EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
TUESDAY, 11 MAY 2010

SESSION THREE

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 1.05 pm

ALLSOP, PROFESSOR STEVE JOHN
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee I welcome you and thank you for your interest and appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in WA. You have been provided with a copy of the committee's specific terms of reference. The committee is a committee of the Legislative Assembly. This hearing is a formal procedure and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important you understand that any deliberate misleading of the committee may be regarded as contempt of Parliament. As a public hearing, Hansard is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Have you completed the "Details of Witness" form?

Professor Allsop: Yes I have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Professor Allsop: Yes I do.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form?

Professor Allsop: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Professor Allsop: No.

The CHAIRMAN: Please state the capacity in which you appear before the committee today.

Professor Allsop: I am a professor and director of the National Drug Institute at Curtin University. I have a number of other positions. I am also deputy chair of the Drug and Alcohol Office, a member of the child death review panel with the WA Ombudsman, and I am chair of the Council of Capital City Lord Mayors' drug advisory committee. I think that is important in terms of the context of evidence I might give.

The CHAIRMAN: We have a lot of questions for you. We have only an hour and quarter, but we will allow you to present a summary to the committee and then we will ask you some of the questions you have not covered in your presentation.

Professor Allsop: As a summary, I will keep my opening statement quite brief. As I am sure you are aware, alcohol contributes to a range of social, cultural, economic and political pains in our community. Many people might enjoy alcohol—many of us do—but we must also acknowledge its substantial harms. In purely economic terms, one estimate has put that at more than $15 billion across Australia. There is some suggestion that that might be a conservative estimate because some harms are yet to be clearly determined. It is important to mention also that alcohol can have a significant impact on a very large proportion of the Western Australian community. I think some people think that harms arise purely for a small number of very heavy drinkers. But, of course, it is very clear that a large proportion of the population, at least occasionally, will drink in a manner that

is risky for them and for other people. As it is a large proportion of the population, that represents a substantial amount of the harm that actually occurs. Even those of us who do not drink, or who do not drink in a risky manner, are affected by alcohol. There is a significant impact on our policing, on our emergency departments and on our actual and perceived safety in the community. Current harms, irrespective of our own drinking status, affect the whole community. Although it is not well documented, and for the want of a better term, that collateral harm, or alcohol's harm to others, can be experienced by families, friends and members of the broader community. For example, in the National Drug Strategy household survey, which is conducted every three years—there are about 30 000 respondents to it—extrapolating out to the whole population from this survey, which is a reasonable sample, we can estimate that three quarters of a million Australians have been physically abused by someone who has been perceived to be alcohol affected, and more than two million have been put in fear in the previous 12 months by someone who is perceived as being alcohol intoxicated. Other studies are now being conducted around the world. A national group led by a team in Melbourne is developing some work on the impact of alcohol on others, and a New Zealand team is also examining this. That is an area that has not been well documented in the past. That is one reason I suggest that the estimate made by Collins and Lapsley may well be an underestimate.

Some good news is that we have seen a decline in alcohol-related deaths in Australia. It is important to acknowledge that good news. I suspect that a large component of that has been the substantial success we have had with random breath testing, particularly in reducing deaths on the road among young people. Many jurisdictions—I have a document to table for the committee—have seen a large increase in alcohol-related hospital and emergency admissions. Some jurisdictions, such as Victoria, over a 10-year period were seen to have a more than doubled rate of alcohol-related hospital admissions, which is of concern.

[1.10 pm]

The evidence about what influences alcohol consumption and alcohol-related harm is consistent. Availability is a critical lever in relation to alcohol-related harm. We simply cannot make alcohol more readily available though reduced price, increased number of outlets and increased hours of sale without increasing adverse outcomes. The way some people in industry settings and retail settings, and in private settings, make alcohol available is not conducive to good health. There is an often repeated argument that if we liberalise the laws, we will end up with less harm in our community. This argument is not only counter-intuitive but it is also, more importantly, contrary to all the available evidence; and many jurisdictions are finding this to their cost.

While many in the alcohol industry try to do the right thing, some do not. We should obviously support those who try to do the right thing; and hold to account, through our legislative and other procedures, those who do not do the right thing. What I think we need to do is ensure that we have quality intelligence about alcohol use and harm. One of the big problems in the alcohol and drug area is getting a good indication of patterns of use and related harm. For me, this means ensuring that we capture sales data and combine that sales data with better information about the impact of alcohol on policing and emergency admissions. They are particularly likely to be sensitive instruments. The good news is that WA is one of the jurisdictions that actually keep sales data. I would be keen from a national perspective to see all jurisdictions do this. Only when we get such data can we make meaningful decisions about the impact of new outlets, and the impact of increased hours of sale or other changes in policy, and only then can we effectively target our policing and other prevention activities. Only when we have such data about the impact of policy on sales, the impact of policy on policing activity, and the impact of policy on emergency department admissions, and only when we are able to bring that data together, can we have a rational liquor licensing system that takes into account public health and social impacts, and monitor the impact of a policy change. One of the things that we have to do, though, is to ensure that our data is current. A lot of the data is actually hard to extract at the moment—I am talking about nationally now, not just locally—and by the time we have got the data and cleaned it up, it is several years out of date. So

we need to put in the resources to ensure that the data is current, and then liquor licensing decisions can be made on the basis of what is going on now.

We need much more emphasis on prevention. As I have said, for me, prevention is substantially about availability. But it is also about connectiveness for individuals. Good evidence shows that young people who are well connected to their community, well connected to school and well connected to adults are much less likely to develop alcohol and drug-related problems and much less likely to become enmeshed in those problems. That means building early educational engagement with vulnerable populations. It means exploring brief interventions with adolescents who are at risk. We also need to have a better targeting of our interventions to the large majority of people who never come into contact with our helping services. A large proportion of people who are affected by alcohol problems do not come into contact with the services that we have. We have seen a big increase in the availability of these services. We have seen an increase in the number of people using them. But a lot of people who are at risk or currently experiencing harm do not access those services. That means investing in effective strategies that build the capacity of the primary health care services to respond more effectively to alcohol problems. That means investing in the innovative use of technology to better access younger populations. That means investing in the better promotion of a range of pharmocotherapies that have been demonstrated to be effective in helping people who are alcohol dependant. There has not been a good uptake of that in our primary health care services.

Finally, we must ensure, if we are going to do that, that we build the capacity of the health workforce to intervene. Western Australia used to be in the position of having the best workforce development, many would have said, in the country. I think that while there is still some good effort being made, we have seen a falling away in the tertiary education sector—not through the efforts of the Drug and Alcohol Office, but in the tertiary education sector—of students enrolled in what I might call broadly addiction studies. The notable exception is Edith Cowan University, which does have very large numbers of students enrolled in addiction studies. Generally speaking, we have got only modest numbers of students enrolled. So, if we want more GPs, more medical officers, more nurses and more social workers to intervene effectively at a primary care level, we need to invest in developing their expertise.

The other issue that often arises in relation to alcohol and other drugs is people who have co-existing mental health and drug problems. People who are thus affected are much bigger users of the services but have much poorer health outcomes. One of the things for me is that if we want to better manage co-existing mental health and drug problems, as well as have broad investment across the area, for me it is also about a significant investment in mental health. Part of the problem is that people in the mental health services do end up being gatekeepers. One of the reasons for that is the huge demand for services. If we want to improve care for people who are affected by both alcohol and drugs and mental health problems, it is about building the drug and alcohol sector, but, importantly, it is also about building much more capacity in the mental health system.

There are two groups that I want to highlight. I choose these because frequently when alcohol problems are discussed they are aimed to address the issues to do with the young people. We also must take into account the ageing population. Even if we do not see any change in patterns of drinking in people who are over the age of 65, the very fact that we have an increasing ageing population means that we are going to have a substantially increased public health problem. The other issue for me is that in the longer term, one of the things that happens is that people tend to take their drinking histories into their older age with them. So, for example, a female who is now 80 years old, her experience of drinking in her late teens and early twenties would have probably been very little alcohol compared with what is going to happen to the current teenagers and 20-year-olds when they 65, 70, 75 and 80. So it is very likely that the drinking problems and drinking patterns that are occurring now are going to have a significant impact for the ageing population. So we need to address the ageing population. Alcohol can have a significant impact, as well as benefits in terms

of socialisation and quality of life. But with medication use, increased risk of injury and a range of other risks, we do need to address the ageing population, who are often neglected in these debates.

[1.20 pm]

The other is Indigenous Australians. Whilst a large proportion of Indigenous Australians do not drink, amongst those who do drink, many drink at very risky levels, and many of those who do not drink do not drink because of health concerns or because of previous existing alcohol problems. As part of the narrowing of the gap in terms of life expectancy, one of the areas that we must address, along with tobacco use, is actually risky alcohol consumption. Thank you.

The CHAIRMAN: Thank you very much for your presentation. I might start the ball rolling. One of the areas that you addressed was the curriculum. You talked about the health workforce. How involved are you with the curriculum for front-line services—nurses, doctors, Aboriginal health workers; and not just those workers? I do not know what course there is for people from Corrective Services. I know that there is a bill currently on the table looking at cannabis, and I am thinking about people from Corrective Services. When we look at some of our prisons, in our prison up in Broome, unfortunately, most of the occupants are Indigenous people. I was told by the prison officers there that the main reason they are there is alcohol-related problems and that they are often repeat offenders. Therefore, could you maybe discuss both programs and how those health professionals—but it is not just the health professionals. Take it another step further, because I would like to see those Corrective Services officers that we have throughout WA all trained in, I guess, motivational interviewing and stages of change, so that when people who have an alcohol problem or a drug problem go to them, they are the front line. Normally, front-line services for us are the doctors, the nurses and the physiotherapists et cetera, or the GPs, but often the front line for our prisoners, or for people who have been in prison, are the Corrective Services officers. I guess I want to know, firstly, about initial training and how they are getting their experience, and then what is happening with those other people from other agencies who come into contact with people who have these alcohol-related problems.

Professor Allsop: If I could deal with the Corrective Services first and then go to the broader development. I actually share your view about the justice system, Corrective Services and people with alcohol problems, particularly, but not uniquely, Indigenous people. For a significant proportion of people in the criminal justice system, particularly Indigenous people, alcohol has either contributed or is coincident to their admission into the justice system. To not intervene is a lost opportunity. It is a lost opportunity for the individual, and, of course, those individuals go back to their communities, and if they go back to their communities with that lost opportunity, then that does not only have an impact for them; it has an impact on the whole community. There is evidence about strategies that can be effective in the justice system. For me, if we want to reduce reoffending and if we want to improve the quality of life for people leaving the justice system, one of the areas that we have to invest in is health care in relation to alcohol and other drug use. Often, alcohol is actually left out of the other drug use element. Part of it, I understand, is that there are very limited resources within the justice system, so for us to be effective, we do need to invest some resources into the justice system, but downstream that is going to have a significant public health benefit for communities, and it is going to have an impact on the justice system. I think if we want to reduce reoffending and if we want to improve a return to community, then to not invest well, at best, is a lost opportunity and, at worst, it can exacerbate matters for the individual and the community.

In terms of workforce development, there is a substantial amount of effort and activity that goes on in Western Australia. The Drug and Alcohol Office is significantly involved in that, along with partners from the non-government sector. I think that compared with where we were 10 years ago, the workforce development activity is fantastic, but that is particularly in relation to continuing education. I think where we have perhaps fallen back from where we were is in relation to the tertiary education. That is due to a number of factors. Partly it is about competition for space on the

curriculum. If you go to nursing or medicine, they say, "Great idea, but we haven't got room for it." Part of it is to find ways to infiltrate alcohol and drug issues into the curriculum, and there are ways to do that.

The other is about resources. In the days when there was very effective tertiary education in Western Australia, some substantial core funding came from the health department and from the Drug and Alcohol Office that went into Curtin University, resources went into Edith Cowan University, and some resources that were linked to federal funding and the Drug and Alcohol Office went into UWA. Those funds, for a variety of reasons, have dried up. Edith Cowan has continued, largely because it has been successful at getting large numbers of students. It has fallen away somewhat. It still continues, and there are some addiction studies in public health at Curtin and there are some addiction studies in nursing at Curtin and in psychology and so on, but, really, I think that we need to re-examine and put in some modest resources to get some leverage to ensure that we get addiction studies front and foremost in nursing and medicine. After all, if you are going to be working as a GP, if you are going to be working as a nurse in the emergency department, you are going to see a large number of alcohol and drug-related cases, so we need to, I think, lift the game in relation to addiction studies. At the moment it is more piecemeal than it should be. By saying that, I do not mean to offend the excellent work that many people are doing, but I think we need to review and reinvigorate our effort in the tertiary education sector.

The CHAIRMAN: In relation to that, because the tertiary education sector gets federal funding, how could that work? Would that be a case of there being a pre-requisite for certain health professionals—maybe the nursing profession and maybe the medical profession—to have a core component of their curriculum on addiction studies—and maybe not just a core component? Where would they then get the practical experience? Behaviour modification can be taught to people who do not have degrees, so it could be given to these health professionals. Yes, you deal with specialists in this area, but it can be provided to people with, I believe, minimal programs, but they then need to get that practice. I am just thinking of the program that used to be run by Bill Saunders. He used to run an excellent program under which people got that hands-on approach. Again, it is not state funding, but the committee is able to make recommendations to the federal government. So how do you think we should address those deficiencies that currently exist?

Professor Allsop: First, the program to which you refer, which was run by Bill Saunders and John O'Connor—those two positions were funded by the Drug and Alcohol Office and the health department of Western Australia. When that funding ended after a substantial period of time, the programs continued, but eventually, as staff moved, the expertise moved with them and the commitment changed somewhat, and other priorities took precedence within the university. I think you have touched on or you have highlighted all the key issues. You need to address it at a professional level. My experience when I was teaching medical students was that if it was on the exam, they wrote it down. So it needs to be seen as something that we tackle with the professional bodies. It needs to be something that we tackle by perhaps sitting down with the universities and looking at what is needed to get addiction studies within the curriculum.

[1.30 pm]

It might take some modest resources that can be used as leverage. For example, in some of the universities there are a lot of bits of alcohol and drug stuff going on but no individual has responsibility—even on a part-time basis—to coordinate that and to make sure that it is current and to report back to and connect with the Drug and Alcohol Office and the non-government sector. It is about providing some modest resources that can be used to create leverage within the various faculties in the universities to continue to work with the various professional groups to ensure that addiction studies are part of the professional development and to ensure that there is access to quality teaching within the universities and, I should an add, within the TAFE sector, because

various professions utilise TAFE. I believe that alcohol and drugs should be a component of the work of people who do occupational health and safety, for example.

The CHAIRMAN: The committee may need to consider asking those universities about their programs and whether they can incorporate that within their programs. In case I forget to do this later, can you table your initial speech as a submission to this committee? It was a very good presentation.

Professor Allsop: I will if I can tidy it up, because it has some scribbles on it.

The CHAIRMAN: That would be useful so we can put it with our submissions. Before we move off the topic of universities, what about the drinking culture within the universities? How do we address the drinking culture that seems to have developed?

Professor Allsop: A lot of debate in the community over the past couple of years has focused on underage drinking, and we should focus on it, but the heaviest risk is to the 18 to 29-year-olds. The transition from school to work, university or post-secondary education is an important time. A substantial proportion of the people who develop high-risk drinking behaviour at that point in their life will put themselves at risk of developing other problems. Many of them are the decision makers of the future in private enterprise, health and government. We need to invest in that area. Some colleagues of mine at Curtin University received funding from Healthway to develop a brief intervention project on the internet called THRIVE. Please do not ask me to explain what that stands for. I was really impressed by the very large number of students who accessed it. I am talking about thousands of students at one university who voluntarily took part in that project and who were willing to be followed up. The project showed that a very brief intervention had a small but significant impact on alcohol consumption. I have now joined that group and we have been bidding for NHMRC funds to expand it to other universities. It is worthwhile targeting interventions. What we see in our treatment services are people who are severely dependent on drugs and alcohol and who have developed a problem over many years, and we need treatment services for those people. What we do not see are the young people who are drinking very heavily on Friday and Saturday nights but who perhaps are not experiencing some of chronic health concerns that may arise later on. We have not successfully targeted that large number of people, which includes some of our university students and people who have just joined the workforce and who are entering the TAFE system. That would seem to me to be an opportune time to have simple, straightforward interventions. We should also acknowledge, reinforce and support the fact that a significant number of young people do not drink hazardously. As well as targeting those who are drinking in a hazardous way, we need to support those people who make healthy choices in relation to alcohol.

Mr P. ABETZ: Back in 1988, some commonwealth funding was provided to get medical schools to put extra energy into training medicos in addiction studies. What are our universities doing today to train our doctors in addiction studies? When the residents finish their university studies and work in the hospitals and move through different sections, do they move through the Drug and Alcohol Office facilities to get some experience?

Professor Allsop: A very small number of them do. Going back to your first question, I had just arrived in Australia and attended my first meeting when the decision was made to fund a medical school in each jurisdiction. Western Australia was one of the last states to appoint someone. One of the difficulties is who to get to do the training if you have not done the training. Gary, who was going to be here today but is not, was originally appointed with that funding but the funding eventually ended. It was a worthwhile investment. Until then the medical profession had very little interest in alcohol and drugs, notwithstanding the interest of a very small but enthusiastic group that had invested its time and energy in it. We had no formal medical training for staff across the country. As a consequence, we have moved forward substantially to the point at which we have an specialist area in addiction medicine, which is very important for a variety of reasons, including career development, access to funding and so on. It is not the backwater it used to be. That funding

had a significant impact and was well worth the investment. I wish we had done it in nursing and Indigenous health so that we would have 15 or 20 Indigenous people with PhDs in the alcohol and drug area in the next 10 years. When the funding ended, we did not see a return to pre-funding levels. A number of medical schools continued but perhaps not with the same level of effort as they had before simply because of the limited resources, but we have seen the enduring impact of those funds.

Medical trainees do not go through our alcohol and drug services, which is unfortunate. For a period of my life I was working in a psychiatric hospital in the UK that had an alcohol and drug treatment unit. At some point in their career, all the nursing and medical staff rotated through the alcohol and drug treatment unit, which meant that during their training and development, all the staff in the hospital had spent time working with alcohol and drug patients. In addition, there was a small group of specialists who had done more intensive development. It is important to expose more medical and nursing staff to alcohol and drug treatment so that it is seen as a career option and a legitimate part of their role. That would also move us away from some of the marginalisation that occurs in relation to alcohol and drug problems. For better or worse, people with alcohol and drug problems are marginalised in our community. That is one of the biggest barriers we have to provide adequate care. The view that they brought it on themselves actually results in some people using that as a legitimate excuse to not provide quality care. Exposure to the humanity of the condition in the same way that people are exposed to the humanity of other medical conditions such as mental health would be an important strategic move and it would be important in the development of the expertise of the staff so that they could more thoroughly connect with the specialist services and develop their own expertise and see it as a legitimate part of their day-to-day work.

Ms L.L. BAKER: Is the advertising or availability of alcohol the biggest problem?

Professor Allsop: The evidence by far is that the availability of alcohol is the biggest problem. The biggest body of evidence we have is to do with the price and taxation of alcohol. A couple of meta-analyses have been done. Meta-analyses are the highest form of analysis in this area. The meta-analysis indicates that a 10 per cent increase in the price of alcohol leads to a four or five per cent reduction in the consumption of alcohol. The reduction in consumption has a broad impact on the public's health.

[1.40 pm]

The other issue in relation to availability that has been considered is that a number of jurisdictions, for example Scotland at the moment, have been looking at what they call a minimum floor price. The reason is that some concern is being expressed at the very low price of some alcohol products, where one can get a bottle of wine cheaper than a bottle of water—sometimes you will see that advertised. What they suggested in a big review in the UK that came out in *The Lancet* very recently demonstrated that simply adding 40 pence to a standard drink, roughly—I cannot tell you what the value is now because the pound is changing so rapidly against the dollar—has a significant impact on alcohol consumption and alcohol-related harm. Importantly, consideration of a minimum floor price is something that can be looked at at the jurisdictional level and not just as taxation. The important thing is that it has a bigger impact on heavier drinkers. The reason for that is if you have a minimum floor price, it will not make much difference to moderate drinkers' weekly expenditure on alcohol, whereas it will have a big impact on the expenditure on alcohol of heavy drinkers; therefore it has a bigger impact on their overall consumption and related harm. The preferred model that has been suggested is a combination of a price system that we pay more for high alcohol products than we do for lower alcohol products and a floor price. As I say, a minimum floor price is something that can be considered at a jurisdictional level.

In relation to promotions, I think part of the problem is that the evidence is still to some extent catching up with new developments in promotion. What we knew about alcohol promotions 10 years ago with the advent of the internet, sponsorship and so on has changed quite radically. One

view is that alcohol promotions make no impact on alcohol consumption. The problem with that is it is based on probably flawed methodology. Putting it simply, what happens is that most of those analyses capture the whole population and look at the overall expenditure on promotion and they say there is not much impact; in fact—the industry does this in its own promotions—we should actually segment the market. It is likely that the effect of alcohol promotions on a 45-year-old man who has been drinking—I had better not name a particular brand—a particular beer for most of his life is probably not going to be affected very much by alcohol promotions for particular products. Whereas a more naive drinker—a young person—is likely to be more influenced by alcohol promotions. Indeed, the evidence about alcohol promotions does suggest that young people, in particular, who are more exposed to alcohol promotions are more likely to have positive attitudes towards alcohol and are more likely to be consuming higher amounts of it.

The CHAIRMAN: Would this be the debate around alcopops?

Professor Allsop: The evidence is not specifically about alcopops; the issue has been that one of the main driving forces is price. At the end of the 90s, for the so-called alcopops or ready-to-drink alcohol—I think it was in 2000—there was a change to the taxation system and you can actually see a significant increase in alcopop consumption amongst young people subsequent to that change in price. That demonstrates that young people are price sensitive, to the point where Australia is one of the heaviest consumers, as a proportion of overall consumption, of alcopops. Obviously, other people—as the industry will point out—drink ready-to-drink alcohol; there is no doubt about that, but subsequent to that change in taxation, and there have been alcohol promotions, but it was particularly subsequent to the change in taxation, that the consumption of ready-to-drink alcohol went up dramatically. Subsequent to the more recent and contentious change in price, despite a lot of the things that were said about the change in consumption, lots of people were saying all that is happening is people are buying bottles of spirits. The evidence was that occurred in the first three months but after that change there was a decline overall of 91 million standard drinks across Australia being consumed. There was an increase in consumption of spirits and beer, which amounted to an overall increase in 48 million drinks. That leaves a net reduction in consumption of nearly 50 million standard drinks. In other words, in the first three months after the change in price there was a significant decrease in alcohol consumption in Australia. The specific impact on young people has not been evaluated so we cannot make claims that it has or has not had a unique impact on young people, but all the available evidence tell us that young people are price sensitive.

The CHAIRMAN: The previous government introduced a change to the Liquor Control Act. It added section 5(3) to the objects of the act, which reads —

> (3) If, in carrying out any of its functions under this Act, the licensing authority considers that there is any inconsistency between the primary objects referred to in subsection (1) —

Which was the primary object of the act —

> and the secondary objects referred to in subsection (2), the primary objects take precedence.

Could you give the committee the benefit of your opinion in relation to the effect that that has had not only alcohol consumption but licence approval, and objections to licence applications through the Department of Racing, Gaming and Liquor?

Professor Allsop: I can comment on what has happened. I cannot say that this is what happened because of the act, but I can make some statements about what I think. Obviously, the alcohol industry will have a very different perspective from me. I am speaking from a public health perspective. From a public health perspective, for me, alcohol availability matters. It is interesting that when it comes to tobacco it is about availability; when it comes to illicit drugs it is about availability; and when it comes to tobacco it is about availability, but when it comes to alcohol it is

not to do with availability. I find that an interesting argument. I acknowledge all the differences there are between illicit drugs, tobacco and alcohol but, nevertheless, availability matters; the evidence consistently tells us this. For me, given that alcohol is a drug—a drug that many of us might enjoy—public health has to be at the forefront of decisions about how we make alcohol available in the community. Of course, business matters. Of course, economics matters. Of course, employment matters. Of course, the enrichment of our communities and social lives matters. But we cannot make those decisions with public health as a secondary element; it must be a primary element. It is with every other drug, so why would you excuse alcohol or make public health secondary for one of the most commonly used drugs in our community?

We have seen across Australia—not uniquely in Western Australia—a continued liberalisation of a variety of laws. The debate about shopping hours has prevailed in this Parliament for a number of years, and alcohol has been part of that debate but then there have been the specific interests of some members of the community, members of the alcohol industry, the retail industry and so on. We have seen a significant liberalisation in terms of the nature and type of outlets. We have seen an increase in the number of hours. We have seen an increase in the number of outlets.

[1.50 pm]

The evidence, again, is consistent on this: evidence from New South Wales demonstrated that those hotels that had extended trading permits compared with those hotels that did not, and those hotels that had 24-hour licensing, when we examined those hotels in the inner-city area, we found a very significant difference in the amount of violence in and around those premises; those that had longer hours had more violence, acknowledging that those that apply for the licences might be different from those that do not. There was a study done by my colleague in the 1990s; one of the criticisms of that study is that it is old, which is a bit like saying that the theory of relativity is old so therefore we should ignore it. The evidence was very clear: for those hotels that got extended trading permits, compared with those hotels that did not, there was a significant increase in the amount of alcohol-related violence and drink-driving associated with those hotels that had extended trading permits. I would say that we cannot increase the availability of alcohol to the extent that we have without anticipating and experiencing an increase in harm.

We were often told that Victoria's liberalisation of alcohol—it was one of the first states to significantly liberalise alcohol—was a major contributor to sensible drinking and, indeed, in the debate that we recently had in Western Australia, the hand often pointed to Victoria. Over that period, Victoria has experienced this twice the national average of hospitalisations related to alcohol consumption. I will table this document for the committee to look at. It has not, however, experienced twice the hospitalisation rate for non-alcohol related illnesses. There is some reason to argue that part of that is because of the liberalisation of laws in that state. It is not that I suggest we should be going back to six o'clock closing; we need to have some balance, where we can enjoy alcohol and the many benefits that many of us might enjoy—the taste and the conviviality—but at the same time minimise the risks. I question the advantages to the broad community of being open to the extent that we are now—the number of outlets that we are seeing, the proliferation of outlets and the hours that they stay open.

It is to do with other things as well. It is to do with the fact that if some outlets are staying open until four, five or six in the morning, people are tired, there is no public transport to get them home, and there is potential for them to use other substances to stay awake so that they can drink longer. We often hear that it is really other drugs, but of course, some people are using the other drugs in order to drink. These things are inextricably tied up. We often hear arguments that we should point to the European model, but of course, if we go to Barcelona, yes, the pubs are open, but so are bookshops, cafes, bus stops and taxi ranks. It is a night-time economy that is not based around alcohol. I should also point out that those countries in Europe that are often held up as paragons of virtue actually have higher rates of alcohol-related harm than we do. In the past, they have had

lower rates of public intoxication; it was publicly frowned upon, but they are now experiencing what some refer to as the Anglo-Celtic way of drinking amongst young people. Every community has found that increased availability increases harm. We can offset some of those harms by focusing on proper service of alcohol, if it is enforced. Training staff can also be effective, if it is enforced. Enforcement of liquor licensing laws and ensuring that there are other community activities in the area that are not focused around alcohol can offset harms, as can ensuring that there is proper public transport. However, I question what proportion of the community are wanting to drink at six and seven in the morning. All the community pays for that. We hear that it is about tourism; I defy members to go to some of these areas at four and five in the morning and see that it is an issue to do with tourism. Tourism matters; the viability of the alcohol industry matters; and supporting those in the alcohol industry that do the right thing matters, but we also have to give much more importance to public health and to the enormous impact on our emergency departments about policing. We keep hearing that we do not have enough resources in our policing services or enough capacity in our emergency departments. If we were to go to our emergency departments on a Friday, Saturday or many other evenings, we would see that if we were to take alcohol out of the equation, we would have a lot more capacity in those services and our police would be working on many other things.

The CHAIRMAN: Coming back to subsection (3) in relation to the objects to the act, in view of the Victorian experience that you have just described to us, since this was inserted into the act, I have heard that it has made it much more difficult for local communities that want to oppose new liquor licences, both the big guys and the smaller people. Could you maybe comment on that? Several people have certainly suggested to me that this is a retrograde step that and should be removed from the act.

Professor Allsop: I think it should; I think that we also should equip communities. If we expect social impact, public impact and public health to matter, we should equip the communities. One way to do that is through local governments, and that is why I flagged at the beginning that I may be perceived to have a vested interest there, but I think we should be equipping local governments representing their communities and other community groups to have a more effective say in decisions about liquor licensing. I also think, as I said at the beginning, that if we have quality data about alcohol sales, policing and hospitalisations, by making that data are available to the community, we equip them to much better influence liquor licensing. We also need to resource liquor licensing and the police to carry out their enforcement of the liquor licensing laws. I think that we have seen a number of steps; putting public health not as a primary object is, I think, a retrograde step. I think we are moving away from the good resourcing that we had in liquor licensing squads in the police; we are now seeing a reversal of that in many communities. If we want communities to have a better say in these decisions, we need to provide the expertise and the resources. One way of doing that is through local governments, but there are a variety of other ways as well. The first is to make it clear that the primary object of the act is, at the very least, including public health.

The CHAIRMAN: You mentioned earlier data; in fact, we heard earlier today from Mr Dillon, who is the acting director of the Drug and Alcohol Office, how useful that data was and how WA collects that data, and that the Northern Territory and South Australia are moving to do so also.

Professor Allsop: Queensland and South Australia had it as part of their election commitments.

The CHAIRMAN: Do you initially collect that data, or do the police collect it? It sounds like it is very useful data, but I was trying to pinpoint where that data goes, because I would like to look at that data from five years ago and 10 years ago, so that we as a committee can see what trends have emerged. Can you tell us a bit more about that data collection?

Professor Allsop: Yes, that data was collected nationally. When states gathered taxes, states had an interest in alcohol and therefore in that data. The data is available out there; at the end of the day, they are till receipts! The industry has that data. Basically, it was the industry reporting sales to state

government representatives, and obviously there was an interest in them from a tax perspective. There were changes to the legislation as a result of a High Court decision; we do not need to go into that, but most of the jurisdictions stop collecting the data, with the exception of the Northern Territory, Western Australia and Queensland. Over recent years, it has become recognised for the incredible public health tool that it is.

[2.00 pm]

We spend lots of money trying to gather data about illicit drug consumption. It is very hard because it is a hidden behaviour. Trying to get quality intelligence about patterns of illicit drug use is seen as being at the forefront of responding to illicit drug problems.

When it comes to alcohol, largely, nationally, we have a household survey that relies on people reporting how much they have consumed. The evidence tells us that at best it accounts for about 60 per cent of all the alcohol consumed. People underestimate it or the heavy drinkers are not in when you do the survey; they are elsewhere. Obviously, sales data is an incredible tool because it can tell you, down to the postcode, where alcohol has been sold depending on the way it is collected. There are some criticisms and limitations of this data. More and more people are buying alcohol over the internet and so on but most of it is still purchased and consumed at that local level. It tells you how much alcohol is being consumed. In combination with the Drug and Alcohol Office, the National Drug Research Institute is looking at how we can best analyse and use this data to produce quality reports. That is funded by the commonwealth. Our hope at the National Drug Research Institute is that we do reinstate these data nationally but we have to negotiate the value, and that is what we are doing at the moment. For example, Western Australia recently did some work looking at the impact of increased outlet density and the impact of adding an extra five bottle shops and three hotels. We were able to do that analysis in Western Australia simply because we had sales data. We could say what the average sales were in these areas. We could do not that analysis in other jurisdictions because they did not have sales data. We simply could not do the analysis.

Ms L.L. BAKER: Is that information ever used in the public interest test for issuing of liquor licenses?

Professor Allsop: We are developing a model that would allow that to happen. That is what we are working on at the moment. You would have the sales data but we do not have quality information about the impact of alcohol on emergency department admissions. At the moment, again in collaboration with the Drug and Alcohol office, we are developing an approach that will allow us to do that. In the past these research studies have employed a couple of nurses or researchers who have stayed in a hospital and asked people questions about their alcohol when they come in. It is very expensive. As soon as you remove the staff, it falls away. We are proposing what are called etiologic fractions where you basically estimate the contribution of alcohol to a particular condition. For example, the etiologic fraction for liver cirrhosis is nearly one. In other words, nearly all liver cirrhosis is caused by alcohol, whereas the etiologic fraction for a broken toe might be 0.01. We have etiologic fractions for hospitalisations. We do not have etiologic fractions for emergency department admissions. We are hoping to develop them, again in collaboration with the Drug and Alcohol Office funded by the commonwealth. The idea would be that we could overlay those etiologic fractions on the emergency department admissions data. If the etiologic fraction for a broken arm is 0.5 and we have had 100 broken arms, we could calculate the cost at the current time with some degree of currency. Again, we are trying to develop that system so that we would have sales data, the local hospital emergency department alcohol contributions and the other one that I would be interested in is police having a simple measure of alcohol's contribution to their work. If you make that data available to local decisions about liquor licensing, you can actually say, "Here's alcohol consumption in our area and here's the harm on two of the more sensitive measures—policing activity and emergency department admissions."

There is another thing that we need to be mindful of in calculating alcohol consumption. We are frequently reminded that alcohol consumption across Australia has been relatively flat over the past decade. We may need to re-examine that data. In Australia and elsewhere it has been evident that the estimation of the alcohol content in wine is below 11 per cent. If you invite me to go into your local bottle shop and look at the alcohol content of wine, it is often around 13.5 to 14.5 per cent. Wine consumption is a very large part of alcohol consumption in Australia. This is not a unique phenomenon. The alcohol content of wine has been increasing in many countries or is at higher levels than is used in the calculations. It is possible—we need to do this reanalysis—that we may find that alcohol consumption has not been level; it has been increasing. We need to get those things right so that communities can have current data. The advantage of those systems is that whilst there is some cost in establishing them, the cost of maintaining them is relatively modest.

The CHAIRMAN: I had a couple of questions but you have probably answered one of them. I was going to ask you about the increase in the number of people drinking at risky levels. From what you just said, it appears that because the data that has been collected has been based on an inaccurate recording of the percentage of alcohol in drinks, we would not really have a true level. I know that you have also questioned in the past what is risky drinking amongst the young. Could you perhaps elaborate on those comments and your concerns in that area?

Professor Allsop: In relation to the young, are you talking about the under aged?

The CHAIRMAN: You have said there is a poor understanding of what levels of use are risky for young people. In your opinion, what constitutes risky drinking for young people? We heard earlier today statistics on the number of children who were drinking from the age of 14.

Professor Allsop: I should preface this by saying that I was one of the NHMRC working party involved in the establishment of the new Australian guidelines. Whilst we can make some good assessment of low risk and high risk drinking for adults, above the age of 65 we do not have good data to make those assumptions. That data is based on adults. I could best sum it up by putting on two hats, one as a father and one as a scientist. As a scientist, the evidence has been accumulating that a young person's brain is developing up to about the age of 25 and, increasingly, because of improved techniques and improved systems of assessment, we have begun to identify some risks for the developing brain. I am not now talking about very, very heavy drinking; I am talking about high levels of drinking that would not necessarily be classed as dependent levels of drinking. Some of the harm appears to be quite subtle. As one of my colleagues put it, it might be the difference between getting a B plus and a C plus. It is not overt cognitive impairment that is obvious; it is much more subtle—impairment of capacity.

The criticism would be that a lot of this research is on relatively small numbers. It is emerging research and quite a bit of it is on animals. Yes, on the basis of the science, I think that we need to be cautious in overstating the case. As a father, it has changed my views of my children. I often say this in public. I was of the mind that children do not get drinking skills wrapped at the bottom of their beds when they turn 18 and perhaps we need to help develop those skills. Some people point to the European style of allowing access to small amounts of alcohol.

[2.10 pm]

I changed from that view, as a father, to one who encouraged my children to delay the onset of drinking. I guess that is the best way I can sum up my position on that. My view would be consistent with the NHMRC, which is at 15 and below young people should not be drinking. From 16 to 17, the best advice is to avoid drinking, delay drinking, but if you are going to drink then drink in the presence of adults and drink no more than the recommended amounts for adults, which is no more than two on a regular basis and no more than four on a single occasion. But my preference would be to delay the onset of drinking at least until they are the legal purchase age.

The CHAIRMAN: My final question for you is the wish list question. What new initiatives do you think the WA government could consider to reduce the risk and manage harm in relation to alcohol consumption? If there were a pot of gold on the table, where do you think that money should go?

Professor Allsop: Some of it will not cost the government anything. I am going to sound like somebody who is selling a house: it is about availability, availability, availability. So I think we do actually need to sit down and review—as a community, not listening to Allsop—how much availability we want in our community. How many outlets? What sort of outlets? What hours of sale? If we are extending hours, what are the risks that that creates and how do we mitigate those risks—for example, by adequate transport? If we want to have better investment in prevention, and we must because most of the effort goes into treatment, availability is where I would first start.

I would also look at building resources in vulnerable communities—for example, some of the Indigenous communities—about just simply getting people into connecting with their schools and their community. Young people who are thus connected are much less at risk of developing a range of harms. There are some very good predictors of risk of alcohol and drug-related problems. Conduct disorder is a predictor; let us start investing some effort in that area. A lot of schoolteachers will be able to tell you who the children are at risk, so let us engage them much more effectively within our schools. In fact, it is not about turning up to school; it is about social and academic confidence. There are programs that are doing that and they are not drug specific, so I would like to see more resources go into those programs.

I would like to see more emphasis going on Indigenous health because things are probably getting worse there, not better; not just in relation to alcohol, but in relation to a range of other drugs. In relation to other drugs in general, things are probably getting a bit better.

We need to think about strategies that engage the at-risk drinkers, not wait for them to get so dependent that they are willing to enter our treatment services. That means putting additional resources into our primary healthcare services. The evidence about brief interventions is consistent and overwhelming; if we do brief interventions, we will have a significant impact on alcohol, tobacco and illicit drugs. But GPs have been underwhelmed in terms of their capacity, if you like, to embrace the interventions. I think part of that is we are asking GPs to be everything to everybody, so we need to actually put some resources into our primary healthcare services. I believe that tonight we might hear about some resources about general support to our primary health care services, but we should actually have some that are specific to alcohol and drugs in GP practices and in our primary healthcare services that respond to Indigenous people.

I would want to see some additional resources going into the justice system, so that we do not lose this huge opportunity to have an impact on people's health when they are in those circumstances and often who come out of the criminal justice system worse, certainly not better.

I would like to see some substantial additional resources go into shared care. One of the problems for GPs is that they refer somebody to a specialist service and they do not hear back from them. So we actually need to have some modest resources that help shared care across our emergency departments, our hospital system, our primary healthcare system, our drug specialist services and our mental health services.

We must put additional resources into our hospitals. Lots of people who are at risk of drinking end up in our hospital services. That is a great opportunity to intervene. There are some additional resources that went into hospitals in relation to amphetamines. I think if we were to boost them in relation to alcohol—Gary Hulse did some work with a colleague a number of years ago in Western Australian hospitals where a simple brief intervention for young people who were identified with an alcohol problem, had a significant downstream impact. What you end up with is fewer readmissions, it is cost efficient, so some small additional resources into our hospitals to boost their investment and involvement in brief interventions.

I am a researcher so I would like to see some modest resources go in to ensuring that we have the data that will allow our communities to recognise the risks and harms that can arise from policy decisions that affect them. If we do not do that, then we are not equipping our community to be on an equal footing with those who have a vested interest.

Mr P. ABETZ: The papers you referred to, like the long hours leading to more violence and that, is that published data that is readily available for us?

Professor Allsop: Yes.

Mr P. ABETZ: Would you be able by way of supplementary information to just perhaps forward that to the committee because that would be very useful for us to have.

Professor Allsop: I have a couple of things that might be useful. I have a report on the hospitalisations. I have three copies of that, if I can table those.

The CHAIRMAN: Yes, thank you.

Professor Allsop: I have a summary that colleagues of mine did in relation to all the evidence about the restrictions on the sale and supply of alcohol. I appreciate that you are very busy people but there is an executive summary that summarises it all and does have reference to all the papers that I have referred to.

This document I am holding is from 2004, so data has come out since, but it still summarises the best available evidence. This is not something you would read, it is a reference text, but the summary guides you through the key evidence produced by colleagues of mine on prevention in relation to alcohol and other drugs. The other papers I referred to, I will make sure I make available to you.

The CHAIRMAN: Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. You agreed to provide us with a neater version of your initial submission.

That finishes the hearing. Thank you very much.

Hearing concluded at 2.17 pm