CENTRAL AUSTRALIAN ABORIGINAL CONGRESS
ABORIGINAL CORPORATION ICN 7823

CENTRAL AUSTRALIAN ABORIGINAL CONGRESS

Submission to the House of Representatives Standing Committee on Health, Aged Care and Sport

Inquiry into the health impacts of alcohol and other drugs in Australia.

December 2024

Table of Contents

Recommendations

Recommendation 1. That the Australian Government prioritise action on alcohol, in recognition of its greater health impacts and social costs compared to other drugs such as opioids, methamphetamine and cannabis. This should include particular strategies to combat the harms of alcohol in remote and very remote areas.

Recommendation 2. That the Australian Government supports and extends services that are effective in reducing alcohol consumption amongst individuals. These include well-resourced interventions in the primary health care setting, such as the Congress model of 'three streams of care' (medical treatment, psychological therapy, and social and cultural support), integrated with appropriately resourced, culturally-safe residential and community-based alcohol treatment programs.

Recommendation 3. Consistent with the National Agreement on Closing the Gap signed by all Australian Governments, Aboriginal community-controlled organisations, especially Aboriginal community-controlled health services, should be recognised as preferred providers for government-funded services to address AOD issues in Aboriginal and Torres Strait Islander communities, in recognition of their greater service effectiveness, their higher levels of employment of Aboriginal people, their cultural responsiveness, and their formal structures for involving Aboriginal communities in decision-making.

Recommendation 4. That, proportionate with the harm that alcohol causes (including especially violence against women) all Australian Governments implement effective regulation of alcohol supply and cost especially in areas with high levels of alcohol-related harm. Interventions should be based on the best evidence from around the world and the well-documented success of the alcohol reforms in Central Australia and the Northern Territory, including:

- developing and implementing restrictions on hours and amounts of sale of takeaway alcohol, including takeaway free days
- implementing a Minimum Unit Prince (MUP) to remove cheap and dangerous alcohol from sale, noting that to maximise effectiveness the MUP should be set at $1.90 per standard drink and indexed annually in line with inflation
- consistently enforcing prohibitions for the sale of alcohol for consumption in 'dry areas'.

Recommendation 5. That the Australian Government regulate the payment of all Centrelink entitlements to fall on days when takeaway sales are prohibited in a region to strengthen the capacity of responsible family members to buy food, pay bills etc before the income is spent on alcohol.

Recommendation 6. That all Governments avoid investment in approaches for which there is no reasonable prospect of effectiveness or which discriminate against or further marginalise disadvantaged groups. These include mandatory treatment linked to criminal

sanctions; non-targeted education and persuasion strategies, including most school-based education and media campaigns; and any program or policy founded upon discrimination on the basis of race.

Recommendation 7. That any approach to addressing alcohol-related harm in Aboriginal communities must be based upon the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the United Nations Declaration on the Rights of Indigenous Peoples.

Recommendation 8. That the Australian Government commits to reducing poverty and inequality as a key way to prevent the addiction to alcohol which, in many Aboriginal families, underlies the poor developmental outcomes of children, including through FASD. This commitment should include an increase all Centrelink entitlements to the poverty line for all participants, with an additional loading on such payments for those in remote or very remote areas to address significantly higher costs of living.

Recommendation 9. That all programs for preventing, diagnosing or treating alcohol and other drug issues where there are significant numbers of Aboriginal people in the community be founded on a positive attitude to Aboriginal culture and ways of being, and resourced to be trauma-informed and healing-focused.

About Central Australian Aboriginal Congress

1. Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Mparntwe (Alice Springs). Established more than 50 years ago, Congress is 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 delivers services to more than 17,000 people living in Mparntwe and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu, Amoonguna, Imanpa, Kaltukatjara (Docker River), and Yulara.

Congress' program logic to address alcohol and other drug issues

2. Congress has developed a comprehensive model of primary health care (PHC), founded on both addressing the determinants of health at a population level as well as treating poor health as it is expressed in the lives of individual Aboriginal community members. This comprehensive approach is mirrored in the organisation's program logic to address alcohol and other drug (AOD) issues in the region (*Figure 1*).

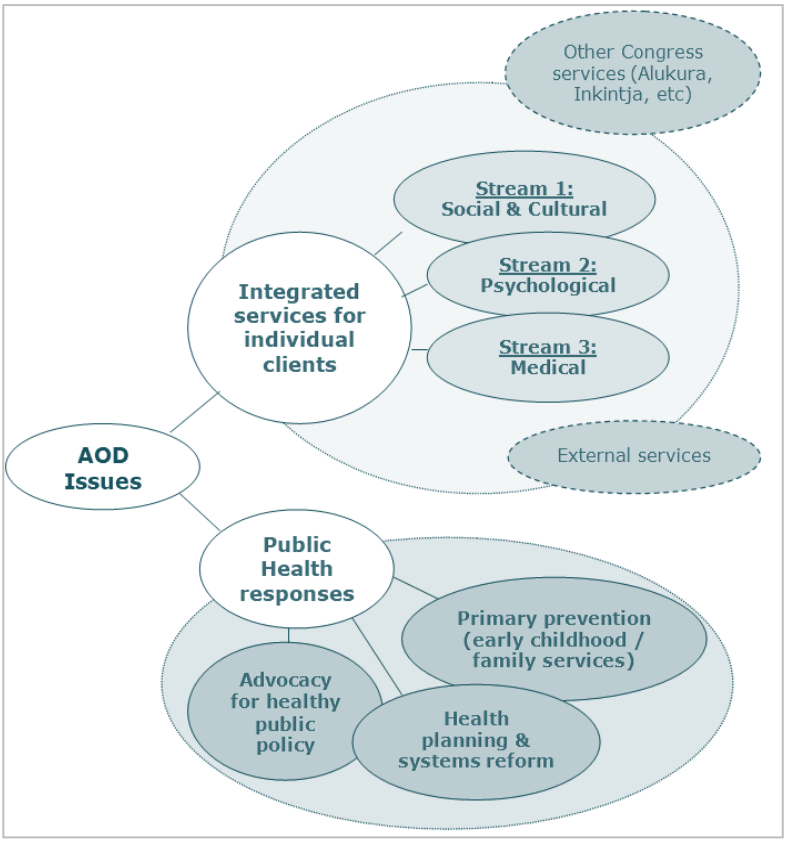


Figure 1: Congress' approach to addressing AOD issues

3. Our approach includes:

   a. Public health responses to the harms caused by alcohol and other drugs, such as:

      i. *Primary prevention* through a suite of early childhood development and family services

ii. *Advocacy* for evidence-based healthy public policy especially focused on reducing alcohol availability and targeting the heaviest drinkers through programs such as the Northern Territory's Banned Drinkers register

iii. *Health planning and systems reform* to reorient health systems meet the needs of Aboriginal communities through a number of principles, including a holistic definition of health; using a social determinants approach; comprehensive primary health care; and Aboriginal community control.

Our public health actions are described in more detail in our responses to *Term of Reference 2: Prevention and reduction of harms* and *Term of Reference 3: Intersectoral approaches* below.

b. An integrated model of care for individual clients based on our three streams of care model including social and cultural support; psychological therapy; and medical support. This model is described in more detail in our response to *Term of Reference 1: Alcohol and other drugs services* below.

Alcohol: the most harmful drug

4. The harm from alcohol and other drugs is a major public health issue requiring sustained, evidence-based action by government. While action on harms from the full range of substances is required, alcohol is deserving of particular attention due to the high level of harm with which it is associated.

5. The total social costs of alcohol, including health care costs, crime, and in the workplace are estimated at around $67 billion per, far larger than any other drugs and second only to tobacco (*Figure 2*). It is responsible for 4.5% of the total burden of disease and injury in Australia [1].

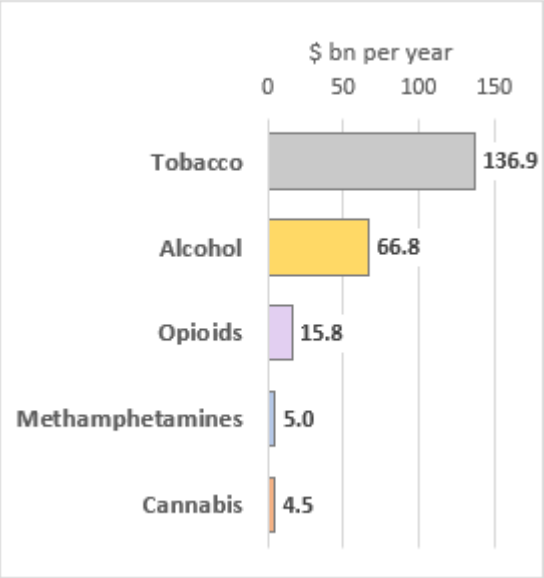


Figure 2: Social costs of alcohol and other drugs

6. However, the harms from alcohol are disproportionately higher in some areas of Australia. The Northern Territory has the highest per capita alcohol consumption in Australia and it causes much greater health and social harms. For example, in the Northern Territory:

- alcohol-attributable deaths for Aboriginal people are up to 10 times higher compared to non-Indigenous Territorians [2]; and
- 69% of treatment episodes for AOD use are for alcohol; in remote / very remote areas of the Territory, the figure is even higher at 76% (*Figure 3*) [3].

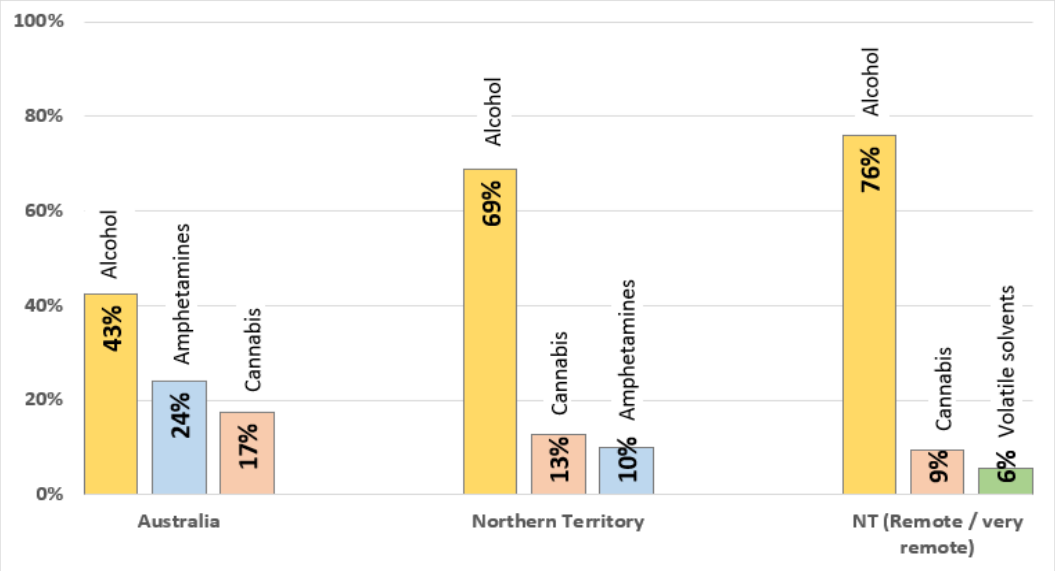


Figure 3: AOD treatment services, treatment episodes by principal drug of concern, Australia and Northern Territory, 2022–23

7. Analysis carried out by the Menzies School of Health Research for Congress shows that in 2020, alcohol-attributable hospitalisations for Aboriginal people in Alice Springs were approximately 110 per 1,000 population (*Figure 4*). This equates to around 11,000 alcohol-attributable hospitalisations per 100,000 population, around twenty times the national average of 510 alcohol-attributable hospitalisations per 100,000 [4].

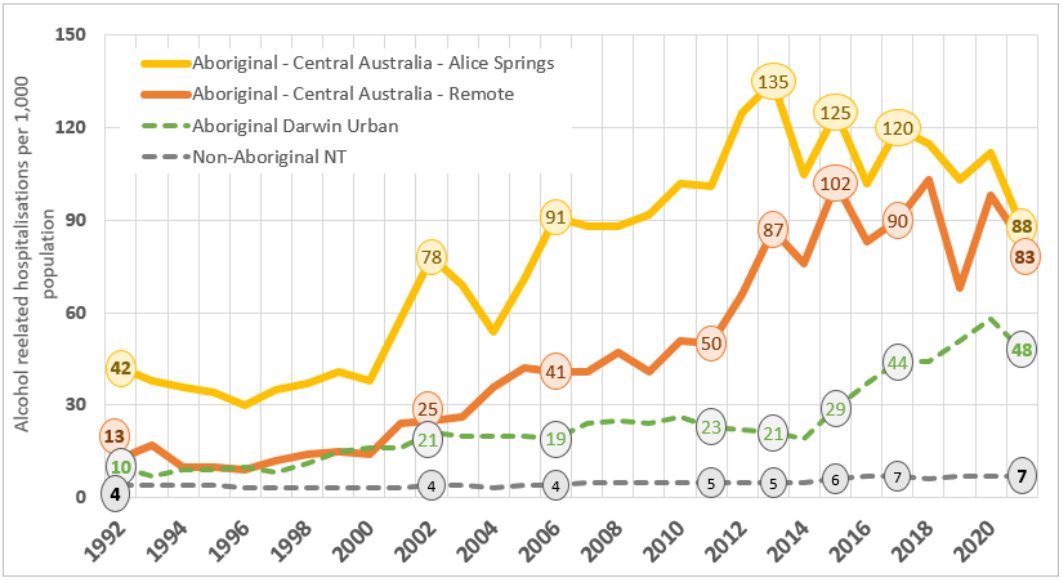


Figure 4: Alcohol-related hospitalisations, Central Australian and Darwin Aboriginal and NT non-Aboriginal populations 1992-2021

Recommendation 1. *That the Australian Government prioritise action on alcohol, in recognition of its greater health impacts and social costs compared to other drugs such as opioids, methamphetamine and cannabis. This should include particular strategies to combat the harms of alcohol in remote and very remote areas.*

Term of Reference 1: Alcohol and other drugs services

Assess whether current services across the alcohol and other drugs sector is delivering equity for all Australians, value for money, and the best outcomes for individuals, their families, and society.

Congress' Three streams of care model: addressing AOD in primary health care

8. In 2008, Central Australian Aboriginal Congress responded to increasing concerns from the Aboriginal community in Central Australia about the lack of culturally-appropriate non-residential treatment options for Aboriginal people with issues with harmful substance use. Over the years, the model has evolved, developing a more stable funding base and moving to greater levels of integration. However, the core of the model has remained the same, based on three inter-related streams of care. An outline of the client care pathways in the 'Three Streams model of care' is at Attachment A.

Stream	Provided by	Support provided
Social and Cultural Support	**Within Congress SEWB Service by:** • Aboriginal Care Management Workers (ACMWs) • Aboriginal Cultural Integration Practice Advisor • Social workers	• Client advocacy • Cultural support • Social support • Access to medical care • AOD counselling, brief interventions • Case management
Psychological Stream	**Within Congress SEWB Service by:** • Psychologists • Mental Health Accredited Social Workers	• CBT and related therapies including Motivational Interviewing, Schema Therapy, Mindfulness Therapies • Brief Interventions • Neuropsychological assessment
Medical Stream	**From Congress clinics and outreach:** • Congress General Practitioners • Registered Nurses • Aboriginal Health Practitioners	• Pharmacotherapies • Chronic disease management

Figure 5: Summary of Congress 'three streams of care' model

9. A key assumption has been that the integrated three streams care are the foundation for the treatment of all SEWB service clients, whether they present primarily with alcohol use or other drug issues, or with social and emotional wellbeing / mental health issues such as other addictions (e.g. gambling), anxiety and depression.

10. The model has been evaluated as it developed with conclusions that the model was well-received by stakeholders and clients; that it demonstrated

> *the viability of, and demand for, evidence-based non-residential treatment for Indigenous clients with alcohol problems [5]*

and that it

> *achieved [its] objective of improving the physical, psychological and social health and wellbeing of clients through the provision of a multi-disciplinary treatment program [6]*

In 2012 it was found that over half (55%) of active clients in the program showed a decrease in their drinking over the course of their engagement with the program, with clients engaging over a longer period showing greater improvements, despite many bearing multiple markers of disadvantage [6].

11. Following a presentation by Congress in October 2016, the Australian National Advisory Council on Alcohol and Drugs (ANACAD) commissioned a project to detail Congress' model to inform the Australian Government on how an integrated comprehensive primary health care service delivery model can address AOD issues through:

    - presenting an evidence-based case-study of the Congress' integrated model, and
    - identifying the enablers, limitations and barriers to the establishment and principles of such a model.

    The resulting paper (*Providing Alcohol and Other Drug Services through Comprehensive Primary Health Care in an Aboriginal Health Service: a model in Central Australia)* accompanies this submission.

12. An important feature of Congress' model is its integration with culturally responsive residential treatment for those with alcohol and other addiction issues. Congress provides medical assessment, management of chronic disease and, where appropriate, prescription of pharmacotherapies to assist with alcohol withdrawal for clients of the Alice Springs-based Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU).

13. A Congress GP works in CAAAPU and assesses clients on admission, ensuring that chronic conditions are managed, medications are prescribed, and a Mental Health Care Plan is developed. Congress psychologists then commence therapy while clients are in residential treatment, claiming Medicare to cover costs. CAAAPU provides additional counselling, social and cultural support, and supported accommodation. On discharge, clients can then continue care through their primary health care service with psychologists they have already got to know while in residential treatment.

Recommendation 2. *That the Australian Government supports and extends services that are effective in reducing alcohol consumption amongst individuals. These include well-resourced interventions in the primary health care setting, such as the Congress model of 'three streams of care' (medical treatment, psychological therapy, and social and cultural support), integrated with appropriately resourced, culturally-safe residential and community-based alcohol treatment programs.*

Aboriginal community controlled health services as preferred providers

14. The 2020 *National Agreement on Closing the Gap*[1] was signed by all Australian Governments and provides the policy foundation for action to AOD issues in Aboriginal and Torres Strait Islander communities. At the centre of the National Agreement are four Priority Reforms that focus on changing the way governments work with Aboriginal and Torres Strait Islander people. These are:

    - Priority Reform 1: Strengthen and establish formal partnerships and shared decision-making
    - Priority Reform 2: Build the Aboriginal and Torres Strait Islander community-controlled sector
    - Priority Reform 3: Transform government organisations so they work better for Aboriginal and Torres Strait Islander people
    - Priority Reform 4: Improve and share access to data and information to enable Aboriginal and Torres Strait Islander communities make informed decisions.

15. When it comes to addressing AOD issues through primary health care in Aboriginal and Torres Strait Islander communities, Aboriginal community controlled health services (ACCHSs) should be considered preferred providers. Other organisations (including non-Indigenous NGOs, government agencies and organisations which are Indigenous-led but not community-controlled) should only be considered if no ACCHS is available or willing to deliver services.

16. ACCHSs also have a range of inter-linked structural advantages in delivering services and hence improved outcomes compared to other types of service. These advantages include:

    - a holistic approach to service delivery, including through addressing the social determinants of child and family wellbeing, based on a lived understanding of the Aboriginal conception of health;
    - culturally responsive services: Aboriginal community-controlled health services are able to provide their care within a culturally responsive setting, based on local knowledge, an Aboriginal governance structure and workforce, and strong relationships with the communities that they serve;
    - better access, based on community engagement and trust: a strong practice of community engagement founded on strong relationships with the community, in turn based on a sense of ownership and history. Aboriginal people consistently prefer to use Aboriginal organisations such as ACCHSs over mainstream services giving them a strong advantage in addressing access issues, particularly when dealing with culturally sensitive issues relating to sexuality, pregnancy, childbirth and addiction;
    - Aboriginal governance: individuals and communities are encouraged and enabled to participate in decisions on service delivery, including though formal governing Boards, including a high proportion of Aboriginal women in governance positions;

- an Aboriginal workforce: community-controlled services are significantly better at attracting, training and retaining Aboriginal staff leading to greater cultural appropriateness of services as well as benefits through providing employment and capacity building in the Aboriginal community, especially for Aboriginal women;
- high levels of accountability: Aboriginal community-controlled health services are highly accountable to their funders for the services they provide through robust data collection and a reporting regime which is above the requirements of mainstream health and wellbeing services.

Recommendation 3. *Consistent with the* National Agreement on Closing the Gap *signed by all Australian Governments, Aboriginal community-controlled organisations, especially Aboriginal community-controlled health services, should be recognised as preferred providers for government-funded services to address AOD issues in Aboriginal and Torres Strait Islander communities, in recognition of their greater service effectiveness, their higher levels of employment of Aboriginal people, their cultural responsiveness, and their formal structures for involving Aboriginal communities in decision-making.*

Term of Reference 2: Prevention and reduction of harms

Examine the effectiveness of current programs and initiatives across all jurisdictions to improve prevention and reduction of alcohol and other drug-related health, social and economic harms, including in relation to identified priority populations and ensuring equity of access for all Australians to relevant treatment and prevention services;

Effective alcohol policy in the Northern Territory

17. We have exceptionally good evidence in the Northern Territory about how healthy public policy on alcohol can reduce alcohol-related harm. This is not anecdotal evidence, but high quality data based on publicly available datasets, that allow us to track and assess the impact of policy and legislative changes. A number of reviews have documented these in detail [7]. Because we believe it is exceptionally important to base public policy on the evidence of 'what works', we present the following analysis as a key case study of how government can act to reduce alcohol related harm by reducing supply and increasing the cost of dangerously cheap alcohol.

The reforms of 2017-18

18. During the period 2017-19, the Northern Territory Government introduced a range of alcohol reforms to deal with the jurisdiction's long-standing issue with high levels of alcohol-related harm. This included [2, 8]:

- a Banned Drinkers Register (BDR) to reduce access to take-away alcohol by problem drinkers (September 2017),
- Police Auxiliary Liquor Inspectors (PALIs) at bottle shops in Alice Springs , Katherine and Tennant Creek to prevent the sale of takeaway alcohol destined for consumption

in declared 'dry areas' which included many Aboriginal communities and town camps (2018);

- a Minimum Unit Price of $1.30 per standard drink to prevent the sale of cheap and dangerous alcohol (October 2018);
- a new Liquor Act that included risk-based licencing and greater monitoring of on-licence drinking (2019); and
- a commitment to high quality, ongoing independent evaluation.

19. These reforms were based on the evidence from around the world on what works to reduce alcohol related harm. Over their first full year of operation from 1 October 2018 they demonstrated significant reductions in sales of alcohol, which fell by 7% across the Northern Territory as a whole. Reductions in sales were greatest in those cheap types of alcohol associated with the greatest harms, with cask wine supply falling 51% and fortified wine sales down 37% following the introduction of the reforms [9].There was a slight rise in the consumption of spirits, but a subsequent independent evaluation found this to be the continuation of a pre-existing trend [10].

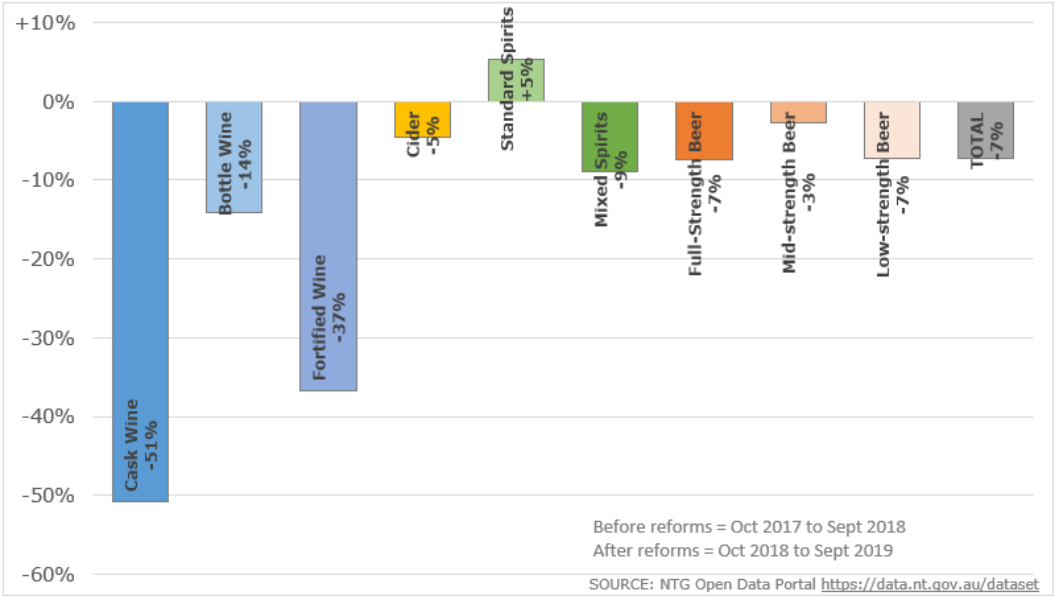


Figure 6: Wholesale supply of alcohol (litres of pure alcohol) Pre- and Post- 2018 Alcohol Reforms, Northern Territory [9]

20. As a consequence, there were falls in alcohol-related harm across the Northern Territory including in alcohol-related hospital presentations; alcohol-related and all domestic violence assaults; property crime; alcohol-related and all assaults; and many other measures (see paragraphs 30 to 36 below).

Effect of COVID-19 and the expiry of Stronger Futures (2019 to 2022)

21. Unfortunately, the COVID-19 pandemic from March 2020 saw an increase in some forms of alcohol-related harm, with domestic violence assaults increasing markedly. While the reasons for this are yet to be examined for the Northern Territory, it is consistent with

other Australian and international research showing that the COVID-19 pandemic was associated with both the onset and escalation of family violence [11].

22. The positive effect of the NT Government's Alcohol Reforms package was further undermined by the expiry of the *Stronger Futures in the Northern Territory Act 2012* (Alcohol Protected Areas) provisions in mid-July 2022. Under these provisions, introduced in the wake of the Northern Territory Emergency Response, 34 town camps, six Aboriginal *Land Rights Act* communities and 74 Community Living Areas were declared 'dry'. The provisions had a sunset clause, expiring on 17 July 2022.

23. Given the lack of any substantive consultation with Aboriginal communities, Congress advocated strongly for the Northern Territory Government to pass legislation to extend the provisions for two years. During this time proper consultations could be held to ensure that all voices in the community were heard. During this consultation period communities should be able to 'opt out' of the provisions if they wish with a formal indication that this is what they want to do. Congress, along with many other community organisations predicted that unless this action was taken, there would be a wave of alcohol fuelled violence, much of it directed at Aboriginal women.

24. However, the NT Government did not act: many communities that wished to remain 'dry' had to 'opt in' to continue the restrictions and few did given the limited consultative processes that were held. This led to an exponential increase in alcohol related harm, much of it suffered by Aboriginal women and children; to serious social disorder; and especially in Alice Springs to mounting community concern and finally national and international media and political attention.

New regulations (January 2023 to present)

25. Fortunately the Northern Territory Government reversed its position and once again supported an evidence-based, public health approach to alcohol in the Northern Territory. Following a visit to Central Australia by the Prime Minister and senior Federal Ministers, on 25 January 2023 the then Northern Territory Chief Minister announced immediate restrictions on take away alcohol availability in Alice Springs [12]:

    - One sale per day per person, following industry guidance;
    - Alcohol free days on Monday and Tuesday for takeaway purchases; and
    - Limiting hours of alcohol being sold between 3pm-7pm, except for on Saturdays.

26. This was followed on 6 February 2023 by a joint statement by the Chief Minister and Prime Minister of a new 'opt out' model to apply to all communities previously subject to alcohol restrictions under the Stronger Futures legislation. Coming into effect on 16 February, this meant that all communities previously under the *Stronger Futures* provisions are subject to interim Alcohol Protection Area (APA) provisions, making them once again 'dry' areas.

27. The statement also announced a package of $250 million from the Australian Government to address the underlying drivers of alcohol abuse and violence in Central Australia, including for improved community safety and cohesion; job creation; better services;

addressing Foetal Alcohol Spectrum Disorders; investing in families; and on-Country learning.

What the evidence from the Northern Territory tells us

28. There is exceptionally good, publicly available data which allows us to track in detail the effects of the shifting effects of government policy on a range of alcohol-related harms in Central Australia and the Northern Territory. This data is backed up by numerous academic and other studies for example [2, 10, 13, 14].

Alcohol consumption

29. Quarterly alcohol wholesale data [15] provides an estimate of alcohol consumption by region across the Northern Territory. latest data shows that for Alice Springs (*Figure 7*):

- alcohol consumption fell 9% after the introduction of the reforms of 2017-18;
- travel restrictions and reduced tourism of the COVID-19 period (March 2020 to June 2022) saw further falls in consumption;
- the expiry of Stronger Futures in July 2022 led to a 15% increase in consumption;
- this was followed by a 26% fall in consumption following the new regulations including 'dry areas' and the two takeaway free days a week from January 2023. Note that while consumption patterns are heavily seasonal, sales for the second quarter of 2024 (72,339 litres of pure alcohol) are the lowest on record for that time of year.

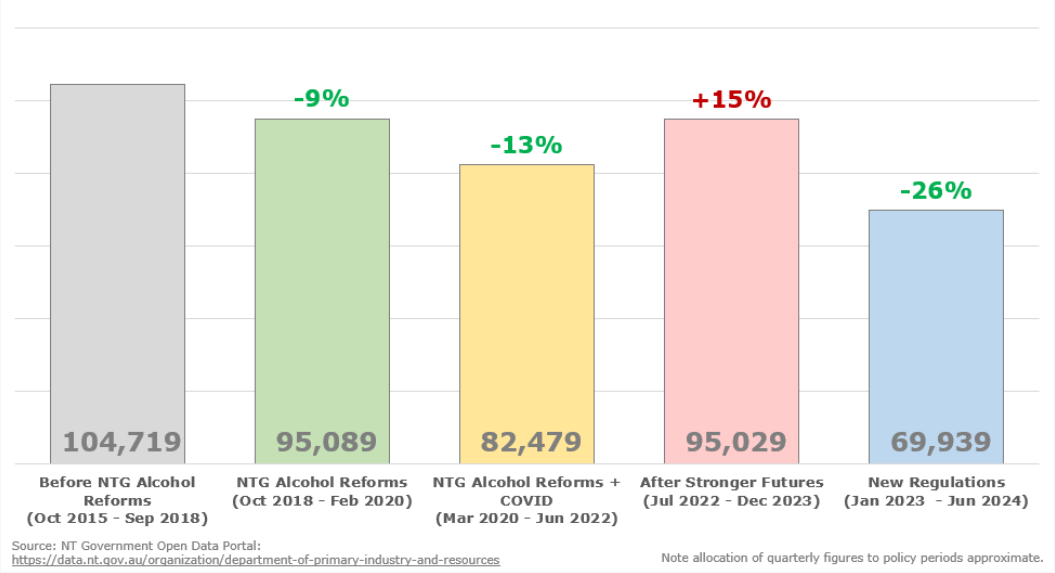


Figure 7: Alice Springs average quarterly wholesale alcohol sales by policy period (litres of pure alcohol)

Domestic violence and homicide and related offences

30. It has been estimated that Aboriginal and Torres Strait Islander women are 35 times more likely to be hospitalised due to family violence-related assaults than non-Indigenous women [16]. This points to a stark reality – family violence is not only a lot more common in Aboriginal communities, it is also much more severe.

31. Rates of family violence in Alice Springs are some of the highest in the country. In 2007, prior to the introduction of the first significant alcohol supply measures, Alice Springs surgeon Dr Abraham Jacob went public with findings that suggested that Alice Springs was the 'stabbing capital of the world': over a seven year period (1998 to 2005) there were 1,550 stabbing injury admissions to Alice Springs Hospital, more than 200 a year, or more than one stabbing every two days. Just over half of the victims were women [17].

32. Northern Territory Police Crime statistics [18] record the monthly number of a wide range of offences by region across the Northern Territory. Once again, the data shows the significant effects of alcohol regulation on alcohol-related domestic violence in Alice Springs (*Figure 8*):

    - alcohol-related DV fell 21% after the introduction of the reforms of 2017-18;
    - as documented in many parts of the world domestic violence rose during the COVID pandemic family violence [11].
    - as predicted by many Aboriginal community organisations, the expiry of *Stronger Futures* in July 2022 led to an tragic 93% increase in alcohol-related domestic violence;
    - the alcohol availability reforms of 2023 led to a considerable reduction in domestic and family violence (alcohol-related Domestic Violence Assaults fell by 41% in the months after the regulations were introduced, and a further 4% since then)

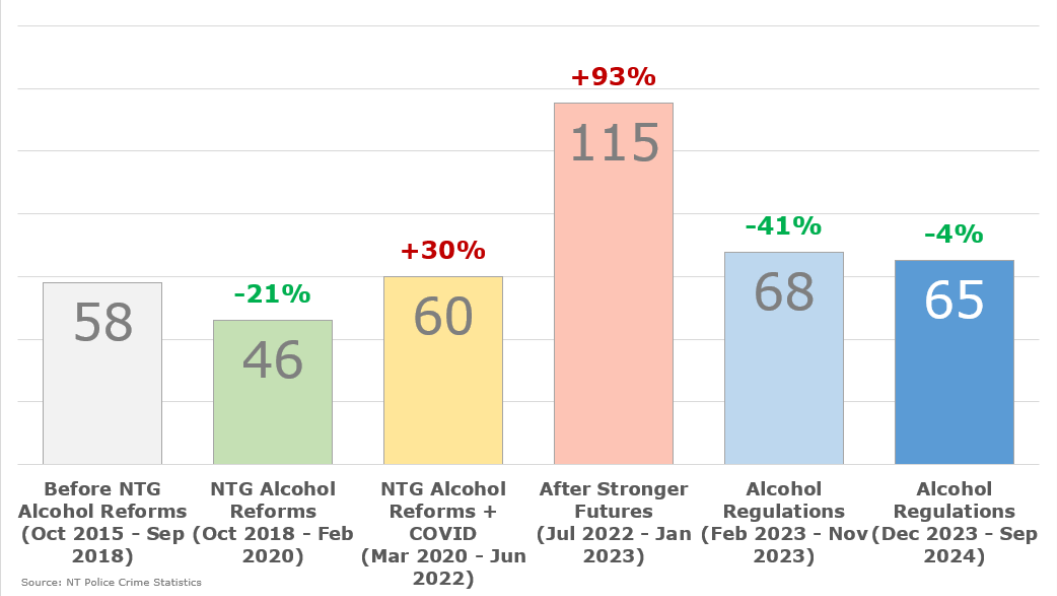


Figure 8: Alice Springs average monthly Alcohol-related DV Assaults by policy period

33. The high rates of family violence in Aboriginal communities is obviously very closely linked to homicide rates. Nationally, homicide rates for Aboriginal and Torres Strait Islander women are eight times higher than for non-Indigenous women. However, while the number of non-Indigenous women who are murdered in Australia over the last three decades has been declining, this is not the case for Aboriginal and Torres Strait Islander women [19, 20].

34. The pattern for homicide and related offences in the Northern Territory shows a similar pattern to that of domestic violence above with rates falling after the reforms of 2017-18 and after the new regulations of 2023 [18] (*Figure 9*).

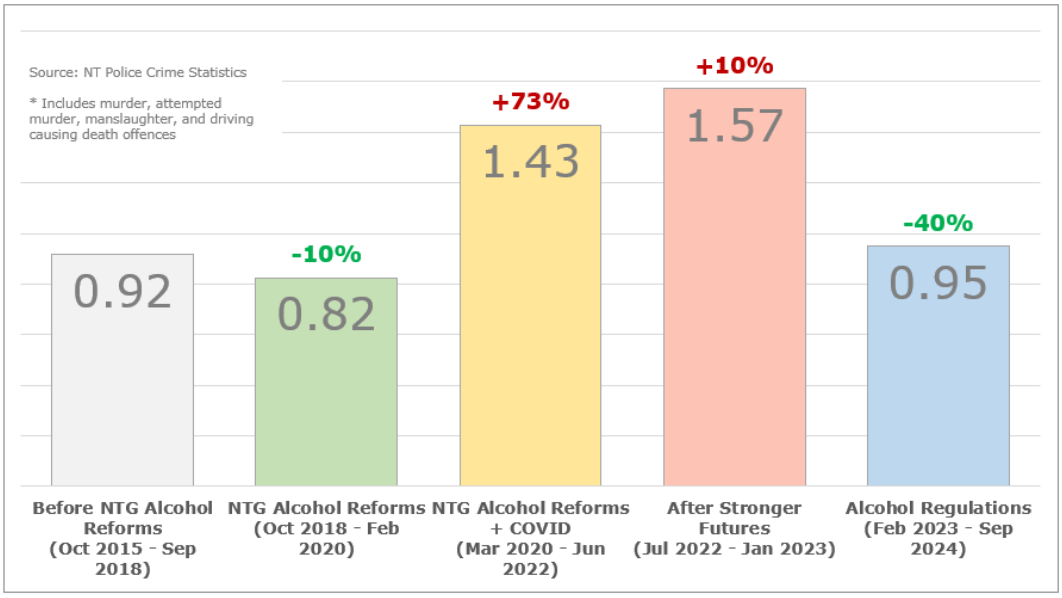


Figure 9: Average Number of homicide and related offences* per month by policy period, Northern Territory, 2015 to 2024

Emergency Department presentations

35. One of the strongest sources of evidence for alcohol-related harm is the number of alcohol-related ED presentations. According to unpublished NT Health data, the number of alcohol-related presentations at the Alice Springs Hospital Emergency Department fell by 25% after the introduction of the alcohol regulations in early 2023 (*Figure 10*).

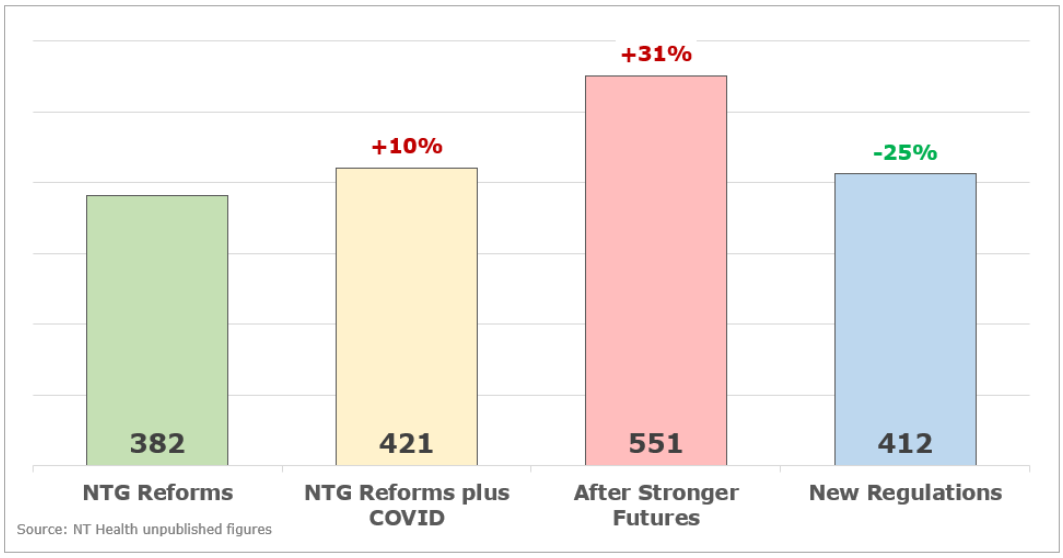


Figure 10: Alice Springs Hospital: Average monthly alcohol related ED presentations by policy period, 2019 to 2024

Alcohol-related mortality

36. Alcohol-related mortality significantly improved in the Northern Territory since sustained action to reduce supply and the other reforms of 2017-18. In 2017, the NT had 16.3

alcohol-induced deaths per 100,000 population, 3.1 times the rate for Australia. Sustained policy action has seen a dramatic decline in the number of deaths to 7.2 per 100,000 in 2022, only 1.2 times the national rate [21].

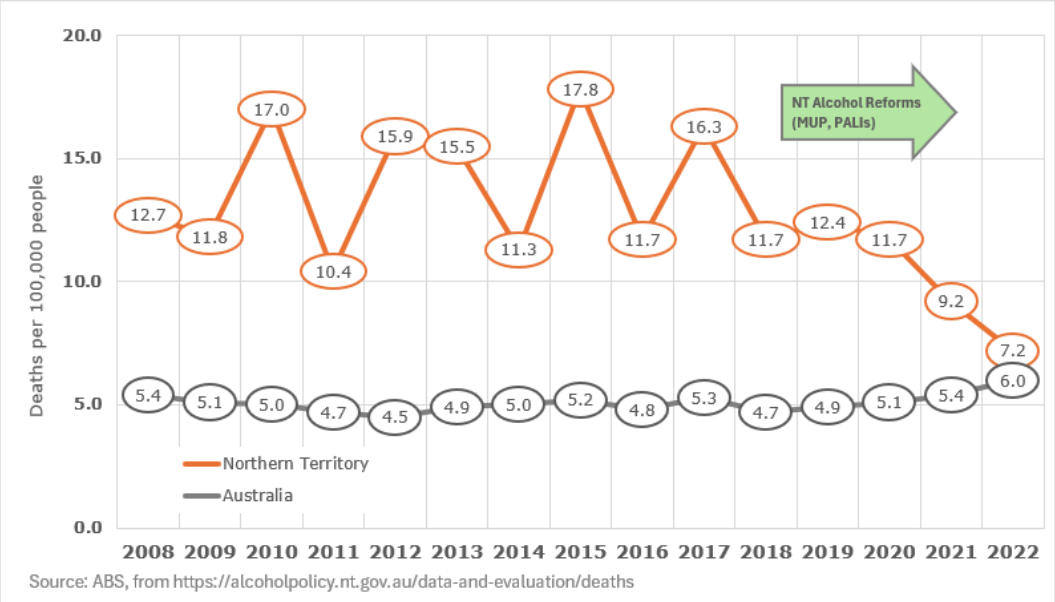


Figure 11: Alcohol-induced deaths: Northern Territory and Australia

The effect of the Minimum Unit Price (MUP)

37. A significant part of the reforms of 2017-18 was introducing a Minimum Unit Price (MUP) of $1.30 per standard drink. This 'floor price' does not affect low to moderate risk drinkers, but removes from sale the cheap and dangerous alcohol used by heavy drinkers that is responsible for many of the harms. In some jurisdictions alcohol is available for as little as 30¢ per standard drink, which is cheaper than bottled water and inconsistent with the dangers that it poses.

38. The recently elected Northern Territory Government now intends to repeal these measures from early 2025, citing the fact that they have not been successful and that they were undermined by a shift to the consumption of spirits. However, it appears that former and current alcohol industry representatives are having an undue influence on the new Government. It is significant that no evaluation of the MUP recommended that it be removed [10, 14].

39. An independent evaluation [10] concluded that the MUP was associated with significant decreases in the rate of alcohol-related assault offences; protective custody episodes; alcohol-related ambulance attendances; and assault-related hospital admissions. The MUP was not associated with any significant changes in tourism numbers or expenditure; or the number of liquor licences across the NT.

40. The MUP did not lead to a shift to the consumption of spirits. The independent evaluation concluded that increases in the consumption of spirits post-MUP were the continuation of an upward trend that pre-dated the introduction of the MUP.

Further measures to increase effectiveness of alcohol availability reforms

41. Rolling back these reforms in the Northern Territory, as is being proposed by the recently elected Northern Territory Government will inevitably lead to rise in crime, violence and ill-health. Instead of doing so, there a number of areas where regulation could be strengthened:

    - the MUP was set in 2018 at $1.30 per standard drink, with this amount to be indexed to ensure it maintained its effectiveness. Unfortunately, successive NT Government have failed to implement this important part of the scheme, so that over time its effectiveness gradually diminishes. Re-setting the MUP to $1.90 per standard drink (around the cost for full-strength beer) and properly indexing it would restore its full effectiveness;

    - the two takeaway free days in Alice Springs have been very effective in reducing harm. However, they could be made more effective by regulating the payment of all Centrelink entitlements on days when takeaway sales are prohibited in the region (e.g. Mondays under the current arrangements). This would strengthen the capacity of responsible Aboriginal family members to buy food, pay bills etc before the income was spent on alcohol.

Summary

42. Both the data and the numerous independent evaluations are clear that the consistent application of evidence-based policy interventions will reduce the amount of harm caused by alcohol, including by significantly reducing assaults, homicides and domestic violence; reducing hospital emergency department presentations; and reducing alcohol induced deaths.

Recommendation 4. *That, proportionate with the harm that alcohol causes (including especially violence against women) all Australian Governments implement effective regulation of alcohol supply and cost especially in areas with high levels of alcohol-related harm. Interventions should be based on the best evidence from around the world and the well-documented success of the alcohol reforms in Central Australia and the Northern Territory, including:*

- *developing and implementing restrictions on hours and amounts of sale of takeaway alcohol, including takeaway free days*
- *implementing a Minimum Unit Prince (MUP) to remove cheap and dangerous alcohol from sales, noting that to maximise effectiveness the MUP should be set at $1.90 per standard drink and indexed annually in line with inflation*
- *consistently enforcing prohibitions for the sale of alcohol for consumption in 'dry areas'.*

Recommendation 5. *That the Australian Government regulate the payment of all Centrelink entitlements to fall on days when takeaway sales are prohibited in a region to strengthen the capacity of responsible family members to buy food, pay bills etc before the income is spent on alcohol.*

Approaches with little evidence of success

43. There are a number of approaches which are sometimes suggested which have little or no evidence to support them in reducing alcohol related harms in both Aboriginal and mainstream contexts.

44. Mandatory treatment linked to criminal sanctions has very little evidence of success in reducing alcohol consumption for high-risk drinkers. 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 [22].

45. Education and persuasion strategies, including school-based education and media campaigns, have at best a minimal, short-term effect in raising awareness and reducing alcohol consumption, and as a substantial review of the international literature notes, 'cannot be relied upon as an effective approach' [23].

46. Approaches which discriminate on the basis of race are likely to be counter-productive. The experience of racism is associated with increased alcohol consumption. Aboriginal Australians commonly experience high levels of racism, from relatively minor incidents such as being called racist names, through verbal abuse, to serious assault [24]. There is a strong association between racism and poor mental health and alcohol misuse [25]. As well as addressing racism directly, this also points strongly to the need for interventions to tackle alcohol in Aboriginal communities to be non-racially discriminatory.

Recommendation 6. *That all Governments avoid investment in approaches for which there is no reasonable prospect of effectiveness or which discriminate against or further marginalise disadvantaged groups. These include mandatory treatment linked to criminal sanctions; non-targeted education and persuasion strategies, including most school-based education and media campaigns; and any program or policy founded upon discrimination on the basis of race.*

Term of Reference 3: Intersectoral approaches

Examine how sectors beyond health, including for example education, employment, justice, social services and housing can contribute to prevention, early intervention, recovery and reduction of alcohol and other drug-related harms in Australia; and

The effects of colonisation and the right to self-determination

47. Contemporary Aboriginal families have been deeply affected by the processes of colonisation including dispossession and impoverishment; the forcible removal of children and its intergenerational effects; the suppression of culture and language; and the experience of racism and discrimination. Aboriginal families continue to live with these effects of colonisation which challenge their capacity to care for their children.

48. It is in this context that the high levels of alcohol use in some Aboriginal communities should be seen. Numerous inquiries and reports, such as the Royal Commission Into

Aboriginal Deaths In Custody in 1991 [26], and the report of the Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, Little Children are Sacred in 2007 [27] have noted the highly adverse role of alcohol in contemporary life.

49. Any approach to addressing the high levels of alcohol-related harm in Aboriginal communities must recognise this underlying process of colonisation and its effects. It should therefore be founded on the rights of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the *United Nations Declaration on the Rights of Indigenous Peoples* [28], which states:

> *Article 22: Particular attention shall be paid to the rights and special needs of … persons with disabilities in the implementation of this Declaration.*
>
> *Article 23: Indigenous peoples ... have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.*

Poverty and inequality

50. Absolute deprivation (poverty) and relative deprivation (inequality) are both strongly correlated with increased rates of addiction including to alcohol [29, 30]. In relation to this fact:

- in remote areas across Australia both poverty and inequality are worsening for Aboriginal people, with Aboriginal incomes falling and the income gap to non-Indigenous people widening [31];
- Aboriginal people are disproportionately dependent on Centrelink entitlements [32] which are inadequate to meet the needs of families and their children, especially in remote areas where the cost of living is much higher, especially for food [33].

Intergenerational trauma and the protective effects of culture

51. The historical and ongoing experience of colonisation for Aboriginal people is now recognised as resulting in 'intergenerational trauma' whereby traumatic experiences

> *… can be transferred from the first generation of survivors that have experienced (or witnessed) it directly in the past to the second and further generations of descendants of the survivors … this intergenerational trauma … is passed from adults to children in cyclic processes as 'cumulative emotional and psychological wounding' [34]*

52. Culture and spirituality are important in addressing intergenerational trauma through supporting resilience, positive social and emotional wellbeing, and living a life free of addiction to alcohol and drugs [35]. In addition, services provided to populations carrying a large burden of trauma need to have the skills and resources to recognise the different ways that unresolved trauma can manifest (for example, in mental health issues including

suicide, addiction, or violence) and be able to address presenting issues in a way that promotes healing [34].

Recommendation 7. *That any approach to addressing alcohol-related harm in Aboriginal communities must be based upon the rights to self-determination of Aboriginal peoples as established under international agreements to which Australia is a signatory, including the United Nations Declaration on the Rights of Indigenous Peoples.*

Recommendation 8. *That the Australian Government commits to reducing poverty and inequality as a key way to prevent the addiction to alcohol which, in many Aboriginal families, underlies the poor developmental outcomes of children, including through FASD. This commitment should include an increase all Centrelink entitlements to the poverty line for all participants, with an additional loading on such payments for those in remote or very remote areas to address significantly higher costs of living.*

Recommendation 9. *That all programs for preventing, diagnosing or treating alcohol and other drug issues where there are significant numbers of Aboriginal people in the community be founded on a positive attitude to Aboriginal culture and ways of being, and resourced to be trauma-informed and healing-focused.*

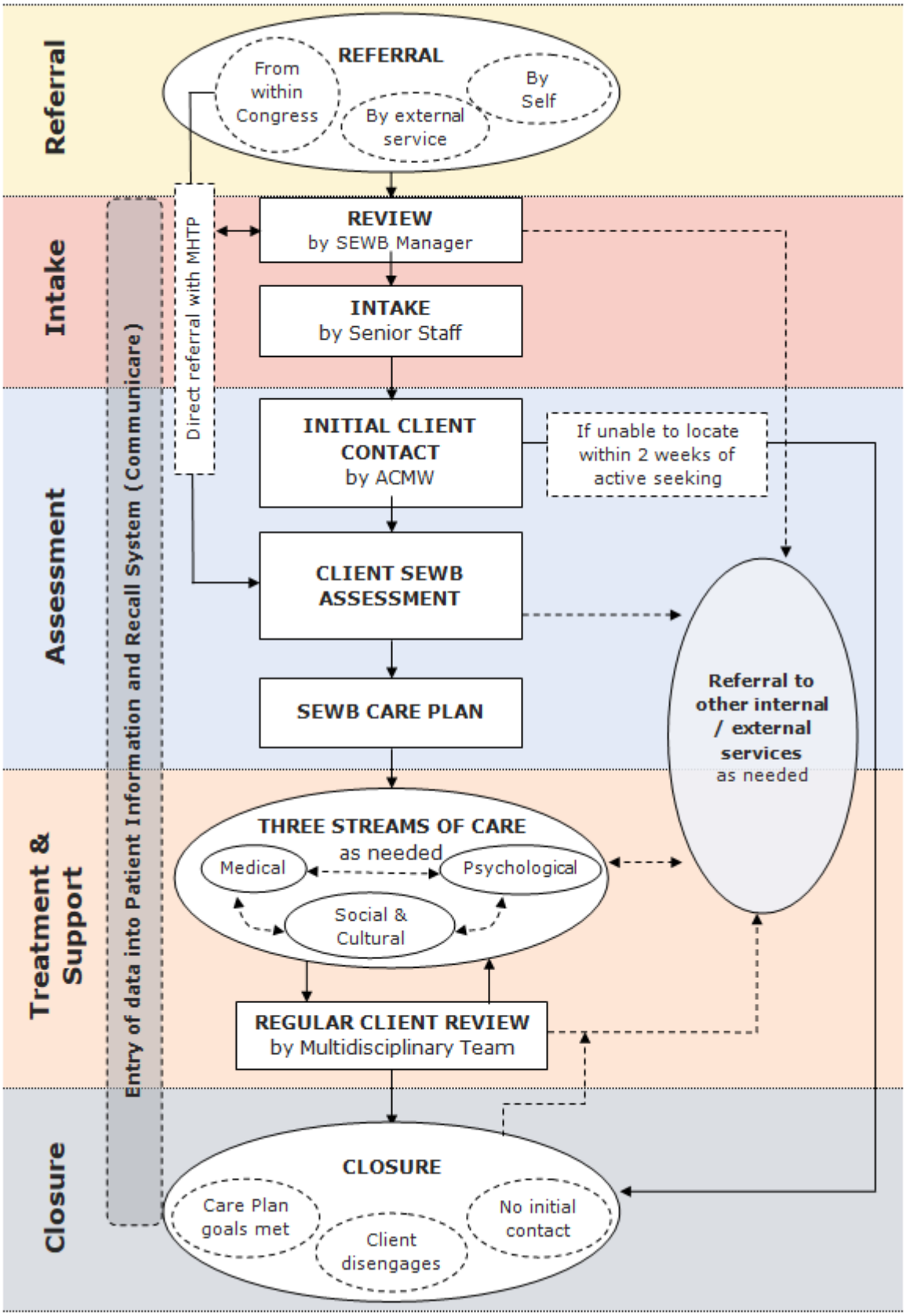
References

1. Australian Institute of Health and Welfare. *Alcohol, tobacco & other drugs in Australia*. 2024 [cited (Web report, updated 10 Jul 2024); Available from: https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/about.
2. Miller, P., et al., *Learning from alcohol (policy) reforms in the Northern Territory (LEARNT): protocol for a mixed-methods study examining the impacts of the banned drinker register.* BMJ Open, 2022. **12**(4): p. e058614.
3. Australian Institute of Health and Welfare. *Alcohol and other drug treatment services in Australia annual report*. 2024 [cited (Web report, updated 14 June 2024); Available from: https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/.
4. National Drug Research Institute (NDRI) and Canadian Institute for Substance Use Research (CISUR). *Australian alcohol-attributable harm visualisation tool*. 2023; Available from: https://ndri.curtin.edu.au/aat/index.php.
5. d'Abbs P, et al., *The Grog Mob: lessons from an evaluation of a multi-disciplinary alcohol intervention for Aboriginal clients.* Aust N Z J Public Health, 2013. **37**(5): p. 450-6.
6. Stearne A, *Central Australian Aboriginal Congress Safe & Sober Support Service: Final evaluation report*. 2012, National Drug Research Institute, Curtin University: Perth.
7. Clifford, S., et al., *A historical overview of legislated alcohol policy in the Northern Territory of Australia: 1979–2021.* BMC Public Health, 2021. **21**(1): p. 1921.
8. Northern Territory Government. *Northern Territory Alcohol Policies and Legislation Reform*. 2019; Available from: https://alcoholreform.nt.gov.au/.
9. NT Department of Industry Tourism and Trade. *Wholesale alcohol supply data*. 2022; Available from: https://industry.nt.gov.au/economic-data-and-statistics/business/wholesale-alcohol-supply/wholesale-alcohol-supply-data.
10. Taylor, N., et al., *The impact of a minimum unit price on wholesale alcohol supply trends in the Northern Territory, Australia.* Aust N Z J Public Health, 2021. **45**(1): p. 26-33.
11. Morgan A and Boxall H, *Economic insecurity and intimate partner violence in Australia during the COVID-19 pandemic*, in *search report, 02/2022*. 2022, ANROWS: Sydney.
12. Central Australian Regional Controller, *Proposed Actions for Alcohol Related Harm in Central Australian Communities*. 1 February 2023, Northern Territory Government.
13. Clifford, S., et al., *A historical overview of legislated alcohol policy in the Northern Territory of Australia: 1979-2021.* BMC Public Health, 2021. **21**(1): p. 1921.
14. Frontier Economics, *Evaluation of Minimum Unit Price of Alcohol in the Northen Territory: A report prepared for the Northern Territory Department of Health*. 2022.
15. Northern Territory Government. *NTG Open Data Portal*. 2024; Available from: https://data.nt.gov.au/.
16. Olsen A and Lovett R, *Existing knowledge, practice and responses to violence against women in Australian Indigenous communities: State of knowledge paper*. 2016, Australia's National Research Organisation for Women's Safety (ANROWS): Sydney.
17. Jacob A, Boseto F, and Ollapallil J, *Epidemic of stab injuries: an Alice Springs dilemma.* ANZ Journal of Surgery, 2007. **77**(8): p. 621-625.
18. Northern Territory Police Force. *Northern Territory Crime Statistics*. 2022; Available from: https://www.pfes.nt.gov.au/police/community-safety/nt-crime-statistics.
19. Cripps K, *Could the Senate inquiry into missing and murdered Indigenous women and children prevent future deaths?*, in *The Conversation*. 2022.
20. Serpell B, Sullivan T, and Doherty L, *Homicide in Australia 2019-20*, in *Statistical Report no. 39*. 2022, Australian Institute of Criminology: Canberra.
21. Australian Bureau of Statistics (ABS), *Causes of Death, Australia, 2021*. 2021, Commonwealth of Australia: Canberra.
22. Pritchard E, Mugavin J, and Swan A, *Compulsory treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*. 2007, Turning Point Alcohol and Drug Centre : Australian National Council on Drugs: Canberra.
23. Babor T and Caetano R, *Alcohol: no ordinary commodity*. 2010, Oxford: Oxford University Press.

24. Ferdinand A, Paradies Y, and M. Kelaher, *Mental Health Impacts of Racial Discrimination in Victorian Aboriginal Communities: The Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey*. 2012, The Lowitja Institute: Melbourne.
25. Zubrick S, et al., *The Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people*. 2005, Perth: Curtin University of Technology and Telethon Institute for Child Health Research.
26. Langton M, et al., *Too Much Sorry Business: The Report of the Aboriginal Issues Unit of the Northern Territory*, in *Royal Commission Into Aboriginal Deaths in Custody* 1991: Adelaide.
27. Wild R and Anderson P, *Little Children are Sacred: Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*. 2007, Northern Territory Government: Darwin.
28. United Nations. *United Nations Declaration on the Rights of Indigenous Peoples*. 2007; Available from: https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html.
29. Wilkinson, R. and M. Marmot, eds. *The Social Determinants of Health The Solid Facts*. 2003, World Health Organization.
30. Baum F, *The new public health (third edition)*. 2nd ed. 2007, Oxford: Oxford Univeristy Press.
31. Markham F and Biddle N, *Income, poverty and inequality*. 2018, Centre for Aboriginal Economic Policy Research,: Canberra.
32. Australian Bureau of Statistics (ABS). *4714.0 - National Aboriginal and Torres Strait Islander Social Survey, 2014-15*. 2016 2 February 2017]; Available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4714.02014-15?OpenDocument#Publications.
33. Northern Territory Council of Social Services (NTCOSS), *Cost of Living Report*. 2019, NTCOSS: Darwin.
34. Atkinson J, *Trauma-informed services and trauma-specific care for Indigenous Australian children*. 2013, Australian Institute of Health and Welfare & Australian Institute of Family Studies: Canberra / Melbourne.
35. Dudgeon P, Milroy H, and Walker R, eds. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (2nd Edition)*. 2014, Commonwealth of Australia: Canberra.

Attachment A: Client care pathways in the 'three streams' model

Central Australian Aboriginal Congress' provision of integrated three streams of care within a primary health care setting for clients with alcohol and other drug issues follows five stages.



Stage 1: Referral

- internal referrals on the principle of 'no wrong door' for clients to access needed services
- external referrals from other Aboriginal organisations (e.g. residential treatment) of mainstream organisations (e.g. hospitals)
- self-referrals

Congress doctors may also, with the agreement of their client, book them directly into a psychologist appointment with a Mental Health Treatment Plan (MHTP), bypassing the usual intake and initial client contact processes (see below) although they are still reviewed by SEWB Manager to check appropriateness of referral and program coding.

Stage 2: Review and Intake

Review by SEWB Manager

- review of referrals to ensure appropriate for scope of services offered and referral to other internal / external service providers if needed
- follow up of incomplete referrals
- allocation of client treatment to funding program to allow for reporting and acquittal of government funding

Intake by multidisciplinary team of senior staff

- multidisciplinary assessment to determine the needs, cultural context, history and risk assessment of the client
- allocation of client to a primary care giver (psychologist, Aboriginal Care Management Worker, or social worker) taking into account client needs and availability / skill set of practitioners

Primary care giver provides case management as needed for the client for the period they are receiving care.

Stage 3: Assessment and Care Planning

Initial Client Contact by ACMW or other Aboriginal staff

- initial contact for those clients who are marginalised and may have difficulty initiating contact themselves to begin the process of social / cultural support or to encourage and support the client to access other services
- initial contact with clients to take place within one week of their allocation during the intake process
- if no contact is able to be established within two weeks, then case to be reviewed for closure

Client consent and assessment by primary care giver

- client consent to treatment and for appropriate sharing of information on a confidential basis amongst the SEWB team
- client assessment using a semi structured interview approach to complete holistic assessment tool developed within Congress. Includes:
    - a suicide / self-harm risk assessment
    - a violence assessment
- client assessment may also include use of
    - *Here and Now Aboriginal Assessment (HANAA)*
    - *Audit-C* where alcohol indicated as an issue
    - *K5* to provide a broad measure of people's social and emotional well-being

- *Drug Use Disorders Identification Test (DUDIT)* where other drugs indicated as an issue

Client assessment may occur over multiple sessions and involve further, more specialized (e.g. neuropsychological) assessments as needed

SEWB Care Plan developed by client / primary care giver

- care plan developed to operationalise client goals and identify who is involved in care (goals, actions, responsibilities, and review dates)
- care plans stored on Client Information System with permissions to restrict access to sensitive information

Stage 4: Treatment and Support

Provision of three streams of care by multidisciplinary team

- Treatment and support provided to meet client goals:
  - Social and Cultural support
  - Psychological therapy
  - Medical treatment
- referrals to other internal / external service providers as needed
- case meetings held with other agencies as needed

Regular client review by multidisciplinary team

- weekly case-management meetings of multidisciplinary teams to review client needs and progress against care plan
- aim to consider each client every three weeks
- high risk clients prioritized
- cases for potential closure reviewed

Stage 5: Closure

Formal case closure by SEWB Manager

- On advice of review where
  - client did not commence treatment and support (e.g. could not be contacted within two weeks of allocation)
  - client declined to engage in service following referral
  - treatment and support completed or no further support is required
  - client moves out of service area (includes referral to service providers in new area where possible)
- Important to manage risk and ensure staff resources able to be allocated to engaged clients requiring care

[1] Available: https://www.closingthegap.gov.au/national-agreement