



Submission to the

**Northern Territory Alcohol Policies and
Legislation Review**

July 2017

Contents

| | |
|---|----|
| Contents..... | 2 |
| Acronyms | 3 |
| Terminology | 4 |
| Introduction | 5 |
| Recommendations | 5 |
| Northern Territory Background and Context..... | 8 |
| The cost of alcohol consumption in the Northern Territory | 8 |
| Alcohol Attributable Deaths in the Northern Territory | 9 |
| Alcohol: The Policy Setting | 9 |
| The Social Determinants of Health | 9 |
| WHO Social Determinants of Health Recommendations | 10 |
| Social Determinants of Alcohol Consumption..... | 10 |
| Structural determinants: power, money and resources..... | 11 |
| Social and Health Impacts and Potential Cost Savings of implementation of National Preventative Health Taskforce Strategy | 12 |
| Prevention works in Public Health..... | 12 |
| Targeting disadvantage to reduce inequity | 13 |
| Aboriginal Australians - ‘Closing the Gap’ | 13 |
| Racism and Alcohol Consumption | 14 |
| The Criminal Justice System and Alcohol..... | 14 |
| Policies and Strategies | 15 |
| Strategies and Interventions that can prevent or minimise alcohol related harm | 15 |
| Which policies are most effective?..... | 15 |
| The Case for Prevention in Alcohol Policy..... | 20 |
| Prevention to bridge the health gap for Aboriginal Australians | 20 |
| Prevalence of FASD in the NT (NTCOSS 2014)..... | 21 |
| Recent Policy Developments and Debate..... | 22 |
| Banned Drinkers Register (BDR)..... | 22 |
| Temporary Beat Locations (TBLs) | 23 |
| Alcohol Mandatory Treatment (AMT) | 24 |
| Concerns about Alcohol Mandatory Treatment..... | 24 |
| Criticism of the AMT Act for ‘Discrimination’..... | 25 |
| Opportunity Cost of the AMT | 25 |
| Supply Side Measures More Effective | 26 |

| | |
|---|----|
| Alternatives to Mandatory Treatment..... | 26 |
| Incarceration must be avoided at all costs | 26 |
| Voluntary treatment..... | 26 |
| Complex Problems: A multifaceted approach to solutions | 27 |
| Addressing underlying issues of trauma, grief and loss for Aboriginal people in the Northern Territory | 28 |
| Need for appropriate throughcare post-release from residential rehabilitation | 29 |
| Responding to people who are homeless..... | 29 |
| Interpreters and Cultural Support | 30 |
| The health aspects of Alcohol Dependence | 30 |
| Alcohol Policy Summit – Tennant Creek (2012) | 31 |
| Effective Treatment and Support Options | 31 |
| Early Childhood Programs..... | 33 |
| Alcohol’s Impact on the NT Child Protection System | 34 |
| Appendix A:..... | 35 |
| Recommendations from NTCOSS Fetal Alcohol Spectrum Disorder Submission to the Legislative Assembly Select Committee on Prevention of Fetal Alcohol Spectrum Disorder..... | 35 |
| References | 38 |

Acronyms

AMT Alcohol Management Treatment

AOD Alcohol and Other Drugs

PAAC People’s Alcohol Action Coalition

NT Northern Territory

NPHT National Preventative Health Taskforce

NTER Northern Territory Emergency Response

TBL Temporary Beat Locations

Terminology

This submission uses the term *Aboriginal* however quotes referenced may use the term Indigenous. The use of the term Aboriginal is used to reflect the NT nomenclature based on wishes of the local community.

NORTHERN TERRITORY COUNCIL OF SOCIAL SERVICE INC (NTCOSS)

NTCOSS is a peak body for the Northern Territory community sector and is a voice for people affected by social and economic disadvantage and inequality. The community sector in the Northern Territory is made up of community managed, non-government, not for profit organisations who work in social and community service delivery, sector development and advocacy.

The community sector plays a vital role in creating social wellbeing for all Territorians and in building safe and healthy communities by providing services that enable people to access and participate in health services, education, employment, economic development, and family and community life.

NTCOSS represents a service sector with a high level of contact with individuals and their families who are impacted by alcohol use including those working in areas such as domestic violence, homelessness and child protection.

Introduction

NTCOSS wishes to thank the Northern Territory Alcohol Policies and Legislation Review Expert Panel for conducting this review and for providing us with the opportunity to make a submission.

While NTCOSS acknowledges the importance of the full range of issues covered in the terms of reference for the Review, this submission will not cover the full range of matters the review will report on.

This submission seeks to provide an evidence based discussion on a number of alcohol policy areas. The submission draws on the interplay between the Social Determinants of Health and alcohol policy responses.

NTCOSS notes that alcohol misuse and harm can affect individuals regardless of age, gender and race.

The submission contains contributions from NT organisations such as Aboriginal Peak Organisations Northern Territory (APO NT) and People's Alcohol Action Coalition (PAAC).

Recommendations

NTCOSS endorses a holistic health approach rather than a punitive approach when creating policy development and implementation to improve alcohol harm to the community. Addressing the broader social determinants of alcohol harm will be effective in decreasing community harm and will result in long term economic benefits.

NTCOSS believes that incarceration related to the harmful use of alcohol must be avoided at all costs.

NTCOSS supports APO NT's statement that "The task of improving health and social outcomes requires empowering individuals through developing self-esteem and strong cultural identity that can underpin educational achievement, enhanced capacity to obtain and remain in employment, and to avoid destructive behaviours such as substance misuse and interpersonal violence that all too often lead to contact with the criminal justice system". (APO NT (2013)).

NTCOSS supports *The National Drug Strategy* three pillar approach to dealing with alcohol harm minimisation: demand reduction, supply reduction and harm reduction.

NTCOSS furthermore endorses the following recommendations:

Recommendation 1: That the NT Government address the drivers of why people drink, including, but not limited to trauma, overcrowding, contestant association with others who drink, boredom and unemployment. Further resources need to be directed to housing, access to health care especially for remote and smaller regional areas.

Recommendation 2: That the NT Government adopt the recommendations of the Legislative Assembly of the Northern Territory Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder (2015) and the House of Representatives Standing Committee on Indigenous Affairs report on the harmful use of alcohol in Aboriginal and Torres Strait Islander communities (2015)

Recommendation 3: That the NT Government adopts a health based approach to alcohol policy rather than a punitive approach. This is consistent with the NSW and Victorian legislation, which does not enforce criminal penalties for failing to participate in or abscond from alcohol treatment. NTCOSS does not support mandatory treatment for people using alcohol, this criminalises a health issue and the behaviours associated with it.

Recommendation 4: That the NT Government invests in early childhood education and support to reducing alcohol-related harm for people across the NT including Aboriginal communities.

Recommendation 5: That NT Government funds the availability of AOD therapeutic and treatment options to courts in the NT.

Recommendation 6: That the NT Government secures greater funding for an increase in the number and type of existing and new voluntary treatment and rehabilitation beds and programs. Such treatment and programs include therapeutic interventions and continuing care, detoxification and residential facilities, psychiatric and general hospitals, in and out-patient programs and primary health care.

Recommendation 7: That in order to ensure the maximum effectiveness of treatment and support options for Aboriginal communities, the following are also required:

- a. Provision of cultural safety: interpreters, cultural support and Aboriginal Liaison services
- b. Aboriginal communities can access the full range of treatment and support options
- c. Individually developed, comprehensive and culturally appropriate after plans are part of everyday practice
- d. A Continuous Quality Improvement (CQI) approach is championed
- e. Five to seven year funding blocks are provided for maximum service effectiveness

Recommendation 8: That Alcohol Management Plans are developed in genuine collaboration with Aboriginal people, communities and organisations addressing specific needs and requirements of individual communities.

Recommendation 9: That the NT Government address alcohol supply and availability through controlling affordability. This includes raising the minimum price of the cheapest beverages.

Recommendation 10: That the NT Government address the regulation of the physical availability of alcohol through reducing trading hours and days of sale as well as limiting the number of alcohol outlets.

Recommendation 11: That the NT Government strictly enforces regulations such as licence suspensions and revocations as well as appropriate population-based outlet densities to be established through evidence based research.

Recommendation 12: That the NT Government enacts legislation which restricts marketing such as banning the promotion of alcohol on free-to-air television before 8.30 pm with no exemptions for sport broadcasting.

Northern Territory Background and Context

The current National Drug Strategy provides a useful backdrop to this policy paper. The aim of the *National Drug Strategy 2010–2015* (Ministerial Council on Drug Strategy (2011)) is to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.

The National Drug Strategy has an overarching approach of harm minimisation, within which there are three pillars, namely:

Demand reduction

- prevent uptake and delay onset of drug use
- reduce use of drugs in the community
- support people to recover from dependence and reconnect with the community
- support efforts to promote social inclusion and resilient individuals, families and communities.

Supply reduction

- reduce the supply of illegal drugs (both current and emerging)
- control and manage the supply of alcohol, tobacco and other legal drugs.

Harm reduction

- reduce harms to community safety and amenity
- reduce harms to families
- reduce harms to individuals

The three pillars apply across all drug types, including alcohol but in different ways, for example, depending on whether the drugs being used are legal or illegal. The approaches in the three pillars will be applied with sensitivity to age and stage of life, disadvantaged populations, and settings of use and intervention (National Drug Strategy 2010-2015).

The burden of disease in Australia is disproportionately borne by Aboriginal Australians, who experience “a starkly lower life expectancy than non-Indigenous Australians” and this is attributable in a significant way to “obesity, tobacco and the harmful consumption of alcohol” (NPHT (2009)).

In addition, a “large part of the differences in health status between advantaged and disadvantaged Australians, and between city dwellers and rural and remote Australians, can be attributed to obesity, tobacco and alcohol” (NPHT (2009)).

The cost of alcohol consumption in the Northern Territory

The social harms from alcohol misuse have been assessed as costing the Northern Territory \$642m per year. This equates to \$4,197 for every adult Territorian, compared to \$943 nationally. These costs range from hospitalisation for chronic health problems and injuries associated with alcohol misuse to costs associated with victims of alcohol-related violence and ambulatory costs (Menzies 2010).

These costs take into account the cost of road accidents; policing alcohol-related crime and antisocial behaviour; the flow through costs to the courts and correctional system.

Alcohol Attributable Deaths in the Northern Territory

Gao et al reported that there were 116 alcohol-attributable deaths in the NT in 2010, which constituted 11.8% of all deaths in the NT, the highest rate of any other State or Territory - and nearly three times the national rate (3.9%).

There were 2708 alcohol-attributable hospitalisations in the NT in 2010, which constituted 2.7% of all hospitalisations in the NT, also the highest in the country and 1.5 times the national rate (1.8%).

These figures compare with the 119 alcohol-attributable deaths in the NT in 2005–06, estimated by (Skov and Chikritzhs et al (2010)), which were around 3.5 times the national rate generally. For these periods, the rates in non-Aboriginal people were about double the national rate, while they were 9–10 times higher in Aboriginal people (Skov and Chikritzhs et al (2010)).

Alcohol: The Policy Setting

Alcohol policies are developed and implemented at many different levels of government. National or subnational laws often establish the legislative framework for alcohol policies. These can include a number of aspects, such as:

- an oversight by the state of production, export and import of commercial alcohol products
- control of wholesaling and retailing
- apprehension of drivers with specified blood alcohol levels
- alcohol marketing restrictions; and the support of treatment and prevention services (Alcohol and Public Policy Group (2010)).

Given the various interested parties, it is rare for policy systems at the national level to be dominated by one decision-making authority alone. Instead it is more likely that there is decentralisation, “with different aspects of policy delegated to a variety of different and sometimes competing decision-making entities, such as the health ministry and the taxation agency” (Alcohol and Public Policy Group (2010)).

Alcohol policy is often the product of competing interests, values and ideologies. Experience suggests that working in partnership with the alcohol industry is likely to lead to ineffective or compromised policy and is best avoided by governments, the scientific community and NGOs (Alcohol and Public Policy Group (2010)).

The Social Determinants of Health

The Social Determinants of Health provides an explanation about how our health and wellbeing is profoundly affected by a range of interacting economic, social and cultural factors, including:

- poverty, economic inequality and social status
- Housing
- employment and job security
- social exclusion, including isolation, discrimination and racism
- education and care in early life
- food security and access to a balanced and adequate diet

- addictions, particularly to alcohol, inhalants and tobacco
- access to adequate health services including services for alcohol and other drugs and social and emotional wellbeing services, and control over life circumstances. (WHO (2008) cited in APO NT (2013)).

WHO Social Determinants of Health Recommendations

The WHO's Commission on the Social Determinants of Health (CSDH) makes three overarching recommendations to tackle the 'corrosive effects of inequality of life chances':

- Improve daily living conditions, including the circumstances in which people are born, grow, live, work and age
- Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions – globally, nationally and locally
- Measure and understand the problem and assess the impact of action (Commission on Social Determinants of Health (2008).

Social Determinants of Alcohol Consumption

Of particular relevance to alcohol consumption (as well as obesity and tobacco use) is the nature of, and inequity in:

- The physical and social experiences in early life
- Access to and quality of education
- The nature of urbanization (planning and designing of cities) and the live-ability and sustainability of rural locations
- Transport options
- Distribution mechanisms and consumer price of food, alcohol and tobacco
- Exposure to marketing of energy dense nutrient poor (EDNP) foods, alcohol and tobacco
- The financial, psychosocial and physical conditions of working life
- The degree of social protection provided (NPHT (2009)).

Culture is also a major social determinant of health. As an example, for Aboriginal people, health status does not correlate with position in the social gradient, as it does with the general population. Irrespective of SES or geographical location, Aboriginality itself is associated with poor health (Baillie, Carson and Chenhall, et al. (2007), cited in NPHT (2009)). Specific recognition of culture, as a major social determinant of Aboriginal health, is important when designing preventative health programs to contribute to 'Close the Gap' (NPHT (2009))

APO NT argue that "The task of improving health and social outcomes requires empowering individuals through developing self-esteem and strong cultural identity that can underpin educational achievement, enhanced capacity to obtain and remain in employment, and to avoid destructive behaviours such as substance misuse and interpersonal violence that all too often lead to contact with the criminal justice system". (APO NT (2013)).

Structural determinants: power, money and resources

At a global level “Promoting health equity through healthy weight, responsible alcohol use and no tobacco use also means tackling some of the fundamental political, economic and cultural issues that affect people’s living conditions, their daily practices and behaviour-related risks.”

This requires “dealing with matters of governance; national economic priorities; trade arrangements; market deregulation and foreign direct investment; fiscal policy; and the degree to which policies, systems and processes are inclusionary” with each of these issues very much related to the Commission on Social Determinants of Health (2008)¹ recommendation of “tackling the unequal distribution of power, money and resources” (NPHT (2009)).

Addressing these structural determinants of health inequity not only helps empower individuals and communities but also empowers national government and other key public sector institutions (NPHT (2009)). For example, good global governance and regulatory frameworks create support for national governments to introduce policies that tackle corporate pressures such as irresponsible marketing Chopra and Darnton-Hill (2004), cited in NPHT (2009)).

Social inclusion initiatives at both the Federal and State Government levels are also critical, “in light of the strong relationship between health and social disadvantage and the clustering of risk in the most vulnerable populations”. Health was seen as one of the key resources to enables full participation in social and economic life – with social exclusion being a contributor to and determinant of poor health. (NPHT (2009)).

The impacts of alcohol and other drug misuse and the underlying causes and the accompanying burden of unresolved and ongoing intergenerational trauma in families and communities requires strong action (APO NT (2013)). Addressing the significant human and social costs of the unacceptably high numbers of Aboriginal people in the NT who misuse alcohol and other drugs must be based on a balanced approach that recognises the complex dimensions of causality and action. (APO NT (2013)).

Research further indicates the importance of key determinants for Aboriginal peoples generally and Aboriginal peoples in Australia in particular. These include:

- the fundamental importance of control and empowerment
- the debilitating impacts of social exclusion, racism and discrimination
- the protective role of culture, language and land. (APO NT (2013)).

APO NT believes that any policy or legislation aimed at tackling alcohol misuse will ultimately be ineffective without simultaneous action to address other relevant social determinants of health. Reports by the WHO and National Drug Research Institute (NDRI) found that social deprivation and associated factors such as income and education are clearly linked to the risk of dependence on alcohol. (APO NT (2013)).

Inadequate housing, infrastructure, job prospects and opportunities for recreation have been identified as areas to help combat alcoholism (Gray and Saggars (2010) cited in APO NT (2013)). Further, policies targeting a particular area of harmful alcohol use need to be based on careful

¹ The Commission on Social Determinants of Health (CSDH) was a global network of policy makers, researchers and civil society organizations brought together by the World Health Organization (WHO) to give support in tackling the social causes of poor health and avoidable health inequalities (health inequities).

assessment of the circumstances and needs of those targeted. For example, “Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice” states:

‘The co-morbidity of mental health and harmful substance use among Aboriginal people needs to be contextualized by the legacy of colonization, racism and marginalization from dominant social institutions. International and Australian research clearly demonstrates that health in general; mental health and substance misuse are affected by social and structural factors such as housing, education, employment, income, transport and access to supportive social networks ’(APO NT (2013)).

Social and Health Impacts and Potential Cost Savings of implementation of National Preventative Health Taskforce Strategy

The NPHT documented the impacts and cost savings over an 11 year period (2010-2020) which would result from the full implementation of the NPHT Strategy on Alcohol, if the targets were met where the proportion of Australians who drink at short-term risky/high-risk levels dropped from 20% to 14%; and the proportion of Australians who drink at long-term risky/high-risk levels dropped from 10% to 7%.

“Reaching these targets over an 11 year period would “prevent the premature deaths of over 7200 Australians and prevent some 94,000 fewer person-years of life being lost”. It would also lead to approximately 330,000 fewer hospitalisations and 1.5 million fewer bed days leading to a cost saving of nearly \$2 billion to the national health sector by 2020”. (NPHT, (2009)).

Prevention works in Public Health

Well-planned prevention programs have made enormous contributions to improving the quality and duration of our lives. The public health revolutions of the 19th century led the way, and in recent years we have seen major improvements in areas such as tobacco control, road trauma and drink driving, skin cancers, immunisation, cardiovascular disease, childhood infectious diseases, Sudden Infant Death Syndrome (SIDS) and HIV/AIDS control.

Examples of successful public health campaigns include:

- In the 1950s three-quarters of Australian men smoked. Now less than one-fifth of men smoke (see Figure 2). As a result, deaths in men from lung cancer and obstructive lung disease have plummeted from peak levels seen in the 1970s and 1980s (AIHW (2008) in NPHT (2009))
- Road trauma deaths on Australian roads have dropped 80% since 1970 with death rates in 2005 being similar to those in the early 1920s (AIHW (2008) cited in NPHT (2009))
- Australia’s commitment to improving immunisation levels has resulted in much higher immunisation coverage rates, eliminating measles and seeing a drop of nearly 90% in sero-group C meningococcal cases in only four years. These have come about as a result of a 34-fold increase in funding over the last 15 years.
- Deaths from SIDS have declined by almost three-quarters, dropping from an average of 195.6 per 100,000 live births between 1980 and 1990 to an average of 51.7 per 100,000 live births between 1997 and 2002 (AIHW (2008) and d’Espaignet T, Bulsara M, Wolfenden L, et al (2008) cited in NPHT (2009)).

Targeting disadvantage to reduce inequity

Major health inequities exist not only between Aboriginal Australians and non-Aboriginal Australians, but between rich and poor, and between rural and city dwellers. Even within a city such as Melbourne, life expectancy can vary by up to six years within a matter of kilometres. (NHPT (2009)).

“The poorest of the poor have the highest levels of illness and premature mortality. But poor health is not confined to those who are worst off. At all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.”

Solely focusing on the difference in health experience at opposite ends of the social spectrum masks the graded relationship between social position and health. A recent analysis of mortality rates, and notably avoidable mortality rates, illustrates how death rates decrease progressively with increasing Socio Economic Status (SES) (NPHT (2009)).

Understanding health inequity in terms of the social gradient in health allows us to embrace not only conditions of poverty and exclusion but social conditions that affect everyone. In doing so, policies and programs will have greater potential to reach a wider population, thereby improving the health of more people. (NPHT (2009)).

PAAC argue that “Addressing the harmful use of alcohol in Aboriginal communities must be situated as part of a broader strategy to tackle the full range of the social determinants of illhealth including poverty, social exclusion and racism, and deficits in early childhood development, education and, employment” (PAAC (2014a)).

Aboriginal Australians - ‘Closing the Gap’

In the current context of high levels of chronic disease in the Aboriginal population, alcohol, as well as obesity and tobacco, make significant contributions to the burden of sickness, injury and death in Aboriginal communities (Boffa, Tilton, Legge, et al. (2009) cited in NPHT (2009)). Together, these factors contribute to almost a quarter of the ‘health gap’ (Vos, Barker, Stanley, et al. (2003) cited in NPHT (2009)).

The proportion of the health gap attributable to obesity, tobacco and is also distributed unevenly. While Aboriginal people in remote areas make up 26% of the total Aboriginal population, they contribute 50% of the health gap due to alcohol, 34% of the total health gap attributable to tobacco, and 38% of the health gap due to high body mass (Boffa, Tilton, Legge, et al. (2009) cited in NPHT (2009)).

The ‘Close the Gap’ commitment by all Australian governments announced in December 2007 recognised the extent and urgency of the problems facing Aboriginal Australians (Boffa, Tilton, Legge, et al. (2009) cited in NPHT (2009)). To be successful in raising the life expectancy of Aboriginal Australians to that enjoyed by non-Aboriginal Australians within a generation, the disparity in levels of sickness and death attributable to alcohol (and obesity and tobacco) must be addressed. Key principles for successful programs to address this disparity include:

- Genuine local Aboriginal community engagement to maximize participation, up to and including formal structures of community control

- Integration of vertical, targeted programs on alcohol, tobacco and obesity with broad-based comprehensive primary healthcare
- Ensuring programs are adequately resourced for evaluation and monitoring so they can contribute to program and policy knowledge
- Evidence based approaches that are reflective and that involve the local community in adapting what is known to work elsewhere to local conditions and priorities
- Adequate and secure resourcing to allow for actions to be refined and developed over time
- Performance indicators and measurement that are linked to accountability and action (NPHT (2009))

Racism and Alcohol Consumption

PAAC have articulated that “The experience of racism is associated with increased alcohol consumption. Aboriginal people in Australia commonly experience high levels of racism, from relatively minor incidents such as being called racist names, through verbal abuse, to serious assault (Ferdinand A, Paradies Y, et al. (2012) cited in PAAC (2014a). The literature demonstrates a strong association between racism and poor mental health and alcohol misuse (Zubrick S, Silburn S, et al. (2005) cited in PAAC (2014a)). As well as addressing racism directly, this also points strongly to the need for interventions to tackle alcohol in Aboriginal communities to be non-rationally discriminatory.

A lack of control over one’s own life has been shown to be an important driver of ill-health and is also associated with a higher consumption of alcohol. “There is good evidence based on biomedicine that the consistent exposure to stress associated with lack of ability to exercise control in life can profoundly undermine physical and mental health” (Syme (2004) cited in PAAC (2014a)). This means that policy makers must be alert to the importance of empowerment approaches in addressing alcohol in the Aboriginal community (PAAC (2014a)).

PAAC also argue that given the association of the experience of racism with increased alcohol consumption, no program or policy designed to address the harmful use of alcohol in Aboriginal communities should be founded upon discrimination on the basis of race. (PAAC (2014a)).

The Criminal Justice System and Alcohol

Aboriginal people are overrepresented within the criminal justice system at a rate of 84% of total detention population (PWC 2017).

Since the dismantling of the NT SMART Court in 2013, there is not a single program for alcohol or other drugs, nor for mental health, nor for Aboriginal people, which puts the NT out of step with the rest of the country, as pointed out by the then Chief Magistrate Hilary Hannam, in July 2013, (Timms (2013), cited in APO NT (2014)).

There is a need for more diversionary AOD Treatment options for courts and properly resourced, evidence based programs to help people break the cycle of offending and reoffending (APO NT (2014)). People charged with an offence are not able to be referred to any treatment program, including mandatory treatment under the AMT scheme, and this applies even to non-violent

offenders². APO NT considers that there should be therapeutic or treatment options available to courts in the NT.

Policies and Strategies

Strategies and Interventions that can prevent or minimise alcohol related harm

The scientific evidence for strategies and interventions that can prevent or minimize alcohol related harm has been reviewed critically by WHO in seven key areas:

1. Controlling Affordability: Pricing and Taxation
2. Regulating the physical availability of Alcohol
3. Modifying the drinking context
4. Drink-driving prevention and countermeasures
5. Restrictions on marketing
6. Education and persuasive strategies
7. Treatment and Early Intervention services (Alcohol and Public Policy Group 2010)

Which policies are most effective?

WHO (2010) have conducted ratings of the effectiveness of strategies and interventions from a public health perspective.

Overall, the research shows that the strongest, most cost-effective strategies in relation to the 7 key areas include;

1. Supply & Availability (Controlling Affordability: Pricing and Taxation)

Increased alcohol prices reduce the level of alcohol consumption and related problems, including mortality rates, crime and traffic accidents - and the effects of pricing apply to all groups of people, including young people or heavy or problem drinkers.

While somewhat limited, the evidence suggests that raising the minimum price of the cheapest beverages is effective in influencing heavy drinkers and reducing rates of harm. Other research shows that alcohol consumption can be reduced by increasing the price of drinks (e.g. alcopops) that are designed and marketed in a way that appeals to young adults. Taxation (despite its apparent effectiveness) appears to have been under-used as a method of reducing harm.

It is interesting to note that over recent decades, “the real price of alcoholic beverages has decreased in many counties at a time when other alcohol control measures have been liberalised or abandoned completely.” (Alcohol and Public Policy Group (2010)).

Raising the price of alcohol through the taxation system has been shown to be highly effective for reducing harm (Meier et al, 2008a, cited in Grog Watch (2015)). These harms include:

- road traffic accidents and fatalities among people of all ages, but particularly younger drivers

² Section 9(2)(a) *Alcohol Mandatory Treatment Act NT*, cited in APO NT (2014)

- cirrhosis deaths
- male suicides, particularly among young adults
- alcohol-related sudden deaths
- intentional and unintentional injuries
- workplace injuries
- sexually transmitted infections
- crimes such as rapes, robberies, homicides, crime, child abuse, domestic abuse
- violence at universities
- violence-related injuries

Alcohol taxation is also highly cost-effective. Australian researchers Collins and Lapsley (2008), cited in (Grog Watch, 2015), estimated that appropriately increased levels of alcohol taxation could reduce the total social costs of alcohol by between \$2.2 and \$5.9 billion per year. These estimates are based on 2004/05 prices so reductions in today's terms could be higher.

The importance of price has been closely demonstrated in the Australian and in particular, in the NT context, for example through work done by the NDRI and Curtin University (2014) in their examination of the evidence available for the effectiveness of a 2002 trial of alcohol control measures in Alice Springs. These measures included indirect price control through the banning of table wine in containers of greater than 2 litres and fortified wine in containers of greater than 1 litre, and their research highlighted the effectiveness of using a minimum unit pricing approach to achieve a planned substitution to more expensive, less harmful forms of alcohol."

Both APO NT (2013) and PAAC (2014b) advocate the NT should introduce a minimum price benchmark for takeaway alcohol products based on retail price of a standard drink of full-strength beer (currently around \$1.30). Takeaway alcohol is the predominant source for the heaviest and most dependent consumers. Only cheap wines would be affected in price with the price of spirits remaining unaffected (AAPO NT 2013). A minimum floor price would prevent product substitution to cheaper forms of alcohol.

PAAC (2014b) believes that a floor price is the most cost effective way of reducing alcohol related harm and that an amendment to the NT Liquor Act would allow "the setting of a floor price by the NT Licensing Commission or other appropriate body, in the absence of voluntary Accords". PAAC also believes a floor price on takeaway alcohol, users should be combined with a "national volumetric tax on all alcohol products directed to a national fund for the reduction of alcohol-related harm" (PAAC 2014b).

APO NT have also articulated that evidence-based population level supply reduction measures should continue to be introduced until per capita population alcohol consumption has reduced by at least one third of the current level, which would see the NT drinking at about the same level as the national average (APO NT (2013)).

In addition, the Federal Government (2015) Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities report, 'Alcohol, hurting people and harming communities'

prepared by the House of Representatives Standing Committee on Indigenous Affairs recommended, among other things, the introduction of a national minimum floor price on alcohol.

2. Regulating the physical availability of Alcohol

“Research indicates strongly that as alcohol becomes more available through commercial or social sources, consumption and alcohol-related problems rise. Conversely, when availability is restricted, alcohol use and associated problems decrease. The best evidence comes from studies of changes in retail availability, including reductions in the hours and days of sale, limits on the number of alcohol outlets and restrictions on retail access to alcohol. Consistent enforcement of regulations is a key ingredient of effectiveness. Licence suspensions and revocations often provide the most direct and immediate enforcement mechanism” (Alcohol and Public Policy Group (2010)).

In general, the regulation of availability can have large effects. The cost of restricting physical availability of alcohol is cheap relative to the costs of health consequences related to drinking, especially heavy drinking. The most notable adverse effects of availability restrictions include increases in informal market activities (e.g. home production, illegal imports). Nevertheless, where a legal supply is available, informal market activities can generally be limited by effective enforcement (Alcohol and Public Policy Group (2010)).

APO NT further support the following measures:

- reducing takeaway sales hours, for example opening at 2pm
- reducing on-site sales hours, for example by limiting trading hours to 12noon to 2am
- adopting restricted alcohol sales days, for example Thursdays and Sundays where no alcohol sales are permitted or take-away sales are banned.

APO NT also highlight their belief that a significant reduction in alcohol-related harm and community disruption in remote and regional communities could be achieved by aligning Centrelink payments to a single day per week (Thursdays) on which no takeaway sales are permitted. APO NT also argues that provision must be made for the outright banning of takeaways in communities supporting such a measure. APO NT also point to the need for the development of a set of minimum Territory-wide standards for restricted takeaway trading hours. (APO NT (2013)).

The NT has the highest density and diversity of liquor outlets in Australia. Strong evidence exists showing a relationship between outlet density and alcohol-related harm. The number of NT liquor outlets has been reduced by buying back take-away licenses from petrol stations, corner stores and roadhouses. In recent years in Alice Springs, the licenses for Gap BP and Hoppy’s have been bought back. APO NT also argue for appropriate population-based outlet densities to be established through evidence-based research.

3. Modifying the drinking context

“Research suggests that licensed premises provide an opportunity for preventing alcohol-related problems through training bar staff in both responsible beverage service and managing or preventing aggression”, but in order for the responsible service of alcohol to be effective, it must be enforced (Alcohol and Public Policy Group (2010)).

Where police, liquor licensing and municipal authorities, for example, enforce laws and regulations, they are likely to have impact through situational deterrents. The “threat of suspending or revoking

the licence to sell in cases of irresponsible selling and, where laws permit, through holding servers and owners liable for the harms resulting from over-service” prove effective (Alcohol and Public Policy Group (2010)).

Community action programs can also be effective in reducing problem behaviour, for example where local organisers work with the police, with a focus on licensed premises. These approaches can be effective because they can incorporate broad multi-component approaches, but they do require extensive resources, as well as long term commitment and enforcement (Alcohol and Public Policy Group (2010)).

4. Restrictions on marketing

There is considerable research to show that “exposure of young people to alcohol marketing speeds up the onset of drinking and increases the amount consumed by those already drinking... and expand[s] the drinking population in emerging markets.” Marketing can take the form of “traditional media (e.g. television, radio and print), new media (e.g. internet and mobile phones), sponsorships and direct promotions, including branded merchandise and point-of-sale displays” (Alcohol and Public Policy Group (2010)).

The relationship of exposure to marketing and increased alcohol consumption means that the issue of controls on advertising is high on policy agendas. Governments use legislation to restrict alcohol advertising – though this happens in the face of much opposition from the alcohol industry.

The Federal Government Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities (June 2015) report, ‘Alcohol, hurting people and harming communities’ prepared by the House of Representatives Standing Committee on Indigenous Affairs recommended, among other things, banning the promotion of alcohol on free-to-air television before 8.30 pm with no exemptions for sport broadcasting.

5. Education and persuasive strategies

Education and persuasion strategies are among the most popular approaches to the prevention of alcohol-related problems. There are some school-based alcohol education programs which have been found to increase knowledge and change attitudes toward alcohol, however drinking behaviour often remains unaffected (Perry, Williams, Veblen-Mortenson, Toomey, Komro, Anstine *et al.* (1996) cited in Alcohol and Public Policy Group (2010)). Scientific evaluations of education programs generally show modest effects that are short-lived unless accompanied by booster sessions (Foxcroft, Ireland, Lowe, Breen (2002), cited in Alcohol and Public Policy Group (2010)).

Some programs include both individual-level education and family - or community level interventions, but even comprehensive programs may not be sufficient to delay the initiation of drinking, or to sustain a small reduction in drinking beyond the operation of the program. The strongest effects have been found in programs directed at high-risk groups, an approach akin to assessment and brief intervention (Alcohol and Public Policy Group (2010)).

Media campaigns prepared by government agencies and non-governmental organizations (NGOs) that address responsible drinking, the hazards of drink driving and related topics are an ineffective antidote to the high-quality pro-drinking messages that appear much more frequently as paid advertisements in the mass media (Alcohol and Public Policy Group (2010)).

The impact of education and persuasion programs tends to be small and “even when positive effects are found, they don’t persist and a focus upon educating and persuading the individual drinker to change his or her behaviour without changing the broader environment cannot be relied upon as an effective approach” (Alcohol and Public Policy Group (2010)).

6. Treatment and Early Intervention services

The past 50 years has seen a steady growth, especially in high-income countries, “in the provision of specialized medical, psychiatric and social services to individuals with alcohol use disorders”. These services cover “diagnostic assessment to therapeutic interventions and continuing care” and may take place in residential facilities, psychiatric and general hospital settings, or in out-patient programs and primary health care settings. The cumulative evidence on the clinical management of non-dependent high-risk drinkers, shows that “brief interventions, consisting of one or more sessions of advice and feedback provided by a health professional, can produce clinically significant reductions in drinking and alcohol-related problems.”

Despite the evidence for the benefits of brief interventions, “it has been found difficult to persuade practitioners to deliver such care” (Alcohol and Public Policy Group (2010)).

The Alcohol and Public Policy Group (2010) have also highlighted the following:

- Detoxification services are directed mainly at patients with a history of chronic drinking (especially those with poor nutrition) who are at risk of experiencing withdrawal symptoms
- Administration of thiamine and multivitamins is a low-cost, low-risk intervention that prevents alcohol-related neurological disturbances, and effective medications have been used for the treatment of alcohol withdrawal
- Treatment that obviates development of the most severe withdrawal symptoms can be life-saving
- Following detoxification, a variety of therapeutic modalities have been incorporated into different service settings to treat the patient’s drinking problems, promote abstinence from alcohol and prevent relapse
- In most comparative studies, out-patient and residential programs produce comparable outcomes (Finney, Hahn and Moos (1996), cited in Alcohol and Public Policy Group (2009))
- The approaches with the greatest amount of supporting evidence are behaviour therapy, group therapy, family treatment and motivational enhancement.
- Despite advances in the search for a pharmacological intervention that could reduce craving and other precipitants of relapse (alcohol-sensitizing drugs, medications to directly reduce drinking and medications to treat co-morbid psychopathology), the additive effects of pharmacotherapies have been marginal beyond standard counselling and behaviour therapies (Anton, O’Malley , Ciraulo, Cisler, Couper and Donovan *et al.* (2006) and Kranzler, Van Kirk (2001) cited in Alcohol and Public Policy Group (2010))
- Mutual help societies composed of recovering alcoholics are inexpensive alternatives and adjuncts to treatment. Mutual help groups based on the Twelve Steps of Alcoholics Anonymous (AA) have proliferated throughout the world. In some countries other approaches, often oriented to the family as well as the drinker, are also flourishing. Research suggests that AA itself can have an incremental effect when combined with formal treatment,

and that AA attendance alone may be better than no intervention at all (Ouimette, Finney, Gima and Moos (1999), cited in Alcohol and Public Policy Group (2010)).

The Case for Prevention in Alcohol Policy

Action to prevent harmful alcohol use include:

- Support and resourcing for community agency and action through the establishment of local community leadership groups
- Adequate long-term investment in social marketing campaigns to shift social norms of smoking and alcohol consumption amongst Aboriginal people
- Resourcing of multi-component community-based programs, including effective and professional evaluation
- Strengthening antenatal, maternal and child health systems for Aboriginal communities
- Strengthening effective screening, intervention and referral pathways in primary healthcare and between primary healthcare and specialist services
- Reform and increased support for treatment and rehabilitation services for alcohol-related problems
- Actions on pricing of alcohol, including a broad review of Australia's alcohol taxation policy as part of a comprehensive approach to alcohol problems in Australia, as recently called for by the Royal Australasian College of Physicians
- Action to restrict alcohol supply, including the numbers and types of licences and hours of sale, especially for takeaway licences (NPHT, 2009).

Prevention to bridge the health gap for Aboriginal Australians

Broad, multifaceted action is needed to address the contribution made by alcohol, tobacco and obesity to the health gap between Aboriginal and non-Aboriginal Australians, combining specific programs addressing these issues with broad action on the social determinants of health, and action to strengthen and extend health services, particularly comprehensive primary healthcare.

For Aboriginal Australians, primary healthcare has come to be recognised by policy makers, health professionals and the Aboriginal community as the key strategy for improving the health of Aboriginal Australians. To the extent that there have been health improvements, these have been credited to improved primary healthcare (Australian Health Ministers' Advisory Council (AHMAC) (2008), cited in NPHT (2009)). Even where measurable improvements are limited (for example, in chronic disease mortality rates), the conclusion has been drawn that while the social determinants continue to drive high levels of ill health, improved primary healthcare services are at least providing a brake on what would otherwise be accelerating mortality rates (Thomas, Condon, Anderson et al., (2006), cited in NPHT, 2009)).

Prevalence of FASD in the NT (NTCOSS 2014)

Internationally, FASD is estimated to affect between 2.8/1000 and 4.8/1000 births, and FASD 9.1/1000 births (Sampson et al (1997), cited in NTCOSS (2014)). There is very little data about FASD in the Northern Territory. In 2003 Harris and Bucens (cited in NTCOSS (2014)) conducted a prevalence study of FASD among children in the Top End of NT. They reviewed medical records children seen by paediatricians at Darwin Hospital between 1990-2000 and found that estimated rates of FAS of:

- 0.68/1000 live births
- 1.87/1000 live births for Aboriginal children

When other conditions on the FASD spectrum were included, the rates were 1.7:1000 live births and 4.7:1000 for Aboriginal children (Harris and Bucens 2003). The results were considered to be an under-estimation due to the fact that many children are not brought in to see paediatricians in Darwin due to distance.

A study of births in WA found a rate of FASD of:

- 0.02/1000 live births non Aboriginal children
- 2.76/ 1000 live births Aboriginal children (Bower et al 2000).

Peadon et al (2008) estimate that the rate of FASD among the Aboriginal community is between 2.76 and 4.7/1000 live births. Others suggest the rates may be significantly higher, with a study in far north Queensland estimating FASD at 15/1000 births and one Cape York Community reporting a prevalence of 26/1000 births.

The over-representation of Aboriginal children among children diagnosed with FASD is of great concern and indicates the need to actively and assertively address this issue among the Northern Territory population. Aboriginal children are already disadvantaged in relation to health outcomes and life expectancy, and brain-injury as a result of foetal alcohol exposure must be actively prevented.

The prevalence of alcohol related harms in the general NT population have been highlighted earlier in this document. Alcohol use in pregnancy is also at concerning levels. Around 50% of pregnancies are unplanned, so there is a risk with high levels of alcohol consumption across the population, which women consuming alcohol in pregnancy will often do so inadvertently.

Across Australia, 1 in 5 Aboriginal mothers with children aged 0-3 reported drinking in pregnancy in 2008 (ABS 2012). Between 2003-2006, it was reported that one in eight Aboriginal pregnant women and one in 12 non-Aboriginal pregnant women in the NT were consuming alcohol at the first antenatal visit. Between 8-8.7% of Aboriginal women and 3.6-4.7% of non-Aboriginal women were still consuming alcohol at 36 weeks (HGPIIS 2010). A recent Australian analysis of alcohol use in pregnancy indicate that while women's consumption of alcohol in pregnancy has declined in recent years, those who use alcohol either weekly or those who engage in binge drinking are less likely to change their pattern of use in pregnancy. 46% of women in the study continued risky drinking patterns in pregnancy (Anderson et al 2014).

NTCOSS made several recommendations to the Legislative Assembly Select Committee on Prevention of FASD. These recommendations are listed in **Appendix A**

Recent Policy Developments and Debate

Banned Drinkers Register (BDR)

Under its 2011 'Enough is Enough' Alcohol Reforms, the NT Government introduced the Banned Drinkers Register (BDR) - an electronic system where all customers were asked to present photo ID before purchasing alcohol (photo ID scanners used) to help enforce bans on problem drinkers. A central database collected information on the identity of banned drinkers.

The BDR began on 1 July 2011, commencing in Darwin and Palmerston; and subsequently rolled out in Alice Springs, Tennant Creek and Katherine from August 2011. People who were not banned were able to buy their alcohol as normal. In reality the BDR applied to take-away only, as only take-away outlets scanned ID – apart from the trial of three bars in Alice Springs (Gapview, Todd Tavern, Heavitree Gap).

After 14 months of operation, the newly elected Country Liberal Government abandoned the scheme, in September 2012, fulfilling an election promise.

During the 2016 NT general election, the then Labor opposition announced the reintroduction of the BDR as an election commitment. The BDR is anticipated to recommence 1 September 2017.

Under the 2011 iteration of the BDR, a person could be banned from purchasing alcohol for the following reasons:

- Any combination of three protective custodies or alcohol infringement notices in 2 years
- Two low range drink driving offences or a single mid-range or high range drink driving offence
- Being the defendant on an alcohol-related domestic violence order
- Having an alcohol prohibition condition on a court order (including protection orders), bail or parole order
- By decision of the BDR Registrar after being referred by an authorised person such as a doctor, nurse or child protection worker, or a family member or carer
- Self-referral for any reasons (NT Government, 2011a)

Previously, people banned under the register were prohibited from purchasing, possessing and consuming alcohol and could be ordered to attend treatment by a Tribunal (technically mandatory treatment although Tribunals cannot enforce their own orders).

However, under the latest BDR therapeutic support options will be available to people who appear on the BDR and in particular people with bans of 6 months or more, will be offered an assessment and recommendations by a clinician but treatment will not be compulsory as evidence provides that someone who seeks treatment voluntarily is more likely to have better long-term outcomes than of a person who is mandated treatment (NT Government 2017).

The 'Hurting People and Harming Communities' report handed down by the Federal Government's House Standing Committee on Indigenous Affairs highlighted the previous BDR as an example of a successful, though short-lived, measure to reduce harmful alcohol use and alcohol related harm (Australian Government 2015) recommended, among other things that the NT Government reinstate the BDR.

NDRI and Curtin (2014) revealed that after the abolition of the BDR in 2012, for each of the indicators examined (Emergency Department presentations for wholly alcohol attributable conditions; Alice Springs Hospital admissions for wholly alcohol attributable conditions; conditions with an alcohol-attributable fraction of 0.4; and assaults) there were increases that were significantly higher than those predicted on the basis of trends during the period in which the BDR was in place. Taken together, these indicators strongly suggest that the BDR was effective in reducing alcohol-related harms to health in Alice Springs.

NTCOSS welcomes the recommencement of the BDR as findings indicate that the Register reduces alcohol related harm whilst considering the human rights of the community.

Temporary Beat Locations (TBLs)

TBLs started under the NT (Labor) Government in May 2012 and involve NT Police being stationed outside bottle shops, asking people to show ID to establish where they will consume liquor. If they cannot demonstrate that they have a valid (legal) location to drink at, police will confiscate any alcohol purchases that they make.

The TBLs are effectively enforcing the restrictions imposed under the NT Emergency Response, which preclude people who live on prescribed areas (where alcohol is prohibited) from buying alcohol. However communities in the region were 'dry' before the NTER – it extended alcohol consumption prohibition to Aboriginal land not just communities. In addition, Alice Springs was already a 'dry' town.

In 2012, the NT Country Liberal Government expanded the use of police outside take away bottle shops, when they came in to office. In late 2014, a six-month trial of TBLs was launched, which effectively meant an intensified effort to have police present during all opening hours in Katherine, Tennant Creek and Alice Springs.

The presence of the TBLs has been consistent at times and less so at others. The scheme has not been without controversy. It has been being criticised for targeting Aboriginal people because the areas where it's illegal to drink, such as town camps and remote communities are mostly populated by Aboriginal people (ABC 2015b). In addition, the then President (Vince Kelly) of the NT Police Association in February 2015 described the TBLs as having been "highly effective", however, he also questioned whether police had the legislative power to run the program (ABC 2015a).

The current Government has argued that the policy has led to big reductions in alcohol related crimes in towns such as Alice Springs and Tennant Creek (ABC 2015b). PAAC (2015a) has highlighted the following:

- Alice Springs, Tennant Creek and Katherine each had a 6% reduction in Pure Alcohol Content (PAC) in take-away sales in 2013, and the number of assaults also fell
- December 2014 figures show that in Alice Springs, assaults reduced by 25% from the 2013 to the 2014 calendar year, with alcohol-related assaults down by just under 30%
- In Tennant Creek there were 57% fewer assaults and more than 56% fewer alcohol-related assaults.

- In Katherine, where TBLs did not operate for as large a part of that year, there were smaller but nevertheless significant reductions.³
- Darwin, by comparison, in 2013, had an increase in assaults of more than 8%, where there were no TBLs
- PAAC argue that given that all areas of the NT have Alcohol Mandatory Treatment and Alcohol Protection Orders in place, that it is the point of sale supply reduction that is responsible for the above improvements

Figures on the exact cost of the running the TBL's have been difficult to establish, particularly since the scheme has become more fluid, meaning officers now moved between bottle shops and other situations more readily than when the strategy was first implemented (NT News 2015). In early 2015, Professor Peter d'Abbs from the Menzies School of Health Research argued that the TBLs need a proper evaluation and that it was too early to know whether the TBL's are worth the cost. (ABC 2015b). PAAC has also called for an evaluation of the TBLs (The Guardian (2015)).

The NT Police Association has also publicly stated that the trial was not sustainable and should not be made long-term policy. Concerns have been raised about the number of police pulled from other areas of the police force, leaving other policing areas exposed. (ABC 2015, and that officers are doing work that would otherwise be handled by the ID scanning machines of the [previously in place] BDR. (NT News, 2015). The Territory Labor Opposition has also questioned whether the policy can be sustained because of the huge strain on police resources. (ABC 2015b)

The NT Police Association had also expressed the following broad concern: "Nothing is really going to change because both sides of politics are beholden to the liquor industry because they accept so much money off them in terms of political donations" (ABC (2015a).

Alcohol Mandatory Treatment (AMT)

In July 2013 The NT Department of Health implemented an AMT program for people who are repeatedly taken into Police protective custody due to their alcohol abuse. The Government described the AMT as a "harm reduction strategy designed to get help to some of the most chronic abusers of alcohol".

The NT Government described that clients subject to AMT are "chronic drinkers with a health problem [and]...are not in treatment because they have committed a criminal or violent offence. People who misuse alcohol and commit such crimes will continue to be dealt with through the criminal justice system and will not be treated at secure or community treatment facilities." (NT Government (2015a)).

Concerns about Alcohol Mandatory Treatment

A number of concerns have been raised in various quarters about the use of alcohol mandatory treatment. The following issues were highlighted by Lander and Gray et al (2015), in the Medical Journal of Australia.

³ In Katherine In relation to statistical data, offences against the person are down, and same with offences against property. (ABC 2015b).

- International guidelines and human rights law confirm that mandatory rehabilitation should only be used for short periods. (The Northern Territory *Alcohol Mandatory Treatment Act 2013* (AMT Act) permits mandatory residential alcohol rehabilitation for up to 3 months.)
- Evidence concerning the efficacy of long-term mandatory alcohol rehabilitation is lacking, and minimal data concerning the efficacy of the scheme have been released.
- Specific legal issues also arise concerning the AMT Act, including its potentially discriminatory application to Aboriginal and Torres Strait Islander peoples.
- The program only permits referral by police, despite the fact that it is ostensibly a medical intervention. Use of a treatment as a method of effectively solving a public intoxication problem is highly dubious, and should be of concern to the medical community.
- Given that more cost-effective and proven measures exist to combat alcohol dependence, the utility of the AMT Act is questionable (Lander and Gray et al, 2015).

In addition to these concerns there is the issue of the lack of housing and support options following alcohol mandatory treatment.

Mandatory treatment linked to criminal sanctions has very little evidence of success. It appears to work least well for young people, can add to the disadvantage experienced by marginalised groups, and may displace voluntary clients from limited treatment spaces (Pritchard, Mugavin et al. (2007) cited in PAAC (2014a)). Note that this does not include short-term mandatory commitment for the purpose of assessment and care of people who may be at risk of harming themselves or others (PAAC 2014a).

Criticism of the AMT Act for ‘Discrimination’

“The AMT Act has also been criticised for de-facto discrimination against Aboriginal people. Reportedly, almost everyone assessed under the AMT Act is Aboriginal (Law Society Northern Territory (2015), cited in Lander Gray and Wilkes (2015)). Homeless or itinerant individuals are much more likely to fall foul of the scheme. Homelessness rates among Aboriginal Australians are up to four times higher than those of non-Aboriginal Australians, (Australian Institute of Health and Welfare (2015), cited in Lander Gray and Wilkes (2015)) and the practice among them of staying in the “long grass” (living rough) has been well documented” (Holmes, McRae-Williams (2008) cited in Lander Gray and Wilkes (2015)).

Opportunity Cost of the AMT

“Finally, it is disquieting that around \$27 million annually is being spent on a potentially discriminatory program lacking in evidence; (Legislative Assembly of the Northern Territory (2014) cited in Lander Gray and Wilkes (2015)).

Between July 2013 and June 2014, a total of 418 people were referred to the program, representing an approximate expenditure of \$64 000 per person (Northern Territory Department of Health (2015), cited in Lander Gray and Wilkes (2015)). There are a number of more cost-effective interventions that could be implemented in place of the AMT scheme, which would represent a significantly less punitive approach towards AOD-dependent people in the NT.”

Supply Side Measures More Effective

“Supply-side interventions, such as restrictions on alcohol pricing and hours and days of sale for licensed premises, have been shown to be effective in reducing harms associated with alcohol consumption (National Drug Research Institute (2007) cited in Lander Gray and Wilkes (2015)).

Rather than punishing individuals for drinking, such restrictions are targeted at those who stand to profit from alcohol misuse. In respect of treatment interventions, capacity-building among primary health care organisations to manage AOD dependence is more readily justifiable than continuation of the AMT scheme, as the clinical and cost-effectiveness of this approach has also been demonstrated (Navarro, Shakeshaft and Doran (2011) cited in Lander Gray and Wilkes (2015)).

Implementation of any or all of these interventions using the significant funding allocated to the AMT scheme could see enormous benefits flow to the NT population more broadly, rather than providing for the temporary and likely ineffective compulsory treatment of a small number of people” (Lander Gray and Wilkes (2015)).

Alternatives to Mandatory Treatment

Community concerns have been expressed that The Northern Territory currently does not offer sufficient access to alcohol treatment and complementary services which could provide less restrictive options to persons now falling within the scope of the AMT Act. The criteria as they are currently worded apply to a fairly small group of people – many of whom sleep rough and make use of public spaces whilst in towns. (APO NT, 2014).

Incarceration must be avoided at all costs

It is crucial that any legislative changes do not exacerbate the incarceration problem further. APO NT have expressed concerns (APO NT, (2013)) that coupled with the Alcohol Protection Orders (see reference below) and the increased monitoring by police of take-away alcohol premises, it is likely that this scheme will ‘increase the interface and negative interactions between Aboriginal people, Police and the justice system.’ Criminalising any part of the treatment pathway is likely to have negative consequences, and in particular, “criminal sanctions against women who drink while pregnant are unlikely to be effective, may actually be detrimental, and should be avoided” (PAAC, 2014a)

Voluntary treatment

At present there is a gap in voluntary treatment services in the NT. Greater funding of existing and new voluntary treatment programs and beds are required to address alcohol related harm and dependence. Such programs include detoxification and residential treatment facilities, which address the needs of individuals.

Danila Dilba provides that it can take 2 to 3 months to enter rehabilitation, which poses significant challenges for the client who may relapse or lose motivation to pursue treatment. Treatment is

effective in reducing alcohol and drug related harm; and that generally residential treatment is not more effective than non-residential treatment (Danila Dilba Health Service 2017).

Complex Problems: A multifaceted approach to solutions

APO NT (2013) described that “The cohort that the Alcohol Mandatory Treatment scheme targets includes individuals with severe alcohol addiction and complex social problems and individuals who engage in harmful binge drinking. Those drinking at very harmful levels will have high rates of associated mental health and chronic health conditions. They will be overwhelmingly Aboriginal, and will present with high rates of homelessness, low formalised education levels, histories of incarceration, and exposure to trauma, both past and present. A significant number will have neurodevelopmental and cognitive impairment as a result of exposure to Foetal Alcohol Spectrum Disorders (FASD) or Early Life Trauma (ELT) and/or from the effects of long-term alcohol and other drug misuse, including volatile substance abuse. As a group they are also heavily stigmatised, experiencing high levels of racism and social opprobrium.

While little research has been undertaken relating to circumstances and drinking behaviours of Aboriginal people with characteristics described above, the most detailed research comprises two research reports commissioned by Larrakia Nation Aboriginal Corporation on Darwin’s Long Grass Community (referred to as the NDLERF Report⁴) and *Message in a Bottle* report⁵.

The *Message in a Bottle* report surveyed the drinking patterns and attitudes amongst Darwin’s homeless. Of 101 homeless people surveyed, 15% did not drink at all and 20% drank on average only one day per week. Almost a third (31.1%) reported drinking every day, many heavily. Nearly 50% drank on six days per week or more. In the survey, alcohol free days spent in a dry community were not counted in the statistics. Port was the most commonly consumed alcohol at 72% of all alcohol consumed (APO NT 2013).

The NDLERF Report states that the dominant reason for leaving remote home communities and staying in the Long Grass was family problems, mostly involving violence or other conflict, as well as a desire to access alcohol, lack of housing, and trouble with authorities (Holmes and McRae-Williams, (2009), cited in APO NT (2013). Some people also come to town or urban centres to access medical treatment or for other purposes, or to accompany spouses or other family members. Those with alcohol problems are more likely to come into contact with police (APO NT, 2013).

The *Message in a Bottle* report also confirmed the findings of the NDLERF report of high levels of trauma and grief amongst the Aboriginal homeless population of Darwin. Notwithstanding that drinking patterns will not be exactly the same across all public areas in the Territory, these results suggest that those drinking at very harmful levels include both alcohol dependent individuals and those who engage in binge drinking at various intervals. Importantly, the finding that over a third of those surveyed wanted to stop drinking indicates a high potential for voluntary rehabilitation.

⁴ Holmes, C, and E McRae-Williams. 2009. An Investigation into the Influx of Indigenous “Visitors” to Darwin’s Long Grass From Remote NT Communities: Phase2 : Being Undesirable : Law, Health and Life in Darwin’s Long Grass. Monograph Series No. 33. Hobart: National Drug Law Enforcement Research Fund.

⁵ Taylor, Penelope, Sandy Japanardi Walker, and Barry Marawi. 2011. “Message in the Bottle: A Survey of Drinking Patterns and Attitudes About Alcohol Policy Amongst Darwin’s Homeless”. Darwin: Larrakia Nation Aboriginal Corporation.

APO NT has argued that by focussing only on mandatory treatment, the NT Government not only ignores the opportunity this presents, but is likely to reduce the capacity for voluntary rehabilitation by swamping capacity with mandatory patients (APO NT 2013).

The data from *Message in a Bottle* also confirms the long-held understanding that cheap, bulk alcohol products are associated with very harmful drinking. This provides an opportunity to significantly reduce the harms and impacts of very heavy drinking by banning or restricting such products, or by instituting a 'floor price' on alcohol. Reducing Supply was seen as a priority area for action at the (2012) Alcohol Summit, as a critical 'circuit breaker' in the fight against alcohol harm (APO NT (2014)).

The findings around trauma and grief experienced by the target population underline APO NT'S understanding of the psychosocial and cultural complexities that must be negotiated in assisting and treating homeless Aboriginal people and that short-term mandatory treatment will not provide (APO NT, 2013)).

Addressing underlying issues of trauma, grief and loss for Aboriginal people in the Northern Territory

APO NT (2013) have noted that alcohol rehabilitation programs are not likely to have long term positive effects "if they do not address the underlying Issues associated with histories of trauma and loss" for people. APO NT cite a "growing evidence base in relation to working with individuals and communities with issues relating to trauma and loss has identified that effective programs rely on genuine community engagement, principles of empowerment and long term work"(APO NT (2013)).

Alcohol and substance misuse is associated with intergenerational and other types of trauma, including childhood trauma. Alcohol and other drugs are often used as a coping mechanism for dealing with unresolved trauma [and grief] and its resulting psychological distress (Atkinson (2002), in APO NT (2013)). A recent study⁶ of alcohol and substance dependent participants found over half were PTSD symptomatic and over 80% had experienced traumatic events, which correlates with the NDLERF study of Darwin's Long Grass residents which found that around 20% of people staying in the Long Grass were PTSD symptomatic and that the vast majority had experienced "an extraordinary number of trauma events". (APO NT (2013)).

The association of alcohol misuse and complex histories of trauma and abuse suggests that the harsh and inappropriate regime of mandatory treatment may serve to exacerbate the underlying causes of substance abuse, and cause re-traumatisation.

APO NT have argued for a specific focus on programs dealing with the prevalence of trauma experienced by those with chronic and harmful alcohol dependence. Evidence shows that effective programs rely on genuine community engagement and principles of empowerment. Increased support is required for community-based recovery strategies such as the Kimberley Healing and Empowerment Program, as well as Social and Emotional Wellbeing programs offered as part of comprehensive primary health care, and the use of healing initiatives, which exist in some communities already (APO NT 2013).

⁶ Dore, Glenys, Katherine Mills, Robin Murray, Maree Teesson, and Philippa Farrugia. 2012. "Post-traumatic Stress Disorder, Depression and Suicidality in Inpatients with Substance Use Disorders." *Drug and Alcohol Review* 31 (3) (May): 294-302

Need for appropriate throughcare post-release from residential rehabilitation

A 2002 review of residential rehabilitation programs targeting Aboriginal people found a lack of suitable post rehabilitation support and that this is a factor in poor outcomes. Since 2006, a remote AOD workforce has been growing throughout government and community controlled primary health care centres, with 30 specified AOD positions throughout 19 communities in 2013. There is considerable evidence and support for the effectiveness of AOD programs as part of comprehensive primary health care. However, there is also a recognised need for the expansion of this workforce to adequately address the AOD service needs throughout remote NT communities (APO NT 2013).

There is a need for comprehensive and culturally appropriate after care plans, which take into account the individual needs of the person being released. After-care post rehabilitation needs to be: properly planned, and based on a strong, culturally appropriate evidence base; available on remote communities as well as urban centres; and adequately staffed and financed. The preparation of aftercare plans needs to be explicitly linked in with services available to that person in their community (APO NT 2013). A review of residential rehabilitation programs targeting Aboriginal people found that there was a lack of suitable support post rehabilitation which is a factor in poor outcomes. (APO NT 2013).

There is also a critical need for the Aboriginal alcohol treatment system to be resourced to assess (in collaboration with the client, their carers and family as necessary) people with cognitive impairment to determine whether their needs are best met through alcohol treatment or disability services. (PAAC 2014a)

Responding to people who are homeless

APO NT have identified strategies for addressing the needs of homeless people and those using public spaces, including people camping rough or living in the long grass (in the Top End), who they argue, require a response by government to provide additional services to reduce avoidable harms and to provide basic facilities, including access to health care and other services. (APO NT 2013), night and day-time patrols; return to country programs; disability support services; and social and emotional wellbeing, alcohol and other drug and trauma programs, all need to be incorporated into primary health care responses (APO NT 2013, p.19)

There are limited social and emotional wellbeing and AOD services available to people in urban towns, and very little available for people in remote communities. A minority of communities have residential AOD workers but many communities have no services at all.

APO NT have also highlighted the need to ensure that alternative sources of long term support are available for clients with cognitive impairment . (APO NT 2013).

There are currently voluntary residential treatment options available in Darwin, Katherine, Alice Springs, Tennant Creek and Nhulunbuy, however available spaces in these services are extremely limited (APO NT 2013). There is a further need for government funded treatment services and complementary programs available in many parts of the NT. (APO NT 2013)

People with severe and harmful alcohol dependency often have complex social problems, and individuals who drink at very harmful levels will have high rates of associated mental health and chronic health conditions. They will be overwhelmingly Aboriginal, and will present with high rates of

homelessness, low formalised education levels, histories of incarceration, and exposure to trauma, both past and present.

A significant number will have neurodevelopmental and cognitive impairment as a result of exposure to Foetal Alcohol Spectrum Disorders (FASD) or Early Life Trauma (ELT) and/or from the effects of long-term alcohol and other drug misuse, including volatile substance abuse. As a group they are also heavily stigmatised, experiencing high levels of racism and social opprobrium. (APO NT 2013).

There is a need for honest recognition that this is a complex problem that has reached the current crisis point through decades of neglect of the many factors that have driven its growth; particularly failure to provide essential housing, services and infrastructure in communities, lack of proper education and employment opportunities, and the failure to address the problems of over consumption of alcohol across the Territory.

Reducing the numbers of homeless people over time will require both short-term strategies to minimise immediate harm as well as long-term strategies to address the drivers of alcohol misuse and chronic dependence. Effective policy recognises that these issues impact on the Aboriginal community as well as substantial numbers of non-Aboriginal people living on the margins of society. (APO NT 2013). Alcohol dependence is recognised as a disease and is a complex problem that requires multi-pronged solutions in order to be addressed effectively over the long run and “Increasing services for the homeless and reducing alcohol supply” are critical to this (APO NT, (2014)).

Interpreters and Cultural Support

Measures such as interpreters and cultural support must be in place to ensure treatment and programs have the best opportunity to be effective. Important cultural safety practices must be in place to address the problems associated with providing health services to Aboriginal people whose first language may not be English, which a number of alcohol residential treatment programs in the NT have adopted (APO NT 2014). The use of Aboriginal Liaison services has been found to lead to “significant reductions in the self-discharge rates and enhanced institutional cultural safety more generally and may also increase service utilisation by a population that has little confidence in hospitals” (APO NT, 2014).

Dunbar (2011) cited in APO NT (2014) has also noted that: “The need for improvement to services at the structural and systemic levels, and how the institution supports staff to provide culturally secure quality health and family services, is critical in the NT... Staff power, miscommunication and lack of cultural knowledge have been identified as central to disparities of quality health and family service outcomes experienced by Aboriginal people” (APO NT 2014) . The benefits of receiving treatment from health workers who not only speak the language of Aboriginal people, but understand their community life and where they have come from cannot be underestimated. This approach should underpin any therapeutic approach to the treatment of alcohol dependence. (APO NT, 2014).

The health aspects of Alcohol Dependence

Alcohol dependence can be a relapsing chronic disorder. An Australian government review⁷ quoted relapse rates of 60% at one year for people undertaking residential rehabilitation. Those who are less

⁷ Department of Health and Ageing (2010). Australian Treatment Guidelines for Alcohol problems.

likely to benefit from treatment include those with cognitive impairment and those living in poor social circumstances and/or who have limited social/family support from people who do not have alcohol problems. People with co-morbidities may also have a lower success rate especially if these are not addressed with ongoing comprehensive support (APO NT 2013).

When combined with evidence that mandatory treatment is less effective than voluntary treatment, relapse rates at one a year are likely to be significantly higher than 60%. Risk of relapse is also related to the behaviours and attitudes to alcohol consumption within the community generally. In some Aboriginal communities, drinking has become normalised, with undertones suggesting 'the choice is simple: drink and belong, or abstain and remain outside', but when removed from these situations, many alcohol users are able to moderate their intake (Gray and Saggars (2002), cited in APO NT, (2013)). APO NT (2013) assert that interventions which target the individual in this scenario are of limited assistance, as upon return to the community, the prevailing culture acts to undermine any progress gained.

Alcohol Policy Summit – Tennant Creek (2012)

At the Grog Summit held by APO NT in November 2012, key Aboriginal organisations, service providers and communities called on both levels of government to, among other things:

- Base alcohol policy on evidence not politics
- Bring back a system (such as the Banned Drinkers Register) to restrict the supply of alcohol to problem drinkers without resorting to criminalisation
- Implement population level supply reduction measures as a 'circuit breaker' for problems in our communities
- Provide significant new resources into evidence-based and culturally appropriate early childhood programs as an absolute priority (APO NT 2013 20)
- Expand government support for community-based recovery strategies, similar to strategies used in Fitzroy Crossing
- Expand and invest in existing rehabilitation programs and in alcohol and other drug treatment in primary health care, including in remote areas. (APO NT 2013, p.20)

Effective Treatment and Support Options

It is a common view that alcohol treatment 'doesn't work.' However, this view is not supported by the international literature that overall demonstrates that treatment can be effective (Gray D and Wilkes E (2010), cited in PAAC 2014a)). Effectiveness, however, should not just be measured by the number of clients who abstain completely from alcohol after treatment, but important measures of success can also include "reduced alcohol consumption and improved social functioning (including within families)". There is evidence for the effectiveness of a number of treatment and support options, which PAAC argue should be the starting point for any public policy aimed at demand reduction and harm reduction (two of the pillars of the National Drug Strategy) in relation to alcohol consumption in Australia, including in the Aboriginal context (PAAC (2014a)). These options include:

a. Well-resourced interventions from the primary health care setting

These are delivered by trained staff, including brief interventions and community based treatment that includes medical treatment, evidence-based psychological care, and social and cultural support⁸

b. Residential and community-based treatment programs

These include social and cultural support for clients during and after treatment and adequate investment in infrastructure and training. Common among alcohol interventions for Aboriginal communities, most such programs are under local Aboriginal community control and run on an abstinence model. Few of these programs have been evaluated so it is not known what percentage of clients who undergo treatment achieve either abstinence or reduced alcohol consumption after treatment, although mainstream literature suggests that for the best programs this figure should be around 20% (Anton and Moak et al (1999), cited in PAAC (2014a)). From this literature, it appears residential treatment may be appropriate for many Aboriginal people affected by alcohol given their health status, and social and economic environment (Babor, and Caetano, et al. (2010). cited in PAAC (2014a)). In all cases, social and cultural support for clients during and after treatment (i.e. assistance with accommodation, education, training and employment) is likely to increase effectiveness (Sarrazin and Hall (2004), cited in PAAC (2014a)).

c. Bans on alcohol advertising and promotion

Exposure to marketing by the alcohol industry leads to young people beginning to drink earlier in their lives, and to drinkers consuming more alcohol. Incomplete bans on alcohol advertising and promotion maybe ineffective as the industry shifts its effort to non-restricted forms of promotion. However, a major international study reviewing the evidence concludes that 'extensive restriction of marketing would have an impact' (Babor T, Caetano R, et al. (2010), cited in PAAC (2014a)).

d. Sobering Up Shelters and Night Patrols

These aim to prevent harm to people who have been drinking (including the risk of arrest and incarceration) and those around them (including through violence and accidents). While there are few evaluations of such programs, they provide opportunities for other treatment (e.g. brief interventions) and may encourage further community-based action to tackle alcohol abuse, Gray and Wilkes (2010) cited in PAAC (2014a).

In addition, specific resourcing of staff is required to enable them to deliver the above interventions. This resourcing needs to go beyond the provision of materials (e.g. to support brief interventions) and needs to include training for staff and provision of in-service public health expertise to maintain a focus on non-acute services such as those related to reduction in alcohol related harm. (PAAC (2014a)).

⁸ Well-structured interventions for Aboriginal clients should provide three inter-related streams of care:

- *the medical stream* uses medicines like Acamprosate, Naltrexone and other pharmacotherapies to address the balance of chemicals in the brain and increase the effectiveness of treatment;
- *the psychological stream* includes structured therapies such as Cognitive Behaviour Therapy (CBT). These approaches are more than counselling, and require an ongoing relationship with psychologist or skilled therapist over many sessions;
- *the social and cultural support stream* helps the client change the social context which is part of the reason that addiction occurs and is maintained. This may include assistance with education and training, finding employment, accommodation, Centrelink, strengthening relationships with kin and country, enhanced cultural identity, group work and many other services.

There are a number of conditions for the successful implementation of treatment to reduce alcohol-related harm in Aboriginal communities. These include:

- *Addressing issues of cultural safety.* Interventions that are adapted to the particular cultural needs of the community they serve are significantly more effective than those which are not (Smith T B, Rodríguez M D, et al. (2011) cited in PAAC 2014a). Developing genuine partnerships with Aboriginal communities to deliver treatment and support services, and respect and support for community controlled services are essential pathways to developing culturally safe services (Taylor K, Thompson S, et al. (2010)).
- *Providing a full range of treatment and support options.* Just as in any community, not all interventions are appropriate or relevant for all those whose use of alcohol puts them and those around them at risk of harm. While some may benefit from pharmacotherapy to address dependency, for others brief interventions or motivational interviewing may be required, and for others again residential treatment. The Aboriginal community in a particular region needs access to the full range of services. The development of a set of 'core services' for alcohol treatment, followed by a region-by-region needs-analysis to document key gaps, and a resource and investment program to meet those needs should be a priority.
- *Investing in a Continuous Quality Improvement (CQI) approach.* Many Aboriginal alcohol treatment services (especially those outside the primary health care sector) face continual activity or outcome evaluation demands from funding organisations. In many cases client numbers are too small to provide statistically significant results, and the services (many of which are substantially and historically underfunded) face a large reporting 'overburden'. The focus should move towards a CQI approach based on appropriate indicators and IT systems which seeks to identify areas for improvement (e.g. staff training, infrastructure) (Gray D, Siggers S, et al. (2000), cited in PAAC (2014a)) and invests in addressing such barriers to effective service provision. An effective CQI approach should also include resources for monitoring and reporting on key performance indicators such as the level of alcohol consumption 12 months after treatment.
- *Providing adequate and secure resourcing to allow for actions to be refined and developed over time.* Developing effective programs and partnerships in complex cross-cultural environments often marked by significant under-resourcing and fragile physical and organisational infrastructure takes time. Short-term funding can undermine community commitment, weaken consistent implementation of quality treatment, and destabilise services through loss of experienced staff and continual diversion of resources into cycles of recruitment and training (d'Abbs P, Togni S, et al. (2013) cited in PAAC (2014a)). Seven year funding blocks should be the standard requirement for effective implementation (PAAC 2014a).

Early Childhood Programs

There is clear evidence from Australia and overseas showing that the early years of a child's life have a profound impact on their future health, development, learning and wellbeing. Research shows that investing in resources to support children in their early years of life brings long-term benefits to them

and the whole community (CCCH & TICHR (2009). Well-designed early [culturally appropriate] childhood development programs are a key, cost-effective intervention to address intergenerational disadvantage (PAAC 2014a).

“Early childhood development programs are an essential contributor to raising children who are resilient and thus better equipped to avoid developing substance addictions and other problems in adolescence. Investment in early childhood education and support is an essential part of the answer to reducing alcohol-related harm in the Aboriginal and broader communities”, and will assist to “break the inter-generational cycle of disadvantage and alcohol abuse that affects many Aboriginal families” (PAAC 2014a).

Alcohol’s Impact on the NT Child Protection System

Exposure to parental alcohol use is associated with an increased risk of children entering care. Walker (2013) in a report, *Prenatal Alcohol Exposure among Children in the Child Protection System in the Northern Territory*, found 86% of children on Protection Orders in the NT were exposed to harmful alcohol use by one or both parents⁹. Drinking while pregnant was associated with entering care - see further comments below. (Walker 2013).

Infants in families with harmful parental alcohol use are extremely vulnerable. Seven families in the sample of 230 families, had experienced an infant death, and harmful maternal alcohol use was identified in six of these cases- and all of the six children were also prenatally exposed to alcohol (Walker 2013). Prenatal exposed to alcohol makes children particularly vulnerable to developmental delays and when combined with concerning parental alcohol use, can lead to neglect and poor health outcomes (Walker 2013).

The report highlighted the need for child protection systems to recognise the impact of FASD on children who are already vulnerable due to their exposure to parental alcohol use, and that it is a social (and health) issue that affects the long term welfare of children. The report also argued that workers need tools to assist them to better assess parents’ drug and alcohol issues, in order to identify children at risk of long term harm, and plan more effective interventions. Identification and planning for high risk infants in families where parents engage in concerning alcohol or other drug use also needs to be a focus in the child protection system to prevent child deaths (Walker 2013).

The alarming figures point to the critical need for meaningful action to reduce alcohol related harms, and that the issue of FASD is not simply a public health issue, with the implications being far reaching for children born with FASD who end up having the disability for life. FASD impacts significantly on the criminal justice, child protection and education sectors as well and there is a real need for better outcomes for those with FASD, their families, carers and communities. The importance of prevention is now abundantly clear in order to achieve this. (Walker 2013).

⁹ *Prenatal Alcohol Exposure among Children in the Child Protection System in the Northern Territory*, examined the files of 230 children involved with the child protection system in the NT in 2011-12.

Appendix A:

Recommendations from NTCOSS Fetal Alcohol Spectrum Disorder Submission to the Legislative Assembly Select Committee on Prevention of Fetal Alcohol Spectrum Disorder

1.1 Establishment of cross-government FASD Working Group with key stakeholders from Health, DCF, Aboriginal health services,

A FASD Working Group should include the following:

- a) Development of a Northern Territory-wide FASD prevention strategy
- b) Development of targeted FASD prevention interventions with high risk communities
- c) A consultative framework with a diverse range of Aboriginal people and organisations to develop and implement culturally appropriate, local strategies to prevent FASD.
- d) Promote community ownership in FASD prevention to ensure that communities are invested in FASD prevention strategies.
- e) Develop a strategy for supporting individuals with FASD, including resourcing existing services to better meet the needs of this group.
- f) Establishment of an FASD advisory committee comprising experts in the field to ensure that FASD interventions are consistent with national and international research, knowledge and practice.

2.1 That the Northern Territory Government commit to a FASD prevention strategy which includes:

- a) Population wide messages about the risks of alcohol in pregnancy including alcohol labelling
- b) Guidelines for health professionals about messages relating to alcohol in pregnancy
- c) Specialised supports for women who have children with FASD and are at risk of further births
- d) Services to women who use alcohol in pregnancy should be supportive and recognise the complex issues relating to alcohol use in pregnancy
- e) Follow up support for at risk mothers after the birth of a child to reduce the risk of harm in future pregnancies
- f) Services for Aboriginal women should be non-judgmental, recognise impact of trauma, and be culturally safe.

2.2. NTCOSS does not support any form of punitive measures for pregnant women as research indicates this to be counter-productive.

3.1 That FASD diagnostic teams be established in the NT

3.2 That FASD be identified as a disability in the NT

3.3 That individuals with FASD be able to access Disability Services

3.4 That Disability Services workers be trained in FASD

4. Development of training and FASD specific resources to enhance the skill and knowledge base for those caring for or supporting individuals with FASD.

5.1 Improved data collection in relation to alcohol in pregnancy

5.2 Development of procedures to ensure all pregnant women receive appropriate screening for alcohol use and training for practitioners to ensure this occurs.

- 5.3 Resources for health practitioners to develop sensitive and culturally safe strategies for assessing alcohol use in pregnancy and providing education to mothers.
- 5.4 Community consultation about appropriate service models to assist pregnant women with alcohol dependence access treatment.
- 5.5 Further training of health providers in identification and diagnosis of FAS and FASD
- 5.6 That the NT government produces resources for health providers on FASD, diagnosis and screening, effects of FASD and intervention strategies.
- 5.7 That procedures be put in place to ensure that children with Fetal Alcohol Exposure are flagged for regular developmental screens
- 5.8 That Fetal Alcohol exposure be recorded on medical files to enable future diagnosis when available
- 5.9 That the NT government ensure that all agencies working with infants, children or families have access to accurate, up to date information about alcohol consumption in pregnancy and the impact of FASD.
- 5.10 That the NT government provides FASD screening guidelines to professionals working with vulnerable infants and children.
- 5.11 That culturally appropriate information is sourced from relevant successful FASD Projects in Australia and adapted where necessary to the NT setting.
- 5.12 That the NT government explore screening of children at preschool for FASD in order to refer for diagnosis and early intervention services.
- 5.13 That staff of early childcare services are provided with education and training in FASD
- 5.14 That successful interventions for children with FASD in preschool years are promoted.
- 5.15 That FASD training be included in professional development for all teachers in the NT.
- 5.16 That DET develop resources on classroom management strategies and individual learning plans that reflect best current international practice.
- 5.17 That Department of Children and Families identify and implement best practice models to assess and support children with FASD.
- 5.18 That workers with vulnerable young people be provided with access to resources and training to assist them in developing more appropriate service responses to young people with FASD.
- 5.19 That international best practice service models for supporting young people with FASD be explored and features of these models be incorporated into existing service design.
- 5.20 That services providing support to vulnerable adults are provided with resources about effective interventions with adults with FASD based on best practice Internationally.
- 5.21 That staff working with adults who may have fetal alcohol exposure be educated and trained about the disorder
- 5.22 That staff working with adults ask about maternal alcohol consumption in pregnancy as part of their assessment.

6.1 That the NT FASD Working group examine good practice models of FASD prevention and intervention both from Australia and Internationally with a view to implementation in selected sites in the NT.

References

- ABC (2015a) *Adam Giles's alcohol policy draining police resources, says Police Association president Vince Kelly* <http://www.abc.net.au/news/2015-02-11/bottle-shop-cops-draining-resources-says-police-association/6085626>
- ABC (2015b) The World Today - NT Government says police manning bottlos has brought down crime stats <http://www.abc.net.au/worldtoday/content/2015/s4208127.htm>
- Alcohol and Public Policy Group (2010) *Alcohol: No ordinary commodity* – a summary of the second edition
<http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2010.02945.x/pdf>
- Alice Springs Alcohol Reference Group (2016) Alice Springs Alcohol Management Plan 2016 – 2016: *Living responsibly with alcohol in Alice Springs – in a safe and healthy community*
http://www.territorystories.nt.gov.au/bitstream/10070/258376/2/Styles-261015-Alice_springs_draft_alcohol_management_plan_released_attachment.pdf
- APO NT (2013) *Not under the influence of evidence: A sober critique of the Alcohol Mandatory Treatment Bill*
- APO NT Submission on the NT Alcohol Mandatory Treatment Bill May 2013
- Australian Government (2015) Federal Government Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities '*Alcohol, hurting people and harming communities*' prepared by the House of Representatives Standing Committee on Indigenous Affairs , June 2015, Canberra
- The Centre for Community Child Health and the Telethon Institute for Child Health Research (CCCH & TICHR), 2009, *A Snapshot of Early Childhood Development in Australia 2012*, Australian Early Development Index (AEDI) National Report
- Collins and Lapsley (2008) *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*. Department of Health and Ageing: Canberra.
- Commission on Social Determinants of Health 2008, *Closing the gap in a generation Health equity through action on the social determinants of health*
- Danila Dilba Health Service (2017) *Submission to the Northern Territory Legislative Assembly Select Committee on Alcohol Policies and Legislation Review*
- Gao, Caroline; Ogeil, Rowan and Lloyd, Belinda (2014) *Alcohol's burden of disease in Australia*, (Turning Point) July 2014
- Grog Watch (2015) *A tale of two taxes* <http://grogwatch.adf.org.au/>

Hogan (2006) *What price do we pay to prevent alcohol-related harms in Aboriginal communities? The Alice Springs trial of liquor licensing restrictions* Hogan, Eleanor; Boffa, John; Rosewarne, Clive; Bell, Stephanie; & Ah Chee, Donna; Drug and Alcohol Review, 25, 1 – 6

Lander, F, Gray, D and Wilkes, E, Alcohol Mandatory Treatment Act, Evidence, Ethics and the Law; Medical Journal of Australia 2015; 203 (1): 47-49.

<https://www.mja.com.au/journal/2015/203/1/alcohol-mandatory-treatment-act-evidence-ethics-and-law>

Menzies School of Health Research (2009) *Moving Beyond the Restrictions: The Evaluation of the Alice Springs Alcohol Management Plan* Kate Senior, Menzies School of Health Research Richard Chenhall, Menzies School of Health Research Bill Ivory, Menzies School of Health Research Christopher Stevenson, Monash University

Menzies School of Health Research (2010) *Harms from and costs of alcohol consumption in the Northern Territory: final report* - Commissioned by the Menzies School of Health Research; prepared by the South Australian Centre for Economic Studies.

Ministerial Council on Drug Strategy (2011) *National Drug Strategy 2010-2015, A framework for action on alcohol, tobacco and other drugs*

National Drug Research Institute, Curtin University (2014). *'Alcohol Control Measures: Central Australia and Alice Springs.'* Appendix to People's Alcohol Action Coalition, Submission No. 7 to the House of Representatives Standing Committee on Indigenous Affairs Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities. May 2014.

http://www.aph.gov.au/Parliamentary_Business/Committees/House/Indigenous_Affairs/Alcohol/Submissions

National Preventative Health Taskforce (2009) *National Preventative Health Strategy Australia: The Healthiest Nation by 2020*

NT Government (2007) Media Release, Chief Minister, Clare Martin, Alice Springs 'Dry Town' Campaign

NT Government (2011a) Alcohol Reform (Prevention of Alcohol-Related Crime and Substance Misuse) Bill 2011 Enough is Enough Alcohol Reform Package (A Safe Territory) A Territory Government Initiative

NT Government (2011b) Department of Justice – What is the SMART Court, Information for Participants

NT Government (2012), Department of Attorney General and Justice, Inquest into the Death of Terence Daniel Briscoe, 17 September 2012

NT Government (2015a) Department of Health Website
http://health.nt.gov.au/Alcohol_Mandatory_Treatment/index.aspx

NT Government (2015b) Department of Transport Website
<http://www.transport.nt.gov.au/mvr/alcohol-ignition-locks>

NT Government (2015c) Department of Business Website <http://www.dob.nt.gov.au/gambling-licensing/liquor/liquor-restrictions/Pages/default.aspx>

NT Government (2017) Department of Health, Banned Drinker Register Frequently Asked Questions

NTCOSS (2014) Submission to the Legislative Assembly Select Committee on Prevention of Foetal Alcohol Spectrum Disorder

NT News (2015) Costs attached to Temporary Beat Locations are not recorded, police say, 4.3.15

PAAC (2014) People's Alcohol Action Coalition Submission to the *Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities*

PAAC (2015) *Strategies that Work*

Skov and Chikritzhs et al (2010), *How much is too much? Alcohol consumption and related harm in the Northern Territory*. Medical Journal of Australia Volume 193 Number 56 September 2010; Steven J Skov, Tanya N Chikritzhs, Shu Q Li, Sabine Pircher and Steven Whetton.

The Guardian (2015) Labor puts banned drinker register back on the cards for Northern Territory

Walker (2013) Prenatal Alcohol Exposure Among Children in the Child Protection System in the Northern Territory, quoted in Australasian Fetal Alcohol Spectrum Disorders Conference Media Release, 19 November 2013

WHO (2010) *Alcohol: No Ordinary Commodity* – a summary of the second edition dd_2945 769. 779
Alcohol and Public Policy Group, in 'Addiction', 105, p.769-779, 2010

Wilson (2009) *A Share in the Future Review of Indigenous Education in the Northern Territory*;
Wilson, Bruce (The Education Business)