Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

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Submission to the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours

Dear Ms Buckley,

Thank you for the opportunity to make a submission to the Select Committee's inquiry into a Northern Territory Harm Reduction Strategy for Addictive Behaviours, and for an extension to the deadline for receiving our submission.

While we are unable to provide a submission specifically addressing the terms of reference of the Committee's inquiry, I am able to provide the following Congress submissions (attached) which are directly relevant to reducing the harm from addiction in the Northern Territory, especially amongst Aboriginal people:

- *Submission to the National Tobacco Strategy 2018-2026* (August 2018).
- *Submission to the Inquiry into the accessibility and quality of mental health services in rural and remote Australia* (May 2018)
- *Submission to the Northern Territory Alcohol Policies and Legislation Review* (June 2017)
- *Submission to the Parliamentary Joint Committee On Law Enforcement Inquiry into crystal methamphetamine (Ice)* (December 2015)
- *Policy Position on Poker machines (Electronic Gaming Machines)* (August 2011)

I would like to draw the Committee's attentions to the following points which are made in more detail in the attached documents:

1. The biological foundations of addiction, whatever the particular form it takes (e.g. alcohol, tobacco, illicit drugs or gambling), are the same. Addiction has

been described as a chronic relapsing brain disease[1] within a particular social, economic and behavioural context. The implications are:

   a. that addiction needs to be primarily addressed as a health and social issue, rather than a moral or criminal problem; and

   b. that there are many common approaches to dealing with addiction whatever the particular substance or activity.

2. In the Aboriginal context, addiction is strongly related to the historical and ongoing experience of colonisation, including the social and economic disadvantage and intergenerational trauma resulting from processes of dispossession, exclusion, discrimination, and the forcible removal of children from their families.

3. We identify a number of key strategies for addressing the underlying drivers of addictive behaviour in the Northern Territory:

   a. tackling disadvantage and inequality – addiction cannot be addressed in isolation from broader efforts to tackle disadvantage in Aboriginal communities, and inequality between those communities and mainstream Australia;

   b. reducing racism and increasing self-determination – there is a strong association between the experience of racism and lack of life-control and poor mental health and addiction;

   c. early childhood development – sustained investment in evidence-informed early childhood programs are a 'best buy' in terms of breaking the intergenerational cycle of harmful drug and other substance use; and

   d. culture as a protective factor – culture and spirituality are important in supporting resilience, positive social and emotional well-being, and living a life free of addiction for Aboriginal people.

4. In the treatment and support of those with addictions, a number of key approaches are critical for success. These must be embedded within all service and policy approaches, and adequately and sustainably funded and include:

   a. ensuring that all services are trauma-informed and validate and support Aboriginal culture and ways of being;

   b. addressing integration within and between primary health care and other services, as many Aboriginal people with addictions have multiple, overlapping and complex issues;

[1] Leshner A I (1997) Addiction Is a Brain Disease, and It Matters. *Science* Vol. 278, 3 October 1997

c. providing a full range of treatment and support options to reflect the diverse needs and backgrounds of Aboriginal people in the Northern Territory, and including healing programs; and

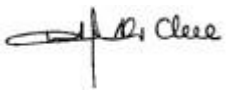
d. providing adequate and secure needs-based funding allocated through collaborative planning structures, noting that short-term funding and/or open competitive tendering processes undermine integration and lead to fragmented and ineffective service systems.

5. Aboriginal community-controlled organisations should therefore always be the preferred provider for all services dealing with addiction for Aboriginal people.

6. We draw the Committee's attention in particular to the model developed at Congress that provides integrated multidisciplinary non-residential treatment for Aboriginal clients with addictions and other mental health / social and emotional well-being issues, by providing three streams of care to address a their holistic needs: social and cultural support; psychological therapy; and medical treatment.

I thank the Committee for the opportunity to provide input to the inquiry, and am happy to provide further detail on request.

Yours sincerely



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Policy Position on Poker machines (Electronic Gaming Machines)
August 2011

Background

40 percent of losses on poker machines come from problem gamblers. Poker machines are a significant cause of crime in the community.

The Productivity Commission concluded in its review of gambling (2010) that poker machines are the most dangerous form of gambling and are responsible for the vast majority of problem gamblers.

The Productivity Commission also reported it was relatively easy to lose up to $1500 an hour playing a standard poker machine. This is meant to be a recreational activity, but you don't lose $1500 an hour going to the movies or dinner.

The Alfred Hospital in Melbourne reported last year that 1 in 5 people who attended its Emergency Department after attempting suicide identified problem gambling as the reason for their suicide attempt.

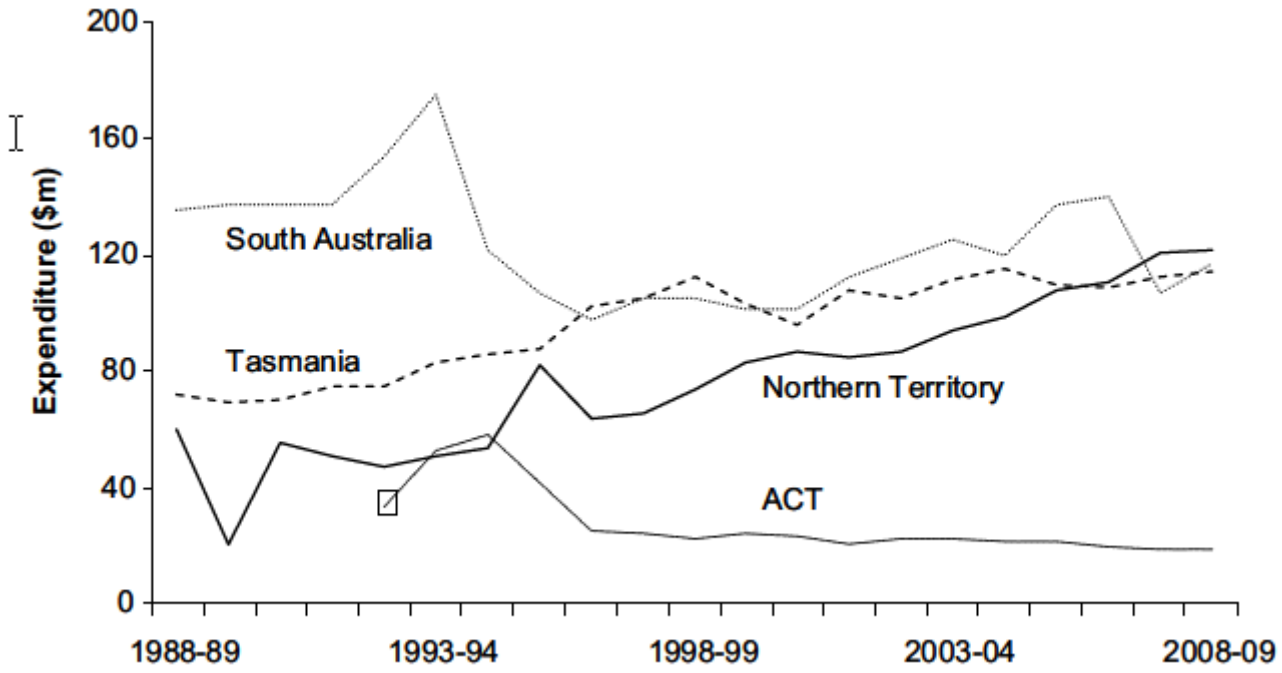
The NT has the highest average expenditure on gambling per adult and per gambling adult in Australia:

Table 2.1 **Gambling expenditure by jurisdiction, 2008-09[a]**

State	*Expenditure[b]*	*Expenditure as proportion of household consumption[c]*	*Average expenditure per adult*	*Average expenditure per gambling adult[d]*
	$m	%	$	$
New South Wales	7 150	3.5	1 319	1 911
Victoria	5 110	3.3	1 229	1 684
Queensland	3 344	2.8	1 016	1 355
South Australia	1 136	2.6	921	1 316
Western Australia	1 129	1.8	672	Unavailable
Tasmania	429	3.4	1 124	1 322
Northern Territory	500	7.5	3 129	4 287
ACT	243	2.0	901	1 234
Australia	**19 042**	**3.1**	**1 147**	**~1 500[e]**

Source: Productivity Commission Report 2010

The rate of growth of gambling expenditure in the NT outstrips all other jurisdictions:



People from low socio-economic groups who have suffered an adverse early childhood are more likely to develop addictions including gambling. This means that that are many vulnerable people in the community of Alice Springs and poker machines are the principal form of gambling addiction

Proposals to address harm from Poker Machines

1. As there is a line between the number of poker machines and harm Congress oppose the introduction of all new poker machines in Alice Springs

2. Congress support mandatory pre-commitment which allows gamblers playing the high intensity machines to choose what they are willing to lose before they start using the machines. It will be a national system to protect all Australians who may become addicted to poker machines. It has been shown to be an effective strategy

Reference

Productivity Commission 2010, *Gambling*, Report no. 50, Canberra.

Central Australian Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Central Australian Aboriginal Congress submission:

Inquiry into the accessibility and quality of mental health services in rural and remote Australia

Context for this submission

Central Australian Aboriginal Congress (Congress) is the largest Aboriginal community-controlled health service (ACCHS) in the Northern Territory, providing a comprehensive, holistic and culturally-appropriate primary health care service to more than 13 000 Aboriginal people[1] living in Alice Springs each year as well as the remote communities of Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg) and Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna.

Congress operates within a comprehensive primary health care (CPHC) framework, providing a range of services in remote areas of Central Australia. Alongside general practice, services and programs on issues such as alcohol, tobacco and other drugs; early childhood development and family support; aged and disability; and mental health and social and emotional well-being are also provided.

As Aboriginal people have significantly more complex health needs, ACCHSs provide a comprehensive model of care that goes beyond the treatment of individual clients for discrete medical conditions to include:

- a focus on cultural security
- assistance with access to health care
- population health programs including health promotion and prevention
- public health advocacy and intersectoral collaboration
- participation in local, regional and system-wide health planning processes
- structures for community engagement and control
- significant employment of Aboriginal people. [1]

Why it is important to specifically consider Aboriginal people in this inquiry

The highest proportion of Aboriginal and Torres Strait Islander people in Australia live in the Northern Territory (25.5 per cent of the NT population), which is predominately a remote area.[2] Furthermore,

[1] In this document, we use the term 'Aboriginal' to refer to 'Aboriginal and Torres Strait Islander' and/or 'Indigenous' as the preferred term in Central Australia

most Aboriginal people (80 per cent) living in the NT live in rural and remote communities. [3] This means that to be effective rural and remote mental health services must consider the specific needs of Aboriginal people. This is further detailed in the response to the Terms of Reference, below.

As an ACCHS, Congress is an exemplar in health service delivery to Aboriginal people in both town and remote areas. Congress has also pioneered a 'three streams' approach to mental health services, which integrates social and cultural matters, physical health, and mental health, including attention to alcohol and other drug issues and suicide prevention. This service is provided in both Alice Springs and in remote communities as an outreach service.

The effectiveness of our services is contingent on the political and policy environment in which we work. Key challenges include competitive tendering which leads to fragmented, complex service delivery environments with multiple providers of health services. On the other hand, the announcement by the NT government to reduce alcohol supply, including by introducing a minimum floor price, is integral to a reduction in alcohol-related harms including suicide. This is alongside the paradigm shift that is currently occurring in youth justice in NT, which includes shifting from a punitive approach to a therapeutic, population health approach to improve long term and intergenerational outcomes.

Summary of key points

Key points raised in this submission are:

- The specific needs of Aboriginal people must be recognised by providers so that services are effective and accessible to Aboriginal people.
- That Aboriginal Community Controlled Health Services (ACCHS) are the most effective providers of culturally safe, integrated, mental health services to Aboriginal people.
- The key challenges to the ACCHS service model include competitive tendering and short term funding cycles, which have a significant impact on integrated, holistic, accessible service delivery in remote and rural areas.
- There is a need to integrate mental health, AOD and primary health care services to overcome the problem of "Dual diagnosis" and lack of access to integrated care based on the 3 streams of care approach – medical (pharmacotherpies), psychological and social and cultural support with intensive case management when needed.
- Suicide in Aboriginal communities is linked to disempowerment, disadvantage and the social determinants of health. Addressing the social determinants of health is imperative to reducing the high suicide rates in Aboriginal communities. This specifically includes:
    - Providing evidenced-informed early childhood learning and parenting programs
    - Reducing young people's contact with the justice system
    - Reducing the number of Aboriginal children in out-of-home
    - Reducing alcohol related harms.

- There is an ongoing need for a high-quality, culturally-competent mental health workforce, including an Aboriginal workforce, alongside the capacity to train clinicians outside of major centres.
- Governments should work with ACCHSs in the development of culturally safe technological solutions for mental health service delivery.

Recommendations

That governments:

1) ***Improve accessibility of mental health services to Aboriginal people by recognising intergenerational trauma. This means:***
    a) ***ensuring that all agencies delivering mental health and social and emotional wellbeing services to Aboriginal people use approaches that are trauma-informed and that validate and support Aboriginal culture and ways of being***
    b) ***supporting healing approaches run by the Aboriginal community***
    c) ***eliminating systemic and institutionalised racism.***

2) ***Recognise the need to combine medical care, psychological therapies and social and cultural support with intensive case management as the best practice model for integrated mental health services to Aboriginal people.***

3) ***Recognise and address the link between the social determinants of health, inequity and risk for suicide.***

4) ***Continue to invest in evidence- informed early childhood development and parenting programs for families at risk of having developmentally vulnerable children to support healthy brain development, resilience and self-control.***

5) ***Recognise the link between contact with the criminal justice system and risk of youth suicide and endorse preventive and diversion measures to reduce the numbers of Aboriginal young people being incarcerated, as well as therapeutic approaches for those where detention is necessary.***

6) ***Recognise the need to address the number of Aboriginal children in out-of-home care as part of a suicide prevention strategy.***

7) ***Undertake measures to reduce the supply of alcohol as the best way to reduce alcohol-related harm, including suicide. In particular this means introducing a minimum floor price and a volumetric tax, to reduce the availability of cheap alcohol and raise funds to address alcohol-related harm.***

8) ***develop strategies for a high-quality, culturally-competent mental health workforce, taking into account rural and remote distribution and Aboriginal health workforce development.***

9) ***reject open competitive tendering processes for the funding of mental health and social and emotional wellbeing services for Aboriginal communities as an ineffective approach that undermines integration and leads to fragmented and ineffective service systems.***

10) ***support and resource needs- informed planning through established collaborative structures that include significant representation from the ACCHS sector, to ensure the effective distribution of resources and appropriate service models to address Aboriginal mental health and social and emotional wellbeing.***

11) ***commit to long term block funding for comprehensive primary health care services including ACCHSs.***

12) ***continue to work with remote and rural service providers particularly ACCHSs in developing culturally safe technological solutions, and the delivery of psychological assessments via telehealth.***

Addressing the Terms of Reference

1. The nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate

To be accessible to Aboriginal people, services must be trauma- informed, culturally safe, and free of racism

Intergenerational trauma

For Aboriginal people living in rural and remote areas services must not only be available, they must also be accessible. This means they must be trauma- informed, culturally safe, and free of racism. The colonisation of Australia and its ongoing process and impacts must be acknowledged by mental health service providers to understand Aboriginal mental ill health and social and emotional wellbeing today.

Dispossession, exclusion, discrimination, marginalisation, the forcible removal of children from their families, and ongoing inequities has led to and continue to impact on poor physical and mental health outcomes for Aboriginal people.[4,5]

This historical and ongoing experience is now recognised as resulting in 'intergenerational trauma' whereby traumatic experiences of the first generation are passed on to the next generation and the next.[6] Intergenerational trauma can manifest in many symptoms of poor mental health and social and emotional wellbeing and adverse behaviours including panic attacks, anxiety, sleep disturbance, severe obesity; smoking, illicit drug use, alcoholism; and intercourse at an early age.[7]

There is growing evidence that unresolved intergenerational trauma underpins many of the social and emotional wellbeing issues and mental illnesses experienced in some Aboriginal communities. For example, a recent study examined the health and wellbeing of Aboriginal people who had either been removed from their families as children, or who had parents, grandparents/great-grandparents or siblings who had been removed. This group is 50 per cent more likely to have been charged by police, 15 per cent more likely to consume alcohol at risky levels and 10 per cent less likely to be employed than the wider Aboriginal and Torres Strait Islander community.[8]

Trauma informed services

There is growing recognition in Australia that policies and service providers must address and respond to traumatic life events appropriately to ensure better outcomes. [9] This includes providing services in a safe way and creating the opportunities for people affected by trauma to regain a sense of control and empowerment. [10] Moreover, a trauma informed service is cognisant of the effects on staff who are exposed to this trauma and, if Aboriginal, may have also had traumatic experiences in their own or their families background.

The service system must recognise the prevalence of intergenerational trauma not only on the wellbeing of individuals, but populations and communities as a whole.[11] All services accessed by Aboriginal people should therefore aim to be 'trauma-informed' such that they are able to recognise the different ways that the experience of unresolved trauma can manifest (for example, in mental health issues, or addiction, or violence) and address them in an informed way.[12]

Healing programs

Culture and spirituality is highly important in supporting resilience and positive social and emotional well-being and good mental health and living a life free of addiction to alcohol and drugs[13]. Cultural is a source of strength, identity, structure and continuity in the face of ongoing change, stress and adversity, and as a protection against suicide.[14]

The recognition of the positive nature of Aboriginal culture and knowledge, despite the impact of ongoing colonisation, racism and harmful policies that impact on the health of Aboriginal communities, supports healing.

There is an emerging body of evidence which demonstrates that in this context, healing programs are an effective way of addressing the effects of intergenerational trauma. In Canada for example, healing centres – spaces which supports healing work for Aboriginal people – are proven to be effective in preventing the negative health and wellbeing outcomes, including suicide, associated with intergenerational trauma experienced by Aboriginal communities. [15]

> *"Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander people."*[16]

Healing will often make use of both mainstream and traditional knowledge and practices, but valuing Aboriginal knowledge and leadership is a prerequisite for adaptive solutions to be developed.[17] Effective healing programs must be:

- Locally led and driven
- Evidence- informed
- Include a combination of Western methods and traditional healing
- informed about and understand the impact of colonisation and intergenerational trauma and grief
- build upon individual, family and community capacity.[18]

Support for living on country

Where appropriate and desired, living on traditional lands with strong connection to family, community, country, language and culture has physical, mental and emotional health benefits, including reduced substance abuse and violence[19].

Addressing racism

Aboriginal people have been consistently excluded from mainstream health services, originally through overt racist practices of exclusion, and more recently through covert racist practices that isolate and inhibit access e.g. failing to provide culturally secure and safe care that reflects an understanding of Aboriginal social and emotional wellbeing.

Racism can be structured into how institutions operate, through policies and assumptions which disadvantage Aboriginal people. Racism in health care institutions contributes to the lack of trust in mainstream health and social services and a corresponding lack of use of services, and Aboriginal people are less likely to receive the care they need.[20]

Racism is also a determinant of mental illness as it debilitates confidence and self-worth, creates psychological distress, depression and anxiety, and exacerbates health risk behaviours such as smoking and alcohol and substance misuse.[21]The experience of racism is overwhelmingly common for Aboriginal and Torres Strait Islander people: a 2012 study found that 97% of Aboriginal Victorians reported experiencing racism in the previous year, with over 70% of those surveyed reporting eight or more such incidents in the previous twelve months.[22]

Governments have a responsibility to eliminate systemic and institutionalised racism, and ensure all services are non-discriminatory and accessible, by being, for example culturally competent.

Service design: Culturally safe, integrated programs delivered by Aboriginal Community Controlled Health Services

The evidence points to ACCHSs as a highly effective model for addressing Aboriginal health, and they are therefore recognised as the best practice model for primary health care services for Aboriginal people in all the key national strategy documents including the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP). A key recent study concluded:

> *... are improving outcomes for Aboriginal people, and … that they achieve outcomes comparable to those of mainstream services, but with a more complex caseload*[23].

The key role of ACCHSs is supported by the fact that Aboriginal people show a clear preference for their use, leading to greater access to care and better adherence to treatment regimes[24].

As an ACCHS, Congress is able to provide fully integrated mental health services as part of comprehensive primary health care and are not stand alone, specialist and separate services, then it is more possible to treat the whole person. Congress has pioneered the '3 streams' approach to mental health services which integrates: a) social and cultural support b) medical care and c) psychological therapy including AOD and suicide prevention including an intensive case management approach when needed.

This integrated approach is supported by the use of a single Clinical Information System that all professionals use including GPs, psychologists, social workers, and Aboriginal Health Workers. All members of the multidisciplinary team treating the whole patient can access the patient's medical record so there is a consistent approach to treating the patient.

Within a comprehensive primary health care service the 3 streams of care service model is possible and the whole person is treated recognising the root causes of poor physical health and poor mental health are the same, and comorbidities are interrelated. This also assists to ensure that the physical health needs of mentally ill patients are not neglected as severely mentally ill people are at risk of dying prematurely of untreated physical health problems such as coronary heart disease and diabetes, rather from their mental illness.[25] Under this service model, patients are able to have both their mental health and physical needs addressed in one visit in the one place.

The benefits of locating a mental health specific service within a comprehensive primary health care service have also been realised with the Congress headspace service where young people are able to access sexually transmitted infection treatments, contraception advice, health checks etc along with mental health and substance misuse diagnosis, treatment and support. Because the service is integrated in this way many young people present in the first place as they access the bulk billing medical service which is the first point of contact for the most disadvantaged young people. They then access services for mental health issues.

Challenges to this service model

Competitive tendering for short-term funding leads to complex service delivery environments with multiple providers of health services rallying for funds in relatively small, sparsely populated areas. This is further detailed under X. The impact of competition also comprehensively discussed in Congress' submission to the Productivity Commission's Preliminary Findings Report: Introducing Competition and Informed User Choice into Human Services; Identifying Sectors for Reform

Recommendation:

That governments

1) improve accessibility of mental health services to Aboriginal people by addressing intergenerational trauma. This means:

- ***a) ensuring that all agencies delivering mental health and social and emotional wellbeing services to Aboriginal people use approaches that are trauma-informed and that validate and support Aboriginal culture and ways of being***
- ***b) supporting healing approaches run by the Aboriginal community***
- ***c) eliminating systemic and institutionalised racism.***

2) recognise the need to combine medical care, psychological therapies and social and cultural support with intensive case management as the best practice model for integrated mental health services to Aboriginal people.

2. The higher rate of suicide in rural and remote Australia

The suicide rate for Aboriginal Australians is almost twice the rate for non- Aboriginal Australians.[26] High rates of suicide are closely linked to social and economic disadvantage: the greater the inequality, the higher the risk is for mental illness.[27]In other words, the need to address inequality cannot be ignored as a fundamental measure to reduce suicide rates in Aboriginal communities. This has been known in the literature since the classic work on Suicide by Emile Durkheim published in 1897 and the key findings in this study have been confirmed by modern social epidemiology yet there continues to be attempts to address suicide through programs and services without the need to address extreme structural inequalities. This will not be sufficient.

For Australian Aboriginal people, these inequalities include poverty, poor education, poor housing, lack of nutrition and lack of meaningful employment. Lack of control over one's life, continual anxiety and insecurity has a powerful effect on health and well-being.[28] Between one-third and one-half of the gap in health between Aboriginal and non- Aboriginal people is estimated to be due to these determinants.[29]

Strengthening community-led initiatives to reduce the rates of suicide requires recognising the impact of colonisation, intergenerational trauma and loss of control. This includes supporting community control of Aboriginal services and programs, connection to family, community, country, language and culture and support for trauma-informed services; healing programs; culturally secure SEWB programs; and where appropriate Aboriginal families living on country.

Action across the full range of social determinants is necessary to reduce rates of suicide in Aboriginal communities by improving resilience and capacity to self-manage at an individual and community-level. This requires a whole-of-government commitment. For example, early childhood development and learning, primary and secondary education accompanied by psychosocial support measures (e.g. positive role models, healthy activities); support for workforce participation and development of skills; healthy relationships and community participation, are all measures that can strengthen social and emotional wellbeing and prevent suicide.[30,31]

Brain development, self-regulation and suicide

Between 2008-2012 the suicide rates for Aboriginal people 15–19 year olds were five times as high as the non-Aboriginal rate.[32] Suicide rates are a key measure of the health and well-being of young people, and an indicator for youth development i.e. the status of young people and their capacity to contribute to and benefit from society[33].

As children's brains and social-emotional skills develop, they learn to regulate their emotions, attention and behaviour. Disruptions to healthy neurodevelopment lead to problems with the brain's executive functions such as impulsivity due to poor emotional self-regulation, problem solving, coping and decision-making skills. This also includes conditions that can occur in utero, such as Foetal Alcohol Spectrum Disorders (FASD). For some young people, underdeveloped self-regulation and coping skills can mean suicidal thoughts quickly escalate as an immediate solution to an emotional life crisis.[34]

Suicide in children, adolescents and young adults is therefore more often related to impulsive behaviour and poor problem-solving skills, such as the inability to deal with an emotionally- stressful life event, rather than depressive illnesses.[35] It is not effective to wait to diagnose "depression" or even depressive symptoms as most young people who suicide do not show these symptoms but act impulsively, often but not always under the influence of alcohol which further reduced the capacity for emotional self-regulation.

Aboriginal children are at a higher risk than non-Aboriginal children for unhealthy brain development and therefore impulsive behaviours. According to the Australian Early Development Census (AECD), 60 per cent of Aboriginal children are developmentally vulnerable on at least one measure of childhood development. Aboriginal children are twice as likely as non-Aboriginal children to be developmentally vulnerable in at least two measures[36]. Furthermore, children living in very remote areas are 2.6 times more likely to be developmentally vulnerable than children living in major cities. One of the key domains of developmental vulnerability is the emotional domain that includes self-control or self-regulation.

Additionally, adverse childhood experiences such as family violence, are a strong predictor for poor social functioning, impaired well-being, health risks and disease, and contribute powerfully to many major public health and social problems.[37] There is a strong association between adverse childhood experiences and increased levels of depression, suicide attempts, sexually transmitted infections, smoking, alcoholism, higher levels of violence and antisocial behaviour, school underperformance and lower IQs, economic underperformance and poor physical health.

Early childhood care, support, education and healthy brain development

Improving cognitive development, resilience and self-control, lies in the area of early childhood, especially in the years from pre-birth to 4 years of age. It is well established that in the first few critical years, children need responsive care and stimulation including strong, positive relationships with primary care givers to develop neural systems crucial for adult functioning and positive mental health. Longitudinal studies show that parenting support and targeted early childhood educational programs reduce the risk factors for children that may lead to poor mental health in adulthood.

Such evidence- informed programs have, for example, reduced rates of alcohol and other substance use by young adults, improved educational and employment outcomes, reduced the proportion of teen pregnancies, and are associated with more active lifestyles and reduced incarceration rates (Tremblay, et al, 2008; Campbell, et al, 2008).

Parenting programs to support healthy development

Parenting programs support and enhance the skills of parents to allow for healthy child development, and reduce exposure to adverse childhood experiences which negatively impact on development and increase the risk of suicide in later life.[38] For example, the Nurse Family Partnership and Parenting Under Pressure (PUP) programs are cost effective programs that promote healthy development in early childhood.[39] [40] and prevent the development of mental and physical health problems in later life.

Reducing contact with, and the impact of, the justice system to reduce the risk for suicide in young Aboriginal people

A young person's risk of suicide is increased if they have been involved in criminal justice system (e.g. being arrested, charged or sentenced) in the previous three months and in particular the last week[41]. This has a disproportionate effect on Aboriginal young people who are held in criminal detention at much higher rates than non-Aboriginal young people, while around one half of young people in detention at any point in time are Aboriginal.[42]

Prevention approaches, and those that divert young offenders away from detention, are the most important strategies to deal long-term with the issue of youth detention. Australia's leading criminologist, Don Weatherburn has very clearly outlined the two key strategies to prevent incarceration evidence - informed early childhood programs and reducing the supply of alcohol[43] For Aboriginal young people, diversion programs have been shown to lead to reduced drug and substance use and reoffending, especially if programs include culturally appropriate treatment and rehabilitation and Aboriginal and community Elders or facilitators.[44].

For that small number of young people where detention is necessary, the focus should be on therapeutic treatment in smaller residential units rather than punishment in large institutions. Such an approach has been shown to achieve exceptional reductions in juvenile recidivism.[45]

Congress' submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory outlines in detail the measures necessary to reduce contact with the justice system and to reduce the impact when children are detained.

Reducing and limiting the impact of Out of Home care to reduce the risk for suicide in young Aboriginal people

Statutory care of children has a direct link with suicide – a recent report notes that more than half of young people who had left out of home care within twelve months had reported that they had experienced suicidal thoughts, and more than a third had attempted suicide.[46] This is deeply concerning for Aboriginal children who are nearly 10 times as likely as non-Aboriginal children to be in Out of Home care due to child protection issues.[47]

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) has recommended a five-point strategy for addressing the rising numbers of Aboriginal children being removed from their families and supporting the implementation of the Aboriginal Child Placement Principles (SNAICC 2014):

- increasing community participation in decisions for the care of Aboriginal and Torres Strait Islander children, supported by community-controlled service design and delivery,
- re-orienting service delivery to early intervention and family support,
- ensuring that funding and policy support holistic and integrated family support and child protection services,
- recognising the importance of supporting and maintaining cultural connection, and
- building capacity and cultural competence for effective service delivery to Aboriginal and Torres Strait Islander children and families.

Additionally, it has been recommended Family Group Conferencing be established as legislated mechanism to ensure that all kinship care options are properly explored prior to foster care arrangements being made.[48]

The contribution of alcohol to suicide

Harmful alcohol use by parents and carers is known to be associated with a lack of responsive care and stimulation in early childhood. Children brought up in these environments often lack the necessary skills for effective emotional regulation and self-control and other executive brain functions that have been shown in longitudinal studies to lead to addictions including alcohol.[49]

Alcohol is also a related and major contributor to mental ill health and poor social and emotional wellbeing, risky behaviour and is a precursor for suicide. Alcohol abuse is directly associated with at least 8 per cent of the burden of disease and injury borne by Aboriginal people, including through homicide, violence, and suicides.[50,51]

A reduction in the supply of alcohol is one of the most cost effective initiatives that could be undertaken in the primary and secondary prevention of mental illness and suicide, particularly among young people and the heaviest drinkers, who are the most disadvantaged and vulnerable to mental illnesses.[52] In particular, there is clear evidence that increasing the price of alcohol reduces consumption and alcohol related harm; it is also a highly cost effective intervention.[53,54,55]

Following the Northern Territory Alcohol Policies and Legislation Review, the Northern Territory Government has committed to introducing a floor price based on the price of full strength beer ($1.30 per standard drink. A commitment by the Commonwealth Government to reduce alcohol supply through taxation would further support this approach, and allow for hypothecation of funds back into addressing the root causes of suicide.

Recommendations:

That governments

3) recognise and address the link between the social determinants of health, inequity and risk for suicide.

4) continue to invest in evidence- informed early childhood development and parenting programs for families at risk of having developmentally vulnerable children to support healthy brain development, resilience and self-control.

***5) recognise the link between contact with the criminal justice system and risk of youth suicide and endorses preventive and diversion measures to reduce the numbers of Aboriginal young people being incarcerated, as well as therapeutic approaches for those where detention is necessary*.**

6) ***recognise the need to address the number of Aboriginal children in out-of-home care as part of a suicide prevention strategy.***

7) undertake measures to reduce the supply of alcohol as the best way to reduce alcohol-related harm, including suicide. In particular this means introducing a minimum floor price and a volumetric tax, to reduce the availability of cheap alcohol and raise funds to address alcohol-related harm.

3. The nature of the mental health workforce

A high quality Aboriginal workforce is important to ensure the system is able to meet the health needs of Aboriginal communities: they are able to bring together professional training with community and cultural understanding to improve patient care and increase cultural safety across the organisation in which they work.[56.]

While Aboriginal people remain under-represented in the health workforce, the role of the Aboriginal community controlled health sector in their training and employment has been an important part of the improvements that have been made.[57]

Nevertheless, particularly in rural and remote areas, substantial barriers remain. Access to adequate pre-school, primary and secondary education is critical for forming the foundation for future workforce gains. Once this foundation is laid, specific training in mental health disciplines must be both culturally appropriate for the trainees, and result in skilled, competent professionals who are enabled to make a contribution to the health of their communities.

Furthermore, there is a need to ensure that all mental health staff (especially non-Aboriginal staff) working for Aboriginal people and communities are able to address the specific health and wellbeing needs of Aboriginal people. This means equipping health professionals with the knowledge, skills, attributes and cultural understanding to competently design and deliver health services and programs and policies for Aboriginal communities. It is particularly important for those service providers in remote

areas (i.e. nurses/Aboriginal Health Workers and GPs) undertaking risk assessments to have the competency to manage and work with clients, and to have the knowledge of available resources.

Additionally, recruitment and retention of health professionals, particularly doctors and clinical psychologists, remains a challenge in rural and remote areas. There is still a need to address their maldistribution, through a combination of incentives to practice in these areas and support for ACCHSs and other primary health care agencies to employ and train registrars as well as considering increased regulations to ensure more practitioners work where they are most needed. [58]

Clinical psychology training needs

In Congress' experience, one of the most important strategies to build a competent local mental health workforce is to build upon the training of psychologists. It is important that there is the support of paid AHPRA approved psychology supervisors located within the services which provisional or registrar psychologists can access in order to complete their training and/or gain their respective endorsements.

The supervision of psychology students requires a high level of clinical oversight and time commitment, particularly for those enrolled in the vocational models of training (4+2 and 5+1 models). If supervisors are unpaid, or not funded, as part of the model this will lead to a lack of commitment to the role as it will interfere with their own work commitments i.e. the provisional of psychological services. This used to occur in the GP training system before supervisors were remunerated properly and trained properly.

It is important that the costs of supervision do not fall upon the training institutes or students as this will lead to ongoing barriers to the development of the workforce, such as increased course costs and lack of incentive for training institutes to continue to run postgraduate level psychology courses which are already operating at a significant loss to the University.

Additionally there is lack of training options, such as post graduate courses, for psychology in the Northern Territory. This means that the majority of trainees leave the Northern Territory to attend training in the metropolitan areas. Unfortunately the amount of psychologists returning to the NT after training is limited. The Northern Territory has the lowest amount of psychologists, and clinical psychologists, in Australia. Additionally, even in other states, there is a lack of psychologists in rural and remote areas. There needs to be incentives to bring psychologists and trainees to rural and remote areas.

Recommendation:

That governments

8) develop strategies for a high-quality, culturally-competent mental health workforce, taking into account rural and remote distribution and Aboriginal health workforce development.

4. The challenges of delivering mental health services in the regions

Competitive tendering undermines integration and leads to fragmented and ineffective service systems

Competitive tendering for short-term funding leads to complex service delivery environments with multiple providers of health services, creates a culture of competition rather than cooperation amongst those providers, promotes an emphasis on individual care rather than population health and short term outcomes rather than long term gains in health, drives increased reporting costs for agencies, and leads to a system that is difficult to navigate for Aboriginal clients (especially where language, literacy and cross-cultural service delivery are issues)[59].

Government funding, policies and processes based on competitive tendering have unfortunately been a major driver of the disconnected, inefficient and hard-to-navigate mental health and social and emotional wellbeing system for Aboriginal communities. As a result of such policies, for example, a remote community in Central Australia had received social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis, for about 400 people. There is little in the way of communication or coordination with the local ACCHS with providers often turning up unannounced and demanding information on and assistance with locating clients, use of buildings and vehicles etc. The result is fragmentation and duplication of service delivery, lack of coordination, waste of resources and suboptimal outcomes for clients.[60]

Needs based planning

The alternative to competitive tendering is collaborative needs-based planning. Collaborative, well-resourced and sustainable processes for needs-based health system planning are now well-recognised as critical foundations for health system effectiveness.[61]

In the NT, the Northern Territory Aboriginal Health Forum (NTAHF), established after the signing of the Framework Agreement on Aboriginal Health in 1998, brings together government and the community controlled sector to work collaboratively to[62]:

- ensure appropriate resource allocation
- maximise Aboriginal community participation and control as a key element of sustainable, viable, effective and efficient health services
- encourage better service responsiveness to / appropriateness for Aboriginal people
- promote quality, evidence- informed care
- improve access for Aboriginal people to both mainstream and Aboriginal specific health services
- increase engagement of health services with Aboriginal communities and organisations.

The NTAHF has been fundamental to ensuring new and existing mental health services are integrated into existing primary health care services and allocated in a planned manner according to need. NTAHF includes the NT Primary Health Network (PHN), ACCHSs, the NT Department of Health, the Commonwealth Department of Health and the Department of Prime Minister and Cabinet.

Using this agreed approach, the NTAHF has overseen the development of the NT Aboriginal health system in a way that is now delivering results in terms of improved health outcomes for Aboriginal people.[63]The NTAHF has also helped to ensure that the social determinants of health are addressed through high level collaboration and advocacy outside the health system.

Short term funding periods

Programs and services developed with short timeframes, limited funding periods and program support do not address health in a holistic manner and ultimately fail patients.[64] Policies, programs and mental health planning and investment directed towards supporting and sustaining locally-based, culturally-relevant programs and services could bring sustainable change in mental health and wellbeing outcomes in Aboriginal populations.

Additionally, a stable, long term funding model is vital for the recruitment and retention of professional staff. Greater funding certainty in rural and remote areas is needed to attract and retain professional staff that will simply not come or leave if a service has to be tendered for every few years.

Congress has repeatedly experienced the problem encountered when short term funding leads to loss of professional staff.[65] The uncertainty created by tendering processes at 2 or 3 year intervals for example, often means the loss of key staff and all of the experience and expertise they have gained in Aboriginal health.

Recommendations:

That governments

9) reject open competitive tendering processes for the funding of mental health and social and emotional wellbeing services for Aboriginal communities as an ineffective approach that undermines integration and leads to fragmented and ineffective service systems.

10) support and resource needs-based planning through established collaborative structures that include significant representation from the ACCHS sector, to ensure the effective distribution of resources and appropriate service models to address Aboriginal mental health and social and emotional wellbeing.

11) commit to long term block funding for comprehensive primary health care services including ACCHSs.

5. Attitudes towards mental health services;

See response under term one.

6. Opportunities that technology presents for improved service delivery

The inclusion of MBS items for psychological assessment and intervention for specific mental health clinicians via e-health technologies will assist in the delivery of services to rural and remote areas, where appropriate. This will also help to further bolster on-the-ground services with the addition of specialist mental health services input (i.e. clinical psychology). While Congress is telehealth enabled we have the capacity to provide clients in remote communities with a face to face outreach service. There is a risk

that telehealth will provide greater access to patients by service providers who are not culturally aware nor trauma informed.

Recommendation:

That governments

12) continue to work with remote and rural service providers particularly ACCHS in developing culturally safe technological solutions, and the delivery of psychological assessments via telehealth.

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Central Australian Aboriginal Congress[1]

Submission to the Parliamentary Joint Committee On Law Enforcement Inquiry into crystal methamphetamine (Ice)[2]

7 December 2015

Executive Summary

The use of Ice in the Northern Territory

1. The use of Ice in the Northern Territory Aboriginal community should be approached primarily as a public health issue, not as a law enforcement one. A policy response solely focused on law enforcement is likely to be ineffective, may discourage Ice users or their families from seeking treatment , and may lead to increased substance misuse problems in the future by undermining family and community structures.

2. There are no reliable figures on Ice use by Aboriginal people in the Northern Territory. Figures that are available are highly influenced by a number of other factors – for example, increased awareness of Ice as an issue may lead to more users seeking treatment, more clinicians detecting the use of Ice as a problem, and to increased policing of methamphetamine related offences.

3. The figures that are available suggest that:

    a) there was a steep decline in reported recent methamphetamine use from 2001 to 2010 in the general Northern Territory population, followed by a small increase from 2010 to 2013

    b) treatment for methamphetamine use in the Northern Territory shows a sharp increase in recent years

    c) coinciding with changes in legislation, there has been a sharp rise in methamphetamine-related criminal offences since the beginning of 2014, with the biggest increase being for non-Indigenous men charged with methamphetamine-related offences, with a smaller but also significant increase in charging of Aboriginal men

    d) for Aboriginal people affected by Ice and their families, the drug can be profoundly damaging. Nevertheless, the data shows that alcohol is still clearly the drug associated with the highest level of harm, particularly given the relatively high cost and low availability of Ice in many parts of the Territory.

4. There is considerable community concern about Ice use in the region serviced by Central Australian Aboriginal Congress, and much anecdotal evidence of the harms that it causes that may not yet be reflected in the data. This community perspective demands the threats posed by Ice be taken seriously, and prevention and treatment approaches that work in collaboration with existing services be resourced.

Strategies to reduce the high demand for methamphetamines

5. There are four key strategies for addressing the high demand for alcohol and drugs including amphetamines in the Northern Territory:

    a) Tackling disadvantage and inequality. The harmful use of drugs such as Ice cannot be addressed in isolation from broader efforts to tackle disadvantage in Aboriginal and Torres Strait Islander communities, and inequality between those communities and mainstream Australia.

    b) Racism and the control factor. There is a strong association between the experience of racism and poor mental health and drug use.

    c) Early childhood development. Sustained investment in evidence-based early childhood programs are a 'best buy' in terms of breaking the intergenerational cycle of harmful drug and other substance use in the long-term.

    d) Culture as a protective factor. Culture and spirituality are important in supporting resilience, positive social and emotional well being, and living a life free of addiction to alcohol and other drugs.

Treatment and support

6. For dependent users, Ice use is often associated with a distinctive addiction cycle, which has several implications for service providers, including the need for 'Ice-specific' training for health professionals, a focus on client engagement and retention, and publicising the availability of services so users know that effective help.

7. Despite the issues specific to Ice, the biological foundations and social determinants of addiction are the same whatever the particular drug involved. This points to the need for a common approach to both treatment and primary prevention, whether regarding Ice, alcohol or any other drug.

8. Comprehensive primary health care provided through Aboriginal Community Controlled Health Services (ACCHSs) is a foundation for appropriate care for Aboriginal users of Ice and their families. ACCHSs should be funded to provide three inter-related streams of care to address addiction, including to Ice:

    - *medical*, to treat the biological component of addiction with medical care, including pharmacotherapies
    - *psychological*, to address the behavioural component of addiction through structured psychological therapies
    - *social and cultural*, to deal with the context of addiction through care management which addresses key social and cultural issues.

9. Ice users are likely to have multiple, complex substance misuse, social and emotional wellbeing and mental health needs, often necessitating access to a number of different service providers. Service integration is thus likely to be highly important for effective care. High staff turnover, unstable funding environments, and policies based on competitive funding may undermine service integration and continuity.

10. Ice dependent people may have significant cognitive impairment and diminished capacity to make decisions in their own best interests and those of their families and

communities. For this reason, Congress supports a formally evaluated trial of Mandatory Treatment for ICE dependent people for a period of up to 2 weeks in involuntary detention in drug and alcohol treatment facilities such as are now available in Alice Springs and Darwin, with the proviso that only qualified health professionals (and specifically doctors and/or psychiatrists) be empowered to commit people to mandatory care.

11. Effective prevention and harm reduction approaches include evidence based early childhood programs, culturally appropriate education resources and education programs for users and families, needle and syringe programs to prevent transmission of blood-borne infections, and the use of media to focus on treatment options and the potential effectiveness of treatment.

Appropriate law enforcement

12. Law enforcement approaches to Ice should take account of the very high imprisonment rate for Aboriginal people (especially men) in the Northern Territory, and the profound social and health problems this poses for the individual, their families and communities. Law enforcement responses should therefore focus on

    a) well-resourced and effective drug diversion programs

    b) ensuring there are adequate police resources, especially in remote communities, to prevent the distribution of Ice and protect community and family members from violence, whether related to Ice, alcohol or other circumstances.

Addressing the Committee's Terms of Reference

We note that this Parliamentary Committee's primary focus is on law enforcement issues, with the first four of the Inquiry's terms of reference being:

a) the role of Commonwealth law enforcement agencies in responding to methamphetamine use;

b) the adequacy of law enforcement resources;

c) the effectiveness of collaborative arrangements between law enforcement agencies; and

d) the involvement of organised crime in methamphetamine related criminal activities.

These issues are largely outside Congress' expertise. Nevertheless, we have considerable experience with dealing with complex health and substance abuse issues amongst Aboriginal people in Central Australia.

Drawing on this experience, on the evidence and on what has worked in similar contexts, we strongly recommend that Ice use in the Aboriginal community should be approached primarily as a public health issue, not as a criminal or law enforcement problem. This is especially the case in the Northern Territory where the Aboriginal imprisonment rate is already one-and-a-half times the national average and rising. In this context a policy response focused solely on law enforcement is likely not only to be ineffective, but also (by undermining family and community structures) to lead to poorer mental health and social and emotional wellbeing and increased substance misuse problems in the future.

This is not to say that law enforcement does not have a place and we will address this (and the hence the Inquiry's related terms of reference) in the section on *Law enforcement approaches* below. However, the majority of this submission will address the Inquiry's three other terms of reference:

e) the nature, prevalence and culture of methamphetamine use in Australia, including in indigenous, regional and non-English speaking communities;

f) strategies to reduce the high demand for methamphetamines in Australia; and

g) other related issues.

The nature, prevalence and culture of methamphetamine use in Australia, including in Indigenous, regional and non-English speaking communities

Definitions and use

Methamphetamine belongs to a group of substances known as amphetamine type-stimulants (ATS) that includes amphetamines, cocaine and ecstasy. Methamphetamine is a type of amphetamine available as powder ('speed'), oily paste ('base') and crystal ('crystal meth' or 'ice'). Ice is usually regarded as the purest and most potent form of methamphetamine. Ice is typically either heated and the vapours inhaled, or injected.

While Ice is certainly addictive, not all users become 'addicts': nationally, in 2013 about three-quarters (75%) of users reported using the drug about once a month or less often, and 40% used the drug only once or twice a year [3].

Long-term, frequent high dose use can lead to a range of clinical problems including[4]:

- confusion
- anxiety and agitation
- mood swings
- sleep problems, including insomnia
- impaired cognitive and motor performance
- aggression, hostility and violent behaviour
- paranoia including paranoid hallucinations
- psychosis.

It is also associated with a range of social harms including violence, breakdown of families and relationships, crime, unemployment and poor education outcomes. Injecting users are also at risk of contracting blood borne viruses such as hepatitis or HIV/AIDS.

Prevalence

There is considerable public disagreement about the extent of the 'Ice problem'. On the one hand, some media reports talk of an 'epidemic' that is 'destroying communities'; on the other, many researchers have argued that the threat is being overstated[5].

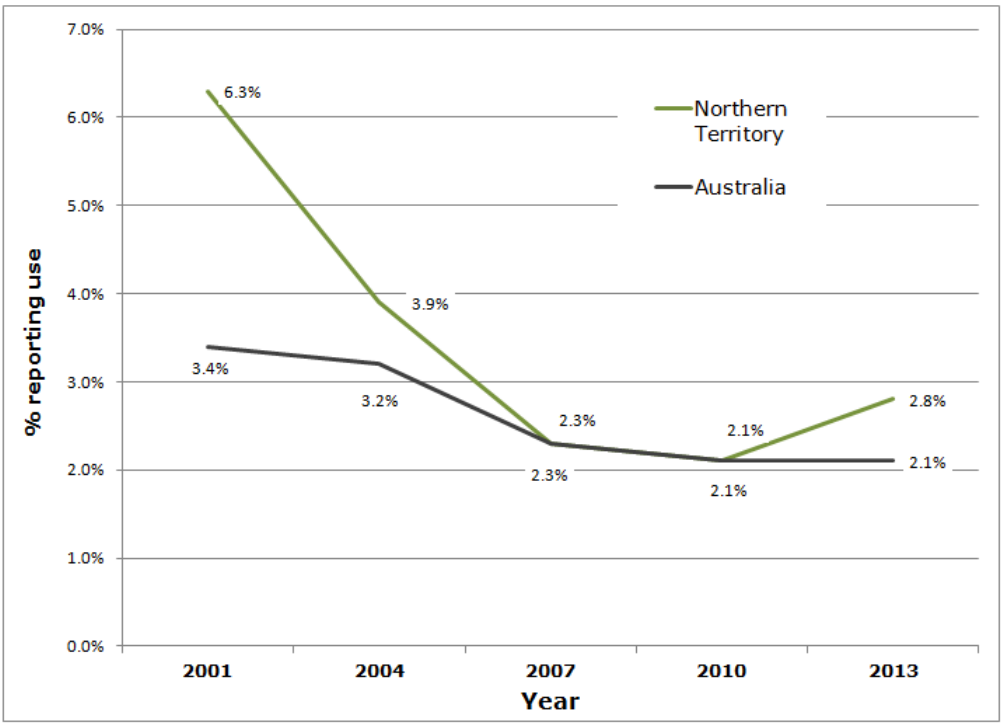
The best data on a national level seems to indicate that overall methamphetamine prevalence remains stable, but that recent years have seen a shift amongst people that already use methamphetamines towards the use of the drug in crystal form (Ice). However, there is little data on use patterns in the Aboriginal and Torres Strait Islander community, although a recent online survey of workers in organisations providing health services to Aboriginal and Torres Strait Islander clients found that four out of five (79%) believed that Ice or speed was a significant issue, and almost nine out of ten (88%) believed usage was increasing in the Aboriginal and Torres Strait Islander community[6].

There are therefore no reliable figures that give a clear picture of methamphetamine use by Aboriginal people in the Northern Territory. In addition, there are no reliable figures for the Northern Territory on Ice use in particular as opposed to methamphetamine use in general.

Figures that are available are highly influenced by a number of confounding factors – for example, increased awareness of Ice as a public issue may lead to more users seeking treatment, more clinicians detecting the use of Ice as a problem, and particularly to increased recording and/or enforcement of amphetamine related offences.

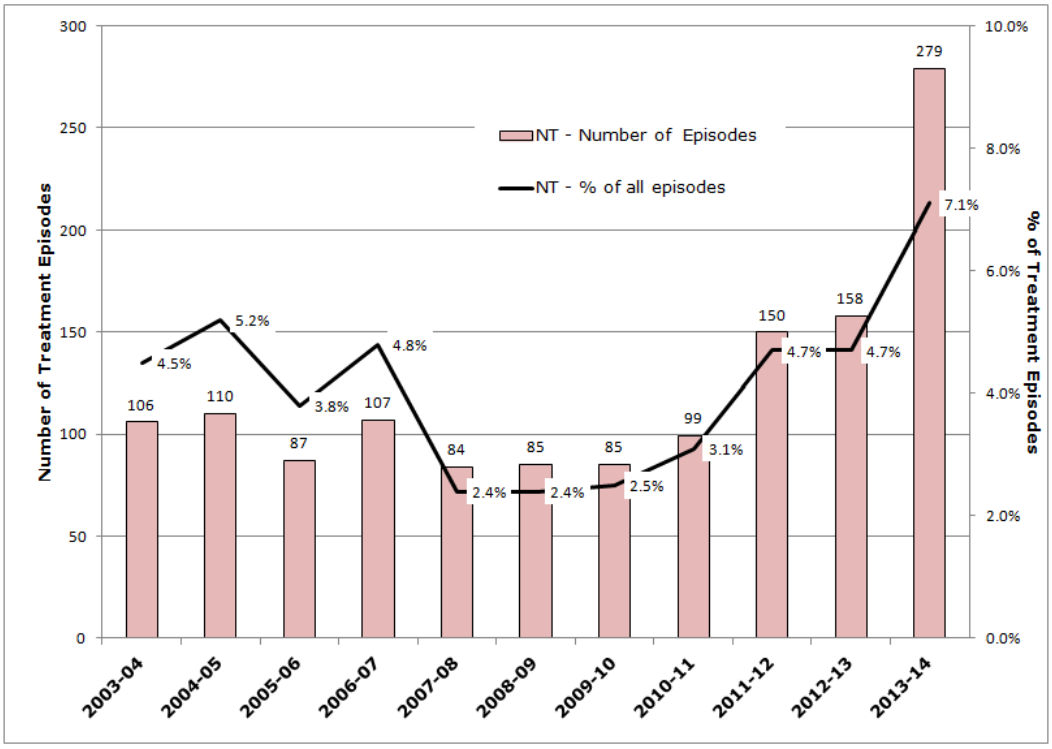
With these important confounding factors in mind, the available figures show that for the Northern Territory population overall, there was a steep decline in reported methamphetamine use from 2001 to 2010 (from 6.3% to 2.1%) , followed by a small increase in reported use from 2010 to 2013 (from 2.1% to 2.8%) (see Figure 1).

Figure 1: Recent use of methamphetamine, persons 14 years or older, Australia and the Northern Territory (AIHW National Drug Strategy Household Survey)



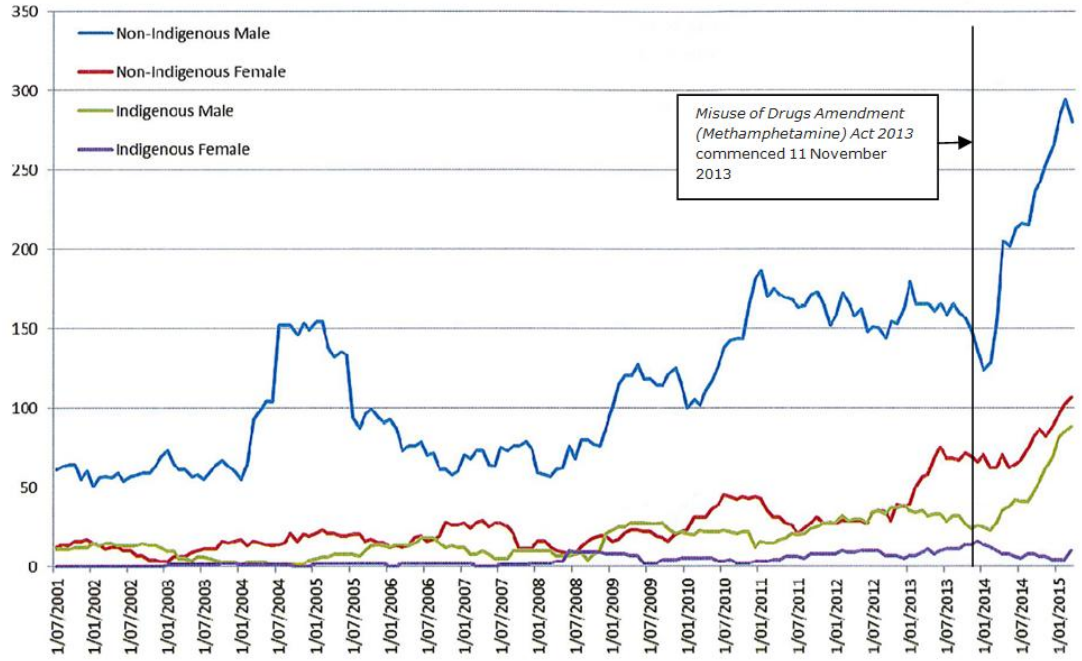
Treatment for methamphetamine use in the Northern Territory shows a sharp increase in recent years with 7% of alcohol and drug treatment episodes in 2013-14 having methamphetamine as a principal drug of concern (see Figure 2).

Figure 2: Treatment episodes provided to clients for amphetamine as a principal drug of concern (AIHW Alcohol and other drug treatment services in Australia 2013-14)



These figures are for the Northern Territory population as a whole. The only data that may give an indication of the differential scale of the Ice problem amongst Aboriginal and non-Aboriginal people of the Territory is offence data from the criminal justice system (see Figure 3).

Figure 3: Methamphetamine offences charged by Indigenous status and sex of defendants (12 month rolling sums) (Department of Attorney General and Justice submission to the Northern Territory 'Ice' Select Committee)



This shows a particularly sharp rise in methamphetamine offences since the beginning of 2014, with the biggest increase amongst non-Indigenous men, with a smaller but also significant increase in the number of Indigenous men charged for these offences. The number of Indigenous women charged for methamphetamine offences remains very low and has not significantly increased.

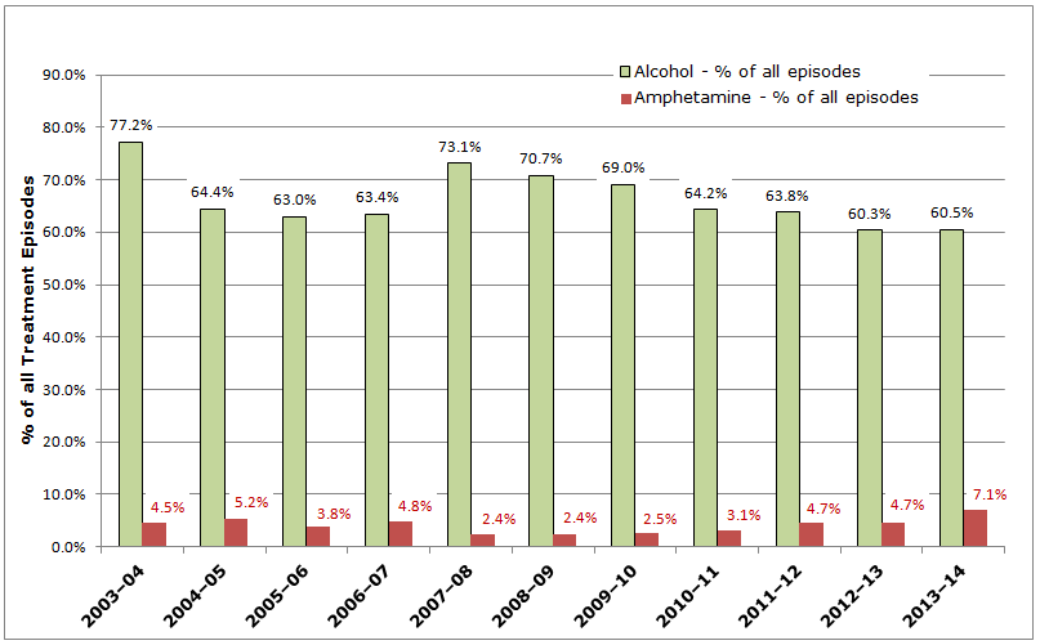
It is important to note that the commencement of the *Misuse of Drugs Amendment (Methamphetamine) Act 2013* seems to coincide with a recent spike in offences and that, the sharp increases in offences charged may reflect changes in policing and legislation rather than changes in use.

Despite the lack of hard data about the prevalence of Ice in the Aboriginal community in the Northern Territory, anecdotally (for example through the public 'Ice Forums' convened by Congress in Alice Springs) it is clear that for Aboriginal people affected by Ice and their families, the drug can be profoundly damaging. Such people and their families need access to appropriate treatment and support, as well as more broadly targeted, evidence-based prevention strategies.

It is important to place the use of Ice in context against the prevalence of harms caused by other drugs, and particularly alcohol. For example, even given the recent spike in treatment for amphetamine use and a recent gradual decline of treatment where alcohol is the principal drug of concern, alcohol is still clearly the drug associated with the highest level of harm in the Northern Territory (see Figure 4). This makes it more important to use the current public and political concern about Ice to strengthen the

treatment system for all drugs (see section on *A common approach to treatment of addiction* below).

Figure 4: Northern Territory, episodes of care where alcohol or amphetamine was a principal drug of concern (AIHW Alcohol and other drug treatment services in Australia 2013-14)



Two important factors in this comparison are cost and availability.

Unlike in other jurisdictions, Ice is a relatively expensive drug in the Northern Territory (estimated at around $150 per point, or at least five times the cost of the drug in Victoria)[7]. With a high level of poverty in the Northern Territory Aboriginal population (income for Aboriginal households in the Territory is only half of that for non-Aboriginal households[8]), Ice may be prohibitively expensive for many in the Aboriginal community[9].

Further, while the major centres in the Northern Territory have large Aboriginal populations and in these places drugs such as Ice may be relatively easily available, the drug does not yet appear to be readily available in remote communities[10].

While Ice is thus both relatively expensive and/or difficult to obtain, alcohol in the Northern Territory is cheap and available in high supply, and therefore continues to be the drug of greatest concern from a public health perspective.

Nevertheless, there is considerable community concern about Ice use in the region serviced by Central Australian Aboriginal Congress, and much anecdotal evidence of the harms that it causes that may not yet be reflected in the data. This community perspective demands the threats posed by Ice be taken seriously, and prevention and treatment approaches that work in collaboration with existing services be resourced.

Strategies to reduce the high demand for methamphetamines

Reducing the demand for amphetamines – as for any drug – is highly dependent on understanding and addressing the context in which that use occurs. In the case of Aboriginal and Torres Strait Islander Australians, this includes a history often marked by

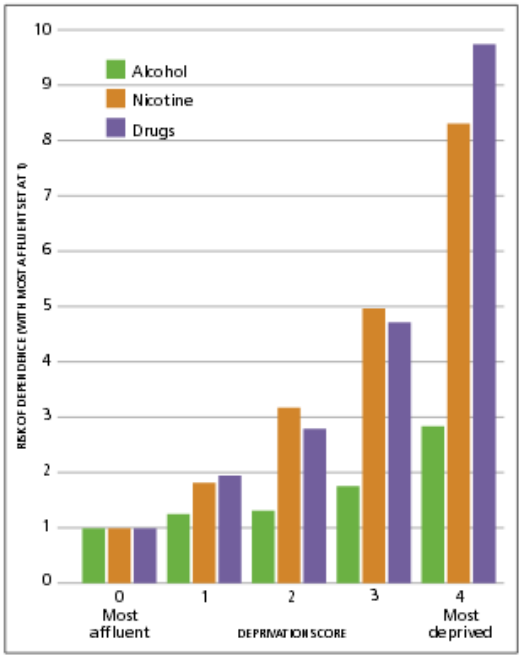
violence, dispossession and state-sanctioned discrimination, the effects of which, left unaddressed, can manifest in intergenerational trauma in which poor mental health and social and emotional wellbeing and use of alcohol and drugs are common. A propensity to develop drug dependence can also be passed on from parents who have a problem through epigenetic changes compounding other intergenerational issues. In addition, Aboriginal people continue to live in a contemporary context in which racism, inequality and discrimination continue to play a significant and profoundly negative part.

In this context, there are four key strategies for addressing the high demand for alcohol and drugs including amphetamines.

1. Addressing disadvantage and inequality

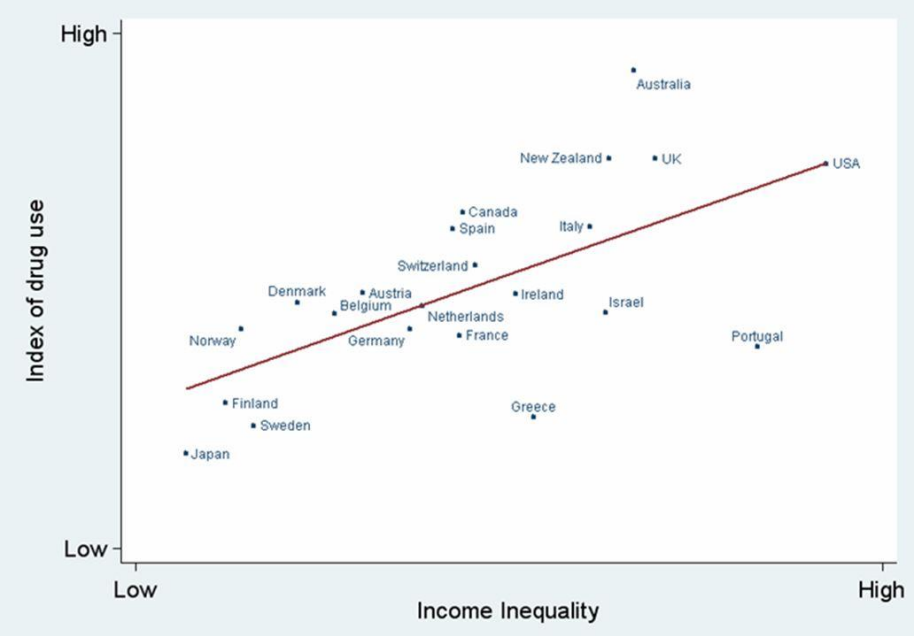
Drug use is not a problem unique to Australia's First Peoples, but a pattern observed globally amongst poor and socially marginalised populations – it has been extensively documented in numerous social environments across the world that drug dependence is closely related to social and economic disadvantage (see Figure 5).

Figure 5: Socioeconomic deprivation and risk of dependence on alcohol, nicotine and drugs, Great Britain, 1993 (Wilkinson R and Marmot M, Eds. (2003). The Social Determinants of Health The Solid Facts, World Health Organization)



There is also evidence that countries marked by greater rates of social inequality have higher rates of drug use (see Figure 6)[11].

Figure 6: Income inequality and drug use, by country (Pickett and Wilkinson (2010) *The Spirit Level: Why Greater Equality Makes Societies Stronger*)



Accordingly, the harmful use of drugs such as Ice cannot be addressed in isolation from broader efforts to tackle disadvantage in Aboriginal and Torres Strait Islander communities, and the economic inequality between those communities and the rest of Australia.

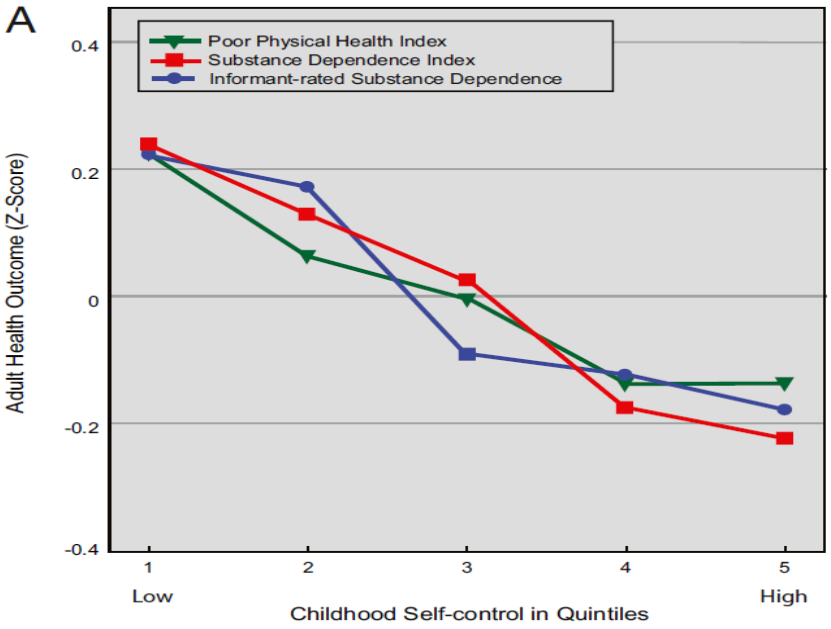
2. Racism and the control factor

Indigenous Australians commonly experience high levels of racism[12] and there is a strong association between racism and poor mental health and drug use[13]. 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[14]. Programs to address drug use in the Aboriginal community must take account of this evidence, and consequently emphasise empowerment, Aboriginal control, and inclusion over punitive, discriminatory or exclusionary approaches.

3. Early childhood development

The link between unhealthy development in the early years and the subsequent development of addictions has been demonstrated by many studies, including a recent major longitudinal study from Dunedin in New Zealand, which followed a cohort of more than one thousand children from birth to age thirty-two. It found that the lower the self-control or emotional development in early childhood (age 4), the greater the risk of developing substance dependence (Figure 7).

Figure 7: Relationship between childhood emotional development and adult health outcomes, including substance dependence (Moffitt T E, Arseneault L, et al. (2011). "A gradient of childhood self-control predicts health, wealth, and public safety." Proceedings of the National Academy of Sciences)



This suggests the existence of a dangerous 'feed-back loop' relating to harmful alcohol consumption amongst disadvantaged populations: harmful drug or alcohol use by parents and carers is known to be associated with a lack of responsive care and stimulation in early childhood; children brought up in these environments are more likely to lack self-control and self-regulation as they grow to adulthood themselves, and will therefore be more susceptible to addictions, including to illegal substances such as Ice; they will be, in turn, less likely to provide their own children with the care and nurture they need. This cycle is reinforced by emerging evidence that every generation born to parents with an addiction is more genetically predisposed to an addiction themselves[15].

Such an intergenerational feedback loop – mirroring and adding to the intergenerational exclusion and disadvantage suffered by many Aboriginal families in other areas of their lives – while not yet proven, is entirely consistent with the evidence, as well as with the experience of many Aboriginal community members and organisations.

Fortunately, there is very strong evidence on how to break such intergenerational cycles of disadvantage though the use of early childhood development programs. Sustained investment in evidence-based early childhood programs can offset early childhood disadvantage, and are a 'best buy' in terms of addressing health and social inequity and breaking the cycle of harmful drug and other substance use in the long-term.

Such evidence-based programs include the Australian Nurse Family Partnership Program (a long term parenting support program based on the work of Professor David Olds[16]) and Abecedarian Educational Day Care (a program that directly stimulates the child in the first 3 years of life based on the work of Professor Joseph Sparling[17]).

4. Culture as a protective factor

Culture and spirituality have been identified as important in supporting resilience, positive social and emotional well being, and living a life free of addiction to alcohol and

drugs[18], with connection to land and family, having an active cultural and spiritual life, and participation in the life of the community being vital for the holistic health of individuals. A recent review from an Aboriginal and Torres Strait Islander perspective identifies ten themes by which cultural and traditional practices can act as a pathway to healing for Aboriginal and Torres Strait Islander peoples, including identifying with cultural lineage; preserving and sharing cultural heritage; connecting with land, country and our history; strengthening communities; and reconnection with spirituality[19].

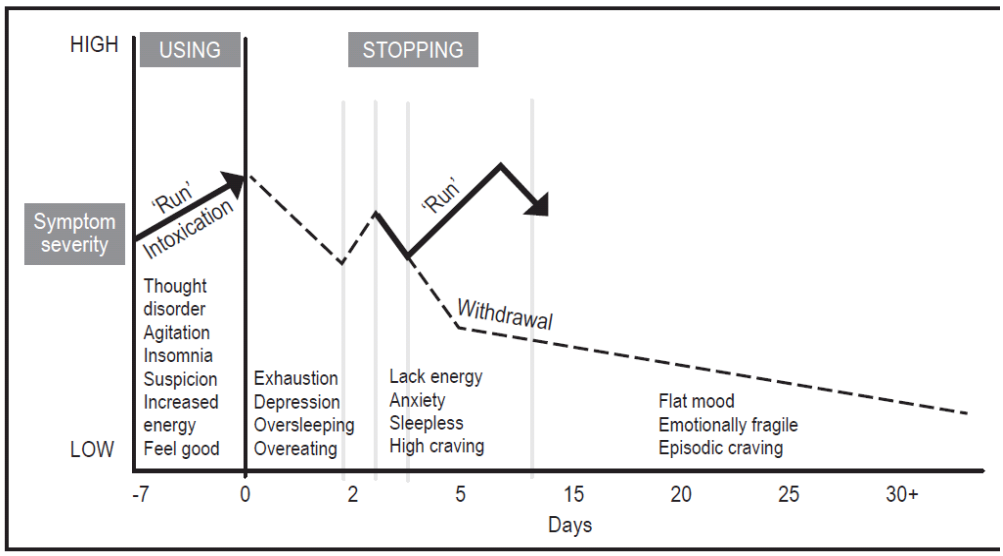
Other related issues

Treatment and support

Issues specific to Ice

For dependent users, Ice use is often associated with a distinctive addiction cycle, marked by up to a week of intensive use, followed by several days of relatively severe withdrawal symptoms during which users may often begin another period of intense use, or (if not) experience gradually diminishing withdrawal symptoms for several weeks or more (see Figure 8).

Figure 8: The Ice Addiction Cycle[20]



This typical cycle has several implications for service providers. In particular, the intensity of cravings during withdrawal and the length of time these cravings are present after abstinence poses particular challenges for attracting users to and maintaining their engagement with treatment. This implies the need for:

- 'Ice-specific' training for health professionals within both primary health care services and alcohol and drug treatment services;
- a particular focus on client engagement and retention, including
    - program funding, policies and processes that support longer detoxification periods (up to two weeks);

- peer interventions as a strategy to attract and retaining users in treatment.

- funded service integration structures and processes, as many Ice users have complex needs and may require support from mental health services, social services etc. (see below); and

- publicising the availability of services so users know that effective help is available.

Given much of the negative media messaging around Ice use, it is important to promote the success of treatment for Ice dependent people, and to address some of the common misconceptions about Ice being significantly different from other drugs in its addictiveness, its responsiveness to treatment and its association with violence. The stereotyping of Ice users as being uniquely prone to violence is not helpful in terms of encouraging users to seek treatment especially as there is strong evidence that Ice users are not as harmful to others as people using alcohol and some other drugs[21].

A common approach to treatment of addiction

The issues specific to Ice described above need to be taken into account in service design for Ice users. However, there is substantial evidence that the biological foundations of addiction are the same, whether the particular drug involved is a methamphetamine such as Ice, an opioid such as heroin, or alcohol: in each case a key factor is the increase in dopamine activity in the 'reward centres' of the brain[22]. Addiction to any substance or activity has been thus described as a chronic brain disease[23].

Addiction results from a complex interaction of neurobiology, genetics, environment, and society. However, the common social environments that lead to addiction (poverty, inequality, discrimination – see section on prevention above) and the common neurobiological basis of addiction points towards the need for a common approach to both treatment and primary prevention, whether regarding Ice, alcohol or any other drug.

Comprehensive primary health care

Aboriginal Community Controlled Health Services (ACCHSs) seek to provide a comprehensive model of primary health care to the communities they service. They are recognised as a key platform for the delivery of culturally appropriate services, and to drive service integration. There is a clear preference for the use of community controlled health services by Aboriginal and Torres Strait Islander people, and strong policy support for the service model. ACCHSs provide Aboriginal and Torres Strait Islander communities with a structure for governance of service delivery and opportunities for leadership and advocacy on health and wellbeing (e.g. advocacy on holistic definitions of health and wellbeing, and delivery of a comprehensive model of primary health care that addresses substance abuse and mental health).

Well-structured interventions for Aboriginal people using Ice at the level of primary health care (and particularly within Aboriginal Community Controlled Health Services) should be supported to provide three inter-related streams of care:

- *the medical stream* to address the biological foundations of addiction. While there is no clear consensus on the use of specific pharmacological interventions to treat amphetamine dependence, medication may be useful to relieve symptoms of

methamphetamine dependence as well as to treat often comorbid conditions such as depression and anxiety disorders[24]. There is also a need for a comprehensive medical assessment on all clients as well the use of Mental Health Care plan (MHCP) to ensure access to psychologists through Medicare as part of treatment. For some clients sickness benefits are also required.

- *the psychological stream* to address the behavioural factors of addiction, including structured therapies such as Cognitive Behaviour Therapy (CBT) and Motivational Interviewing including support through withdrawal are considered the main treatment option[25]. 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. It may require assisting the client to connect with appropriate new social networks where drug use is not the norm.

Service integration: care coordination and the patient journey

ACCHSs are also an important foundation for service integration. Users of Ice are likely to have multiple, complex substance misuse, social and emotional wellbeing and mental health needs, often necessitating access to a number of different service providers including specialist mental health and alcohol and other drug treatment services. Given these complex needs in a cross-cultural environment, service integration is likely to be highly important for effective care.

This may include 'horizontal' integration or coordination of care through the network of community-level services addressing substance misuse, mental health, homelessness and housing, and physical health; and 'vertical' integration of the patient journey from the community level to residential / hospital and specialist care, and back again.

Congress has developed an innovative new service model in partnership with DASA the provider of a 20 bed residential treatment facility. In order to ensure the clients admitted to this facility are able to access the 3 streams of care Congress GPs assess all clients on admission and commence them on a MHCP as well as any other required medications. A medical certificate is also provided for the period in residential treatment. Congress psychologists then work with the client while in residential treatment. The residential treatment facility provides accommodation as well as counselling, education and a range of other support services. This model ensure good integration of services and when clients are discharged they can continue to see their regular GP and psychologist in the community. This has already worked very well in the rehabilitation of Aboriginal people on ICE as well as alcohol and other drugs. This could become a more widespread service model requiring the integration of residential treatment, General Practice and psychological services. In the case of a community controlled health service this is made much easier because these services are already integrated in one employer with a common patient information system.

Policy making and program design need to recognise that high staff turnover, unstable funding environments, and policies based on competitive funding may all undermine service integration.

Trialling mandatory treatment

Mandatory treatment of people with drug or alcohol dependency issues – where 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[26].

However, Ice dependent people may have significant cognitive impairment and therefore diminished capacity to make decisions in their own best interests and those of their families and communities. They can often not be diagnosed as psychotic and so mental health legislation cannot be used to protect them and the community, although they may be acting against their own interests in a state of drug induced clouded judgement.

In this situation, short-term involuntary commitment of people who may be at risk of harming themselves or others for the purpose of getting the person to the point where they are able to engage in treatment should be explored.

Accordingly Central Australian Aboriginal Congress supports trial of mandatory treatment in alcohol and drug treatment facilities for Ice dependent people where there is a risk of harm to themselves, their families or the community. This should be for a maximum of 2 weeks, after which the client may decide whether they want to continue in treatment voluntarily.

The Northern Territory's *Alcohol Mandatory Treatment Act (2014)* provides a model of how this may be achieved. However, to support an evidence-based public health approach, only qualified health professionals (and specifically doctors and/or psychiatrists) should be empowered to commit people to treatment – police, for example, would need to seek the authorisation of such health professionals before Ice users were sent to mandatory care.

The quality of treatment provided needs to be the best available with medical care, clinical psychologists and Aboriginal alcohol and drug workers, and based upon the three streams of care outlined in the section on *Comprehensive Primary Health Care* above.

Treatment is currently available at drug and alcohol treatment facilities in Darwin and Alice Springs, but care should be taken to ensure that these facilities are not co-located with gaols of other parts of the criminal justice system to emphasise the fact that this is a *treatment* intervention, not a *punitive* one.

It is unclear from the evidence how effective such a program would be, so it is important that this is a trial, with a formal evaluation for each client including resources for follow up at 1 and 2 years post treatment.

Effective prevention and harm reduction approaches[27]

These include:

- *the development of educational resources* appropriate for the Aboriginal and Torres Strait Islander community

- *culturally appropriate education* of families about methamphetamine dependence and expected behaviours
- *needle and syringe programs* to prevent transmission of blood-borne infections
- *use of media to focus on treatment options*, noting that mass media campaigns may be counter-productive as only a relatively small proportion of population use Ice.

Law enforcement issues

Globally speaking, for many decades law enforcement has been the dominant method governments have supported to address the harms associated with illicit drug use; despite this, the production, consumption and variety of such drugs continues to increase, along with the harms they cause[28].

This points strongly towards the need for a change of approach to one based on public health principles.

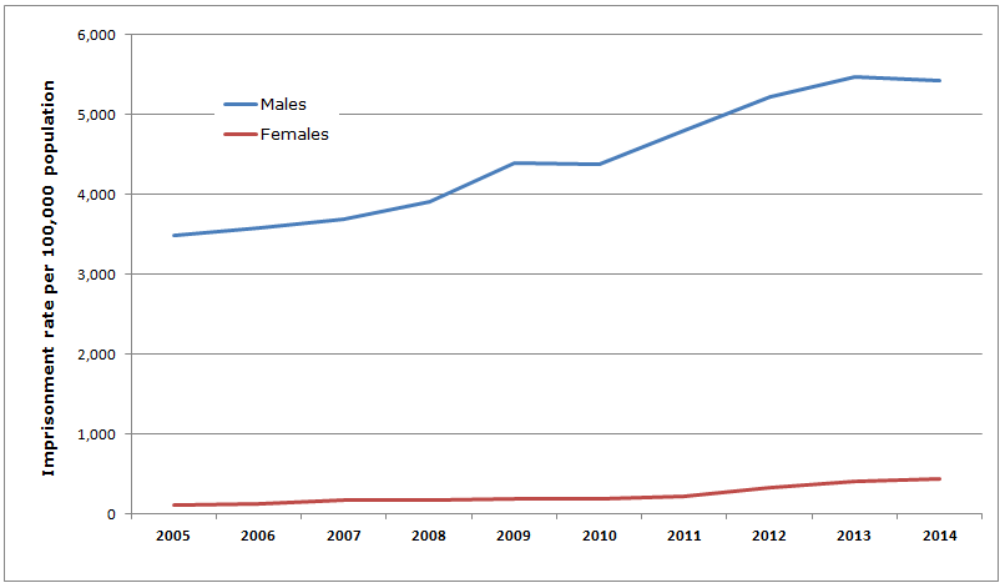
Consequently, the six areas for action identified by the National Ice Task Force (which includes law enforcement as part of a broader strategy that also includes primary prevention; intervention, treatment and support; support for local communities; tools for frontline workers; and improved research and data) is to be welcomed[29].

In the Northern Territory Aboriginal context, law enforcement approaches similarly have a place in dealing with the use of Ice and other illicit drugs. However, law enforcement policies and practices should be designed to deliver most benefit and least harm, taking account of the Northern Territory context.

In particular, a sole focus on law enforcement can discourage people using methamphetamines to seek treatment as the perception can be that approaches to doctors or health services may lead to involvement with the criminal justice system.

This is in a context where the imprisonment rates for Aboriginal Territorians are of particular concern: the last ten years have seen increasing numbers of Aboriginal people (especially men) imprisoned (see Figure 9).

Figure 9: Northern Territory Aboriginal and Torres Strait Islander imprisonment rates, 2005 – 2014 (ABS (2015) Corrective Services, Australia, June Quarter 2015)



It has been estimated that at any given point in time, between 4-14% of men and 0-2% of women between 20-39 years are missing from an average Aboriginal community and that this has severe social and economic impacts effects on these places [30] . Imprisonment has negative effects on the individual themselves, their relationships and future health and employment prospects. It also undermines family ties and community stability, with a particular impact on children. Aboriginal people with mental health and/or substance misuse issues are also over-represented in the prison population[31].

In this context, imprisonment should be a last resort for offenders in the Northern Territory, and a 'tough on crime' response to Ice addition can only worsen the imprisonment rates for Aboriginal people, and further undermine social and family stability, reinforcing the intergenerational cycle of disadvantage and a predisposition to substance misuse in future generations. In this context, the figures for offending related to amphetamines (see Figure 3 above) are of concern.

Law enforcement responses to Ice must therefore not focus on 'locking up' individuals for use or possession, but instead on

- drug diversion programs that assist Ice users to address their addiction and support them to reintegrate in society, taking care to ensure that 'drug diversion' does not merely become the first step in criminalising users; and
- ensuring there are adequate police resources, especially in remote communities, to prevent the distribution of Ice focussing on dealers and suppliers, and provide adequate and appropriate protection for community and family members from violence, whether related to Ice, alcohol or other circumstances.

Appendix 1: About Central Australian Aboriginal Congress

In the 40 years since it was established, Central Australian Aboriginal Congress (Congress) has become the largest Aboriginal community controlled primary health care service in the Northern Territory.

Congress promotes a broad approach to improving Aboriginal health, following the principles of the National Aboriginal Health Strategy:

> *Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity*[32].

Congress is one of the most experienced organisations in the country in Aboriginal health, a national leader in comprehensive primary health care, and a strong advocate for the health of our people. We provide a broad range of services including:

- Clinical Services
- Separate Male and Women's Health Services
- Child and Family Services
- Social and Emotional Wellbeing (SEWB) programs
- Remote Health services
- Education and Training

Notes

[1] See Appendix 1 for a background to Central Australian Aboriginal Congress.

[2] Central Australian Aborignal Congress would like to acknowledge the assistance of Edward Tilton Consulting in preparing this submission.

[3] National Drug Strategy Household Survey detailed report 2013: online data tables

[4] Lee et al. (2007). *Clinical treatment guidelines for Alcohol and Drug Clinicians, No 14: Methamphetamine dependence and treatment*. Turning Point. Fitzroy

[5] For example Midford et al. (2015) Is the 'ice epidemic' a media myth? A Northern Territory perspective' Available: http://www.onlineopinion.com.au/view.asp?article=17642; *Don't panic: the 'ice pandemic' is a myth.* The Age, May 18, 2015. http://www.theage.com.au/comment/dont-panic-the-ice-pandemic-is-a-myth-20150515-gh2plm.html#ixzz3po7Hqx00

[6] National Indigenous Drug and Alcohol Committee (NIDAC) and the National Aboriginal Community-Controlled Health Organisation (NACCHO) (2014) *Online consultation: Amphetamine-Type Stimulants use.* Available: http://www.aodknowledgecentre.net.au/print/4592. Unfortunately, the number of responses from the Northern Territory is too low to allow separate reporting.

[7] Borg F & Johnston A (2015) Managing Meth: Working with clients that abuse methamphetamines. Unpublished PowerPoint prepared by Caraniche Consulting on NT Ice Training

[8] Australian Institute of Health and Welfare (2015) Aboriginal and Torres Strait Islander Health Performance Framework 2014: Online data tables

[9] This analysis is borne out through the Congress-hosted forums for Ice users and their families in Alice Springs. Of the relatively small number of users involved, all were employed, reasonably well educated, and able to return to employment once their addiction was treated.

[10] Northern Territory police say there is no evidence of crystal methamphetamine in remote Central Australian communities. *NT News*, 29 May 2015.

[11] Pickett K, Wilkinson R (2010) *The Spirit Level: Why Greater Equality Makes Societies Stronger*. Penguin.

[12] Ferdinand A, Paradies Y, et al. (2012). Mental Health Impacts of Racial Discrimination in Victorian Aboriginal Communities: The Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey. Melbourne, The Lowitja Institute.

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[17] Campbell, F. A., B. H. Wasik, et al. (2008). "Young adult outcomes of the Abecedarian and CARE early childhood educational interventions." Early Childhood Research Quarterly **23**(4): 452-466

[18] Dudgeon P, Walker R, Scrine C, Shepherd CCJ, Calma T & Ring I (2014) *Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people*. Issues paper no. 12. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies

[19] The Healing Foundation (2013) *Our Healing Our Solutions – Sharing Our Evidence*, Canberra.

[20] Taken from Borg F & Johnston A (2015) Managing Meth: Working with clients that abuse methamphetamines. Unpublished PowerPoint prepared by Caraniche Consulting on NT Ice Training.

[21] Nutt D, King L & Phillips L (2010) Drug Harms in the UK: a multicriteria decision analysis. Lancet online Nov 1 2010.

[22] Kalant H (2010) What neurobiology cannot tell us about addiction. *Addiction*. 2010 May;105(5):780-9

[23] Leshner A I (1997) Addiction Is a Brain Disease, and It Matters. *Science* Vol. 278, 3 October 1997

[24] See Lee N, Jenner N, Nielsen S (2014) *Medication treatment options for amphetamine-type stimulant users*. Canberra: Australian National Council on Drugs

[25] National Drug Research Institute (NDRI) and NT Department of Health (NTDH) submissions to the Legislative Assembly of the Northern Territory - 'Ice' Select Committee

[26] Pritchard E, Mugavin J, et al. (2007). Compulsory treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs. A report prepared for ANCD by Turning Point Alcohol and Drug Centre, Australian National Council on Drugs.

[27] Australian Drug Foundation (ADF), National Drug Research Institute (NDRI) and NT Department of Health (NTDH) submissions to the Legislative Assembly of the Northern Territory - 'Ice' Select Committee

[28] Wodak A (2011) Demand reduction and harm reduction. Working paper prepared for the First Meeting of the Global Commission on Drug Polices, Commission, Geneva, 24-25 January 2011

[29] See http://www.dpmc.gov.au/taskforces/national-ice-taskforce

[30] Payer et al. (2015) *Who's missing? Social and Demographic Impacts from the Incarceration of Indigenous People in the Northern Territory*. Research Brief Issue 5, Northern Institute (Charles Darwin University), Darwin.

[31] Australian Health Ministers' Advisory Council (2015) *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, AHMAC, Canberra p 102

[32] National Aboriginal Health Strategy Working Party (1989) *A National Aboriginal Health Strategy*, Commonwealth of Australia, Canberra.

Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Submission to the National Tobacco Strategy 2018-2026

31 August 2018

Summary of key recommendations

The National Tobacco Strategy (NTS) should:

- include a specific focus on Aboriginal[1] tobacco use
- recognise that action to tackling Aboriginal disadvantage and marginalisation are central to attempts to address smoking rates for Aboriginal people
- maintain and extend evidence-informed whole-of-population tobacco control approaches as an important part of reducing smoking prevalence in Aboriginal communities
- include recommendations that no trade agreements should be entered into by the Australian Government which in effect reduce the price of tobacco products, or empower tobacco companies to challenge legislation to protect the health of Australian citizens
- continue the *National Tobacco Strategy 2012-2018* commitment to working in partnership with Aboriginal communities and community-controlled organisations
- commit to supporting evidence-informed local and/or regional approaches as well as national Aboriginal and Torres Strait Islander strategies
- identify Aboriginal community controlled health services as the preferred provider of any programs within a comprehensive primary health care approach to reducing smoking in Aboriginal communities
- recommend Aboriginal specific media campaigns, both mass-reach and developed locally under Aboriginal leadership
- include a recommendation that State and Territory governments commit to establishing and appropriately enforcing smoke-free areas especially in the most disadvantaged and remote Aboriginal communities

[1] This paper uses the term 'Aboriginal' to refer to 'Aboriginal and Torres Strait Islander' and/or 'Indigenous' on the basis that this is the preferred term in Central Australia where Congress is based.

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Aboriginal health in Aboriginal hands.

- include a focus on the needs of priority groups within the Aboriginal population including pregnant women, young people, those in remote areas, and prisoners
- note that further research and evidence is required on the link between alcohol consumption and smoking, and on the use of e-cigarettes in the Aboriginal community
- include a nationally agreed set of outcome indicators and targets with regular public reporting
- recommend the permanent inclusion of an appropriately worded question on smoking status in the Australian Census
- recommend the development of an agreed, nationally consistent set of indicators for the Tackling Indigenous Smoking program, aligned with the NTS objectives and indicators
- be formally endorsed by the Council of Australian Governments (COAG) Health Council to ensure translation into practice by all Australian governments.

Background

1. Central Australian Aboriginal Congress (Congress) is pleased to provide this submission to inform the development of the new *National Tobacco Strategy* (NTS).

2. Congress is a large Aboriginal community controlled health service based in Alice Springs. Since the 1970s, we have developed a comprehensive model of primary health care (PHC) delivering quality, evidence-informed services on a foundation of cultural responsiveness. We are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care, and a strong advocate for the health of our people. We provide services to 15,000 individuals across the Central Australia region including Alice Springs and six remote Aboriginal communities.

3. Congress is currently funded under the Australian Government Tackling Indigenous Smoking (TIS) program to deliver the Congress Smoke-Free Program, a multi-level, outcomes-based, culturally responsive service that includes a range of evidence-informed activities to support smoking prevention and cessation, such as:

    - anti-smoking and passive smoking campaigns;
    - community events and education including in schools;
    - social marketing;
    - group activities;

- exercise and health promotion;
- referral pathways to psychological, social support, clinical and non-clinical services;
- brief interventions;
- Nicotine Replacement Therapies (NRT) and other pharmacotherapies; and
- intensive support for quit attempts.

A focus on Aboriginal tobacco use

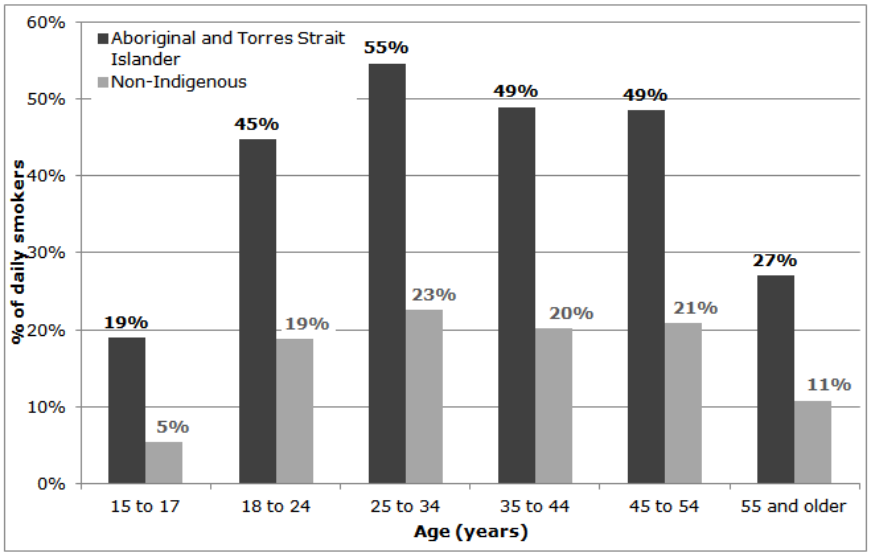
4. Congress welcomes the drafting of a new National Tobacco Strategy. A national strategy is important for us because mainstream policy on tobacco impacts strongly on Aboriginal communities in their attempts to reduce the harms it causes.

5. It is, however, vital that the NTS include a specific focus on Aboriginal and Torres Strait Islander tobacco use, as did the previous *National Tobacco Strategy 2012-2018*. This is because despite successes in reducing smoking prevalence in Aboriginal communities over the last twenty years from 55% in 1994 to 45% in 2014-15 [1], smoking remains a significant health issue for Aboriginal communities, as follows:

    - tobacco is the most significant modifiable risk factor contributing to the gap in health status, responsible for 12% of the lost years of life for Aboriginal and Torres Strait Islander people [2];

    - smoking rates amongst Aboriginal and Torres Strait Islander people are still 2.6 times that of other Australians [3], with young people particularly at risk (the smoking rate is 3.5 times greater amongst Aboriginal and Torres Strait Islander young people aged 15 to 17; see Figure 1);

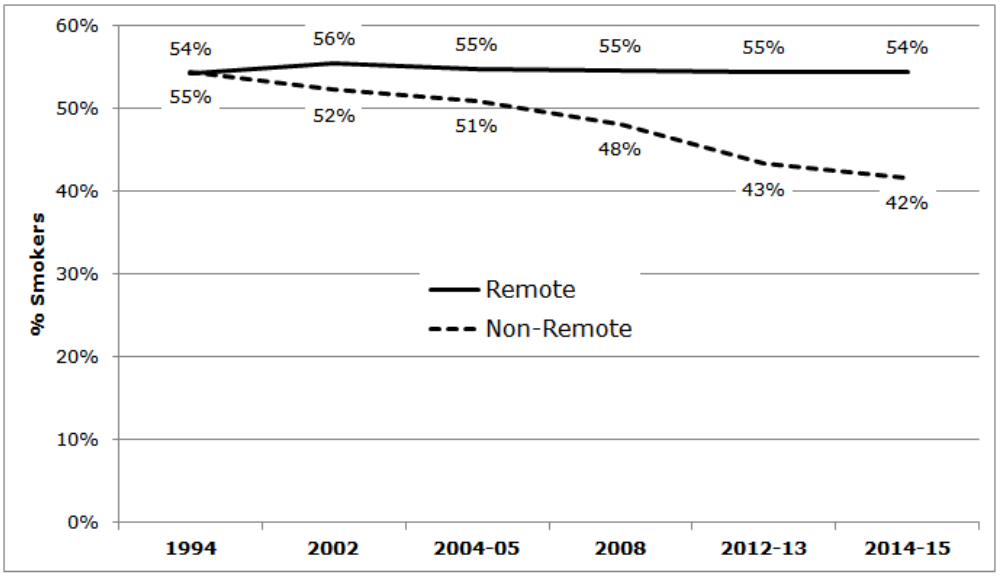
Figure 1: Aboriginal and Torres Strait Islander (2012-13) and non-Indigenous (2011-13) smoking rates



Data: Aboriginal and Torres Strait Islander Health Survey 2012-13; Australian Health Survey 2011-13

- progress is uneven, with the failure to reduce smoking rates in remote Australia of particular concern (see Figure 2). Smoking rates in some jurisdictions appear to be considerably higher than the national average, with rates in the Northern Territory as recorded by primary health care service providers averaging 55% in 2017 and ranging from 35% in some geographical areas up to 68% in others, and showing no change from the previous two years [4].
- Aboriginal communities have particular needs in terms of priority groups and requirements for effective service delivery (see Section 5 below).

Figure 2: Smoking rates among Aboriginal and Torres Strait Islander peoples aged 18 years and over from 1994 to 2014-15.

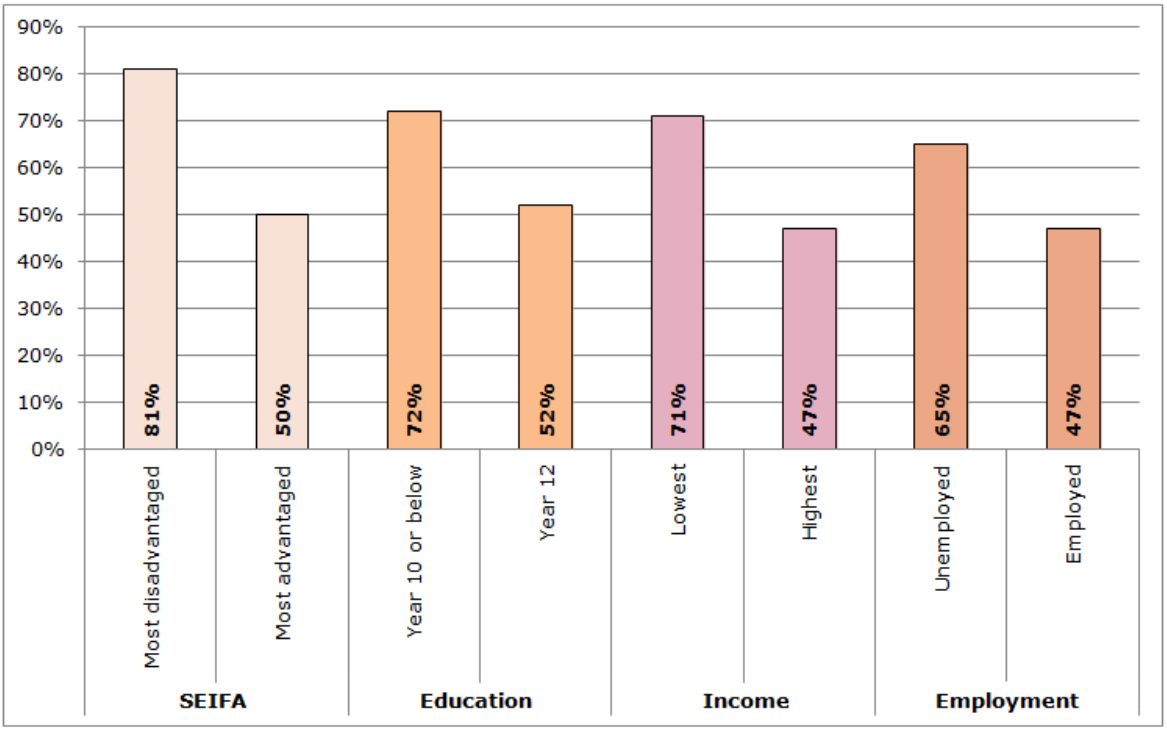


6. Nevertheless, there are factors that encourage further action in the expectation that properly evidenced, targeted interventions will continue to reduce smoking rates: for example Aboriginal people (including those in Central Australia where Congress is based) are similar to other Australians in knowing about the harmful effects of smoking; in their negative attitudes to smoking; and in their desire to quit [3, 5].

Addressing the determinants of tobacco use

7. Explanations of illness based on an individual's exposure to risk factors such as smoking have been the basis for many improvements in the health of populations. However, risk factors are not evenly distributed and addiction to nicotine is closely related to social and economic disadvantage [6]. This pattern is evident in Aboriginal Australia, where socio-economic disadvantage, low income, lack of access to education and unemployment are all strongly associated with higher rates of smoking (Figure 3).

Figure 3: Relationship between being a smoker and selected social factors, Indigenous Australians 15 years and over, 2014–15 [7]



8. Relative inequality may also lead to higher smoking rates and poorer health outcomes: high levels of inequality in wealthy nations such as Australia mean that the poorest have less to gain from stopping smoking relative to its perceived short-term benefits; in addition the chronic stress caused by high levels of inequality may lead to increased smoking as a coping mechanism [8].

9. Relevant to the evidence that both absolute and relative poverty are associated with increased smoking rates is the fact that while nationally Aboriginal and Torres Strait Islander incomes are gradually increasing and the gap to non-Indigenous incomes very slowly narrowing, Aboriginal and Torres Strait Islander people continue to have significantly lower incomes than other Australians. In very remote areas, Aboriginal and Torres Strait Islander incomes are falling, and the income gap is rapidly widening [9].

10. Action to reduce Aboriginal disadvantage should therefore be central to attempts to address smoking rates. Policies which are liable to increase poverty or to increase the gap between rich and poor are likely to affect Aboriginal people disproportionately, and undermine progress on Aboriginal smoking prevalence.

Population health approaches

11. Whole-of-population tobacco control programs play a role in motivating Aboriginal people to quit smoking and hence to reducing the harm caused by tobacco [10]; maintaining and extending evidence-informed whole-of-population approaches is therefore an important part of reducing smoking prevalence in Aboriginal communities.

12. The existing National Tobacco Strategy, informed by the extensive national and international evidence base, provides a sound basis for these whole-of population approaches [11]. Congress supports continued government action on these approaches to reducing tobacco- related harm, including:

    - protecting public health policy from tobacco industry interference, in recognition that the interests of the tobacco industry and of ordinary Australians (including Aboriginal people) are fundamentally opposed;
    - strengthening mass media campaigns to motivate and support quit attempts, discourage uptake of smoking, and support social norms about the unacceptability of smoking;
    - reducing the affordability of tobacco products as a key determinant of smoking prevalence;
    - eliminating tobacco industry advertising, promotion and sponsorship opportunities, in recognition that these activities seek to increase the sale and consumption of tobacco, especially amongst young people;
    - regulating the contents, packaging and supply of tobacco products, including implementing stringent licensing regimes;
    - extending smoke-free environments in workplaces, public transport, and public places to address exposure to second-hand smoke and reinforce the social unacceptability of smoking; and
    - providing access to evidence-informed quit programs.

13. In addition, free trade agreements based on neo-liberal principles have resulted in increases in smoking rates in some countries due to reduced prices of tobacco products [12] and have also empowered tobacco companies to challenge national laws to protect the health of citizens, such as legislation on plain packaging in Australia and elsewhere [13].

14. The NTS should therefore include recommendations that no trade agreements should be entered into by the Australian Government which in effect reduce the price of tobacco products, or empower tobacco companies to challenge legislation to protect the health of Australian citizens.

Aboriginal specific approaches and issues

15. Whole of population approaches to tobacco control are necessary but not sufficient to continue and extend the improvements in smoking prevalence in Aboriginal Australia. This is because of the significantly higher rates of tobacco use amongst Aboriginal peoples; the existence of sub-groups in the Aboriginal community with particular needs; and the social and cultural requirements of effective service delivery to Aboriginal people.

16. Aboriginal smoking patterns and their drivers vary from place to place, with (for example) the social and communal practices of smoking posing a particular challenge to reducing smoking in remote areas [5]. This suggests the need wherever possible for evidence-informed local and/or regional approaches as well as national Aboriginal and Torres Strait Islander strategies.

17. The *National Tobacco Strategy 2012-2018* included a focus on Aboriginal and Torres Strait Islander smoking, and committed to *"strengthen[ing] existing partnerships between governments and Aboriginal and Torres Strait Islander communities and community-controlled organisations"*. It also identified eleven specific actions to tackle smoking among Aboriginal and Torres Strait Islander people. Congress endorses the continuation of these approaches, with the following additional information and recommendations.

Primary health care and the importance of Aboriginal community controlled health services

18. The network of some 150 Aboriginal community controlled health services (ACCHSs) have been established around the nation by Aboriginal communities to address the health needs of the Aboriginal community.

19. Based on a comprehensive model of primary health care (PHC) that includes health promotion and illness prevention as well as treatment and management of disease, ACCHSs are:

    - more effective in delivering outcomes than mainstream primary health care, achieving comparable outcomes, but with a more complex caseload [14];
    - more cost effective than mainstream services, with one major study concluding that *"up to fifty percent more health gain or benefit can be achieved if health programs are delivered to the Aboriginal population via ACCHSs, compared to if the same programs are delivered via mainstream primary care services"* [15]; and
    - the provider of choice for Aboriginal people who show a clear preference for the use of ACCHSs, leading to greater access to care and better adherence to treatment regimes [15, 16]. The capacity of ACCHS to

deliver culturally safe care is fundamental to this preference, which in turn is founded upon formal processes that guarantee Aboriginal community control of the design and delivery of services.

20. Relating to reducing the prevalence and harms associated with tobacco, a recent study concluded that *"the high level of commitment and experience within ACCHSs provides a strong base to sustain further tobacco control measures to reduce the very high smoking prevalence in Aboriginal and Torres Strait Islander populations"* [17]. This conclusion is supported by evidence from Central Australia that remote community members in particular are less likely to know of mainstream services that could help them with their smoking, such as Quitline [5].

21. Within comprehensive PHC there is evidence to support multifaceted interventions which incorporate Aboriginal leadership and community engagement; brief smoking cessation interventions; and pharmacological services, supported by the adaptation of approaches to the local social and cultural context, and capacity-building for the tobacco control workforce [18].

22. The Australian Government's Tackling Indigenous Smoking Program, recently extended by four years, recognises the significant role of ACCHSs by providing funding to 37 organisations[2] to undertake multi-level approaches to tobacco control, combining a range of evidence-informed tobacco control activities to meet the needs of different population groups within a region.

23. Accordingly, ACCHSs must be identified in the NTS as the preferred provider of any programs within a primary health care approach including multi-faceted programs, brief interventions, NRT and other pharmacotherapies, counselling and support for quit attempts, and referrals to other services.

Aboriginal-specific media campaigns

24. Mainstream anti-tobacco campaigns do reach Aboriginal people, though they are less effective in remote areas due to higher proportions of people in those places for whom English is a second language and the fact that mainstream campaigns may not align with local cultural contexts[3]. However, advertising that is specifically targeted at Aboriginal people themselves – including that developed locally – leads to higher levels of motivation to quit [19].

25. Accordingly, whole-of-population mass-media campaigns should be supplemented with Aboriginal specific media campaigns, either mass-reach such as the recent *"Don't make smokes your story"* campaigns or developed locally under Aboriginal leadership.

[2] Thirty-six of the 37 TIS regional organisations are ACCHSs.

[3] For example, the Congress Tackling Indigenous Smoking team has been told by community members that they don't relate to the warning pictures on cigarette packages as they are of non-Indigenous people.

Smoke-free settings

26. Legislative tobacco control through the establishment of smoke-free settings are important as a way of de-normalising smoking, reducing the opportunities for smoking, and decreasing the exposure of non-smokers to second-hand smoke [20].

27. In work settings, a similar proportion of employed Aboriginal and Torres Strait Islander smokers report total indoor smoking bans at work as for the general population. However, a recent survey found that those in remote areas or in the most disadvantaged regions were significantly less likely to work in places with effective bans [21]. This matches Congress' own observations that smoke-free settings in remote areas including at work and community and sporting events remain less common than in urban areas.

28. More needs to be done especially by State and Territory Governments to establish and appropriately enforce smoke-free areas in the most disadvantaged and remote Aboriginal communities, noting that this will require community consultation and support to be effective.

Priority groups

29. There are a number of priority groups within the Aboriginal population that require a particular focus within the new NTS. Foremost amongst these are:

- **Pregnant women:** while the proportion of Aboriginal and Torres Strait Islander women who smoke during pregnancy is falling (from 50% in 2009 to 43% in 2016), it is still over three and a half times the smoking rate for non-Indigenous mothers [22].
- **Young people:** smoking rates for young Aboriginal people are significantly higher than for their non-Indigenous peers (see Figure 1 above), with many Aboriginal children experimenting early with tobacco which is often sourced from ashtrays or discarded cigarette butts. Addressing social normative beliefs around smoking (e.g. through primary health care brief interventions and the establishment of smoke-free homes and public places) is a key approach to preventing smoking uptake amongst Aboriginal young people [23].
- **Remote areas:** as described above (see Figure 2 and accompanying text) Aboriginal smoking rates in remote areas are not falling as they are elsewhere, and action in collaboration with Aboriginal leaders and community-controlled services in remote areas is a priority.
- **Prisoners:** Smoking rates among people entering prison are much higher than in the general community, and especially so for Aboriginal people, three quarters (73%) of whom report being daily smokers [24]. While prisons in most jurisdictions including the Northern Territory are now

smoke-free, most prisoners recommence smoking on release [25]. Culturally responsive quit support should be provided within prisons, with referral to local ACCHSs on release for assistance with remaining smoke-free.

Issues requiring further research and evidence

30. It is important that public policy is based upon sound evidence, including the lived experience of Aboriginal people. Two areas that may require further investigation regarding Aboriginal smoking are:

- **The link between alcohol consumption and smoking:** while there is a high degree of geographical variation in patterns of drinking, Aboriginal Australians are more likely to drink at harmful levels than non-Indigenous Australians [26]. As well as contributing significantly to their total burden of disease and injury and undermining progress on many social and economic goals, alcohol consumption is also associated with smoking uptake and reduced capacity to quit [20, 27].
- **e-cigarettes:** fewer Aboriginal and Torres Strait Islander people have used e-cigarettes compared to non-Indigenous people [28]. However, this is an emerging issue for Aboriginal communities and further work is needed to confirm the fact that e-cigarettes are less harmful than conventional cigarettes, and to address concerns that they may act as a 'gateway' to smoking.

Implementation, monitoring and evaluation

31. To ensure translation of the new NTS into practice, the Australian Government should ensure that it (including its national priorities and targets) is agreed with all Australian governments by being formally endorsed by the Council of Australian Governments (COAG) Health Council.

32. The existing National Tobacco Strategy 2012-2018 includes a set of robust national outcome indicators, as well as specific targets to (by 2018):

- reduce the national adult daily smoking rate to 10 per cent of the population; and
- halve the Aboriginal and Torres Strait Islander adult daily smoking rate (to 24%).

33. The Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* also includes four targets relating to Aboriginal and Torres Strait Islander tobacco use by 2023:

- reduce the rate of Aboriginal and Torres Strait Islander youth aged 15–17 years who smoke from 19% to 9%;

- increase the rate of Aboriginal and Torres Strait Islander youth aged 15–17 years who have never smoked from 77% to 91%;
- increase the rate of Aboriginal and Torres Strait Islander youth aged 18–24 years who have never smoked from 42% to 52%; and
- reduce the smoking rate among Aboriginal and Torres Strait Islander peoples aged 18 plus from 44% to 40%.

34. It is important that the new NTS includes a similar set of nationally agreed outcome indicators and Aboriginal and Torres Strait Islander targets, with regular public reporting against these.

35. In order to provide national figures on progress and assist in monitoring and evaluation at the local and regional levels for Aboriginal communities, the NTS should recommend that an appropriately worded question on smoking status be permanently included in the Australian Census [29].

36. The Tackling Indigenous Smoking program is a substantial ($184M over four years) investment in reducing tobacco-related harms in Aboriginal communities. The development of an agreed, consistent set of indicators for the TIS program and its regional service delivery organisations, aligned with the NTS objectives and indicators, would provide a more consistent national picture about smoking rates and what is working to address them.

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Central Australian Aboriginal Congress

Submission to the

Northern Territory Alcohol Policies and Legislation Review

28 June 2017

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Executive Summary

Central Australian Aboriginal Congress (Congress) is a large Aboriginal community controlled primary health care service based in Alice Springs. We have been active for many years in both the treatment of alcohol-related problems amongst the communities we serve, and in advocating for evidence-based policy to prevent alcohol-related harm.

The levels of alcohol-related harm in the Northern Territory are so great that the Northern Territory Government has both the opportunity and the responsibility to lead community opinion and forcefully advocate for an evidence-based approach that will save many lives and contribute to the development of a safe, productive Territory.

Demand Reduction

- The harmful use of alcohol cannot be completely addressed in isolation from broader efforts to tackle disadvantage across the whole range of the social determinants of health, particularly in Aboriginal communities.
- Early childhood is a key intervention point for the primary prevention of alcohol related harm through sustained investment in evidence-based early childhood programs.
- Poor housing contributes to alcohol-related consumption and harms through children's poorer socio-emotional outcomes and decreased school attendance and through contributing to a range of social and emotional wellbeing issues such as stress, depression, anxiety and suicide which are also associated with alcohol consumption.
- Overcrowded, poor quality, poorly maintained and insecure housing is another social determinant of problems with alcohol.
- There is a strong association between the experience of racism and poor mental health and alcohol misuse, pointing to the need for any policy approaches to address alcohol-related harm to be non-racially discriminatory and to support Aboriginal control of services to the Aboriginal population.
- Primary health care interventions are known to be effective in managing alcohol consumption and harm in individuals.
- Residential and community treatment options are important in decreasing consumption, improving health, reducing criminal behaviour, improving psychological wellbeing, and improving community participation. Treatment in all settings should be provided for both alcohol and other drugs, and needs to include the three streams of care approach: medical care including pharmacotherapies and co-morbid chronic disease management; psychological therapy; and social and cultural support with intensive case management for those who need it.
- Advertising and marketing leads to young people beginning to drink earlier in their lives, and to drinkers consuming more alcohol.
- In the Northern Territory, alcohol industry representatives continue to be amongst the highest spenders when it comes to donations to political parties and candidates.

Such political donations have a potentially unhealthy influence on policy making processes.

Supply Reduction

- Increasing the price of alcohol reduces consumption and hence alcohol related harm; it is a highly cost effective intervention that saves lives and prevents harm.
- There is substantial support for the introduction of a minimum unit price (MUP) in the Northern Territory, from health and community organisations; parliamentary inquiries; Northern Territory businesses; and the Australian Hotels Association (NT Branch).
- In relation to setting a MUP for alcohol, it should be noted that:
  - there is no evidence that price control measures are ineffective in reducing consumption in Aboriginal communities;
  - drinkers of lower socioeconomic status have the most to gain from increases in price, with gains in health more than offsetting increases in the cost of alcohol;
  - a MUP should be accompanied by restrictions on alcohol advertising and promotion to prevent non-price competition.
- After price (economic availability), the most important determinant of alcohol consumption is its physical availability, and in particular trading hours and license density, so policies that reduce hours of trade including take away and late-night trading, and the number of liquor licences are highly likely to be effective in reducing alcohol-related harm.
- Congress welcomes the Northern Territory Government's reintroduction of a Banned Drinkers register in conjunction with scanning of photo identification at point-of-sale. High quality expert evaluation of this and other alcohol measures in the Northern Territory are needed.

Harm Reduction

- Sobering Up Shelters and Night Patrols provide opportunities for other treatment (e.g. brief interventions) and may encourage further community-based action to tackle alcohol abuse.
- Licensed clubs on remote Aboriginal communities have long been associated with high levels of alcohol-related harm. However, restrictions on their operation from 2007 show that if well-managed there is no evidence to suggest that communities with clubs experience higher rates of alcohol-related harms than other communities. It is strongly suggested that Income Management in such communities was not significant in reducing consumption by itself.

Monitoring and evaluation

- Reliable, long-term datasets that can monitor patterns of alcohol consumption and harm in the community at a regional level are an essential tool for targeting effort and monitoring the effect of programs and policies.

Recommendations

1. *Addressing the harmful use of alcohol in the Northern Territory must be situated as part of a broader strategy to tackle the full range of the social determinants of ill-health including poverty, social exclusion and racism, unhealthy early childhood development, housing, education and employment.*

2. *Access to evidence-based early childhood development programs is a key strategy for the primary prevention of alcohol-related harms in the future and for breaking the intergenerational cycle of the harmful use of alcohol. Sustained investment in such programs should be a foundation for addressing alcohol related harm in the Northern Territory.*

3. *Given the association of the experience of racism with increased alcohol consumption:*

    a. *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; and*

    b. *commissioning for health and wellbeing services to Aboriginal populations should explicitly recognise Aboriginal community controlled organisations as preferred providers, due to a range of inter-linked structural advantages they have in delivering services and hence improved health and wellbeing outcomes compared to non-Indigenous services (government or private).*

4. *There are a number of treatment and support options which have evidence of effectiveness. These should be the starting point for any public policy aimed at demand reduction and harm reduction in relation to alcohol consumption in Australia, including in the Aboriginal context. They include:*

    a. *well-resourced interventions from the primary health care setting, delivered by trained staff, including brief interventions and community based treatment that includes medical treatment, evidence-based psychological care, and social and cultural support;*

    b. *residential and community-based treatment programs which include social and cultural support for clients during and after treatment and adequate investment in infrastructure and training; and*

    c. *Sobering Up Shelters and Night Patrols.*

5. *Ensuring the maximum effectiveness of treatment and support options for Aboriginal communities requires at least:*

    a. *addressing cultural safety and supporting community control;*

b. *providing a full range of treatment and support options;*

c. *investing in a Continuous Quality Improvement (CQI) approach; and*

d. *providing adequate and secure resourcing (five-year block funding) to support maximum service effectiveness.*

6. *That the Northern Territory Government enact legislation to:*

   a. *ban all forms of alcohol promotion and advertising in the Northern Territory; and*

   b. *ban political donations in the Northern Territory from the alcohol industry and its representatives.*

7. *That the Northern Territory Government, recognising that raising the price of alcohol is the most cost-effective way to reduce alcohol-related harm in the Northern Territory including in the Aboriginal community:*

   a. *amend the Liquor Act to allow Licensing NT to set the price of alcohol;*

   b. *introduces a minimum unit price (MUP) for takeaway alcohol products equivalent to the existing minimum price of takeaway full-strength beer, currently at approximately $1.50 per standard drink; and*

   c. *advocate to the Australian Government for a volumetric tax to create a national fund for the reduction of alcohol related harm, with access to this fund by jurisdictions to be determined on the basis of their actions to reduce alcohol-related harm across the whole population, including for the Aboriginal and Torres Strait Islander community.*

8. *That the Northern Territory Government takes action on reducing the availability of alcohol as a key measure to reduce alcohol related harm, including at a minimum:*

   a. *one take-away free day per week in locations where a need is identified as a way to reduce total take away trading hours;*

   b. *reduced and modified late night trading in accordance with the successful Newcastle and Sydney CBD trials; and*

   c. *additional measures, with community support, implemented through local Alcohol Management Plans for specific communities or living areas.*

9. *That in relation to the number of licensed outlets in the Northern Territory:*

   a. *the Northern Territory Government should introduce a moratorium on new, transferred, and reactivated take-away liquor licences for all licensed premises, with no exemptions;*

b. the Northern Territory Government should introduce a buy-back scheme for certain types of liquor licences especially those in "corner stores" where food sales are not the major focus of a stores turnover (for example where alcohol sales are greater than 20% of total turnover; and

c. the December 2016 legislation restricting take away licences to a floor area of 400m^2 should be supported and continued as an important measure to reduce harm.

10. That the Northern Territory Government, with the support of the Australian Government and other stakeholders as necessary, commission a high quality expert longitudinal evaluation of alcohol measures in the Northern Territory including:

a. the Banned Drinkers Register as it operated in the Northern Territory between 2011 and 2012;

b. Temporary Beat Locations from 2012 to the present; and

c. the current iteration of the BDR expected to commence on 1 September 2017.

11. That licensed clubs in remote communities should only be established in accordance with the criteria outlined in recently released Managing Alcohol Consumption – a review on licensed clubs in remote Indigenous communities in the NT *and the* Congress Position Paper on Aboriginal Social Clubs*, and always include an evaluated trial to ascertain that they are acting as an effective harm minimisation strategy.*

12. The Northern Territory Government should avoid investment in approaches for which there is no reasonable prospect of effectiveness or which discriminate against or further marginalise Aboriginal people. This includes:

a. mandatory treatment linked to criminal sanctions; and

b. education and persuasion strategies, including school-based education and media campaigns.

13. That the Northern Territory Government implement within the Territory and advocate at the national level for the establishment of an alcohol data infrastructure that would allow for targeting of effort at areas of most need as well as ongoing, routine monitoring of the effect of programs and policies aimed at reducing alcohol-related harm. This should include appropriate longitudinal datasets able to be analysed at a regional level containing agreed minimum datasets on sales / consumption and alcohol-related harms, with appropriate identification of Aboriginality.

1 Background

1.1 About us

Central Australian Aboriginal Congress (Congress) is a large Aboriginal community controlled health service based in Alice Springs. Since the 1970s, we have developed a comprehensive model of primary health care delivering quality, evidence-based services on a foundation of cultural appropriateness. Today, we are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care, and a strong advocate for the health of our people.

Congress has been active for many years in both the treatment of alcohol-related problems amongst the communities it serves, and in advocating for evidence-based policy to prevent alcohol-related harm.

1.2 About this submission

This submission is structured around the three pillars of harm minimisation that are the basis of national approaches to reducing alcohol-related harm in Australia [1]:

- *Demand Reduction*: strategies to prevent the uptake of alcohol use, delay the first use of alcohol, and reduce the harmful use of alcohol in the community. It includes supporting people to recover from dependence and re-integration with the community.
- *Supply Reduction*: strategies to control, manage or regulate the supply of alcohol.
- *Harm Reduction*: strategies that aim to reduce the negative outcomes from alcohol use when it is occurring by encouraging safer behaviours, creating supportive environments and reducing preventable risk factors.

While this submission places a strong emphasis on an evidence-based approach, we acknowledge that there is some truth in the old cliché that, in relation to addressing the harm caused by alcohol, "what works is not popular, and what is popular does not work".

However, we believe that the levels of harm in the Northern Territory are so great that the Northern Territory Government has both the opportunity and the responsibility to lead community opinion and forcefully advocate for an evidence-based approach that will save many lives and contribute to the development of a safe, productive Territory.

This submission is based upon Congress' many years of advocacy in this area. We also draw on work by the Peoples Alcohol Action Coalition (PAAC), an Alice Springs-based community alcohol reform group of which Congress is an organisational member and that of the Foundation for Alcohol Research and Education (FARE), an independent, not-for-profit organisation working to stop the harm caused by alcohol. We acknowledge in particular the joint FARE-PAAC publication *Calling time on too much grog in the Northern Territory* [2] and the PAAC *Submission to the House of Representatives Standing Committee on Indigenous Affairs Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities.* We have drawn on these documents in the preparation of this submission.

2 Alcohol consumption and related harms

The Review's Discussion Paper [3] summarises some of the key data about consumption and alcohol-related harm in the Northern Territory , and it is not the purpose of this submission to re-state the well-known facts about the very high levels of alcohol consumption and harm in the Territory. There are however, a few key points we would like to emphasise:

- *Alcohol is a very significant net cost to the Northern Territory*. The Review's Discussion Paper claims that the *'supply, purchase and consumption of alcohol makes a significant contribution to many sectors of the Territory economy through employment, new and existing business growth and consumption expenditure'* (page 5). However, this claim is specifically rebutted by a major study estimating the burden on the Northern Territory economy from alcohol [4], which states (page iv) that:

  > *It is sometimes claimed that economic activity from consumer expenditure on alcohol (and associated employment, wages, and profits) represents a social benefit which at least partially offsets social costs arising from alcohol consumption ... However, as expenditure on alcohol would have been spent on some other good or service if not spent on alcohol, the economic activity related to alcohol does not represent a net social benefit to the Northern Territory.*

  This same study (quoted in the Discussion Paper) estimated the costs of alcohol in 2004/05 to be $642M or over $4,000 per person, more than four times the national average, with the bulk of those costs falling upon Territory households. Of course the costs today to Territorians, twelve years later, would be very significantly higher.

- *There is strong community support for government action to address alcohol-related harm.* A recent national survey shows that four out of five Australians (81%) believe that more needs to be done to reduce the harm caused by alcohol, and six in ten (61%) believe that governments are not doing enough [5]. While recent figures are not available, even during a divisive public debate about alcohol in Alice Springs in 2002, over half of Alice Springs residents (54%) and two thirds of Aboriginal town camp residents (67%) wanted restrictions on the supply of alcohol maintained or strengthened [6, 7].

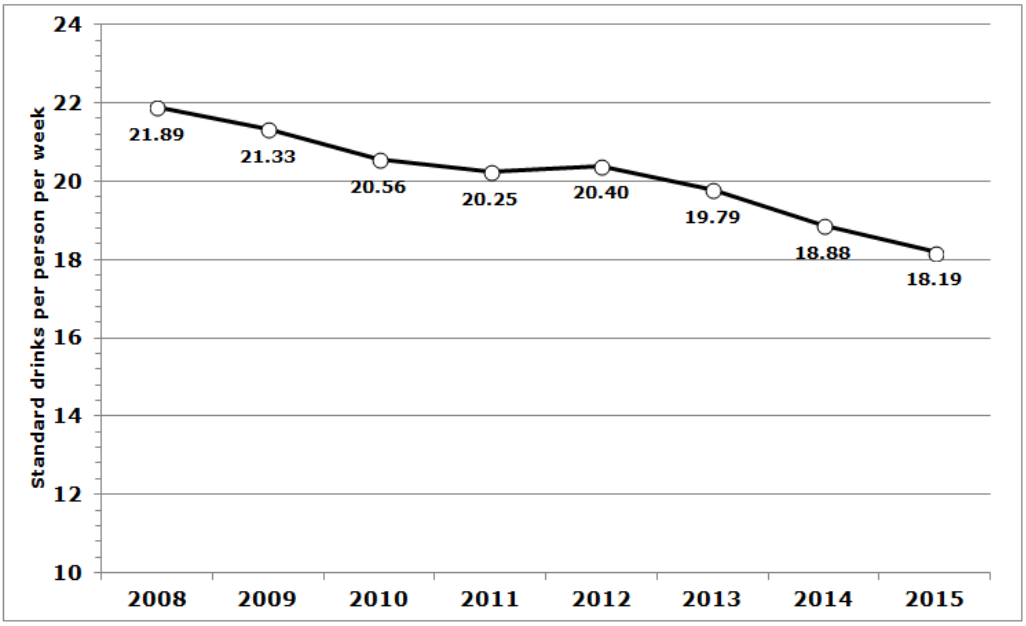
- *Alcohol is an issue for the whole Northern Territory community*. Territorians as a whole experience high levels of alcohol-related harm, including both men and women, and Aboriginal and non-Aboriginal people. The Territory has the highest per capita consumption in Australia (over 18 standard drinks per week per person over the age of 15) [8] and one in three (30%) drinkers consumes alcohol at a level that puts them at risk of long term harm [9].

- *Nevertheless, alcohol disproportionately harms Aboriginal Territorians.* In 2012-13, alcohol-related hospitalisations were nine times higher for Aboriginal people than for other Territorians [10]. Excessive alcohol consumption – especially binge drinking – also leads to increased levels of violence, with women often the victims: in 2011/12 Aboriginal women in the NT were 80 times more likely to be hospitalised as a result of assault than non-Indigenous women [11].

- *Alcohol is a major cause of child neglect* both through increased exposure to domestic violence and lack of responsive care and stimulation from addicted parents. The NT has the highest rate of substantiated child neglect in Australia [12]. Consequences of neglect include increased risk of developmental delay (intellectual, physical and emotional), poor educational outcomes, compromised physical and mental health, drug use and incarceration and premature death [13, 14] (see also *3.1.2 Early childhood development* below).

- *The NT has been making progress in reducing consumption based on effective evidence based measures (Figure 1)*.

Figure 1: estimated per capita consumption of alcohol in the Northern Territory (people aged 15 years and above), standard drinks per week, 2008-2015 [8]



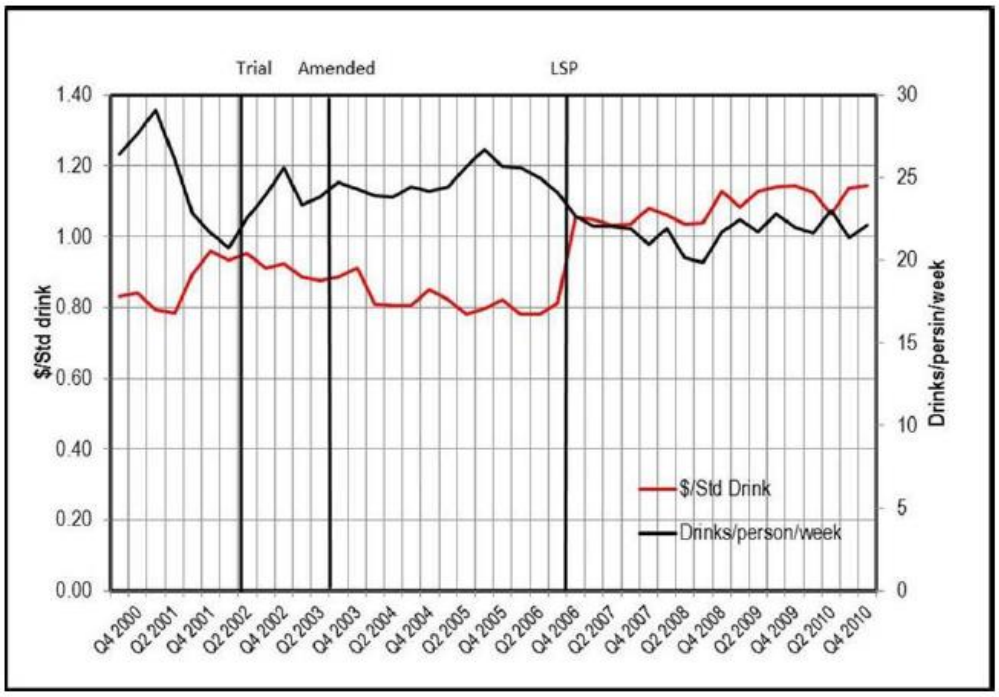
While there is still an unacceptable level of preventable harm from alcohol, a number of measures have contributed to the decline in consumption, including:

  - the ban on the sale of 4 and 5 litre wine casks which began in Alice Springs in 2006 and became Territory wide in 2010;
  - an effective floor price introduced into Alice Springs in 2011 at about 75 cents per standard drink (pubs continued to sell cheap 2 litre cask at this price even though all the supermarkets had implemented a voluntary MUP of $1 per standard drink or more); and
  - in 2011/ 12 the Banned Drinkers Register (BDR) was complemented by episodic Temporary Beat Locations (TBLs), followed from 2013 by the full implementation of Temporary Beat Locations (TBLs) despite the removal of the BDR.

- *There is strong evidence from Alice Springs that measures increase the effective price of alcohol lead to decreased consumption and to reduced harms, especially for alcohol-fuelled violence*. Unfortunately, statistics on the Northern Territory as a whole are not readily available – pointing to the need for regular, public reporting on consumption and harms across the Territory (see *Monitoring and evaluation* on page

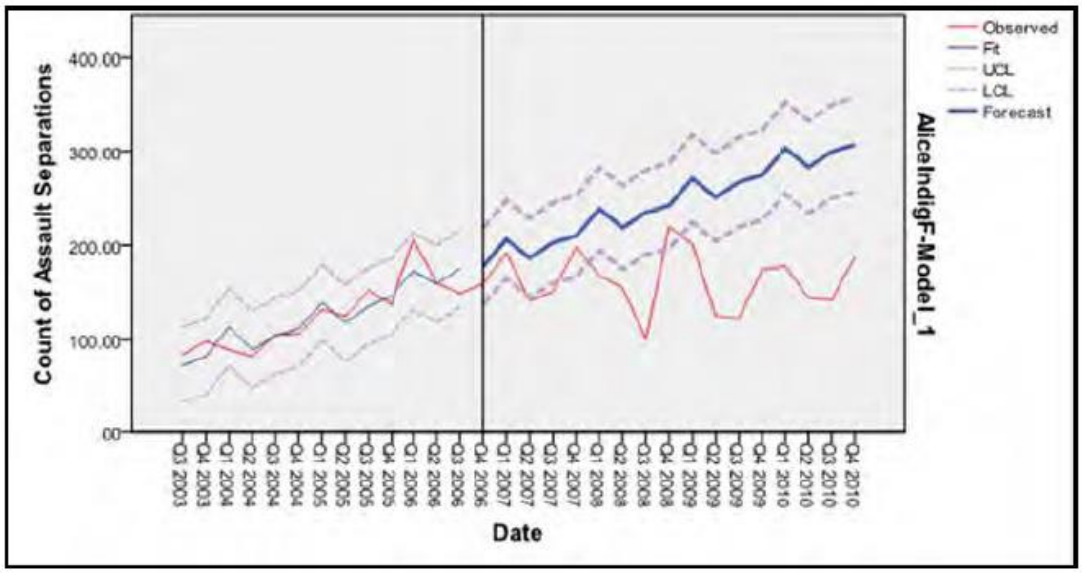
27). Nevertheless, the 2006 Liquor Supply Plan in Alice Springs provides important evidence whereby the removal of the cheapest alcohol from the market led to an increase in the average price per drink and a fall in consumption (Figure 2).

Figure 2: Mean wholesale price per standard drink (2010 dollars) and mean weekly consumption of alcohol (standard drinks) per person ≥15 years by quarter, Central Australia, 2000 – 2010



This in turn was associated with significant reductions in a range of alcohol-related harms, but in particular of the alcohol related assault of Aboriginal women as measured by comparing the predicted numbers of such assaults on the basis of the rates before the LSP, to the observed rates after the restrictions were introduced (*Figure 7*; see also *section 4.1.1* and Attachment A).

Figure 3: Alice Springs Hospital admissions for assault for Aboriginal women observed and forecast values 2003 – 2010



3 Demand Reduction

3.1 The social and economic determinants of harmful alcohol use

Explanations of illness based on exposure to individual risk-factors such as smoking, alcohol misuse, or being overweight have been the basis for many improvements in the health of populations, especially when it comes to chronic disease. However, these risk factors are not evenly distributed in society: beneath these individual risk factors lie deeper causative factors known as the social determinants of health. A person's social and economic position in society, their early life, exposure to stress, educational attainment, access or lack of it to employment, access to health services, their exclusion from participation in society, and their access to food and transport: all exert a powerful influence on a person's health and their exposure to risk.

A number of the social determinants of health are of particular relevance to alcohol use in the Northern Territory.

3.1.1 Poverty

It has been extensively documented across the world that alcohol dependence is closely related to social and economic disadvantage [15, 16].

It is in this context that Aboriginal alcohol consumption in particular must be placed. Aboriginal people are not inherently susceptible to alcohol or dangerous levels of drinking: higher levels of alcohol consumption and thus higher levels of alcohol-related harm is not a problem unique to Australia's First Peoples, but a pattern observed globally amongst poor and socially marginalised populations.

Given that the median total personal income of Aboriginal Territorians is only $269, less than a third (29%) of that for non-Indigenous Territorians [17], the harmful use of alcohol cannot be completely addressed in isolation from broader efforts to tackle disadvantage across the whole range of the social determinants of health, particularly in Aboriginal communities.

3.1.2 Early childhood development

Early childhood is a key intervention point for the primary prevention of alcohol related harm. The experience of the child, including in the months before birth, is critical for building a platform for a healthy life and deficits at this time are powerfully linked to disadvantage and ill health later in life including to an increased risk of unhealthy levels of alcohol consumption [18, 19].

This suggests the existence of a dangerous 'feed-back loop' relating to harmful alcohol consumption amongst disadvantaged populations. Harmful alcohol use by parents and carers is known to be associated with a lack of responsive care and stimulation in early childhood. Children brought up in these environments often lack the necessary skills for effective emotional regulation and self-control and other executive brain functions that have been shown in longitudinal studies to lead to addictions including alcohol [20]. More susceptible to addictions, including to alcohol, as they grow to adulthood they will be, in turn, less likely to provide their own children with the care and nurture they need. This cycle is reinforced by emerging evidence that every generation born to parents with an alcohol addiction is more genetically predisposed to an addiction [21].

Such an intergenerational feedback loop – mirroring and adding to the intergenerational trauma and disadvantage suffered by many Aboriginal families resulting from the process of colonisation – is consistent with the evidence and supported by the experience of many Aboriginal community members and organisations.

Fortunately, we know how to break such intergenerational cycles of disadvantage through sustained investment in evidence-based early childhood programs including parenting programs. If properly designed, these can offset early childhood disadvantage, and are widely acknowledged as a 'best buy' in terms of breaking the long-term cycle of harmful alcohol use [22]. Congress has been able to successfully adapt evidence-based programs such as Nurse Home visiting to ensure they are appropriate for the cross-cultural environment of central Australia.

Such evidence-based investments in early childhood development are not just beneficial for the children themselves as they grow into adulthood; they are a corner-stone of economic development and productivity and have been identified by the Organisation for Economic Co-operation and Development (OECD) as the single most important thing Australia can do to grow its economy and be competitive in the future [23].

3.1.3 Housing and overcrowding

Overcrowded, poor quality, poorly maintained and insecure housing is another social determinant of problems with alcohol. First, children growing up in overcrowded and poor living conditions have poorer socio-emotional outcomes and decreased school attendance [24, 25], which are associated with higher rates of alcohol use later in life. Second, insecure or overcrowded housing is associated with a range of social and emotional wellbeing issues such as stress, depression, anxiety and suicide [26] which again are associated with increased risk of dangerous levels of alcohol consumption.

3.1.4 Racism and the 'control factor'

There is a strong association between the experience of racism and poor mental health and alcohol misuse [27]. Aboriginal and Torres Strait Islander Australians commonly experience high levels of racism, from relatively minor incidents such as being called racist names, through verbal abuse, to serious assault and systemic barriers to services, including health services [28, 29]. Tackling racism is therefore part of the suite of policies needed to tackle alcohol abuse in the Aboriginal community. This also points strongly to the need for interventions to be non-racially discriminatory.

Lack of control over one's life is an important driver of ill-health and is associated with 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 [30, 31]. Policy makers will thus need to be alert to the importance of empowerment approaches in addressing alcohol in the Aboriginal community. In these circumstances, Aboriginal community controlled organisations should be the preferred service provider in all cases.

1 Addressing the harmful use of alcohol in the Northern Territory must be situated as part of a broader strategy to tackle the full range of the social determinants of ill-health including poverty, social exclusion and racism, unhealthy early childhood development, housing, education and employment.

2 Access to evidence-based early childhood development programs is a key strategy for the primary prevention of alcohol-related harms in the future and for breaking the intergenerational cycle of the harmful use of alcohol. Sustained investment in such programs should be a foundation for addressing alcohol related harm in the Northern Territory.

3 Given the association of the experience of racism with increased alcohol consumption:

a. 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; and

b. commissioning for health and wellbeing services to Aboriginal populations should explicitly recognise Aboriginal community controlled organisations as preferred providers, due to a range of inter-linked structural advantages they have in delivering services and hence improved health and wellbeing outcomes compared to non-Indigenous services (government or private).

3.2 Primary health care interventions

Interventions from the primary health care setting are known to be effective in other populations [32], and there is evidence of their effectiveness in the Aboriginal context [33]. Congress has developed – and is in the process of documenting for the Australian National Advisory Council on Alcohol and Drugs (ANACAD) – a set of well-structured interventions for Aboriginal clients based on 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) and other approaches that require the development of an ongoing relationship with psychologist or skilled therapist over many sessions; and
- *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, including assistance with education and training, finding employment, accommodation, Centrelink, strengthening relationships with kin and country, enhanced cultural identity, group work and many other services.

To be effective in the face of the high acute care demand primary health care services face, the successful and sustainable delivery of such interventions requires specific resourcing which goes beyond the provision of materials (e.g. to support brief interventions) to include training for staff and the provision of in-house public health expertise to maintain a focus on non-acute services such as those related to reduction in alcohol related harm.

3.3 Residential and community-based treatment programs

Treatment is an important response to alcohol-related harm in the community, and is effective in decreasing consumption, improving health, reducing criminal behaviour, improving psychological wellbeing, and improving community participation [34]. In the

Northern Territory, the number of publicly funded AOD treatment services in the Northern Territory has been falling and the sector struggles to keep up with the demand from the community (80 per cent of services report that they are unable to meet demand) [2]. Adequate and sustained funding, that includes provision of evidence-based treatment models; social and cultural support for clients during and after treatment (such as assistance with accommodation, education, training and employment); and integration with other health and community services is required.

The situation of the treatment sector has been further undermined in recent years by the former NT Government's mandatory approach to alcohol treatment. Introduced in 2013, this program refers adults who are taken into police protective custody three or more times within a two-month period for being intoxicated in public to a tribunal which may impose either mandatory residential or community treatment, or another form of community management for up to three months. Initially, those under order from the tribunal could be imprisoned for up to three months if they absconded from treatment, though this provision was removed in 2014.

Numerous health and community services – including Congress – opposed the introduction of Alcohol Mandatory Treatment (AMT) on the basis that it adds to the disadvantage experienced by marginalised groups, may displace voluntary clients from limited treatment spaces, and is likely to be ineffective.

A review of the AMT program has now been completed which bears out those warnings: it found the program was poorly designed and monitored; expensive (in 2015/16 it cost $18 million to deliver mandatory treatment to 190 people at an average cost per person of well over $50,000 each); and had no long-term health benefits with numerous people cycling in and out of the AMT system with no effective intervention [35].

Congress therefore welcomes the decision of the Northern Territory Government to repeal the AMT Act and create better pathways to treatment.

3.4 Conditions for success

There are a number of conditions for successful implementation of treatment and support measures 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 [36]. Developing genuine partnerships with Aboriginal communities to deliver treatment and support services, and support for community controlled services are essential pathways to developing culturally safe services [37].

- *Integration of primary health care and community / residential treatment services*. Poor integration is a major barrier of effective service delivery for clients with complex needs; it is a priority to ensure that clients of treatment services have access to all three streams of care (see above) including medical services and socio-cultural support. This integration supports effective care and also continuing care (after care) for clients once they complete a session of treatment and return to the community.

- *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 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 [38]) 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 [39]. Congress welcomes the decision by the Northern Territory Government to offer five-year funding blocks for all services that it funds; this should be the standard for all government to support effective implementation.

4 There are a number of treatment and support options which have evidence of effectiveness. These should be the starting point for any public policy aimed at demand reduction and harm reduction in relation to alcohol consumption in Australia, including in the Aboriginal context. They include:

a. well-resourced interventions from the primary health care setting, delivered by trained staff, including brief interventions and community based treatment that includes medical treatment, evidence-based psychological care, and social and cultural support.

b. residential and community-based treatment programs which include social and cultural support for clients during and after treatment and adequate investment in infrastructure and training;

c. Sobering Up Shelters and Night Patrols.

5 Ensuring the maximum effectiveness of treatment and support options for Aboriginal communities requires at least:

a. addressing cultural safety and supporting community control;

b. providing a full range of treatment and support options;

c. investing in a Continuous Quality Improvement (CQI) approach; and

d. providing adequate and secure resourcing (five-year block funding) to support maximum service effectiveness.

3.5 Bans on alcohol advertising, promotion and political donations

The effect of advertising and marketing on young people's drinking patterns in particular is well-established: it leads to young people beginning to drink earlier in their lives, and to drinkers consuming more alcohol [40]. While incomplete bans on alcohol advertising and promotion maybe ineffective as the industry shifts its effort to non-restricted forms of promotion, a major international study reviewing the evidence concludes that 'extensive restriction of marketing would have an impact' [32].

In the Northern Territory, alcohol industry representatives continue to be amongst the highest spenders when it comes to donations to political parties and candidates [41]. While those both making and receiving the donations deny that these have any influence on policy, independent studies have repeatedly shown that political donations *do* have an undue influence on political and policy making processes [42]. This raises questions as to whether policy decisions are being made in the public interest. The World Health Organization (WHO) Director-General Dr Margaret Chan has stated that, *'In the view of WHO, the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests'* [43].

Most Australians (57%) believe that the alcohol industry has too much influence with governments and over half (55%) believe that it makes political donations to influence policy; three quarters (72%) believe that political parties should not be able to receive donations from the alcohol industry [5].

6 That the Northern Territory Government enact legislation to

a. ban all forms of alcohol promotion and advertising in the Northern Territory; and

b. ban political donations in the Northern Territory from the alcohol industry and its representatives.

4 Supply Reduction

4.1 Reducing economic availability: a minimum unit price for alcohol

There is incontrovertible evidence that increasing the price of alcohol reduces consumption and hence alcohol related harm; it is also a highly cost effective

intervention [32]. There are several commonly used approaches to increasing the price of alcohol:

- a *volumetric tax* has the advantage of generating tax income, a proportion of which could be set aside for treatment programs or other approaches to reduce alcohol-related harms;
- a *minimum unit price* (MUP or floor price) approach sets a price per standard drink (or unit of pure alcohol) below which alcoholic beverages cannot be sold. This increases the price of the cheapest alcohol products, and is particularly effective in reducing alcohol consumption and related harms amongst heavy drinkers and young people, while not significantly affecting the price of relatively more expensive products that the majority of responsible drinkers purchase; and
- *local level agreements* have been successful in the Aboriginal context but have often proved difficult to enforce and to sustain [44, 45].

Note that volumetric and floor price approaches can be combined to utilise the advantages of each [46].

The increasing availability of cheap alcohol in the Northern Territory over the past 20 years warrants considered action by government. For example, in relation to wine, the same proportion of a Darwin person's wage in 2016 could purchase 1.7 times as much wine as was possible in 1997. A floor price is the most effective policy intervention available to any government [47].

4.1.1 Effectiveness of a MUP, especially in preventing community violence

There is strong evidence for the effectiveness of a minimum unit price from Canada, where a 10% increase in the minimum price of alcohol reduced its consumption by 16% [48].

There is also very good de-facto evidence for setting a minimum price for take-away alcohol from the introduction of the Alice Springs Liquor Supply Plan (LSP) in 2006 (see Attachment A for details). By banning the sale of wine and fortified wine in large containers, the LSP in effect increased the average price of a standard drink from 80 cents to $1.10 and doubled the minimum price per standard drink from 25 cents to 50 cents.

A substantial study by the National Drug Research Institute [49] found that this led to a significant decrease alcohol consumption in Central Australia from around 25 to about 20 standard drinks per person per week. This fall in consumption led to significantly lower levels of alcohol-related harm, as measured by hospital admissions and Emergency Department presentations (particularly for assaults), as well as alcohol-related anti-social behaviour. The effect of the LSP on halting the alarming rate of increase in assaults suffered by Aboriginal women was particularly noteworthy.

4.1.2 Support for a MUP

There is substantial support for the introduction of a MUP in the Northern Territory:

- it has been a key policy proposal by health and community organisations concerned about the harm alcohol is doing to Territorian for many years [2, 50];

- it has been a central recommendation of recent parliamentary inquiries, including the House of Representatives *Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities* [51] and the *Northern Territory Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorders* [52];

- Northern Territory businesses have already voluntarily entered into retailers' accords that set a floor price on the cheapest take away alcohol in recognition of the social problems these products cause [53]; and

- the Australian Hotels Association (NT Branch) has expressed support for the introduction of a floor price as one way to address alcohol-related harm [41, 54].

4.1.3 Issues to consider in introducing a MUP

There are a number of issues to consider in introducing a minimum price for alcohol, as follows:

- *Price elasticity in the Aboriginal context.* There have been arguments that for Aboriginal drinkers the demand for alcohol is inelastic (that is, not responsive to price) and that increased prices will simply lead to drinkers spending more on alcohol and less on necessities such as food [6]. However, the data of a commonly cited study [55] to support this view has recently been re-examined and it is now clear that *'the study does not support the assertion ... that population-based price control measures are likely to be ineffective in reducing consumption in Indigenous communities'* [56]. The effectiveness of the LSP in Alice Springs in reducing violence against Aboriginal women is further compelling if indirect evidence that removing the cheapest alcohol from the market reduces consumption amongst Aboriginal drinkers (see Attachment A).

- *Disadvantage to low-income drinkers.* The introduction of a floor-price can be considered regressive, in that it will result in poor drinkers paying a larger proportion of their income for alcohol compared to better-off drinkers who consume less of the cheapest alcohol on the market. However, this regressive effect will be substantially outweighed at a population level by the reduction in harm to the least well-off. A recent substantial study of alcohol consumption and socioeconomic class showed that the risk of harm from high levels of alcohol use was much greater for drinkers living in socially deprived areas, and that:

  > *drinkers of lower socioeconomic status have even more to gain than do those of higher socioeconomic status from the most effective public health alcohol policies —namely, increasing alcohol taxation, setting a minimum unit alcohol price, and reducing alcohol availability. This inference should undermine any opposition to raising alcohol taxes because of the notion that this policy would have socially inequitable effects on drinkers of lower socioeconomic status* [57].

  Note also that any comprehensive effort to address alcohol-related harm must include broad measures to reduce poverty and inequality (refer 3.1.1 Poverty above).

- *Increased non-price competition*. It has been suggested that a MUP may encourage alcohol producers and retailers to compete with each other through increasing their advertising and promotion activities, as competition through lower pricing will be restricted by the floor price [46]. This could encourage higher rates of consumption and undermine the reduced consumption achieved through a MUP, and points to the

need for an MUP to be accompanied by restrictions on alcohol advertising and promotion (see *3.5* above).

- *Windfall profits for the alcohol industry*. There are also concerns that an MUP will lead to greater profits for alcohol supplies and retailers. There is obviously a complex relationship between consumption levels, prices and costs that underlie alcohol industry profits. A couple of points may be relevant:
    - while increased taxation to offset the potential effect of an MUP to increase industry profit is constitutionally not an option, it is open to the Northern Territory Government to substantially increase licence fees (for example, with a new much higher scale of fees on a risk-based system) to ensure that the introduction of an MUP did not simply lead to windfall profits; and
    - the windfall for the alcohol industry may not eventuate. For example, in Alice Springs where there has been an effective MUP of about $1 per standard drink for some time, it appears anecdotally that the poorest quality alcohol products are no longer sold as there is no demand for these products at higher prices when other better quality alcohol sells at the same price.
- *The Northern Territory Legislative Assembly has the authority to introduce a minimum price for alcohol* through amending the *Liquor Act* to control liquor pricing; the provisions of Part XA of the Liquor Act authorises restrictive trade practices by licensees (section 120C) [2].

All the points above, point to the need for an ongoing commitment to monitoring and evaluation of an MUP (see 6 *Monitoring and evaluation* below).

7 That the Northern Territory Government, recognising that raising the price of alcohol is the most cost-effective way to reduce alcohol-related harm in the Northern Territory including in the Aboriginal community:

a. amend the *Liquor Act* to allow Licensing NT to set the price of alcohol

b. introduces a minimum unit price (MUP) for takeaway alcohol products equivalent to the existing minimum price of takeaway full-strength beer, currently at approximately $1.50 per standard drink

c. advocate to the Australian Government for a volumetric tax to create a national fund for the reduction of alcohol related harm, with access to this fund by jurisdictions to be determined on the basis of their actions to reduce alcohol-related harm across the whole population, including for the Aboriginal and Torres Strait Islander community.

4.2 Reducing physical alcohol availability

After price, the most important determinant of alcohol consumption is its physical availability, and in particular trading hours and license density [32, 58].

4.2.1 Reduced hours for take-away and on-license trading

Restrictions on trading hours have intermittently been applied in a number of places in the Northern Territory over the last twenty years, the most sustained and effective example being the ban on take-away sales on Thursdays in Tennant Creek which were in

effect from 1996 to 2006 [59]. Although the effectiveness of the restrictions diminished over time because new Centrelink provisions meant that from recipients of benefits would no longer automatically receive their payments on Thursdays, they were associated a 20% reduction in the consumption of pure alcohol, and significant declines in alcohol-related harm and alcohol-related offences [44].

The restrictions introduced in 2007 on remote Aboriginal community licensed clubs also provide good evidence that restrictions on trading hours (along with bans on certain types of alcohol and take-away, but *not* Income Management) can significantly reduce consumption (see *5.2 Licensed clubs in remote Aboriginal communities* below).

There is also good evidence that restrictions on late-night on-premises trading reduces the amount of alcohol related harm, particularly assaults. For example, in Newcastle (NSW), restricting pub closing times to 3 am in reduced assaults by 37% [60]. Similarly, the 2014 Kings Cross and Sydney CBD entertainment precincts restrictions (1:30 ban on entry to licensed premises, 3am last drinks) reduced assaults by up to 70%, with a similar reduction in serious (77%) and less serious (73%) antisocial behaviour [61].

4.2.2 Reducing the number and types of liquor outlets

The other major availability factor with a strong correlation to alcohol-related harm is the number and type of liquor outlets.

Generally the more licensed premises there are in a given area, the greater the harms through assaults, domestic violence, drink driving, homicide, suicide, child maltreatment, adolescent drinking, and alcohol-related chronic disease [62]. The Territory has very high rates of alcohol availability as measured by the number of outlets, with one licence for every 353 people aged 18 years and above in 2016 [2]. Congress has argued for many years that the Northern Territory Government needs to address this preventable driver of alcohol-related harm through the buy-back of licences, particularly from corner stores and petrol stations.

Within this overall picture, it is important to note that some types of liquor outlet are more harmful than others. In particular, take-away chain stores (so-called 'big box liquor stores') characterised by large warehouse-style outlets with large floor-spaces are particularly associated with harms such as domestic violence, with a recent study showing that each additional chain outlet was associated with a 35% increase in intentional injuries and a 22% increase in unintentional injuries [63]. Recent moves by a chain store to open a very large take-away outlet in Darwin have the capacity to disproportionately cause harm given the large increase in availability and ability to market cheap alcohol. To this end, the Northern Territory Government's December 2016 legislation to restrict take away alcohol venues to a maximum of $400m^2$ is sound public health policy and to be supported.

8 That the Northern Territory Government takes action on reducing the availability of alcohol as a key measure to reduce alcohol related harm, including at a minimum:

a. one take-away free day per week in locations where a need is identified as a way to reduce total take away trading hours;

b. reduced and modified late night trading in accordance with the successful Newcastle and Sydney CBD trials; and

c. additional measures, with community support, implemented through local Alcohol Management Plans for specific communities or living areas.

9 That in relation to the number of licensed outlets in the Northern Territory:

a. the Northern Territory Government should introduce a moratorium on new, transferred, and reactivated liquor take-away licences for all licensed premises, with no exemptions;

b. introduce a buy-back scheme for certain types of liquor licences especially those in "corner stores" where food sales are not the major focus of a stores turnover (for example where alcohol sales are greater than 20% of total turnover)

c. the December 2016 legislation restricting take away licences to a floor area of 400m^2 should be supported and continued as an important measure to reduce harm.

4.3 Reintroduction of a Banned Drinkers register

Congress welcomes the Northern Territory Government's reintroduction of a Banned Drinkers register in conjunction with scanning of photo identification at point-of-sale.

The previous version of the BDR in operation from July 2011 to August 2012 has never been formally evaluated. However, the National Drug Research Institute (NDRI) carried out an analysis of the Alice Springs Hospital's Emergency Department presentations and hospital admissions for alcohol-related conditions and for assaults for the period 2005 to 2013 [64]. This analysis concludes that *'taken together, these indicators strongly suggest that the BDR was effective in reducing alcohol-related harms to health in Alice Springs'*. In particular, the figures show that the *removal* of the BDR led to a significant increase in harms:

- Alcohol-caused hospital admissions doubled from around 40 to about 80 per month which equates to nearly 500 additional alcohol-caused hospital admissions per year.
- Alcohol-related presentations to the Emergency Department also doubled from about 140 per month to about 280 per month.

Given this, it is clear that photo-licensing at the point of sale coupled with a BDR is an important and effective part of an overall, comprehensive approach to address the harm caused by alcohol misuse. It is a population-wide approach that effectively targets the heaviest drinker and applied more widely it is likely to make a major contribution to reducing alcohol caused harms in both the Aboriginal and non-Aboriginal communities.

4.4 Temporary Beat Locations

It is important to note that in the last few months of 2012, the Northern Territory Police began complementing the operation of the BDR with the introduction of what became known as Temporary Beat Locations or TBLs whereby police were stationed outside take-away liquor outlets, asking customers to show ID as a way of establishing where they plan to consume take-away alcohol that they have bought or which they intend to purchase. Police could seize liquor if they form a reasonable belief that an offence was being, or was likely to be, committed – for example, that alcohol was to be consumed in a 'dry' area (which, for example, applies to most of Alice Springs).

Following the overturning of the effective BDR and photo-licensing at point of sale, the previous CLP government was faced with a major increase in consumption and harms but was not prepared to re-introduce the BDR. We understand that they then asked the police to make the TBLs permanent which the police agreed to do for an initial trial period of 3 months. Following the trial period the reduction in consumption and harm was so great it was decided by government to make these permanent.

A number of questions have been raised about the operations of TBLs, including:

- their effectiveness –figures from the NT Government's Department of Business show a significant decline in per capita alcohol consumption since their introduction in Alice Springs, Tennant Creek and Katherine following the introduction of TBLs. There is also much anecdotal evidence from Alice Springs Hospital, the town council and others about the reduction in harm and the improvement in public amenity that they have achieved, however no formal evaluation of the measure has been carried out;
- whether they are a sustainable, long-term solution given the opposition to the measure from the police union on the grounds that it is not the tole of the police to do this type of work and it diverts police resources away from other police work;
- their apparently discriminatory application, as in practice they are largely applied to Aboriginal people, thus adding to community tension [65]; and
- their legality, for example whether people are obliged to tell police where they reside in these circumstances.

Overall, the TBLs appear to have been effective but potentially unsustainable and in practice discriminatory in the way they operate. Faced with this situation, Congress has adopted a view that they need to continue until such time as they can be replaced by a range of effective, non-discriminatory evidence-based strategies.

10 That the Northern Territory Government, with the support of the Australian Government and other stakeholders as necessary, commission a high quality expert longitudinal evaluation of alcohol measures in the Northern Territory including:

a. the Banned Drinkers Register as it operated in the Northern Territory between 2011 and 2012;

b. Temporary Beat Locations from 2012 to the present;

c. the current iteration of the BDR expected to commence on 1 September 2017.

5 Harm Reduction

Harm reduction strategies aim to reduce the negative outcomes from alcohol, tobacco and other drug use when it is occurring by encouraging safer behaviours, creating supportive environments and reducing preventable risk factors.

5.1 Sobering Up Shelters and Night Patrols

Sobering Up Shelters and Night Patrols 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 [66].

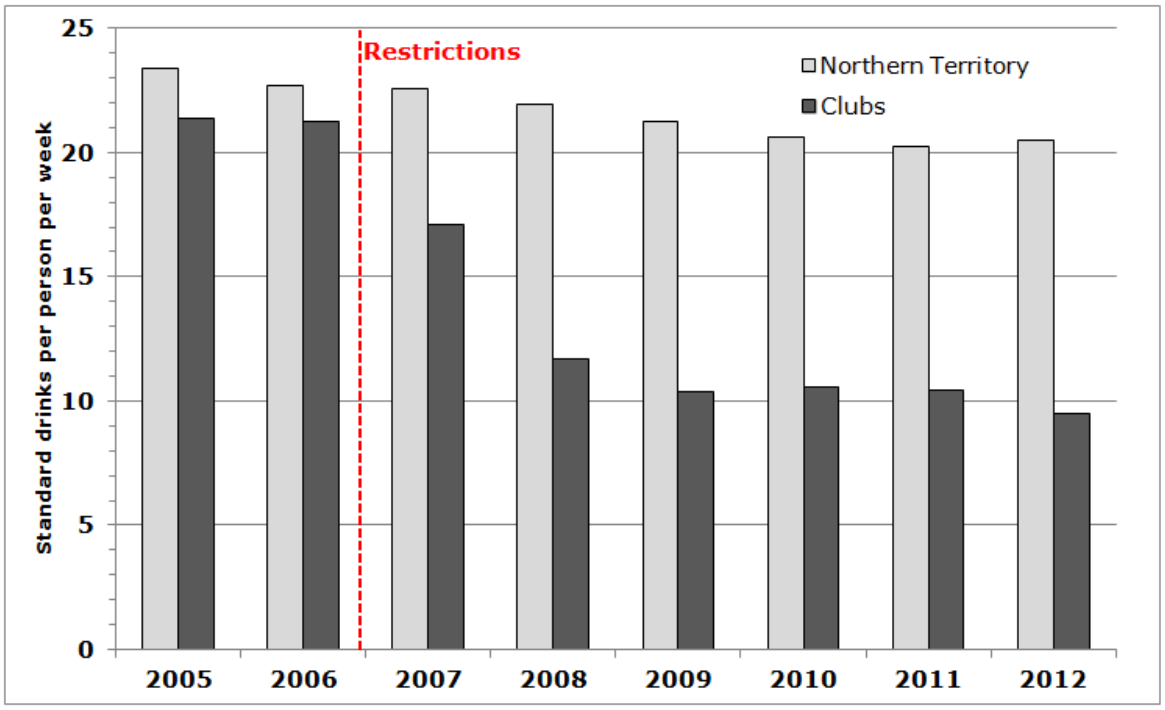
5.2 Licensed clubs in remote Aboriginal communities

Beginning in the 1970s, many remote Aboriginal communities have established licensed clubs with the aim of providing their residents with a safe place to drink alcohol without having to leave the community, of encouraging safe drinking, and of generating profits for re-investment in community activities. Despite the sometimes enthusiastic backing of government agencies, these clubs were largely unregulated (except to the extent that they were expected to operate within the particular conditions of their license) and operated without practical support, guidance or review. As a result, they were frequently associated with high levels of drinking and negative social consequences; became the centre of much community conflict especially between 'drinkers' and 'non-drinkers'; and the subject of considerable public and policy controversy [67].

However, in 2007 as part of the Northern Territory Emergency Response (NTER) the Commonwealth Government imposed uniform restrictions on (most) of the licensed clubs operating in remote communities at that time. These included restrictions on opening hours (a maximum of 12 hours per week); restrictions on the type of alcohol available (low- and mid-strength beer only); and the abolition of take away sales. In addition, all these communities were, as part of other changes introduced by the NTER, subjected to income management under which half of residents' Centrelink income is quarantined from spending on alcohol or tobacco.

A review of the effect of these changes was completed in 2014, and has now been released [68]. It shows *a significant reduction in consumption of alcohol through the clubs*, from around 20 to around 10 standard drinks per person per week (see Figure 4).

Figure 4: Apparent per capita consumption of alcohol by persons aged 15 and over, NT and remote community social clubs, 2005-12 (standard drinks / week)



Note that of course these figures do not include alcohol consumed in the community obtained from other sources e.g. sly grog.

Importantly, in the one community where the restrictions on trading conditions were *not* imposed, but Income Management *was*, the consumption of alcohol per person continued to rise steeply after 2007, strongly suggesting that Income Management was not significant in reducing consumption by itself.

The restrictions did not see a reduction in the overall number of assaults in the communities with clubs, although the proportion of assaults which were alcohol-related declined. Once again the exception was the community that did not have availability restrictions imposed where alcohol-related assaults continued to increase sharply after the introduction of restrictions in 2007, again demonstrating the ineffectiveness of Income Management in the absence of other supply and harm reduction measures.

The qualitative research which was part of the Review also revealed high-levels of support for the clubs and the restrictions they operate under, from both drinkers and non-drinkers, and from other service providers.

Overall, the Review concluded that, contrary to the situation before the introduction of the restrictions, when the operation of these licenses is appropriately tightly controlled:

> *…there is no evidence to suggest that communities with clubs experience higher rates of alcohol-related harms than other communities* (page 102).

Critically however, the Review recommended:

- the restrictions on trading hours and on selling full-strength beer should be maintained at existing clubs and be required of any proposed new clubs;

- strengthened governance arrangements for all clubs, including incorporation under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006*;
- the establishment of a unit within the Northern Territory government focused exclusively on licensed clubs in Aboriginal communities and working proactively with those communities to ensure the clubs function responsibly; and
- a range of standards for clubs, including provision of hot meals, appropriate layout and design, high standards of governance, working with local health services on alcohol-related health issues, transparency of decision-making and re-investment of profits, and regular review and evaluation.

The findings of the Review and its recommendations are similar to the Congress Position Paper on Aboriginal Social Clubs (2009) – Attachment B.

11 That licensed clubs in remote communities should only be established in accordance with the criteria outlined in recently released Managing Alcohol Consumption – a review on licensed clubs in remote Indigenous communities in the NT and the Congress Position Paper on Aboriginal Social Clubs, and always include an evaluated trial to ascertain that they are acting as an effective harm minimisation strategy.

5.3 Harm reduction approaches with little evidence of success

The best practice treatments and supports listed above, combined with the conditions for success, provide an evidence-based pathway to effectively recuing the harm done by alcohol in Northern Territory Aboriginal communities. Notwithstanding the need for well-structured, rigorously evaluated innovation under some circumstances, there are some approaches which have little evidence of success. These include:

- *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 [69]. Note that this does not include short-term mandatory commitment of people who may be at risk of harming themselves or others for the purpose of assessment and care; and
- *education and persuasion strategies, including school-based education and media campaigns, have at best a minimal, short-term effect* and as a substantial review of the international literature note, 'cannot be relied upon as an effective approach' [32].

12 The Northern Territory Government should avoid investment in approaches for which there is no reasonable prospect of effectiveness or which discriminate against or further marginalise Aboriginal people. This includes:

a. mandatory treatment linked to criminal sanctions; and

b. education and persuasion strategies, including school-based education and media campaigns.

6 Monitoring and evaluation

Healthy public policy needs to be backed by evidence of the scale of the problem and what is working to address that problem. Accordingly, reliable, long-term datasets that can monitor patterns of alcohol consumption and harm in the community at a regional level are an essential tool for targeting effort and monitoring the effect of programs and policies. Unfortunately, routine, consistent reporting on alcohol consumption patterns have not been the rule in Australia.

Sales data – which provide a proxy measure of consumption – are collected in the Northern Territory and despite their inherent limitation in not being able to be disaggregated to provide data on consumption by population sub-groups, for example Aboriginal Australians. Such data – including historical data – needs to be made publically available on a regular basis.

In addition, regular reporting of alcohol related harms on a regional basis is a key tool for targeting programs and policies to areas of need and evaluating their effect. Unfortunately, as with consumption data, this information is not consistently available for governments, researchers, health services and policy makers. Key data to be collected on harms is detailed in Attachment C.

13 That the Northern Territory Government implement within the Territory and advocate at the national level for the establishment of an alcohol data infrastructure that would allow for targeting of effort at areas of most need as well as ongoing, routine monitoring of the effect of programs and policies aimed at reducing alcohol-related harm. This should include appropriate longitudinal datasets able to be analysed at a regional level containing agreed minimum datasets on sales / consumption and alcohol-related harms, with appropriate identification of Aboriginality.

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Attachment A:

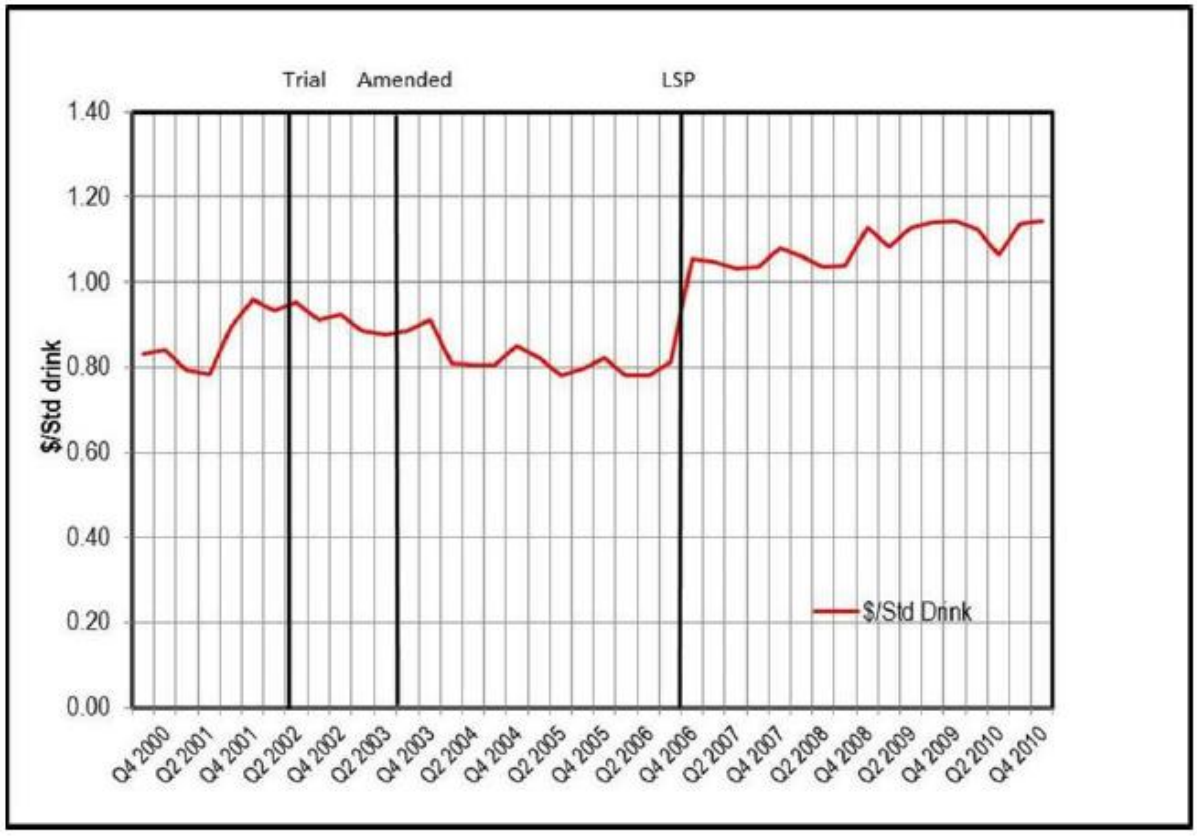
Setting a minimum price for alcohol – a de-facto case study from Central Australia

In the Northern Territory, an important de-facto case-study has shown the benefits of increasing the minimum price at which cheap alcohol is available. This was the Alice Springs Liquor Supply Plan (LSP) of 2006.

Effect on price of alcohol

While regulatory price controls were not introduced, the LSP banned the sale of cheap alcohol (wine and fortified wine in large containers). A substantial study of alcohol price, consumption and harms in Central Australia for the period 2000 to 2010 carried out by the National Drug Research Institute [49] found that by banning the sale of cheap take away alcohol, the LSP in effect increased the average price of a standard drink from 80 cents to $1.10 and the minimum price per standard drink from 25 cents to 50 cents [70] (see Figure 5).

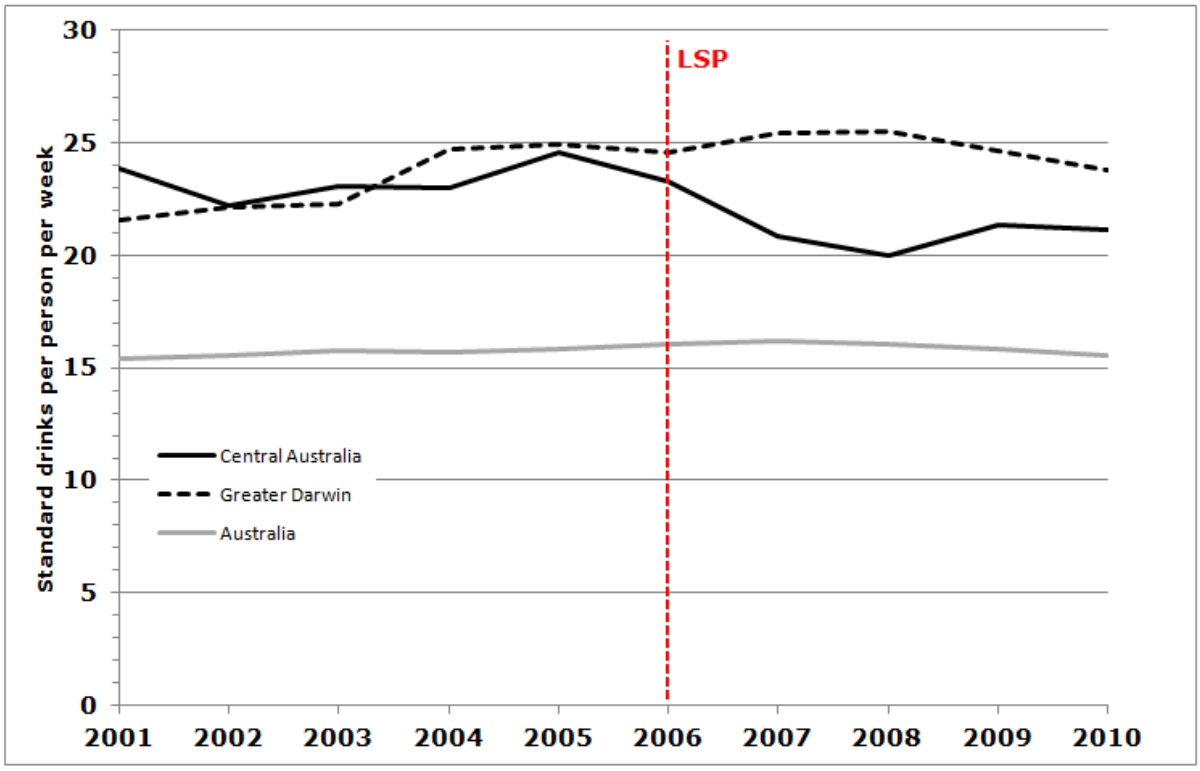
Figure 5: Mean wholesale price per standard drink by quarter, Central Australia, 2000 – 2010 (2010 dollars)



Effect on consumption of alcohol

The introduction of the LSP was accompanied by a significant decrease in per capita alcohol consumption in Central Australia. Consumption in the control area of Greater Darwin did not show significant reductions in this period.

Figure 6: Estimated of per capita consumption (standard drinks per week) of alcohol (persons ≥15), 2001 to 2010, Central Australia, Greater Darwin, and Australia



Effect on levels of alcohol-related harm

The reductions in the level of consumption resulting from the introduction of the LSP were accompanied by significant reductions in health and social harms. This included [49]:

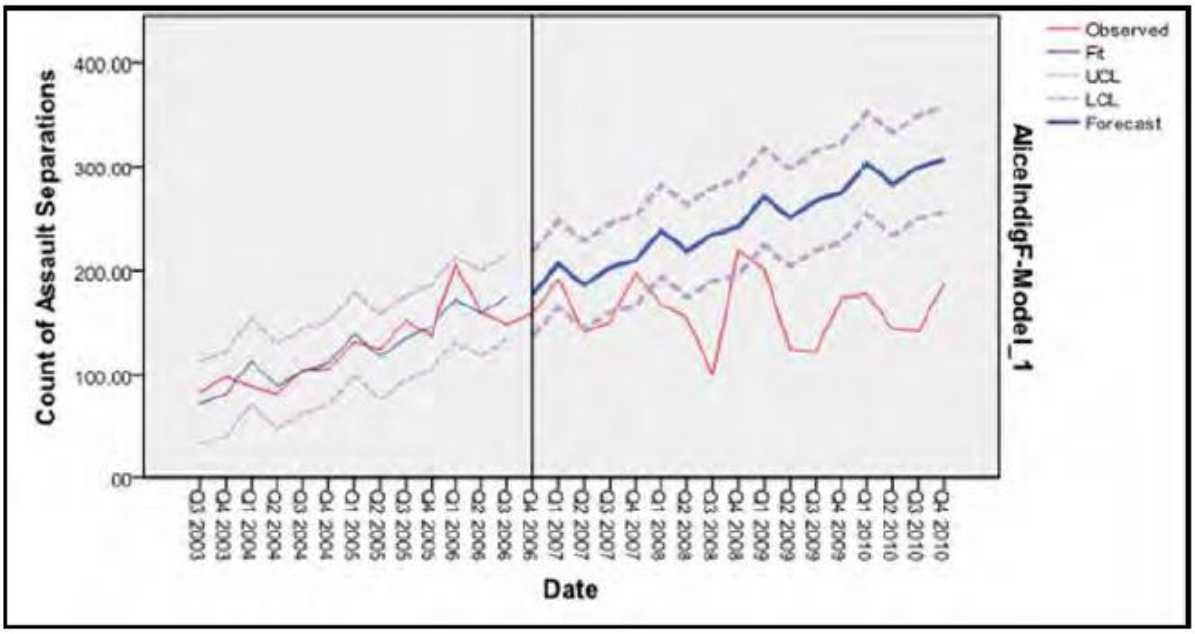
- significantly lower rates of hospital admissions for alcohol–attributable conditions compared to those forecast, due to declines in acute cases and particularly alcohol-related assaults;
- a significant decrease in Emergency Department presentations triaged as assaults; and
- significant reductions in the percentage of anti-social behaviour incidents that were alcohol-related.

Prevention of community violence

While there is a complex causality for community violence, the LSP's restrictions on the availability of cheap alcohol were shown to be effective in contributing to community safety, in particular through reducing the number of Aboriginal women who were subjected to assault.

Between 2003 and 2006, the rate of hospitalisation of Aboriginal women for assault was growing rapidly. After the introduction of the LSP, although there were wide fluctuations this trend stabilised at around 175 separations per quarter. This was confirmed by modelling which showed significant differences between observed and expected numbers of hospital admissions for assault amongst Aboriginal women (Figure 7).

Figure 7: Alice Springs Hospital admissions for assault for Aboriginal women, observed and forecast values 2003 – 2010



Price elasticity amongst Aboriginal drinkers

Some researchers (and some community members) have posited that demand for alcohol amongst Indigenous drinkers is price inelastic: in effect, that Indigenous heavy drinkers will respond to increases in the price of alcohol by increasing their expenditure on alcohol and maintaining their consumption [6]. The NDRI study provides indirect evidence that this is incorrect: not only did increases in price correlate strongly with reduced consumption across Central Australia as a whole, but the significant reductions in the rate of hospital admissions for Aboriginal women for assault strongly suggests that the increases in price were accompanied by a reduction in consumption amongst Aboriginal drinkers in Central Australia.

Attachment B:

Congress Position Paper: Aboriginal Social Clubs (2009)

An Aboriginal Community Social Clubs is a social club, generally on a remote Aboriginal community, with a license to sell alcohol. The purpose is often to provide a place where alcohol can be consumed safely by community residents.

Congress is aware of the published evidence to date which suggests that Aboriginal community social clubs lead to an increase in alcohol caused harms in the communities in which they are present and do not lead to a decrease in community members travelling to regional centres to drink alcohol. There was therefore a net increase in harms without evidence that they led to responsible drinking. This led Prof Peter D'Abbs to draw this conclusion:

> "It is concluded that, while the rights of Aboriginal communities to establish community controlled clubs should be respected, the notion that they are under some sort of obligation to do so should be exposed as a measure likely to add to the health burdens of people already inadequately serviced by health, education and other services" (*Aust NZ J Public Health* 1998;22:679-84)

At present there appears to be at least one Aboriginal social club that is operating well and achieving the key objectives of providing a place where people can socialise together and drink responsibly with food without causing an increase in harm. Congress believes that a further independent evaluation of existing Aboriginal social clubs is required to assess whether the clubs running under more stringent rules than those evaluated previously by Prof D'Abbs are operating well and not leading to increased harm.

Until there is further evidence from such an evaluation, Congress remains concerned that any increase access to alcohol may have a negative impact on the community and its residents and that any Aboriginal social clubs agreed to by communities need to be evaluated to assess their impact in an ongoing way.

Congress supports the establishment of licensed clubs in communities on a trial basis under the following conditions:

All decision-making processes about the introduction of licensed clubs or canteens must satisfy the NT Liquor Licensing Commission that:

- The proposed license application has involved the local population and obtained their consent.
- Proposals for community approval for a social club are voted on in secret ballot.
- That the presence of the club will not lead to an increase to the total quantum of harms accruing to the members of the community, including to non-drinkers, and the wider public.
- That the operation of the license is transparent and accountable and will be conducted independently of all community and liquor retailers.

- If a local ownership model is proposed, provisions for addressing conflict of interest issues are clearly defined.

Any licensed clubs must be:

- Governed by Rules and Directors committed to the principles of community well-being and public health.
- Governed by a Management Committees where none of the committee members have an alcohol problem.
- Governed and managed by people who have a range of expertise, including public health, public safety and financial planning.
- Governed and managed according to protocols which ensure minimal conflicts of interest – with all applications for a liquor license demonstrating how they will address these issues.
- Accompanied by a Local Alcohol Management Plan - with details of how Management will address individual behavioural issues (e.g. local rules for addressing issues where people are not attending work).
- Managed on a not-for-profit basis with all profits going back into the community for a public good.
- Supported by the existence of a permanent and adequate police presence, a functional women's safe house and a fully operational night patrol on the community.

License Applications must also observe the following criteria:

- No takeaway alcohol to be served.
- Food must be available for patrons during all opening hours.
- Processes must be in place for ensuring no patron is served to intoxication including limiting the number of standard drinks that can be served to a person.
- Processes to ensure that people prohibited from consuming alcohol are not served alcohol (e.g. consider the use of the IdEye system for selling alcohol over the counter).
- Established Rules on patrons making purchases on behalf of other customer(s) with penalties for supplying alcohol to someone who is prohibited from drinking (i.e. if on an alcohol court order).
- Intoxicated persons must be evicted from the licensed premises.
- Low alcohol products must be available at all times.
- All purchases should be opened prior to being taken away from the bar.
- Alcohol should not be served to people at high risk including pregnant woman and people with severe chronic diseases.
- No credit or book up to be given for any purchases under any circumstances.

- Management must be capable of understanding and enforcing the licensed club's rules at all times, or else the licensed club must remain closed until it has the capability to do so.
- Community must have access to transparent and responsive complaints process.
- After 3 years there should be a review of the license including a further assessment as to whether the community wants the license to continue.

Congress also believes that some of these criteria should be applied to all licensed on site premises in urban, rural and remote areas to limit the harmful effects of alcohol.

Footnote

The Liquor Licensing Commission has advised that the *licensee* can be an individual, incorporated body or any other legal entity. The *nominee* is the manager of the service and this is always a designated individual. Normally if the Licensing Commission has an issue with an outlet they will approach the nominee first depending on the seriousness and only go to the licensee as a second step.

Attachment C:

Suggested minimum dataset on alcohol consumption and alcohol-related harm

Main indicators

- Apparent per capita consumption
- Hospital separations for selected acute and chronic alcohol-related conditions
- Alcohol-related deaths
- Confirmed assaults
- Serious road injuries (fatalities or injuries requiring hospitalisation)
- Proportion of alcohol consumed at risky and high-risk levels
- Proportion of the population drinking at risky and high-risk levels
- Estimated acute and chronic hospital separations attributed to risky and high-risk drinking

Additional Measures

- Alcohol-related admissions to treatment agencies
- Ambulance callouts
- Admissions to sobering up shelters
- Apprehensions without arrest/ protective custodies
- Night patrol encounters
- Confirmed public order incidents
- Alcohol-related prison reception