cancer. Neither did I know that up to one in 10 cases of breast cancer in Australia is linked to drinking alcohol.

It took doing this research for me to find that it doesn't matter what type of alcohol – it's all connected to increased risk of cancer. The uncomfortable truth is that alcohol is classified as a Group 1 carcinogen by the International Agency for Research on Cancer. This is the same classification as tobacco smoke, radiation and asbestos. Yes, asbestos. Now, I plan to shout about the link between alcohol and breast cancer with all my might. Because it might just save a life."

Mental health impacts – mental ill-health, dependence and suicide

There are strong associations between alcohol use and mental ill-health, such as depression and anxiety.[12] Stress can lead to the onset and maintenance of high-risk alcohol use, and alcohol can also be used to attempt to manage anxiety. People are more likely to have increased alcohol use if they had more severe symptoms of depression or anxiety.[13]

People experiencing alcohol dependency are at higher risk of physical and psychological harms from alcohol, and commonly experience complex, interconnected social and economic harms. Alcohol dependence, or 'Alcohol Use Disorder', has criteria defined in the 2013 Diagnostic and Statistical Manual of Mental Disorders (DSM–5).[14] Whilst many people using alcohol at high risk levels do not meet the diagnostic criteria for alcohol dependence,[15] the risk of dependence does increase with increased levels of use.[16]

Lived experience (in their own words): **My son wanted to live but he couldn't navigate his alcohol addiction - Rachel[17]**

"No parent expects their child's life to be cut short by alcohol. My son Dylan was just 26 when he died from alcohol-induced hepatitis, or liver inflammation. The suffering he endured at the end of his life was confronting and heart-breaking. I wouldn't wish it upon any other mother or their child.

When he was dying, Dylan told me: "Mum, I want things to change." Reflecting on the damage caused by the cask wine that had destroyed his liver, my beautiful son told me he wanted to raise awareness about how harmful alcohol can be. Sweet, cheap and in abundance, these lethal boxes contain so much alcohol that it is possible to consume very high-risk amounts for the cost of a meal.

Dylan said if he could have left any legacy, it would be to get warning labels on the alcohol that put him on a path to dependence. It's just too easy to become addicted when alcoholic products are so cheap, and retailers ignore the obvious suffering of customers who come in day after day to buy vast quantities of alcohol. It's not just me, Dylan's mother, who has been affected by his death. His sisters are haunted by the memory of witnessing his final moments. Seeing him deteriorate so rapidly was shocking."

Suicide is complex, with multiple, inter-related contributing risk factors, including the use of alcohol and other substances.[18] Alcohol is the second leading risk factor among males aged 15 and over for suicide, responsible for 17 per cent of the burden of suicide and self-inflicted injuries among males aged 15 years and over in 2019.[19] Between 2010 and 2015, more than 26 per cent of suicide deaths in Australia had a blood alcohol concentration (BAC) above 0.05 g/100 ml.[20] Alcohol use is associated with a 65 per cent increased risk of suicidality.[21]

Harmful physical and mental health impacts intersect and interact with social, cultural, human rights and economic factors in complex ways contributing to further harms, injustice and inequity.

Cultural and social harms – stigma and violence against women and children

Despite causing significant harms, alcohol enjoys wide cultural acceptance, in part due to its portrayal by the alcohol industry, media and entertainment, where alcohol use and even alcohol harms are often normalised and even glamorised.[22]

Stigma and discrimination are common experiences for people with alcohol dependence. They are often quite pervasive and damaging to their quality of life, creating barriers to accessing support. The alcohol industry has long blamed and stigmatised individuals with high-risk alcohol use, (despite them being their most profitable customers), [23] by focussing their narrative on 'individual responsibility'.[24] This is an attempt to shift responsibility away from the harm caused by their products and aimed at deregulation of the alcohol industry.

Alcohol is a significant contributor to gendered violence in Australia. Alcohol is implicated in one in three (34 per cent) intimate partner violence incidents and over a quarter (29 per cent) of family violence incidents[25]. Research from 2022, indicates that up to 54 per cent of family violence incidents reported to police were classified as alcohol related.[26] Harms to children are significantly greater in households where a person drinks alcohol at higher risk levels. One in six children (17.1 per cent) have experienced harm from the alcohol use of adults around them, with two-thirds of harm being attributed to an adult in their home.[27] Data from Notices of Child Abuse, Family Violence or Risk, shows in over half of matters, one or more parties alleged that high risk AOD use had caused harm to a child.[28]

Lived experience (in their own words): **Gut-wrenching sound of alcohol delivery in an abusive relationship - Kym[29]**

"The crackle and squeak of car tyres pulling up. Lights piercing through the front window. The sound of footsteps coming towards the door. However innocent this description of home alcohol delivery may sound, it sends shivers down the spines of victims of domestic violence.

When you live with an alcoholic, it's like sharing a household with two different people – only the time spent with the better version is punctuated by anxiety in the expectation that things could take a pernicious turn at any point when the next case of beer arrives. A phone call to the police is never far away.

An alcoholic's journey to domestic abuse can be slow and insidious. The abuser is often a skilled manipulator – adept at making a rational argument to justify a six-pack here, a bottle of wine there."

Financial harms – hardship, financial abuse and housing insecurity

Longer term and higher risk alcohol use, including dependent use, can have significant impact on employment and finances.[30] People in lower socio-economic groups experience more alcohol-related harm, despite them being less likely to report exceeding recommended drinking limits.[31]

Harms to women and children caused by men's alcohol use includes financial deprivation, placing women in precarious financial positions.[32] Men's alcohol use contributes to a loss of resources for the household and overall household financial instability, reducing women's already diminished economic power and increases her caring burden.[33]

There is a strong association between AOD use and experiences of homelessness.[34] Of people who had experienced housing instability or homelessness, high risk use of substances was also reported for alcohol (57 per cent), and illicit drug use (39 per cent) in the previous six to 12 months.[35]

Injustice – human rights, criminalisation and colonisation

People in contact with the criminal justice system are more likely to have experienced mental ill-health and problematic AOD use.[36] They are already physically isolated by their sentences, but ongoing stigmatisation further isolates them, inflicting further punishment beyond sentencing.[37]

People with Fetal Alcohol Spectrum Disorder (FASD) do not experience equitable justice. This is demonstrated by the over-representation of people with FASD detained in the criminal justice

system. A representative study of young people in detention in Western Australia, found a high prevalence (89 per cent) of FASD and severe neurodevelopmental impairment.[38]

Democratic impacts – political influence and regulatory capture

Alcohol companies and their lobby groups seek to prevent effective government regulation of alcohol marketing and availability. They seek to exclude issues that are contrary to their commercial interests, including opposing evidence-based harm reduction measures.[39]

Alcohol industry activities are major obstacles to effectively implementing the WHO '*Global alcohol action plan 2022 -2030'* around the world. The alcohol industry does not pursue public health objectives in response to the global alcohol burden. They have a fundamental conflict of interest between their profit motive and alcohol harm reduction and a track record of interference against effective implementation of the WHO plan. Neither self-regulation, nor corporate social responsibility has brought any positive changes to the global alcohol burden.[40]

Preventing alcohol harms

The goal of primary prevention is to address the causes of alcohol harms to protect people from developing higher risk use or dependency in the first place. We know that the development of recreational pursuits, positive relationships with family and role models and being engaged in a community are all protective factors that can help to reduce higher risk use of AOD. We also know a sense of disconnection, unemployment, abuse or trauma, poor mental health, or a feeling of having no clear future – combined with AOD availability – are strong risk factors for AOD harms.

Secondary prevention seeks to identify risk factors and early warning signs through screening for early detection and treatment, resulting in a decrease in the number of cases of a disorder or illness. Tertiary prevention focusses on effectively treating conditions and preventing their reoccurrence.

Prevention needs to be a key focus of any approach to alcohol harm reduction.

1. Human rights, justice and self-determination

Centring lived expertise

People with lived and living experience of alcohol harm are best placed to inform how laws, policies, programs and systems can be designed and implemented to best meet their needs. Reducing alcohol harm requires meaningful and sustained engagement with the people and communities who are most impacted.

A focus on data alone can sometimes obscure the real-life pain, suffering and trauma experienced by people harmed by alcohol, as well as the far-reaching ripple effects on the health and wellbeing of their families and loved ones. Engaging people with lived and living experience as active partners in co-design and co-production ensures policies are informed by people who are most affected by them.

Governments need to work with AOD lived experience advocates to co-design and co-produce a framework and strategy for engaging people with AOD lived experience. This should include principles for engagement and suggestions to overcome potential barriers to participation. They also need to genuinely engage AOD lived experience advocates in the co-design of a range of policy and program measures to reduce alcohol harm in the community. These should include policies to address alcohol marketing, availability and online sales and delivery; and programs to increase awareness of alcohol harms.

Lived experience (in their own words): **From Misdiagnosis to Understanding: Sharing our FASD story - Angelene**[41]

"As a mum of a kiddo with FASD, I have navigated the challenge of disclosing my story, getting an accurate diagnosis and advocating for the support my son needs. My journey began with a series of concerns others might recognise. My son was born with a low birth weight. He had a weak suck reflex, making breastfeeding difficult. As he grew, his developmental milestones seemed delayed. By two years old, it was clear he wasn't meeting the typical speech and motor skills markers. He had behaviours different from those of his peers, such as difficulties with sleep and speech delays.

Despite these signs and being open about his prenatal alcohol exposure risk with health professionals, it took years to get a proper diagnosis. The most selfless thing a mother can do if there is a risk—as hard as it might feel in the moment—is to go straight to a doctor and say, "My baby was prenatally exposed to alcohol." Stigma can be a significant barrier to getting the proper support. Many mums are worried about judgement and hesitate to disclose alcohol exposure. Yet FASD is the largest spectrum of disability in Australia by a long way.

What I want everyone reading to know is that prenatal alcohol exposure is never, ever malicious. There are many reasons why women may consume alcohol during pregnancy – from being unaware of the risks, not knowing they are pregnant, or being physically dependent on alcohol. What I want women reading this to know, if you suspect prenatal alcohol exposure, you are not alone. There is support out there. Raise it with your doctor and keep advocating for your kiddo."

Recommendation 1. Establish a national network of AOD lived experience advisory groups to ensure that policy and programs reflect people's experiences. This should comprise people from diverse communities with lived experience of harms, including domestic and family violence, mental ill-health, dependence, FASD and chronic diseases. (Commonwealth, and States and Territories)

Human rights, stigmatisation and criminalisation

Human rights

Human rights laws are designed to help protect people from discrimination and harm. A human rights-based approach to alcohol policy requires that communities are empowered to make decisions about the policies adopted to manage alcohol within their community. It also ensures that measures are reasonable, proportionate and necessary. The combination of these factors will ensure policies have the greatest likelihood of success and will respect and protect the human rights of our communities.[42]

In 2021, the Queensland State Development and Regional Industries Committee asserted that the Queensland Human Rights Act requires public policy to address alcohol harm.

> *"Alcohol remains a significant cause of family and domestic violence in Australia: the use of alcohol and other drugs accompanies around half of all family and domestic violence incidents. Legislative measures which increase accessibility to alcohol, and especially alcohol usage in private homes, may therefore limit the rights of children and families and the right to security and liberty of the person. HRA section 26 emphasises the importance of the family, imposes an obligation on the State to protect the interests of children. Easy access to alcohol threatens not only children and families of alcohol consumers, but also the mental and physical health and security of consumers themselves."*[43]

The implication of this requirement is that the Queensland Government has an obligation to protect the rights of children when considering legislative changes to alcohol availability. A 2019 ACT Auditor-General's report also recommended that the ACT Justice and Community Safety Directorate include explicit consideration and documentation of human rights in all decision-making.[44]

Recommendation 2. Ensure alcohol policy reflects Australia's commitments under international human rights instruments to protect the rights of children when making legislative or regulatory changes to laws and policies relating to alcohol. (Commonwealth, and States and Territories)

Stigma

Stigma and discrimination can occur in social settings, healthcare, welfare, support services, criminal justice and employment. Navigating service systems can be challenging enough for people seeking help with disability, mental health or AOD dependence. It is made even more difficult by the structural discrimination that can exist in the systems designed to help. For example, a person may be turned away from services because they are intoxicated, because they are homeless, or because of judgements made about their use of alcohol or other drugs.

Language also plays a critical role in preventing stigma – it can help make people feel included, welcome and safe. However, it can also be used to create the opposite effect, and this can be particularly harmful when talking about alcohol in media reporting, which can stigmatise or glamorise alcohol use.

There are many messaging guidelines available to assist people working in health, policy and media contexts.[45] These need to be adopted by Governments and the media. Examples include avoiding stigmatising 'individual responsibility' language (eg. '*problem drinker*', '*drink responsibly*', '*alcohol abuse / misuse'*); and instead, using non-stigmatising language that centres people and acknowledges the social determinants of health (eg. '*people who use alcohol*', '*people experiencing alcohol harms'*).[46]

This guidance should also allow people with lived experience of AOD harms to continue to self-identify with language they are comfortable with, without that justifying its use in government, media or industry communications.

Recommendation 3. Reduce stigmatisation by ensuring that adequate funding is provided for anti-stigma training and resources for all related workforces.

Recommendation 4. Develop guidelines for all government communications that avoids stigmatising and blaming language and promotes non-stigmatising language that centres people and acknowledges the social and commercial determinants of health. These guidelines should build on existing examples such as Mindframe's *'Guidelines for communicating about alcohol and other drugs',* and NADA's *'Language matters'.* (Commonwealth, and States and Territories)

Justice

There is continued criminalisation of people experiencing alcohol harms. People in contact with the criminal justice system are more likely to have experienced mental ill-health and problematic AOD use.[47] For example, most people in detention in Victoria (over 75 per cent of men and at least 83 per cent of women), report experiencing problematic AOD use before being imprisoned.[48] Problematic AOD use is highly prevalent in prison populations and are often a direct cause of offending and recidivism. Punitive responses to health and social issues are expensive and ineffective.[49]

Ongoing stigmatisation and criminalisation inflict further punishment beyond sentencing.[50] The provision of effective mental health and AOD programs is also a key component in criminal justice settings. However, there are long waiting lists for AOD programs and transitional support services for people in detention and community-based support services for people who were formerly in detention, are limited.[51] Evaluations of preventative public health and diversion programs confirm their positive impact both on recidivism and on costs.[52] For example the Drug Court of Victoria offers Drug Treatment Orders as an alternative to imprisonment. Its aims are to improve the health and well-being of participants and reduce the severity and frequency of reoffending.[53]

Another contributor to the criminalisation of people experiencing alcohol harms, is the criminalisation of children, including people with FASD. Raising the Minimum Age of Criminal Responsibility is based on neuro-developmental research and human rights obligations:

- Research evidence on developmental psychology shows that children are not sufficiently able to reflect before acting or to comprehend the consequences of a criminal action.[54]
- Australia has human rights obligations under the United Nations Convention on the Rights of the Child. These obligations state that the MACR should be at least 14 years old. [55]

In addition, the criminalisation of children is expensive and does not work:

- In Queensland it costs more than $1,600 to keep one young person in detention each day.[56]
- Research on early childhood trauma shows criminalising children under 14 years old leads to a lifetime of harmful consequences, including sustained contact with the justice system.[57]

Recommendation 5. Increase investment in accessible, trauma-informed mental health and AOD supports and treatment in criminal justice systems. Expand diversion programs, including Drug Courts, prioritising treatment over incarceration. (States and Territories)

Recommendation 6. Raise the Minimum Age of Criminal Responsibility to at least 14 years in all jurisdictions without exception, in line with Australia's International human rights obligations. (States and Territories)

Decolonising alcohol policy

The United Nations Declaration on the Rights of Indigenous Peoples is a crucial tool in decolonising alcohol policy responses.[58] The four Declaration principles that must be considered are:

1. self-determination
2. free, prior and informed consent
3. respect for and protection of culture
4. non-discrimination and equality.

Policies and programs delivered in line with these principles will result in the empowerment of communities to develop and implement responses, which is most likely to have a positive impact. Aboriginal and Torres Strait Islander communities know the most effective solutions to challenges they face. [59]

Peter d'Abbs and Nicole Hewlett identify some key features of the diverse policy and program responses in Aboriginal communities in their book '*Learning from 50 Years of Aboriginal Alcohol Programs - Beating the Grog in Australia'*.[60] One such successful program was the community-led alcohol restrictions in Fitzroy Crossing, Western Australia. There was strong support for the alcohol restrictions, with almost all survey respondents accepting the need for alcohol restrictions and that no one wanted a return to the social conditions prior to their introduction. A formal evaluation found that the alcohol restrictions were having significant health and social benefits.[61]

d'Abbs and Hewlett note that all the program interventions necessarily target the symptoms of alcohol harms, not the causes, (such as poverty, marginalisation, intergenerational trauma and the ongoing legacy of colonisation). They suggest that these social, political and economic determinants of alcohol harms must also be addressed. They concluded that there were three key issues relevant to all alcohol program domains, with implications for future program design. These were community control, personal relationships, and defining relevant knowledge.

An example of relevant knowledge was identifying models of sickness and health that are grounded in Aboriginal cultural perspectives rather than western biomedical models. This can result in tensions between mainstream ideas of treatment efficacy and beliefs among Aboriginal service providers that

these are not suited to the gradual and complex processes entailed in Indigenous healing. Some attempts have been made to develop program designs more attuned to Aboriginal priorities.

Governments need to engage broadly, early and continuously with Aboriginal and Torres Strait Islander communities, identifying all relevant groups, reaching out and meaningfully engaging at multiple stages. This recognises self-determination and helps ensure that alcohol policy and program solutions are community led.

Recommendation 7. Ensure that Aboriginal and Torres Strait Islander peoples and organisations are genuinely engaged in decision-making about alcohol programs, policies and laws.

2. Gendered violence

Alcohol is a significant contributor to gendered violence in Australia. Alcohol increases the frequency and severity of gendered violence. Between 2010 and 2018, over half (52 per cent) of male intimate partner homicide offenders used alcohol at high-risk levels at the time of the homicide.[62] Men's drinking results in direct, indirect and hidden harms to women that are cumulative, intersecting and entrench women's disempowerment.[63] Changes in their partners' drinking play a central role in women's journey to safety and can complicate their ability to leave.[64] Action on alcohol is an important part of any comprehensive approach to the prevention of violence against women and children.

Following an initial National Cabinet meeting in May 2024 to discuss gendered violence, the Domestic, Family and Sexual Violence (DFSV) Commissioner, Micaela Cronin, convened an expert roundtable of '*Crisis Talks into Murdered and Missing Women*'. The DFSV Commission issued a communique from the roundtable that committed '*to work with Commonwealth and state and territory governments to urgently consider what role they can play in regulating and responding to factors that can exacerbate domestic and family violence, such as the accessibility of AOD, gambling, and pornography*'.[65]

Subsequently the Prime Minister announced an expert led '*Rapid Review of Prevention Approaches to End Gender-Based Violence*' (Rapid Review) that would provide practical advice to government on further action to prevent gender-based violence. The Rapid Review report "*Unlocking the Prevention Potential: accelerating action to end domestic, family and sexual violence"* was released in August 2024.[66] It included specific recommendations for governments to regulate the sale and marketing of alcohol, as well as support improvements in cross-sectoral collaborations between the AOD sector, the DFSV sector, and other related sectors, to support people with complex and intersecting needs.

National Cabinet then met in September 2024, to again discuss gendered violence, with the Prime Minister acknowledging that tackling the impacts of alcohol on violence was a priority. He acknowledged the role of systems and industries in exacerbating violence. State and Territory First Ministers agreed to review alcohol laws and its impact on family and domestic violence victims to identify and share best practice and reforms and to report back to National Cabinet on progress.[67]

Lived experience (in their own words): **This wasn't the first time her husband had been drinking and it wouldn't have been the last - Joan[68]**

"He was a very heavy drinker. He would begin to drink when he got home on a Friday night and just continue to drink for the whole weekend. It was on a Friday night that he attacked her. They barricaded themselves in a bedroom and called the police.

She'd been working and holding the family together and providing a stable income for the home. For my daughter, it didn't just become an issue of trying to get her life back together, she lost her dream, and she will never really be able to do that now. She's just not physically or emotionally capable of pursuing that career. For my daughter, this wasn't the first time her husband had been drinking and it wouldn't have been the last."

Recommendation 8. Fully implement the recommendations relating to alcohol in '*Unlocking the Prevention Potential: accelerating action to end domestic, family and sexual violence'* the report of the '*Rapid Review of Prevention Approaches to End Gender-Based Violence*'.

Recommendation 9. Ensure that each jurisdiction meets its National Cabinet commitment to review alcohol laws by establishing minimum principles, timeframes and transparent consultation processes for each for their reviews. This would include the primary objects prioritising the minimisation of harm and prevention of violence against women and children. (States and Territories)

3. Systemic reforms

AOD sector governance

The AOD sector is currently without a national governance structure that can facilitate dialogue between the AOD sector, different tiers of government, funding and commissioning bodies and other intersecting systems. This has been the case since the cessation of the Council of Australian Governments and its AOD-sub group, the Ministerial Drug and Alcohol Forum, in 2020. In years gone by, national governance structures such as the Ministerial Council on Drug Strategy, the Intergovernmental Committee on Drugs and the National Indigenous Drug and Alcohol Committee were integral to the development and implementation of National Drug Strategies.

The absence of a national Ministerial governance structure for alcohol and other drugs, has resulted in there being ineffective national monitoring and evaluation of national strategies, such as the *National Drug Strategy 2017-2026* and the *National Alcohol Strategy 2019-2028.* It also means there is no implementation or monitoring of the *National Quality Framework for Drug and Alcohol Treatment Services.* The national sub-strategies (*National Aboriginal and Torres Strait Islander People's Drug Strategy* and *National Alcohol and Other Drug Workforce Development Strategy)* have also lapsed.

Recommendation 10. Establish a national, AOD sector inclusive governance structure with the ability to support integrated planning between tiers of government and between relevant portfolios, implement national strategies and respond to both long-standing and emerging AOD sector priorities.

Alcohol harm reduction bill

Each State and Territory has distinct laws that govern the control of alcohol. These legislative and regulatory instruments are often referred to as Liquor Acts and Regulations and include information on liquor licensing, community engagement, and the service of alcohol. These instruments were largely established in the 1970s and are no longer fit for purpose. Over the past 50 years the way

alcohol is promoted, sold, and consumed has changed profoundly. The laws have not kept pace with this change and are failing to keep people safe.

We are also now moving into an environment in which existing controls on alcohol availability, which were designed with brick-and-mortar stores in mind, are no longer suitable in a world where every phone is a bottle shop and a billboard. These digital changes are not addressed in our laws, despite the rapid delivery of alcohol via online order being the fastest growing area for expansion in alcohol retail. This, in combination with digital marketing technologies which facilitate targeted, round-the-clock advertising, creates a frictionless environment – where a targeted ad can, with one click, result in the rapid delivery of unlimited quantities of alcohol to an individual's doorstep.

These laws currently have dual objects of encouraging industry development and minimising harm. This often creates tension and an environment where community views are not prioritised and where individuals are over-penalised for harms.

Lived experience (in their own words): **The availability of fast delivery alcohol, and targeted ads, contributed to my friend's death" - Alex[69]**

"*We went to the emergency department. Unfortunately, he didn't leave the hospital. A couple of days after he was admitted, we were told that he had kidney failure that was secondary to alcohol-related liver disease, and he was going to be looked after in palliative care. I returned from what was to be a pretty special family holiday with an empty seat next to me. It was devastating.*

I think the availability of fast delivery alcohol, and the targeted ads he was shown on social media, contributed to my friend's death. He had a broken ankle, so his ability to get to a bottle shop was limited, but when I went over to check on him, I saw empty bottles and bags with the branding of fast delivery alcohol companies. I'm quite sure that if he had left the house to try and procure the alcohol himself, he would have likely been denied service."

Recommendation 11. Commission the development of a framework for model alcohol legislation for Australia that prioritises alcohol harm reduction and uses a human rights and public health approach, by collaborating with experts and civil society organisations across the country and internationally. This should include provisions relating to the online promotion, sale and delivery of alcohol.

Alcohol marketing reform

Alcohol marketing in Australia is currently regulated under a fragmented patchwork of regulation by the Australian Government and states and territories. This occurs primarily by state and territory liquor licencing regulation and, in the limited case of marketing related to health and nutrition claims, the federal Food Standards Australian New Zealand (FSANZ) Act 1991.

In place of federal regulation, alcohol marketing is largely left for consideration against the alcohol industry developed and implemented Alcohol Beverages Advertising Code (ABAC), overseen by the ABAC Scheme Limited. The ABAC Scheme is funded and governed by alcohol industry bodies: the Brewers Association of Australia, Spirits & Cocktails Australia and Australian Grape & Wine.

In practice, this patchwork of limited regulation, which is narrow in scope and coverage, results in alcohol marketing being largely unregulated in Australia. Key issues include:

- Mostly focuses on content (not quantity/exposure) and often leaves room for interpretation.
- Limited in media covered – eg. some regulations around TV and in licenced premises, but little in other spaces including online.
- There is no proactive monitoring and enforcement – complaints are community driven and can take a long time to resolve.

- Self-regulation – vested commercial interests where the primary goal to maximise profits inherently works in opposition to regulation that effectively restricts alcohol marketing.

This leads to the current environment where our community is saturated with alcohol marketing. Further exacerbating the issue, data-driven digital marketing of alcohol now means that children and other people most at risk of harm are directly targeted with alcohol marketing when they are online.

Young people's exposure to alcohol marketing increases the likelihood they will start drinking alcohol at a younger age and that they will go on to drink alcohol at high-risk levels later in life.[70] Alcohol marketing can increase positive alcohol-related emotions and cognitions and trigger alcohol cravings among people at-risk of or experiencing an alcohol problem and is seen to trigger a desire to drink among people in recovery from an alcohol use disorder.[71]

There is strong evidence and public health consensus that comprehensive federal regulation of alcohol marketing will be best placed to reduce community exposure to alcohol marketing.[72] The regulatory framework must be developed and implemented by the Australian Government and meet the following fundamental conditions:

- A legislative basis with compliance mandatory,
- The development, administration and enforcement are independent of vested commercial interests,
- An effective administration and deterrence system for infringements on harmful product marketing restrictions, and
- A proactive system for surveillance of harmful product marketing.

A comprehensive piece of legislation that aims to reduce alcohol marketing in Australia will be best placed to protect children and young people from exposure to alcohol advertising while also reducing exposure by other people most at risk of harm and the wider community.

Children and young people do not exist in social isolation – they are exposed to a range of environments alongside adults, and this has meant that policies with a limited scope focusing on environments with large audiences of children, or advertising content that primarily appeals to children, are largely ineffective at protecting children and young people from alcohol marketing.[73] Similarly, people who are most at risk of alcohol harm, including people who are living with or recovering from alcohol use disorder or dependency remain exposed to alcohol marketing.

Recommendation 12. Develop and implement a regulatory framework with a legislative basis that effectively reduces community exposure to alcohol marketing. This must include effective administration, surveillance and deterrence systems for infringements of alcohol marketing.

Alcohol pricing

Australian alcohol taxes vary greatly across different types of alcohol and different methods of delivery. Most taxes are volumetric (charged per litre of alcohol) within each category, but not across categories. Wine is charged an 'ad valorem', not volumetric, tax as a proportion of the assessed dollar value. Generally, beer is taxed much less than spirits and beer on tap is taxed at a fraction of the rate of packaged beer.

Australian Alcohol Tax Levels ($ per litre of alcohol)[74]

Type of alcohol	Volume or Sub-type	2024
Low strength beer (≤3%)	Packaged in container ≤48lt	$51.63
	On tap in container >48lt	$10.32
Mid strength beer (>3, ≤3.5%)	Packaged in container ≤48lt	$60.12
	On tap in container >48lt	$32.33
Full strength beer (≥3.5%)	Packaged in container ≤48lt	$60.12
	On tap in container >48lt	$42.37
Spirits	Brandy	$95.12
	All other spirits	$101.85
Wine - wine equalisation tax (WET)	Wholesale sales tax (- rebate for small producers)	29%

The recommendation for a volumetric tax on alcohol has sat with the Australian parliament since 2010 in the Henry Tax Review.[75,76] Ken Henry suggested alcohol tax should be volumetric, based on evidence, and on the social cost of harm from alcohol. He especially criticised the Wine Equalisation Tax (WET) and pointed out the disproportionate tax rates of beer and cheap wine. Despite the many government reviews as well as the National Alcohol Strategy 2019-2026 recommending taxation reform, Australian Governments have not chosen to take this action.

Cask wine is the cheapest alcoholic beverage available in Australia. The mean price per standard drink for cask wine ($0.55) is much lower than for bottled wine ($4.40), and at the bottom end, cask wine has a minimum price as low as $0.24 per standard drink.[77] Introducing a minimum unit price (MUP) of at least $1.30 per standard drink across Australia could dramatically reduce alcohol use in Australia by 1.5 standard drinks per week for the population on average.[78] Research has also shown that the MUP in the Northern Territory there have been significant reductions of alcohol harms since the introduction of the MUP and other reforms.[79]

Recommendation 13. Continue to index the excise on beer and spirits.

Recommendation 14. Replace the Wine Equalisation Tax (WET) with a volumetric tax rate.

Recommendation 15. Introduce a Minimum Unit Price (MUP) for alcohol in each state and territory, that is properly indexed to inflation.

4. Prevention

Preventive health approaches

The benefits of prevention include reducing chronic conditions and living longer, healthier lives and improving the health of future generations. Prevention also generates benefits by reducing pressure on the health budget and by increasing workforce participation and productivity.

Specific, measurable and relevant evidence-informed targets are the first step towards effective prevention of alcohol harms, followed by effective, evidence-informed policy and program measures. The Australian Government's recently published National Preventive Health Strategy 2021-2030 recognises the harm caused by alcohol use, and sets targets to reduce this harm:[80]

- At least a 10 per cent reduction in harmful alcohol consumption by Australians (≥14 years) by 2025 and at least a 15 per cent reduction by 2030.
- Less than 10 per cent of young people (14-17-year-olds) are consuming alcohol by 2030.
- Less than 10 per cent of pregnant women aged 14 to 49 are consuming alcohol whilst pregnant by 2030.

Education campaigns

Well-designed and implemented public education campaigns can be an effective primary prevention of alcohol harms. These education campaigns can be about mental health and alcohol, drink driving, cancer, FASD, or the National Health and Medical Research Council (NHMRC) guidelines to reduce health risks from drinking alcohol. The NHMRC guidelines recommend:[81]

1. To reduce the risk of harm from alcohol-related disease or injury, healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day.
2. To reduce the risk of injury and other harms to health, children and people under 18 years of age should not drink alcohol.
3. To prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol. For women who are breastfeeding, not drinking alcohol is safest for their baby.

Australians have a low awareness of the risks of alcohol use, and of the NHMRC guidelines. A National Poll found that only 26 per cent of Australians are familiar with the current NHMRC guidelines.[82] This highlights the need for continued promotion of the Guidelines to ensure that Australians are informed of the risks of alcohol use.

Case Study –Every Moment Matters and Strong Born - A National Awareness Campaign on Alcohol, Pregnancy, Breastfeeding, and Fetal Alcohol Spectrum Disorder (FASD)

The National FASD Campaign is the first comprehensive national health promotion campaign on alcohol and pregnancy globally, raising awareness of alcohol related harm during pregnancy and breastfeeding. Funded by the Australian Government as part of the *National FASD Strategic Action Plan 2018-2028*, this unique campaign uses a strength-based strategy to prevent prenatal alcohol exposure and represents a critical turning point in Australia's approach to reducing the prevalence of FASD. The strength of the National Campaign is that it is delivered in partnership by Foundation for Alcohol Research and Education (FARE), the National Organisation for Fetal Alcohol Spectrum Disorder (NOFASD Australia), the National Aboriginal Community Controlled Health Organisation (NACCHO), along with health professional colleges and communities across Australia who have endorsed, informed and promoted the campaign.

Prenatal alcohol exposure presents significant public health concerns, particularly with its effects on fetal development and long-term health outcomes for children, including diagnosis of FASD which is the leading preventable developmental disability in Australia. FASD is characterised by a range of adverse physical, learning, and behavioural effects after exposure to alcohol during pregnancy, with challenges occurring into childhood and adult life. Despite guidelines from the National Health and Medical Research Council (NHMRC) recommending complete abstinence from alcohol when pregnant or planning for pregnancy, there is a high prevalence of alcohol exposure during pregnancy, with estimates suggesting 60 per cent of Australians' pregnancies are exposed to alcohol.[83,84]

The National FASD Campaign (2020-2024) aims to reach four key populations; women who are at an increased risk of alcohol use during pregnancy, health professionals, Aboriginal and Torres Strait Islander people and the general Australian population. The campaign is delivered through the '*Every Moment Matters'* public awareness campaign and dedicated health professional eLearning modules led by FARE, development of dedicated resources for priority groups led by NOFASD, and the comprehensive '*Strong Born'* campaign led by NACCHO empowering Aboriginal and Torres Strait Islander communities.

The independent evaluation demonstrated that the '*Every Moment Matters*' campaign successfully raised Australians' awareness about the risks associated with alcohol consumption during pregnancy, awareness of the NHMRC guidelines, and increased intention to avoid alcohol during conception.

The final evaluation report showed that among women who were planning a pregnancy in the next two years (who were not actively trying to conceive), there was a significant increase in intention to abstain from alcohol when trying to conceive from 34.2 per cent pre-campaign to 54.0 per cent post-campaign among those who had seen the '*Every Moment Matters'* campaign. The proportion of Australians who correctly identified the alcohol guidelines for women who are pregnant or planning pregnancy increased significantly from 32.7 per cent pre-campaign to 44.6 per cent post-campaign. The proportion of women with planned pregnancies who reported abstaining from alcohol while trying to conceive from 30.7 per cent to 58.3 per cent. Awareness of the guidelines for breastfeeding women also increased significantly from 64.7 per cent pre-campaign to 74.0 per cent post-campaign.[85]

This innovative world-leading National FASD Campaign represents significant progress in efforts to reduce alcohol related harms. Ongoing commitment and funding to ensure implementation of the National FASD Strategic Action Plan in its entirety is essential for outcomes to be achieved to reduce alcohol related harms during pregnancy and breastfeeding, and to ensure appropriate FASD diagnosis and services are accessible.

Recommendation 16. Fund the development and implementation of a national public education campaign on the NHMRC '*Australian guidelines to reduce health risks from drinking alcohol'* to increase the community's understanding of the risks associated with alcohol use.

Recommendation 17. Extend funding for the '*National Campaign on Alcohol, Pregnancy and Breastfeeding'*, for at least five years.

5. Screening and supports

Early identification

Social services, including domestic violence, health, housing and community services, provide many benefits to communities including improved health, safety and wellbeing. This establishes strong protective factors against experiencing AOD harms. Social services can also provide accessible locations for early identification and referral for people experiencing AOD harms, with adequately trained staff and co-ordinated referral pathways. To achieve this, there needs to be equitable access to culturally responsive, trauma-informed and non-stigmatising social services. Services need to be well co-ordinated and integrated with AOD services where possible to provide wrap-around care.

AOD screening and brief interventions delivered in primary healthcare settings are also effective in helping to prevent AOD-related harms. However, there are several barriers, including competing demands on health practitioners' time, reluctance by health providers to question people about AOD use, and a lack of referral options for follow-up support or treatment. People experiencing AOD dependence can also have an impaired capacity to respond to health measures.[86] These barriers can be addressed with improved training and support for staff and adequately resourced and coordinated referral pathways.

Screening tools

One validated assessment tool for alcohol dependency is the 10-question 'Alcohol Use Disorders Identification Test' (AUDIT)[87] developed by the WHO, for use in primary care, with ten questions on consumption and its consequences.[88] The full AUDIT tool (and the similar ASSIST tool)[89] reflects the eleven symptoms listed in the DSM–5 diagnostic criteria for Alcohol Use Disorder.[90] A common screening version of the AUDIT tool used in clinical practice and academic research is the AUDIT-C,[91] which has three questions (the first three AUDIT questions).

Risk assessment, diagnostic criteria and screening tools (including AUDIT) for AOD usually address some or all the following domains:

- Levels of use (volume and frequency)
- Physical (eg. cancer, diabetes, liver, injuries),
- Dependence (eg. tolerance, withdrawal, cravings, memory),
- Psychological (eg. impulse control: inability to reduce / stop),
- Behavioural (eg. risk-taking, unable to do normal tasks),
- Social / relational (eg. concerns, financial, legal, work / study problems), and
- Emotional (eg. guilt, remorse, resentment, envy).

A number of these domains describe symptoms that can impair people's decision-making and make it challenging for them to respond positively to health measures. However, many do experience significant improvements in their health and wellbeing if such supports and interventions are accessible and culturally safe.

***Lived experience (in their own words):* "It was condoned, it was encouraged" - James[92]**

"It was something that built up, so I didn't even realise how poor the way I was using alcohol was during my 20s, but it did snowball considerably before I got married. I was living by myself at the time, I could use alcohol 24/7. It was a cycle of depression, and then using alcohol, and then causing depression and then causing alcohol use. That was the progression I experienced. The critical point was when my wife said: "It's me or the grog. You've got a problem, let's help you sort it out.

I did end up in a clinical rehab, which really saved my life. As a man there's quite a strong momentum of being strong, invulnerable, drinking culture, party culture, alpha male, which was an early part of my career. I can share so many stories of harm and horrible outcomes from work functions. It was condoned, it was encouraged."

Recommendation 18. Prioritise resourcing equitable access to social services, including family support, and primary healthcare as sites for early identification of potential AOD issues. This should include community-led early intervention programs that use community development approaches.

Recommendation 19. Increase the capacity for cross-sector screening for AOD, by funding AOD, mental health, primary healthcare and family and domestic violence services to increase cross-sector collaboration and supports for screening, assessment, and treatment for AOD (including but not limited to psychosocial interventions, aftercare and postvention).

6. Fetal Alcohol Spectrum Disorder (FASD)

Systemic FASD prevention

Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term describing a range of neuro-developmental impairments[93]. FASD is a lifelong disability, which describes impacts on the brain and body of individuals prenatally exposed to alcohol. People with FASD experience challenges in their

daily living and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential.[94]

There is no known safe level of prenatal alcohol exposure.[95] This is why the National Health and Medical Research Council (NHMRC) recommends *'women who are pregnant or planning a pregnancy should not drink alcohol'.*[96] Other risks of alcohol use in pregnancy include miscarriage, stillbirth, low birth weight and pre-term birth.

Crucial systemic prevention of FASD is achieved through increased awareness by education campaigns, like the '*National Awareness Campaign on Alcohol, Pregnancy, Breastfeeding and FASD'*, (see above under '4. Prevention – Education campaigns'). NoFASD plays a crucial role as the peak body supporting people and families living with FASD. The FASD Hub provides evidence-based content about alcohol and pregnancy and FASD.

The FASD Hub is a one-stop shop for all information, tools, resources, research and consumer support about FASD in Australia. It provides a central repository for clinically accurate information, diagnostic tools, referral services, research and consumer information for clinicians, health practitioners, researchers and consumers. NOFASD Australia provides information services to individuals and families affected by FASD. Its mission is to provide a strong and effective voice for individuals and families living with FASD, while supporting initiatives across Australia to promote prevention, diagnosis, intervention and management.

The Senate Inquiry into *'Effective approaches to prevention, diagnosis and support for FASD'*, included the following recommendations:[97]

- provide funding for professional development training for all health professionals involved in antenatal care, to embed routine FASD screening practices and tools, including AUDIT-C,
- run a specific public education campaign with respect to the roll-out of mandatory pregnancy warning labels,
- undertake a national audit of current FASD diagnostic services and funding to identify priority areas and inform a longer-term and sustainable funding model,
- include Medicare Benefits Schedule Items that cover the range of clinical practices involved in FASD assessments, diagnoses and treatments,
- implement as a matter of priority marketing, pricing and taxation reforms as set out in the *National alcohol strategy 2019–2028*,
- screen children and young people entering the youth justice and child protection systems for FASD,
- develop and trial protocols for screening children and young people within child protection and youth justice systems for FASD,
- fund an independent study into best-practice diversionary programs and alternative therapeutic facilities for individuals with FASD or suspected FASD within the justice system,
- fund an independent study into the social and economic cost of FASD in Australia.

Recommendation 20. Provide secure, ongoing and indexed funding for National Organisation for Fetal Alcohol Spectrum Disorder (NOFASD) Australia, the FASDHub and the FASD Australian Register.

Recommendation 21. Implement fully the recommendations of the Senate Inquiry into Effective approaches to prevention, diagnosis and support for FASD, that reported in 2021.

FASD screening, diagnosis and supports

The complexity and clustering of risks and unmet needs of children with FASD increase the likelihood of future problems, including ongoing contact with criminal justice. This highlights the importance of

early, coordinated and sustained help for children with FASD and their families. There are no specific FASD screening tools that are recommended for use in Australia.[98]

Specific funding and resourcing are needed for assessment and diagnosis of FASD. Diagnosis of FASD is complex, time-consuming and expensive and so it becomes difficult to access, and many people miss out on the treatment and support that a diagnosis facilitates. Receiving a diagnosis is critical to children being supported appropriately to reach their full potential. To ensure that this can occur, it is important that there is enough health professionals with the expertise required to undertake a FASD diagnosis.

Australia now has a National FASD Diagnostic Tool providing the necessary clinical guidance on diagnosing FASD.[99] However, there are insufficient diagnostic services available, and some jurisdictions, like the ACT, do not have diagnostic clinics. This means that families seeking a diagnosis, which involves months of appointments, often need to travel outside their area to access the services. Current waitlists for Australian children suspected of FASD are up to 3 years at some health services.[100]

Lived experience (in their own words): **My perspective towards FASD has changed a lot… I'm in a much better place, but it wasn't like that in the beginning - Gilberto[101]**

"*I had started Zemble and was living in Minneapolis and one of my co-founders flew over to see me and she was pregnant. I noticed she wouldn't drink a lot of things, for example coffee, and she would say 'that is not good for the baby,' which is something very common to say. One day I thought about how my mother drank while she was pregnant, and how this could mean something.*

It was very surprising for me the fact I had never heard of FASD before, not on TV, movies, or at school. It's not like I have been isolated. I have travelled in five continents, I've lived in Spain, the UK, the US and Australia, and I have never heard of FASD.

It was interesting because before my diagnosis I thought this is how everybody experiences things. I thought it was normal not to remember things all the time. I had a lot of fear about what people would think of me. I think one of the reasons I was depressed was because I was reading so many negative things about FASD. I always felt different, and I didn't know why, but now I know why."

Recommendation 22. Implement a National Partnership Agreement to adequately fund FASD assessment and diagnosis across Australia.

Recommendation 23. Implement FASD professional development for all health, education, child protection and community services professionals, within the broader disability context, to improve awareness, understanding and capacity. This must be culturally secure. (States and Territories)

Recommendation 24. Implement effective referral pathways to appropriate and adequately funded community services for people with FASD, their families and carers, including housing, healthcare, education, disability, employment, and other social services. (States and Territories)

Justice reforms

There is an over-representation of people with FASD among people detained in criminal justice systems. Representative research at the Banksia Hill Youth Detention Centre in Western Australia identified that more than a third of the young people screened in detention were diagnosed with FASD. [102] This means that people with FASD do not experience equitable justice.

Appropriate assessment and diagnostic pathways need to be available when concerns are identified for people involved with criminal justice systems. Currently, to access government support for people with disability in the criminal justice system, you need to have a type of disability that falls within the relevant definition, and to have certain impairments as a result of that disability.[103] For people with FASD coming into contact with the criminal justice system this can mean having to meet

some criteria for cognitive impairment that do not match FASD characteristics, for example needing to be assessed as having an IQ below 70.

There have been some notable efforts to establish FASD screening methods for people in justice settings. These include training correctional officials to identify FASD, and intensively screening all inmates via medical evaluation. However, there is only one early study where researchers empirically evaluated a screening tool in a correctional environment. [104] There are no validated, standardised methods for screening offenders for FASD in Australia.[105] However, clinical research is continuing efforts to develop such a validated screening tool, including the necessary protocols.[106]

People who are incarcerated are excluded from the National Disability Insurance Scheme (NDIS), Disability Support Pension (DSP), Pharmaceutical Benefits Scheme (PBS) and Medicare. The exclusion of people in prison who have a cognitive disability from essential health and social security supports represents a substantial barrier to getting adequate support, care and protection for their complex needs. Screening, diagnosis and support should be covered and made available for people.

Recommendation 25. Restore eligibility of people in criminal justice systems, (including people with FASD), to universal services, i.e. National Disability Insurance Scheme (NDIS), Disability Support Pension (DSP), Pharmaceutical Benefits Scheme (PBS) and Medicare.

Recommendation 26. Implement mandatory FASD professional development for all justice professionals, within the broader disability context, to improve awareness, understanding and capacity. (States and Territories)

Recommendation 27. Implement adequately funded, neuro-developmental (including FASD) assessment, diagnosis, and support, within the broader disability context, in all youth and adult justice systems by building capacity in community owned and managed organisations. (States and Territories)

Recommendation 28. Design and implement disability specialist courts, modelled on the FASD Court in Manitoba, Canada. These specialist courts would be culturally secure, disability-accommodating (including FASD), and provide diversionary alternatives. (States and Territories)

7. Harmful industries

Commercial determinants

The commercial determinants of health are private sector activities that affect people's health. The private sector influences the social, physical and cultural environments through business actions and societal engagements, including through product design and packaging, marketing, research funding, lobbying, preference shaping and others.[107] Alcohol industry activities operate as key commercial determinants of health. Their actions contribute to high-risk alcohol use, resulting in a range of health and social harms to individuals, families and communities.[108]

The *Rapid Review of Prevention Approaches* notes that it is standard public health practice to regulate or prevent the availability of products that contribute to harm.[109] It also notes that a failure to consider domestic, family and sexual violence in alcohol policy has allowed unprecedented growth in alcohol availability, both in the density of liquor outlets and online delivery hours of operation. The National Cabinet meeting on 6 September 2024 addressed the role that harmful industries play in exacerbating violence.[110]

Industry influence

Addressing commercial determinants of gendered violence includes preventing the policy influence of the alcohol industry and making them accountable for the harms their products cause. Alcohol companies and their lobby groups seek to prevent effective regulation of alcohol marketing and

availability. Research has shown that political donations enable alcohol lobbyists to build long-term relationships with politicians and influence short-term decision making in their favour.[111]

Companies that profit from gambling and alcoholic products and their lobby groups paid more over $2 million to major political parties in the last federal election year, including large sums from groups lobbying for cuts to alcohol taxation. [112] The latest disclosures in February 2024 bring alcohol-related payments to political parties to a total of $16.3 million over the last decade.[113]

Recommendation 29. Include addressing the commercial determinants of alcohol harms in all strategic documents (eg. National Alcohol Strategy), alongside social determinants of health and of alcohol harms.

Recommendation 30. Prohibit political donations from alcohol companies and their lobby groups.

Recommendation 31. Exclude alcohol companies and their lobby groups from the development of laws policies or programs related to alcohol harm reduction.

Conclusion

FARE's submission to the Inquiry into the health impacts of alcohol in Australia, has outlined how the significant and complex intersecting harms that people experience from alcohol can be addressed.

Our recommendations outline the steps that Australian Governments can take to help reduce and prevent alcohol harms by taking a human rights approach that is centred on lived experience. These include evidence-informed recommendations about systemic and preventive reforms, gendered violence, AOD screening and support, FASD and harmful industry reforms.

This will allow Governments to take alcohol harm seriously and prioritise the wellbeing of communities above the profits of alcohol companies.

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