



Dr Sharman Stone  
Chair, Standing Committee on Indigenous Affairs  
House of Representatives  
PO Box 6021  
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Canberra ACT 2600.

*CC: Committee members:*

Hon Warren Snowdon MP ((Deputy Chair) (Australian Labor Party, Lingiari, NT)  
Mr Andrew Giles MP (Australian Labor Party, Scullin, Vic)  
Ms Michelle Landry MP (The Nationals, Capricornia, Qld)  
Hon Shayne Neumann MP (Australian Labor Party, Blair, Qld)  
Mr Graham Perrett MP (Australian Labor Party, Moreton, Qld)  
Ms Melissa Price MP (Liberal Party of Australia, Durack, WA)  
Mr Rowan Ramsey MP (Liberal Party of Australia, Grey, SA)  
Ms Fiona Scott MP (Liberal Party of Australia, Lindsay, NSW)  
Mr Bert van Manen MP (Liberal Party of Australia, Forde, Qld)

April 2014

*Submission to the Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities*

Dear Dr Stone,

We are pleased to have the opportunity to make a submission in response to the Committee's inquiry in to the harmful use of alcohol in Aboriginal and Torres Strait Islander communities. This submission is informed by our research project funded by the Department of Prime Minister and Cabinet, the Lowitja Institute, and the Foundation for Alcohol Research and Education.

We have been conducting research on Alcohol Management Plans in the Northern Territory. We have undertaken a case study at Jilkminggan and fieldwork at a number of locations in the Northern Territory, exploring the impact of alcohol misuse in community and town contexts, as well as the complex policy and legislative setting. During the course of our work, we have had significant input to the development of guidelines for Alcohol Management Plans under the *Stronger Futures in the Northern Territory Act 2012* through our work with the Department of Prime Minister and Cabinet (and the former Department of Families, Housing, Community and Indigenous Affairs). We have also undertaken an extensive review

on the impact of past alcohol interventions in Australia, with a focus on the development of Alcohol Management Plans. Our submission outlines some of the relevant outcomes from our research and our subsequent recommendations for action.

Regards,

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## **Inquiry Terms of Reference**

1. Patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders
2. The social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities
3. Trends and prevalence of alcohol-related harm, including alcohol-fuelled violence and impacts on newborns e.g. Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders
4. The implications of Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders being declared disabilities
5. Best practice treatments and support for minimising alcohol misuse and alcohol-related harm
6. Best practice strategies to minimise alcohol misuse and alcohol-related harm
7. Best practice identification to include international and domestic comparisons

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### **1. Patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders**

Supply of alcohol is a key issue, but varies contextually from towns to small communities in remote areas in the Northern Territory. Addressing supply has economic implications for the commercial entities retailing alcohol in that limiting supply as proposed in some Alcohol Management Plans or implementing a 'floor price' would affect their income. There seems to be little political will in the Northern Territory to adopt a floor price or approve Alcohol Management Plans that limit supply to local residents even though the economic impacts of alcohol misuse on, for example, morbidity and mortality, the nutrition status of children, school attendance, work-readiness, vehicle accidents, assault rates, hospital admissions, increased policing, and the increased involvement of Indigenous people in the criminal justice system, have been reported. These impacts include welfare spending on alcohol and illicit substances rather than food and sustenance for which social security is intended. This was a key factor in introducing income management under the *Northern Territory Emergency Response* legislation, and continued under the *Stronger Futures in the Northern Territory Act 2012*. It has been suggested that the lack of political will to adopt policies other than income management to overcome the impact of alcohol misuse can be attributed to the well-funded lobby campaign for the alcohol industry in the NT. It has been reported that the largest funder of political parties in that jurisdiction is the alcohol industry, and the funding level is 14-times that for other jurisdictions.

Supply issues need to be addressed regionally rather than focused on a single community/town/outlet because of the links between the geographical placement

of take-away liquor outlets, variable restrictions (opening hours/volume/type) and proximity to different communities. Thus, if one outlet has more stringent liquor licensing conditions than another, people will simply travel further to the next outlet in closest proximity, or with more lenient conditions or to the regional towns (which then impacts on issues of itinerate populations in town centres).

Indigenous mobility is much higher than for the rest of population and is a factor in addressing supply issues. More research is needed to explore the mobility patterns and affiliations between town camps, town houses/neighbourhoods, and remote areas.

There is a high level of distortion of the facts associated with the perpetrators of alcohol-related crime in regional towns, leading to the misapprehension that the majority of serious offences are committed by 'out-of- towners' and visitors from bush communities. There has been a perpetuation and exploitation of these myths by the media and some other stakeholders.

The data on supply of alcohol in the Northern Territory is difficult to access, and when it is publicly available for limited periods, it is not disaggregated into smaller local areas. The data is relevant only for the larger towns. Without disaggregated alcohol supply data for non-urban areas, it is difficult for small communities to plan and implement alcohol management strategies. This data is essential as a basis for developing and implementing these strategies.

## **2. The social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities**

Alcohol has long been a focus of national Aboriginal policy with various responses. The harms attributable to the misuse of alcohol are substantial, impacting on individual drinkers, their families, communities, and society as a whole. Current levels of Aboriginal alcohol consumption and alcohol-associated harm are extreme, by any comparative standard. Specific policies pertaining to alcohol have always been embedded within a series of national "Aboriginal Affairs" policies such as protectionism, assimilation and self-determination. These policies have arguably had as much, if not more, impact on the use of alcohol by Indigenous Australians over time. It is only in recent decades that Aboriginal people have had legal access to alcohol. A little under 50 years ago the provision of alcohol to Aborigines was strictly prohibited and intoxication was an offence for Aborigines, as was the possession of alcohol. This was altered by the introduction of the Aborigines and Torres Strait Islanders Affairs Act 1965, allowing Aboriginal people access to liquor, but only away from reserves.

The history of alcohol prohibition and Aboriginal people in Australia cannot be understood without being contextualised within a wider trajectory, particularly addressing the overlapping issues of civil rights and Indigenous identity over a similar

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timeframe. Brady (2004) argues that the international strategies from the World Health Organization were a key influence over alcohol policy throughout Australia.

Policy and public discussion tends to focus on long-term problem drinkers whose behaviour is highly visible and draws attention to the problem of anti-social behaviour in public places while ignoring the anti-social behaviour in domestic and community contexts. The outcome of this perception is that most policies and interventions do little more than shift the problem of alcohol-related violence and other anti-social behaviour from one place to another. An especially concerning outcome here is the closure of drinking camps and prohibition of consumption of alcohol in public places. These measures force problem drinkers into life threatening behaviour in other places, such as homes, communities, and, for example, intoxicated people walking on roads resulting in fatalities (Stuart Highway near the Mataranka Hotel, Roper Road).

We recommend that child-based approaches and family-based responses be considered at the centre of any policy framework that aims to reduce alcohol-related harms in Aboriginal and Torres Strait Islander communities. This includes centralising support on the households that experience the impact of alcohol abuse in its multiple dimensions. The approach that centralises the child and family as the focus for reducing alcohol-related harms, and especially violence, is based in the evidence that shows the harms from alcohol misuse do not fall solely on the individual drinker but ripple outwards impacting on others. This approach recognises that some of the greatest harms from alcohol misuse fall on those closest to the drinker. Some of the more severe harms include child abuse, physical violence and fatalities.

**3. Trends and prevalence of alcohol-related harm, including alcohol-fuelled violence and impacts on newborns e.g. Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders**

We recommend a greater focus on the impacts of alcohol abuse on early childhood development to ensure that the long-term trends of harm are addressed. Studies of brain development in the early years of childhood demonstrate the contribution of timely stimulation and nurture in developing skills for the entire life cycle. They also show the negative impact of the absence of these elements, and more dramatically the deleterious effects of violence, abuse and neglect on developing neurophysiology, which in turn predispose children, young people and adults to health, behavioural and social problems throughout life (Keating & Hertzman, 1999; National Scientific Council on the Developing Child, 2010). There are additional flow on effects that extend beyond the child, ultimately impacting upon families, communities and society at large.

During the course of our research, we were informed by John Boulton (pediatrician, WA), that any child-focused response needs to include the following parenting pre-requisites:

The pre-requisites of human parenting comprise a robust tradition of transitional (weaning) practice with food security; the necessary demographic age profile to enable cooperative parenting within a pre-modern micro-society in transition; and the absence of barriers from violence and existential stress to the reproductive strategy of long term investment in offspring. A long-term strategy would need to address the following elements:

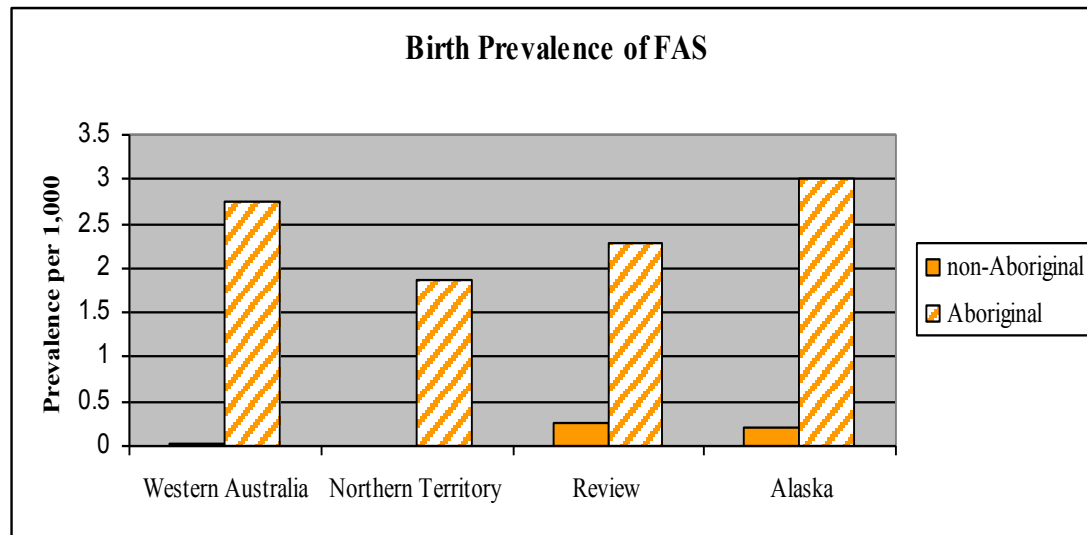
- *Prevention of fetal alcohol spectrum disorder* and causes of early life trauma, and supporting families whose children suffer the effects of FASD.
- *Structural Violence*. Freedom from severe stress, particularly stress caused by a high risk of inter-personal violence.
- *Nutrition and education strategies* for preventing growth faltering because of nutritional neglect.
- *Working in partnership* with Indigenous organisations and Aboriginal families to achieve social norms of personal behaviour in relation to alcohol consumption, parenting, education, etc.

An example from the Kimberley is the partnership developed through the network of agencies and local organisations in Fitzroy Crossing with the Sydney University George Institute of International Health. This was set up by the women who achieved the alcohol restrictions. Its focus is on the prevention of fetal alcohol spectrum disorders and causes of early life trauma, and supporting families whose children suffer the effects of FASD. Its scientific focus is on the identification of the extent of neuro-developmental disability from FASD, and creating a system for assisting these damaged children at school and in later life. This example illustrates how we can use our organisational ability and knowledge of community and population health to help local people, and make a difference at a community level. But one's involvement is itself a function of hard-won credibility, of being recognized as one of the white people who not only keep turning up to deliver a service but who are actually interested and care for the children and families of that community. To achieve this requires a systematic approach within the profession as well as a particular approach by the individual doctor. (John Boulton, pers. comm. 2012)

There is very little available data in Australia on the prevalence of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorders (FASD). This is primarily due to problems of diagnosis (discussed further in section 4). However, from the little data that has been gathered, it is evident that the prevalence of FAS is highly distorted, with levels being extremely high in the Aboriginal population comparatively to the non-Aboriginal population (see figure 1). This is not a distinctly Australian problem, with similar misrepresentations occurring internationally.

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**Figure 1. Prevalence of FAS (per 1,000 births)**



(Abel & Hannigan, 1995; Bower, Silva, Henderson, Ryan, & Rudy, 2000; Egeland et al., 2005; Harris & Bucens, 2003)

**4. The implications of Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders being declared disabilities**

There is a range of issues related to the potential declaration of Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorders (FASD) as disabilities. The first, and most obvious, being the difficulties related to the diagnosis of FASD, particularly in the early years of childhood. This has implications on the difficulty governments would have in ascertaining levels of support required for people with FASD, and the subsequent issues related to accessing potential support for individuals due to under-recognition and/or misdiagnosis. This is an unrecognised issue for Indigenous and non-Indigenous people alike. Across the health profession there is a broad lack of knowledge about how to recognise and how to respond to foetal alcohol issues. This means that we have to look to the Government to advocate on the issue. Research conducted by O'Leary et al. (2007) identified the significant lack of knowledge among health professionals in identifying and accurately diagnosing FASD. This research has resulted in a program aimed at improving the education of doctors and health professional to allow for a greater understanding of the disorders and how to recognise this in children.

Accordingly there is also an urgent need to develop and support programs to address how best to recognise and educate children in the classroom with FASD, which would include the support for the training of special education teachers.

We recommend an independent expert assessment of the number of special needs teachers needed in schools to cope with classroom and education requirements of children who have behavioural issues, including FASD-related conditions.

Strategies are also required to ensure the support of healthy pregnancies to improve the outcome for Aboriginal and Torres Strait Islander babies. Current national, state and Territory data are inconclusive in a number of areas that measure perinatal and child health outcomes, due to the lack of complete and accurate Indigenous identification in statutory and administrative data sets. For example birth weight statistics reports have significant variations across and within states and territories. Data can be misleading, thus we have to be sure that we are clear about what we are measuring and how robust the data are to support policies and initiatives aimed at improving Indigenous infant and child health.

There are significant preventative issues that need to be taken into account. Over fifty per cent of pregnancies are unplanned, inferring that antenatal care is not well attended and pregnancy is not well detected, sometimes until the final trimester, thus interventions such as the former Banned Drinkers Register and the current Alcohol Protection Orders in the Northern Territory would only capture a small proportion of the community.

We recommend four stages of prevention to consider when addressing promotion and education for maternal alcohol consumption:

1. *Primary prevention* is necessary where actions are taken to prevent the onset of drinking during pregnancy before it happens.  
Education programs are needed in communities to encourage higher levels of health literacy on the dangers of drinking during pregnancy alongside the promotion of healthy pregnancies. Efforts should be aimed at targeting women before and during their reproductive years, as well as their partners, extended family members and community members who may influence a specific target group of women. Education programs regarding drinking throughout pregnancy should be family-oriented and culturally appropriate, addressing the knowledge, attitudes and perceptions of the woman, her partner and family, in the context of the community in which they live.
2. *Secondary prevention* is required to identify those at risk; screening and the provision of an early intervention program for women of all ages who are in their reproductive years can achieve this. Emphasis should be directed towards women who drink or exist in a drinking environment. Information should be provided to all health professionals regarding the risks of alcohol use during pregnancy with the aim of accelerating early



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recognition of at-risk drinking, and early intervention. Education programs should be designed to provide health professionals with skills that will motivate, encourage and support lifestyle changes for at risk drinkers.

3. *Tertiary prevention* attempts to lessen the prevention of the occurrence of FAS or FASD. Specific programs should be designed for children who have been diagnosed with FAS or FASD. Although family planning is a concept that has not been adopted by indigenous people, it should be offered to all women and their partners who are within the risk category especially if they already have a child with FAS or FASD.
4. *Lobbying for change within the alcohol industry* to place warning labels on all alcohol consumable products, and to make it illegal to serve pregnant women alcohol.

We recommend that government support local projects for sober, senior women to work with younger women to raise their awareness of FASD, including numeracy and literacy programs and raising awareness of the damage that alcohol does to their bodies especially when they are pregnant. The projected outcome is that the group members will gain an in-depth understanding of FAS/FASD.

**5. Best practice treatments and support for minimising alcohol misuse and alcohol-related harm**

Alcohol consumption is prohibited on the majority of Aboriginal land in the Northern Territory under the Stronger Futures Act, designating communities as Alcohol Protected Areas. As a result, drinkers residing in communities often establish informal drinking camps at the edge of community boundaries. Informal drinking areas can be extremely hazardous environments for a number of reasons, including: lack of access to food and water; high levels of unmonitored violence and other anti-social behaviour; lack of shelter to protect against exposure to extreme weather conditions; minimal access to phones or other forms of communication when emergencies arise; and the proximity to busy roads and highways, resulting in fatalities when intoxicated people from these informal drinking camps wander onto roads.

We were informed of eight deaths involving intoxicated people wandering from drinking camps into the path of fast moving vehicles on roads on the Stuart Highway near the Mataranka Hotel and on the Roper Highway. Governments have been hesitant to sanction safer drinking areas as a mechanism to reduce the harms of alcohol. A key concern is that placing drinking areas close to communities will jeopardise the safety of women, children and families. However, there have been no alternate measures proposed to counter the life-threatening harms posed for drinkers using informal drinking camps.

Community controlled, safer drinking areas could be an effective measure to minimise harms if well-managed places, operating under approved guidelines and conditions, were authorised. Safer drinking practices could be encouraged, access to essential services and regular police and night patrols. Resolving this problem would save lives. The land tenure problem is one of the obstacles to establishing these 'safe-drinking areas.' Because most Aboriginal land under the *Aboriginal Land Rights (Northern Territory) Act 1976* has been declared 'dry' under the Alcohol Protected Areas provision of the *Stronger Futures Act*, it is not possible for the Minister to declare safe drinking areas, primarily because the Commonwealth does not want to be liable for deaths or injuries that might occur in such places. To resolve this dilemma, the Land Councils would need to approve long-term leases for these places. The four Territory Land Councils can grant, if they wish to, long term leases under two sections of the Act, sections 19 and 19A, which both protect underlying title of Indigenous traditional land owners. This must be actively encouraged or moved into the hands of a competent authority that could make timely decisions.

#### **6. Best practice strategies to minimise alcohol misuse and alcohol-related harm**

We have found that much of the research conducted in connection with Indigenous alcohol problems in Australia has contributed little to increasing the capacity of individuals or groups to manage alcohol more effectively, although it intermittently assists governments to measure the performance of community groups funded by them. This is because, with a few exceptions, research often fails to examine the causal mechanisms that give rise to the problems in the first place.

A greater emphasis needs to be placed on using approaches that have had a positive impact in the past, not only in alcohol-related areas, but also in other areas of socio-economic disadvantage. There has been a range of highly successful community programs implemented in Aboriginal communities in the past. However, there are also large numbers of programs that have not delivered the intended results. Evidence shows that there are a range of elements that ensure the success of community programs. Many of these programs:

- use a child-centred approach;
- support personal agency;
- create safe environments to live, work, learn and raise families;
- support households;
- support abusers; and,
- build capacity among health and other related professionals.

We recommend that policy design principles should be based upon:

- Supply and consumption reduction to reduce harm in a way that does not simply shift the problems from one location to another.
- Legislative frameworks integrated with social programs to manage second order effects.
- A regional approach recognising the links between communities and towns.

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- The development of personal agency and personal responsibility

Many policies have explicitly targeted small populations that tend to be problem drinkers, but do not address the general problem of drinking across the NT. To appropriately focus on the broader issue, it is important to include strategies that address the supply chain, those enabling the drinking (hotel industry, pub owners, liquor markets). It is also necessary to respect and consider the differences between the open towns versus prescribed drinking areas as posing different problems that require some different solutions.

Greater engagement between the different agencies and initiatives is also required to ensure that they complement each other rather than compete, acknowledging that competition is encouraged through the funding cycle. However, greater accountability of the outcomes of funded programs should be demanded. There also needs to be a more in-depth interrogation of why interventions have worked well in the past, for example the local liquor accords that have been implemented in different locations.

Based on our recent research, we believe that Alcohol Management Plans could be an appropriate and effective approach to reducing harm in Indigenous Communities predicated on a number of factors, including:

1. Willingness within communities to participate and engage in the process and provision of government resources for planning, implementation and evaluation. Preferably, this would be driven by community organisations. Roles and responsibilities need to be clearly defined, as determined collaboratively by government and the community. Building the governance capacity in communities would be extremely useful in this process.
2. AMPs need to be built up over time and developed on the basis of guidelines that include an evaluation framework with benchmarks and indicators. Planning, implementation and evaluation needs to be contextualised over time, and it is unfair to expect communities to conduct extensive and detailed evaluations and analysis before, during and after implementation without strong support and resources. A set of basic standards and indicators must be available for use in planning, implementing and evaluating AMPs, and in their further development. These standards and indicators will be based on the on-the-ground experience of communities, as monitored, reported and evaluated by them, using participatory action research tools, including various forms of consultation.

This process should involve a number of key steps including:

- incorporation of background information on the history and current status of AMPs and alcohol-related reforms in the specific community, including operational issues related to their objectives, strategies and management processes, in addition to information pertaining to their duration, budget and participating stakeholders;
- identification of the purpose of the evaluation in collaboration with stakeholders, identify the major evaluation objectives and questions in accordance with evaluation criteria such as relevance, validity in design, effectiveness,

sustainability, impact, factors affecting performance, alternative strategies and unanticipated results;

- specify the evaluation methodology, utilising the evaluation template articulated in this document;
- list the relevant information sources to be used by the evaluation as set out in this document;
- specify the composition of the evaluation team (this should include relevant stakeholders from community and government, in addition to an evaluation specialist);
- specify the involvement of key stakeholders who will use the evaluation results for decision-making;
- describe the evaluation work plan, including detailing the roles and responsibilities of the evaluation personnel, detail specific tasks to be undertaken, as well as the timelines involved;
- Indicate which audience are to receive which information at what time, what the nature and the schedule of written briefings will be and how the findings will be disseminated and to whom;
- specify logistics support including transportation, administrative support, data processing, office and other equipment; and,
- specify the detailed evaluation budget.

Critical to the success of communities and governments wishing to reduce alcohol harms are the requirements of a clear set of evidence-based indicators and targets on which alcohol responses can be based, as well as a list of guidelines, or minimum standards, by which communities can prepare, implement and evaluate (including monitoring and reporting) their plans over time. Evaluations, at minimum, should include the following elements or regimes: steps in the process of evaluation (such as monitoring and reporting) and set guidelines as measured quantitatively by indicators benchmarked against acceptable national and international standards.

## **7. Best practice identification to include international and domestic comparisons**

Please see our published research brief for further information:

SMITH, K., LANGTON, M., D'ABBS, P., ROOM, R., CHENHALL, R. & BROWN, A. 2013. Alcohol management plans and related reforms. Sydney, NSW: Indigenous Justice Clearinghouse.

<<http://www.indigenousjustice.gov.au/briefs/brief016.pdf>>

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