Winemakers' Federation of Australia

leadership strategy advocacy support

23 October 2015

Darren Button
Associate Director
Health Outcomes International

Via email: darren@hoi.com.au

Dear Darren,

Draft National Drug Strategy 2016-2025 as at October 2015

The Winemakers' Federation of Australia (WFA) is the peak national industry body for Australia's winemakers. As the lead representative advocacy body for winemakers at the national level, we have a long history of collaborative engagement with successive federal governments on policy development. We welcome this opportunity to assist in the development of the National Drug Strategy (NDS) for 2016-2025.

The comments in this letter constitute our formal submission to Health Outcomes International (HOI), as the Commonwealth's appointed contractor for the management of stakeholder consultations on behalf of the Intergovernmental Committee on Drugs (IGCD).

Wine is a legal, heavily regulated and taxed alcohol product which can be consumed safely in moderation. In this regard, it is different to both tobacco and illicit drugs but this is not recognised in the draft NDS. The draft NDS instead treats alcohol, tobacco and illicit drugs with equivalency. This major flaw needs to be acknowledged by the Committee and reflected in the final version of the NDS.

Specifically, there is no consistent acknowledgement of safe levels of wine consumption in the draft and therefore no discussion or inclusion of performance indicators related to the promotion of moderation, an increase in moderate drinking levels and the subsequent lowering of harm. In sections of the draft it is unclear whether or not the draft NDS advocates total abstinence for alcohol products as it is confusingly integrated with generic commentary regarding tobacco and illicit drugs.

In the current draft, the suggestion is that all Australians engage in risky alcohol consumption. The draft seems to give the same meaning to "harm" as it does to "use" with no recognition of the responsible use of alcohol in moderation with *no* resulting "harm". This lack of clarity is myopic and reckless and needs to be addressed with the acknowledgement that wine and alcohol are different; different from tobacco and different from illicit drugs, and will require a specific 'fourth' pillar around 'promoting moderation' for harm minimisation.

By not recognising the importance of promoting moderation, the draft strategy advocates minimal engagement with industry to assist with harm minimisation. In doing so, the draft diminishes the opportunity for collaboration for initiatives that can drive changes in Australia's cultural norms around what is acceptable when alcohol consumption takes place. For example, the work of DrinkWise Australia in this regard and the potential to build on its successes cannot be ignored.

The draft NDS is not supported by WFA and should be amended significantly to reflect the differences between alcohol and tobacco and illicit drug use. Subsequent to this, more emphasis is required on promoting a targeted message of moderation around wine and alcohol consumption that is distinct from other drug and tobacco strategies.

WFA is also concerned that the cited 'evidence' in the draft 'cherry-picks' from the referenced sources to create a picture of a crisis where all Australians are harming themselves through consumption of alcohol. We would refer HOI and indeed, the Committee, to the submission made by Dr Creina Stockley of the Australian Wine Research Institute (AWRI). Her submission provides greater technical insight and highlights significant concerns with the references cited. In addition to cherry-picking, in other instances, discredited references are used. We would draw your attention to the repeated use of Collins and Lapsley (2008) and to the unattributed reference on page 31 of the draft NDS of $36billion, which Dr Stockley notes has come from an in-house report for Foundation for Alcohol Rehabilitation and Education (FARE) by Laslett et al (2010). Dr Stockley observes that these figures on purported costs associated with alcohol harms "*differ by a magnitude of 10*" and then goes on to note that "*Marsden Jacob Associates (2012) in an analysis commissioned by the Australian Preventative Health Agency in 2013 to examine the basis on which differing cost figures were determined stated 'Figures, such as costs of $36 billion, are obtained by adding together separate analyses reflecting different purposes and different concepts and methodologies and some double counting. These figures inflate the assessment of likely costs.'"* The draft NDS' reliance on this discredited figure of $36 billion is extremely misleading, especially when it is used to justify pursuing a strategy of reducing alcohol consumption across the *entire* population rather than focusing on measures to reduce consumption of known at-risk groups while simultaneously ignoring the achievements and opportunities of further encouraging moderation. This severely undermines the credibility of the draft strategy and must be corrected.

Meanwhile, figures from government agencies which clearly show a more moderate drinking culture are being achieved, are ignored. Specifically, we are deeply concerned about the lack of any reference in the draft to the 2015 ABS data that indicates Australians' consumption of alcohol has been declining over the past six years and in 2013/14 was at the lowest levels in 50 years[1]. This finding complemented that of the Australian Institute of Health and Welfare (AIHW) which showed in 2013 a lower proportion of Australians aged 14 years or older were consuming alcohol in risky quantities compared to 2010. Further, it showed that both the proportion of lifetime risky drinkers and single occasion risky drinkers had declined. The draft NDS will remain incomplete without these important data sets. The exclusion of these findings would deny both the importance and legitimacy of responsible consumption of alcohol and of Australians achievements in applying moderation.

Further, by omitting these data sets, cherry-picking others and conflating alcohol 'use' with alcohol 'harm' the draft NDS sets up a false premise that all Australians who consume alcohol are being harmed by alcohol to an extent that it is a crisis which warrants population wide controls. This approach flagrantly tries to skew the evidence to support a preferred approach of the anti-alcohol lobby; an approach that favours price controls as a "catch-all" for reducing *all* alcohol consumption across the *entire* population instead of focussing efforts on reducing harmful levels of drinking and real alcohol abuse among known at-risk population sub groups. We would also refer the Committee to the submission made by Dr Creina Stockley and the section on evidence relating to price and its impact on at-risk drinkers.

There is also a lack of commitment in the draft NDS to working with industry. This commitment is present in the current strategy. Its omission is concerning particularly in light

[1] Australian Bureau of Statistics, '4307.0.55.001 - Apparent Consumption of Alcohol, Australia 2013-2014 ' http://www.abs.gov.au/ausstats/abs@.nsf/mf/4307.0.55.001

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of the World Health Organisation's directive to Member States in its '*Global strategy to reduce the harmful use of alcohol 2010'* to engage with "industry associations" and specifically to "organise open consultations with representatives of industry".

In summary, WFA strongly recommend the following amendments to the draft NDS:

1. Explicitly separate alcohol from tobacco and illicit drugs;
2. Introduce a fourth pillar on 'promoting moderation' for harm minimisation;
3. Specifically acknowledge ABS and AIHW data showing declines in alcohol consumption;
4. Re-examine the cost of alcohol-related harms and cite credible sources;
5. Examine the factors behind the achievements of moderation so that successful measures can be strengthened and replicated;
6. Identify strategies which specifically target at-risk groups; and
7. Explicitly state a commitment to working with the alcohol industry.

We trust that the advised changes in this submission will be reflected in future drafts of the NDS and indeed in the final document. WFA would welcome the opportunity to meet with you to detail our concerns and to identify opportunities for industry collaboration. In the first instance, please contact WFA through our General Manager of Government Relations, Melissa Cheesman-Faull; Melissa@wfa.org.au or 08 8133 4312. We would appreciate you amending your records to include this contact information.

Yours sincerely,

Paul Evans
Chief Executive

Attachment:

1. Submission by Dr Creina Stockley, Health & Regulatory Information Manager at The Australian Wine Research Institute

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The Australian Wine Research Institute

SUPPORTING AUSTRALIAN WINE FOR 60 YEARS

Darren Button
Associate Director
Health Outcomes International

16 October 2015

Dear Darren,

Draft National Drug Strategy 2016-2025 - October 2015

Thank you for the opportunity to comment on the Draft National Drug Strategy 2016-2025, October 2015. My comments are provided on the following pages, and have been confined to areas and issues in which The Australian Wine Research Institute has access to information and mechanisms, and expertise or knowledge.

I will be happy to provide further comments and feedback on request, as well as participate in any additional public consultations or forums.

Yours sincerely,

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cc. Dr Daniel Johnson

Comments on Draft National Drug Strategy 2016-2025 - October 2015

1. General comments

Since 1985, the National Drug Strategy has demonstrated its effectiveness in establishing a framework that has guided strategy, policy, service and treatment development in relation to reducing drug-related harm in Australia. The consistency of the core principles of harm minimisation, evidence based or informed practice and cross-sectoral partnerships has created a strong basis for addressing the negative health, social and economic impacts of drug use on Australians. It should, therefore, be stated in the introduction on page 5 that the apparent consumption of alcohol in Australia has been declining over the past six years and in 2013/14 was the lowest since 1962/63 (ABS 2015). This data complements that published by the Australian Institute of Health and Welfare (AIHW 2014) which shows that in 2013 a lower proportion of Australians aged 14 years or older consumed alcohol in risky quantities compared to 2010 and that both the proportion of lifetime risky drinkers and single occasion risky drinkers had declined.

The draft National Drug Strategy 2016-2025 has many similarities with the current National Drug Strategy 2010-2015 (MCDS 2011). Furthermore, it is not dissimilar to the previous six iterations of the Strategy and contains commentary based on that of the World Health Organisation's (WHO) *Global strategy to reduce the harmful use of alcohol* of 2010 (WHO 2010). It includes the three pillars of demand reduction, supply reduction and harm reduction, and many specific strategies, but has been significantly simplified in detail, language and layout, with updated content, especially on emerging issues.

Importantly, more emphasis has been placed on evidence such as "evidence of good practice" and an "evidence informed approach", as well as emphasising that drug use is only one factor in complex social issues and accordingly all approaches and their specific strategies should reflect this.

In addition, in the Foreword on page 3 it states that the National Drug Strategy has historically focused on relationships between law enforcement and health as well as with other areas of government, the non-government sector and the community in minimising harms associated with alcohol use. There is no mention of a relationship with the industry. Specific partnerships outlined in this document are only those with national, state and local government and associated agencies, enforcement agencies, service providers and the community, for example. "Trade" is, however, included in the list on page 7, and "industry" is, included on pages 16 and 24 in relation to regulation. Inclusion of industry in partnerships should be considered given that the WHO's *Global strategy to reduce the harmful use of alcohol* of 2010 requests Member States " to encourage mobilization and active and appropriate engagement of *all* concerned social and economic groups, including scientific, professional, nongovernmental and voluntary bodies, the private sector, civil society and *industry* associations, in reducing harmful use of alcohol", and specifically "to organize open consultations with representatives of the *industry, agriculture and trade sectors* in order to limit the health impact of harmful alcohol consumption" (WHO 2010).

Concerning the key principle of evidence informed responses, a primary reference to the evidence based approaches and strategies in the draft Strategy is Miller et al. (2015). This reference is not

actually cited as such in the text of the draft Strategy and should be included on page 7. In Miller et al. (2015) it is stated that the evidence for effectiveness of interventions or measures was from "the Delphi method which provides a reliable consensus of opinion from a panel of experts". In addition, the actual panels of 'experts' or 'respondents' employed by Miller et al. (2015) are not listed and hence the expertise cannot be evaluated.

2. Harm minimisation approach

It is important that the harm minimisation approach adopted in previous six iterations of the Strategy has continued in this draft Strategy where previously it has been cited that "Harm minimisation is the acceptance of alcohol consumption within the general community, where strategies were designed to minimise the harms ensuing from that consumption, *without necessarily reducing consumption*" (MCDS 2011). In the draft Strategy, wording such as "*encourage cessation*" (page 9) and "*reducing use by the whole population*" (page 11) conversely imply that reduction of *any* alcohol consumption may be important to the success of the draft Strategy. Given that the draft Strategy refers to both illicit and licit drugs and a reduction consumption of the former is important, the inclusion of alcohol in this wording may be inadvertent. Indeed, other wording in the demand and supply sections of the draft Strategy refers to "reduce harmful use" and "reduced harmful consumption levels".

3. Evidence informed approach and specific strategies

Specific strategies under each of the three pillars have been elucidated from the current Strategy for each drug type, namely tobacco, alcohol, illicit drugs and illicitly used drugs, as well as in combination as "all drugs", presumably for clarity and consistency. However, where the current Strategy also contains actions to achieve each strategy, the draft Strategy mixes evidence informed approaches with strategies rather than actions. References for the evidence on which each strategy is based are also not included, simply the heading of "evidence informed approach".

The evidence for effectiveness of education/social marketing at changing social norms and the drinking behaviour of young people has been demonstrated in the reduction in alcohol consumption and the delay in initiation of drinking age in young people over the past three or more years. This reduction coincides with the campaigns by DrinkWise Australia and other community and government groups. This was referenced on page 12 of the draft Strategy. Accordingly it was pleasing to see that despite the low rating in effectiveness by Miller et al (2015), education/social marketing strategies were included in the draft Strategy, although mainly for demand reduction rather than harm reduction, and as part of broader campaigns.

Demand reduction strategies

It is important that page 11 includes "building social inclusion and resilience" as a means of "reducing the impact of stressors and use of alcohol" in demand reduction strategies. This builds on objective #3 in the current Strategy which recognises the importance of supporting people to recover from dependence and reconnect with the community. This is a more holistic approach to preventing or solving a potential problem for an individual rather than a merely mechanistic one for a 'target

audience'. Included in the table of evidence informed approaches and specific strategies on pages 14 and 15 are those listed in the WHO factsheet on Alcohol under "Ways to reduce the burden from harmful use of alcohol" (WHO 2015), such as:

- Price mechanisms – excise tax, volumetric excise tax, minimum floor price and regulation of price discounting and bundling;
- Restrictions on promotion – enforced advertising standards and restriction, regulation of price promotion, promotion at point of sale and in key settings such as those aimed at young people;
- Treatment; and most importantly,
- Building community knowledge and changing acceptability of use.

The draft Strategy appears subtly changed from the current Strategy with increased emphasis on "acceptability of use".

Supporting the evidence informed approach of building community knowledge and changing acceptability of use included in the table on page 15 are statistics provided in the introduction to demand reduction pages 11 and 12). These are from the Cancer Council Victoria in 2012 which undertook the 2011 Australian Secondary Students' Alcohol and Drug survey for the Drug Strategy Branch of the Australian Government Department of Health and Ageing. Estimates found in 2011 were also compared with those from surveys conducted in 2008 and 2005, and focused on estimates for the age groups 12- to 15-year-olds, 16- to 17-year-olds and 12- to 17-year-olds. The other primary source of statistics was the Australian Institute of Health and Welfare's (AIHW) National Drug Strategy Household Survey (NDSHS). It should, therefore, be emphasised on page 12 that together these data sets show clearly that alcohol consumption by young people is declining. It would also strengthen the draft Strategy if the rationale for this decline could be considered to enable those strategies considered to be successful to be strengthened and/or continued to be supported.

Supply reduction strategies

In Section 4.1 *What we know* (page 17), the accompanying text to the table on pages 20-21, states that "the relative price of wine, in particular, has substantially reduced in recent years. The evidence shows that the price of alcohol highly influences the rate of consumption and rates of alcohol-related harm, particularly amongst young people and heavy or problem drinkers". This statement is in contras twith what has been generally observed in the peer-reviewed literature, which suggests that while price affects heavy drinking, the magnitude of the effect is significantly smaller than effects on overall drinking in a population.

For example, Manning et al. 1995, Kenkel 1996, Ayyagari et al. 2013 and Nelson 2013 all observed that heavier alcohol consumers were less sensitive to price changes observed. In the review by Wagenaar et al. (2009) of 19 studies on the price sensitivity of heavy drinkers and alcoholic liver cirrhosis, only two studies found that heavy drinkers significantly decreased their consumption in response to increased prices and there were similar findings for alcoholic liver cirrhosis. Indeed, Manning et al. (1995) observed in a random US-wide survey of 18,000 adults that moderate consumers were the most price sensitive compared to light and heavy consumers and that no significant responsiveness to price was found among the heaviest consumers, specifically the 5% of the population responsible for 36% of (then) USA's total alcohol consumption. In addition, while

price might be important for drinking participation by youth and young adults, heavy drinking by youth and young adults, regardless of gender, is not easily dissuaded by higher prices. Furthermore, heavy drinkers have been coined 'risk tolerant' by Dave and Saffer (2008), and whether alcohol consumers are 'risk tolerant' or 'risk aversive' also influences their sensitivity to price changes.

For alcohol from the seven strategies promulgated by the World Health Organisation in 2015 and included in Babor et al. (2010), the broad brush supply reduction strategies include:

- Regulating retail sale;
- Age restrictions (which are already in place);
- Border control such as duty free restrictions and interruption of illegal imports (both of which are already in place); and
- Regulating production and wholesale distribution, and detecting and disrupting illegally produced products.

While the draft Strategy suggests it will target 'at risk' groups with the evidence informed approaches, the majority of the strategies included in the draft Strategy appear to be aimed at reducing whole-of-population alcohol consumption. Accordingly, more strategies specifically targeting 'at risk' groups should be considered.

Harm reduction strategies

In section 5.1 *What we know*, (page 23), it is too simplistic to state that "Substance use during pregnancy poses a risk of fetal harm, including Fetal Alcohol Spectrum Disorders (FASD)... and that some drinking occurs among approximately 20% of pregnant women after learning of their pregnancy (Callinan and Room 2012)." Indeed the implication from this text is that all or any alcohol drinking during pregnancy causes FASD where the available evidence continues to be conflicting as to whether any amount of alcohol harms the developing foetus (O'Leary 2010). It is not yet known how much alcohol is safe to drink during pregnancy, although it is known that the risk of damage to the developing foetus increases the more women drink and that binge drinking is especially harmful. Recent reviews by May and Gossage (2011) and May et al. (2013) of maternal risk factors for foetal alcohol-related abnormalities suggest that maternal risk is multidimensional, including factors related to quantity, frequency, and timing of alcohol exposure; maternal age; number of pregnancies; number of times the mother has given birth; the mother's body size; nutrition; socioeconomic status; metabolism; religion; spirituality; depression; other drug use; and social relationships. This would also suggest that more research is needed to more clearly define what type of individual behavioural, physical and genetic factors are most likely to lead to having children with alcohol-related foetal abnormalities. In Australia, the estimate of FAS in the non-Aboriginal population is 0.02/1000 and in the Aboriginal population 2.76/1000 (Bower et al. 2000) with the highest estimate of 4.7/1000 reported for FASD in Aboriginal children in the Northern Territory (Harris et al. 2003, O'Leary et al. 2013). It is pleasing to note that since 2007, the proportion of Australian women consuming alcohol during pregnancy has declined and the proportion abstaining has increased and most pregnant women tend to change their drinking behaviour once they find out they are pregnant (AIHW 2014).

The draft Strategy includes similar harm reduction strategies to those suggested in the WHO *Global strategy to reduce the harmful use of alcohol* (2010), such as:

- Safe transport and sobering up services (currently being introduced);
- Safer settings such as dry areas, mandatory plastic glassware, free water at licensed venues and lockout times (currently being introduced);
- Programs to reduce alcohol and other drug use during pregnancy (currently being introduced); and
- Reduction of driving under the influence of alcohol by random breath testing (already in place), zero blood alcohol concentration requirements for novice drivers (already in place) and penalties and intervention programs for recidivist drink drivers (already in place).

4. Priority populations

Priority populations in the draft Strategy are the same as those in the current Strategy and are Aboriginal and Torres Strait Islander people, people with mental illness, young people, older people, people in contact with the criminal justice system, culturally and linguistically diverse populations and people identifying as gay, lesbian, bisexual, transgender or intersex. In contrast to the current Strategy, some specific strategies for each priority group to minimise harm from alcohol consumption have been identified.

As stated on page 29 in section 6.6, some culturally and linguistically diverse populations, namely migrants, may have higher rates of drug use. In addition, migrants' beliefs about when to seek help for alcohol problems may differ from host-country norms. The best practice approaches cited appeared more focused on asylum seeker/refugee populations and may be less relevant to other migrant populations. An audit of 393 cases of screening in specialist alcohol and other drug services in Victoria, Australia, which examined whether alcohol problem severity at the time of help-seeking was influenced by drinking norms in countries of birth, showed that clients born in high consumption countries such as those in Europe and the UK had significantly higher levels of alcohol problem severity at intake compared with Australian-born clients and clients born in low consumption countries (Savic et al. 2014). This suggests that clients from high consumption countries might have delayed seeking help in line with the alcohol norms in their country of origin such that screening this group for alcohol problems in primary health care might avoid significant cumulative harm.

5. Accompanying evidence

Overall, the text throughout the draft strategy is minimally referenced, and the references that are included are not necessarily correct, peer-reviewed or based on recent research.

The statistics cited are selective, providing only a small snapshot of the actual alcohol consumption environment in Australia and often suggesting that all Australians engage in risky alcohol consumption or are affected by it, which could miss the real population groups at risk of harm, for

which specific and targeted strategies and interventions are needed. The following three examples highlights where additional text should be included in the draft Strategy.

1. While the text accompanying the demand reduction table on page 12 acknowledges that underage alcohol consumption has decreased, it also states that "more than 18% of Australians consume alcohol on a daily basis at levels that place them at risk of long-term harm and 26% drink at levels on a monthly basis that pose a risk in terms of short-term harms, such as injury".

   Consultation of the AIHW *National Drug Strategy Household Survey (NDSHS): Detailed Report 2013* reveals that of these 26% Australians, "**adults aged 18–24** were more likely to drink at harmful levels on a single occasion than the rest of the adult population, and males were more likely to drink at harmful levels than females". Indeed "overall, Australia has seen a decrease in the proportion of daily drinkers, and this **reduction was most noticeable among people in their late 30s to 50s**", that is, "a lower proportion of Australians aged 14 or older consumed alcohol in risky quantities in 2013 compared to 2010 where the proportion of lifetime risky drinkers and single occasion risky drinkers declined."

2. The text in section 7.2 Alcohol on page 32 states that "In the 2013 National Drug Strategy Household Survey, respondents were asked if anyone under the influence of or affected by alcohol had perpetrated verbal abuse, physical abuse or put them in fear in the preceding 12 months; 22.3% reported verbal abuse, 12.6% reported being put in fear and 8.7% reported being physically abused." When the 2013 National Drug Strategy Household Survey (AIHW 2014) was consulted, however, it also stated that while most of these incidents involved verbal abuse (22%), this proportion had declined from 2010 (from 24% to 22%). It also stated that certain groups were also more likely to have undergone alcohol-related incidents than others. For example:

   - males were more likely than females to experience verbal (26% compared with 19%) or physical abuse (10.4% compared with 7.1%) in the past 12 months, but a greater proportion of females were put in fear (13.8% compared with 11.3%) (Online Table 4.25)

   - people aged 18–24 were more likely than other age groups to experience verbal abuse (35%), physical abuse (15.2%) or be put in fear by someone under the influence of alcohol (18.6%) (Online Table 4.26)

   - risky drinkers were approximately twice as likely, compared to both low-risk drinkers and abstainers, to have suffered both verbal and physical abuse by someone affected by alcohol (Figure 4.9); but the proportion of abstainers and low-risk drinkers experiencing physical abuse increased between 2010 and 2013 (from 5.2% to 9.4% and from 4.7% to 6.0% respectively).

   Therefore, it is risky drinkers that appear most at risk of alcohol-related incidents such as verbal abuse, physical abuse and fear, as well as potentially being the perpetrators of that harm. This should be stated and addressed in the draft Strategy.

3. It is not disputed that the harmful use and misuse of alcohol costs society, both directly and indirectly. Accurate figures and contexts should, however, be provided in the draft Strategy. For

example, on page 31 in section 7.2 *Alcohol, it* states that "in 2010, the cost of alcohol-related harm (including harm to others) was reported to be $36 billion" from a paper by Miller et al. (2015). The figure of $36 billion actually comes from Laslett et al. (2010), which is not referenced in the draft Strategy, and where the entire quote from which it comes is:

"The annual cost of alcohol-related harm in Australia is estimated to be between $15.6 (Collins and Lapsley 2008) and $36 billion (Laslett et al. 2010) depending on the model used and whether harm to others is included in the model."

The Laslett et al. 2010 reference is not from a peer-reviewed publication, merely an in-house report for the Foundation for Alcohol Rehabilitation and Education (FARE). Conversely, a figure of $14.352 billion for the direct societal costs of alcohol was cited by Manning et al. (2013) in an Australian Institute of Criminology publication while other estimates of the annual social (non-private) costs for Australia actually range from to $3.8 billion (Crampton et al. 2011) to the $36 billion which combines the estimates of Collins and Lapsley (2008) and Laslett et al. (2010).

Given that these figures differ by a magnitude of 10, Marsden Jacob Associates (2012) in an analysis commissioned by the Australian Preventative Health Agency in 2013 to examine the basis on which differing cost figures were determined stated:

> "The analysis concluded that caution should be exercised when using figures at either extreme of the range provided...Caution should be exercised in using the work of Crampton et al. (2011) on which the industry submissions largely rely. The assumptions in this cost analysis do not accord with widely held Australian norms. For example, this work excludes costs that would derive to the society from a child born with foetal alcohol syndrome on the basis that this is a "private cost"; other inappropriate assumptions have meant that this analysis yields costs ($3.8 billion) well below those derived from an analysis based on assumptions and value judgements reflecting community preferences including as expressed in legislation. Caution should also be exercised in relation to figures submitted by a number of the public interest groups. Figures, such as costs of $36 billion, are obtained by adding together separate analyses reflecting different purposes and different concepts and methodologies and some double counting. These figures inflate the assessment of likely costs."

In addition, the correct reference for the statement on page 31 in section 7.2 "alcohol is also associated with 3,000 deaths and 65,000 hospitalisations very year" should be Collins and Lapsley (2008) and not Miller et al. (2015).

6. Measurement of success

The five measures of success included on page 35 of the draft Strategy are less comprehensive and detailed than those in the current Strategy.

7. References

Australian Bureau of Statistics. 2015. 4307.0.55.001. Apparent consumption of alcohol, Australia 2013-14. Australian Bureau of Statistics, Canberra.

Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey: Detailed Report 2013. Drug statistics series no. 28. Cat. No. PHE 183. Australian Institute of Health and Welfare, Canberra.

Ronksley, P.E., Brien, S.E., Turner, B.J., Mukamal, K.J., Ghali, W.A. 2011. Association of alcohol consumption with selected cardiovascular disease outcomes: a systematic review and meta-analysis. British Medical Journal. 34: 363-70.

Ayyagari, P., Deb, P., Fletcher, J., Gallo, W., Sindelar, J.L. 2013. Understanding heterogeneity in price elasticities in the demand for alcohol for older individuals. Health Economics. 22: 89-105.

Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Osterberg, E., Rehm, J., Room, R., Rossow, I. 2010. Alcohol: no ordinary commodity - research and public policy (2nd ed.). Oxford University Press, Oxford.

Bower, C., Silva, D., Henderson, T.R., Ryan, A., Rudy, E. 2000. Ascertainment of birth defects: the effect on completeness of adding a new source of data. Journal of Paediatric and Child Health. 36: 574–576.

Collins, D., Lapsley, H. 2008. The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004-2005. Commonwealth of Australia, Canberra.

Crampton, E., Burgess, M., Taylor, B. 2011. The cost of cost studies. University of Canterbury, College of Business and Economics, Department of Economics and Finance, Working Paper No. 29/2011.

Dave, D., Saffer, J. 2008. Alcohol demand and risk preference. Journal of Economic Psychology. 29: 810–831.

Harris, K.R., Bucens, I.K. 2003. Prevalence of fetal alcohol syndrome in the Top End of the Northern Territory. Journal of Paediatric and Child Health. 39: 528–533.

Kenkel, D.S. 1996. New estimates of the optimal tax for alcohol. Economic Inquiry. 34: 296–319.

Laslett, A-M., Catalano, P., Chikritzhs, Y., Dale, C., Doran, C., Ferris, J., Jainullabudeen, T., Livingston, M, Matthews, S., Mugavin, J., Room, R., Schlotterlein, M., Wilkinson, C. 2010. The range and magnitude of alcohol's harm to others. Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health, Fitzroy, Victoria.

Manning, W.G., Blumberg, L., Moulton, L.H. 1995. The demand for alcohol—the differential response to price. Journal of Health and Economics. 14: 123–148.

Marsden Jacob Associates. 2012. Bingeing, collateral damage and the benefits and costs of taxing alcohol rationally. http://www.fare.org.au/wp-content/uploads/research/FINAL-MJA-Report-Bingeing-Collateral-Damage-and-Taxation-2012.pdf

Marsden Jacob Associates, 2013. A note on the role of value judgements in public interest tests on alcohol policy. http://competitionpolicyreview.gov.au/files/2014/12/Marsden_Jacob_Associates.pdf

May, P.A., Blankenship, J., Marais, A.S., Gossage, J.P., Kalberg, W.O., Joubert, B., Cloete, M., Barnard, R., De Vries, M., Hasken, J., Robinson, L.K., Adnams, C.W., Buckley, D., Manning, M., Parry, C.D.H., Hoyme, H.E., Tabachnick, B., Seedat S. 2013. Maternal alcohol consumption producing fetal alcohol spectrum disorders (FASD): quantity, frequency, and timing of drinking. Drug and Alcohol Dependence. 133: 502-512.

May, P.A., Gossage, J.P. 2011. Maternal risk factors for fetal alcohol spectrum disorders: not as simple as it might seem. Alcohol Research and Health. 34: 15-26.

Ministerial Council on Drug Strategy. 1987. National Campaign Against Drug Abuse 1987-1992. Australian Government Printing Service, Canberra.

Ministerial Council on Drug Strategy. 1998. National Drug Strategic Framework 1998-99 to 2002-03. Commonwealth of Australia, Canberra.

Ministerial Council on Drug Strategy. 2004. National Alcohol Strategy: Australia's Integrated Framework 2005-2009. Commonwealth of Australia, Canberra.

Ministerial Council on Drug Strategy. 2011. National Drug Strategy 2010-2015. Commonwealth of Australia, Canberra.
National Drug Strategy Committee. 1993. National Drug Strategic Plan 1993–1997. Australian Government Printing Service, Canberra.
Nelson, J.P. 2013a. Does heavy drinking by adults respond to higher alcohol prices and taxes? A survey and assessment. Economic Analysis and Policy, Forthcoming. Available at SSRN: http://ssrn.com/abstract=2230649
Nelson, J.P. 2013b. Meta-analysis of alcohol price and income elasticities – with corrections for publication bias. Health Economics Review. 3: 17. doi: 10.1186/2191-1991-3-17.
O'Leary, C.M, Nassar, N., Zubrick, S.R., Kurinczuk, J.J., Stanley, F., Bower, C. (2010) Evidence of a complex association between dose, pattern and timing of prenatal alcohol exposure and child behaviour problems. Addiction. 105: 74-86
O'Leary, C.M., Halliday, J., Bartu, A., D'Antoine, H., Bower, C. 2013. Alcohol-use disorders during and within one year of pregnancy: a population-based cohort study 1985-2006. BJOG. An International Journal of Obstetrics and Gynaecology. 120: 744-753.
O'Leary, C., Leonard, H., Bourke, J., D'Antoine, H., Bartu, A., Bower, C. 2013. Intellectual disability: population-based estimates of the proportion attributable to maternal alcohol use disorder during pregnancy. Developmental Medicine and Child Neurology. 55: 271-277.
Savic, M., Barker, S.F., Best, D., Lubman, D.I. 2014. Alcohol problems among migrants in substance use treatment: the role of drinking patterns in countries of birth. Australian Journal of Primary Health. 20: 220-221.
Wagenaar, A.C., Salois, M.J., Komro, K.A. 2009a. Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction. 3: 179–190.
Wagenaar, A.C., Maldonado-Molina, M., Wagenaar, B.H. 2009b. Effects of alcohol tax increases on alcohol-related disease mortality in Alaska: time-series analyses from 1976 to 2004. American Journal of Public Health. 99: 1464–1470.
World Health Organisation. 2010. Global strategy to reduce the harmful use of alcohol. World Health Organisation, Geneva.
World Health Organisation. 2015. Alcohol fact sheet. World Health Organisation, Geneva.