



Central Australian Aboriginal Congress Aboriginal Corporation

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The Central Australian Aboriginal Congress Aboriginal Corporation

Submission to

Legislative Assembly of the Northern Territory

***Select Committee on Action to Prevent Foetal Alcohol
Spectrum Disorder***

9th June 2014

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AN ORGANISATION OF ABORIGINAL PEOPLE, FOR ABORIGINAL PEOPLE, CONTROLLED BY ABORIGINAL PEOPLE

Introduction

The Central Australian Aboriginal Congress Aboriginal Corporation (CAACAC), commonly referred to as Congress, was formed in 1973 to provide advocacy and support to Central Australian Aboriginal people in the struggle for justice and equity. Initially Congress addressed housing, education and land issues. In 1975 a medical service was established by Congress in Alice Springs which has become one of the oldest and largest Aboriginal community controlled health services in Australia (CAAC, 2002; CAAC, 2011).

Congress is governed by a board of Directors comprising six Aboriginal community members and three specialist non-member directors, who have expertise in primary health care, finance and governance and administration, and who are appointed by the elected Directors. It adopts a social justice and social view of health and is guided by principles of comprehensive primary health care, including accessibility, equity and actions to address the broader social determinants of health, being locally driven and responsive to community needs, and providing a mix of treatment, prevention, promotion, and rehabilitative services. Mechanisms it uses to achieve these goals include multi-disciplinary teamwork, intersectoral and interagency collaboration, cultural respect, and a public health perspective (see attached 2013 annual report for more information).

TOR 1: The prevalence in the Northern Territory of Foetal Alcohol Spectrum Disorder (FASD)

No reliable figures are available on the prevalence of Foetal Alcohol Spectrum Disorder (FASD) in the Northern Territory. However, it is likely that the Northern Territory has a significant problem with FASD, particularly amongst the Aboriginal community just as it has a higher prevalence of most alcohol related problems. However, what we do have is data on the very high prevalence of developmental vulnerability in children in the NT from the Australian Early Development Index (AEDI 2012) data. It is very clear that in terms of cognitive development and emotional development in particular the NT has a very large problem and unfortunately the level of disability in many children at Age 5 is very hard to reverse. Some of this disability will be due to undiagnosed FASD but much of it is the direct result of a disadvantaged early childhood of which alcohol addiction amongst parents is a major cause. Given the lack of specific prevalence data on FASD it is important for the Inquiry to consider the high prevalence of other alcohol related conditions, including the AEDI data, as this also provides the context in which the specific problem of FASD exists and a clear imperative for action in spite of the lack of exact FASD prevalence data. Early Childhood is the key to the prevention of intergenerational disadvantage and alcohol misuse prior to, during and in the early years following pregnancy is leading to a new generation of children who will not developed their potential. This is largely preventable.

Alcohol misuse has devastating impacts on Aboriginal lives and communities (Closing the Gap: Prime Ministers Report, 2013). It is a major factor contributing to the burden of ill-health and premature deaths in these communities. Alcohol misuse is a major cause of short and long-term health conditions and premature deaths, including cirrhosis of the liver, pancreatitis, haemorrhagic stroke, suicide and motor vehicle accidents (Aboriginal Medical Services Alliance Northern Territory, 2008; Symons, Gray, Chikritzhs, Skov, Siggers, Boffa & Low, 2012; National Aboriginal Community Controlled Health Organisation 2012), and foetal alcohol spectrum disorder (Symons et.al 2012; Whetton, Hancock, Chandler, Stephens & Karmel 2009; Breen & Burns, 2012). The Northern Territory's premature death rates from these conditions are amongst the highest in Australia. Alcohol is also linked to increased rates of homicide, manslaughter, domestic violence and sexual and other assaults, the neglect and abuse of children, and the disruption and dysfunction of communities (Aboriginal Medical Services Alliance

Northern Territory, 2008; Central Australian Aboriginal Congress, 2011). The negative consequences of alcohol consumption in Aboriginal communities are understood within the wider context of alcohol consumption in Australia. This gives rise to, or contributes to, a number of costs including alcohol-related violence and crime, preventable disease, death and disability from injuries, and negative impacts on families and communities (Whetton et al, 2009). Since its inception, Congress has been very aware of the harms being caused by alcohol and current Congress data suggest that 25% of the Aboriginal population over the age of 18 are drinking at harmful levels.

TOR 2: The nature of the injuries and effects of FASD on its sufferers

In many ways FASD is best understood as one particular type of harm caused by alcohol that adds to all of the other harms and requires a whole of population response. This is primarily because most of the harm caused by alcohol in pregnancy occurs at the time of conception and in the early weeks of the pregnancy, mainly the first 3 to 6 weeks (NH&MRC 2009). In addition, most pregnancies are not planned and therefore amenable to targeted prevention measures and given the lack of planning exposure to alcohol in the 3 months prior to pregnancy is high (NIDAC 2012).

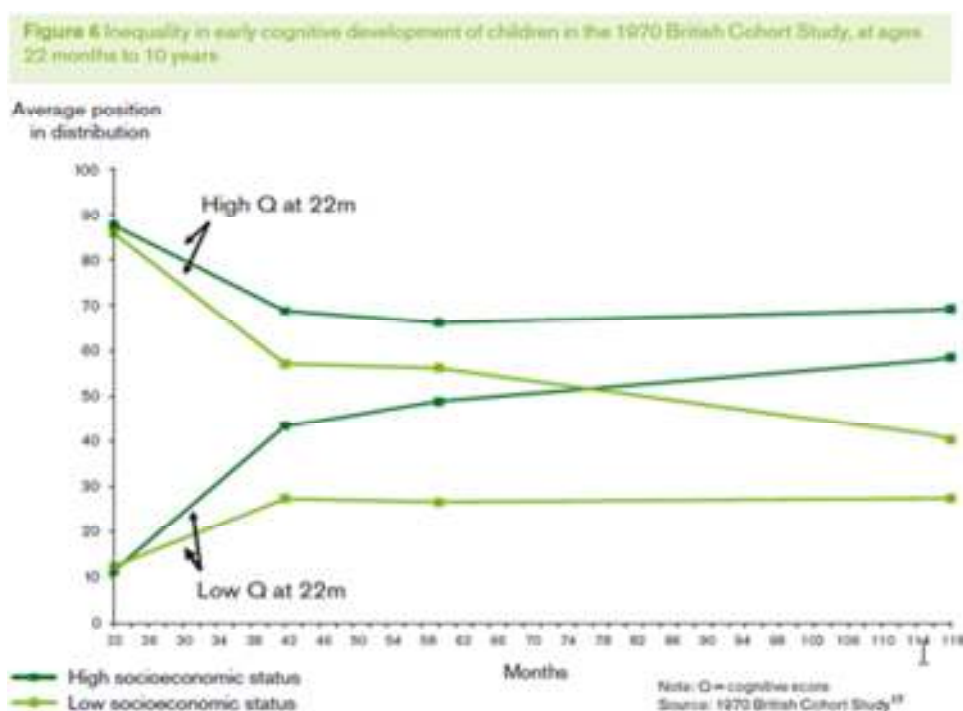
It has been known for a long time that by the end of the first trimester of pregnancy (up to week 12) the developing foetus is fully formed with all of its adult organs and tissues developed – no new organs or tissues develop after this point the foetus simply gets bigger. This is primarily why most “teratogenic” substances that are toxic to the unborn child do their damage in the first trimester of pregnancy as once the foetus is fully formed there is an element of protection against toxins. This is not to suggest that there is no harm from heavy alcohol use after the first trimester as alcohol in high doses is a neurotoxin at all ages and even in adults it kills brain cells. However, if the major brain damage that occurs to the unborn child in early pregnancy is to be prevented then heavy alcohol use needs to be prevented in women at the time of conception and in the early weeks of pregnancy *before women know they are pregnant*. The key approach has to be on reducing heavy alcohol use amongst all women and not an approach that primarily attempts to reduce alcohol consumption amongst pregnant women from about 8 weeks of pregnancy although this is also necessary. It is also clear that many women who drink at high levels before pregnancy continue to do so during pregnancy (Anderson et al 2014), again highlighting the need for effective interventions prior to pregnancy to reduce heavy drinking amongst women and men.

In addition to this there is now good evidence that heavy alcohol use amongst the father prior to and at the time of conception can also have serious adverse effects on the developing foetus (Astley 2010). The concept of the “drunken sperm” is something that is not yet widely understood but this also leads to a high prevalence of developmental problems in the foetus as well as epigenetic changes to the genetic code of the foetus which can predispose that foetus to a range of chronic conditions in later life (Taylor and Francis 2014). In order to prevent this there again needs to be an approach which reduces the level of heavy drinking amongst all men as well as women.

Harmful alcohol consumption can have life-long negative effects on a child, irrespective of the presence of diagnosed FASD. Parental alcohol misuse is frequently associated with lack of responsive care, stimulation and neglect of children during their critical early years, with profound and permanent effects on brain chemistry and development which continues into the school years (Mustard 2006). Although the prevalence of FASD in the NT is not known, the prevalence of children at Age 5 who are developmentally vulnerable on two or more domains is well known through the Australian Early Development Index scores (AEDI 2012). The Northern Territory has the highest prevalence of unhealthy development in early childhood in Australia and heavy drinking in parents is a significant factor in this.

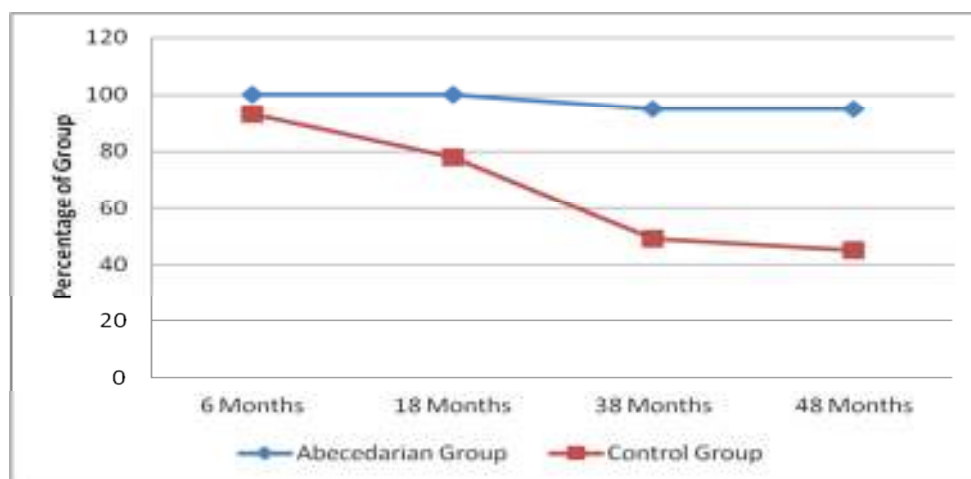
It is also now clear from many longitudinal studies that much of the harm from unhealthy development occurs after birth in the first 3 years of life and this harm is caused by lack of responsive care and appropriate stimulation coupled with or without an early childhood environment where the child is living in constant fear of their personal safety due to violence. Families where one or both parents drink heavily are often characterised by some or all of these adverse factors and this is probably a major reason for the unhealthy cognitive and emotional development that is revealed in the NT AEDI scores. It is very likely that for most children much more harm is done after birth from heavy alcohol consumption than occurs during pregnancy and all of this combined harm is preventable. It is also clear that whether a specific diagnosis of FASD is made or not most children from disadvantaged families, including those families where heavy drinking is an issue, will benefit from key early childhood programs such as the Nurse Home Visiting Program and the Abecedarian Educational Day Care program discussed later in the section on demand reduction. These programs will help to prevent the “natural” decline in cognitive, emotional and other brain potential that tends to occur in disadvantaged families without any specific supports.

The following graph is taken from Prof Sir Michael Marmots report “Fair Society Healthy Lives” (Marmot et al 2010) where he considers the impact that a disadvantaged early childhood had on the cognitive development of children in the British Cohort Study. This study followed 70 000 children all born in the same week in 1970 and it found that children born into disadvantaged families rapidly lose their cognitive potential in the first 3 years of life – *even when born with very high IQ*. Given the magnitude of the loss after birth it is very likely that most of the children who are developmentally vulnerable at age 5 in the NT as evidenced by the AEDI scores were not born with this level of impairment but have *acquired* this after birth as has been described in this and other cohort studies.



This evidence is further reinforced in the Abecedarian cohort studies from Prof Joseph Sparling. The graph below (Ramey and Ramey 2004) shows the extraordinary difference in cognitive development for children who were born into disadvantaged families and did not get the additional stimulation of Educational Day Care – the control group in red. In this group more than 50% had an IQ less than 85 by Age 3 again showing the large loss of brain potential that occurs after birth. The blue line represents children from disadvantaged families who were given the additional stimulation and responsive care provided by the Abecedarian Educational Day Care program and for these children nearly 100% had a

normal IQ by age 3. Parental alcohol abuse is one of the major mechanisms through which social disadvantaged is expressed and if this could be reduced then you could expect to see a significant improvement in the development of children. The fact that nearly all of the blue line group who accessed the program end up with normal IQ suggests that even if these children suffered some loss of their brain potential due to exposure to alcohol in utero, which is likely for some, they still were able to develop with normal IQ with the appropriate support, in this case, the Abecedarian Educational Day Care Program.



It seems that irrespective of heavy exposure to alcohol to the developing brain in utero for most children this, by itself, will not lead to severe disability unless it is compounded many fold by what happens in the first few years after birth. It is critical to ensure that all children from disadvantaged families have access to the additional support and stimulation provided by key evidence based early childhood programs discussed later.

TOR 3: Actions the Government can take to reduce FASD based on evidence

The need for a population-based, rather than an individually targeted approach is a key issue that we believe the Inquiry needs carefully to consider. Most of the damage that is being done to young children due to alcohol abuse would not be accurately diagnosed as FASD, even if we could closely assess every possible case. Although it is important to be able to diagnose FASD when it exists, population level interventions are for all disadvantaged children and this will include both diagnosed and undiagnosed children suffering from cognitive and behavioural issues.

The key is to focus on the interventions that are needed to address the problem of alcohol related unhealthy brain development and not whether or not a subset of all the children affected by a parent or parents who abuse alcohol can be correctly diagnosed as having Foetal Alcohol Spectrum Disorder.

In the light of this, actions to address FASD in the Northern Territory must take account of:

- the high levels of drinking at harmful levels amongst women of child-bearing age and their partners in the Northern Territory;
- the likelihood that such women will drink at levels dangerous to their unborn child before becoming aware that they are pregnant;
- one of the risk factors for having a child with FASD is a male partner who drinks;
- the emerging evidence that pre-conception drinking by men may also lead to abnormal development of the unborn child;

- the relatively high proportion of women who may be expected to continue to drink at risky levels even after becoming aware of their pregnancy;
- the fact that there is no ‘cure’ for FASD, although a person with FASD can be assisted by programs to help them with their learning and behaviour; and
- the need to address alcohol-related developmental deficits in children *whatever their likely source*, whether incurred through FASD or through lack of parental care and nurture after birth.

There is an urgent need for more action to address alcohol misuse amongst Aboriginal people but some of the most effective, evidence based policy options need to be implemented at a population wide level. Such population wide policies will have a differential impact on the heaviest drinkers in the population which includes many Aboriginal people who drink including both women and men who are likely to conceive and then have children. Any response that is only specific to Aboriginal people and Aboriginal communities will not be adequate nor is a response that is only specific to drinking in pregnancy and Congress urges the Inquiry to recommend whole of population measures that differentially impact on the heaviest drinkers. These measures form part of the 3 pillars of the national alcohol strategy and include supply reduction, demand reduction and harm minimisation.

Alcohol Supply Reduction

By the late 70’s Congress began advocating for a reduction in alcohol supply in Alice Springs calling for reduced take-away outlets and reduced trading hours. These calls at that time fell on deaf ears. In 1990, Congress decided to take matters into its own hands and it purchased the former corner store and take-away outlet at 23 Gap Road, next door to our clinic, and the grog was tipped into the gutter and the take-away license was let lapse at considerable cost to Congress. This was a very powerful public statement of the need to reduce supply and as a result there was one less take away license in Alice Springs. However, it was still not possible to get government to seriously listen to what was needed in terms of alcohol supply reduction.

Then, in November 1995, the late Arrernte Leader, Dr Perkins, while he was the Central Zone ATSIC Commissioner, called a big public meeting on alcohol which was held under the old sales in the mall. Over 400 people attended and it was realised that if serious action was going to be taken to reduce alcohol supply then all the Aboriginal organisations and other key groups such as churches, health professional bodies, trade unions and others needed to join together to advocate on this issue. This was the beginning of the Peoples Alcohol Action Coalition (PAAC) of which Congress was a founding member and Congress and PAAC have together advocated for the major supply reduction measures that will make a difference to alcohol misuse in Aboriginal communities, including the specific problem of FASD.

Such measures include:

1. An alcohol floor price at the price of beer (\$1.30 per standard drink) with or without a volumetric tax on alcohol
2. The reintroduction of photo-licensing at the point of sale coupled with an electronic register that has the capacity to ban people from accessing take-away alcohol based on defined criteria that mean the banned person has a serious alcohol problem

3. A reduction on total take-away hours of trade through the introduction of one take-away free day per week linked to Centre Link payments

For a fuller explanation of the importance of both a minimum price and the use of photo-licensing at the point of sale in reducing population level alcohol consumption here in Alice Springs please see the attached paper from the National Drug Research Institute, “Alcohol Control Measures Central Australia”.

Alcohol Demand Reduction

Treatment

Congress has always taken a multi-faceted approach to the alcohol issue of which supply reduction is one part. Since the beginning of the Congress clinic in 1975 we have been treating people with alcohol dependency to try to reduce the demand for alcohol. Congress initially set up the alcohol treatment “farm” on the land where CAAAPU is now located. From the late eighties, as the alcohol problem got worse Congress was part of a movement with Tangentyere Council and other organisations that led to the establishment of the Central Australian Alcohol Programmes Unit or CAAAPU. It was realised there was a need for an Aboriginal community controlled specialist residential alcohol treatment organisation and Congress allowed this to be built on the land where the farm had been and eventually gifted the land to CAAAPU.

In addition to the need for residential rehabilitation Congress was aware of the need to offer improved community based treatment for people who had either left residential treatment and were back home or for people who for one reason or another did not want residential treatment. Thus in 2008, Congress became part of a national research project through the National Drug Research Institute and set up the “Grog Mob” treatment program based on case management and 3 streams of care medical, psychological and social and cultural. This program was evaluated and found to be very successful and this then led to the funding of the Safe and Sober Support Service (see the attached paper on the evaluation of the Grog Mob program as well as the evaluation of the Safe and Sober Support Service). A key problem with all of the attempts that Congress has made to provide effective, community based alcohol treatment has been the lack of ongoing funding and this is highlighted in the grog mob paper and has continued to create enormous problems for the Safe and Sober Support Service. Another key support that is needed for some people who are in treatment and trying to remain sober is the option of alcohol free supported accommodation for long periods of time and this is currently not available.

There are some people who have a serious problem with alcohol dependency and in spite of our best efforts refuse to engage in treatment. For these people, Congress has been prepared to accept the need for a well evaluated trial of Mandatory Treatment, including an initial period of detention for the purpose of assessment. However, this must be done without criminalising the treatment process in any way and it is a major concern to Congress that current legislation in the NT makes it a criminal offence for people who leave Alcohol Mandatory treatment. This needs to be amended. In addition, there is a need to improve the protections for people in the assessment phase and Congress has provided a submission to the AMT review which we will make available to the inquiry. These provisions could be provided to pregnant women who refuse to engage in treatment but only with the same safeguards as already mentioned and as part of a well evaluated trial to see if this approach is effective. The initial point of entry for pregnant women who are heavy drinkers into possible Mandatory Treatment could be through the Child Protection System and the Act would need to be amended to allow health professionals to make Child Protection Referrals in such situations as has occurred in Victoria. It needs to be reinforced that Alcohol Mandatory

Treatment in its current form would not be acceptable for this, or any other purpose because of the criminal consequences that currently exist.

Early Childhood Programs

The key to demand reduction is in the primary prevention of demand through supporting healthy development in early childhood. The importance of Early Childhood and the need for effective evidence based programs in this area was highlighted in the Early Childhood feature section of the 2013 annual report (see attached).

As described earlier, 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 (Stanley et al 2005) including to an increased risk of unhealthy levels of alcohol consumption. 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 alcohol use in the long-term.

In addition to FASD, there are critical periods in early brain development where if a child is not provided with appropriate care and parenting, then significant brain potential is permanently lost. Children who are not exposed to rich conversational language, read to daily, encouraged much more often than they are discouraged, who do not get sufficient regular sleep, and who come to expect and demand immediate gratification, are unlikely to develop brain potential in areas such as language and cognitive and emotional development.

Parental alcohol use is frequently associated with lack of responsive care, understimulation and neglect of children during their early years, causing deficits in development which children carry into their school years and beyond. In particular, the link between poor development in the early years and the subsequent development of addictions and other life-long problems has been demonstrated by many studies, including a recent longitudinal study from Dunedin in New Zealand (Moffitt et al 2011). It followed more than one thousand children from birth to age thirty-two and found that the lower the self-control or emotional development in early childhood, the greater the risk of developing substance dependence in **Figure 2)**

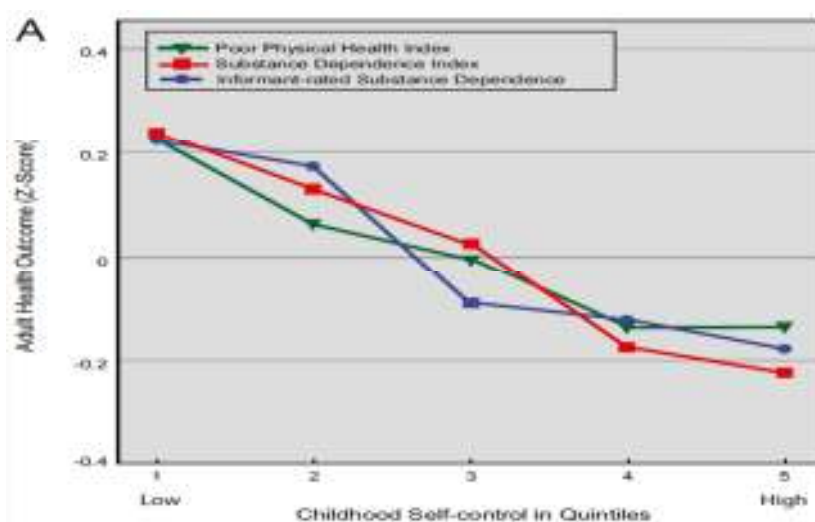


Figure 2: Relationship between childhood emotional development and adult health outcomes, including substance dependence

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 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 alcohol; 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 (Nieratschker et al 2013).

Once this pattern of development and behaviour is established, youth interventions, while necessary, are far more costly and less effective. There is ample evidence that it is much more effective – and efficient in terms of resources – to invest in early childhood development programs which aim to offset developmental deficits already incurred and to prevent the development of this pattern of behaviours. Examples of such preventative programs include the Nurse Family Partnership (NFP) Program Home Visitation and the Abecedarian model of Educational Day care. These programs work with children to access the stimulation, quality relationship and access to services to optimise healthy development. While NFP uses an outreach based model with emphasis on home visits and contact with mothers, the Abecedarian Educational day care has a focus on daily contact with the child at a centre where children experience enriched care. Such early childhood programs can:

- reduce the use of alcohol and other substances by young adults (Olds et al 1997) including reducing the number of young women who start drinking before the age of 17 (Campbell et al 2014);
- more than double school retention rates (Campbell et al 2008); and
- dramatically reduce the youth incarceration rates (Tremblay et al 2008);

Early childhood development programs are an essential contributor to raising children who are resilient and thus better equipped to avoid developing substance addictions and other problems in adolescence. Early childhood education and support are thus an essential part of the answer to reducing alcohol-related harm through addressing developmental deficits in children, *whatever their starting point*, that is, whether originating with exposure to alcohol before birth (FASD) or with family dysfunction related to alcohol consumption after birth.

Alcohol Promotion

Finally, demand could be reduced by banning the way in which increased consumption of alcohol is promoted by the alcohol industry, especially linked to sporting events which are frequented by young people.

Alcohol Harm Minimisation

There is a need to maintain the types of harm minimisation services that have serviced the community well for many years and this includes the Sobering Up Shelters, night patrols and other measures.

In addition, to these measures Congress supports the establishment of Aboriginal Social Clubs in remote communities as long as they meet the criteria outlined in the attached Congress position paper on Aboriginal Social Clubs which critically includes the view that they should only be implemented as part of a well evaluated trial.

A brief history of the partnership between Congress and the Peoples Alcohol Action Coalition (PAAC)

The People's Alcohol Action Coalition originated as the People's Alcohol Action Group (PAAG), a community-based response to growing awareness of excessive alcohol use and associated harm in the Central Australian region. As mentioned earlier, PAAG began in November 1995 following a public rally called in Alice Springs by the late Aboriginal activist and Australian and Torres Strait Islander Commission (ATSIC) Central Zone Commissioner, Dr Perkins (Rosewarne & Boffa, 2003).

Initially, PAAG received funding from the Northern Territory Government to employ a project officer to support the group, and these funds were administered by the Central Australian Aboriginal Congress. Congress became the employer of the PAAG project officer and was the key agency providing support to the group. As PAAG decided to focus more of its effort on alcohol supply reduction the group became more at odds with the NT government of the day and its funding ceased in 1998.

In September 2000 another public meeting was called to debate strategies for a campaign aiming to reduce alcohol-related harm. At this meeting it was decided to re-activate the group as PAAC – a coalition rather than a group (PAAC, 2013). PAAC is an unincorporated association of organisations and individuals with a history of dealing with the deleterious effects of alcohol. While the involvement of some parties has not been sustained over time, there is a core group of organisations and dedicated individuals, including Congress, who have remained committed to the reducing alcohol caused harms.

PAAC forms one part of Congress' advocacy for effective public health policy and addressing social determinants of health; recognising their extreme disparity in Alice Springs and Central Australia, and the direct link to negative health outcomes. Congress bases its work on social practice within the communities' lived experiences, and with Aboriginal people owning the solutions (<http://www.caac.org.au/aboriginal-health/social-determinants-of-health>).

Congress has produced a number of key policy papers on alcohol over the years which have very much helped to lead the development of alcohol policy within PAAC. This includes the 1997 position paper on Substance Misuse and the 1998 article published on the CARPA Newsletter: "Substance Misuse in Central Australia". It also includes the paper published on the National Drug and Alcohol Review "What price do we pay in preventing alcohol related harms" (Hogan et al 2006). In 2009 Congress developed a position paper on Aboriginal Social Clubs (see attached). Congress provided a major submission to the former NT government's process that led to the development of the "Enough is Enough" alcohol reforms in 2011 (see attached) and in that same year key alcohol policy proposal were outlined in the 2011 "Rebuilding Family Life" paper (<http://www.caac.org.au/files/pdfs/Rebuilding-Families-Congress-Paper.pdf>). Finally, Congress recently provided a submission to the review of the NT Alcohol Mandatory Treatment Legislation (see attached, 2014)

Congress has also been involved in substantial research projects on alcohol in Alice Springs including the evaluation of the grog mob (D'Abbs 2013) and Safe and Sober Support Services (Stearne, 2012) as well a longitudinal study in Alice Springs that looked at the relationship between alcohol price, consumption and harms (Symons et al 2012). There have also been many presentations at conferences on alcohol including the APONT summit in Darwin November 2012 attended by 150 people (NACCHO, 2012), the APONT Alice Springs summit in mid-2013 and the joint NTCOSS / AADNT forum on alcohol in the NT in May 2013

PAAC works in partnership with Congress and other coalition members towards reducing the impacts of alcohol-related harm. As part of this partnership Congress has worked with PAAC in developing the PAAC submission to the inquiry and we endorse all of the following recommendations for which further justification and references are contained in the PAAC submission which should be read in conjunction with the Congress submission.

Recommendations

Recommendation 1. More information is needed about the prevalence of FASD and other alcohol-related cognitive impairment in the Northern Territory. Research should be supported which aims to identify patterns of prevalence and incidence of harm, whether caused in pregnancy through FAS/FASD, through lack of responsive care, stimulation and neglect in early childhood, directly through the health effects of alcohol consumption, or otherwise indirectly through violence, accidents and injury.

Recommendation 2. That the Northern Territory Government, recognising that raising the price of alcohol is the most cost-effective way to reduce alcohol-related harm including FASD,

- a) allows for the implementation of a floor price on take-away alcohol in the NT through an amendment to the NT Liquor Act to allow the setting of a floor price by the Licensing Commission or other appropriate body, in the absence of voluntary Accords; and
- b) advocates for the introduction of a national floor price for take-away alcohol to be set at the retail price of a standard drink of full-strength beer (currently around \$1.30). This should be combined with a volumetric tax on all alcohol products directed to a national fund for the reduction of alcohol-related harm.

Recommendation 3. That the Northern Territory Government takes action to reduce the availability of alcohol as a key measure to reduce alcohol-related harm, including FASD. Minimum interventions would include:

- a) one take-away free day per week as a way to reduce total take away trading hours, alcohol consumption, expenditure on alcohol and alcohol-related harm; and
- b) reduced and modified morning and late night trading.

Recommendation 4. That the Northern Territory Government reintroduce the effective photo ID scanning at the point of sale coupled with a Banned Drinkers Register, with resources for evaluation to be included from commencement.

Recommendation 5. That the Northern Territory Government support the trialling of a home visiting program modelled on the evidence-based Parent-Child Assistance Program of the United States to reduce the risk of FASD amongst high-risk mothers. Such a trial should, however take account of:

- a) existing successful home visiting programs focussed on early childhood development (for example the Australian Nurse-Family Partnership Program in Central Australia); and
- b) current workforce and organisational capacity factors in the implementation of such a program.

Recommendation 6. That the Northern Territory Government legislate to allow for the trial of a process whereby referral to child protection could be made where there are concerns for an unborn child due to a dangerous level of alcohol consumption by the mother. Such referrals would allow for:

- a) intensive support by child protection authorities and other service providers for the woman, including her family, during pregnancy;

- b) application of banning and or residential treatment orders and child protection income management coupled with a re-instated Banned Drinkers Register scheme (see Recommendation 4); and
 - c) early intervention by child protection services to protect the child immediately following birth.
- Legislation must not criminalise women who consume alcohol during pregnancy and must preserve their individual rights, such as the right to representation. Rigorous evaluation would need to be built into such a trial, and its use discontinued in the event that no clear benefits resulted.

Recommendation 7. There are a number of treatment and support options which have evidence of effectiveness in reducing alcohol consumption amongst individuals. They include:

- a) well-resourced interventions in 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) readily available, culturally appropriate family planning for women and/or their partners who consume alcohol and where the woman does not wish to become pregnant; and
- c) 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 transitional accommodation.
- d) provision of secure, alcohol free supported accommodation for pregnant women

Recommendation 8. The alcohol treatment system needs to be resourced to assess (in collaboration with the client, their carers and family as necessary) those with cognitive impairment to determine whether their needs are best met through alcohol treatment or disability services. Those specifically diagnosed with FASD or other equivalent cognitive or behavioural impairment should be recognised as having a disability and should be entitled to all the benefits and assistance that flow from such recognition.

Recommendation 9. Government should avoid investment in approaches for which there is no reasonable prospect of effectiveness or which discriminate against or further marginalise disadvantaged groups .

These include:

- a) criminal sanctions against women who drink while pregnant;
- b) mandatory treatment linked to criminal sanctions;
- c) non-targeted education and persuasion strategies, including most school-based education and media campaigns; and
- d) programs or policies founded upon discrimination on the basis of race.

Recommendation 10. Provision of access to evidence-based early childhood development programs for children aged 0 to 4 in at risk families is a key strategy for the primary prevention of alcohol-related harm 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.

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