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ALCOHOL AND OTHER DRUGS COUNCIL OF AUSTRALIA

ADCA

CONTENTS

STOP PRESS:

Alcohol Restrictions and STIs: Is There a Link?

By Revle Bangor-Jones, Grant Akesson, Paul Armstrong, Lisa Bastian, Carole Reeve, Jianguo Xiao, Tarun Weeramanthri – Department of Health, Western Australia

Evidence is accumulating on the health and social benefits of alcohol restrictions in remote areas of Western Australia (WA).[1, 2]

There has been no analysis of the effect of such restrictions on the incidence of sexually transmitted infections (STIs). We looked at the available data on alcohol sales and STI rates for corresponding time periods before and after the introduction of alcohol restrictions in the remote communities of Fitzroy Crossing and Halls Creek in the Kimberley region of WA.

The Kimberley region has some of the highest rates of alcohol-related health and social problems in the country[3] and the highest rates of STIs in the State (1339 per 100 000 population for chlamydia, 1689 per 100 000 for gonorrhoea, with a rate ratio of 3.2:1 and 14.7:1 respectively for Aboriginal: Non-Aboriginal people in 2007).[4]

Improved sensitivity of testing, the introduction of mandatory laboratory notification in 2006 in WA, and increased disease transmission have all contributed to the increasing rates of both diseases.

In October 2007, alcohol restrictions (the "intervention") were introduced in Fitzroy Crossing. In May 2009, similar restrictions were imposed in Halls Creek.

The restrictions "prohibit the sale of packaged liquor, exceeding a concentration of ethanol in liquor of 2.7% at 20°C to any person, other than a lodger".

The measured beneficial effects have been remarkable, including a reduction in alcohol-related presentations to health services and a reduction in police tasks.[1, 2]

In Fitzroy Crossing from July to September 2007, 9360 litres of pure alcohol were sold, although data is lacking on alcohol brought in to the community. In the corresponding period in 2008, 2079 litres were sold, a 78% reduction.[1]

For the Kimberley region, data is collected on both STI notification rates and on testing performed for STIs, by postcode area. It was possible to analyse this data for both Fitzroy Crossing and Halls Creek.

Testing for the period 2004-2009 in Fitzroy Crossing showed an increase in testing due to the implementation of a comprehensive sexual health program in 2003. This included an increase in dedicated human resources, community-based education, and improved availability of testing and treatment.

In Fitzroy Crossing, there was a significant decline in both gonorrhoea (>50%) and chlamydia (30%) for the two years post – compared to the two years pre – restrictions. Since restrictions were introduced in Halls Creek, data on disease notification and testing show similar trends.

Time series analysis of the notification rates of STIs from January 2007 to April 2010 demonstrated a statistically significant decrease in notification rates after the intervention (*p* values for the intervention variable are 0.005 for Fitzroy Crossing and 0.012 for Halls Creek).

A systematic review of literature from 1995 to 2003[5] found 11 articles that included specific measures of problem drinking. Eight of these found a significantly increased risk of at least one STI among problem drinkers. One study conducted in an Aboriginal community in Central Australia[6] found that persons with alcohol abuse were significantly more likely to have an incident gonococcal infection (RR, 1.46; p=0.007), but there was no significant association with chlamydial infections (RR, 1.18; p=0.28) or syphilis.

Continued on page 2

Alcohol Restrictions and STIs: Is There a Link?

Continued from page 1

If alcohol consumption is associated with an increased risk of STIs, is this relationship causal? Suggested pathways for the link include the effect of alcohol on behaviour (number of partners, unsafe sex) and on sexual arousal[7] or on the immune system.[8]

Alcohol consumption and STIs may be linked by a third factor, such as "risk taking" or "sensation seeking" behaviour.[9] Alternatively, the association may reflect the link between problem drinking and certain social and sexual networks or neighbourhood characteristics.[9,10,11]

One study found a strong association between the number of sales outlets for alcohol and the rate of gonorrhoea.[12]

We have found very little evidence, from trials or documented real world experience, linking alcohol restrictions to a reduced risk of STIs. Our findings are suggestive that this may be the case.

The size of any effect depends on the strength of the restrictions, access to alcohol from other sources, and other measures introduced to reduce alcohol consumption.

The availability of a dedicated sexual health program will influence the incidence of STIs and the capacity of clinical services to detect and treat these conditions.

It is plausible that alcohol restrictions create a window of opportunity for presentation to clinical services for a range of conditions, including STIs. In addition, screening for alcohol problems should be considered by all clinicians involved in treating people with STIs.

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Drug Action Week 2012 Heading for Success

The national Drug Action Week (DAW) 2012 is shaping up to be another highly successful seven days of awareness raising and celebratory activities on the alcohol and other drugs (AOD) sector calendar.

The national launch has been locked in for Wednesday, 13 June 2012, at Parliament House in Canberra, and some 120 organisations have already registered events to coincide with DAW 2012 from Sunday, 17 June through to Saturday, 23 June.

"This early response is very encouraging, and follows on from the record 800 registrations recorded for DAW 2011," the Chief Executive Officer (CEO) of the Alcohol and other Drugs Council of Australia (ADCA), Mr David Templeman said.

"From feedback through the website at www.drugactionweek.org.au and via our Twitter and Facebook social media pages, we know that health and wellbeing organisations have aligned their activities with this year's DAW central theme of "Looking After ***YOUR*** Mind!" to assist in increasing awareness of the dangers of excessive consumption of alcohol and the misuse of other drugs."

Even at this early stage, registrations have been received from all jurisdictions with the expectation the target of 1000 activities will be achieved by early June.

To keep up with all of the latest DAW 2012 news and updates log onto the website at www.drugactionweek.org.au or follow us on Twitter at @DrugActionWeek and on Facebook at www.facebook.com/DrugActionWeekAustralia.

By incorporating these social media communication tools into this year's awareness campaign means DAW 2012 is reaching out to a much wider audience than ever before.

Mr Templeman said this also allows for increased interaction with event managers, as well as others across the alcohol and other drugs (AOD) and community sectors.

Facebook and Twitter not only provide a higher and more personalised level of participation, but also provide feedback to help plan future Drug Action Weeks.

For more details on DAW 2012, contact Brian Flanagan, Manager Strategic Communications, by phone on 02 6215 9802 (w)/ 0400 860 058 (m); or send an email to brian.flanagan@adca.org.au.

From the CEO's desk

2012 has certainly started off at a hectic pace for all non-government organisations (NGO) across the alcohol and other drugs (AOD) sector.

On 31 January 2012, the Alcohol and other Drugs Council of Australia (ADCA) and other State/ Territory AOD Peaks welcomed the news from Ms Wendy Morton, Executive Director of the Northern Territory (NT) Council of Social Service (NTCOSS), that the NT Government had agreed to fund a peak AOD body.

Initially, this means a funded position will sit with NTCOSS with the expectation of the peak becoming incorporated within three years. We all await updates as this initiative progresses.

LANDMARK PAY DECISION

Then on the following day, 1 February 2012, the AOD sector woke to hear Fair Work Australia's (FWA) landmark decision for equal pay for community sector workers.

This means that staff working in AOD treatment services could benefit from the ruling that community sector workers should receive pay increases of as much as 65 per cent.

ADCA has suggested to the State/ Territory AOD Peaks that the critical issue was to ensure that the AOD workforce nationally was not disadvantaged or overlooked in future negotiations about award/ employment arrangements.

ADCA also encouraged Peaks to liaise with their respective Council of Social Services (COSS) organisation to gain an understanding of the quantum of additional funding required, together with the level of coverage and application across the sector, as it was very clear that funding to cover increased wages would be essential.

ADCA also contributed an article on this issue which was run with the heading of ***Peaks must lead on pay rises*** in the Of *Substance E-Bulletin* published by the Australia National Council on Drugs (ANCD).

FLEXIBLE FUNDING OUTCOMES

The deadline is fast approaching for the Department of Health and Ageing (DoHA) to announce the outcomes of the Flexible Funding Process which began with the lodgement of funding applications in late December 2011.

On 20 February, DoHA sent a letter to all applicants to clarify the requirements for continuing participation in the funding process, and to highlight that DoHA may require further information from applicants in order to properly and fairly assess each application.

The letter reiterated that the Department anticipated concluding the assessment process "...by around the end of March 2012 and will notify successful and unsuccessful applicants after that time.".

ADCA subsequently alerted DoHA that the AOD/ NGO sector was concerned any delays in the process could lead to loss of key personnel and business closures. It is understood that the Minister responsible for alcohol and other drugs (AOD) matters, the Hon Mark Butler MP, will announce the outcomes in late March/ early April.

ALCOHOL ADVERTISING REVIEW BOARD

On behalf of ADCA, I have accepted an invitation to be a Panel Member of the new Alcohol Advertising Review Board launched on 16 March 2012.

This new national body will review alcohol advertising in Australia to counter the out of control advertising and marketing of alcohol, which is seeing increasing levels of alcohol-related harm.

The Board will consider and adjudicate complaints from the community about alcohol advertising, providing an independent alternative to Australia's current inadequate and ineffective advertising self-regulation system.

This is a world-first, and is an initiative of the McCusker Centre for Action on Alcohol and Youth (MCAAY) and Cancer Council Western Australia.

The Board is strongly supported by ADCA and other major health groups across Australia, and was officially launched by children's health advocate and former Australian of the Year, Professor Fiona Stanley AC, who will chair it.

Any member of the public, or frontline workers in the NGO/ AOD sector, are invited to direct complaints about alcohol advertising and promotion to www.alcoholadreview.com.au.

STRONG ARGUMENT FOR ALCOHOL TAX REFORM

To finish off the quarter, the 27 March 2012 Editorial in *The Age* newspaper posed the question *"When will Australia follow suit?".*

This of course refers to the British Government's decision to tackle the chronic binge-drinking problems head-on by lifting the minimum price of alcohol – almost doubling the floor price of cheap, strong drinks such as cider and wine.

ADCA, along with some 70 other members of the National Alliance for Action on Alcohol (NAAA), has since the Henry Review of Taxation in 2010 called for taxation reform to help change the drinking culture in Australia.

As the Editorial says…"it is worth recalling that alcohol abuse in this country is even more appalling (than Britain): it accounts for an estimated 60 deaths and 15oo hospital cases a week, and costs the Australian community about $36 billion a year in associated health, social and workplace problems."

Alcohol abuse continues to be a significant problem in all communities with an estimated 40 per cent of people detained by police affected by alcohol.

We should seriously consider taking up the challenge and follow the British example, with additional revenue directed to preventative health measures.

ADCA MEMBERSHIP FEEDBACK

You will note the recent first issue of *ADCA Activities,* the new electronic monthly report for Members. Please feel free to comment on, or to seek additional information about any of the subject matters in the report. Contact details, phone/ email, are listed with the name of the relevant ADCA contact officer for each item.

David Templeman,
ADCA Chief Executive Officer

Dr Alex Wodak Retires from St Vincents – Best Wishes from ADCA

The Patron of the Alcohol and other Drugs Council of Australia (ADCA), Professor Ian Webster AO, and the President of ADCA's Board, Professor Robin Room, have acknowledged the retirement on 29 February 2012 of Dr Alex Wodak (at left) from his position as Director of the Alcohol and Drug Service at St Vincents Hospital in Sydney.

Professor Webster wrote: Alex's contribution is beyond my few words. He approached the University of New South Wales in 1985 with a proposal to bid for a national research centre of excellence as part of the National Campaign Against Drug Abuse. With Syd Lovibond and Chris Clarke from psychology, Robin Richmond and myself from Community Medicine we sought the Government's funding. The fact that St Vincent's Drug and Alcohol Centre was at the epicentre of the nation's drug problem at that time was central to our claim. It was a hard battle; but we won. Thus started the now famous National Drug and Alcohol Research Centre.

That was but one of Alex's ideas. He is full ideas of what needs to be done and what should be done. Establishing supervised injecting centres was one such idea. And Alex, with others, successfully argued at the Drug Summit in 1999 for the Medically Supervised Injecting Centre now based in Kings Cross. There were other initiatives; many of international significance.

At a community forum in Perth organised by the ANCD I could not believe the anger being directed at sensible drug policies and the people who espoused them. I said so. And of an interjector I asked, "Have you ever spoken to a drug user or indeed ever treated one". Of course he hadn't. He disparaged Alex Wodak's views. "Alex," I said, "is one of the most admired people within medicine - by the profession itself - where his reputation stands high".

That is the highest accolade of all - to command respect and admiration of one's peers. And there are others of different perspectives who also admire Alex's forthright and uncompromising stand on public health and social justice: judges, lawyers, religious leaders, public health advocates, health and medical researchers and, above all, those marked and marginalised by their personal encounters with drugs and alcohol.

Where there are injustices, where power oppresses the dispossessed, that is where Alex's advocacy and work is to be found. His leadership and moral courage have strengthened all who work to lift the burden of disease from the lives of so many. He is to be especially honoured for speaking up for those harmed by substance use and blood borne virus infections.

A long period of service to inner Sydney has come to an end but he will march on to another drum - of harm reduction - through the Australian Drug Law Reform Foundation and international public health agencies.

Thanks Alex, and best wishes in your new roles.

From the ADCA Board, Professor Room said: On behalf of your Director colleagues on the Board of the Alcohol and other Drugs Council of Australia (ADCA), Members of the ADCA Council/ Policy Forum, as well as ADCA's Chief Executive Officer (CEO) and staff, our sincere best wishes for a well earned retirement.

While you are closing the door on such a dedicated and distinguished 30 years of service at St Vincent's Hospital, I am not surprised that you plan to continue briefly in a clinical role in the handover to your replacement. This is very commendable and will I am certain be appreciated by your clients and hospital staff.

I am also aware that after you finally finish at St Vincents, you plan to take on a full-time drug law reform role with the Australian Drug Law Reform Foundation (ADLRF), as well as maintaining your involvement with some committees.

This certainly doesn't sound like full-time retirement, and we at ADCA sincerely hope this means that you will be continuing in your role as a Board Director, and as Chair of the Illicit Drugs Working Group?

Your contributions to Board deliberations on sensitive alcohol and other drugs issues, comments on ADCA submissions, and input to the development of policy position papers through the Working Group has been invaluable from ADCA's perspective.

On a broader front, your leadership as Director of the Alcohol and Drug Service, your unstinting service to clients, as well as your advocacy particularly in relation to the establishment of the Medically Supervised Injecting Centre in Kings Cross in Sydney, has been a valuable lesson for all of us.

Your energy and commitment to tackling the challenges across the health and wellbeing field in Australia, in addition to striving for international reform, will I am certain be a model for future generations of medical practitioners, researchers, and last but not least the frontline workers in prevention and treatment services across Australia.

This note would be incomplete without thanking your family for sharing your valuable skills and experience with us after you chose such a worthwhile career, and given hope to so many people.

EDITORIAL

What, Who, When, Where, and What Outcomes!

By Ms Jeannie Little, ADCA Life Member and Chair of ADCA's Australian Indigenous Peoples' Working Group (AIPWG), in consultation with Co-Chair, Mr Wayne Flugge, and AIPWG Members

In order for us, as members of the Alcohol and other Drugs Council of Australia's (ADCA) Working Group (AIPWG), to address the important aspects within the ***What, Who, When, Where, and What Outcomes***, we must first diligently identify these, and then facilitate a sound and solid process, together with the relevant stakeholders, in a timely and proper manner for those of all genders and ages who are struggling for freedom from the different levels of substance use and abuse.

To achieve our goals, we have decided to activate the words within our Core and Guiding Principles, our Terms of Reference (ToRs), our Ways of Working, and our Organisational Practice where we have created questions within each layer to clarify and act on our roles and responsibilities that will actively support our Aboriginal and Torres Strait Islander (A&TSI) Peoples.

Each of our members who I refer to as "Pelicans" on the ground because of their special skills and a depth of knowledge of their own people, all have individual responsibilities and efforts within each State that can often be very challenging!

I believe to begin this process we need to have an initial face-to-face meeting to get our process started, and we have been given this opportunity through all of us being in Perth in Western Australia for the National Indigenous Drug and Alcohol Committee (NIDAC) Conference from 6 to 8 June this year. Other important issues will also be discussed.

Here are our principles, ToRs, our ways of working, and organisational practice:

1) **The core principle on/ about advice and support to ADCA relates to:**

   a. Specific policies, positions and submissions with A&TSI Peoples in mind. What is it that we need to do? And what are the key issues ADCA should consider when developing written statements?

2) **Our Guiding Principles that place high priority on networking, building strategic partnerships with other stakeholders regarding enhancing A&TSI Peoples capacity building:**

   a. This is a huge but important task that we need to commit to individually within each State. What is it that we need to do and with whom?

   b. The part we can only do collectively is collating what is achieved by individual members within each State.

3) **The Terms of Reference (ToRs):**

   a. What, when, and with whom do we provide evidence-based advice to the ADCA Board on our Group's specific policy positions and submissions?

   b. What is it that we need to do to initiate as appropriate, our Group's policy issues for consideration by ADCA?

   c. What, and when do we need to contribute to ADCA our Group's strategic planning, and when appropriate, participate in ADCA's Policy Forums?

   d. What, and with whom do we need to identify strategies that may help to facilitate on behalf of our A&TSI Peoples the reduction of, or delay the onset of the use of legal/ illegal substance use and abuse?

4) **What are our ways of Working?**

   a. As a group, what, when, and with whom do we need to identify each year two specific emerging issues to address actively and provide significant information to the ADCA Board based on current community information and latest literature?

   b. What plan do we need to put in place to call for research on exploring both licit and illicit drug misuse amongst A&TSI Peoples in urban settings to establish rates of use and misuse, and with whom?

   c. What literature and research relating to urban A&TSI Peoples substance misuse do we need to examine, and with whom in order to facilitate advocacy for a renewed research agenda into substance abuse?

   d. To whom do we go to call for research to be undertaken as to the current evidence supporting particular treatment and rehabilitation approaches and programs for co-occurring alcohol and other drugs misuse, and as well mental health problems, so as to identify examples of best practice?

5) **What is our Organisational Practice?**

   a. We are to meet a minimum of four times annually (teleconferencing) with at least one face-to-face meeting.

   b. We will have a Chair and Co-Chair of different genders – embracing our men's and women's business.

   c. Our Chair and Co-Chair will be the Executive Committee and be the quorum to discuss any urgent matters external to our specific meeting times.

   d. Generally, a quorum for all our other meetings will be three members with one of our members being the Chair or Co-Chair.

   e. ADCA will provide a secretarial support for our group in consultation with the Chair and Co-Chair.

ADCA Lodges Submission to Federal Parliamentary Inquiry into Foetal Alcohol Spectrum Disorder (FASD)

By ADCA's Senior Policy Officer, Ms Meredythe Crane, and Policy Officer, Ms Lucy Barnard

On 8 November 2011, the Minister for Families, Housing, Community Services and Indigenous Affairs, The Hon Jenny Macklin MP, and the (then) Minister for Health and Ageing, The Hon Nicola Roxon MP, asked the House of Representative's Standing Committee on Social Policy and Legal Affairs to Inquire into and report on the incidence and prevention of foetal alcohol spectrum disorder.

By 23 March 2012, a total of 61 submissions had been lodged with the committee, and public hearings had been conducted in Cairns and Townsville on 31 January 2012, and in Canberra on 15 March 2012. The next public hearing is scheduled to be held in State Parliament House in Sydney (New South Wales) on Friday, 13 April 2012.

Venues and dates for any further public hearings will be advised on the House of Representatives Committees website that can be accessed by visiting http://www.aph.gov.au/fasd. The Secretariat can also be contacted by telephoning 02 6277 2358.

FASD is an umbrella term covering a range of disorders caused by foetal exposure to alcohol. It describes a range of potentially harmful effects including physical, mental, behavioural and learning disabilities that may remain with those affected for the whole of their life.

FASD is caused by foetal exposure to alcohol during its development and can occur at any stage during pregnancy. The greater and more frequent the level of consumption, the greater the risk to the baby and the level of harm.

On 22 December 2011, the Alcohol and other Drugs Council of Australia (ADCA) lodged a submission with the House of Representative's Standing Committee on Social Policy and Legal Affairs for the Inquiry into and report on the incidence and prevention of foetal alcohol spectrum disorder (FASD).

The submission addressed the severe harms and importance of raising public awareness of an otherwise preventable condition.

It is not clear however whether there is a safe level of consumption and whether stage of pregnancy is relevant to the types of effect seen. What is clear is that if no alcohol is consumed during pregnancy then there is no risk of FASD, and that if someone develops FASD, there is no cure.

Children diagnosed with FASD may have brain damage, birth defects, poor growth, cognitive and/or developmental delay, social, behavioural and mental health problems, problems with speech, hearing and vision, high levels of activity, difficulty remembering, a short attention span, low IQ, problems with abstract thinking, poor judgement, and difficulty forming and maintaining relationships.

These children require ongoing management of their development to provide support and minimise the impact of their condition. Without this, children with FASD have a high risk of developing secondary disabilities such as mental health problems, trouble with the law, dropping out of school, unemployment, homelessness and/or developing alcohol and other drug problems. This has a significant impact on society.

While prevalence in Australia is not well understood, health researchers believe FASD is a serious public health, social and economic issue that affects people regardless of their cultural background or socio economic groupings.

As a condition it is under recognised, under diagnosed, and under reported and therefore its reach is probably much greater than we currently understand. Although FASD has been a particular issue in some Indigenous communities, it is not just an indigenous issue; it is occurring in indigenous and non indigenous communities across Australia, and affects both children and adults.

Cultural change around alcohol is required in Australia to alter attitudes to drinking and reduce the harm associated with its consumption. Alcohol is embedded in Australian society and is the most widely used drug.

A significant percentage of the female population in Australia consumes alcohol, with 37 per cent of women aged 18-29 years consuming four or more standard drinks on a single occasion at least once a week.

Many women also drink during pregnancy, reported at 48 per cent of women in Australia, though it should be noted that most women are not putting their baby at serious risk.

Women need support from their partners, families and the community to stop or reduce their alcohol consumption before, during and after pregnancy.

The effects of alcohol on the developing foetus occur throughout pregnancy but the foetus is most vulnerable in the first trimester, during the early stages of which the majority of women are unaware that they are pregnant.

Hence, and in light of the unknown and potentially varying effects of the level of consumption, the 2009 National Health and Medical Research Council (NHMRC) Guidelines suggest that the safest option for women is to avoid alcohol if they are pregnant, or are planning a pregnancy.

A public campaign is required to increase awareness and understanding of the Guidelines since research has shown that there is low awareness of the Guidelines, and that people are ignoring them.

Prevention, intervention and management of FASD is important to achieve better outcomes for the individual and the community at large.

Education and information campaigns and other clinical and community-led strategies are needed to help prevent FASD. Such campaigns should address some of the common myths associated with FASD, including themes such as whether there is a "safe" time to drink while pregnant, and whether FASD is only a problem for Indigenous communities, or is an issue for non-Indigenous communities as well.

However, any campaign to raise awareness of and diagnosis of FASD needs to be done in a way that does not stigmatise women, and in particular the parents of FASD affected individuals, or high risk groups.

Stigmatisation of the parent, particularly the mother, may inhibit access to support services for the individual and family which could lead to increased likelihood of detrimental effects.

Messages should be factual and be presented in a non-blaming way, as well as show how the family and community can support women. It should be noted that men have an important role in supporting women in not drinking and this should also be portrayed in education campaigns.

The foetus is most vulnerable to the effects of alcohol in the first trimester and therefore it is critical that the health workforce educate patients about alcohol consumption prior to pregnancy, especially in areas where access to specialist health services is limited and opportunities for intervention are limited.

A really important added benefit of greater awareness and early diagnosis is that it may prevent the same condition arising in subsequent pregnancies. This is particularly significant since overseas evidence shows exponentially increased risk and severity of FASD conditions in second and subsequent children to the same mother.

Interventions that have been recommended for children include pharmacological, educational behavioural, social skills and communication interventions. These include educational and learning strategies, virtual reality training, cognitive control therapy, language and literacy therapy, mathematics intervention, rehearsal training for memory, social and behavioural strategies and Attention Process Training.

Generally, FASD sufferers benefit from a broad management plan that uses a range of services and requires the support of family and/or other caregivers, clinical staff and teachers.

Early identification of FASD will allow adequate supports to be put in place to assist families and those affected to manage behaviour and prompt an appropriate approach in responding to issues.

The National Drug Strategy 2010-2015 identifies that action is needed to improve the diagnosis and clinical management of children affected by FASD and appropriate supports made available to those children and their families. An important first step is the development of an accurate and reliable diagnostic tool that will make diagnosis easier and faster.

All health professionals and other members of the health workforce have an important role in recognising risk factors and symptoms associated with FASD and referring clients to appropriate interventions.

As a significant number of pregnancies are unplanned and most pregnancies are not confirmed until sometime after conception, the developing embryo can be potentially exposed to alcohol inadvertently. This is a particular concern with the increasing trend of binge drinking amongst young women.

Greater research is required to better understand the scope of the problem in Australia and address the myths associated with FASD, as current data is insufficient. Evidence is needed on the prevalence, risk, health and social impact (on child, parent, family, society), and economic impact of FASD, noting that many cases are thought to go unreported.

Longitudinal research will provide further insight into the long-term impact of FASD. Maternal alcohol use would also be useful in addition to extending our knowledge on the physical and brain related impact of FASD.

Additional research on the effect of alcohol on lactation and on breastfed infants is also required as evidence demonstrates an effect on lactation, infant behaviour and psychomotor development.

The prevalence of at-risk alcohol use among pregnant women needs to be understood along with any association with socio-demographic groups.

FASD places significant burden on patients, families and the community. As a preventable condition, raising awareness and adopting prevention strategies will contribute to minimising associated harms.

These activities should be part of an overall effort to achieve cultural change and attitudes towards alcohol in Australia. Changing the physical and economic availability of alcohol is one of the most effective and reliable ways of reducing the harmful consumption of alcohol.

Appropriate labelling of products containing alcohol is another important strategy, with mandatory pregnancy health warnings of particular relevance to FASD.

A strategic approach to FASD is required that is holistic in nature and culturally appropriate for community care and support services across the different states and territories within Australia. Such an approach needs to address the diversity of cultural influences and the availability of resources in a variety of socioeconomic locations.

Three Years On – Alcohol Guidelines Invisible and Unknown

Australia's Alcohol Guidelines turned three on 6 March 2012, but there's little reason to celebrate.

New research by Mr Michael Livingston at the Centre for Alcohol Policy Research (CAPR), with funding from the Foundation for Alcohol research and Education (FARE), shows that 95 per cent of people are unable to correctly identify safe drinking levels.

Mr Livingston's research was released in Melbourne at the *Out of Sight, Out of Mind: Australia's Alcohol Guidelines Forum* hosted by FARE, CEPR, and the journal *Drug and Alcohol Review*.

Health experts who attended were presented with a range of new research on the awareness of the National Health and Medical Research Council's (NHMRC) Australian Guidelines to Reduce Health Risks from Drinking Alcohol, the ability of the Guidelines to influence perceptions, and were offered advice on how to better promote the Guidelines throughout Australia.

The study, *Perception of low-risk drinking levels among Australians during a period of change in the official drinking guidelines,* found fewer than five per cent of people were able to correctly identify safe drinking levels to avoid short and long-term harms, and between 30 and 50 per cent of respondents could not even provide estimates.

Addressing the Forum, Mr Livingston said he used data from the 2007 and 2010 National Drug Strategy Household Survey (NDSHS), which surveyed over 26 000 people from across Australia, and found that misconceptions were particularly pronounced among young people.

"Young people are significantly overestimating the number of standard drinks to consume per occasion to reduce the risk of short term harms, with young men aged 14-19 years estimating 8.8 drinks, while their female counterparts estimated 6.5 drinks," Mr Livingston said.

"The 2009 Guidelines recommend no more than four standard drinks."

The research also found the change in the Guidelines had a small effect on men's perception on what constitutes low risk drinking to avoid long-term harm.

About five per cent more men selected 1-2 drinks as being the amount they could consume in anyone day, compared to 2007.

"While this slight change in perceptions is positive, this study clearly shows that the Guidelines haven't changed broader perceptions," Mr Livingston said.

"Given the time, effort, and cost expended developing the Guidelines, and the potential to reduce alcohol harms when properly promoted, these findings are extremely disappointing."

Those sentiments were shared by the Chief Executive of FARE, Mr Michael Thorn; the Director of CAPR, Professor Robin Room; and the Director of the McCusker Centre in Perth, Professor Mike Daube.

"Three years since the introduction of the revised Guidelines we still have young men believing it is okay to have nine drinks in one sitting," Mr Thorn said.

"Clearly, you can't expect to change behaviours if you don't first educate and inform. People aren't going to make healthier choices if they aren't even aware what those safe choices are."

Professor Room, who is also President of the Board of the Alcohol and other Drugs Council of Australia (ADCA), said it was clear that comprehensive and on-going public education campaigns do have the potential to improve knowledge of alcohol guidelines.

"Denmark provides a great example of how public education campaigns can be effective in raising awareness of the guidelines," Professor Room said.

"Denmark followed the introduction of guidelines in 1990 with a 10-year-long national public education campaign that resulted in widespread knowledge and understanding of the guidelines, so much so, that by 1999 more than half of all respondents surveyed were aware of the Danish drinking guidelines for their gender."

According to Professor Daube, independent research clearly demonstrated that the introduction of a mandatory alcohol warning label regime, to compliment and reinforce the Guidelines, would have an immediate and cost-effective impact on reducing alcohol-related harm.

"We know the scope of the problem, but more important than that, we know how best to tackle it," Professor Daube said.

"Alcohol problems impact on the lives of all Australians, and there is growing and justified concern about drinking patterns among your people, and a culture of drinking to get drunk. If the Government is serious about this important issue, then the time to act is now."

To reinforce this point, CEO ADCA, Mr David Templeman, emphasised that the sector needed to adopt a consistent and joined-up appreciation of the critical issues exacerbating alcohol harm.

"We can't have different groupings within the sector focussing on different orders of priority," Mr Templeman said. "The National Alliance for Action on Alcohol (NAAA), now comprising over 70 member organisations, has a clear remit to tackle issues of the price of alcohol, its ready accessibility, and the way alcohol is marketed and advertised."

Mr Templeman called for organisations like the Australian National Preventative Health Agency (ANPHA), and the IGCD's Standing Committee on Alcohol to work with NAAA in address these core priorities.

Continued on page 9

Communiqué Endorsed and Issued
Continued from page 8

Communiqué Endorsed and Issued

The Forum clearly demonstrated the need for a comprehensive public education campaign and evidence-based alcohol warning labels to promote the NHMRC Alcohol Guidelines.

A Communiqué issued following the Forum was endorsed by the Foundation for Alcohol Research and Education (FARE), the McCusker Centre for Action on Alcohol and Youth, the Alcohol and other Drugs Council of Australia (ADCA), the Public Health Association of Australia (PHAA), the Cancer Council of Victoria, the Australian Drug Foundation (ADF), the Telethon Institute for Child Health Research, the Victorian Health Promotion Foundation, and the Turning Point Alcohol and Drug Centre. It read:

- Alcohol use and misuse is the cause of substantial harms to the Australian community. Every week, on average, 60 Australians die and a further 1500 are hospitalised as a result of alcohol. Alcohol is also a significant contributor to crime and violence as well as chronic diseases including cancer. Young people are disproportionately affected by alcohol-related harms resulting in injury, hospitalisation and death.
- In 2009 the National Health and Medical Research Council (NHMRC) released revised alcohol guidelines which were updated from 2001. The revised edition includes four guidelines which relate to reducing the risk of alcohol-related harm over a lifetime, reducing the risk of injury on a single occasion of drinking, alcohol consumption among children and young people and avoiding exposure of the unborn child and breastfed babies to alcohol.
- Today (6 March 2012) marks the third anniversary of the release of the NHMRC Alcohol Guidelines. During this time there has been no comprehensive public education campaign to promote the revised Guidelines. The Department of Health and Ageing's (DoHA's) own commissioned evaluation of the limited material regarding the NHMRC Alcohol Guidelines astutely pointed out that "The Guidelines will not engage the community nor influence attitudes towards the consumption of alcohol merely by virtue of their existence or being the 'official' recommendations.".
- The community is largely unaware of the NHMRC Alcohol Guidelines. Recent analysis of the National Drug Strategy Household Survey found that only five per cent of Australians are able to accurately estimate Guidelines 1 and 2 which provide advice on how to reduce long and short term harms from alcohol.
- Young people were more likely to provide higher estimates of the number of drinks to consume in one session to avoid alcohol-related harms such as injury. Young men aged between 14 and 19 years provided an average estimate of 8.8 standard drinks and young women provided an estimate of 6.5 standard drinks. These estimates are well above the recommended four drinks per session.
- Comprehensive and ongoing public education campaigns can improve public awareness of alcohol guidelines. A 10-year-long public education campaign following the introduction of guidelines in Denmark in 1990 resulted in more widespread public knowledge, with more than half of all respondents aware of Danish drinking guidelines for their gender in 1999.
- Alcohol health warning labels are also effective in raising awareness of health messages. Labels in the United States being shown to raise awareness of the health messages used on the labels, and to stimulate conversations about the risks of alcohol consumption. Immediate action is needed to raise awareness of the NHMRC Alcohol Guidelines.

The Communiqué concluded by calling on the Federal Government to immediately fund and implement:

- A comprehensive public education campaign to promote the NHMRC Guidelines to Reduce the Health Risks from Drinking Alcohol. The campaign should aim to raise awareness of alcohol-related harms and information on how to avoid these harms. It should also use a broad range of media to promote messages targeted at the general public and targeted population groups including women of child bearing age and their partners, young people, and Aboriginal and Torres Strait Islander peoples.
- Evidence-based mandatory alcohol warning labels on all alcohol products sold in Australia. The warning labels should be developed and regulated by Government, be applied consistently on all products, be based on the NHMRC Alcohol Guidelines, and include a symbol and text. The warning label regime should commence with the development and implementation of an evidence-based mandatory pregnancy warning label, with specifications for alcohol producers on the location and size of the label.

The comprehensive public education campaign and alcohol warning label regime should complement each other, rather than being two distinct policy initiatives. This would contribute to a reinforcement of the same evidence-based messages through a range of media.

ADCA Expresses Concern Over Statement by CLGCA

The Alcohol and other Drugs Council of Australia (ADCA) on 21 February 2012 wrote to Mr Chris Sidoti, Chairperson of the New South Wales (NSW) Casino Liquor and Gaming Control Authority (CLGCA), in response to a statement made by the Authority in relation to the evidence about the relationship between pricing and alcohol-related harm.

ADCA is still waiting for a response to the letter signed by the Chief Executive Officer (CEO) of ADCA, Mr David Templeman, which read:

Dear Mr Sidoti

We write in relation to the recent statement by the New South Wales (NSW) Casino, Liquor and Gaming Control Authority (CLGCA) on Thursday 26 January 2012, on supermarket bottle shops and alcohol pricing, to express concern about a number of comments made in the CLGCA statement that are clearly incorrect.

ADCA is the national peak body representing the interests of the Australian non-government sector for alcohol and other drugs. It works collaboratively with the government, non-government, business and community sectors to promote evidence-based, socially just approaches aimed at preventing or reducing the health, economic and social harm caused by alcohol and other drugs to individuals, families, communities and the nation.

The CLGCA statement on supermarket bottle shops and alcohol pricing states that the 'evidence is inconclusive' about the relationship between alcohol abuse and liquor pricing. It goes on to say that there is a lack of *conclusive* evidence that 'current alcohol pricing increases consumption and associated community impacts'.

These are disappointing statements from an organisation that claims to be concerned about the '*potential* social impact of alcohol pricing'. On the one hand, the statement refers to 'potential impact' but on the other *requires* 'conclusive evidence'. CLGCA is obviously conflicted.

It is essential that all parties understand what it is that we are dealing with in relation to alcohol. Alcohol is the most widely used drug in Australia (AIHW 2008). Next to tobacco, excessive alcohol consumption is a major risk factor for morbidity and mortality, and has been associated with diseases such as cancers, stroke, brain impairment, heart attack, and liver cirrhosis.

It is also associated with injuries arising from events such as motor vehicle and bicycle accidents, incidents involving pedestrians, harm in the workplace, falls, fires, drowning, sports and recreational injuries, overdose, assault, violence, and intentional self-harm (NHMRC 2009; Chikritzhs et al 2003).

It has been estimated that harm from alcohol was responsible for 3.2% of the total burden of disease and injury in Australia in 2003 (Begg et al. 2007), and for 2004-2005, the total social cost of alcohol abuse was estimated at $15.3 billion (Collins & Lapsley 2008).

When these costs were combined with those to others due to harms caused by the drinker, it is estimated that the social cost of alcohol in Australia in 2008 was $36 billion (Laslett et al 2010).

In addition to the many physical effects on the individual drinker, the consumption of alcohol has a broad social and economic impact. It includes several forms of violence (eg aggression, assault, sexual assault etc) and various forms of anti-social behaviour, including offensive behaviour, property damage, petty crime and drink driving.

A study by Turning Point Alcohol and Drug Centre in 2005 found that as a result of the drinking by *others*, 367 people died, 14 000 people were hospitalised, (some) 24 000 people were victims of alcohol related domestic violence, 20 000 children were victims of alcohol-related abuse, and, overall, 70 000 Australians suffered from alcohol related assault.

Economic costs are realised in the workplace through absenteeism, accidents, lost productivity, lost wages and premature death (NHMRC 2010) with the cost of alcohol related absenteeism alone estimated to be $1.2 billion per annum for 2001 (Australian Safety and Compensation Council 2007).

Of key importance here is that there is indeed good evidence for a link between alcohol consumption and price and associated harms. A meta-analysis of the effects of pricing and promotion on alcohol consumption and related harm in the UK by the University of Sheffield found that, amongst a number of things:

- there is strong and consistent evidence to suggest that price increases have a significant effect in reducing demand for alcohol,
- there is strong evidence to suggest that young drinkers, binge drinkers and harmful drinkers tend to choose cheaper drinks, and
- a large number of studies consistently suggest evidence for an association between increases in taxation or pricing of alcohol and reductions in harm.

Studies looked at within the meta analysis found that increases in the price of alcohol reduce the alcohol consumption of young people, with a greater impact on more frequent and heavier drinkers than on less frequent and lighter drinkers.

Price was also found to influence drinking to intoxication, which is associated with the highest levels of acute harm with one large survey in the USA finding that a 10% increase in price would decrease the number of intoxication episodes per month by 8% (defined as consuming 5+ drinks on one occasion). There was also strong evidence that hazardous drinkers tend to choose cheaper drinks, whether they are young binge drinkers or problem drinkers.

The Sheffield study found that an increase in the price of alcohol was shown to reduce alcohol consumption, hazardous and harmful alcohol consumption, alcohol dependence, the harm done by alcohol, and the harm done by alcohol to others than the drinker. It also found evidence of a clear relationship between taxation or price increases and a decrease in consumption and associated harms.

According to Carragher and Chalmers (2011) economic modelling undertaken as part of the Sheffield study showed that a £0.50 minimum price per unit of alcohol would result in a 6.9 per cent reduction in consumption in the population as a whole.

Continued on page 12

NDSIS Update

Jane Shelling, Manager
National Drugs Sector
Information Service

To start the year here is a reminder of all the great resources and information available to you from the National Drugs Sector Information Service (NDSIS) and its projects.

NDSIS – National Drugs Sector Information Service http://ndsis.adca.org.au

Did you know? The Drug database (www.drug.org.au) lists the largest collection of AOD related resources in the world. Each item is available from the NDSIS free of charge to ADCA members.

Most popular: Full text electronic journal access available to all ADCA members. Simply login to the Member's only area of the ADCA website. For full instructions go to **www.adca.org.au/ndsis/ejhelp.php.**

Drugfields – professional development for the AOD sector www.drugfields.org.au

Did you know? The Professional Development page of Drugfields **(www.drugfields.org.au/my-professional-development**) contains the most comprehensive listing of AOD conferences, workshops and seminars in Australia.

Most popular: Drugfields monthly E-Blast (see link at **www.drugfield.org.au**) which delivers the latest Australian AOD professional development information.

National Inhalants Information Service – www.inhalantsinfo.org.au

Did you know? A new edition of our *Developing an Inhalant Misuse Community Strategy* by Sarah McLean will soon be available. Contact ruth.mahon@adca.org.au for a free copy.

Most popular: The NIIS electronic newsletter (NIIS CAN) produced every three months. The newsletter highlights news and views about inhalant abuse from around Australia and the world. Also included is a list of resources added to the inhalants database at **www.inhalantsinfo.org.au/online_resources.php.**

RADAR – www.radar.org.au

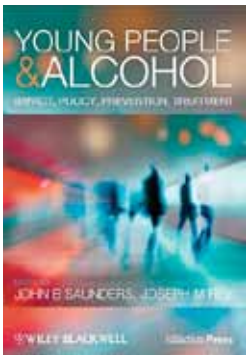
Did you know? No matter how big or small your AOD research project is, it can be included on the RADAR website (see Submit Project on the RADAR home page to do it yourself or contact di.piper@adca.org.au for help).

Most popular: An advanced search of RADAR which lists current AOD research projects taking place in Australia. Information which is useful to both funders and researchers.

BOOKS FOR LOAN

Handbook of child and adolescent drug and substance abuse: pharmaceutical, developmental and clinical considerations / Louis Pagliaro and Ann Marie Pagliaro. Wiley, 2012

Treating adolescent substance abuse: using family behaviour therapy a step by step approach / Brad Donohue and Nathan Azrin. Wiley, 2012



Young people & alcohol: impact, policy, prevention, treatment / edited by John Saunders and Joseph Rey. Wiley, 2011

"Young People and Alcohol" is a practical and comprehensive reference for professionals and researchers in the field of alcohol misuse who work with people aged 12 to 25 years. The book provides readers from a range of professional backgrounds with authoritative and up to date information about the effects of alcohol use in the young and, particularly, its management, with an emphasis on interventions whose effectiveness is supported by evidence.

JOURNAL NEWS

Addiction Science & Clinical Practice provides a forum for clinically relevant research and perspectives that contribute to improving the quality of care for people with unhealthy alcohol, tobacco, or other drug use and addictive behaviours across a spectrum of clinical settings.

Addiction Science & Clinical Practice is now accepting articles of clinical relevance related to the prevention and treatment of unhealthy alcohol, tobacco, and other drug use across the spectrum of clinical settings. Previously published by NIDA, *Addiction Science & Clinical Practice* is now available free from BioMed Central at www.ascpjournal.org.

ADCA Expresses Concern Over Statement by CLGCA

Continued from page 10

Based on these findings, the Chief Medical Officer for England in 2009 predicted that over 10 years a £0.50 minimum price per unit of alcohol would result annually in 3393 fewer deaths, 45 800 fewer crimes, 97 900 fewer hospital admissions, and 296 900 fewer sick days; ultimately saving over £1 billion. In Australia, Chikritzhs et al (2005) found that even small increases in the price of alcohol can have a significant impact on consumption and harm.

Further evidence for the relationship between price and alcohol related harm can be found in the report by the World Health Organisation on the *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm.*

WHO found that there was "indisputable evidence that the price of alcohol matters. If the price of alcohol goes up, alcohol-related harm goes down". WHO found this to be true for each of the countries studied.

The report states that policies that increase alcohol prices delay the time when young people start to drink, slow their progression towards drinking larger amounts, and reduce their heavy drinking and the volume of alcohol drunk on each occasion. Price increases reduce the harm caused by alcohol, which is an indicator that heavier drinking has been reduced, with a greater impact on heavy consumers than light consumers.

Carragher and Chalmers (2011) provide timely support for these findings in their report on behalf of the NSW Bureau of Crime Statistics and Research. They found that based on the policies that have been implemented and evaluated both nationally and internationally, those which increase alcohol prices and taxes are considered to be most effective in reducing alcohol consumption and related harms.

They go on to say that there was a *consistent finding* that population level alcohol consumption is inversely related to alcohol prices. They also mention that young people and heavy drinkers are responsive to increases in alcohol prices, although young people may be less responsive than older people.

While these studies refer to price in general rather than specifying a particular price level, the reality is that it would be difficult to provide evidence of harm related to the "current price" as sought by CLGCA, since price is not a stable factor.

It fluctuates and varies between products and would change before any research could be undertaken. But to put some context around the *current* price of alcohol, we are now seeing situations in NSW where the price of alcohol is cheaper than bottled water – surely something which should be of concern to the CLGCA.

A related issue is the association between outlet density and alcohol related harm. There is a plethora of research in this area also. WHO (2009) recognises this association reporting that "an increased density of alcohol outlets is associated with reduced social capital and increased levels of alcohol consumption among young people, with increased levels of assault and with other harms such as homicide, child abuse and neglect, self-inflicted injury and, with less consistent evidence, road traffic accidents".

They found consistent evidence that regulating and limiting outlet densities can reduce alcohol-related harm.

Kathryn Stewart of the Pacific Institute for Research and Evaluation provides a rundown on some of the findings in the USA over the past 20 years that show a strong association between outlet density and violence, regardless of the economic, ethnic or age profile of the community. Conner et al (20011) found a similar association in their research in New Zealand.

Positive associations between alcohol outlet density and both individual level binge drinking and alcohol-related problems appeared to be independent of individual and socio economic status.

The work of Liang and Chikritzhs (2011) demonstrates the complexity of the issues surrounding outlet density and alcohol related harm. They found that while both on and off-site alcohol outlets influence levels of violence, the mechanisms by which this occurs appears to differ.

The presence of liquor stores drives violence which occurs not only in domestic settings but also influences violence that occurs at on-license premises such as hotels. The authors postulate that the reason for this is because liquor stores have the potential to strongly influence pre-loading behaviour because it is cheaper to buy alcohol beforehand and then go out to on-licence premises.

ADCA appreciates that any decision limiting the extent to which the industry can market and sell discounted and low priced alcohol and alcohol products will be unpopular.

However, alcohol is not a commodity like bread or milk or household goods – alcohol is a potentially addictive product with known harmful health and social consequences and therefore needs to be treated with caution.

A decision to approve an increase in the number and density of alcohol outlets in the face of the evidence relating to alcohol related harm would seem a high risk strategy by CLGCA and quite irresponsible, which could potentially leave the NSW Government open to litigation.

ADCA calls on the CLGCA to reconsider their decision in light of the above evidence and in the interests of openness and transparency, make available all the submissions referred to in the Statement of 26 January 2012 by the three supermarket chains, and to invite other interested parties to provide advice on the weighting that "the issue"' (presumably of the potential impact of cheap alcohol) should be given when assessing bottle shop applications.

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