

Tasmanian Alcohol Action Plan 2009 – 2014

DRAFT FOR CONSULTATION

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1 Foreword

The Foreword is yet to be written. It will be written at the conclusion of the consultation phase and will be an address from the Hon Lara Giddings, Deputy Premier, Attorney General, Minister for Justice and Minister for Health.

2 Executive Summary

Alcohol is the most widely used psychoactive, or mood-changing, recreational drug used in Australia. Alcohol-related harm impacts significantly across a wide range of areas including personal and public safety; property damage; road accidents including deaths; law enforcement; workforce productivity; and healthcare services including ambulances, hospitals and treatment services. The economic, social, legal and health costs of alcohol misuse are significant and affect all aspects of the Tasmanian community.

The *Tasmanian Alcohol Action Plan 2009-2014* (the Plan) is one of three initiatives under the *Tasmanian Drug Strategy 2005-2009* (TDS) framework. The TDS identifies three priorities in responding to the use of alcohol, tobacco and other drugs in the Tasmanian community: community safety; prevention and reduction; and improved access to quality treatment.

The Plan sets out to provide a policy framework for a collaborative and partnership approach to minimising the harms to and improving the safety of all Tasmanians arising from the use of alcohol, and to guide the development of activities to reduce the harms associated with the misuse of alcohol in Tasmania. Its aims to build upon the number of significant initiatives already undertaken as a result of close cooperation between State Government agencies and non-government organisations and services and with local government.

The strategic policy framework for the Plan includes the Tasmania *Together* Goal 2: 'Confident, friendly and safe communities'; the *Tasmania Drug Strategy 2005-2009*; the *National Drug Strategy 2004-2009*; the *National Alcohol Strategy 2006-2009*; the National Binge Drinking Strategy; and the work of the National Preventative Health Taskforce in developing the National Preventative Health Strategy of which alcohol-related harm is one component.

The Plan has been developed within the context of a policy framework which is presently undergoing significant review nationally. The future practical application and implementation of specific actions to achieve the Plan's objectives and recommended responses will also be informed by those national changes.

The focus is on long term change across government, industry, other stakeholders and the wider Tasmanian community. The Plan has been developed on the basis of the need for individuals, families, communities, and government and non government bodies to work together to address alcohol misuse. The identified priority areas and recommended responses are not the responsibility of Government alone, but are actions for all Tasmanians.

The four (4) priority areas of the Plan are:

1. Public safety and amenity
2. Intoxication
3. Health of the population
4. High risk groups

The Executive Summary will be finalised at the conclusion of the consultation process as part of the final Plan, and will incorporate the final priority areas and recommended responses.

3 Introduction

Alcohol is the most widely used psychoactive, or mood-changing, recreational drug used in Australia. The consumption of alcohol is an accepted part of our culture, our socialising and relaxation. Heavy drinking is part of our folk lore. However from a public health and safety perspective, the wide acceptance of alcohol as an intoxicating and toxic substance is of increasing concern.

Alcohol-related harm impacts significantly across many areas. Barbor et al contend that alcohol is no ordinary commodity¹. Alcoholic beverages are an important economically embedded commodity with its production and sale generating profits for farmers, manufacturers, advertisers and investors; providing employment across a range of industries; and generating taxation revenues for governments. However, the sale and use of alcoholic beverages as a commodity comes at an enormous cost to society.

The total health, economic and crime costs rising from the misuse of alcohol was estimated in 2004-05 in Australia to be \$15.3 billion². A recent National Drug Law Enforcement Research Fund report makes the point that *'There are few, if any, other commodities which exact such social and health costs, which are tolerated by the Australian community to the same extent as alcohol'*³.

Alcohol-related harm impacts across a wide range of areas including personal and public safety; public nuisance; property damage; road accidents including deaths; law enforcement; workforce productivity; and healthcare services including ambulances, hospitals and treatment services. The economic, social, legal and health costs of alcohol misuse are significant and affect all aspects of the Tasmanian community.

Tasmania is not immune to alcohol-related harm, with the cost to the Tasmanian community being significant. The background section which follows provides an overview of the impacts of the misuse of alcohol on the Tasmanian community.

4 Background – Why do we need an Alcohol Action Plan?

The purpose of the Tasmanian Alcohol Action Plan (the Plan) is to provide a policy framework to guide the development of activities to reduce the social harms associated with the misuse of alcohol in Tasmania.

The impacts of the misuse of alcohol on the Tasmanian community are significant. Tasmania Police report⁴ that in Tasmania during 2007-08:

- 1,194 family violence offenders and 552 victims reported being affected by alcohol;
- 4,865 drivers exceeded prescribed alcohol limits;
- alcohol is a factor in 25% of fatal crashes;
- of the 1,185 public place assaults, a significant proportion of offenders were affected by alcohol; 50% were committed by a stranger; 40% occurred on Friday and Saturday evening; most occurred at or near a licensed premise; and there is an increasing trend of females offenders and victims;
- 2,350 liquor infringement notices were issued and there were 1,351 instances of liquor confiscations; and
- 1,171 people were detained in custody for drunkenness and 266 detained due to level of intoxication

In addition:

- The proportion of Tasmanian adults drinking at levels with a high risk for long term harm has almost doubled over the last ten years in Tasmania, with 11.5% of the adult population currently consuming alcohol at these levels. Since 1995, the proportion of Tasmanian adults drinking at medium risk levels has increased from 4.2% to 7.1%, whilst those drinking at high risk levels have risen from 2.7% to 4.4%⁵.
- Tasmania's rates for deaths caused by alcohol consumption for young people aged 15-24 years are the third highest of all jurisdictions (at 1.2 per 10,000 population)⁶.
- In 2006, 19.2% of all serious casualties in Tasmania involved alcohol as a crash factor. In 2007, this proportion was 23.5%. In the same year, alcohol was implicated in 41 serious casualties (31.1%) involving drivers aged 17-29 years. Of those, the majority (51%) involved young people under 21 years⁶.
- Tasmania has the highest proportion of young people who drink alcohol at risky or high risk levels (19.8%), well above the Australian proportion of 15.3%⁶.

Appendix A provides more detailed Tasmanian Alcohol Trends.

Appendix B outlines the national and international framework.

5 What has been achieved to date?

In July 2008, the Minister for Police and Emergency Management convened a Tasmanian Alcohol Forum. Well attended by key stakeholders from industry, government and non government and community, the Forum provided an opportunity to discuss and consider strategies to enhance public safety and reduce alcohol-related incidents, crime and anti-social behaviour.

Whilst Tasmania has not previously developed nor implemented a strategic policy framework specifically to address alcohol-related harm, a number of significant initiatives have been undertaken as a result of close cooperation between many agencies, services and between state and local government.

Regulatory and legislative related initiatives include:

- Amendments to the *Liquor Licensing Act 1990* increasing penalties for the sale and supply of liquor to young person and to persons who appear to be drunk.
- Under the *Liquor Licensing Act 1990* changes to the requirements for successful completion of a Responsible Service of Alcohol (RSA) course, and requirement for licensees to keep a RSA register.
- Amendments to the *Police Offences Act 1935* prohibiting the consumption of alcohol in prescribed public places during prescribed days and times.
- Amendments to the *Marine Safety (Misuse of Alcohol) Regulations 2006* allowing breath-testing of operators of marine vessels.
- Amendments under the *Road Safety (Alcohol and Drugs) Act 1970* enabling the immediate disqualification of repeat drink drivers and those exceeding .15 blood alcohol content.
- Regional forums are conducted around the State with licensees and key staff to provide information on legislation, licensing policy and RSA, and to discuss issues.
- Representatives of the Commissioner for Licensing have met with all Australian Rules Football Associations administrators to discuss issues relating to the service and supply of alcohol.
- A strategy has been adopted by the Commissioner for Licensing for the conduct of major events, eg sporting, entertainment, wine and food festivals.
- The spiking of a persons drink is now prohibited under the *Police Offences Act 1935*. Statewide distribution of the National Drink Spiking Project materials has occurred.

Local Government and intra-government initiatives include:

- Late night trading agreements have been introduced in Launceston and Hobart.
- The Burnie Liquor Accord introduced in 2008 is the first liquor accord to be trialled in Tasmania.
- The *Who's Des Driver?* Program involving Burnie City Council, Tasmanian Police and the local community.

- The Lighthouse *Can Do Will Do Project* in the Devonport area.
- Activities in the Kingborough area including the *Road Show*; young men's groups; outreach services at Yspace Youth Centre; and development of best practice *Safe Partying* program.
- Funding provided to the King Island Council under the first round funding of the National Binge Drinking Strategy to provide alcohol-free venues for youth related activities.

(Other) Intervention initiatives include:

- Distribution of the '*National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*'.
- Establishment of the Inter-Agency Support Teams (IAST) statewide.
- Development of the *Population Alcohol Strategies: Primary and Secondary Prevention of Alcohol Related Harms - Summary of Future Directions Report (2008)*.
- Development of tri-annual Alcohol Trends Fact Sheets.
- Provision of advice to the Australia and New Zealand Food Regulation Ministerial Council regarding the placement of mandatory health warning on packaged alcohol by Population Health with the Department of Health and Human Services.
- Establishment of the Tasmania Police Public Order Response Teams (PORT) in each of the four geographic districts.
- Support and promotion of the *Party Safe* initiative.
- The "*Just like that*" social marketing campaigns.
- A review of the alcohol, tobacco and other drugs services sector, with the development of a 5 year Future Service Directions Plan, with additional funding commitment over the next four years.
- 1st National Conference on Foetal Alcohol Spectrum Disorder facilitated by the Drug Education Network (DEN), and establishment of a Prenatal Exposure to Alcohol National Clearinghouse.
- Development by the DEN of a booklet for GPs to increase knowledge and awareness of pharmacotherapies and treatment of alcohol dependence.

Appendix C provides more detail on these recent achievements.

6 Policy and Legislative Framework

The Tasmanian Drug Strategy 2005-2009 identifies the need for a coherent approach and consistency at national, state and local levels. Alcohol policy and responses, and legislative and regulatory frameworks play a significant role in defining the scope of the Plan and the context in which the priority areas and recommended responses will be actioned.

The Plan will provide a framework for a collaborative and partnership approach to minimising the harms to and improving the safety of the Tasmanian community arising from the use of alcohol. The strategies and priority areas in the Plan will be evidence based, and align to existing strategic policy and directions, including:

- Tasmania *Together*
- Tasmanian Drug Strategy 2005-2009
- A Social Inclusion Strategy for Tasmania (under development)
- National Drug Strategy 2004-2009
- National Alcohol Strategy 2006-2009
- National Binge Drinking Strategy
- National Preventative Health Strategy (under development)
- National Aboriginal and Torres Strait Islander Complementary Action Plan 2003-2009
- National Corrections Drug Strategy 2006-2009
- The Ministerial Council on Drug Strategy report to the Council of Australian Governments on options to reduce binge drinking (under development)

For a detailed examination of each of these policy directions, see **Appendix D**.

The Plan is also linked to a specific legislative framework, and this must be taken into account when establishing new strategic priority areas. An important component of the Tasmanian Alcohol Action Plan will be to ensure that legislative frameworks in Tasmania are strengthened in response to the harms experienced from the availability, sale and consumption of alcohol. Legislation that currently informs or provides a legislative framework for the Plan includes:

- Liquor Licensing Act 1990
- Police Offences Act 1935
- Road Safety (Alcohol and Drugs) Act 1970
- Youth Justice Act 1977
- Alcohol and Drug Dependency Act 1968
- Family Violence Act 2004
- Guardianship and Administration Act 1995
- The Marine Safety (Misuse of Alcohol) Regulations 2006
- Children, Young Persons and Their Families Act 1997
- Land Use Planning Approvals Act 1993
- Public Health Act 1997

For a detailed examination of each of these, see **Appendix E**.

7 Key Strategic Directions

7.1 Goal and aims

The goal of the plan is to develop, implement and measure the effectiveness of strategies to reduce the human, health, economic and social costs associated with the misuse of alcohol in Tasmania.

Aims

The aims of the Plan will be consistent with the aims of the *Tasmanian Drug Strategy 2005-2009* which are to:

- Reduce the incidence of mortality and morbidity related to the misuse of alcohol;
- Reduce the level of social, economic, health and legal costs related to the misuse of alcohol;
- Reduce the incidence of violence, including family violence, disruption, antisocial behaviour and crime related to the misuse of alcohol; and
- Reduce the incidence of harmful alcohol use in the Tasmanian community.

7.2 Priority Areas and Recommended Responses

The four (4) priority areas of the Plan are:

1. Public safety and amenity
2. Intoxication
3. Health of the population
4. High risk groups

The priority areas and recommended responses are linked to the *Tasmania Together* standards and indicators and to the *Tasmanian Drug Strategy 2005-2009*. They are also strongly linked to the *National Alcohol Strategy 2006-2009* which has as its goal 'to prevent and minimise alcohol-related harm to individuals, families and communities in the context of developing safer and healthy drinking cultures in Australia.'

The following six principles have been identified in the *Tasmanian Drug Strategy 2005-2009* as the basis for priorities and suggested actions. These principles will likewise provide the basis for the priorities and suggested actions in this Plan. Those principles are:

- > Partnerships and collaborative effort are essential in shaping our responses to drug use across the community.
- > Building capacity in the community and the alcohol and other drugs sector is fundamental in addressing drug use.

- > The concept of harm minimisation underpins our practice and philosophy.
- > Prevention and early intervention are critical in responding to drug use.
- > Equity of access to evidence-based service delivery is fundamental
- > Research, data collection and evaluation are critical elements for increasing understanding of and improving responsiveness to emerging trends.

To monitor and evaluate progress against the identified priority areas, objectives and recommended actions the Inter Agency Working Group on Drugs on behalf of Government will ensure the development of and reporting to Annual Implementation Plans. These will consider the range of recommended responses in the Plan, and the progress of inter-related National alcohol policy initiatives.

Of particular importance will be consideration of and Tasmanian appropriate responses to the final proposals, options and timelines for action agreed to by the Council of Australian Governments arising from the Ministerial Council on Drug Strategy report on options to reduce binge drinking.

Priority Area 1: Public safety and amenity

Goal 2 of Tasmania *Together* is confident, friendly and safe communities. The *Tasmanian Drug Strategy 2005-2009* identifies that the use of alcohol and other drugs has a major impact on the health and community safety of Tasmanians. Community Safety is one of three priorities of the Tasmanian Drug Strategy. Priority Area 2 of the National Alcohol Strategy is Public Safety and Amenity, its aim being to enhance public safety and amenity at times and in places where alcohol is consumed.

Priority Objectives

- 1.1 Prevent and reduce the community safety consequences of the misuse of alcohol
- 1.2 Increase public awareness of alcohol-related social harms
- 1.3 Increase the capacity of communities to respond to alcohol-related public health and safety issues

Recommended Actions

- 1 (a) Identify additional legislative strategies to respond to emerging issues (such as secondary supply to minors)
- 1 (b) Review current legislation for drink driving offences
- 1 (c) Improve support for brief interventions and other treatments for repeat drink driving offences
- 1 (d) Develop strategies to enhance the capacity of local government and communities to respond to alcohol-related social harms
- 1 (e) Investigate strategies to increase the integration between planning processes and liquor licensing arrangements

- 1 (f) Develop and implement proactive broad and multi-tiered social marketing campaigns

Priority Area 2: Intoxication

The National Alcohol Strategy ⁷ notes that drinking to intoxication is a major cause of short term alcohol-related harm, which can result in increased injury and death, verbal abuse, violence, motor vehicle accidents, and drownings. The effects of levels of intoxication have a corresponding effect on all aspects of the Tasmanian community. The Royal Hobart Hospital, Department of Emergency Management reports that alcohol-related presentations due to intoxication have been steadily increasing. Associated with such presentations are severe trauma; assault; and minor injuries.

Priority Objectives

- 2.1 Reduce the incidence of drinking to intoxication
- 2.2 Reduce the adverse health and social harms resulting from intoxication

Recommended Actions

- 2 (a) Assess the impact of recent changes to liquor licensing laws and regulations on the levels of intoxication, utilising police, health and community perceptions
- 2 (b) Increase community education regarding the unacceptability of intoxicated behaviour
- 2 (c) Review responsible service of alcohol and the Responsible Service of Alcohol (RSA) program to ensure current and ongoing consistency with the national frameworks
- 2 (d) Review current liquor licensing arrangements, legislation and regulation to ensure current and ongoing consistency with the national frameworks
- 2 (e) Develop strategies to enhance data collection and collation to inform alcohol use trends
- 2 (g) Develop and implement strategies to reduce alcohol-related deaths, accidents and injuries (particularly those related to workplaces)
- 2 (h) Consider, and where appropriate to the Tasmanian environment, support National initiatives aimed at reducing the levels of and harms from intoxication

Priority Area 3: Health of the Population

Some research exists on the positive health benefits of moderate alcohol consumption. However, both the short and long term adverse health impacts resulting from the misuse of alcohol are well documented. Alcohol consumption accounts for 3.2% of the total burden of disease and injury in Australia; it has been causally linked to more than 60 different medical conditions and was linked to 3,430 deaths per year⁸. Long-term patterns of high alcohol consumption resulting in health

events such as stroke and sudden cardiac death have been shown to have the greatest proportion of the burden of disease overall. Many of these harms are largely preventable.

Priority Objectives

- 3.1 Improve health outcomes
- 3.2 Reduce the incidence of preventable alcohol-related chronic conditions
- 3.3 Improve the range of and access to treatment interventions

Recommended Actions

- 3 (a) Increase community awareness of alcohol-related harms
- 3 (b) Support the development of a sustainable approach to the monitoring and analysis of alcohol-related trends including consumption levels, patterns of drinking, and related harms, and the regular production and dissemination of this information
- 3 (c) Review current legislative and regulatory frameworks to strengthen consistency in relation to the availability, control and use of alcohol, with the specific aim to promote the health of the Tasmanian community consistent with the intent of the Public Health Act 1997
- 3 (d) Consider and where appropriate to the Tasmanian environment support National population based prevention initiatives in line with the National Health Preventative Health Strategy under development by the Preventative Health Taskforce, including consideration of the development of a Tasmanian Alcohol Prevention Strategy
- 3 (e) Enhance access to, and the range and type of, evidence-based alcohol treatment interventions
- 3 (f) Develop strategies to reduce barriers to access to treatment interventions and services
- 3 (g) Develop strategies to enhance the capacity of the health services workforce across the primary, secondary and tertiary continuum to address alcohol-related harms, particularly promotion, prevention and early intervention
- 3 (h) Investigate a range of possible alcohol screening/assessment and brief interventions with a view to developing and implementing appropriate programs in Tasmania

Priority Area 4: High Risk Groups

Pregnant women, Aborigines, young people, poly-drug users and prisoners have been identified as particularly at risk, and a focus of the Plan. The rationale for the identification of each of these high risk groups is detailed in **Appendix F**.

Priority Objectives

- 4.1 Reduce the uptake and onset of high risk alcohol consumption, particularly amongst high risk groups

- 4.2 Enhance existing and establishing new partnership programs aimed at supporting early childhood interventions and building resilience
- 4.3 Enhance access to targeted evidence-based treatment interventions for high risk groups
- 4.4 Develop strategies to reduce barriers to access to treatment interventions for high risk groups

Recommended Actions

- 4 (a) Support existing and develop new strategies and programs targeting early childhood interventions and supporting families
- 4 (b) Develop, implement and monitor strategies and interventions targeting under-age drinking
- 4 (c) Develop, implement and monitor strategies targeting youth drinking more generally
- 4 (d) Work with the Tasmanian Aboriginal community and organisations to review current and develop new strategies consistent with the *Aboriginal and Torres Strait Islander Complementary Action Plan 2003-2009*
- 4 (e) Develop and implement professional development programs for people working or coming into contact with high risk groups, specifically around identification of risky use of alcohol (for example community health centre staff, other health professionals, those working in the education system, ambulance officers)
- 4 (f) Support the development and implementation of a Tasmanian response to the *National Corrections Drug Strategy 2006-2009*
- 4 (g) Develop strategies and programs for enhancement of evidence-based school alcohol education within a schools-based alcohol policy context
- 4 (h) Develop targeted community awareness raising, education and resources for high risk groups
- 4 (i) Establish appropriate prevention and intervention strategies targeting alcohol use in pregnancy

8 Where to from here?

8.1 Development of the Tasmanian Alcohol Advisory Group

An Alcohol Advisory Group will be convened as the principal advisory body to the Inter Agency Working Group on Drugs (IAWGD) on alcohol related matters. Its primary purpose will be to develop, implement, monitor and report against an annual Implementation Plan for each year of the life of the Tasmanian Alcohol Action Plan 2009-2014.

8.2 Implementation

The IAWGD, under advice of the Alcohol Advisory Group, will consider each of the Plans identified priority areas objectives and recommended actions; and the progress of inter-related National initiatives to determine annual priorities for Tasmania. The Alcohol Advisory Group will be responsible to develop and implement annual Implementation Plans for each year of the Plan, and to report annually to the IAWGD on progress.

The annual Implementation Plans will outline specific actions to be undertaken and the lead and partner agencies/organisations that will be required to report annually to the IAWGD on progress.

8.3 Monitoring and Evaluation

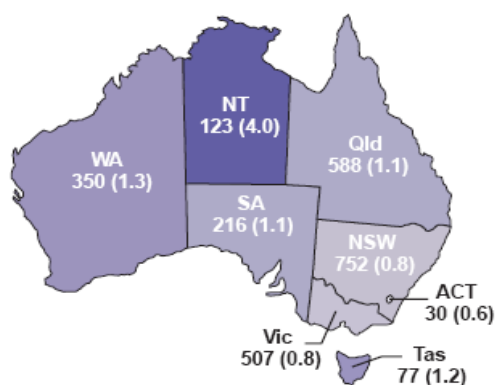
The IAWGD will be directly responsible for the overall implementation of the Plan and each successive annual Implementation Plan, and will report to Government through the Minister for Health.

Each annual Implementation Plan will be reviewed no later than two (2) months prior to its expiration, and a formal evaluation of the effectiveness of the Tasmanian Alcohol Action Plan 2009-2014 will be undertaken during the last year.

Appendix A: Tasmanian Alcohol Trends⁹

Data for deaths caused by alcohol consumption for young people aged 15-24 years are available from by the National Drug Research Institute. Tasmania's rates are the third highest of all jurisdictions at 1.2 per 10,000 population.

Estimated Number of Deaths Attributed to Alcohol, 15-24 Years by Jurisdiction, 1993-2002 (per 10,000)



NDRI, National Alcohol Indicators, November 2004

Data are also available for under-age drinkers. From 1993 to 2002, an estimated 0.60 per 10,000 Tasmanians aged 14-17 years died as a result of injury or disease caused by alcohol consumption, again the third highest rate of all jurisdictions.

Alcohol, speed, inattentiveness, and inexperience are the leading crash factors resulting in serious casualties, according to road crash statistics collected by the Department of Infrastructure, Energy and Resources. In 2006, 19.2% of all serious casualties in Tasmania involved alcohol as a crash factor. In 2007, this proportion was 23.5%.

Serious Casualties* Involving Alcohol as a Crash Factor, Tasmania, 2006 and 2007

	2006	2007
Number of casualties	369	379
Number involving alcohol	71	89
% involving alcohol	19.2%	23.5%

*fatalities and serious injuries (hospitalised for 24 hours or more)

Department of Infrastructure, Energy, and Resources, Tasmanian Serious Casualties, 2006, 2007

Alcohol-related car crashes are more prevalent among young people. In 2007, alcohol was implicated in 41 serious casualties (31.1%) involving drivers aged 17-29 years. Of those, the majority (51%) involved young people under 21 years.

Serious Casualties* Involving Alcohol as a Crash Factor, Aged 17-29 Years, Tasmania, 2007

	2007
Number of casualties	132
Number involving alcohol	41
% involving alcohol	31.1%

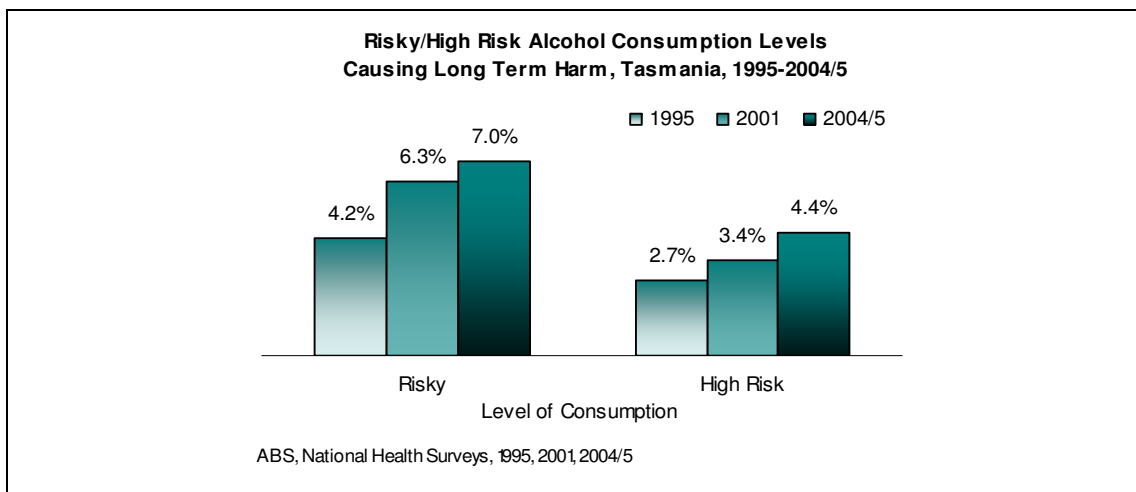
*fatalities and serious injuries (hospitalised for 24 hours or more)
 Department of Infrastructure, Energy, and Resources, Tasmanian Serious Casualties 2007

The proportion of Tasmanian adults drinking at high risk for long-term harm has almost doubled over the last ten years in Tasmania, with 11.5% of the adult population current consuming alcohol at these levels ⁵.

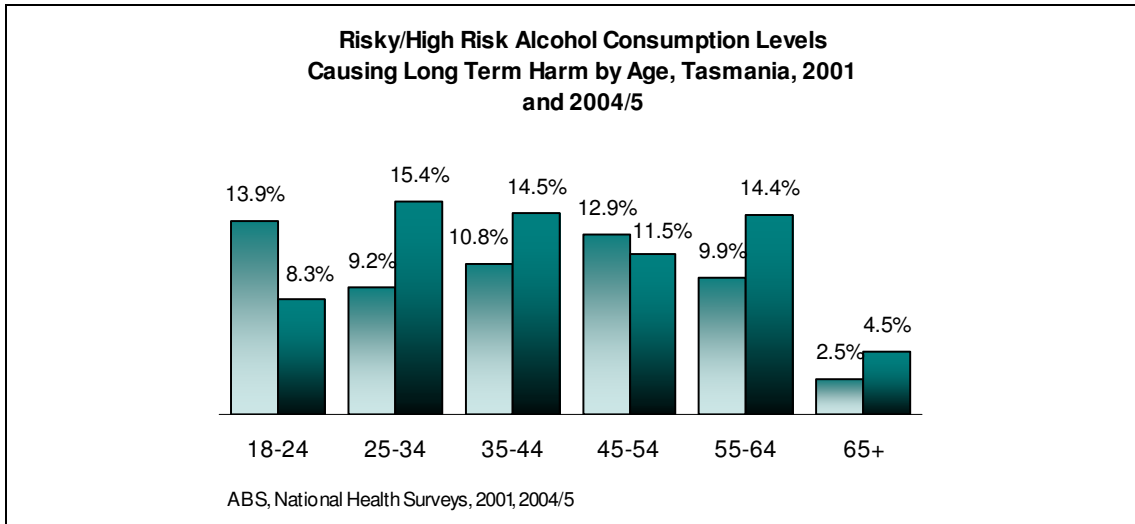
The National Health Survey uses measures of consumption to quantify alcohol consumption levels associated with short and long-term harm. These categories are based on the average daily consumption of alcohol in the week preceding the survey. In 2004/05 the proportion of Tasmanians consuming alcohol at medium and high-risk levels were lower than for Australia as a whole (p<0.01).

However, since 1995, the proportion of Tasmanian adults drinking at medium and high-risk levels has increased from 4.2% to 7.1% of adults drinking at medium risk levels and from 2.7% to 4.4% of adults drinking at high-risk levels (p<0.01).

The prevalence of alcohol consumption at levels risky to health in the long-term has increased since 1995. Risky and high risk consumption increased by 65% from 6.9% in 1995 to 11.4% in 2004/5, but this difference is statistically not significant.

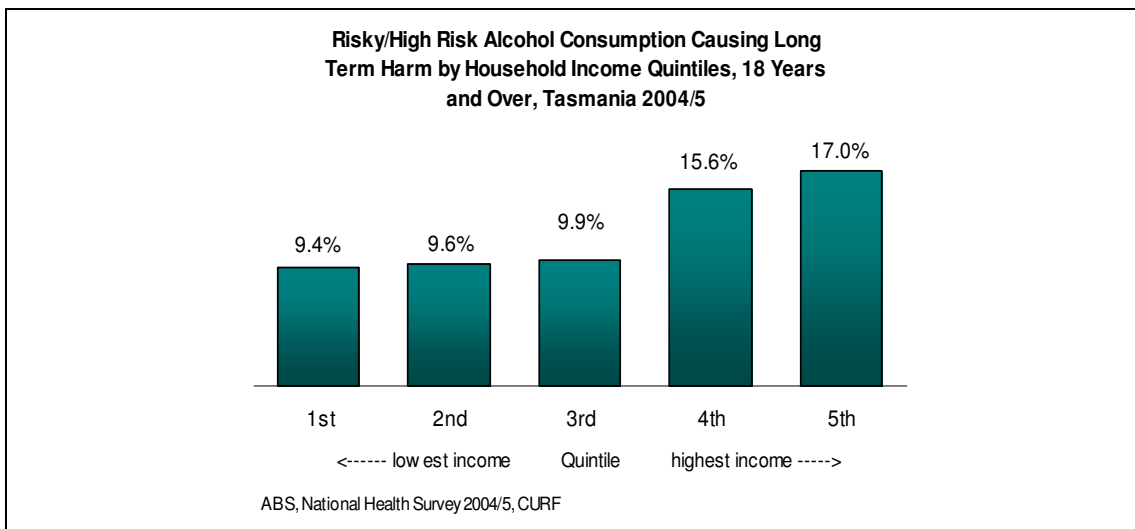


Risky and high-risk consumption of alcohol causing long-term harm has increased for most age groups since 2001. For those aged 35-44 years, the increase from 10.8% to 14.5% was statistically significant.

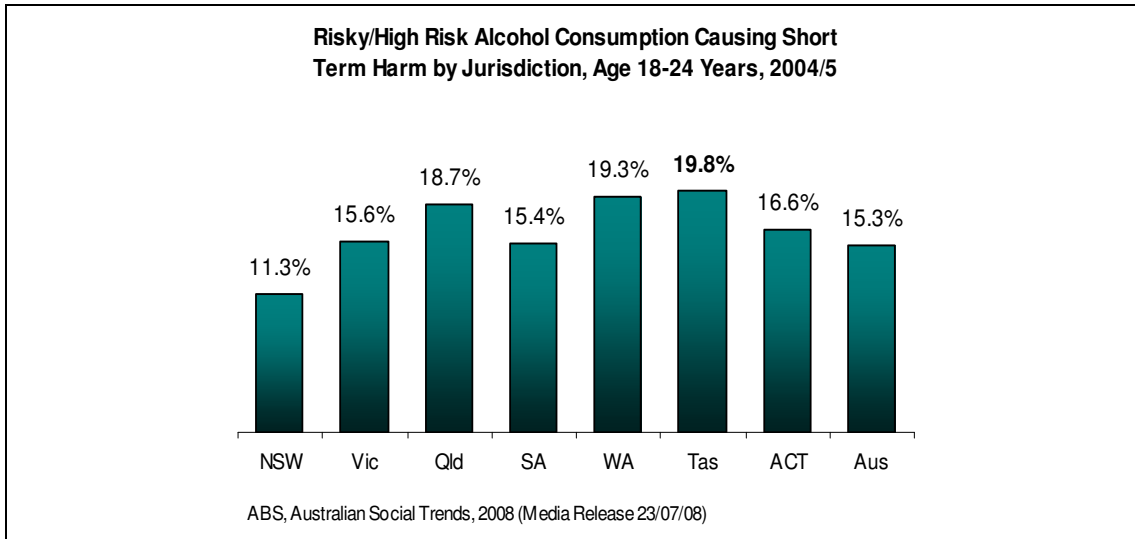


Risky and high-risk alcohol consumption causing long-term harm is more prevalent among higher income groups.

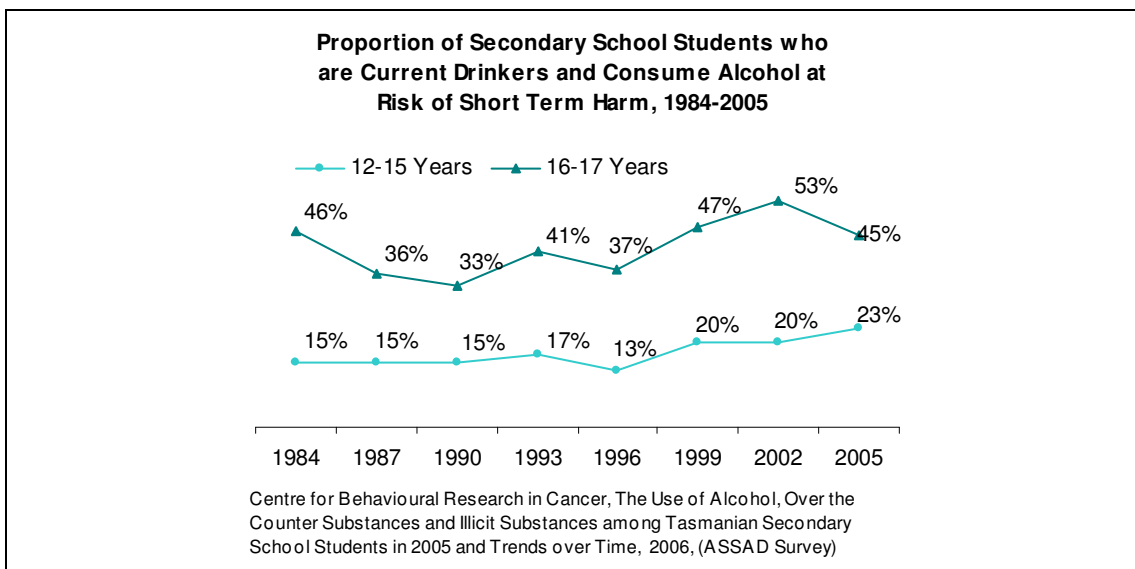
Of all Tasmanians with the highest household income, 17% are drinking at levels harmful to long-term health, compared to 9.4% of Tasmanians with the lowest household income.



Tasmania has the highest proportion of young people who drink alcohol at risky or high-risk levels (19.8%), well above the Australian proportion of 15.3%.



Between 1984 and 2005, the proportion of Tasmanian secondary students aged 12-15 years at risk of short-term harm from excessive alcohol consumption remained relatively unchanged, until 1999 when it began steadily increasing. For 16-17 year old students it has remained relatively unchanged.



Tasmanian Police report ⁴ that in Tasmania in 2007-08:

- 1,194 family violence offenders and 552 victims reported being affected by alcohol
- 4,865 drivers exceeded prescribed alcohol limit (9.9% increase) from 680,000 random breaths tests
- Alcohol is a factor in 25% of fatal crashes
- Increase in public order offences, such as noise, vandalism, offensive behaviour
- Police issued 4,504 'move-on' directions
- Of the 1,185 public place assaults, a significant proportion of offenders were affected by alcohol; 50% were committed by a stranger; 40% occurred on Friday and Saturday evening; most occurred at or near a

licensed premises; and there is an increasing trend of female offenders and victims

- 2,350 liquor infringement notices were issued and there were 1,351 instances of liquor confiscations
- 1,171 people were detained in custody for drunkenness and 266 detained due to level of intoxication
- There were 1,238 alcohol-related offences against police (10% increase)

Appendix B: National and International Context

Alcohol is the most widely used psychoactive, or mood-changing, recreational drug used in Australia, and is the cause of significant drug-related harm. Alcohol causes slightly more deaths and hospitalisations of young people including children than all the illicit drugs combined and many more than tobacco, mainly by either intentional or unintentional injuries¹⁰. Despite this, illicit drugs receive the most negative media attention and are perceived as the drugs most associated with a drug problem. In the 2007 National Drug Strategy Household Survey only one in ten Australians nominated alcohol as a 'drug problem' compared to heroin (39.4%) and marijuana/cannabis (29.2%)¹¹.

Much has been written about the culture of drinking in Australia. The National Alcohol Strategy⁷ notes there is no single factor for determining Australia's drinking cultures, which are driven by a mix of both social and availability forces, and cultural influences. Much has also been written about the adverse health and social effects. However, alcohol abuse impacts across a broad range of areas including healthcare services, road accidents, workforce productivity, law enforcement and property damage, and on the health and wellbeing of individuals, families and communities.

The total social cost arising from the misuse of alcohol has been estimated in 2004/05 in Australia to be \$15.3 billion per annum as shown in figure 1 below².

Figure 1: Total tangible and intangible social costs associated with alcohol abuse 2004/05

Tangible	(\$m)
Labour (net) *	3,538.0
Healthcare (net)	1,976.7
Road accidents not elsewhere included	2,202.0
Crime (net)	1,424.0
Resources used in abusive consumption	1,688.8
Intangible	
Loss of Life **	4,135.0
Pain and suffering (road accidents)	353.6
Total	15,321.1

* includes workforce and household labour less consumption resources saved
 **based on the loss of a year's living

In 2004/05, alcohol-related road trauma cost \$3.12 billion and crime costs attributable to alcohol were estimated to be \$1.7 billion. This included:

- Police \$747.1 million
- Criminal Courts \$85.8 million
- Prisons \$141.8 million
- Property \$67.1 million
- Insurance administration \$14.3 million
- Violence \$187.5 million
- Productivity of prisoners \$358.0 million
- Loss of life (violence) \$124.4 million

In 2004/05 net health care costs attributable to alcohol, when factoring in the savings to the health care system from premature deaths caused by alcohol misuse (an unfortunate reality) were estimated to be \$1.9 million, broken up into:

- Medical \$0.54 million
- Hospitals \$0.66 million (including pharmaceuticals inside hospital systems)
- Nursing homes \$0.41 million
- Pharmaceuticals \$0.3 million (outside hospital systems)
- Ambulances \$0.07 million

Young people are particularly vulnerable to the effects of alcohol. However, hazardous drinking by young people is common, with up to 80% of alcohol consumed by young people aged 14 – 17 years being drunk at risky/high risk levels for acute harm¹². The *2007 National Drug Survey Household Survey: first results* noted the proportion of teenagers drinking at least weekly is around 22%¹¹. It is estimated¹³ approximately 264 young people aged 15-24 years die each year as a result of risky alcohol consumption. Figure 2 below shows the most common alcohol-attributable causes of deaths.

Figure 2: Causes of alcohol-attributable deaths and hospitalisation (%) for males and females aged 15-24 years (data from 2004 NAIP¹⁴)

Deaths		%	Hospitalisations		%
Males			Males		
Road injury	52		Assault	30	
Suicide	19		Falls	19	
Assault	7		Road injury	17	
Pedestrian road injury	9		Alcohol abuse	10	
Drowning	4		Alcohol dependence	4	
Females			Females		
Road injury	37		Assault	23	
Suicide	22		Alcohol abuse	19	
Assault	20		Suicide	18	
Pedestrian road injury	5		Falls	10	
Drowning	3		Road injury	8	

The National Alcohol Strategy indicates that local governments spend approximately \$62 million each year on alcohol-related public safety and order, including cleaning up litter and bodily fluid spills⁷.

The *Drug Use Monitoring in Australia 2007 Annual Report* noted that alcohol dependency among police detainees has increased since monitoring began¹⁵. Heavy alcohol use was reported in the past year by three quarters of male detainees and two-thirds of female detainees. Half of male detainees and one-third of female detainees had drunk heavily in the 48 hours prior to being arrested.

Research undertaken by the Alcohol, Education and Research Foundation¹⁶ over the 2007/08 Christmas-New Year holiday period found 2.2 million Australians over 14 years of age reported being physically or verbally abused by someone under the influence of alcohol. The survey also found more than 30% of teenagers surveyed claimed they feared for the safety of their family and friends as a consequence of excess drinking.

A survey undertaken on behalf of the Australian National Council on Drugs (ANCD)¹⁷ in late 2007 found that a third of Australians did not agree or were uncertain that alcohol is a drug; nearly half were not aware or were unsure of the National Alcohol Guidelines; and there was confusion on how many drinks could be considered as 'binge' drinking.

The World Health Organisation (WHO) Expert Committee on problems related to alcohol consumption noted that for 2002, alcohol was estimated to cause a net harm of 3.7% of all deaths and 4.4% of the global burden of disease¹⁸.

In 1988, alcohol was classified by the World Health Organization (WHO) International Agency for Research on Cancer (IARC) as a Group 1 carcinogen¹⁹. This is the highest IARC classification for humans. Alcohol is a risk factor for cancers of the mouth, pharynx, larynx, oesophagus, and liver. Average intake of approximately four drinks per day increases the risk of cancer by 22%. High alcohol consumption averaging approximately eight drinks per day increases the risk of cancer at any site by 90%. Four standard alcoholic drinks a day increase a man's risk of developing bowel cancer by 64%. For women, just two standard drinks a day increases their risk of developing breast cancer by up to 22%. For both men and women, two standard drinks a day increase the risk of developing mouth cancer by 75%.

Types of alcohol-related harm and responses

Total alcohol consumption trends across a population are an important measure from a public health perspective as an indicator of the number of individuals who are exposed to high levels of alcohol consumption. In Australia, per capita alcohol consumption remains high by world standards, ranked within the top 30 out of 180 of the highest alcohol consuming countries²⁰.

However, equally as important from a policy perspective, as an indicator of harm, are patterns of alcohol consumption (the ways in which alcohol is consumed).

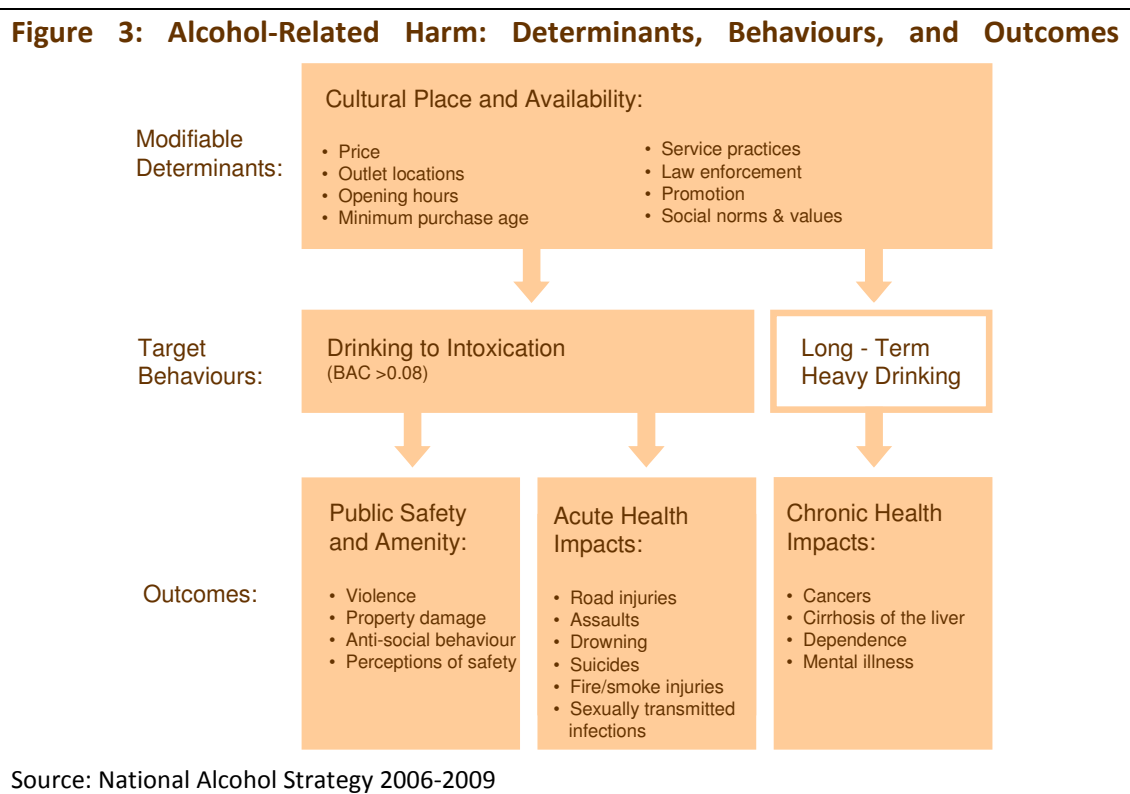
According to the *2007 National Drug Strategy Household Survey*,¹¹ 89.9% or nine out of every ten Australians aged 14 years or older had tried alcohol at some time in their lives and 9% (or 1.4 million) of Australians drank alcohol on a daily basis. Some 41% drink on a weekly basis. 37.4% of males and 41.2% of females aged 14 – 19 years of age consumed alcohol at levels which put them at risk of harm in the short-term. The average age at which people first used alcohol has remained stable at 17 years of age. The proportion of teenagers drinking at least weekly was around 22%.

The WHO considers intoxication, dependence and toxicity as the three main mechanisms of alcohol-related harm¹⁸.

The WHO Expert Committee report of 2006¹⁸ on problems related to alcohol consumption considered a range of alcohol policies for analysis of effective strategies and interventions to reduce alcohol-related harm. It considered a range of measures including reduction of availability of alcohol; alcohol price and taxes; restrictions on sale of alcohol; regulation; restrictions on alcohol marketing; drink-driving countermeasures; education and persuasion; and early intervention and treatment services. It concluded that despite some deficiencies, there is an evidence base to support strategies in terms of relative effectiveness. It found that alcohol supply can considerably affect the rates of alcohol-related problems. Alcohol control legislation and licensing systems were found to have proven benefits. These include limits on density of outlets and hours of sale; prohibition on underage sales and sales

to intoxicated persons; and enforcement. High taxation rates on alcoholic beverages as a control level strategy were also proven effective. Strong evidence was also found for specific drink-driving countermeasures, and assessment and brief intervention in the context of primary health services as an effective strategy in reducing heavy drinking or alcohol-related problems.

The National Alcohol Strategy identifies four priority areas: intoxication; public safety and amenity; health impacts; and cultural place and availability. It suggests linkages and interactions between the determinants, behaviours and outcomes of alcohol-related harm and the identified priority areas as summarised below in figure 3 below.



Other social and structural determinants of patterns of alcohol consumption and related harms include socio economic status, disposable income, housing, education and employment. Evidence that the first years of life are critical in shaping later developmental and behavioural issues abound¹⁰, and support a need to examine the social determinants and broader macro environmental influences, demographic factors and inter-related relationships that influence developmental risk factors (and protective factors). These and understanding and acknowledgement of the broader macro environmental influences, demographic factors and inter related relationships that influence development risk factors need to be also considered particularly from a preventative policy perspective.

From available research, the National Alcohol Strategy identifies that amongst the most effective interventions for alcohol-related harms are those related to economic availability and physical availability: being price and access respectively.

Appendix C: What has been achieved to date?

This appendix provides additional information on the achievements to date as summarised under Section 5.

Regulatory and legislative related initiatives include:

- Amendments to the *Liquor Licensing Act 1990* enacted in May 2008 increased penalties for the sale and supply of liquor to young persons and to persons who appear to be drunk.

The amendments included a new offence for a young person using false identification and for a licensee if a person authorised by them to sell liquor on the licensed premises sells liquor to a person who appears to be drunk. A range of other penalties were also increased, including for a person authorised by the licensee to sell liquor to a person who appears to be drunk. These are summarized in Attachment D.

- Under the *Liquor Licensing Act 1990*, licensees must not allow anyone to serve alcohol on licensed premises unless that person has successfully completed a Responsible Service of Alcohol (RSA) course or been an employee for less than three months and is enrolled in or undertaking an approved RSA course. Amendments to the Act enacted in May 2008, require licensees to keep a RSA register. Both the register and RSA certificates must be available to the Commissioner for Licensing or an authorised officer at all times.

Before the issue of a new liquor license or prior to the transfer of a liquor license the applicant is visited by a representative of the Commissioner for Licensing. The purpose of this visit is to ensure that the applicant fully understands his/her responsibilities under the *Liquor Licensing Act 1990* with a particular emphasis on RSA and underage issues.

The Commissioner for Licensing administers RSA training in conjunction with the Tasmanian Qualifications Authority (TQA) delivered by Registered Training Organisations (RTO). Moderation sessions are conducted annually for the principals of RTOs and their trainers to ensure that training is relevant, up to date and in accordance with legislation, liquor licensing policy and the national competency standard.

- Amendments to the *Police Offences Act 1935* enacted in November 2007, provide Tasmania Police with the power to prohibit the consumption of alcohol in prescribed public places during prescribed days and times.
- The *Marine Safety (Misuse of Alcohol) Regulations 2006* has provided police officers with the power to breath test operators of marine vessels for alcohol, and charge and direct operators not to use vessels if found to be affected by alcohol.

- Amendments to the *Road Safety (Alcohol and Drugs) Act 1970* enacted in December 2007 provide Tasmania Police with the power to issue Excessive Drink Driving Notices and to immediately disqualify drivers exceeding .15 blood alcohol content or who are repeat offenders.
- The Commissioner for Licensing conducts regional forums around the State with licensees and key staff to provide up to date information on legislation, licensing policy and RSA as well as providing an open forum for licensees to debate licensing issues and discuss best practice initiatives.
- During the 2008 football season representatives of the Commissioner for Licensing met with the administrators of every Australian Rules Football association in Tasmania to discuss a range of harm minimisation issues relating to the service and supply of alcohol. Issues discussed included conduct of their facilities, limitations of their liquor licenses, preventing the supply of alcohol to persons under 18 years of age and restricting the public carrying alcohol into football grounds.
- The Commissioner for Licensing has adopted a strategy for the conduct of major events (sporting, entertainment, wine and food festivals) both to promote RSA and to create a safe environment for these events. This involves representatives of the Commissioner for Licensing monitoring the events as well as engaging with all stakeholders in pre and post event meetings to ensure compliance with the law and RSA best practice.
- In November 2007 legislation was introduced to prohibit the spiking of a person's drink under the *Police Offences Act 1935*. The National Drink Spiking Project materials have been distributed to Tasmania Police, Health Services, licensed premises and emergency departments throughout Tasmania to raise awareness about the drink spiking issue and appropriate responses.

Local Government and intra-government initiatives include:

- Representatives of the Commissioner for Licensing, working with Tasmania Police, local government and industry stakeholders have introduced late night trading agreements in Launceston and Hobart. The agreements operate in the CBD of each city and consider issues such as: late night trading; a ban on liquor promotions after midnight; and the implementation of a 3:00 am lockout, where no new patrons are admitted to premises after this time.
- Representatives of the Commissioner for Licensing, working with Tasmania Police, the Burnie City Council, the Australian Hotels Association, local licensees and community groups, have developed the Burnie Liquor Accord. This is the first liquor accord to be trialled in Tasmania, and encourages licensees to take certain actions in local communities to reduce alcohol related anti-social behaviour offences and violence and improve public safety and amenity issues. During 2009 liquor accords will be rolled out in Hobart and Launceston.

- The *Who's Des Tonight?* designated driver program is currently conducted in the semi-rural Burnie area. This represents a partnership initiative between Burnie City Council, Tasmania Police and the local community. This initiative has won state and national awards for its role in reducing alcohol-related harm among young adults.
- The Devonport City Council is delivering a holistic early intervention program with young people 'at risk' from ages 10-19. The Lighthouse *Can Do Will Do Project* was initiated by the Devonport Community Safety Liaison Group and the Mersey Police & Community Youth Club (PCYC) and works in partnership with the Latrobe and Kentish Councils, Tasmanian Police, the PCYC, Youth Justice, the Department of Education, Youth service providers, the employment sector and local community. The program does not specifically target alcohol issues, but is aimed at reducing the longer-term social, economic and health issues related to the misuse of alcohol for young people and the local community.
- The Kingborough Council runs a number of activities in relation to drug and alcohol issues for young people. The *Road Show* is a health initiative coordinated by Department of Health and Human Services health workers delivered at Kingston High School and Woodbridge District High School in which professional facilitations deliver programs including alcohol and drug components. Young Men's Groups for 'at risk' young people identified by local schools participate in therapeutic physical activity at the Kingborough Sports Centre aimed at building resilience and minimising harm. The Yspace Youth Centre is utilised by the Alcohol and Drug Youth Workers to provide weekly outreach services for one-on-one counselling and group work, and also by a private social worker for counselling and group work for young people and their families. The Council's Youth Development Officer is working with the Drug Education Network to develop a best practice *Safe Partying* program.
- The King Island Council was successful in the first round under the National Binge Drinking Strategy to secure funding for a Youth Access Program to provide alcohol-free venues for youth related activities.

(Other) Intervention initiatives included:

- The '*National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*' have been distributed to all acute, primary and tertiary health services.
- Inter-Agency Support Teams (IAST) in Tasmania bring together relevant State and local government service providers to support children, young people and their families. The IASTs consider a range of issues including drug and alcohol misuse. Tasmania Police has led the development of these Teams that operate on a statewide basis.

- The Department of Health and Human Services together with other key Government Agencies and community and professional organisations has developed a *Population Alcohol Strategies: Primary and Secondary Prevention of Alcohol Related Harms - Summary of Future Directions Report (2008)*. This identifies and endorses population level goals and strategies around alcohol use in Tasmania. A number of the higher level goals are included in the draft Tasmanian Alcohol Action Plan 2009-2014 under consideration. More detailed strategies from this process will be included in the future annual implementation plans.
- Population Health has developed a sustainable approach to the monitoring and analysis of alcohol related trends for Tasmania. Alcohol Trends Fact Sheets are now produced tri-annually.
- Population Health continues to provide advice to Australia and New Zealand Food Regulation Ministerial Council regarding the placement of mandatory health warning on packaged alcohol.
- In July 2006, Tasmania Police established a District Response in each of the four geographic districts to enhance the police capacity to respond to antisocial behaviour, prevent crime and offences in public places, and support early intervention strategies throughout the State. The Tasmania Police Public Order Response Teams (PORT) focus on providing an increased presence around hotels, nightclubs and other licensed premises. The Teams work with the Licensing Units to monitor and enforce legalisation concerning access to alcohol by under-age persons; general compliance by licensees with liquor laws and public order practices; and training, registration and conduct of security personnel. The PORTs have enhanced the capacity of Tasmania Police to respond to antisocial behaviour, prevent crime and offences in public places, and support early intervention strategies throughout the State.
- Tasmania Police continues to support and promote the *Party Safe* initiative. *Party Safe* aims to encourage young people and parents/responsible adults to organise and conduct parties in a responsible manner. *Party Safe* features on the Tasmania Police website, and provides links to resources and information to assist in supporting a safe environment for those conducting or attending a party, and the wider community.
- The Road Safety Task Force has undertaken social marketing campaigns providing information to the community using print and electronic media. The “*Just like that*” campaign has highlighted alcohol-related harms.
- In 2006, the State Alcohol and Drug Service commenced a review of the alcohol, tobacco and other drugs service sector, engaging an external consultant to assist the review. A five year Future Service Directions Plan has been developed in consultation with key stakeholders including community sector organisations, that provides a blueprint for establishing a strong, contemporary and sustainable alcohol and drugs service sector in Tasmania which is responsive to the needs of

clients and service providers. The Government provided additional funding of \$1.5 million to the Alcohol and Drug Service in 2007-08; and a further \$17.1 million will be provided over the next four years for the development of alcohol and other drugs services in Tasmania.

- In 2007, the Drug Education Network (DEN) held the 1st National Conference on Foetal Alcohol Spectrum Disorder (FASD). The DEN has established a Prenatal Exposure to Alcohol National Clearing House in its North West office providing a library of resource information, and offers support and advice to individuals and families affected by FASD. Joint education sessions have also been conducted with the Launceston General Hospital to provide information on FASD and to provide maternity care providers with practical skills and tools to address the issue with women in pregnancy.
- The Den has also undertaken a project funded by the Alcohol, Education and Rehabilitation Foundation to develop a booklet to increase General Practitioners knowledge and awareness of pharmacotherapy and psychosocial treatment options for alcohol dependence, and to encourage the use of this form of treatment.

Appendix D: Strategic Policy Framework

Tasmania Together

Tasmania Together is a long-term social, environmental and economic plan that provides the opportunity for all sectors of the Tasmanian community to work together to achieve common long term objectives. A number of goals and standards have been developed by which progress can be measured. The goal particularly relevant to alcohol is Goal 2. Confident, friendly and safe communities, of which the following standards and indicators are relevant:

Standard 1: To support safe and responsible behaviour and ensure that community facilities and spaces, transport systems, workplaces and private homes are, and are perceived to be, safe environments.

- Indicator 1.1 Injuries and poisoning (as measured by hospital separations)
- Indicator 1.2 Percentage of people who feels safe in public places
- Indicator 1.4 Crime victimisation rate
- Indicator 1.5 Reported level of family violence
- Indicator 1.7 Incidence of workplace injuries
- Indicator 1.8 Road crash fatalities and serious injuries

Standard 2: To support young people who are at risk.

- Indicator 2.1 Deaths due to external causes for people aged 0 – 24
- Indicator 2.3 Proportion of 14-24 year olds at risk of short term alcohol related harm

Tasmanian Drug Strategy 2005-2009

The Plan is one of three initiatives under the *Tasmanian Drug Strategy 2005-2009* (TDS) framework. The TDS²¹ identifies three priorities in responding to the use of alcohol, tobacco and other drugs in the Tasmanian community: community safety; prevention and reduction; and improved access to quality treatment.

A Social Inclusion Strategy for Tasmania

To be completed following consultation phase.

National Drug Strategy 2004-2009

The Mission of the *National Drug Strategy 2004-2009* is 'To improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian Society.'

National Alcohol Strategy 2006-2009

The goal of the *National Alcohol Strategy 2006-2009 'Towards Safer Drinking Cultures'* is 'to prevent and minimise alcohol-related harm to individuals, families and communities in the context of developing safer and healthy drinking cultures in Australia.' To achieve this goal, the National Alcohol Strategy has four aims:

1. Reduce the incidence of intoxication among drinkers.
2. Enhance public safety and amenity at times and in places where alcohol is consumed.
3. Improve health outcomes among all individuals and communities affected by alcohol consumption.
4. Facilitate safer and healthier drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability.

The National Alcohol Strategy was developed through a collaborative process between Australian Governments, non government and industry partners and the broader community to provide the broad strategic foundation for the development of the Plan. The development of the National Alcohol Strategy was based on consultations with over one thousand key stakeholders around Australia including the health sectors, liquor licensing authorities, police, local government and the alcohol beverage and hospitality industry, and included an extensive literature review⁷. The National Alcohol Strategy in particular informs the Plan.

National Binge Drinking Strategy

In March 2008, the Prime Minister announced a new national strategy to address binge drinking among young Australians. The Australian Government is working with State and Territory Governments, communities, parent and young people to implement a National Strategy on Binge Drinking.

National Preventative Health Strategy

The Preventative Health Taskforce was established by the Australian Government in April 2008. It will provide evidence-based advice to government and health providers – both public and private – on preventative health programs and strategies, and support the development of a National Preventative Health Strategy. The Strategy will provide a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco, and excessive consumption of alcohol. It will be directed at primary prevention and will address all relevant arms of policy and all available points of leverage, in both the health and non-health sectors, in formulating its recommendations.

National Aboriginal and Torres Strait Islander Complementary Action Plan 2003-2009

The *National Alcohol Strategy 2005–2009* also supports the six key result areas of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*. Key Result Areas of the Plan are:

1. Enhance community capacity to address current and future issues and promote their own health and wellbeing.
2. Whole-of-government effort in collaboration with non-government organisations to reduce drug-related harm.
3. Substantially improved access to health and wellbeing services that address drug issues.

4. Holistic approaches, from prevention to treatment and continuing care, that are locally accessible.
5. Workforce initiatives to enhance capacity of community-controlled and mainstream service organisations.
6. Improved ownership and partnerships of research, monitoring, evaluation and dissemination of information.

National Corrections Drug Strategy 2006-2009

The National Corrections Drug Strategy 2006–2009 was developed with the endorsement and support of the Ministerial Council on Drug Strategy, Corrective Service Ministers' Conference, Corrective Services Administrators' Conference, Community and Disability Services Ministers' Advisory Council, Australasian Juvenile Justice Administrators, the Australian National Council on Drugs and the Inter-Governmental Committee on Drugs to provide a framework for a coordinated, integrated approach to addressing drug related issues in Australian adult correctional and juvenile justice facilities and related services.

The Strategy is closely linked to and seeks to complement the National Drug Strategic framework. Its mission is to improve health, social and economic outcomes for adult and juvenile offenders within correctional and community based facilities and services. The strategy seeks to prevent anticipated and actual harm to individuals, families and to the wider community resulting from drug misuse and drug related crime by preventing the uptake or continuation of drug misuse, reducing the harmful effects of drugs, and reducing re-offending.

The Ministerial Council on Drug Strategy (MCDS) report to the Council of Australian Governments (COAG) on options to reduce binge drinking

In March 2008, the COAG members agreed to the importance of addressing alcohol misuse and binge drinking among young people. The MCDS was asked to report to COAG on options to reduce binge drinking including in relation to closing hours, responsible service of alcohol, reckless secondary supply and the alcohol content in ready-to-drink beverages. The MCDS is presently considering and finalising its report on developing an integrated approach to addressing demand for, and supply of, alcohol through law enforcement, regulation, treatment and prevention. The MCDS Report to COAG will provide COAG with a number of key proposals and a range of other options which the MCDS believes would make an effective contribution to the reduction of harmful levels of alcohol consumption in Australia. The areas being considered and finalised by the MCDS fall under the main headings of liquor licensing; secondary supply; advertising; and alcohol content of ready-to-drink beverages.

A number of the key proposals and other options being considered by the MCDS for reporting to COAG will impact on the Tasmanian community. Individual States and Territories will be asked to support and implement a range of actions to ensure national consistency. The Tasmanian Alcohol Action Plan final proposed priority

areas, recommended responses and specific actions under the annual implementation plans will also be informed by the final proposals, options and timelines for action agreed to by COAG.

The Australian New Zealand Food Regulation Ministerial Council has also requested Food Standards Australia New Zealand to consider mandatory health warnings on packaged alcoholic beverages.

Appendix E: Legislative and Regulatory Framework

Liquor Licensing Act 1990 and Liquor Licensing Amendment Bill 2008

The Act provides for five types of licence. They are a general licence, a club licence, an on licence, an off licence and a special licence, and are all granted by the Licensing Board. With the exception of a special licence, the licences permit the sale of alcohol between the hours of 5 am and 12 midnight daily. The Act also provides for an out of hours permit to fill the gap between midnight and 5am. A special licence authorises the sale of liquor between specified times and subject to conditions specified in the licence. This licence is usually issued to restaurants, function centres, tertiary institutions, accommodation providers, wine producers or tourist attractions.

There are four types of liquor permit issued – an out-of-hours permit, an on-permit, an off-permit and a special permit. An out-of-hours permit is required by general, on, off and club licence holders to sell liquor for any period between midnight and 5 am. The Act requires that, before granting an out-of-hours permit the Commissioner must be satisfied that the sale of liquor would not cause undue annoyance, disturbance, or the occurrence of disorderly conduct in the neighbourhood. An on permit authorises the sale of liquor on premises specified in an off-licence between any times and subject to the compliance with any conditions imposed. An off-permit authorises the sale of liquor on premises specified in an on-licence between any times and subject to the compliance with any conditions imposed. Special permits are generally issued for low risk events or functions and are based on the amount of time a permit is required: a period of up to four days, from four to thirty days, up to six months, and up to twelve months.

Amendments to the *Liquor Licensing Act* enacted in May 2008 creates a new offence if a person authorised by the licensee to sell alcohol on licensed premises sells alcohol to a person who appears to be drunk, and increases penalties for the sale and supply of liquor to young persons and to persons who appear to be drunk to a maximum fine of \$12,000. The amendments also increased the maximum penalty from \$1,200 to \$6,000 that may be applied to a person who sells alcohol to a young person; who supplies a young person with alcohol; who sends a young person to obtain alcohol; and who sells or supplies liquor to a person who appears to be drunk. The maximum penalty that may be applied to a licensee for selling alcohol to a young person increased from \$2,400 to \$12,000. Presentation of fraudulent identification by a young person has also been made an offence, including allowance for such identification to be seized and destroyed.

Under the *Liquor Licensing Act 1990*, licensees and staff serving liquor on licensed premises are required to have undertaken, or be enrolled to undertake within 3 months, an accredited Responsible Service of Alcohol (RSA) course. The Tasmanian course (like all other state RSA courses) is based on the national qualification THHFB09B and Tasmania accepts RSA qualifications gained in other jurisdictions. Also from May 2008, licensees must keep a RSA register. Both the register and RSA certificates must be available to Police Officers or Liquor and Gaming Inspectors at any time.

The Commissioner has the power to cancel or suspend a license, upon sufficient evidence of infringements. Staff of the Department of Treasury and Finance facilitates the licensing and compliance processes required under the Act.

Police Offences Act 1935

Under the *Police Offences Act 1935*, Tasmania Police currently have the powers to seize and dispose of liquor. Tasmania Police also have the power to prohibit the consumption of alcohol in public places during prescribed days and times. Drunkenness when in charge of any vehicle or in possession of any dangerous weapon is an offence.

Consumption of liquor in a public street or any public place, excluding premises licensed under the Liquor Licensing Act, is prohibited under the Act.

Under the Act, Tasmania Police have the powers to take a person into custody, or to a place of safety or releasing them into the care of a responsible person if believed to be intoxicated, and (a) is behaving in a manner likely to cause injury to himself, herself or another person, or damage to any property; or (b) is incapable of protecting himself or herself from physical harm.

A '*Place of Safety*' is defined in the Act to mean, 'a hospital, charitable institution or any other appropriate facility that is capable of caring for an intoxicated person and includes a place declared by the Minister under Section 4C to be a place of safety for the purposes of the Act'. Designated places of safety include the Royal Hobart Hospital; the Launceston General Hospital; the North West Regional Hospital; Salvation Army Bridge Program; Launceston City Mission, Frederick Street, Launceston and Launceston City Mission North West Sulphur Creek facility.

Road Safety (Alcohol and Drugs) Act 1970

Under the *Road Safety (Alcohol and Drugs) Act 1970* it is an offence to drive a vehicle whilst alcohol is present in a concentration greater than 0.05 blood alcohol content (BAC), with Tasmania Police currently having the powers to arrest an offender and confiscate the vehicle. It is also an offence to drive a vehicle whilst consuming alcohol. The Act contains a range of penalties dependent upon the BAC and number of prior offences. Tasmania Police also have the powers to impose immediate disqualification of a driver's license under certain circumstances.

Youth Justice Act 1977

Under the *Youth Justice Act 1997*, Tasmania Police currently have the ability to informally and formally caution young people (under 18 years of age) for a range of offences, including underage drinking in a public place, diverting them away from the criminal justice system. Under a formal caution any undertaking that a young person enters into is agreed, but is not enforced.

The *Youth Justice Act 1997* also provides the ability for more serious offences, or repeat offenders to participate in a community conference convened by Community Youth Justice, Department of Health and Human Services (DHHS). Undertakings agreed by a young offender in a community conference are enforceable, and a breach of an undertaking can be referred to the criminal justice system.

Alcohol and Drug Dependency Act 1968

Under the *Alcohol and Drug Dependency Act 1968* a person under certain circumstances may be admitted and detained in a treatment centre, with respect to the treatment and control of alcohol dependency (or drug dependency). For the purposes of this Act a person shall be regarded as suffering from alcohol dependency if he consumes alcohol to excess and (a) is thereby dangerous at times to himself or others or incapable at times of managing himself or his affairs; or (b) shows prodromal signs of becoming so dangerous or so incapable.

The following premises are declared to be treatment centres for the purposes of the Act: (a) the Royal Hobart Hospital; (b) the Launceston General Hospital; (c) the North West Regional Hospital (consisting of the Burnie Campus and the Mersey Campus); and (d) that part of the Carruthers Building, St Johns Park, New Town that is used by the Alcohol and Drug Service.

Family Violence Act 2004

The *Family Violence Act 2004* contains provision for specialist assessments to determine program suitability assessments under the Department of Justice Family Violence Offender Intervention Program (FVOIP). Individuals who have been charged under the Act who are assessed as medium to high risk of offending and have been referred to the FVOIP as a result of mental health, disabilities and/or drug and alcohol related issues are the principal target group.

Guardianship and Administration Act 1995

The *Guardianship and Administration Act 1995* provides power to the Guardianship and Administration Board to deal with the detention and/or treatment of people with a disability which can include people who are temporarily or permanently incapacitated due to alcohol or drug dependency. It is difficult to seek or obtain a treatment order under the Act due to the complexity of assessment of alcohol and other drug dependency, and the meaning under the Act.

The Marine Safety (Misuse of Alcohol) Act 2006

The Act aims to improve marine safety by containing provisions that place certain restrictions on the use of alcohol by persons having responsibilities connected with the operation of vessels and by providing for the enforcement of those restrictions. A person must not operate a marine vessel if there is alcohol in that persons' breath or blood. The Act further provides that the owner or person in charge of a commercial vessel must not cause or allow a person who has alcohol in his or her breath or blood to operate the commercial vessel.

The Act also provides police officers with the power to breath test operators of marine vessels, and may direct a person not to operate a vessel if the police officer reasonably suspects that a person operating or apparently about to operate a commercial vessel has consumed alcohol; or a person operating or apparently about to operate a vessel has more than the permitted concentration of alcohol in that person's blood. Permitted concentration of alcohol means a concentration of 0.05 of a gram of alcohol in – (a) 210 litres of breath; or (b) 100 millilitres of blood.

Children, Young Persons and Their Families Act 1997

The *Children, Young Persons and Their Families Act 1997* contain requirements for the informing of concern of abuse or neglect (Part 3/14) and assessment (Part 4/20 and 22) of children at risk, by prescribed persons. Prescribed persons includes: a registered medical practitioner; a nurse; a person registered as a dentist, dental therapies or dental hygienist; a registered psychologist; a police officer; a probation officer; a principal and teacher in any educational institution; a person who provides child care or a child care service; a person concerned in the management of a licensed child care service; any other person who is employed or engaged as an employee or volunteer in a Government Agency that provides health, welfare, education, child care or residential services whole or partly for children and an organisation that receives funding from the Crown for the provision of such services; or any other person determined by notice in the *Gazette* to be a prescribed person.

A prescribed person under the Act must inform the Secretary if, in the course of his work, he or she believes or suspects on reasonable grounds, or knows that a child has been or is being abused or neglected or is an affected child within the meaning of the *Family Violence Act 2004*, or that there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides.

Land Use Planning Approvals Act 1993

The Act contains provision for planning directives; preparation, coordination and modification of planning schemes; and planning controls.

Public Health Act 1997

The *Public Health Act 1997* confers on the Director of Public Health the function to (inter alia) develop and implement strategies to promote and improve public health. The health of the Tasmanian community is promoted and improved, and the incidence and severity of preventable consequences, conditions and diseases are reduced through the legislative requirements and administration of the *Public Health Act 1997*.

The National Competition Policy

In 1992 Federal, State and Territory governments agreed to the development of the National Competition Policy, followed by agreement in 1995 to implement a range of reforms to remove barriers to competition, unless there was a demonstrated 'public interest' not to do so. Liquor licensing legislation was included in the related reforms. The liberalisation of liquor licensing laws as a result of the impact of the National Competition Policy has arguably resulted in incompatibilities between the Commonwealth and the states and territories in the administration of liquor licensing laws³.

Appendix F: High Risk Groups

Pregnant Women

The draft National Medical Health Research Council (NMHRC) 2007 Australian Alcohol Guidelines²² acknowledge the reported high rates of alcohol consumption in Australia by pregnant women, and the risks of such consumption on the foetus due to the ease with which alcohol crosses the placenta. Such foetal exposure can cause a range of adverse effects, collectively referred to as foetal alcohol spectrum disorder. The draft low-risk drinking guidelines suggest not drinking is the safest option for pregnant women.

Tasmanian Aborigines

Many surveys show that whilst the majority of Indigenous Australians are less likely than non-Indigenous Australians to consume alcohol, significantly more are likely to drink at high risk levels²³. The National Alcohol Strategy notes that Aboriginal and Torres Strait Islander People are more than seven times more likely to be hospitalised for acute intoxication than the rest of Australia⁷.

The National Corrections Drug Strategy 2006-2009²⁴ recognises the disproportionate numbers of Aboriginal and Torres Strait Islander peoples in correctional and community based facilities and services, with Aboriginal and Torres Strait Islander peoples being incarcerated at 17 times the rate of the non-Indigenous population. An Australian Institute of Criminology Report²⁵ notes high levels of substance use amongst Indigenous offenders, with alcohol often the primary area of concern in relation to Indigenous substance use and offending.

Young People

The draft National Medical Health Research Council (NMHRC) 2007 Australian Alcohol Guidelines notes the particular vulnerability of young people to the effects of alcohol. Underage drinking contributes to the three leading causes of death among adolescents — unintentional injuries, homicide and suicide, with alcohol consumption as an adolescent or young adult also associated with physical injury, risky sexual behaviour, adverse behavioural patterns and academic failure. The *2007 National Drug Survey Household Survey: first results* noted the proportion of teenagers drinking at least weekly is around 22%¹¹ and that males aged 20–29 years (17.2%) were the most likely group to consume alcohol at risky or high-risk levels for short-term harm at least weekly. Data available from the Department of Infrastructure, Energy and Resources²⁶, notes that alcohol related car crashes in Tasmania are more prevalent among young people. In 2007, alcohol was implicated in 41 serious casualties, of which 31.1% involved drivers aged 17-29 years. Of those, the majority (51%) involved young people aged under 21 years.

Poly-Drug Users

The latest Tasmanian findings from the Ecstasy and Related Drugs Reporting System (EDRS)²⁷ noted that a large majority (86%) of the 2007 survey of 100 regular ecstasy users reported drinking alcohol when under the influence of ecstasy and three quarters of these (76%) typically consumed more than five standard drinks. The

report further notes that whilst concurrent use of alcohol or whilst coming down from ecstasy had declined in 2006 from the high rates reported in 2004 and 2005, there was an increase in the 2007 cohort. It was also noted that most of the overdose episodes reported in the 2007 study involved alcohol and/or polydrug use. Additionally, a large majority (89%) of the 2007 sample had used alcohol at least weekly during the six months preceding the interview, which is substantially higher than both the Tasmanian (39.4%) and national (41.2%) estimates of prevalence for the general population, and among those aged 20-29 nationally (56.7%).

Prisoners

Another high risk group includes prisoners, with the *National Corrections Drug Strategy 2006-2009*²⁴ noting that research estimates between 41% and 70% of violent crimes are committed under the influence of alcohol.

Appendix G: Glossary

Alcohol-related harm	Any adverse social, physical, psychological, legal or other consequence of alcohol use that is experienced by a person using alcohol or by people living with or otherwise affected by the actions of a person using alcohol.
Binge Drinking	<p>Whilst there is no agreed definition or understanding as to what constitutes ‘binge drinking’ it can generally be accepted to refer to heavy drinking over a short period of time or drinking continuously over a number of days or weeks - sometimes also referred to as heavy episodic drinking. Binge drinking is often associated with drinking with the intention of becoming intoxicated.</p> <p>The term can refer to drinking, on any single occasion, significantly more than the low-risk levels advised by the National Health and Medical Research Council (NHMRC). Common short-term effects of binge-drinking episodes are hangovers, headaches, nausea, shakiness and possible vomiting and memory loss. The short-term risks of binge drinking include the risks of harm such as falls, assaults and car accidents. Young people in particular often are not aware of the dangers associated with acute intoxication, and are more likely to indulge in risky behaviour while intoxicated, such as driving, unsafe or unwanted sex, swimming, verbal or physical abuse.</p> <p>The long-term effects of drinking heavily over a long period of time can include physical and psychological dependence. Over time, alcohol can damage parts of the body, including the brain and liver, and lead to the development of emotional problems, such as depression, and problems at school, work and within relationships.</p>
Early Intervention	<p>A therapeutic strategy that combines early detection of hazardous or harmful substance use and treatment of those involved (WHO 1994). Treatment is offered or provided before such time as patients might present of their own volition and in many cases before they are aware that their substance use might cause problems. It is directed particularly at individuals who have not developed physical dependence or major psychosocial complications. Early intervention is therefore a pro-active approach. The first stage consists of a systematic procedure for early detection. Some of the several approaches include:</p> <ul style="list-style-type: none"> • routine enquiry about use of alcohol, tobacco, and other drugs in the clinical history; and • the use of screening tests, for example in primary health care settings. <p>Supplementary questions are then asked in order to confirm the diagnosis.</p> <p>The second stage (treatment) is usually brief and takes place in the primary health care setting (lasting on average 5–30 minutes). Treatment may be more extensive in other settings.</p>
Foetal (or Fetal) Alcohol Spectrum Disorder	In this document the word ‘foetal’ is used and refers to the broad term for a range of outcomes observed among individuals with prenatal alcohol exposure.
Low –risk drinking or low levels of drinking (based on the NHMRC draft guidelines – see below)	<p>In each case, ‘low-risk’ has been conservatively defined as the level of alcohol intake that, for healthy adults, will:</p> <ul style="list-style-type: none"> • keep the risk of accidents and injuries, or of developing alcohol-related diseases, at tolerably low levels (compared with not drinking) • reduce the lifetime risk of death from an alcohol-related injury, or from an alcohol-related disease, to less than 1 in 100 (that is, one death for every 100 people who drink at that specified level and pattern). <p>To achieve these outcomes, the recommended alcohol intake for both men and women is the same:</p> <p>two (2) standard drinks or less in any one day.</p>

National Health and Medical Research Council (NHMRC) Alcohol Guidelines	<p>The NHMRC <i>Australian alcohol guidelines for low risk drinking</i> are presently being reviewed. The draft new guidelines, available at http://www.nhmrc.gov.au/guidelines/consult/alcohol_guidelines.htm are intended to give Australians clear guidelines on how to avoid, or minimise, the harmful consequences of drinking alcohol — both the immediate effects of each drinking occasion and the longer-term effects of regular drinking.</p> <p>When finalised, the guidelines will provide a valuable resource for a wide range of groups and individuals including health professionals, community groups, professional and educational organisations, policy makers, the general public and those businesses responsible for providing alcohol.</p> <p>(draft) Guideline 1 recommends a single, universal low-risk level of alcohol intake for both men and women. In setting the guideline, the NHMRC considered the risks of increasing levels of alcohol intake for two patterns of drinking and two types of harm:</p> <ul style="list-style-type: none"> • drinking on any single occasion with the attendant risk of accidents and injuries • regular drinking over a period of time with the attendant risk of developing alcohol-related diseases. <p>(draft) Guidelines 2 and 3 make special recommendations for children and adolescents and pregnant women respectively.</p>
Prevention	<p>Broadly defined as an intervention designed to change the social and environmental determinants of drug and alcohol abuse, including discouraging the initiation of drug use and preventing the progression to more frequent or regular use among at-risk populations. Prevention activities may be broad-based efforts directed at the mainstream population(s), (e.g. mass media general public information and education campaigns, community focused initiatives and school based programs directed at youth or students at large). Prevention interventions may also target vulnerable and at-risk populations. Essentially, prevention addresses the following:</p> <ul style="list-style-type: none"> • creating awareness and informing/educating about drugs and the adverse health and social effects of drug use and abuse; • promoting anti-drug norms and pro-social behaviour against drug use; • enabling individuals and groups to acquire personal and social life skills to develop anti-drug attitudes and avoid engaging in drug using behaviour; and • promoting supportive environments and alternative healthier, more productive and fulfilling behaviours and lifestyles, free of drug use.
Risky or high-risk drinking (or drinking to risky or high risk levels)	<p>Risky/high-risk drinking in the short term = seven or more standard drinks on any one day for males; five or more standard drinks on any one day for females.</p> <p>long-term risk of harm is the equivalent of consuming 29 or more standard drinks per week for males and 15 or more standard drinks per week for females</p>

Appendix H: Consultations undertaken

This Section will be written at the conclusion of the consultation process, as part of the final Plan. It will include a snapshot of consultations and a list of written submissions received throughout the consultation phase.

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