
The Parliament of the Commonwealth of Australia

Alcohol, hurting people and harming communities

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

**House of Representatives
Standing Committee on Indigenous Affairs**

June 2015
Canberra

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Foreword

The consumption of alcohol at high risk levels is a national issue, however, the focus of this inquiry is the harmful use of alcohol in Aboriginal and Torres Strait Islander communities.

Many reports and studies have recommended stemming the flow of alcohol to address the problems, but usually these works do not analyse why a person drinks at levels which cause them and their loved ones harm. The social and economic determinants of harmful alcohol use such as unemployment, poor housing, racism, trauma, poor education and peer pressure mean that Aboriginal and Torres Strait Islander communities are overly impacted by the harm caused by alcohol consumed at high levels.

A recent Amnesty reports note that it costs \$440,000 per year to keep one young person in detention in Australia. This report recommends that justice reinvestment strategies should redirect these resources to overcoming the deprivation and despair in so many Aboriginal and Torres Strait Islander communities.

This report addresses strategies and treatments found to help in addressing the harmful use of alcohol. Community led solutions are always the key to uptake and success. Unfortunately slow government processes, for example approving community produced alcohol management plans and the short length of project funding often frustrates community initiatives.

The magnitude of the problem caused by high risk consumption of alcohol is often hidden by the lack of collection of useful data for example at the time of hospital admissions, when children are put into out of home care because of their neglect, when people are incarcerated because of alcohol related crime and when children are born with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Spectrum Disorder (FASD) at some of the highest rates in the world.

The committee found examples of the world's best practice at places like Groote Eylandt and Fitzroy Crossing. These communities, led by women's initiatives,

have demonstrated courage and determination to tackle alcohol harm to provide a safe environment for their families and community. The committee commends them and hopes that their strategies can be used as examples of a way forward for other communities.

FASD or FAS is creating generations of children whose brain damage will reduce their potential to live lives full of promise and well-being. The rates of FAS and FASD in some Aboriginal and Torres Strait Islander communities in Australia are amongst the highest in the world and yet FAS and FASD are not recognised as a disability for many social security allowances and payments. The lack of knowledge about, and recognition of FASD and FAS extends beyond the failure to have it officially recognised for social security and NDIS purposes, it also needs to be understood in schools, the criminal justice system and in the health sector.

The committee found that impacts of alcohol on children in communities represents a national tragedy as it is manifested in children growing up with fathers, and increasingly mothers, who are incarcerated, as the children's abuse and neglect leads to the need for out of home care at record levels, missed schooling and too often ultimately become young alcohol addicts or abusers of other illicit substances.

This committee urges adoption of these recommendations as a matter of urgency given the extent of harm and intergenerational afflictions when alcohol is consumed at such high risk levels.

The Hon Dr Sharman Stone MP
Chair



Membership of the Committee

Chair The Hon Dr Sharman Stone MP

Deputy Chair The Hon Mr Warren Snowdon MP

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	Mr Andrew Giles MP	Mr Graham Perrett MP
	Mr Bert van Manen MP	Ms Melissa Price MP
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Terms of reference

The Committee will inquire into and report on the harmful use of alcohol in Aboriginal and Torres Strait Islander communities, with a particular focus on:

- patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders
- the social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities
- 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
- the implications of Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders being declared disabilities
- best practice treatments and support for minimising alcohol misuse and alcohol-related harm
- best practice strategies to minimise alcohol misuse and alcohol-related harm, and
- best practice identification to include international and domestic comparisons.



List of abbreviations

AA	Alcoholics Anonymous
AADANT	Association of Alcohol and other Drug Agencies Northern Territory
ABAC	Alcohol Beverages Advertising Code
ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ACCHS	Aboriginal Community Controlled Health Services
ACEM	Australasian College for Emergency Medicine
ADAC	Aboriginal Drug and Alcohol Council (SA) Inc.
ADF	Australian Drug Foundation
AHA	Australian Hotels Association
ADS	Alcohol and Drug Service
AHCWA	Aboriginal Health Council of Western Australia
AHMRC	Aboriginal Health and Medical Research Council of New South Wales
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
AMP	Alcohol Management Plan

AMSANT	Aboriginal Medical Services Alliance Northern Territory
AMT	Alcohol Mandatory Treatment
AOD	Alcohol and other drugs
APO NT	Aboriginal Peak Organisations of the Northern Territory
APY	Anangu Pitjantjatjara Yankunytjatjara
ARBD	Alcohol-related birth defects
ARND	Alcohol-related neurodevelopmental disorders
ATSIA committee	House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs
BDR	Banned Drinkers Register
BRADAAG	Barkly Region Alcohol and Drug Abuse Advisory Group
CAAAPU	Central Australian Aboriginal Alcohol Programmes Unit
CAAC	Central Australian Aboriginal Congress
CAALAS	Central Australian Aboriginal Legal Aid Service
CAAPS	Council for Aboriginal Alcohol Program Services
CATSINM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CDEP	Community Development Employment Projects
CLANT	Criminal Lawyers Association of the Northern Territory
CLC	Central Land Council
COAG	Council of Australian Governments
DASA	Drug and Alcohol Services Association
DNA	Deoxyribonucleic acid
Drug Survey	National Drug Strategy Household Survey
DSP	Disability Support Pension

EBP	Evidence based practices
FARE	Foundation for Alcohol Research and Education
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorder
FESP	Family Engagement and Support Program
Health Survey	National Aboriginal and Torres Strait Islander Health Survey
Henry Tax Review	2010 Australia's Future Tax System report
HPF	Aboriginal and Torres Strait Islander Health Performance Framework
HRLC	Human Rights Law Centre
IHS	Indian Health Service
IRAG	Intervention Rollback Action Group
KALACC	Kimberley Aboriginal Law and Culture Centre
LSP	Liquor Supply Plan
MWRC	Marninwarntikura Fitzroy Women's Resource Centre
NAAA	National Alliance for Action on Alcohol
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSILS	National Aboriginal and Torres Strait Islander Legal Services
NCETA	National Centre for Education and Training on Addiction
NCNS	Nepean Community and Neighbourhood Services
NDRI	National Drug Research Institute
NHMRC	National Health and Medical Research Council
NIDAC	National Indigenous Drug and Alcohol Committee
NNADAP	National Native Alcohol and Drug Abuse Program

NOFASD	National Organisation for Fetal Alcohol Spectrum Disorders
NTPA	Northern Territory Police Association
PAAC	People's Alcohol Action Coalition
PFAS	Partial Fetal Alcohol Syndrome
PHAA	Public Health Association of Australia
PM&C	Department of the Prime Minister and Cabinet
PTSD	Post Traumatic Stress Disorder
QAIAS	Queensland Aboriginal and Torres Strait Islanders Corporation for Alcohol and Drug Dependence Services
QAIHC	Queensland Aboriginal and Islander Health Council
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RFFADA	Russell Family Fetal Alcohol Disorders Association
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SEWB	Social and emotional well-being
Social Survey	National Aboriginal and Torres Strait Islander Social Survey
TBLs	Temporary Beat Locations
TEWLS	Top End Women's Legal Service
VAADA	Victorian Alcohol and Drug Association
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
WANADA	Western Australia Network of Alcohol and other Drug Agencies
WHO	World Health Organisation



List of recommendations

Social and economic determinants of harmful alcohol use

Recommendation 1

That the Commonwealth Government, states and territories, at the late 2015 Council of Australian Governments (COAG) meeting, place harmful impacts of alcohol on the agenda for coordinated action. This should:

- formally recognise the social and economic determinants of harmful uses of alcohol namely poverty, mental health, unemployment, an ongoing sense of grief and loss, alienation, boredom, cultural acceptance of drunkenness, ease of access and cost of alcohol, peer pressure 'to drink' and epigenetics in some Aboriginal and Torres Strait Islander communities and for some individuals
- ensure that within each specific target of Closing the Gap in Indigenous Disadvantage, the impact of alcohol is recognised in all strategies and targets including addressing the social and economic determinants of high risk drinking, and
- develop a framework, methodology and resource allocation for the collection and publication of a national standardised wholesale alcohol sales dataset. The framework and relevant agreements should be in place by December 2015 with comprehensive data available no later than February 2017.

Recommendation 2

That all strategies developed or funded by the Commonwealth or other governments are developed in partnership with the relevant Aboriginal and Torres Strait Islander peoples and/or their organisations.

Health and alcohol-related harm

Recommendation 3

That the Commonwealth develops a public awareness campaign, highlighting the risks of alcohol consumption, focussing on:

- where to find help to reduce harmful drinking
- where to find help to reduce alcohol related violence, and
- providing information on other diseases associated with risky drinking.

The campaign should have sections targeted for populations in the criminal justice system and the education system.

Best practice strategies to minimise alcohol misuse and alcohol-related harm

Recommendation 4

That the committee recommends:

- the introduction of a national minimum floor price on alcohol, and
- prompt consideration be given to the recommendations of the Henry Tax Review on volumetric tax.

Recommendation 5

That the states and territories conduct detailed analysis of any demand increase for liquor licences particularly in areas of high risk drinking, with a view to moving towards a risk-based licencing system similar to that of New South Wales.

Recommendation 6

That the Commonwealth takes steps to ensure a nationally consistent and coordinated approach to alcohol advertising, including:

- Banning alcohol advertising during times and in forms of the media which may influence children
- Banning alcohol sponsorship of sporting teams and sporting events, including but not limited to those in which children participate or may be involved, and
- That the Australian Communication and Media Authority change the Commercial Television Code of Practice to ensure that alcohol is not able to be advertised before 8.30pm and that no exemptions are given for alcohol promotion during sport broadcasting.

Recommendation 7

That governments at all levels:

- prioritise Aboriginal and Torres Strait Islander community driven strategies to reduce the harmful effects of alcohol
- ensure that communities are empowered to develop the strategies that will work for their communities, and
- cooperate and facilitate any work in Aboriginal and Torres Strait Islander communities which aims to change the liquor trading hours in their community.

Community Alcohol Management Plans and other community driven strategies need to be reviewed and processed within a maximum of a six month period, including where any alterations are recommended.

The current backlog of Community Alcohol Management Plans in the Department of Prime Minister and Cabinet need to be cleared by January 2016.

Recommendation 8

That the Northern Territory Government re-introduce the Banned Drinker's Register and set up a comprehensive data collection and evaluation program which monitors criminal justice, hospital and health data.

Best practice alcohol abuse treatments and support**Recommendation 9**

That the Commonwealth re-establish the National Indigenous Drug and Alcohol Committee.

Recommendation 10

That the Commonwealth develop a protocol for the recording and sharing of effective, evidence-based practices in Aboriginal and Torres Strait Islander communities, in particular such practices that have relevance to Aboriginal and Torres Strait Islander communities. This protocol should be available by December 2016.

Recommendation 11

That where the Commonwealth funds Aboriginal and Torres Strait Islander alcohol treatment and support programs, these are funded over a longer cycle for at least four years, particularly for well-established and successful programs.

Recommendation 12

That the Commonwealth and key Aboriginal and Torres Strait Islander groups ensure access to training and career pathways for alcohol treatment and support workers. The employment conditions should be fair and equitable.

Recommendation 13

That the Department of the Prime Minister and Cabinet ensure that a full range of evidence-based, best practice treatments are available in order to meet the needs of all Aboriginal and Torres Strait Islander people, regardless of where they live. The treatment services should provide for families, follow-up services, and include detoxification and rehabilitation.

Prevention Strategies**Recommendation 14**

That Commonwealth, states and territories, through the COAG process implement justice reinvestment to reduce the number of Aboriginal and Torres Strait Islander people incarcerated as a result of harmful alcohol use.

Recommendation 15

That the Northern Territory Government prioritise the resourcing of voluntary alcohol treatment and rehabilitation programs in place of the Alcohol Mandatory Treatment program.

FAS and FASD**Recommendation 16**

That the Commonwealth, as a matter of urgency, increase its efforts to ensure that consistent messages:

- about the risks of consuming any alcohol during pregnancy, and
 - about the importance of supporting women to abstain from alcohol when planning pregnancy, when pregnant or breastfeeding
- to reduce the risk of Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorder are provided to the whole community.

Recommendation 17

That the Commonwealth, as a priority, ensure that the National FASD Diagnostic Tool and accompanying resource are released without any further delays.

Recommendation 18

That states' and territories' teacher training, education and in-service systems provide:

- information and education on alcohol and drug exposed children's behaviour, and
- details of the impact on the child's mental health and their achievement at school.

Recommendation 19

That the Commonwealth:

- include FAS and FASD as recognised disabilities for Carer's allowance to allow fast-tracking of the application
- include FAS and FASD as a recognised disabilities in the Better Start for Children with a Disability initiative, and
- include FASD in the operational Guidelines for the National Disability Insurance Agency.

Recommendation 20

That the Commonwealth, in consultation with the FASD Technical Network, include in the appropriate table in the Social Security Tables for the Assessment of Work-related Impairment for Disability Support Pension Determination 2011:

- A person with Fetal Alcohol Spectrum Disorder who does not have an IQ below 80 should be assessed under this Table.

Recommendation 21

That the Commonwealth, in consultation with the FASD Technical Network, and relevant organisations from the criminal justice system:

- develop a model definition for cognitive impairment, and
- conduct a review of Commonwealth law and policy to identify where eligibility criteria need to change to ensure that people with FAS and FASD and other cognitive impairments can be included.

Determining patterns of supply and demand**Recommendation 22**

That the Australian Institute of Health and Welfare review and update the methodology and instrument of the National Drug Household Survey to obtain reliable estimates on Aboriginal and Torres Strait Islander and non-Indigenous illicit drug and alcohol use. These changes should be implemented for the conduct of the 2017 survey.

Recommendation 23

That the Australian Bureau of Statistics conducts a review of the relevant sections of the National Aboriginal and Torres Strait Islander Social Survey and the National Aboriginal and Torres Strait Islander Health Survey to ensure international best practice is adopted in the instrument and conduct of surveys on alcohol consumption.

Social and economic determinants of harmful alcohol use

Introduction

- 1.1 The National Health and Medical Research Council (NHMRC) state that the reasons for drinking are likely to be closely related to age, culture and socioeconomic status.¹
- 1.2 The committee found that while the harmful use of alcohol is a societal issue that can profoundly affect any family, regardless of cultural or ethnic background, alcohol consumption causes more harm amongst poor and socially marginalised populations.²
- 1.3 This chapter examines the evidence around social and economic determinants of high risk alcohol consumption such as health, employment, education and trauma.

Social and economic determinants

- 1.4 The social determinants of health include the conditions in which people are born, grow, live, work and age.³

1 National Health and Medical Research Council (NHMRC), *Australian guidelines to reduce health risks from drinking alcohol*, 2009, p. 14.

2 World Health Organisation (WHO), *Global status report on alcohol and health*, 2014, WHO Press, Geneva, p. 9.

3 Department of Health and Human Services (Tasmania), *Working in health promoting ways – a strategic framework for DHHS 2009-2012*, 2010, p. 25.

1.5 The World Health Organisation (WHO) states:

Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.⁴

1.6 Research published by the Australian Institute of Health and Welfare (AIHW) found the social and economic determinants relevant to understanding health inequities between Aboriginal and Torres Strait Islander people and non-Indigenous people in Australia included:

- educational attainment
- connection to family, community, country and culture
- employment
- housing
- racism, and/or discrimination, and
- interaction with government systems, including: access and treatment within the health system and contact with the criminal justice system.⁵

1.7 Where an individual lives can have a significant effect on their health and quality of life. The Ministerial Council on Drug Strategy noted in 2003 that Aboriginal and Torres Strait Islander people, especially those living in rural or remote areas, carry a greater burden of disadvantage in health, employment, education, incarceration levels and public health infrastructure, when compared with the non-Indigenous population.⁶

1.8 The Aboriginal Peak Organisations of the Northern Territory (APO NT) reports that international and Australian research clearly demonstrates that health in general, mental health and substance misuse are affected by social and structural factors such as housing, education, employment, income, transport and access to supportive social networks.⁷

1.9 The Queensland Government reports that the experience in Queensland is consistent with that occurring in other jurisdictions in that the harmful

4 WHO, 'The Determinants of Health' <<http://www.who.int/hia/evidence/doh/en/>> viewed 3 November 2014.

5 Australian Institute of Health and Welfare (AIHW), *What works? A review of actions addressing the social and economic determinants of Indigenous Health*, 2013, pp. 4-9.

6 Ministerial Council on Drug Strategy, *National Drug Strategy – Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009*, p. 18.

7 Aboriginal Peak Organisations of the Northern Territory (APO NT), *Submission 72*, p. 7.

alcohol use is determined by a complex range of inter-related issues including:

- poor educational attainment
- parenting skills and effective supervision of teenagers
- low employment and economic participation rates, and
- lack of and access to culturally capable health and rehabilitation services.⁸

- 1.10 APO NT believes that policies or legislation aimed at tackling alcohol addiction will not have long-lasting effects if the policies do not also address the social determinants of high risk drinking including housing, education, health and control.⁹

Educational Attainment

- 1.11 A range of submitters to the inquiry support the view that educational attainment is a key factor influencing a person's health.¹⁰
- 1.12 The APO NT quotes strong evidence about the fundamental importance of education in underpinning the future health, wellbeing and economic security of individuals, families and communities.¹¹
- 1.13 Educational attainment has been observed to have a protective effect on reducing high risk alcohol consumption. The Australian Bureau of Statistics (ABS) notes that for Aboriginal and Torres Strait Islander adults, there are lower rates of binge drinking with higher levels of educational attainment.¹²
- 1.14 The ABS notes that although there are different patterns of association between education and binge drinking across Aboriginal and Torres Strait Islander people and non-Indigenous people, the rates of binge drinking for Aboriginal and Torres Strait Islander adults remain well above those for non-Indigenous adults across all levels of educational attainment.¹³
- 1.15 The ABS also makes the point that while there is an association between education and health risk behaviours, higher rates of risks to health

8 Queensland Government, *Submission 98*, p. 7.

9 APO NT, *Submission 72*, p. 12.

10 See for example People's Alcohol Action Coalition (PAAC), *Submission 7.1*, p. 8; The Lyndon Community, *Submission 16*, p. 6; The Victorian Health Promotion Foundation, *Submission 49*, p. 3; The Foundation for Alcohol Research and Education (FARE), *Submission 83*, p. 22; The Wirrpanda Foundation, *Submission 17*, p. 2.

11 APO NT, *Submission 72*, Attachment 4, p. 8.

12 Australian Bureau of Statistics (ABS), 4102.0 - Australian Social Trends, Mar 2011

13 ABS, 4102.0 - Australian Social Trends, Mar 2011

behaviours among Aboriginal and Torres Strait Islander adults may also be attributable to a range of other factors,¹⁴ not just education access and attainment.¹⁵

- 1.16 The Department of the Prime Minister and Cabinet (PM&C) notes the effect that alcohol abuse can have on the education of Aboriginal and Torres Strait Islander children. They contend that it is unrealistic and unfair to think that children are able to go to school and concentrate and learn if:
- they have not eaten because there is no money for food, because family funds have been spent on alcohol
 - they are tired because of sleep disturbance when parents, relatives or community members argue and fight through the night because of alcohol-fuelled anger and violence, or they roam the streets at night to avoid the anger and violence at home
 - they may have been the victim of alcohol-related violence
 - their parents are suffering the effects of alcohol use and are unable to get them to school, or
 - they have been abusing alcohol themselves.¹⁶

Connection to culture and country

- 1.17 Connection to country is of great importance to many Aboriginal and Torres Strait Islander lives. In addition, family and kinship ties are of great importance to Aboriginal and Torres Strait Islander communities.¹⁷
- 1.18 Ms Kirstie Parker the Co-Chair of the National Congress of Australia's First Peoples notes:

Culture is really central to all Aboriginal and Torres Strait Islander people. It does not matter where they live. Of course we see a lot of programs that are dedicated to remote areas but more Aboriginal and Torres Strait Islander people live in urban and regional areas than not. The issue is that culture cannot happen in a vacuum. There are things that are important to people not

14 The ABS notes that in examining the link between education and socio-economic and health outcomes, it is important to recognise that the relationships can be complex and it is difficult to infer causal associations from household surveys.

15 ABS, 4102.0 - Australian Social Trends, Mar 2011

16 Department of Prime Minister and Cabinet (PM&C), *Submission 102*, p. 4.

17 Queensland Government, *Respecting Cultures*, <<http://www.qld.gov.au>> viewed 13 May 2015

embracing their culture but feeling strongly connected to their culture.¹⁸

- 1.19 Milliya Rumurra Aboriginal Corporation in Broome emphasise the protective effect that functioning family connectedness can have in the prevention of excessive alcohol use, family violence and disconnectedness from community and culture. They state:

When families remain connected, there is a greater understanding and practise of respect (self, others and community). Children are more likely to have supportive environments; receive appropriate nurturing and are more likely to engage with the education system and the wider mainstream community.¹⁹
- 1.20 The Kimberley Aboriginal Law and Culture Centre (KALACC) contend that there is solid evidence of a correlation between positive social outcomes and supportive activities which encourage culture, language and being on country.²⁰
- 1.21 Aboriginal and Torres Strait Islander organisations have developed philosophies and treatment regimes which emphasise connection with culture and country. The Yiriman project of KALACC is a diversionary program for Aboriginal and Torres Strait Islander youth, which immerses young people in a cultural framework and helps them to build community relationships and capacity. Its primary means of engaging with youth is through intensive cultural camps in the bush.²¹
- 1.22 Similarly, Bushmob in Alice Springs run a residential program for young people aged 12 to 24 who may be affected by drugs, alcohol or petrol/solvent sniffing. It has a treatment focus on relationship building and 'getting back to country'.²²
- 1.23 The Aboriginal Health Council of Western Australia (AHCWA) notes that, in particular, intergenerational social determinants which negatively affect women and children need to be addressed to encourage positive, emotional and cultural wellbeing.²³
- 1.24 The Northern Territory Police Association (NTPA) draw attention to the 'Healthy Country' guiding principles where rural Aboriginal and Torres Strait Islander communities manage their land sustainably for economic

18 Ms Kirstie Parker, Co-Chair, National Congress of Australia's First Peoples, *Committee Hansard*, Sydney, 5 September 2015, p. 9.

19 Milliya Rumurra Aboriginal Corporation, *Submission 114*, p. 4.

20 Kimberley Aboriginal Law and Culture Centre (KALACC), *Submission 2*, Attachment 2, p. 5.

21 KALACC, *Submission 2*, p. 5.

22 Bushmob, *Submission 12*, p. 1.

23 Aboriginal Health Council of Western Australia (AHCWA), *Submission 69A*, p. 1.

and social outcomes.²⁴ They note that these communities use work and cultural opportunities to create an environment where alcohol has no, or a negligible place.²⁵

- 1.25 There is evidence that strong positive cultural environments can have a protective effect. KALACC reports that strength in one's own cultural identity helps protect against and treat family dysfunction, violence, child neglect and the health consequences of high risk drinking.²⁶

Employment and employment opportunities

- 1.26 Having meaningful employment is important for physical and mental health and participating in society as well as providing financial independence and improving living standards. As well as individual benefit, there is also a benefit to a community to have its members in employment.²⁷
- 1.27 The committee received evidence that some communities identified lack of employment opportunities, boredom and lack of recreational activities in rural communities as contributing factors in abuse of alcohol, tobacco and other drugs by young people.²⁸
- 1.28 PM&C states that one of the priorities of the current government is to get Aboriginal and Torres Strait Islander people into jobs. They contend that too often education and training programs provide 'training for training's sake'.²⁹
- 1.29 The 2014 Closing the Gap Report states 'No progress has been made against the target to halve the employment gap within a decade'.³⁰
- 1.30 PM&C highlight how unrealistic it is for adults to gain and keep a job if:
- they are subjected to alcohol-fuelled violence and disruption in the home and/or the community continually
 - they have been the victim of alcohol-related violence
 - they are suffering the effects of alcohol use themselves

24 Northern Territory Police Association (NTPA), *Submission 27*, p. 19.

25 NTPA, *Submission 27*, p. 19.

26 KALACC, *Submission 2*, Attachment B: 'Demonstrating the value of the Yirman Project', p. 86.

27 ABS, 4102.0 - Australian Social Trends, Nov 2013

28 Ministerial Council on Drug Strategy, *National Drug Strategy – Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009*, p. 24.

29 PM&C, *Submission 102*, p. 1.

30 PM&C, *Submission 102*, p. 2.

- they have not been able to gain the knowledge and skills to work because alcohol abuse (either their own or their parents) has prevented them from going to school, or
 - they are unable to secure work because of criminal histories arising from alcohol-fuelled behaviours.³¹
- 1.31 As well as not being able to speak English competently reduces their opportunity to gain employment, Dr Barry Pittock gave evidence that unemployment can lead to a 'culture of poverty', in which people lose self-respect and resort to excessive alcohol use.³²
- 1.32 The Northern Territory Government refers to unemployment and poverty as fundamental determinants of harmful alcohol use and gave evidence that the remoteness of many communities across the Territory also greatly reduces opportunities for people to engage in meaningful, paid employment.³³
- 1.33 The Central Land Council (CLC) states that a lack of real work employment opportunities, coupled with the demise of Community Development Employment Projects (CDEP) has led to more people being idle in Aboriginal and Torres Strait Islander communities and, subsequently, an increase in substance abuse issues.³⁴
- 1.34 Ms Donna Ah Chee from the Central Australian Aboriginal Congress (CAAC) states that unemployment, high levels of alcohol consumption and addictions are related. She believes that reducing harmful alcohol use may assist in addressing high unemployment.³⁵ Dr John Boffa from the People's Alcohol Action Coalition (PAAC) agrees that there is an association between unemployment and harmful alcohol use, but suggests that a range of other factors are also interrelated, meaning that the causal relationships between harmful alcohol use and its determinants are complex and often difficult to determine.³⁶
- 1.35 PM&C also links socioeconomic status and the risk of dependence on alcohol. They note that the *Australian Aboriginal and Torres Strait Islander Health Survey 2012-13* (Health Survey) found that Aboriginal and Torres Strait Islander people who were unemployed were more likely to binge

31 PM&C, *Submission 102*, p. 4.

32 Dr Barry Pittock, *Submission 115*, p. 1.

33 Northern Territory (NT) Government, *Submission 60*, p. 4.

34 Central Land Council (CLC), *Submission 68*, p. 4.

35 Ms Donna Ah Chee, Central Australian Aboriginal Congress (CAAC), *Committee Hansard*, Alice Springs, 31 March 2014, p. 15.

36 Dr John Boffa, Spokesperson, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 15.

drink than those who were employed. However, which condition preceded the other is sometimes difficult to establish.

- 1.36 The Health Survey found that those whose highest year of schooling was Year 10 were more likely to consume alcohol at harmful levels than those who had completed Year 12.³⁷
- 1.37 The CLC notes the lack of employment opportunities in central Australia both within the major centres and in remote communities and considers this one of the significant factors linked to substance abuse.³⁸ They state:
- There is certainly a sentiment among some senior Aboriginal people in central Australia that the demise of CDEP and other employment opportunities has resulted in more people being idle in communities leading to an increase in substance abuse issues.³⁹
- 1.38 Those who have brain damage as a consequence of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Spectrum Disorder (FASD) are also much more likely to find it difficult or impossible to gain or maintain employment.⁴⁰
- 1.39 Groups such as the Wirrpanda Foundation acknowledge lack of employment as an issue and have developed an Indigenous Employment Program, designed to inspire and create opportunities for long-term unemployed people.⁴¹

Housing

- 1.40 The environment and dwelling that a person lives in impacts on health and wellbeing. Housing is a key determinant affecting the poor health and wellbeing of many Aboriginal and Torres Strait Islander people.⁴²
- 1.41 In some urban and remote Aboriginal and Torres Strait Islander communities of the Northern Territory, Western Australia, Queensland and South Australia there are housing shortages, homelessness, dilapidation of housing and significant overcrowding.⁴³
- 1.42 Ms Toni Vine-Bromley from NT Shelter notes that overcrowding has a negative impact on childhood development, educational achievement,

37 PM&C, *Submission 102*, p. 7.

38 CLC, *Submission 68*, p. 4.

39 CLC, *Submission 68*, p. 4.

40 Ms Prue Walker, *Submission 86*, p. 11.

41 The Wirrpanda Foundation, *Submission 17*, p. 3.

42 Ms Toni Vine Bromley, Executive Officer, NT Shelter, *Committee Hansard*, Darwin, 2 April 2014, p. 6.

43 Ms Vine Bromley, NT Shelter, *Committee Hansard*, Darwin, 2 April 2014, p. 6.

family violence prevention, endemic diseases, participation in the workforce, and family and community wellbeing.⁴⁴

- 1.43 In Tennant Creek there is a strong belief that if housing can be addressed, then there is a better chance of addressing alcohol abuse:

In Tennant Creek there are households of 20 to 30 people. The government spends a lot of money on health promotion and health education. To tell people in a household of 20 or 30 people not to drink, not to smoke, not to do whatever, you are wasting your money. We really have to attack the social determinant if we are to make an impression.⁴⁵

- 1.44 At the Central Australian Alcohol Summit, the interconnections between alcohol and housing were highlighted:

We can't change health status while people are living in overcrowded housing, and all the problems that go with that. Will education on alcohol be effective on those living in unsatisfactory or overcrowded accommodation?⁴⁶

- 1.45 The Top End Women's Legal Service (TEWLS) gave evidence that a lack of available housing can mean victims of domestic violence do not have the option of leaving abusive relationships.⁴⁷

- 1.46 Ms Georgina Bracken from the Tennant Creek Women's Refuge notes that there is a real need for housing support, particularly for vulnerable women, elderly women and children. She explained family members who are desperate for somewhere to stay:

... will eat them out of house and home, move in and wreck the joint. ... they are vulnerable to violence and humbugging.⁴⁸

- 1.47 The problems associated with people coming into towns from remote communities were stated. Visitors may 'live rough' or alternatively they may stay with people who are living in public housing. Ms Vine-Bromley

44 Ms Vine Bromley, NT Shelter, *Committee Hansard*, Darwin, 2 April 2014, p. 6. See also: APO NT, *Submission 72*, Attachment 2, p. 16; Ms Michelle Kudell, Executive Officer, Association of Alcohol and other Drug Agencies NT (AADANT), *Committee Hansard*, Darwin, 2 April 2014, p. 2.

45 Mr Trevor Sanders, General Manager, Anyinginyi Health Aboriginal Corporation, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 14.

46 APO NT, *Submission 72*, Attachment 2, p. 15.

47 Top End Women's Legal Service (TEWLS), *Submission 96*, p. 2.

48 Ms Georgina Bracken, Manager, Tennant Creek Women's Refuge, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 21.

explains that if they create issues when visiting this can put the tenancy of their host at risk.⁴⁹

Racism

- 1.48 Canadian researchers Reading and Wien in their 2013 paper *Health Inequalities and Social Determinants of Aboriginal Peoples' Health* report that groups subjected to racial and other forms of discrimination may experience more negative health outcomes because of the stress of living in a racially charged environment.⁵⁰
- 1.49 When considering the experience of indigenous youth in Canada, research indicates those who experience social exclusion show an increase in alcohol and drug use. Furthermore, 27 per cent of those who experienced racism say that it had some, or a strong, effect on their level of self-esteem.⁵¹
- 1.50 National Congress of Australia's First Peoples state:

Racial discrimination in policies, practices and discourse is a social determinant of alcohol consumption, and its prevalence is counter-productive to strategies to mitigate its harm.⁵²
- 1.51 National Congress of Australia's First Peoples comments that government driven interventions focussing on alcohol consumption by Aboriginal and Torres Strait Islander people may perpetuate negative stereotyping and other tacit forms of racism.⁵³
- 1.52 National Congress of Australia's First Peoples further reports that when undertaking a survey of their members on their attitudes and perceptions of their health and the health system that 39.6 per cent of respondents reported experiencing racial discrimination in their interaction with the health system.⁵⁴
- 1.53 The Public Health Association of Australia – NT Branch asserts that stigmatisation of Aboriginal and Torres Strait Islander people contributes to racism, and is itself a source of Aboriginal and Torres Strait Islander disadvantage.⁵⁵

49 Ms Vine Bromley, NT Shelter, *Committee Hansard*, Darwin, 2 April 2014, p. 6.

50 Reading C, Wien, F *Health Inequalities and Social Determinants of Aboriginal Peoples' Health* 2013, p. 24.

51 Reading C, Wien, F *Health Inequalities and Social Determinants of Aboriginal Peoples' Health* 2013, p. 24.

52 National Congress of Australia's First Peoples, *Submission 97*, p. 6.

53 National Congress of Australia's First Peoples, *Submission 97*, p. 3.

54 National Congress of Australia's First Peoples, *Submission 97*, p. 7.

55 Public Health Association of Australia – NT Branch, *Submission 91*, p. 5.

- 1.54 PAAC note that the experience of racism is associated with increased alcohol consumption.⁵⁶
- 1.55 The Intervention Rollback Action Group (IRAG) refers to a police operation, Operation Leyland, which was introduced in Alice Springs in February 2014. This operation has police stationed outside the ten take-away alcohol outlets to enforce Section 95 of the *NT Liquor Act* which:
- ... allows police to stop people, search them and confiscate alcohol if they have a reasonable suspicion that the alcohol will be taken to a restricted area.⁵⁷
- 1.56 The IRAG notes that Aboriginal and Torres Strait Islander people are routinely stopped by police, even when entering supermarkets which are adjacent to bottle shops, asked to produce ID and questioned about their intention to buy alcohol and where they will be taking it to consume it. Occasionally non-Indigenous people are also stopped, but they are only asked to show identification and never interrogated in the same manner about their intentions.⁵⁸ Aboriginal and Torres Strait Islander people feel stigmatised by this.
- 1.57 The IRAG contends that:
- Operation Leyland has brought out the systemic racism of Stronger Futures, long experienced by people in town camps through police raids, out into display in front of the broader community.⁵⁹
- 1.58 They also note the deep feelings of hurt, shame and anger in the Aboriginal and Torres Strait Islander community as well as the distress of having such open segregation on display.⁶⁰
- 1.59 The IRAG notes from the rally held in March 2014 in Alice Springs to 'say no to racist laws and racist policing', that there is not opposition to the idea of alcohol restrictions in general.⁶¹ However, they state:
- ... the imposition of race-based restrictions such as those contained in Stronger Futures is viewed, not as evidence of government concern about alcohol related harm, but of a desire by government to isolate, demonise and control Aboriginal people. The segregation and humiliation caused by such restrictions

56 PAAC, *Submission 7.1*, p. 24.

57 Intervention Rollback Action Group (IRAG), *Submission 57*, p. 3.

58 IRAG, *Submission 57*, p. 3.

59 IRAG, *Submission 57*, p. 3.

60 IRAG, *Submission 57*, p. 3.

61 IRAG, *Submission 57*, pp. 3-4.

compounds broader feelings of social marginalisation and disempowerment, which in turn feed into the anger and despair which underlie the acute problem of alcohol.⁶²

Alcohol-fuelled violence

- 1.60 Alcohol-fuelled violence is a serious issue affecting many Australian communities. While alcohol may not always be the direct cause of violent acts, alcohol misuse is implicated in the prevalence and severity of assaults and domestic violence.⁶³
- 1.61 Aboriginal and Torres Strait Islander women are vastly overrepresented as victims of alcohol-fuelled violence. The Australian Human Rights Commission (AHRC) reports that Aboriginal and Torres Strait Islander women are 33 times more likely to be assaulted than non-Indigenous women.⁶⁴ In comparison, Aboriginal and Torres Strait Islander men are 6.2 times more likely to be assaulted than non-Indigenous men.⁶⁵ The AHRC notes that around half of these assaults were reported to be alcohol-related.⁶⁶
- 1.62 Harmful alcohol use is also associated with the increased severity of violence, which can result in the loss of life. The AHRC reports that up to 71.4 per cent of Aboriginal and Torres Strait Islander homicides involve alcohol at the time of the offence, compared with 24.7 per cent of non-Indigenous homicides.⁶⁷
- 1.63 A number of witnesses gave evidence of the relationship between alcohol use and high rates of assault in Aboriginal and Torres Strait Islander communities. For example, the NTPA states that 60 per cent of all assaults in the Northern Territory involve alcohol.⁶⁸
- 1.64 The prevalence of alcohol-fuelled violence contributes to the overrepresentation of Aboriginal and Torres Strait Islander people in the criminal justice system.⁶⁹
- 1.65 The Central Australian Aboriginal Legal Aid Service (CAALAS) states that a large amount of its work is alcohol-related domestic violence cases, and

62 IRAG, *Submission 57*, pp. 3-4.

63 Australian Crime Commission (ACC), *Submission 59*, p. 5; Central Australian Aboriginal Legal Aid Service (CAALAS), *Submission 56*, p.5.

64 Australian Human Rights Commission (AHRC), *Submission 31*, p. 4.

65 Royal Australasian College of Physicians (RACP), *Submission 28*, p. 14.

66 AHRC, *Submission 31*, p. 4.

67 AHRC, *Submission 31*, p. 4.

68 NTPA, *Submission 27*, p. 3.

69 ACC, *Submission 59*, p. 5.

cases of assault as a result of drunken fights between friends and strangers.⁷⁰

- 1.66 Dr Mandy Wilson and Ms Jocelyn Jones report that their research indicates alcohol is the most commonly used substance among Aboriginal and Torres Strait Islander offenders. They note that high risk alcohol consumption is more likely to be reported by Aboriginal and Torres Strait Islander prison entrants than by their non-Indigenous counterparts.⁷¹

Box 1.1 Halls Creek Hospital

Almost every single day we treat patients in the Emergency Department who are under the influence of alcohol. Often these presentations also include threatening behaviour directed at other patients, or staff and which impacts on our ability to care effectively for others.

We see children frightened, loved ones distressed and embarrassed, elders disgusted and other patients who are in need of medical and nursing care having to wait until the aggressor is controlled.

Those who present intoxicated cannot be accurately medically assessed until they have sobered up, thus putting themselves at increased risk. The effect of alcohol masks signs and symptoms of illness and injury and impacts on the ability to provide effective diagnosis and treatment. Also those patients who are under the influence of alcohol often do not remain to have their health needs addressed thus they are putting themselves at high risk of complications and deterioration.

The community must be aware that even in smaller quantities the ingestion of alcohol alters ones perceptions. Thus alcohol influences behaviours of concern, of which we regularly witness the effects in the hospital environment.

These effects include significant issues such as suicide/attempted suicide, family violence, aggression, sexual abuse, elder abuse and children at risk.

Finally the most significant effect of alcohol in the community which affects our ability to effectively serve the community is the increased violence towards ambulance staff (our orderlies and nurses).

The hospital provides a 24 hours ambulance service to the community. Increasingly the violence is directed personally to those staff members who at times "have feared for their life".

In response to this we recently met with Halls Creek Police to develop strategies to support the ambulance team. The understanding is clear – If staff do not feel safe

⁷⁰ CAALAS, *Submission 56*, p. 4.

⁷¹ Dr Mandy Wilson and Ms Jocelyn Jones, National Drug Research Institute (NDRI), *Submission 118*, p. 2.

in a situation they will not enter until the police are also present.

The community need to understand that this delays assessment and treatment of the patient and the usual cause of the threat is alcohol.

Source: *Halls Creek Hospital, Submission 105, p. 1.*

Family violence

- 1.67 A number of witnesses gave evidence of the relationship between alcohol use and rates of domestic violence in Aboriginal and Torres Strait Islander communities.⁷² For example, the NTPA stated that 67 per cent of domestic violence incidents in the Northern Territory involve alcohol.⁷³
- 1.68 St Vincent's Hospital also drew attention to statistics from the Office of the Status of Women which found a correlation between domestic violence and alcohol and other substance use in Aboriginal and Torres Strait Islander communities, with 70 – 90 per cent of assaults being committed under the influence of alcohol and or other drugs.⁷⁴
- 1.69 Several witnesses gave evidence that alcohol restrictions have been effective in reducing domestic violence in some communities.⁷⁵
- 1.70 In contrast Leedal Pty Ltd disputed the notion that liquor restrictions have reduced the incidence of domestic violence in Fitzroy Crossing.⁷⁶
- 1.71 The committee received evidence from several witnesses highlighting the importance of funding for women's shelters in providing safe respite from alcohol-related domestic and community violence.
- 1.72 For example, Ms Georgina Bracken from the Tennant Creek Women's Refuge said that women's shelters are highly dependent on government funding to provide support and crisis accommodation for victims of domestic and family violence.⁷⁷ Ms Bracken said that the shortage in

72 ACC, *Submission 59*, p. 5; NT Government, *Submission 60*, pp. 15-7; The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 6; AHCWA, *Submission 69*, p. 1; Ms Bracken, Tennant Creek Women's Refuge, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 20; Mr Kelly, NTPA, *Committee Hansard*, Canberra, 5 June 2014, p. 9; Detective Superintendent James Migro, Licensing Enforcement Division, Western Australia Police, *Committee Hansard*, Perth, 30 June 2014, p. 5.

73 NTPA, *Submission 27*, p. 3.

74 The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 6.

75 RACP, *Submission 28*, p. 24; AHRC, *Submission 31*, p. 6; FARE, *Submission 83*, p. 15; Superintendent Michael Sutherland, Superintendent, Kimberley Police District, Western Australia Police, *Committee Hansard*, Broome, 1 July 2014, p. 5.

76 Leedal Pty Ltd, *Submission 18*, p. 9.

77 Ms Bracken, Tennant Creek Women's Refuge, *Committee Hansard*, Tennant Creek, 1 April 2014, pp. 20-23.

available housing means that it can take an extended period of time before women are able to find stability in their housing arrangements.⁷⁸

- 1.73 The Marninwarntikura Fitzroy Women's Resource Centre gave evidence that the Fitzroy Women's Shelter operates 24 hours a day, seven days a week, offering support and crisis and short-term accommodation to women and their children experiencing family and domestic violence.⁷⁹ The Centre noted that without adequate funding, the women's shelter will struggle to respond to the high levels of domestic and family violence in the community.⁸⁰

Impacts on children

- 1.74 Alcohol misuse in Aboriginal and Torres Strait Islander communities is linked to increased rates of the neglect and abuse of children.⁸¹ Alcohol misuse is often closely linked with other key risk factors such as family and domestic violence.⁸²
- 1.75 There are close links between issues of child abuse/neglect and alcohol misuse. Up to 15 per cent of Aboriginal and Torres Strait Islander children in some states and territories live in households where parents misuse alcohol.⁸³
- 1.76 The Mayor of Ceduna, Mr Allan Suter, comments on the impact the misuse of alcohol has on children in the Ceduna community:
- It is a problem here. However, we are seeing some younger people in the drinking group and, of course, their children suffer the consequences. At one stage there were large numbers of youths roaming unsupervised in Yalata because most of the carers were in here drinking. That is an issue and, of course, drugs are an issue in every community these days, Indigenous and non-Indigenous. We do have a concern that the children of the drinking group will probably end up in the same place because they have not got any avenue to do otherwise.⁸⁴

78 Ms Bracken, Tennant Creek Women's Refuge, *Committee Hansard*, Tennant Creek, 1 April 2014, pp. 20-23.

79 Marninwarntikura Fitzroy Women's Resource Centre (MWRC), *Submission 106*, Attachment 4, p. 5

80 MWRC, *Submission 106*, Attachment 4, p. 2.

81 CAAC, *Submission 84*, p. 2; ACC, *Submission 59*, p. 1.

82 PM&C, *Submission 102*, p. 7.

83 NCETA, *Submission 34*, p. 4.

84 Councillor Allan Suter, Mayor, District Council of Ceduna, *Committee Hansard*, Ceduna, 5 May 2015, p. 4.

- 1.77 The Australian Crime Commission (ACC) identifies child neglect as the most common form of child abuse in Aboriginal and Torres Strait Islander communities. This can include overburdened grandparents caring for children while parents are drinking, gambling, using illicit substances and/or are incarcerated.⁸⁵
- 1.78 Representatives of the Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation note that grandparent care was prevalent within the Ceduna community due to the neglect children experience as a result of the misuse of alcohol.⁸⁶
- 1.79 In cases of child neglect where children are left to fend for themselves, they are likely to not attend school regularly or at all and are at an increased risk of experiencing or committing harms and sexual and other abuse.⁸⁷
- 1.80 The ACC also comments that a high number of children from remote communities are taken into care whilst visiting regional and urban towns. They stated that in these situations, parents and carers tend to become more negligent because their time is consumed by pursuing greater opportunities to drink alcohol and/or to gamble. Some children in remote communities are also neglected as a consequence of food money being spent on fuel to travel relatively long distances to buy drugs and alcohol.⁸⁸
- 1.81 The CAAC states that one factor contributing to developmental concerns in early childhood is the impact of adverse childhood experiences leading to developmental problems. These problems, often unnoticed in early childhood, have consequences in later life and are observed in low educational attainment, poor health outcomes, substance misuse, significant mental health problems and higher incarceration rates.⁸⁹

Trauma

- 1.82 Trauma is often associated with alcohol and substance misuse. The Healing Foundation notes that alcohol abuse is a significant issue in a number of Aboriginal and Torres Strait Islander communities and families but they state that it is not an addiction that takes place without cause:

85 ACC, *Submission 59*, p. 4; Dr Wenitong, Royal Australian College of General Practitioners (RACGP), *Committee Hansard*, Melbourne, 30 May 2015, p. 24.

86 Mrs Debra Miller, Chairperson, Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation, *Committee Hansard*, Ceduna, 5 May 2015, pp. 18-19.

87 ACC, *Submission 59*, pp. 4-5.

88 ACC, *Submission 59*, p. 5.

89 CAAC, *Submission 84 Attachment 1*, p. 37.

The impact of colonisation and its outcomes, including the forced removal of children from their families, dislocation of our people from their land and culture and the marginalisation of our people has led to significant trauma that has been passed from one generation to the next. The use of alcohol to manage this pain has led to increased levels of distress for individuals and communities.⁹⁰

- 1.83 The APO NT notes that alcohol and other drugs are often used as a coping mechanism for dealing with unresolved trauma and its resulting psychological distress. They report that in a recent study of alcohol and substance addicted participants, it was found that over half were Post Traumatic Stress Disorder (PTSD) symptomatic and over 80 per cent had experienced traumatic events.⁹¹
- 1.84 Aboriginal Medical Services Alliance Northern Territory (AMSANT) contends that the high level of complex trauma at both the individual and community level in Aboriginal and Torres Strait Islander communities can result in cascading impacts, which include mental health issues, substance misuse, family and community violence, self-harm and suicide as well as associated poor health outcomes.⁹²
- 1.85 Residents of town camps in Alice Springs report an experience of multidimensional disadvantage which Tangentyere Council contends includes the daily experience of racism, poverty, language barriers, low levels of literacy and numeracy as well as the experience of grief, loss and trauma.⁹³
- 1.86 Tangentyere Council also notes that town camp communities are impacted by high levels of violence, including family and domestic violence, and drug and alcohol misuse.⁹⁴

Loss of Aboriginal and Torres Strait Islander culture

- 1.87 A number of witnesses gave evidence about the relationship between harmful alcohol use and the interruption, or the loss of transmission of

90 The Healing Foundation, *Submission 42*, p. 2.

91 APO NT, *Submission 72, Attachment 5*, p. 10.

92 Mr John Paterson, Executive Officer, Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Committee Hansard*, Darwin, 3 April 2014, p. 21.

93 Tangentyere Council, *Submission 95*, p. 3.

94 Tangentyere Council, *Submission 95*, p. 3.

cultural knowledge between generations of Aboriginal and Torres Strait Islander people.⁹⁵

- 1.88 Traditional cultural loss has been referred to in the evidence both as a determinant and as a consequence of harmful alcohol use. Similarly, a person's connection to their culture has been described either as a protective factor in reducing the risk of harmful alcohol use, or as a way of assisting a person to overcome alcohol problems. However, cultural norms that require reciprocity, i.e. sharing of all things with family and community, can also mean it is more difficult to resist pressures to drink at high risk levels.
- 1.89 The Association of Alcohol and other Drug Agencies NT (AADANT) gave evidence that one of the reasons alcohol has destabilised Aboriginal and Torres Strait Islander cultures is that many elders are heavy drinkers, which results in a lack of sober role models in communities.⁹⁶
- 1.90 AHCWA states that the harmful use of alcohol is detrimental to the survival of Aboriginal and Torres Strait Islander cultures.⁹⁷
- 1.91 Children born with FAS or FASD as a consequence of alcohol exposure in the womb are also unable or less able to learn and pass on their community's culture.⁹⁸
- 1.92 The Australian Drug Foundation (ADF) notes that alcohol use is a common response to the cultural alienation experienced by colonised peoples.⁹⁹
- 1.93 The National Congress of Australia's First Peoples describes the preservation of your culture as being vital for overcoming the harmful use of alcohol in Aboriginal and Torres Strait Islander communities.¹⁰⁰ Similarly, members of the Western Australia Network of Alcohol and other Drug Agencies (WANADA) say that the maintenance of connections to your culture and family is paramount.¹⁰¹

95 AADANT, *Submission 11*, p. 3; AHCWA, *Submission 69*, p. 10; Healing Foundation, *Submission 42*, p. 2; Australian Drug Foundation (ADF), *Submission 92*, p.6; National Congress of Australia's First Peoples, *Submission 97*, p. 8.

96 AADANT, *Submission 11*, p. 3.

97 AHCWA, *Submission 69*, p. 10.

98 AHRC, *Submission 31*, Attachment 2, p. 2.

99 ADF, *Submission 92*, p. 6.

100 National Congress of Australia's First Peoples, *Submission 97*, p. 10.

101 Western Australia Network of Alcohol and other Drug Agencies (WANADA), *Submission 87*, p. 4.

Governance

- 1.94 A number of witnesses referred to the weakening of Aboriginal and Torres Strait Islander governance structures as one of the social determinants of harmful alcohol use. For example, the Healing Foundation gave evidence that the destruction of Aboriginal and Torres Strait Islander traditional and effective forms of governance and community organisation were part of the legacy of colonisation in Australia, and contributed to historical trauma.¹⁰²
- 1.95 Superintendent Sutherland from the Western Australian Police says that traditional forms of governance, including respect for elders, has broken down in some Aboriginal and Torres Strait Islander communities.¹⁰³
- 1.96 The National Congress of Australia's First Peoples notes:
- The serious consequences of alcohol related harm upon those affected is uncontested. It impacts on the health and quality of life for individuals, families and communities. Combatting the effects of alcohol related harm will undoubtedly help Closing the Gap in health inequality and the quality of life for Aboriginal and Torres Strait Islander Peoples, as efforts towards a nuanced understanding of the issues and proportionate response is a worthy investment of time and resources.¹⁰⁴

Conclusion

- 1.97 The social and economic determinants of health are complex contributors to a person's choice to consume alcohol at levels that causes harm to themselves and others.
- 1.98 The committee heard from many witnesses that it is vital to consider the social and economic determinants affecting harmful alcohol use and dependence when considering strategies to overcome this.
- 1.99 There is significant evidence that prevention of alcohol-related harm must not just focus on reducing alcohol access or the behaviour of risky drinking, but must also address the underlying factors that cause that behaviour.

102 Healing Foundation, *Submission 42*, p. 3. See also: Mr Roy Monaghan, Workforce Manager, National Aboriginal Community Controlled Health Organisation (NACCHO), *Committee Hansard*, Canberra, 1 July 2014, p. 5.

103 Superintendent Michael Sutherland, Superintendent, Kimberley Police District, Western Australia Police, *Committee Hansard*, Broome, 1 July 2014, p. 6.

104 National Congress of Australia's First Peoples, *Submission 97*, p. 2.

- 1.100 Problems such as inequalities, poor education, employment and housing must be addressed as part of any action to reduce alcohol-related harm. The committee notes that there are already many actions taking place in all states and territories and through the federal government, however examples of successful outcomes are few and far between.
- 1.101 While acknowledging concerns relating to Operation Leyland in Alice Springs, the committee notes that Temporary Beat Locations (TBLs) have had a very positive impact on reducing alcohol-related harm in and around those venues where police were stationed.
- 1.102 The high rate of alcohol-fuelled violence in Aboriginal and Torres Strait Islander communities is totally unacceptable. It destroys lives and places pressure on support services such as hospitals and police that impact on them being able to function effectively.
- 1.103 The committee considers that a standardised, national wholesale alcohol sales dataset is necessary for monitoring trends in alcohol consumption and for assessing the effectiveness of strategies to reduce harmful alcohol use.
- 1.104 The committee sees it as critical that the Commonwealth work with the states and territories to develop a framework for a national wholesale alcohol sales dataset, with comprehensive data to be publically available in 2017.
- 1.105 Visits to women's shelters gave the committee a perspective on how difficult it is to live in a community struggling with alcohol impacts. In places where accommodation is already stretched, shelters cannot always provide shelter so abused women and children have nowhere else to go.
- 1.106 The committee is very concerned about how alcohol impacts on children in Aboriginal and Torres Strait Islander communities. The close connection between alcohol and child abuse and neglect means that many children from Aboriginal and Torres Strait Islander communities live out of home, fail to survive, and face a lifetime of disadvantage, health and mental health impacts.
- 1.107 The committee notes that many of the Closing the Gap targets such as employment outcomes, early childhood education in remote communities, and reading, writing and numeracy for Aboriginal and Torres Strait Islander children are either not met or not on track.¹⁰⁵
- 1.108 The committee notes and commends the fact that the targets for Aboriginal and Torres Strait Islander children mortality and Year 12 or
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105 PM&C, *Closing the Gap – Prime Minister's Report 2015*

equivalent attainment for Aboriginal and Torres Strait Islander people are on track.

- 1.109 The harmful use of alcohol in Aboriginal and Torres Strait Islander communities must be given a higher level of attention and action as part of Closing the Gap in Indigenous Disadvantage.
- 1.110 The harm from alcohol consumption in some Aboriginal and Torres Strait Islander communities is at such extreme levels that underestimating this harm may mean that targets are unrealistic and, without proper strategy, are never met.
- 1.111 The committee wants the Commonwealth Government and the states and territories through the Council of Australian Governments (COAG) to focus on the harmful use of alcohol and ensure that it is properly considered and monitored, and that measured and appropriate action is taken.

Recommendation 1

- 1.112 **That the Commonwealth Government, states and territories, at the late 2015 Council of Australian Governments (COAG) meeting, place harmful impacts of alcohol on the agenda for coordinated action. This should:**
- **formally recognise the social and economic determinants of harmful uses of alcohol namely poverty, mental health, unemployment, an ongoing sense of grief and loss, alienation, boredom, cultural acceptance of drunkenness, ease of access and cost of alcohol, peer pressure 'to drink' and epigenetics in some Aboriginal and Torres Strait Islander communities and for some individuals**
 - **ensure that within each specific target of Closing the Gap in Indigenous Disadvantage, the impact of alcohol is recognised in all strategies and targets including addressing the social and economic determinants of high risk drinking, and**
 - **develop a framework, methodology and resource allocation for the collection and publication of a national standardised wholesale alcohol sales dataset. The framework and relevant agreements should be in place by December 2015 with comprehensive data available no later than February 2017.**

- 1.113 The committee is also clear that any action taken should not further disempower Aboriginal and Torres Strait Islander people. They must be partners in all developments.
- 1.114 The committee is clear that there needs to be more consultation with Aboriginal and Torres Strait Islander people and communities, more collaboration, more partnering and greater consideration as to how these social and economic determinants can be addressed, in the words of Gray and Wilkes:

... with and not for Indigenous people.¹⁰⁶

Recommendation 2

- 1.115 **That all strategies developed or funded by the Commonwealth or other governments are developed in partnership with the relevant Aboriginal and Torres Strait Islander peoples and/or their organisations.**

Conduct of the inquiry

- 1.116 On 13 February 2014, the Minister for Indigenous Affairs, Senator the Hon Nigel Scullion asked the committee to inquire into and report on the harmful use of alcohol in Aboriginal and Torres Strait Islander communities with a focus on:
- patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders
 - the social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities
 - trends and prevalence of alcohol related harm, including alcohol-fuelled violence and impacts on newborns e.g. FAS and FASD
 - the implications of FAS and FASD being declared disabilities
 - best practice treatments and support for minimising alcohol misuse and alcohol-related harm
 - best practice strategies to minimise alcohol misuse and alcohol-related harm, and

¹⁰⁶ NDRI, *Submission 47*, p. 4.

- best practice identification to include international and domestic comparisons.
- 1.117 The committee received 134 submissions from interested individuals and organisations including state and territory governments, Aboriginal and Torres Strait Islander Health organisations and Aboriginal and Torres Strait Islander communities. A list of submissions received by the committee is at Appendix A.
- 1.118 The committee conducted 26 hearings in a range of locations across Australia. A list of these hearings is at Appendix B.
- 1.119 Submissions received and transcripts of evidence can be found on the committee's website.¹⁰⁷

Previous inquiries

Inquiry into alcohol in Aboriginal and Torres Strait Islander communities

- 1.120 In 1976, the House of Representatives Standing Committee on Aboriginal Affairs conducted an inquiry into Alcohol Problems of Aboriginals.¹⁰⁸
- 1.121 The report and recommendations of the committee emphasised that Aboriginal and Torres Strait Islander communities should be responsible for making decisions about access to alcohol and the management of alcohol misuse within those communities. The committee also favoured the provision of assistance to Aboriginal and Torres Strait Islander communities for the management and treatment of alcohol misuse.

Inquiry into the incidence and prevalence of Fetal Alcohol Spectrum Disorder

- 1.122 In 2012 the House of Representatives Standing Committee on Social Policy and Legal Affairs undertook an inquiry into the incidence and prevalence of Fetal Alcohol Spectrum Disorder.
- 1.123 In its report, *FASD: The hidden harm*, the committee found that:

¹⁰⁷ House of Representatives Standing Committee on Indigenous Affairs, *The harmful use of alcohol in Aboriginal and Torres Strait Islander communities*, <http://www.aph.gov.au/Parliamentary_Business/Committees/House/Indigenous_Affairs/Alcohol> viewed 13 May 2015

¹⁰⁸ House of Representatives Standing Committee on Aboriginal Affairs, *Alcohol Problems of Aboriginals*, 1977, Australian Government Publishing Service, Canberra, p.iiv.

- there is little awareness of FASD or the risks of maternal alcohol consumption, in both the wider community and among health professionals
- FASD can be prevented by providing pregnant women with the appropriate information, knowledge and support
- Australia is lagging behind when it comes to standardised FASD diagnostic criteria and prevalence data, and
- FASD cannot be managed adequately without awareness and understanding among teachers, parents and carers, judicial officers, police and youth workers.¹⁰⁹

Structure of the report

- 1.124 The committee's report consists of eight chapters. This chapter sets out the context and conduct of the inquiry and discusses the social and economic determinants of harmful alcohol use. The role of, education, employment, racism and trauma are all factors in why Aboriginal and Torres Strait Islander people may choose to consume alcohol at levels that cause them harm.
- 1.125 Chapter 2 describes health and the harm caused by alcohol in Aboriginal and Torres Strait Islander communities.
- 1.126 Chapters 3 and 4 talk about some of the best practice treatments and strategies for dealing with alcohol related harm. The importance of an evidence base and also cultural connection are highlighted.
- 1.127 Chapter 5 looks at prevention strategies and what can be done to ensure that drinking alcohol does not become the default activity. The importance of sport and programs such as justice reinvestment are discussed.
- 1.128 Chapter 6 raises the serious issue of the conditions of FAS and FASD, the current lack of recognition of these conditions and how they are caused. The importance of FASD being declared a disability is identified.
- 1.129 Chapter 7 looks at how demand is measured and highlights the lack of robust data on alcohol consumption in Australia.
- 1.130 The final chapter in the report looks to international best practice. In countries such as Canada and the United States there has been greater

¹⁰⁹ House of Representatives Standing Committee on Social Policy and Legal Affairs, *FASD: The hidden harm. Inquiry into the prevention, diagnosis and management of Fetal Alcohol Spectrum Disorder*, November 2012.

awareness of the links between culture and treatment, and best practice strategies and treatments have been developed and evaluated.

Health and alcohol-related harm

Introduction

- 2.1 Throughout the inquiry the committee took evidence on the trends and prevalence of alcohol related harm in Australia. Alcohol abuse and alcohol-related harm is a nationwide problem in Australia, and not just in Aboriginal and Torres Strait Islander communities.
- 2.2 Alcohol-related harms disproportionately affect Aboriginal and Torres Strait Islander people, whose lives are impacted by alcohol related violence, domestic violence, health conditions and death.¹
- 2.3 This chapter explores the harmful impacts of alcohol misuse in Aboriginal and Torres Strait Islander communities in Australia and the trends and prevalence of these impacts.
- 2.4 As discussed in this chapter, the evidence to the inquiry indicates that the harm resulting from the misuse of alcohol is diverse and far reaching, affecting both individuals and the broader community. The extent of the harmful effects of alcohol misuse is still largely unknown because alcohol abuse is not always immediately identified as the underlying or main cause of these problems.

Health inequity

- 2.5 The Australian Institute of Health and Welfare (AIHW) acknowledge Aboriginal and Torres Strait Islander people have much poorer health

1 Foundation for Alcohol Research and Education (FARE), *Submission 83*, p. 5.

than the general population. Aboriginal and Torres Strait Islander people have:

- a substantially lower life expectancy
- are more likely to experience adverse birth outcomes and greater morbidity and disability, and
- higher rates of hospitalisation.²

2.6 The 2005 Social Justice report of the Australian Human Rights Commission (AHRC) notes that there are substantial inequities between Aboriginal and Torres Strait Islander people and non-Indigenous people, particularly in relation to chronic and communicable diseases, infant health, mental health and life expectation.³

2.7 The AIHW notes that Aboriginal and Torres Strait Islander people have a life expectancy of around 10 years less than non-Indigenous people⁴ and that chronic diseases are the main contributors to the mortality gap between Aboriginal and Torres Strait Islander people and non-Indigenous people.⁵

2.8 Health inequality and its determinants are highly complex. The National Preventative Health Taskforce notes that:

The use of tobacco and alcohol, and the poor nutrition and lack of physical activity which contribute to obesity, are embedded in a complex social, historical and political context, marked by processes of intergenerational powerlessness, poverty and social exclusion. Health inequality is intimately bound up with these processes.⁶

2.9 A person's health can be influenced by a wide range of factors. The People's Alcohol Action Coalition (PAAC) states:

A person's social and economic position in society, their early life, exposure to stress, educational attainment, access or lack of it to employment, access to health services, their exclusion from

2 G Draper, G Turrell and B Oldenburg, *Health Inequalities in Australia: Mortality. Health Inequalities Monitoring Series No. 1* Australian Institute of Health and Welfare (AIHW) Cat. No. PHE 55. Canberra: Queensland University of Technology and AIHW, 2004, p. 3.

3 Australian Human Rights Commission (AHRC), *Social Justice Report 2005 - Achieving Aboriginal and Torres Strait Islander health equality within a generation - A human rights based approach*, p. 10.

4 AIHW 2014. *Mortality and life expectancy of Indigenous Australians 2008 to 2012*, Cat. no. IHW 140, p. 6.

5 AIHW 2014. *Mortality and life expectancy of Indigenous Australians 2008 to 2012*, Cat. no. IHW 140, p. iv.

6 National Health Preventative Taskforce, *Reducing the harm from Alcohol, Tobacco and Obesity in Indigenous Communities - Key Approaches and Actions*, 2009, p. 18.

participation in society, and their access to food and transport: all exert a powerful influence on a person's health and their exposure to risk.⁷

Behavioural risk factors

- 2.10 In addition to health inequity, behavioural or health risk factors can influence an individual's chance of experiencing ill-health.⁸ These may include tobacco smoking, alcohol consumption, poor eating habits and lack of exercise.⁹
- 2.11 Importantly, the AIHW notes that these behaviours are also influenced by the broader social, cultural and economic environment in which Aboriginal and Torres Strait Islander people live.¹⁰
- 2.12 Numerous national agencies and authorities note that the use of alcohol, tobacco and other drugs does serious harm to physical health, but possibly even more harm to the social health of individuals, families and the fabric of their communities. It impedes education and work opportunities.¹¹
- 2.13 The Royal Australian College of Physicians (RACP) assert that the significant inequities which are experienced by Aboriginal and Torres Strait Islander people in the areas of education, employment, community capital and housing are undoubtedly major contributory factors to harmful alcohol use.¹²
- 2.14 The Central Land Council (CLC) contends that domestic violence, alcohol related deaths, child neglect, property damage and other criminal activity, a breakdown in cultural obligations, and negative impacts on education and employment outcomes are all outcomes of alcohol abuse.¹³
- 2.15 It is well documented that cultures which have experienced the historical processes of colonisation, for example the Indigenous people of Canada, the United States, New Zealand, and Aboriginal and Torres Strait Islander people, experience high rates of harmful alcohol and substance use.¹⁴

7 People's Alcohol Action Coalition (PAAC), *Submission 7.1*, p. 8.

8 AIHW 2014. *Australia's health 2014*. Australia's health series no. 14, Cat. no. AUS 178, p. 160.

9 AIHW 2014. *Australia's health 2014*. Australia's health series no. 14, Cat. no. AUS 178, p. 164.

10 AIHW, *What works? A review of actions addressing the social and economic determinants of Indigenous Health*, 2013, p. 9.

11 National Indigenous Drug and Alcohol Committee (NIDAC), *Submission 94*, Attachment 6, p. 2; Department of Prime Minister and Cabinet (PM&C), *Submission 102*, p. 4.

12 Royal Australasian College of Physicians (RACP), *Submission 28*, p. 11.

13 Central Land Council (CLC), *Submission 68*, p. 1.

14 Australian Drug Foundation (ADF), *Submission 92*, p. 6.

Health problems

- 2.16 Harmful alcohol consumption is associated with a wide range of health problems for those who drink, including liver disease, high blood pressure, stroke and some cancers.¹⁵ The National Centre for Education and Training on Addiction (NCETA) notes that people experiencing alcohol-related harm are at risk of a range of co-morbid conditions including infectious and non-communicable diseases.¹⁶
- 2.17 The health of Aboriginal and Torres Strait Islander people is already of a poorer status than non-Indigenous people. NCETA notes that they have a shorter life expectancy, and are more likely to experience multiple morbidities including diabetes, renal disease, dental disease and infectious and parasitic diseases.¹⁷
- 2.18 Alcohol is the fifth leading cause of disease among Aboriginal and Torres Strait Islander people.¹⁸ The burden of disease attributable to alcohol among Aboriginal and Torres Strait Islander people is twice the level of non-Indigenous people.¹⁹
- 2.19 The PAAC notes that for Aboriginal and Torres Strait Islander men in particular, alcohol is strongly associated with four of the top ten causes of premature mortality: suicide (9.1 per cent of potential years of life lost), road traffic accidents (6.2 per cent), alcohol dependence and harmful use (3.9 per cent), and homicide and violence (2.8 per cent).²⁰
- 2.20 Alcohol consumption impacts on rates of hospitalisation. For health conditions related to alcohol, Aboriginal and Torres Strait Islander men are hospitalised at rates between 1.2 and 6.2 times higher than non-Indigenous men, and Aboriginal and Torres Strait Islander women at rates between 1.3 and 33 times higher. Deaths from alcohol-related causes are overall 7.5 times greater for Aboriginal and Torres Strait Islander people than those of non-Indigenous people.²¹
- 2.21 Alcohol can also prevent appropriate treatment for other conditions. The Aboriginal Drug and Alcohol Council (SA) Inc. explain that there are many medical conditions that are unable to be properly identified or treated due to alcohol addiction.²²

15 PAAC, *Submission 7.1*, p. 10.

16 National Centre for Education and Training on Addiction (NCETA), *Submission 34*, p. 3.

17 NCETA, *Submission 34*, p. 3.

18 ADF, *Submission 92*, p. 6.

19 ADF, *Submission 92*, p. 6.

20 PAAC, *Submission 7.1*, p. 11.

21 FARE, *Submission 83*, p. 4.

22 Aboriginal Drug and Alcohol Council (SA) Inc. (ADAC), *Submission 40*, p. 5.

- 2.22 The role that alcohol plays in the health of an individual can be significant but the National Indigenous Drug and Alcohol Committee (NIDAC) emphasises that alcohol and other drugs can impact on the ‘fabric’ of communities.²³

Mental Health

- 2.23 The Aboriginal Peak Organisations of the Northern Territory (APO NT) contend that mental health strongly relates to alcohol and drug misuse.²⁴ The Kimberley Mental Health and Drug Service described that:
- With mental health we have a very high proportion of people with co-morbid drug and alcohol issues. Somewhere over 50 per cent would present with a co-morbid drunk and alcohol mental health problem.²⁵
- 2.24 PAAC reports that Aboriginal and Torres Strait Islander people are more than twice as likely as non-Indigenous people to have psychological distress and more likely to drink at harmful levels.²⁶
- 2.25 The misuse of alcohol can be a contributing factor in the development of mental health issues in individuals. The depressive effects of alcohol make it a significant risk factor in the development of mental health problems, particularly depression.²⁷
- 2.26 Milliia Rumurra Aboriginal Corporation notes that over the last few years they have seen an increase in complex client presentations involving multiple drug use and related mental health issues.²⁸
- 2.27 The Queensland Government notes that there is an over-representation of Aboriginal and Torres Strait Islander communities in data describing alcohol-related mental health admissions to hospital:
- In 2012–13, across discrete Indigenous communities, the annual rate of hospital admissions where alcohol-related mental and behavioural conditions were diagnosed, ranged from 12.0 per 1,000 persons (15 years and older) up to 162.2 per 1,000 persons (15

23 NIDAC, *Submission 94*, Attachment 4, p. 3.

24 Aboriginal Peak Organisations of the Northern Territory (APO NT), *Submission 72*, Attachment 4, p. 14.

25 Mr Bob Goodie, Regional Manager, Kimberley Mental Health and Drug Service, WA Country Health Service, *Committee Hansard*, Broome, 1 July 2014, p. 16.

26 PAAC, *Submission 7.1*, p. 12.

27 National Drug Strategy, Monograph 71, Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician, p. 6.

28 Milliia Rumurra Aboriginal Corporation, *Submission 114*, p. 2.

years and older). This compares with a state-wide rate of 10.0 per 1,000 persons (15 years and older).²⁹

- 2.28 Mental health can be a factor influencing drinking when pregnant. In the Kimberley, midwives report that the majority of women who are drinking or using other substances have underlying mental health problems and are dealing with issues like domestic violence.³⁰

Suicide and alcohol abuse

- 2.29 Alcohol is a major risk factor associated with suicide. *The National Alcohol Indicators Bulletin* no. 11 noted that suicide accounted for 19 per cent of alcohol-attributable deaths amongst Aboriginal and Torres Strait Islander men from 1998 to 2004.³¹
- 2.30 The Kimberley Aboriginal Law and Culture Centre (KALACC) notes that in the year from January 2006 to January 2007, there were some 13 suicides in the small community of Fitzroy Crossing in the Kimberley, Western Australia.³² The population of Fitzroy Crossing was approximately 1500 at that time.³³
- 2.31 KALACC note that the Coroner made comment that of the 21 deaths by suicide in 2006, only two did not have any evidence of alcohol or cannabis. The Coroner further notes that in 16 of the 21 cases the blood alcohol level of the deceased was in excess 0.15 per cent, three times the maximum permissible level for driving a motor vehicle.³⁴
- 2.32 The Western Australian Coroner, in February 2008, highlighted the extremely high statistical correlation between alcohol and suicide.³⁵

Prevalence of alcohol-related harm

- 2.33 As noted earlier, there is limited data on the trends and prevalence of alcohol-related harm.

29 Queensland Government, *Submission 98*, p. 9.

30 Dr James Fitzpatrick, Paediatrician and Senior Clinical Research Fellow, Telethon Kids Institute, *Committee Hansard*, Perth, 30 June 2014, p. 41.

31 ADAC, *Submission 40*, Attachment 8, p. 2.

32 Kimberley Aboriginal Law and Culture Centre (KALACC), *Submission 2*, p. 2.

33 Government of Western Australia, *Fitzroy Futures Town Plan*, March 2009, p. 3.

34 KALACC, *Submission 2*, p. 2.

35 KALACC, *Submission 2*, p. 4.

- 2.34 The Australasian College for Emergency Medicine contends that 15 deaths and 446 hospitalisations per day in Australia are attributable to alcohol.³⁶ They note however that this is likely to be an underestimate:
- ... screening and collection of alcohol-related presentation data is not compulsory in Australian emergency departments, and as a result, current data sets are likely to significantly under-estimate alcohol-related presentations.³⁷
- 2.35 The Alcohol and Drug Service of St Vincent's Hospital (St Vincent's ADS) in Sydney notes that data is limited and has been shown to underestimate actual consumption. St Vincent's ADS stated that from the data available, the prevalence of harmful alcohol use among Aboriginal and Torres Strait Islander population is about twice as great than that in the non-Indigenous population.³⁸
- 2.36 St Vincent's ADS contend that the higher prevalence of risky and high-risk alcohol use among Aboriginal and Torres Strait Islander people is reflected in the higher rates of alcohol-related hospital admissions and deaths among this population.³⁹
- 2.37 Rates of premature death due to harmful alcohol use are also higher among the Aboriginal and Torres Strait Islander population, with approximately seven per cent of Aboriginal and Torres Strait Islander deaths resulting from harmful alcohol use.⁴⁰ The rates of death from alcohol-related causes for Aboriginal and Torres Strait Islander males were five times the rate of non-Indigenous males. For females it was eight times. Most deaths were due to alcoholic liver disease.⁴¹
- 2.38 In Coober Pedy there was consistently more Aboriginal and Torres Strait Islander women than Aboriginal and Torres Strait Islander men presenting to the hospital with drug or alcohol related issues. Aboriginal and Torres Strait Islander women represented 57 per cent of the time to Aboriginal and Torres Strait Islander men 43 per cent over the 2012-14 period.⁴²

36 Australasian College for Emergency Medicine (ACEM), *Submission 133*, p. 1.

37 ACEM, *Submission 133*, p. 1.

38 The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 3.

39 The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 5.

40 The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 5.

41 The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 5.

42 Coober Pedy Hospital & Health Services, *Submission 131*, p. 3.

- 2.39 Rates of death wholly attributed to alcohol abuse are eight times higher for Northern Territory Aboriginal and Torres Strait Islander men than non-Indigenous men, and 16 times higher for women.⁴³
- 2.40 South Australian Police notes that the data collected by the police about whether an incident or offence is alcohol-related, is reliant on the honest answer of the offender or victim:
- In terms of a victim report of an offence, say, an assault, a domestic violence incident, a robbery, questions are asked about alcohol consumption, whether the person had consumed alcohol prior to the offence. I guess it is reliant on their honest answer. Sometimes it is obvious. But we do not actually record a breath analysis reading against a victim related offence.⁴⁴
- 2.41 Chief Superintendent Scott Duval adds:
- ... we have got no legislative authority to take a breath analysis test of someone who is charged with an assault where it may be obvious that they have consumed alcohol.⁴⁵

Epigenetics

- 2.42 Epigenetics refers to changes in genes and the way in which the expression of genes can be influenced by certain factors.
- 2.43 Epigenetic changes may last for the life of a living thing or, in some cases, can be inherited. Inherited epigenetic changes are 'semi-permanent' changes to the way that genes operate and may be passed down through generations.
- 2.44 Professor Elizabeth Elliott states that epigenetics is a burgeoning field of research and the impacts are now very well substantiated.⁴⁶
- 2.45 A number of submissions to the inquiry referred to the growing evidence that physical and mental health difficulties arising from, or exacerbated by, the misuse of alcohol and other substances can have epigenetic consequences that compound across generations. For example: children born to parents with alcohol addiction may be more genetically

43 Northern Territory Police Association (NTPA), *Submission 27*, p. 3.

44 Chief Superintendent Scott Duval, Coordination Branch (Regional Operations Service), South Australia Police, *Committee Hansard*, Adelaide, 5 May 2015, p. 3.

45 Chief Superintendent Duval, South Australia Police, *Committee Hansard*, Adelaide, 5 May 2015, p. 3.

46 Professor Elizabeth Elliott, Paediatrician, Westmead Children's Hospital and the University of Sydney, *Committee Hansard*, Sydney, 5 September 2014, p. 5.

- predisposed to addiction themselves.⁴⁷ There is increasing evidence of epigenetics as the biological mechanism behind the intergenerational damage arising from alcohol misuse.⁴⁸
- 2.46 The study of epigenetics is contributing to the understanding of how intergenerational damage may be transmitted, and the overall health status of Aboriginal and Torres Strait Islander communities.⁴⁹
- 2.47 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack note research that indicated experiencing stress, particularly in childhood can predispose an individual to alcohol use disorders. They noted experiments with animals has indicated that stress induces alcohol cravings, which has been linked to changes to the brain's neurochemistry, including changes to the reward centre. Some of these changes are mediated through alterations to gene expression (epigenetic changes).⁵⁰ Dr Hamill commented that if there are epigenetic factors that have been introduced to the DNA of both the mother's and father's genome, then the factors are inherited by the child.⁵¹
- 2.48 Dr Wenitong states that the epigenetic changes that occur due to alcohol misuse and which cause intergenerational damage would best be treated alongside other early childhood trauma caused by the misuse of alcohol.⁵²

Conclusion

- 2.49 The committee heard and saw compelling evidence of the totally unacceptably high levels of harm experienced by children and adults as a result of alcohol in Aboriginal and Torres Strait Islander communities.
- 2.50 Alcohol related health problems, including mental health and suicide, mean that communities are seeing too many young people dying. The burden of the health cost of alcohol damage is so significant that it needs to be more widely known.

47 Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU), *Submission 73*, p. 9; Tangentyere Council Inc, *Submission 95*, p. 3; PAAC, *Submission 7*, p. 9.

48 Dr Tim Senior, Medical Advisor, National Faculty for Aboriginal and Torres Strait Islander Health, Royal Australian College of General Practitioners (RACGP), *Committee Hansard*, Melbourne, 30 May 2014, p. 17.

49 Dr David Cooper, APO NT, *Committee Hansard*, Darwin, 3 April 2014, p. 22.

50 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, p. 5.

51 Dr Janet Hammill, Research Fellow, Synapse, *Committee Hansard*, Brisbane, 20 June 2014, p. 38.

52 Dr Mark Wenitong, Committee Member, National Faculty for Aboriginal and Torres Strait Islander Health, RACGP, *Committee Hansard*, Melbourne, 30 May 2014, p. 17.

- 2.51 The burgeoning research area of epigenetics needs greater policy attention, particularly in relation to the intergenerational effects in the Aboriginal and Torres Strait Islander communities.
- 2.52 The committee considers it important that there is more information available about the risks of consuming alcohol. Alcohol is a risk factor in many health conditions and this message is not as widely known as it should be.
- 2.53 Public health messages of this nature need constant repetition and also need to be targeted to particular audiences and it is the view of the committee that all Australians would benefit from hearing more about the harms of alcohol.

Recommendation 3

- 2.54 **That the Commonwealth develops a public awareness campaign, highlighting the risks of alcohol consumption, focussing on:**
- **where to find help to reduce harmful drinking**
 - **where to find help to reduce alcohol related violence, and**
 - **providing information on other diseases associated with risky drinking.**

The campaign should have sections targeted for populations in the criminal justice system and the education system.

Best practice strategies to minimise alcohol misuse and alcohol-related harm

Introduction

- 3.1 Much evidence received by the committee related to strategies to reduce the supply of alcohol. This included taxation regimes, liquor licencing and reducing alcohol-related marketing.
- 3.2 The committee heard that Aboriginal and Torres Strait Islander people have developed a variety of locally based strategies to reduce alcohol access in their communities. In many cases, these strategies have been established in cooperation with a range of stakeholders, including government agencies, licensees and police.
- 3.3 Attention was also drawn to the importance of community support in the development of measures to control the supply of alcohol. The importance of community consultation in the development and operation of alcohol supply reduction measures was stressed as key.¹

Population-level supply reduction

- 3.4 The committee heard that reduction in supply showed reduction in alcohol-related harms across populations.² Population-level supply

1 Australian Human Rights Commission (AHRC), *Submission 31*, p. 8; Aboriginal Peak Organisations of the Northern Territory (APO NT), *Submission 72*, p. 27.

2 The Lyndon Community, *Submission 16*, p. 1.

- reduction is seen as critical to any program to reduce alcohol-related harm.³
- 3.5 Others argue it displaces the problem to somewhere else. Foundation for Alcohol Research and Education (FARE) notes that despite evidence of the wide range of alcohol-related harms, alcohol is more available than it has ever been before and is more affordable than it has been for three decades.⁴
- 3.6 FARE believes population-wide reduction strategies reduce the consumption levels across a population. Regulatory control of the access to and price of alcohol can be used to ensure alcohol-related harm is minimised.
- 3.7 A number of ways in which regulatory control can be used were raised during the inquiry, and ranged from the role of the alcohol industry, reducing alcohol advertising, eg during sport, to supply reduction measures such as strengthening liquor licencing regimes and changing alcohol taxation.
- 3.8 The Public Health Association of Australia (PHAA) gave evidence that while clinical services are essential, there is a great need for population-based responses to the harmful use of alcohol.⁵

Challenging the Alcohol Industry

- 3.9 In Australia, all alcoholic products made for commercial purposes are subject to various excise duties and taxes, and all state and territory jurisdictions have laws regulating the production, retail and consumption of alcohol. These regulations and laws balance the public interest with the interests of the alcohol industry.⁶
- 3.10 Concerns were raised that this balance is currently tipped too far in favour of the interests of the alcohol industry, which includes alcohol manufacturers, distributors, and retailers. It was argued that the primacy of the alcohol trade needs to be challenged, and that the alcohol industry takes more responsibility for reducing the harmful use of alcohol, particularly in Aboriginal and Torres Strait Islander communities.⁷
- 3.11 The Northern Territory Police Association (NTPA) asserts while 'society picks up the bill for the sustained disadvantage and misery which results

3 People's Alcohol Action Coalition (PAAC), *Submission 7.1*, p. 2.

4 Foundation for Alcohol Research and Education (FARE), *Submission 83*, p. 35;

5 Public Health Association of Australia (PHAA), *Submission 91*, p. 5.

6 National Drug Research Institute (NDRI), *Submission 47*, p. 14.

7 Mr Michael Thorn, Chief Executive, FARE, *Committee Hansard*, Canberra, 28 August 2014, p. 1.

from the excessive consumption of alcohol', the supply of alcohol remains unchanged.⁸

3.12 The NTPA comments:

Such is the power and influence of alcohol manufacturers, distributors, and retail suppliers ... the availability of alcohol goes unchecked, save as to age based restrictions and trading hours, by the legislature. The supply chain is kept open unabated. The profits of suppliers, from manufacturers and distributors, to pubs, clubs and stores, are relentlessly protected, guaranteed, and defended.⁹

3.13 Professor Peter d'Abbs from the Menzies School of Health Research says that alcohol misuse systems have been institutionally sustained by liquor licensees and their suppliers, as well as their political representatives.¹⁰

In places where heavy episodic drinking has taken root over several generations, both the drinking itself and the activities that sustain it – such as grog runs – have not only become culturally normal, they are also institutionally sustained, both by institutions that benefit directly from the status quo – most obviously takeaway and on-premise liquor outlets and their suppliers, employees and political representatives – and by other institutions that have accommodated themselves to the status quo, if only for their own peace of mind, such as local workplaces and schools that tailor their expectations regarding attendance and absenteeism to the local income-bingeing cycle.¹¹

3.14 The Lyndon Community notes that local groups wishing to make changes are not well-informed or well-resourced about how to reduce alcohol supply. The Lyndon Community believe that the alcohol industry is a major impediment to reducing the supply.¹²

Taxation on alcohol

3.15 There was strong support for the introduction of a volumetric tax as well as a minimum or floor price on alcohol in Australia.

3.16 The Royal Australasian College of Physicians (RACP) notes taxation of alcohol can be used to generate direct revenue to fund alcohol treatment

8 Northern Territory Police Association (NTPA), *Submission 27*, p. 9.

9 NTPA, *Submission 27*, p. 8.

10 Professor Peter d'Abbs, Menzies School of Health Research, *Submission 99*, p. 20.

11 Professor Peter d'Abbs, Menzies School of Health Research, *Submission 99*, p. 20.

12 The Lyndon Community, *Submission 16*, p. 10.

- services or prevention programs. They also note that volumetric tax based on evidence of harm associated with particular beverage types, can provide an additional element of flexibility in targeting.¹³
- 3.17 Volumetric taxation is placed on alcohol products based on their alcohol content. It was described as one of the most effective ways of reducing harmful alcohol use and related harm in both Aboriginal and Torres Strait Islander and non-Indigenous communities.¹⁴
- 3.18 A study in 2013 in the Medical Journal of Australia found that if the Wine Equalisation Tax was abolished and replaced with a volumetric tax on wine, taxation revenue would increase by \$1.3 billion per year, alcohol consumption would be reduced by 1.3 per cent, and \$820 million would be saved in health care costs and 59 000 disability-adjusted life-years would be averted.¹⁵
- 3.19 Dr John Boffa from the People's Alcohol Action Coalition (PAAC) drew the committee's attention to a study of the effectiveness of Canadian price-based harm minimisation policies.¹⁶
- 3.20 The study found that for every 10 percent increase in alcohol price, the number of alcohol-attributable deaths decreased by one third.¹⁷ The results of this study support earlier research in Alaska and Florida, United States, which reported substantial reductions in mortality following tax increases on alcohol.¹⁸
- 3.21 The National Aboriginal and Torres Strait Islander Legal Services and the Human Rights Law Centre propose that a volumetric system would replace existing excises on alcohol with a common tax based on alcohol content. This would be across all forms of alcohol and would help to

13 Royal Australasian College of Physicians (RACP), *Submission 28*, p. 21.

14 See, for example: PAAC, *Submission 7.1*, p. 27; Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, p. 11; NDRI, *Submission 47*, p. 17; Professor Dennis Gray, Member, National Indigenous Drug and Alcohol Committee (NIDAC), *Committee Hansard*, Canberra, 15 May 2014, p. 71; Professor Marcia Langton, *Committee Hansard*, Melbourne, 30 May 2014, p. 32.

15 C Doran, L Coblac, B Vandenberg et. al., *Estimated impacts of alternative Australian alcohol taxation structures on consumption, public health and government revenues*, Medical Journal of Australia, 2013, 199(9), p. 619.

16 Dr John Boffa, Spokesperson, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 6.

17 J. Zhao, T. Stockwell, G. Martin et. al., *The relationship between minimum alcohol prices, outlet densities and alcohol-attributable deaths in British Columbia, 2002-09* Addiction, June 2013, Vol. 108(6), p. 1059.

18 M. Maldonado-Molina and A. Wagenaar, *Effects of alcohol taxes on alcohol-related mortality in Florida, time-series analyses from 1969 to 2004*, Alcoholism: Clinical and Experimental Research, 2010, 34(11), p. 1915; A. Wagenaar, M. Maldonado-Molina, and B. Wagenaar, *Effects of alcohol taxes on alcohol-related disease mortality in Alaska, time-series analyses from 1976 to 2004*, American Journal of Public Health, 2009, 99(8), p. 1464.

reduce alcohol-related harm by increasing the relative cost of drinking higher alcohol beverages and making lower alcohol beverages more affordable and attractive.¹⁹

3.22 FARE argues that Australia needs to address:

... the inequitable alcohol taxation system that allows for alcohol to be purchased for as little as 25 cents per standard drink.²⁰

3.23 The National Drug Research Institute (NDRI) supports a tiered volumetric tax on alcohol, similar to that which was proposed in the 2010 *Australia's Future Tax System* report:

Under such a proposal, all beverage types (beer, table wine, fortified wine, spirits, etc.) would be taxed on the basis of alcohol content, with beverages in tiers (low, medium, and high alcohol content for example) being taxed at different rates with lower rates on low alcohol content beverages. The advantage of such a system is that it would apply on a national basis and be a disincentive to high levels of consumption among all drinkers.²¹

3.24 In addition to instituting volumetric taxation, there was strong support for a minimum or floor price on alcohol.²² This sets a minimum price per standard drink or unit of alcohol at which alcoholic beverages must legally be sold.

3.25 Dr John Boffa said that it is the 'minimum price that makes the biggest difference to the heaviest drinkers'²³ and supported the introduction of a volumetric tax that incorporates a floor price:

If a volumetric tax could be achieved, it is the gold standard and it should be done, but it has to be done in a way that implements a minimum price.²⁴

3.26 Dr John Boffa notes that substitution is not a major issue in relation to alcohol interventions that are price based because alcohol is 'the drug of choice'.²⁵ Referring to evidence from Canada, Dr Boffa says that:

19 National Aboriginal and Torres Strait Islander Legal Services and the Human Rights Law Centre, *Submission 58*, p. 18.

20 FARE, *Submission 83*, p. 37.

21 NDRI, *Submission 47*, p. 16; The Treasury, *Australia's Future Tax System*, Final Report: Part 2, 2010, pp. 431-443.

22 See, for example: FARE, *Submission 83*, p. 40; NDRI, *Submission 47*, p. 22; PAAC, *Submission 7.1*, p. 2; Central Land Council (CLC), *Submission 68*, p. 7; APO NT, *Submission 72*, p. 6; Criminal Lawyers Association of the Northern Territory (CLANT), *Submission 76*, p. 1; Central Australian Aboriginal Congress (CAAC), *Submission 84*, p. 4; PHAA, *Submission 91*, p. 7; Australian Drug Foundation (ADF), *Submission 92*, p. 15.

23 Dr Boffa, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 6.

24 Dr Boffa, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 6.

... alcohol is still readily available; it is just at a higher price. So you get very little substitution. It is not prohibition. If you had prohibition, you would get a lot of substitution, but we are only talking about regulation.²⁶

Liquor licencing regimes

- 3.27 The retail and wholesale of alcohol requires a licence from the liquor licensing authority of the relevant state or territory.
- 3.28 FARE is concerned that alcohol is more accessible now than it has been previously:
- Alcohol is more readily available than it ever has been in Australia. The number and density of liquor licenses has consistently increased over the past 10 to 15 years. This is despite the fact that research overwhelmingly demonstrates that as alcohol becomes more available, consumption and alcohol-related problems increase, and that to reduce alcohol-related harms, a reduction in access and availability are effective measures.²⁷
- 3.29 Internationally, research has shown that extended late night trading hours result in increased alcohol consumption and alcohol-related harm.²⁸ Similarly, research shows that as the density of liquor outlets increases, the incidence of alcohol-related harm increases.²⁹
- 3.30 The committee heard that changes to liquor licencing laws, such as limiting the density of alcohol outlets and reducing trading hours could reduce the supply of, and harm caused by alcohol in Aboriginal and Torres Strait Islander communities.³⁰
- 3.31 The NDRI reports that restrictions on trading hours have been effective in reducing alcohol consumption and alcohol-related harm in Aboriginal and Torres Strait Islander communities, and that this is supported by strong international evidence.³¹

25 Dr Boffa, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 6.

26 Dr Boffa, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 6.

27 FARE, *Submission 83*, p. 12.

28 T Stockwell and T Chikritzhs, 'Do relaxed trading hours for bars and clubs mean more relaxed drinking? A review of international research on the impacts of changes to permitted hours of drinking', *Crime Prevention and Community Safety*, 2009, vol. 11, p. 153.

29 M Livingston, T Chikritzhs and R Room, 'Changing the density of alcohol outlets to reduce alcohol-related problems', *Drug and Alcohol Review*, 2007, vol. 26, p. 564.

30 See, for example: FARE, *Submission 83*, p. 14; NDRI, *Submission 47*, p. 23; The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 13.

31 NDRI, *Submission 47*, pp. 23-24.

- 3.32 In addition to reducing trading hours and outlet density, there was strong support for strengthening existing liquor licencing regimes. For example, Aboriginal Peak Organisations of the Northern Territory (APO NT) stress the need for stronger enforcement of existing licensing laws,³² while the NTPA calls for more work to be done on the legislative level to strengthen licencing requirements and reduce the availability of alcohol.³³
- 3.33 The committee heard that several jurisdictions were moving towards a risk-based licencing system.³⁴ The New South Wales Government gave evidence that it has introduced stronger licensing provisions as part of its package of reforms to reduce alcohol-related violence and antisocial behaviour. The measures include a periodic, risk-based licencing scheme that imposes higher fees for venues and outlets that have later trading hours, poor compliance records or are located in high risk locations.³⁵
- 3.34 FARE supports the expansion of a risk-based liquor licensing regime, where the fees that a licensee pays to operate are related to the risks of their operations.³⁶

Reducing alcohol-related marketing

- 3.35 The pervasiveness of alcohol advertising in sport was highlighted as an example of where regulations need to change, particularly where children are frequently exposed to alcohol promotion.³⁷
- 3.36 Professor Mike Daube from the McCusker Centre for Action on Alcohol and Youth comments that:

Aboriginal children are as vulnerable as any others, and possibly more so, to the massive and cynical exposure of children to alcohol promotion, particularly through sports such as AFL, NRL and cricket. Aboriginal children are as aware as any others that the State of Origin game is not New South Wales against Queensland; it is VB against XXXX.³⁸

32 APO NT, *Submission 72*, p. 9.

33 NTPA, *Submission 27*, pp. 14-18.

34 Mr Thorn, FARE, *Committee Hansard*, Canberra, 28 August 2014, p. 7.

35 NSW Government, *Submission 62*, p. 9.

36 Mr Thorn, FARE, *Committee Hansard*, Canberra, 28 August 2014, p. 7.

37 Professor Mike Daube, Director, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, Perth, 30 June 2014, p. 19; National Alliance for Action on Alcohol (NAAA), *Submission 54*, p. 1.

38 Professor Daube, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, Perth, 30 June 2014, p. 19.

- 3.37 Currently, alcohol advertising in various media in Australia is self-regulated according to industry compliance with the Alcohol Beverages Advisory Code.³⁹
- 3.38 Alcohol advertising on television is regulated by the Commercial Television Industry Code of Practice, which restricts the times where alcohol advertisements can be shown on television to M, MA and AV classification periods. Typically, alcohol advertising on commercial television is restricted to between 8.30pm and 5.00am; however an exemption allows advertisements to be shown during live sporting broadcasts at any time of the day.⁴⁰
- 3.39 The National Alliance for Action on Alcohol (NAAA) asserts that, in order to protect children from alcohol marketing and promotions, the loophole that allows alcohol advertising during live sport needs to be closed.⁴¹
- 3.40 The McCusker Centre for Action on Alcohol and Youth says that current approaches to regulating alcohol advertising have failed and that a comprehensive regime needs to be established:
- Independent, legislated controls on the content, placement and volume of all forms of alcohol advertising and promotion are urgently needed. Such a system would include comprehensive codes and enforceable decisions with sanctions that genuinely act as a deterrent.⁴²
- 3.41 While restrictions on alcohol advertising aim to limit the exposure of people, particularly children, to the promotion of alcohol products and drinking as desirable, the committee heard that such changes need to be part of a broader suite of measures to reduce access to alcohol.⁴³

Conclusion

- 3.42 There is high availability of cheap alcohol across Australia. The committee considers that alcohol outlet trading hours are too long and have been shown to be not always in the best interests of the public.

39 The Alcohol Beverages Advertising Code Scheme, *About the ABAC Scheme*, 2014, < <http://www.abac.org.au/about/> > viewed 20 April 2015.

40 Australian Communications and Media Authority, *Commercial Television Industry Code of Practice*, January 2010, p. 31.

41 NAAA, *Submission 54*, p. 1.

42 McCusker Centre for Action on Alcohol and Youth, *Submission 21*, p. 3.

43 Professor Elizabeth Elliott, Paediatrician, Westmead Children's Hospital and the University of Sydney, *Committee Hansard*, Sydney, 5 September 2014, p. 1; Lililwan Project Team, *Submission 90*, p. 4.

- 3.43 The committee believes that the taxation system is a very effective way to address reducing harms related to alcohol. The impact of a volumetric tax and a minimum floor price on the health of the Australian community needs greater investigation.
- 3.44 The committee notes that the findings of the 2010 *Australia's Future Tax System* report (Henry Tax review), indicate that a volumetric tax would better address alcohol-related harm than current taxation arrangements.
- 3.45 The committee considers that the way forward is the introduction of volumetric tax in conjunction with a minimum floor price. There would need to be an exploration of the system needed, for example, whether a tiered volumetric system would be the most appropriate.

Recommendation 4

- 3.46 **That the committee recommends:**
- **the introduction of a national minimum floor price on alcohol, and**
 - **prompt consideration be given to the recommendations of the Henry Tax Review on volumetric tax.**
- 3.47 The states and territories are responsible for licencing laws in their jurisdiction and therefore have a key role in regulating the supply and access to alcohol.
- 3.48 The committee is concerned about statistics which highlight a correlation between the density of liquor outlets and an increase in domestic violence. The steps taken by the alcohol industry retailers to introduce liquor outlets closely clustered with other outlets and in total disregard of the views of the local community are of great concern.
- 3.49 Opening hours for liquor sales should be modified according to community wishes. If a community wants to take steps to reduce alcohol-related harm, they need to be supported in ensuring they can make the necessary changes.
- 3.50 The committee commends the introduction, in New South Wales, of risk based licences. These licences impose higher fees on venues and outlets that have later trading hours, poor compliance or are in high risk locations.
- 3.51 The committee wants risk-based licencing and licencing fees based on the possible harm caused given greater consideration by states and territories.

Recommendation 5

- 3.52 **That the states and territories conduct detailed analysis of any demand increase for liquor licences particularly in areas of high risk drinking, with a view to moving towards a risk-based licencing system similar to that of New South Wales.**
- 3.53 The committee notes that marketing of alcohol is a big business and one that the alcohol industry self-regulates through the Alcohol Beverages Advertising Code (ABAC) Scheme which includes the ABAC Responsible Alcohol Marketing Code.
- 3.54 Currently advertisements for alcoholic drinks may not be broadcast during times when children would typically be watching unless it is part of a live broadcast of a sporting event. This makes a mockery of the regulations, given the strong connection between Aboriginal and Torres Strait Islander children and sport.
- 3.55 Watching a sporting program should not involve a child being bombarded with advertisements for alcohol, both directly and indirectly through sponsorship badges and caps for example.
- 3.56 The committee heard evidence about how sport can give Aboriginal and Torres Strait Islander people many positive things but is worried that the advertising of alcohol in sport could provide mixed messages.
- 3.57 The committee feels that the welfare and future of children is certainly more important than the profits of either sporting teams or the alcohol industry and considers that there is much to be gained by stopping alcohol advertising on television before 8.30pm.

Recommendation 6

- 3.58 **That the Commonwealth takes steps to ensure a nationally consistent and coordinated approach to alcohol advertising, including:**
- **Banning alcohol advertising during times and in forms of the media which may influence children**
 - **Banning alcohol sponsorship of sporting teams and sporting events, including but not limited to those in which children participate or may be involved, and**

- **That the Australian Communication and Media Authority change the Commercial Television Code of Practice to ensure that alcohol is not able to be advertised before 8.30pm and that no exemptions are given for alcohol promotion during sport broadcasting.**

Local supply reduction measures

- 3.59 Targeted strategies to reduce alcohol-related harm should be implemented in such a way as to ensure that the particular requirements of a community or a group of individuals are best met.
- 3.60 These strategies currently include supply reduction measures such as declaring communities as being dry, the development of alcohol management plans to control the way alcohol can be consumed in a particular community and 'alcohol accords'.
- 3.61 Across Australia there are many communities that have developed local supply reduction measures. For example, FARE observes that some remote communities, including Aurukun in Queensland and the Anangu Pitjantjatjara Yankunytjatjara (APY) lands in South Australia are 'dry', meaning that no alcohol is permitted in the community. Other communities, such as Tennant Creek in the Northern Territory, Ceduna in South Australia and Fitzroy Crossing and Karratha in Western Australia, have restrictions on when and what type of alcohol products can be purchased.⁴⁴

Community led

- 3.62 The Australian Drug Foundation (ADF) believes that Aboriginal and Torres Strait Islander communities must be empowered to control or end the supply of alcohol if that is what they wish.
- 3.63 ADF also recognises the value of any support for communities including scope for monitoring and the evaluation of the strategies so that communities can learn from their own and from other communities' experience.⁴⁵
- 3.64 The Central Land Council (CLC) states that community driven initiatives are the most common forms of treatment and support services in central
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44 FARE, *Submission 83*, p. 13.

45 ADF, *Submission 92*, p. 4.

Australia for minimising alcohol related harm. However, the problem is too often short-term funding and lack of follow-up for the time it takes to remain sober. They state:

These services effectively take people away from potentially dangerous situations reducing the risk of violence/accidents due to alcohol abuse and are mostly run by local people who have an in-depth understanding and knowledge of community dynamics. They also reduce the potential for arrests and people being taken into police custody.⁴⁶

- 3.65 The Australian Society for Medical Research believes that fostering the creation of local, community-driven initiatives will result in flexible, tailored support, capable of meeting the demand of individual communities.⁴⁷
- 3.66 The Healing Foundation notes that locally driven responses and leadership are critical to quality outcomes being realised.⁴⁸
- 3.67 APO NT notes the importance of Aboriginal and Torres Strait Islander people being in control of their own actions and services and the need to engage Aboriginal and Torres Strait Islander people in the planning and development of strategies to address the misuse of alcohol.⁴⁹

Community based Alcohol Management Plans

- 3.68 An Alcohol Management Plan (AMP) is a community agreement to tackle the harm caused by alcohol abuse. AMPs are developed in partnership with communities and with support from local organisations and governments.
- 3.69 A range of stakeholders were generally supportive of AMPs.⁵⁰
- 3.70 Other stakeholders were critical of current arrangements around AMPs. In particular:
 - few AMPs are actually in place, particularly in the Northern Territory⁵¹ despite many having been prepared and submitted for approval

46 CLC, *Submission 68*, p. 4.

47 Australian Society for Medical Research, *Submission 75*, p. 6.

48 Healing Foundation, *Submission 42*, p. 6.

49 APO NT, *Submission 72*, p. 13.

50 AHRC, *Submission 31*, p. 10; APO NT, *Submission 72*, p. 15, pp.31-33; University of Melbourne, *Submission 44*, p. 9; Mr John Patterson, Executive Officer, Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Committee Hansard*, Darwin, 3 April 2014, p. 21; ADF, *Submission 92*, p. 13; Aboriginal Health Council of Western Australia (AHCWA), *Submission 69*, p. 2; RACP, *Submission 28*, p. 24; FARE, *Submission 83*, p. 15.

- the CLC said that the benchmark criteria for Ministerial approval was too high⁵²
 - Dr Shelley Bielefeld was concerned that Ministerial approval was required⁵³ causing delays, and
 - the Australian Crime Commission (ACC) said that AMPs are difficult to enforce.⁵⁴
- 3.71 FARE comments that management plans designed to reduce alcohol harm that are not culturally appropriate will not be effective in Aboriginal and Torres Strait Islander communities, and the most effective approach requires AMPs to be driven and led by Aboriginal and Torres Strait Islander communities and agencies, with support from governments if needed to build the local capacity to develop the plans.⁵⁵
- 3.72 Concern was raised during the inquiry that once a community has mobilised to develop an AMP, the lack of responsiveness from governments can mean that impetus and motivation is lost. Professor Langton notes that some AMPs with community endorsement had been waiting for approval for two years or longer.⁵⁶
- 3.73 Other submitters called on the Government to make it a priority that once AMPs are finalised they are swiftly ratified by the Minister.⁵⁷
- 3.74 The Northern Territory (NT) Government said that there was scope for better coordination of the AMP process between the NT Government and the Commonwealth.⁵⁸ IRAG expresses the following view:
- Aboriginal people can come up with their own solutions for their own problems, that's why we [Mt Nancy town camp] worked on our Alcohol Management Plan. This has never been supported by the NT government and it has never been supported by the federal government. Our time and effort has been wasted, money has been wasted to recreate the wheel. We know that there are social issues and we know that there is violence. We try very hard to do what we can to stop these.⁵⁹

51 Mr Patterson, AMSANT, *Committee Hansard*, Darwin, 3 April 2014, p. 20; Intervention Rollback Action Group (IRAG), *Submission 57*, p. 2.

52 CLC, *Submission 68*, p. 7.

53 Dr Shelley Bielefeld, *Submission 67*, p. 4.

54 Australian Crime Commission (ACC), *Submission 59*, p. 7.

55 FARE, *Submission 83*, p. 19.

56 Professor Marcia Langton, *Committee Hansard*, Melbourne, 30 May 2014, p. 29.

57 Dr David Cooper, Manager, Research Advocacy Policy, AMSANT, *Committee Hansard*, Darwin, 3 April 2014, p. 23; APO NT, *Submission 72*, p. 6.

58 Northern Territory (NT) Government, *Submission 60*, p. 25.

59 IRAG, *Submission 57*, p. 4.

Targeted supply restrictions

- 3.75 The committee heard that strategies to manage the supply of alcohol in Aboriginal and Torres Strait Islander communities were also in response to increases in harmful alcohol use at certain times of the year.
- 3.76 For example increases in visitors from remote communities to town camps in the Northern Territory during events such as football carnivals often alter drinking patterns in those locations.⁶⁰
- 3.77 Mrs Brahim from the Julalikari Council Aboriginal Corporation in Tennant Creek observes that ‘in the football season you will see a huge influx of people – families, as well as kids that are not going to school.’⁶¹
- 3.78 The Lyndon Community describes the strategies to reduce alcohol-related violence in Orange, NSW on specific days or occasions. They noted there was early closing on high risk days such as Christmas and Anzac Day and restrictions on the alcohol content of drinks served at races.⁶²
- 3.79 The committee heard that local police played a key role in cooperating and managing alcohol supply during football carnivals in places such as Tennant Creek.⁶³

Changes to liquor licencing laws Coober Pedy

- 3.80 The Coober Pedy Hospital and Health Services comment that, following changes to liquor licencing laws in Coober Pedy in September 2013, the overall number of accident and emergency presentations decreased by about 14 per cent.⁶⁴

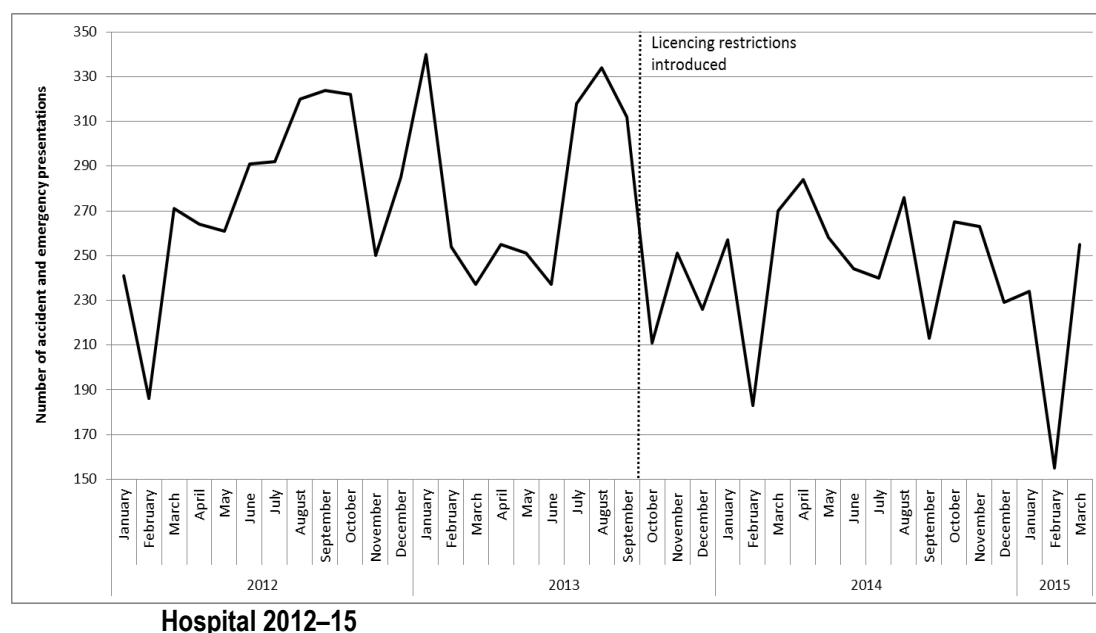
60 ACC, *Submission 59*, p. 6.

61 Mrs Patricia Brahim, Chief Executive Officer, Julalikari Council Aboriginal Corporation, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 26.

62 The Lyndon Community, *Submission 16*, p. 9.

63 Mr Stewart Naylor, Member, Tennant Creek Alcohol Reference Group, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 3.

64 Coober Pedy Hospital and Health Services, *Submission 131*, p. 3.

Figure 3.1 The impact of changes to liquor licencing laws on hospital presentations: Coober Pedy

Source Coober Pedy Hospital and Health Services, *Submission 131*, p. 8.

3.81 Figure 3.1 illustrates that accident and emergency presentations at the Coober Pedy Hospital have trended downwards since September 2013, from a peak of 340 in January 2013 to a low of 155 in February 2015.⁶⁵ The number of accident and emergency presentations varies seasonally, with February recording the lowest number of presentations in each year.

3.82 The Coober Pedy Hospital reports that there have been substantial decreases in accident and emergency presentations for Aboriginal and Torres Strait Islander people experiencing a variety of conditions since the licencing changes, including:

- psychosocial presentations by 17 per cent
- lacerations by 34 per cent, and
- musculoskeletal problems by 33 per cent.⁶⁶

3.83 In addition, inpatient admissions for Aboriginal and Torres Strait Islander people seeking treatment for alcohol issues increased by 30 per cent.⁶⁷

⁶⁵ Coober Pedy Hospital and Health Services, *Submission 131*, p. 8.

⁶⁶ Coober Pedy Hospital and Health Services, *Submission 131*, p. 4.

⁶⁷ Coober Pedy Hospital and Health Services, *Submission 131*, p. 6.

Alcohol Accords

- 3.84 An Alcohol Accord is a term used to describe a voluntary agreement between licensees and other stakeholders to limit the harm caused by alcohol in communities.
- 3.85 Government and alcohol industry stakeholders were supportive of the role of alcohol accords in reducing harm.⁶⁸ For example, the Australian Hotels Association (AHA) gave evidence that local liquor accords can be a valuable tool for reducing alcohol-related harm and ensuring local licensees work together to address community concerns.⁶⁹
- 3.86 Similarly, the Queensland Government said that accords play a key role in harm minimisation and enable effective communication and problem solving between licensees and other stakeholders.⁷⁰
- 3.87 Conversely, the NDRI observes that voluntary accords have limited effect.⁷¹

Canteens and licenced clubs

- 3.88 Some witnesses drew attention to the provision of ‘wet’ canteens and licenced clubs in some communities, owned and operated by Aboriginal and Torres Strait Islander community councils.
- 3.89 Dr Maggie Brady explains that community licenced clubs and canteens were introduced in many Aboriginal and Torres Strait Islander communities following the end of prohibition laws in the 1960s which were:
- ... based on a very laudable idea that people could have limited amounts of alcohol and be eased into learning about drinking moderately.⁷²
- 3.90 The idea that licenced clubs could teach people responsible drinking is supported by the Association of Alcohol and Other Drug Agencies NT.⁷³ The Association argues that:

68 Australian Hotels Association (AHA), *Submission 45*, p. 5; NSW Government, *Submission 62*, p. 9; Mr Jordan Jenkins, Licensees Alcohol Accord Tennant Creek, *Committee Hansard*, Tennant Creek, 1 April 2014, pp. 8-13; NT Government, *Submission 60*, p. 8; Queensland Government, *Submission 98*, p. 20.

69 AHA, *Submission 45*, p. 5.

70 Queensland Government, *Submission 98*, p. 20.

71 NDRI, *Submission 47*, p. 31.

72 Dr Maggie Brady, *Committee Hansard*, Canberra, 23 October 2014, p. 1.

73 Association of Alcohol and Other Drug Agencies NT, *Submission 11*, p. 5.

... without the opportunity to learn responsible drinking behaviour, young people are introduced to alcohol on the side of the road where the behaviour is anything but responsible.⁷⁴

- 3.91 Associate Professor Alan Clough describes the management of canteens by Aboriginal and Torres Strait Islander councils as a conflict of interest:

The conflict of interest was that these councils, which generally had few funds at that time to support community and social services, came to rely on the funds from the canteens to support a lot of the community activities. At the same, of course, they were essentially obliged to keep the peace and keep good order.⁷⁵

- 3.92 Professor d'Abbs states of the small number of communities that established licensed clubs in the Northern Territory, most were shown to have significantly higher levels of alcohol consumption than in the Northern Territory as a whole.⁷⁶

- 3.93 Dr Paul White, a specialist physician in psychiatry, asserts that the introduction and operation of licenced canteens in Cape York in Queensland had a damaging impact on communities:

They have lost two or three generations of Indigenous folk on the Cape, and it was very much around the introduction of the canteens into the towns in the 1970s, and the movement of people from the outstations into those centres.⁷⁷

Banned Drinkers Register

- 3.94 The Northern Territory's Banned Drinkers Register (BDR) was highlighted as an example of a successful, albeit short-lived, measure to reduce harmful alcohol use and alcohol related harm.⁷⁸ The BDR was designed to stop problem drinkers from purchasing alcohol, and included a central database that collected information on the identity of banned drinkers. The BDR was in operation in the Northern Territory from July 2011 to August 2012.⁷⁹

74 Association of Alcohol and Other Drug Agencies NT, *Submission 11*, p. 2.

75 Associate Professor Alan Clough, *Committee Hansard*, Cairns, 17 February 2015, p. 3.

76 Professor Peter d'Abbs, Menzies School of Health Research, *Submission 99*, p. 4.

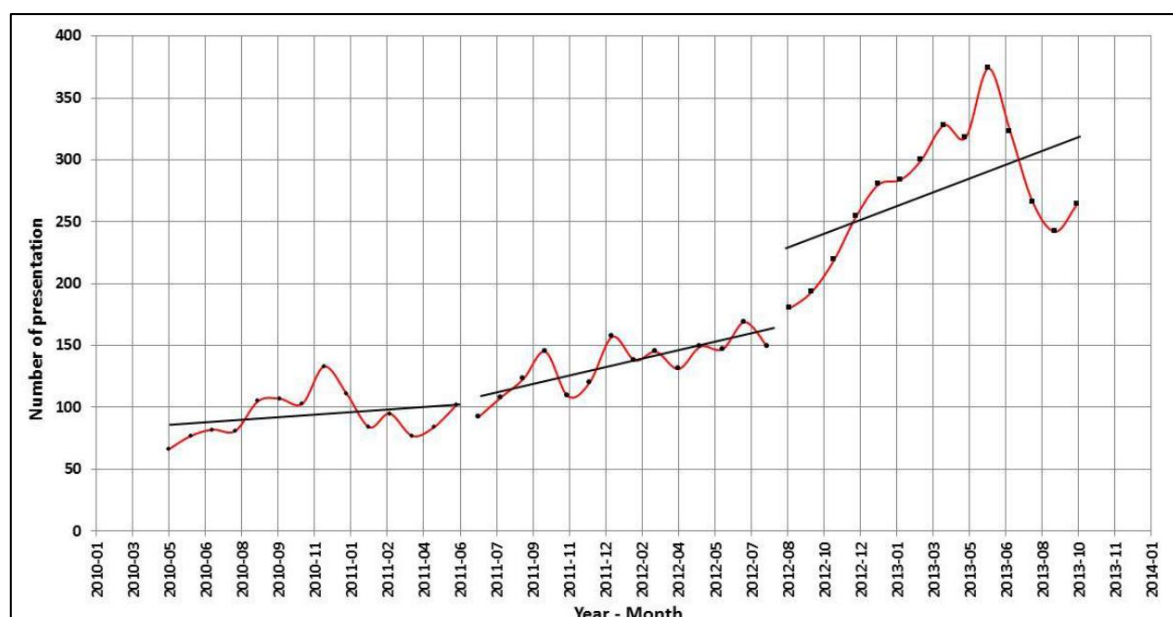
77 Dr Paul White, Specialist Physician, Synapse, *Committee Hansard*, Brisbane, 20 June 2014, p. 40.

78 See, for example: Mr Vince Kelly, President, NTPA, *Committee Hansard*, Canberra, 5 June 2014, p. 2; Dr John Boffa, Spokesperson, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 3.

79 PAAC, *Submission 7.1*, p. 40.

- 3.95 It was emphasised that when the BDR was abolished, alcohol-related harms in the Northern Territory increased. The NTPA notes alcohol-related hospital emergency admissions rose by 80 per cent in the 14 months following the abolition of the BDR in the NT.⁸⁰

Figure 3.2 Alice Springs Hospital Emergency Department presentations for conditions wholly attributable to alcohol before, during and after the operation of the Northern Territory Banned Drinkers Register



Source People's Alcohol Action Coalition, Submission 7.1, p. 39.

- 3.96 Figure 3.2 illustrates that when the BDR was removed in August 2012, alcohol-related admissions to the hospital's emergency department were approximately double the average monthly admissions when the BDR was in operation.⁸¹
- 3.97 The NTPA asserts that the BDR needed time to mature,⁸² while a substantial number of witnesses called for the reintroduction of the BDR.⁸³
- 3.98 Both FARE and the PAAC note that while no formal evaluation of the BDR was conducted by the NT Government, subsequent analysis by the NDRI has shown that there was a reduction in alcohol-related harms in Alice Springs as a result of the BDR.⁸⁴ This is in contrast to statements

⁸⁰ NTPA, Submission 27, pp. 13-14.

⁸¹ For further analysis, see Submission 7.1, pp. 39-44.

⁸² NTPA, Submission 27, p. 11.

⁸³ See, for example: Ms Andrea Mason, Coordinator, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, Committee Hansard, Alice Springs, 31 March 2014, p. 5; PAAC, Submission 7.1, p.5; CLC, Submission 68, p. 7; CLANT, Submission 76, p. 1; FARE, Submission 83, p. 11.

⁸⁴ FARE, Submission 83, p. 37; PAAC, Submission 7.1, p. 23.

made by the NT Government that the BDR was abolished because it was not working.⁸⁵

Conclusion

- 3.99 A range of local supply reduction measures that communities are being used to meet the particular requirements of a community.
- 3.100 The change in a community when alcohol consumption is moderated or excluded can be dramatic, for example on Groote Eylandt or Fitzroy Crossing. The committee also heard about the positive effect of accords and targeted supply restrictions
- 3.101 The committee saw clear evidence of the benefit of steps being taken to change the availability of alcohol for the duration of a big event. This requires police and state or territory cooperation and planning with the community. The whole community can then feel safe and enjoy the event that is not marred by alcohol-related violence and associated harm.
- 3.102 The committee strongly believes that governments at all levels should support these local strategies, rather than hinder them through unnecessary restrictions, red tape or timeframes.
- 3.103 The committee notes with concern the lack of cooperation from the Northern Territory Government to this inquiry. The committee was prevented from obtaining any direct evidence from hospital staff and police in the Northern Territory on their experience of alcohol-related harm. Although the Northern Territory Government provided an aggregated submission, this did not address many of the concerns of those dealing with alcohol-related harm on a daily basis in the Territory.
- 3.104 The committee commends Coober Pedy for developing a whole-of-community solution to addressing the harmful use of alcohol, especially their willingness to adopt restrictions in the non-Indigenous and Aboriginal and Torres Strait Islander communities.
- 3.105 In relation to Alcohol Management Plans, the committee heard of completed plans sitting on minister's desks for years, with the goodwill and momentum of the community slowly dissipating. This needs to change.
- 3.106 Governments at all level must facilitate the efforts of a community to reduce alcohol-related harm in their community. This can involve

85 The Hon Robyn Lambley, Deputy Chief Minister, NT Government 'New alcohol statistics again show BDR was a useless tool', *Media Release 140228*, 28 February 2014.

flexibility around licencing conditions for events, quickly approving AMPs and being willing to listen to a community rather than dictating to them.

- 3.107 The committee considers it important that support for community driven initiatives to minimise alcohol misuse in Aboriginal and Torres Strait Islander people is prioritised and that communities are empowered and supported to drive these initiatives.

Recommendation 7

- 3.108 **That governments at all levels:**

- **prioritise Aboriginal and Torres Strait Islander community driven strategies to reduce the harmful effects of alcohol**
- **ensure that communities are empowered to develop the strategies that will work for their communities, and**
- **cooperate and facilitate any work in Aboriginal and Torres Strait Islander communities which aims to change the liquor trading hours in their community.**

Community Alcohol Management Plans and other community driven strategies need to be reviewed and processed within a maximum of a six month period, including where any alterations are recommended.

The current backlog of Community Alcohol Management Plans in the Department of Prime Minister and Cabinet need to be cleared by January 2016.

- 3.109 The evidence shows that the Northern Territory's BDR was working effectively to reduce the supply of alcohol to problem drinkers, and that its abolition was associated with increases in alcohol-related harm.
- 3.110 The committee is concerned that, despite evidence of its effectiveness and significant support from stakeholders, the BDR was abolished after one year of operation. The committee is of the view that the BDR needed more time to develop, and that a longer period of operation would have yielded better results.
- 3.111 The committee calls on the NT Government to immediately reinstate the BDR. While recognising that the abolition of the BDR was a decision for the NT Government, the committee asserts that it is the Northern Territory's responsibility to act in the best interests of Aboriginal and

Torres Strait Islander people in the Territory and reinstate a measure that has been shown to be effective.

Recommendation 8

- 3.112 **That the Northern Territory Government re-introduce the Banned Drinker's Register and set up a comprehensive data collection and evaluation program which monitors criminal justice, hospital and health data.**

Best practice alcohol abuse treatments and support

Introduction

- 4.1 The committee took evidence on the current treatment options for Aboriginal and Torres Strait Islander people who are suffering from alcohol-related harm.
- 4.2 It was evident that there is no 'one-size-fits-all' intervention that effectively treats and minimises the harmful effects of alcohol in Aboriginal and Torres Strait Islander communities.
- 4.3 This chapter explores the experience among health professionals, community groups and other stakeholders related to best practice treatments for harmful alcohol use in Aboriginal and Torres Strait Islander communities. The issues discussed include effective primary care, investment in training and infrastructure, community-based approaches, and social and cultural support.
- 4.4 The evidence to the inquiry indicates that culturally appropriate treatments are important, as is the need to foster evidenced-based approaches to treatments adequate resources for these programs.

Evidence based treatment

- 4.5 The importance of an evidence base to develop best practice treatment strategies for alcohol-related harm was strongly emphasised by a number of peak bodies during the inquiry.

- 4.6 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack emphasise the importance for Aboriginal and Torres Strait Islander young people to have appropriate access to a full range of proven evidence-based treatments for alcohol dependence, including skilled counselling, relapse prevention medications, and management of mental health conditions, adapted to be culturally appropriate and accessible.¹
- 4.7 The Royal Australasian College of Physicians (RACP) submits however that obstacles to treatment can include geographic isolation or development of cultural resources.²
- 4.8 The People's Alcohol Action Coalition (PAAC) states that both national and international experiences and expertise will help inform future policy. They suggest that this is based on an agreed national data collection and reporting system which will allow monitoring of the effectiveness of programs.³
- 4.9 Australian Indigenous HealthInfoNet current resource development program, the Australian Indigenous Alcohol and Other Drugs Knowledge Centre (Knowledge Centre), aims to foster an evidence-based approach to reducing alcohol harm in Aboriginal and Torres Strait Islander communities.⁴
- 4.10 Among its recommendations for future policy, PAAC emphasises that evidenced-based early intervention is vital as a primary means to prevent alcohol-related harms in the future.⁵ PAAC also stress the importance of early intervention in breaking the intergenerational cycle of harmful alcohol use.
- 4.11 The *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* is an evidence based policy framework for improving Aboriginal and Torres Strait Islander health. It has been developed to provide an overarching framework which builds links with other major Commonwealth health activities and identifies areas of focus to guide future investment and effort.⁶

1 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, pp. 2, 10. See also: Royal Australasian College of Physicians (RACP), *Submission 28*, p. 2.

2 RACP, *Submission 28*, p. 29.

3 People's Alcohol Action Coalition (PAAC), *Submission 7.1*, p. 2.

4 Australian Indigenous HealthInfoNet, *Submission 35*, p. 2.

5 PAAC, *Submission 7.1*, p. 3.

6 Department of Health, *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, 2013.

Culturally sensitive treatment

- 4.12 The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINM) describes cultural safety as being the absence of racism and appropriate consideration given to the cultural values, meanings and protocols of Aboriginal and Torres Strait Islander people in institutional settings.⁷
- 4.13 The Western Australian Network of Alcohol & other Drug Agencies (WANADA) emphasises the need for cultural awareness and competency, ensuring that any strategies incorporate an Aboriginal and Torres Strait Islander holistic concept of health and well-being and are grounded in an Aboriginal and Torres Strait Islander understanding of the historical factors, including traditional life, the impact of colonisation and its ongoing effects.⁸
- 4.14 The Northern Territory (NT) Government further states that Aboriginal and Torres Strait Islander leadership, community consultation, direction, negotiation and involvement, form the basis of the development of programs, services, policies and strategies that impact the Aboriginal and Torres Strait Islander people.⁹
- 4.15 A key component of adapting strategies to specific cultural needs, as noted by the Australian Drug Foundation (ADF), is to enable Aboriginal and Torres Strait Islander people, organisations and communities to use their unique knowledge and expertise to lead alcohol and drug services that are being provided to Aboriginal and Torres Strait Islander individuals, families and communities.¹⁰
- 4.16 ADF notes that cultural adaptation is an important issue because interventions for alcohol harm designed for non-Indigenous people would not necessarily resonate with an Aboriginal or Torres Strait Islander, given differences of worldview, literacy and language.¹¹
- 4.17 Associate Professor Ezard from St Vincent's Hospital Alcohol and Drug Service explains the concept of 'culturally compelling' interventions for

7 Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINM), *Submission 24*, p. 6. See also: National Centre for Education and Training on Addiction (NCETA), *Submission 34*, p. 9.

8 Western Australian Network of Alcohol & other Drug Agencies (WANADA), *Submission 87*, p. 4.

9 Northern Territory (NT) Government, *Submission 60*, p. 22.

10 Australian Drug Foundation (ADF), *Submission 92*, p. 11.

11 ADF, *Submission 92*, p. 12; the study cited by ADF on 'Motivational Care Planning' can be accessed at <<http://www.substanceabusepolicy.com/content/7/1/33>> viewed 15 May 2015.

alcohol-related harm.¹² This concept recognises that culture has a significant impact on all peoples lifestyle choices, and their understanding of health and illness, and utilises the underlying knowledge of a specific culture to make distinctions on issues that may be culturally bound, that are normally mistaken for common sense issues.¹³

Aboriginal and Torres Strait Islander controlled services

- 4.18 The RACP consider that Aboriginal Community Controlled Health services (ACCHS) have a unique role to play in making treatment services more accessible. There is significant evidence that community control of health organisations can improve access to care, make the healthcare provided more appropriate, and provide a more holistic approach to better serve people with complex needs.¹⁴
- 4.19 The Healing Foundation comments that mainstream services are often not equipped to provide appropriate services to Aboriginal and Torres Strait Islander people suffering from the trauma that leads to alcohol or drug related harm as well as depression, anxiety, and family and domestic violence.¹⁵
- 4.20 The Aboriginal Health Council of South Australia Inc describes how Aboriginal and Torres Strait Islander people can present to ACCHS for a variety of reasons which can provide the chance for early intervention when alcohol-related problems are starting to emerge.
- 4.21 Aboriginal Peak Organisations of the Northern Territory (APO NT) recommends that ACCHS be resourced, at all levels of government, to deliver social and emotional well-being programs (SEWB) for Aboriginal and Torres Strait Islander people together with integrated SEWB, mental health and alcohol and other drug (AOD) services, as effective, evidence-based mechanisms to address harms caused by alcohol.¹⁶
- 4.22 A number of other submissions to this inquiry, including those from state and territory governments, support partnerships between government

12 Associate Professor Nadine Ezard, Clinical Director, The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Committee Hansard*, Sydney, 5 September 2014, pp. 41-42.

13 Associate Professor Ezard, The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Committee Hansard*, Sydney, 5 September 2014, pp. 41-42.

14 RACP, *Submission 28*, p. 29.

15 Healing Foundation, *Submission 42*, p. 10.

16 Aboriginal Peak Organisations of the Northern Territory (APO NT), *Submission 72*, p. 6.

and Aboriginal and Torres Strait Islander community groups to deliver evidence-based best-practice treatments for alcohol-related harm.¹⁷

National Indigenous Drug and Alcohol Committee

- 4.23 The National Indigenous Drug and Alcohol Committee (NIDAC) was the leading voice in Aboriginal and Torres Strait Islander alcohol and drug policy advice,¹⁸ until it was abolished in December 2014. NIDAC's responsibilities have been transferred to the Australian National Advisory Council on Alcohol and Drugs (Advisory Council).¹⁹
- 4.24 As part of its advisory role, NIDAC contributed to the development of government policies to address alcohol and drug issues in Aboriginal and Torres Strait Islander communities. NIDAC also worked with the Aboriginal and Torres Strait Islander community controlled health sector, and convened an annual conference to develop the capacity of those working to address alcohol and drug related harms.²⁰
- 4.25 The former Deputy Chair of NIDAC, Mr Scott Wilson, comments that where previously organisations would go to NIDAC for Aboriginal and Torres Strait Islander perspectives on alcohol and drug issues, there is now no single point of contact for such advice.²¹

Training and recruitment

- 4.26 The ACCHS is the largest private employer industry of Aboriginal and Torres Strait Islander people within Australia, estimated at 5,829 workers, 3,215 who are Aboriginal and Torres Strait Islander.²²
- 4.27 The vital role of Aboriginal and Torres Strait Islander health workers in alcohol-related harm treatment programs was emphasised. The importance of adequate staffing and sufficient funding for training and

17 See The National Aboriginal and Torres Strait Islander Legal Services and the Human Rights Law Centre, *Submission 58*, p. 5; NT Government, *Submission 60*, p. 31; New South Wales Government, *Submission 62*, p. 8; Central Land Council (CLC), *Submission 68*, pp. 2-3; WANADA, *Submission 87*, p. 5; Queensland Government, *Submission 98*, p. 13.

18 National Indigenous Drug and Alcohol Committee (NIDAC), *Submission 91*, p. 1.

19 The Treasury, *Mid-Year Economic and Fiscal Outlook*, Appendix A: Policy decisions taken since the 2014-15 Budget, December 2014, p. 171.

20 NIDAC, *Submission 91*, p. 1; Mr Scott Wilson, Deputy Chair, NIDAC, *Committee Hansard*, Canberra, 15 May 2014, p. 1.

21 Mr Scott Wilson, Director, Aboriginal Drug and Alcohol Council (SA) Inc. (ADAC), *Committee Hansard*, Adelaide, 5 May 2015, p. 11.

22 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 52*, p. 3.

recruitment to deliver these services effectively was also a common theme in the evidence.

- 4.28 Professor Conigrave, Dr Lee and Mr Jack comment that Aboriginal and Torres Strait Islander health workers have a key role in ensuring accessible and appropriate treatment.²³
- 4.29 Healing Foundation emphasises that ‘there is a strong need within Australia to develop an appropriately trained and qualified Aboriginal and Torres Strait Islander social and emotional well-being workforce’²⁴ but cautions that several workforce-related issues currently impede the development of the community services sector including:
- high risk of vicarious or secondary trauma in the Indigenous social and emotional wellbeing workforce, many of whom are supporting kin and community members whilst attending to their own trauma and distress
 - over-reliance on non-Indigenous professionals who may not have the requisite skills or experience to assist Indigenous people with trauma presentations, and
 - inequitable distribution of health and social and emotional wellbeing workers across the country.²⁵
- 4.30 The National Centre for Education and Training on Addiction (NCETA) agrees that Aboriginal and Torres Strait Islander health and community workers have a vital role to play in dealing with alcohol-related harm in their communities but stresses that they cannot be expected to bear the full brunt of this responsibility and that staff require more investment, training and support.²⁶
- 4.31 NCETA explains that Aboriginal and Torres Strait Islander AOD workers face unique stressors which include:
- heavy work demands and a lack of clearly defined roles and boundaries reflecting high community need and a shortfall of Aboriginal and Torres Strait Islander AOD workers
 - dual forms of stigmatisation stemming from attitudes to AOD work and racism
 - difficulties translating mainstream work practices to meet the specific needs of Aboriginal and Torres Strait Islander clients
 - challenges of isolation when working in remote areas, and

23 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, pp. 2-3.

24 Healing Foundation, *Submission 42*, p. 10.

25 Healing Foundation, *Submission 42*, p. 10.

26 NCETA, *Submission 34*, p. 7.

- dealing with clients with complex comorbidities and health and social issues.²⁷
- 4.32 The Lyndon Community contends that there is a significant shortfall in those with the training and skills needed to treat Aboriginal and Torres Strait Islander people with alcohol problems, given that few Australian university courses provide drug and alcohol subjects, despite substance misuse being identified as the key issue in areas of work that relate to the health and community service sector.²⁸
- 4.33 NCETA submits that Aboriginal and Torres Strait Islander workers have distinct needs in their workplaces and suggests a number of measures to address these, including establishing professional and peak bodies for Aboriginal and Torres Strait Islander health workers, providing equal pay and working conditions, good infrastructure, promoting AOD work as a career option for Aboriginal and Torres Strait Islander graduates, and addressing any literacy problems.²⁹
- 4.34 The Aboriginal Health & Medical Research Council of New South Wales (AHMRC) notes there are some training and support resources available for Aboriginal and Torres Strait Islander health workers in NSW.³⁰
- 4.35 AHMRC adds that mainstream services and government drug and alcohol services may provide clinical mentorship and greater clinical and advisory support to drug and alcohol workers, particularly those working within the ACCHS.³¹
- 4.36 Mr Bob Goodie from the Kimberley Mental Health and Drug Service commented in Broome:

We know we are seeing more Aboriginal referrals, because we have the right people in place actually meeting and providing the support people require.³²

27 NCETA, *Submission 34*, p. 7.

28 The Lyndon Community, *Submission 16*, p. 13.

29 NCETA, *Submission 34*, pp. 8-9.

30 Aboriginal Health & Medical Research Council of New South Wales (AHMRC), *Submission 70*, p. 4.

31 AHMRC, *Submission 70*, p. 4. See also: Milliya Rumurra Aboriginal Corporation, *Submission 114*, p. 2.

32 Mr Bob Goodie, Regional Manager, Kimberley Mental Health and Drug Service, WA Country Health Service *Committee Hansard*, Broome, 1 July 2014, p. 14.

Resourcing

- 4.37 The resourcing of treatment and support programs for alcohol-related harm in Aboriginal and Torres Strait Islander communities was emphasised throughout the inquiry.
- 4.38 The PAAC note that a lack of resourcing and administrative deficiencies has affected the sustainability of Aboriginal and Torres Strait Islander-specific projects. Capacity building needs to occur to ensure the continued and ongoing success of these projects. This includes building skill to enable Aboriginal and Torres Strait Islander people to actively participate in and conduct project administration and research. It also includes improving the relevant cultural understandings of non-Indigenous workers and organisations, including language training.³³
- 4.39 PAAC emphasises that short funding cycles have a significantly negative impact on the retention, training and recruitment of staff:
- Short-term funding can undermine community commitment, weaken consistent implementation of quality treatment, and destabilise services through loss of experienced staff and continual diversion of resources into cycles of recruitment and training. Seven year funding blocks should be the standard requirement for effective implementation.³⁴
- 4.40 Ms Ilana Eldridge from the Larrakia Nation Aboriginal Corporation notes that few funding programs provide an administrative component and reiterated the critical role of professional administration in running programs.³⁵
- 4.41 RACP states that under-funding is often due in part to the complexity of the requirements for dealing with Aboriginal and Torres Strait Islander health issues such as alcohol-related harm.³⁶
- 4.42 RACP further comments that the demands placed on existing Aboriginal and Torres Strait Islander clinical staff due to funding constraints make it difficult for them to undergo further training and skills development.³⁷

33 The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 13.

34 PAAC, *Submission 7.1*, pp. 17-18.

35 Ms Ilana Eldridge, Executive Officer, Larrakia Nation Aboriginal Corporation, *Committee Hansard*, Darwin, 3 April 2014, p. 32.

36 RACP, *Submission 28*, p. 28. See also: Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 9.

37 RACP, *Submission 28*, p. 28. See also: National Drug Research Institute (NDRI), *Submission 47*, p. 11.

Conclusion

- 4.43 The committee has heard that developing the evidence base for what has worked in treating and supporting Aboriginal and Torres Strait Islander people with alcohol-related conditions is crucial for reducing harmful alcohol use and for informing future policy considerations.
- 4.44 Current evidence suggests that early intervention, as well as sustained, longer-term treatments can be highly effective in reducing harmful alcohol use and preventing alcohol-related harms in Aboriginal and Torres Strait Islander communities.
- 4.45 Given that the provision of alcohol treatment and support programs in Aboriginal and Torres Strait Islander communities is administered by a range of government, non-government and community-controlled health services, the sharing of knowledge and expertise about evidence-based practices is particularly important, but is not always occurring.
- 4.46 Advisory bodies such as NIDAC have played an important role in fostering collaboration, coordination and knowledge-sharing across the AOD sector.
- 4.47 The committee is concerned about the loss of NIDAC, as the specialist body consulting with Aboriginal and Torres Strait Islander people about alcohol and drug-related issues.

Recommendation 9

- 4.48 **That the Commonwealth re-establish the National Indigenous Drug and Alcohol Committee.**
- 4.49 The committee asserts that there are important benefits to be derived from the Commonwealth Government committing funding to conduct research to develop the best practice evidence base for effective alcohol treatments for Aboriginal and Torres Strait Islander people, and to encourage collaboration about what works across the AOD sector.
- 4.50 The committee considers it vital that international evidence is taken into consideration.

Recommendation 10

- 4.51 **That the Commonwealth develop a protocol for the recording and sharing of effective, evidence-based practices in Aboriginal and Torres Strait Islander communities, in particular such practices that have relevance to Aboriginal and Torres Strait Islander communities. This protocol should be available by December 2016.**
- 4.52 The committee notes that short funding cycles for Aboriginal and Torres Strait Islander AOD programs makes it difficult for many organisations and health care providers to remain viable and build relationships, and contributes to difficulty in attracting and retaining suitably trained staff.
- 4.53 The administrative work to apply, run and acquit short term funding grants can also detract from service provision and add pressure to organisations.
- 4.54 The committee also asserts that short term strategies can be counterproductive in engaging with communities and reducing harmful alcohol use and alcohol-related harm. The committee notes that sustained, evidence-based solutions that have community support are clearly preferable over short term measures, and encourages all jurisdictions to incorporate longer timeframes in their strategies to minimise the harmful use of alcohol in Aboriginal and Torres Strait Islander communities.
- 4.55 The committee recommends that Commonwealth Government funding to programs providing treatment and support for Aboriginal and Torres Strait Islander people experiencing problems with alcohol is provided over a longer term cycle, particularly for effective programs.

Recommendation 11

- 4.56 **That where the Commonwealth funds Aboriginal and Torres Strait Islander alcohol treatment and support programs, these are funded over a longer cycle for at least four years, particularly for well-established and successful programs.**
- 4.57 The committee is concerned by evidence that many Aboriginal and Torres Strait Islander alcohol treatment and support workers do not have adequate or equitable access to appropriate training, career support and development, pay and working conditions.

- 4.58 The committee acknowledges there is an urgent need to develop the Aboriginal and Torres Strait Islander alcohol treatment and support workforce to ensure that culturally appropriate and accessible care is available for all Aboriginal and Torres Strait Islander people who require it. Moreover, it is vital Aboriginal and Torres Strait Islander workers in the sector are acknowledged, and appropriately supported in their workplaces.

Recommendation 12

- 4.59 **That the Commonwealth and key Aboriginal and Torres Strait Islander groups ensure access to training and career pathways for alcohol treatment and support workers. The employment conditions should be fair and equitable.**

Effective treatment of harmful alcohol use

- 4.60 The different effective interventions for alcohol-related harm in Aboriginal and Torres Strait Islander communities include medications, counselling and psychological care, social and cultural support, family involvement, follow-up care, and infrastructure such as sobering up shelters.
- 4.61 A lack of access by Aboriginal and Torres Strait Islander people to the best treatment options was frequently raised. Adequate investment, including infrastructure development, was identified as a key component to building best-practice care.
- 4.62 The Lyndon Community emphasises that effective treatments for harmful alcohol use are well documented but that their availability is particularly limited in remote Aboriginal and Torres Strait Islander communities.³⁸
- 4.63 The Victorian Alcohol and Drug Association (VAADA) states that much research in mainstream service settings is not readily applicable to Aboriginal and Torres Strait Islander communities.³⁹
- 4.64 The Aboriginal Drug and Alcohol Council (SA) Inc. (ADAC) emphasises that the National Aboriginal and Torres Strait Islander Drug Strategy should remain the basis of any approach to minimising harmful alcohol

38 The Lyndon Community, *Submission 16*, p. 10. See also: NDRI, *Submission 47*, p. 12.

39 Victorian Alcohol and Drug Association (VAADA), *Submission 29*, p. 3.

use and that only mainstream interventions that are culturally adapted for use in Aboriginal and Torres Strait Islander cases are effective treatment approaches.⁴⁰

- 4.65 ADAC stress that adaptation of mainstream intervention should include:
- ... an understanding of historical factors including traditional life, the impact of colonisation and its ongoing effects. Support for traditional ways of learning, providing teachings on how to attain and maintain connection with creation, and use of elders and returning to country.⁴¹
- 4.66 The National Drug Research Institute (NDRI) states in its submission that effective treatments should include:
- ... withdrawal management, screening, brief interventions, pharmacotherapies, counselling modalities, social support and on-going care (after-care).⁴²
- 4.67 BushMob highlights the need for youth specific AOD treatment programmes given the lack of youth AOD service provision around Australia.⁴³
- 4.68 The Northern Territory Government notes there is a barrier of remote geography in providing intervention services to some communities.⁴⁴
- 4.69 Ms Eileen Hoosan from the Central Australia Aboriginal Alcohol Programmes Unit (CAAAPU) states that different approaches are key to effective treatment and that mandatory treatment can be appropriate for Aboriginal and Torres Strait Islander people suffering from alcohol harm:
- For instance, for our people who are sick, mandated treatment ordered by the tribunal can provide a place of safety and refuge for them to become well enough to make strong decisions and engage in treatment.⁴⁵
- 4.70 CAAAPU states that 'there is no one-size fits all approach to dealing with Aboriginal alcohol and substance abuse'⁴⁶ and states that there needs to be flexible options around the delivery of services which can include

40 ADAC, *Submission 40*, p. 7.

41 ADAC, *Submission 40*, p. 7.

42 NDRI, *Submission 47*, p. 12.

43 BushMob, *Submission 12*, p. 1.

44 NT Government, *Submission 60*, p. 5.

45 Ms Eileen Hoosan, Chairperson, Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU), *Committee Hansard*, Alice Springs, 31 March 2014, p. 23.

46 CAAAPU, *Submission 73*, p. [13].

mandatory and residential treatment options, supported with outreach and aftercare services.⁴⁷

One size does not fit all

- 4.71 A number of submissions to the inquiry also emphasise that a 'one-size-fits all' strategy is not the correct approach to providing effective treatment for alcohol-related harm in Aboriginal and Torres Strait Islander communities.⁴⁸
- 4.72 The Foundation for Alcohol Research and Education (FARE) also emphasises in its submission that flexibility is needed in the treatment of alcohol harm among Aboriginal and Torres Strait Islander people to accommodate differing needs.⁴⁹ They describe a project utilising home detoxification in the Illawarra region of New South Wales as being an example of a diverse treatment option which may be successful in that region but not necessarily in others.⁵⁰
- 4.73 FARE also expresses the view that although Aboriginal and Torres Strait Islander people do access mainstream alcohol treatment services, more needs to be done to adapt these interventions to the Aboriginal and Torres Strait Islander context:
- ... to have access to Aboriginal and Torres Strait Islander staff, peer support groups and that treatment options that integrate the health care of the individual, the family and the community.⁵¹
- 4.74 FARE recommends psychosocial interventions, pharmacotherapy and aftercare as examples of evidenced based care that it believes should receive further support.⁵²
- 4.75 Queensland Aboriginal and Torres Strait Islanders Corporation for Alcohol and Drug Dependence Services (QAIAS) considers that best practice treatment is holistic and considers the complex history of each individual based on a comprehensive medical, social and psychological assessment.⁵³ They note that treatment considers physical and mental

47 CAAAPU, *Submission 73*, p. [13].

48 See VAADA, *Submission 29*, pp. 3, 5; Alcoholics Anonymous (AA) Australia, *Submission 64*, pp. 14, 20; The Australian Society for Medical Research (ASMR), *Submission 75*, p. 5; Royal Australian College of General Practitioners (RACGP), *Submission 82*, p. [5]; University of Wollongong, *Submission 88*, p. 14.

49 Foundation for Alcohol Research and Education (FARE), *Submission 83*, p. 32.

50 FARE, *Submission 83*, p. 32.

51 FARE, *Submission 83*, p. 33.

52 FARE, *Submission 83*, p. 33.

53 Queensland Aboriginal and Torres Strait Islanders Corporation for Alcohol and Drug Dependence Services (QAIAS), *Submission 110*, p. 3.

health challenges, legal issues, domestic violence, childhood trauma, emotional well-being, cognitive functioning (FAS or FASD impacts), educational background and social relationships.⁵⁴

Residential rehabilitation

- 4.76 A number of witnesses refer to the need for more specialist residential rehabilitation services catering for Aboriginal and Torres Strait Islander people.⁵⁵
- 4.77 Professor Peter d'Abbs notes that while the states and territories are responsible for funding prevention and treatment services, the Commonwealth has provided funding for residential rehabilitation services for Aboriginal and Torres Strait Islander people for a long time.⁵⁶
- 4.78 The Department of the Prime Minister and Cabinet (PM&C) provided evidence that in the 2013-14 financial year, funding of \$72.671 million was allocated for the Indigenous Drug and Alcohol Treatment Services programme.⁵⁷
- 4.79 The Lyndon Community provided a map of the distribution of residential programs in NSW to show that there is a lack of accessible residential withdrawal and rehabilitation services in rural New South Wales, particularly in the central and western parts of the state.⁵⁸
- 4.80 The Lyndon Community further comments that residential rehabilitation services are seen by many communities as the most effective approach for a number of reasons, such as ensuring a safe and controlled environment for the patient, and providing relief to those affected by the person misusing alcohol.⁵⁹ Lyndon Community notes, however, that an understanding of different and in some cases more appropriate treatment options is sometimes lacking.⁶⁰
- 4.81 The Lyndon Community states that while residential rehabilitation is a popular treatment preference, particularly in the justice system, it may not be the best option in all cases.⁶¹

54 QAIAS, *Submission 110*, p. 3.

55 Mrs Rebecca MacBean, Chief Executive Officer, Queensland Network of Alcohol and other Drugs Agencies (QNADA), *Committee Hansard*, Brisbane, 20 June 2014, p. 49; Mr Daniel Morrison, Chief Executive Officer, Aboriginal Alcohol and Drug Service, *Committee Hansard*, Perth, 30 June 2014, p. 27.

56 Professor Peter d'Abbs, Menzies School of Health Research, *Submission 99*, p. 3.

57 Department of Prime Minister and Cabinet (PM&C), *Submission 102*, p. 18.

58 The Lyndon Community, *Submission 16*, p. 12.

59 The Lyndon Community, *Submission 16*, pp. 10-11.

60 The Lyndon Community, *Submission 16*, pp. 10-11.

61 The Lyndon Community, *Submission 16*, pp. 2, 10.

- 4.82 NIDAC commissioned a cost-benefit analysis of establishing a 'break the cycle' network of Aboriginal and Torres Strait Islander-specific residential rehabilitation services for courts to use as an alternative to incarceration. It found that there were significant benefits, both financial and in terms of improvements in health and mortality, associated with the diversion of offenders into residential rehabilitation rather than incarceration.⁶²
- 4.83 The Central Land Council (CLC) reports that residential based treatment centres are often under-resourced and unable to provide the level of service required to assist clients with support beyond their time in the centre. CLC contends that if more resources to assist people with employment/training, accommodation and education were provided, this would increase the effectiveness of the program once people exit.⁶³

Sobering up Shelters

- 4.84 A number of submissions to the inquiry indicate that sobering-up shelters are needed as part of a best-practice treatment framework for alcohol-related harm in Aboriginal and Torres Strait Islander communities.⁶⁴
- 4.85 Sobering up shelters are a place where intoxicated people are taken and can recover from the intoxication, shower or have a meal. In Tennant Creek, their clothes are also washed.
- 4.86 The NT Government describes that sobering up shelters:
- ... provide care, protection and a safe environment for people found to be intoxicated in public, thereby limiting the risk of harm to individuals and the community and reducing police incarceration.⁶⁵
- 4.87 Evidence was given that these overnight stays keep people alive but do not deal with the problems underlying the addiction.

62 NIDAC, *Submission 94*, Attachment 7, p. xi.

63 CLC, *Submission 68*, p. 4.

64 See Victorian Aboriginal Community Controlled Health Organisation (VACCHO), *Submission 33*, p. [6]; NCETA, *Submission 34*, p. 6; ADAC, *Submission 40*, p. 8; National Alliance for Action on Alcohol (NAAA), *Submission 54*, p. [3]; The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 10; CLC, *Submission 68*, p. 4; FARE, *Submission 83*, pp. 11, 36-37; Central Australian Aboriginal Congress Aboriginal Corporation (CAACAC), *Submission 84*, p. 5; NIDAC, *Submission 94*, p. 3; Tangentyere Council Inc., *Submission 95*, p. 7; PM&C, *Submission 102*, p. 11.

65 NT Government, *Submission 60*, p. 50.

Detoxification and withdrawal management

- 4.88 A range of witnesses gave evidence on the need to improve access to detoxification and withdrawal services, and for improved coordination with rehabilitation and other treatment services.
- 4.89 Professor Conigrave, Dr Lee and Mr Jack was concerned that there is a lack of withdrawal management services available to Aboriginal and Torres Strait Islander people, and poor coordination between withdrawal management and rehabilitation services. They stated that there is anecdotal evidence of general hospitals being reluctant to admit Aboriginal and Torres Strait Islander people for withdrawal management.⁶⁶
- 4.90 Similarly, the Indigenous Health Unit, University of Wollongong, was concerned that while a number of detoxification and rehabilitation services have been developed for Aboriginal and Torres Strait Islander people in New South Wales, these services are not always accessible due to lack of resourcing.⁶⁷
- 4.91 FARE provided the example of a successful home detoxification service for Aboriginal and Torres Strait Islander people in the Illawarra region of New South Wales.⁶⁸
- 4.92 Tangentyere Council referred to the need for providing medically-supervised detoxification services as part of its sobering up shelter program.⁶⁹
- 4.93 Mr Selwyn Button from the Queensland Aboriginal and Islander Health Council (QAIHC) said that alcohol treatment management services in Queensland, including detoxification services, could be better coordinated.⁷⁰
- 4.94 Ms Nadia Currie from the Aboriginal Health Council of Western Australia (AHCWA) drew the committee's attention to the shortfall of detoxification facilities in the Kimberley. Aboriginal and Torres Strait Islander people requiring detoxification often needed to travel to Perth or Katherine.⁷¹

66 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, p. 7.

67 Indigenous Health Unit, University of Wollongong, *Submission 78*, p. 2.

68 FARE, *Submission 83*, p. 32.

69 Tangentyere Council, *Submission 95*, p. 21.

70 Mr Selwyn Button, Chief Executive Officer, Queensland Aboriginal and Islander Health Council (QAIHC), *Committee Hansard*, Brisbane, 20 June 2014, p. 28.

71 Ms Nadia Currie, Principal Policy Officer, Aboriginal Health Council of Western Australia (AHCWA), *Committee Hansard*, Perth, 30 June 2014, p. 32.

- 4.95 Mr Gillie Freeman from the Galiamble Men's Recovery Centre said that people accessing their service needed to go through detoxification first, and that there was currently a three month wait for detoxification beds. This delay caused many to give up on their treatment.⁷²

Screening and brief interventions

- 4.96 Screening and brief interventions are used to help identify excessive drinking patterns and provide an opportunity for intervention to help risky drinkers reduce or cease consuming alcohol. Screening and brief interventions are usually carried out in local health clinics and hospitals. A number of witnesses gave evidence that screening and brief interventions can be effective in reducing people's alcohol intake and in identifying those who require further treatment or referral.⁷³
- 4.97 The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) reported that brief interventions have resulted in fewer deaths and a larger reduction in alcohol consumption compared to those in control groups.⁷⁴
- 4.98 QAIAS gave evidence that the brief intervention component of its outreach services provide the opportunity for a dialogue to occur around alcohol use and promoting a healthier lifestyle, particularly for women of childbearing age.⁷⁵
- 4.99 The Royal Australian College of General Practitioners (RACGP) found it concerning that there was evidence suggesting that general practitioners are not routinely screening for alcohol problems, or carrying out brief interventions.⁷⁶
- 4.100 The Australasian College for Emergency Medicine (ACEM) consider that within the constraints of the busy acute care setting, there is an opportunity for clinicians to deliver screening, brief intervention and referral for treatment (SBIRT) for risky drinkers. They note that international research suggests that SBIRT can be an effective tool to identify, reduce, and prevent high risk use or abuse of alcohol and other drugs. SBIRT involves:

72 Mr Gillie Freeman, Counsellor/ Assistant Manager, Galiamble Men's Recovery Centre, *Committee Hansard*, Melbourne, 30 May 2014, p. 15.

73 RACGP, *Submission 82*, p. 4; Dr Tim Senior, Medical Advisor, RACGP, *Committee Hansard*, Melbourne, 30 May 2014, p. 22; VACCHO, *Submission 33*, p. 5.

74 VACCHO, *Submission 33*, p. 5.

75 QAIAS, *Submission 110*, p. 7.

76 RACGP, *Submission 82*, p. 4.

- a healthcare professional assessing a patient for risky drinking and/or drug taking using a standardized screening tool
 - conducting a structured conversation about risky alcohol and/or drug use
 - providing feedback and advice, and
 - referring the patient to a brief therapy or additional treatment if appropriate.⁷⁷
- 4.101 ACEM also recommends dedicated AOD workers in emergency departments who can screen patients and offer a brief intervention and follow-up as necessary.⁷⁸

Aftercare

- 4.102 A number of witnesses gave evidence that comprehensive after care was important for supporting clients transitioning out of residential care. For example, CAAAPU comments that residential rehabilitation programs must be supported by strong aftercare planning and outreach support.⁷⁹
- 4.103 Mr Stewart Naylor from the Barkly Region Alcohol and Drug Abuse Advisory Group (BRADAAG) asserts that in order for individuals to make lifestyle changes, a 24 month follow-up and after care plan is desirable.⁸⁰
- 4.104 Several witnesses expressed concern that there was limited capacity amongst service providers for the provision of aftercare for people completing treatment.⁸¹ For example, the Central Australian Aboriginal Legal Aid Service (CAALAS) note that in Alice Springs, there are two alcohol rehabilitation programs that treat clients on court orders, however these programs have restricted capacity and provide little comprehensive aftercare.⁸²
- 4.105 Ms Elizabeth Stubbs from the Council for Aboriginal Alcohol Program Services (CAAPS) says that capacity constraints mean that less transitional housing reduced support for people to reintegrate into the community.⁸³

77 Australasian College for Emergency Medicine (ACEM), *Submission 133*, p. 2.

78 ACEM, *Submission 133*, p. 2.

79 CAAAPU, *Submission 73*, p. 3.

80 Mr Stewart Naylor, Chief Executive Officer, Barkly Region Alcohol and Drug Abuse Advisory Group (BRADAAG), *Committee Hansard*, Tennant Creek, 1 April 2014, p. 2.

81 FARE, *Submission 83*, p. 33.

82 Central Australian Aboriginal Legal Aid Service (CAALAS), *Submission 56*, p. 16.

83 Ms Elizabeth Stubbs, Clinical Supervisor, Council for Aboriginal Alcohol Program Services (CAAPS), *Committee Hansard*, Alice Springs, 31 March 2014, p. 3.

- 4.106 The RACP comments that intense aftercare for typically long periods is a vital part of treating alcohol-related harm and access difficulties can exist for Aboriginal and Torres Strait Islander people in more remote areas:

However Aboriginal and Torres Strait Islander people may be returning to rural or remote communities where there is limited or, more often, no access to treatment or support services. Severe alcohol dependence typically behaves as a chronic disease, with periods of remission and relapse. Treatment and support services for alcohol dependence should be informed by models for chronic disease management.⁸⁴

- 4.107 Ms Eileen Hoosan from CAAAPU said that strong aftercare planning and outreach support is best provided in the context of family and community, and requires appropriate resourcing and security of funding.⁸⁵
- 4.108 Meanwhile, other commentators referred to how difficult it is for people to cease drinking in communities which continue to have a serious problem with alcohol.⁸⁶

Conclusion

- 4.109 In reviewing the evidence on best practice treatment options, the committee observes that there is no single solution.
- 4.110 The severity and complexity of harmful alcohol use and alcohol-related harms differ greatly both within and between different communities. Therefore a range of interventions, treatments and support options are required, depending on the needs of individuals, their age and gender, families and communities.
- 4.111 The committee is concerned that for geographic, cultural or other reasons, many do not have access to the range of best practice alcohol treatment and support options that are available to some other Australians in metropolitan settings.
- 4.112 The committee is concerned that there are not enough residential rehabilitation places for those who voluntarily seek help. The long waiting

84 RACP, *Submission 28*, p. 28.

85 Ms Eileen Hoosan, Chairperson, CAAAPU, *Committee Hansard*, Alice Springs, 31 March 2014, p. 23.

86 See, for example: Mr Noel Hayes, Chairperson, CAALAS, *Committee Hansard*, Alice Springs, 31 March 2014, p. 20; Ms Patricia Brahim, Chief Executive Officer, Julalikari Council Aboriginal Corporation, *Committee Hansard*, Darwin, 1 April 2014, p. 25.

times and having to relocate for months at a time may detract for an individual who would otherwise seek help.

- 4.113 Although there is some evidence that mandatory treatment can help some individuals the committee is concerned about mandatory treatment when there is no community follow-up. The committee was also concerned about the recriminalisation of drunkenness. The committee believes priority should be given to voluntary rehabilitation.
- 4.114 The importance of detoxification and withdrawal support were stressed to the committee. Where appropriate, these and other forms of treatment should be available to individuals with an alcohol problem. Aftercare should be built into all treatments to support those who are endeavouring to reduce drinking.
- 4.115 Given the overrepresentation of alcohol-related harm in some Aboriginal and Torres Strait Islander communities, the committee recommends that Aboriginal and Torres Strait Islander people be provided with better access to a full suite of evidence-based alcohol treatment and support options, bearing in mind that reducing the social and economic drivers of harmful drinking will ultimately make treatment and rehabilitation less necessary.
- 4.116 Give many crimes placing Aboriginal and Torres Strait Islander people in prison are alcohol related, prison authorities should focus on the treatment of addictions, as well as addressing the social and economic determinants of alcohol abuse. This is particularly important for young people, who should receive literacy, English language training, employment related skills development and parenting skills training.

Recommendation 13

- 4.117 **That the Department of the Prime Minister and Cabinet ensure that a full range of evidence-based, best practice treatments are available in order to meet the needs of all Aboriginal and Torres Strait Islander people, regardless of where they live. The treatment services should provide for families, follow-up services, and include detoxification and rehabilitation.**

Prevention Strategies

Introduction

- 5.1 The chapter examines a range of ways that demand for alcohol can be reduced, including through early intervention, the promotion and provision of alternatives to drinking, education, diversion, treatment and ongoing care.
- 5.2 It also raises some of the consequences of prevention strategies, some of which are unintended and can cause issues of their own.
- 5.3 The chapter also considers strategies such as that of the Alcohol Mandatory Treatment of the Northern Territory.

Alternatives to alcohol

- 5.4 While the reasons why people consume alcohol at harmful levels are many and complex, providing people with alternatives to drinking through greater opportunities for a better life through recreation, education and work are important demand reduction strategies.
- 5.5 Ms Nicola Coulter from the Northern Territory Council of Social Service asserts that demand reduction involves the provision of alternative activities away from alcohol, as well as health promotion and countering the view that 'alcohol is cool'.¹

1 Ms Nicola Coulter, Board Member, Northern Territory Council of Social Service , *Committee Hansard*, 3 April 2014, Darwin, p. 9.

- 5.6 The Wirrpanda Foundation runs the Happy Families Employment Program. In this program Aboriginal and Torres Strait Islander men work with mentors to support them in gaining meaningful employment and soft skills also with a focus on health and fitness creating a happier future for themselves and their families in Kwinana in Western Australia.²
- 5.7 The Foundation also runs the Indigenous Employment Program which is aimed at inspiring and creating opportunities for long-term unemployed Aboriginal and Torres Strait Islander people aged over 18 to reach their full potential and gain employment.³

Sport and recreation

- 5.8 The House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs (ATSIA committee) June 2011 report *Doing Time – Time for Doing: Indigenous youth in the criminal justice system* found that recreational activities, including sport, assisted young people to develop self-confidence and self-worth, ambitions for the future, and a commitment to community responsibility.⁴
- 5.9 In Ceduna, the committee heard that boredom contributes to young people drinking, particularly in the sporting off-season, or where parents are absent due to their drinking.⁵
- 5.10 While involvement in sport and recreation programs are seen as beneficial in providing people with alternatives to drinking, it was emphasised that responsible drinking practices also need to be promoted in sport at all levels.⁶
- 5.11 The Australian Drug Foundation (ADF) highlights the work of the Good Sports Program in the Northern Territory, which has assisted in reducing alcohol-related harm. The program helps sporting clubs to become healthier, safer and more family friendly places, and is estimated to have prevented over 1 300 alcohol-related injuries, assaults and road accidents combined in 2011 and 2012.⁷
- 5.12 The ADF noted:

2 Wirrpanda Foundation, *Submission 17*, p. 1.

3 Wirrpanda Foundation, *Submission 17*, p. 2.

4 House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Doing Time – Time for Doing: Indigenous youth in the criminal justice system*, June 2011, pp. 61; 64-72.

5 Senior Sergeant Matthew Steinbeck, Officer in Charge, Ceduna Police Station, *Committee Hansard*, Ceduna, 5 May 2015, p. 25.

6 Australian Society for Medical Research, *Submission 75*, p. 7.

7 Australian Drug Foundation (ADF), *Submission 92*, p. 19.

Good Sports is an example of the positive benefits that can come from implementing a simple yet effective program. For this reason Good Sports has now been adopted by over 6,500 clubs around Australia. It is often incorporated into wider community initiatives such as Liquor Accords and local Alcohol Management Plans as a key way of tackling alcohol problems in the important setting of sporting clubs.⁸

- 5.13 The Queensland Government reports that the provision of alternative activities away from alcohol are included as part of its Alcohol Management Reform Program.⁹ The Queensland Government comments that diversion from drinking programs, including sport and recreation activities such as cultural dance and music, youth discos, and wet season holiday programs can also contribute to crime prevention, health and wellbeing.¹⁰
- 5.14 The *Sport: More than a Game* report of the ATSIA committee focused on the importance of sport in improving Aboriginal and Torres Strait Islander wellbeing and supporting Closing the Gap targets.¹¹

Diversion

- 5.15 There is strong support for alcohol and drug diversion programs that redirect people who come into contact with the criminal justice system into the health system, with the aim of reducing alcohol dependency and minimising further offending.¹²
- 5.16 The National Congress of Australia's First Peoples state that 'prevention, early intervention and diversion of alcohol related crime offenders deliver significantly higher economic and social outcomes' than conventional sentences.¹³
- 5.17 There are a range of diversionary options available for people experiencing problems with alcohol and other drugs (AOD), who come before the courts. The Clontarf Foundation funds a number of programs for Aboriginal and Torres Strait Islander boys across Australia.

8 ADF, *Submission 92*, p. 20.

9 Queensland Government, *Submission 98*, p. 4.

10 Queensland Government, *Submission 98*, p. 21.

11 House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Sport: More than a game*, June 2013.

12 Foundation for Alcohol Research and Education (FARE), *Submission 83*, p. 33; Victorian Aboriginal Community Controlled Health Organisation Inc (VACCHO), *Submission 33*, p. 2.

13 National Congress of Australia's First Peoples, *Submission 97*, p. 13.

- 5.18 In New South Wales, there are a number of programs that aim to address the needs and risks of re-offending of Aboriginal and Torres Strait Islander offenders. These programs include the Balunda-a (Tabulam) Program, which is a court diversionary program provided in a community-based residential facility. The program aims to improve life skills and address specific areas of risk to reintegration in the community, including drug and alcohol misuse.¹⁴

Education

- 5.19 Educating people about the harmful effects of alcohol, particularly while they are young, is a strategy that can assist in preventing people from developing excessive drinking patterns.
- 5.20 There is support for more education about alcohol to be available at the national level. Professor Mike Daube from the McCusker Centre for Action on Alcohol and Youth argues that Australia needs 'strong, independent, sustained and well-funded public education on alcohol through mass media' in order to counter messages about the desirability of drinking from alcohol marketing and promotion.¹⁵
- 5.21 Professor Daube comments that, given the success of public health campaigns against tobacco smoking, a similar strategy could be used to inform the public about the harms of alcohol misuse.¹⁶
- 5.22 The Central Australian Aboriginal Legal Aid Service (CAALAS) stresses the need to educate communities about the health consequences of harmful alcohol use, and to encourage people who are struggling with their drinking to seek help as early as possible.¹⁷
- 5.23 The Wirrpanda Foundation illustrates that important work is currently being done in some schools to educate young people about harmful alcohol use and the problems it can cause.¹⁸ It provides the example of the Troy Cook Health and Leadership program, which caters for Aboriginal and Torres Strait Islander boys aged 10-17 years who are at risk of anti-social behaviour and disengaging from school. The program educates

14 New South Wales Government, *Submission 62*, p. 12.

15 Professor Mike Daube, Director, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, Perth, 30 June 2014, p. 19.

16 Professor Daube, McCusker Centre for Action on Alcohol and Youth *Committee Hansard*, Perth, 30 June 2014, p. 21.

17 Central Australian Aboriginal Legal Aid Service (CAALAS), *Submission 56*, p. 19.

18 Wirrpanda Foundation, *Submission 17*, p. 4.

- participants about the risks of alcohol and other drugs and promotes living a healthy and fulfilling life.¹⁹
- 5.24 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack from the University of Sydney comment that educating young people about the harms of AOD is unlikely to be effective if it occurs in isolation, and should be 'combined with measures to increase youth resilience and opportunity'.²⁰
- 5.25 MilliYa Rumurra Aboriginal Corporation suggests that there are school based AOD education programs which should be supported with parallel family based interventions.²¹
- 5.26 MilliYa Rumurra believes families are a critical focus area for AOD interventions and have developed a culturally secure Family Engagement and Support Program (FESP). The FESP centres on the Boab tree which is unique to the Kimberley region and has significance in traditional Aboriginal and Torres Strait Islander history. The FESP aims to engage with family members of clients during treatment.²²

Focus on Early Childhood

- 5.27 The People's Alcohol Action Coalition (PAAC) strongly support an approach which is based on early childhood development programs which they consider will break the inter-generational cycle of disadvantage and alcohol abuse that affects many Aboriginal and Torres Strait Islander families.²³
- 5.28 The Central Australian Aboriginal Congress (CAAC) state that the key to alcohol demand reduction is in the primary prevention of demand through supporting health development in early childhood.²⁴
- 5.29 PAAC note that there is an abundance of strong evidence that well-designed early childhood development programs are a key, cost-effective intervention to address intergenerational disadvantage.²⁵

19 Wirrpanda Foundation, *Submission 17*, p. 4.

20 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, p. 2.

21 MilliYa Rumurra Aboriginal Corporation, *Submission 114*, p. 3.

22 MilliYa Rumurra Aboriginal Corporation, *Submission 114*, p. 3.

23 People's Alcohol Action Coalition (PAAC), *Submission 7.1*, p. 2.

24 Central Australian Aboriginal Congress (CAAC), *Submission 84*, p. 5.

25 PAAC, *Submission 7.1*, p. 31.

Early intervention

- 5.30 For people who are at risk, or who have already developed problematic alcohol use, early intervention can be effective in reducing alcohol consumption, particularly with youth and young adults.²⁶
- 5.31 The ADF comments that the adequate resourcing of primary prevention and early intervention would 'reduce the demand for more intensive and expensive subsequent treatment of alcohol disorders'.²⁷
- 5.32 The ADF further note that evidence-based prevention and early intervention programs are a cost-effective way to reduce the development of harmful patterns of alcohol use. In particular, prevention programs that target whole communities by applying interventions using a coordinated strategy are likely to be more effective than interventions applied in isolation from each other and on a less coordinated basis.²⁸

Justice Reinvestment

- 5.33 Justice reinvestment was highlighted as a promising strategy for reducing the number of Aboriginal and Torres Strait Islander people who are incarcerated for alcohol-related offenses.²⁹
- 5.34 Ms Jillian Smith from the Council for Aboriginal Alcohol Program Services (CAAPS) supports justice reinvestment, in particular:
- ... looking at early intervention and prevention, where resources are better utilised by diverting a proportion of the corrections budget to communities that have high rates of alcohol-related offending to invest in education, housing and healthcare programs that will improve the wellbeing of families and, in particular, children.³⁰
- 5.35 The Aboriginal and Torres Strait Islander Social Justice Commissioner, Mr Michael Gooda, highlights a number of developments towards justice

26 Queensland Aboriginal and Torres Strait Islanders Corporation for Alcohol and Drug Dependence Services (QAIAS), *Submission 110*, p. 1, 7.

27 ADF, *Submission 92*, p. 12.

28 ADF, *Submission 92*, p. 12.

29 See, for example: Top End Women's Legal Service (TEWLS), *Submission 96*, p. 6; Ms Jill Rundle, Chief Executive Officer, Western Australian Network of Alcohol and other Drugs Agencies (WANADA), *Committee Hansard*, Perth, 30 June 2014, p. 30;

30 Ms Jillian Smith, Chief Executive Officer, Council for Aboriginal Alcohol Program Services (CAAPS), *Committee Hansard*, Darwin, 3 April 2014, p. 1

- reinvestment in his 2014 *Native Title and Social Justice Report*, including community initiatives in Bourke and Cowra, New South Wales.³¹
- 5.36 Commissioner Gooda notes that while governments in Australia have not yet adopted justice reinvestment, these community initiatives are doing some very positive work.³² Commissioner Gooda stresses:
- ... community governance, capacity and involvement are crucial in developing justice reinvestment plans with Aboriginal and Torres Strait Islander communities.³³
- 5.37 Commissioner Gooda asserts that justice reinvestment requires a shift away from punitive measures towards a preventative approach to crime reduction, stating that:
- ... there is a serious need to reorientate the conversation towards safe communities. If we can create safer communities, this will lead to less offending which in turn means less people going to jail. This may show that imprisonment is not cost effective in these times of economic restraint.³⁴
- 5.38 Proponents of justice reinvestment emphasise the significant financial cost of keeping people in detention, and argue that money can be better spent on community initiatives that minimise offending. In recommending Australia adopt a comprehensive justice reinvestment approach, Amnesty International recently reported that it costs about \$440,000 each year to keep a young person in detention in Australia.³⁵
- 5.39 In its 2011 report *Doing Time – Time for Doing: Indigenous youth in the criminal justice system*, the ATSIA committee supports the principles of

31 Commissioner Michael Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, *Native Title and Social Justice Report*, 2014, Australian Human Rights Commission (AHRC), p. 116.

32 Commissioner Michael Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, *Native Title and Social Justice Report*, 2014, AHRC, p. 108.

33 Commissioner Michael Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, *Native Title and Social Justice Report*, 2014, AHRC, p. 115.

34 Commissioner Michael Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, *Native Title and Social Justice Report*, 2014, AHRC, p. 116.

35 Amnesty International, *A brighter tomorrow: Keeping Indigenous kids in the community and out of detention in Australia*, 2015, p. 27. For original data, see: Productivity Commission, *Report on Government Services 2015*, Table 16A.1 'state and territory government real recurrent expenditure on youth justice services, (2013-14 dollars)', <www.pc.gov.au/research/recurring/report-on-government-services/2015/community-services/data/rogs-2015-volume-f-chapter16-attachment.xlsx>, viewed 5 June 2015.

justice reinvestment, and recommends that government effort should concentrate on early intervention and diversionary programs.³⁶

Alcohol Mandatory Treatment – Northern Territory

- 5.40 There is wide ranging concern about the Alcohol Mandatory Treatment (AMT) Scheme in the Northern Territory.³⁷ AMT is a compulsory assessment, treatment and aftercare program for people who have been repeatedly taken into protective custody for public intoxication.³⁸
- 5.41 Under this scheme, any people in the Northern Territory brought into protective custody three times in two months for being intoxicated in public are able to be held in a secure facility while their suitability for mandatory alcohol treatment is assessed. A person may be ordered by the Alcohol Mandatory Treatment Tribunal to undertake community based alcohol treatment for up to three months or be detained in a residential rehabilitation facility for up to three months. They can also be subject to welfare income management.³⁹
- 5.42 Criticisms of the AMT scheme included that it criminalised public drunkenness⁴⁰ which was against the recommendations of the Royal Commission into Aboriginal Deaths in Custody.⁴¹
- 5.43 The Law Society of the Northern Territory is concerned that there is a trend of criminalising addiction within the Territory.⁴²
- 5.44 In relation to people who have a serious alcohol dependency and refuse to engage in treatment, the CAAC considers that there should be no criminalising of the treatment process.⁴³ Criminalising alcohol consumption, in the view of the National Congress of Australia's First Peoples, is a failed strategy that adds to increasing rates of incarceration

36 House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Doing Time – Time for Doing: Indigenous youth in the criminal justice system*, June 2011, p. 321.

37 See, for example: Royal Australasian College of Physicians (RACP), *Submission 28*, p. 28; CAALAS, *Submission 56*, p. 13; Aboriginal Peak Organisations of the Northern Territory (APO NT), *Submission 72*, p. 36; Criminal Lawyers Association of the Northern Territory (CLANT), *Submission 76*, pp. 5-8; Mr Jonathon Hunyor, Principal Legal Officer, North Australian Aboriginal Justice Agency (NAAJA), *Committee Hansard*, Darwin, 3 April 2014, p. 13.

38 Northern Territory (NT) Government, *Submission 60*, p. 6.

39 CAALAS, *Submission 56*, p. 12.

40 Tangentyere Council, *Submission 95*, p. 20.

41 CAALAS, *Submission 56*, p. 13.

42 The Law Society of the Northern Territory, *Submission 89*, p. 6.

43 CAAC, *Submission 84*, p. 5.

and means that problems become hidden in watch houses, prisons and institutions.⁴⁴

- 5.45 Evidence was heard that young children and babies of women who were in mandatory treatment were not able to be accommodated and there was rarely any follow-up support after the release of the person back into their community.
- 5.46 Other criticisms of the AMT approach is that it is not supported by evidence of what works, is not being effectively evaluated, and is too expensive.⁴⁵
- 5.47 The Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU), an organisation that administers an AMT program, supports mandatory treatment. CAAAPU says that AMT provides another treatment path and assists many people who have alcohol problems to take control of their lives and their health.⁴⁶

Consequences of reduced supply

- 5.48 It was highlighted that where there is a demand for alcohol and a supply point is not available, people will engage in a range of activities to circumvent alcohol restrictions.⁴⁷
- 5.49 These activities include trafficking alcohol to restricted areas, sometimes referred to as 'grog' running or 'sly grogging', the presence of drinking camps set up outside of restricted areas, or the movement of community members to locations where alcohol is more readily available.
- 5.50 There is also the concern that when alcohol is less available, that substitution will take place, often with illicit drugs.

Humbugging

- 5.51 A number of submitters gave evidence of the practice of humbugging, where people are intimidated or pressured into handing over their money to others for inappropriate needs such as alcohol purchasing.⁴⁸

44 Ms Kirstie Parker, Co-Chair, National Congress of Australia's First Peoples, *Committee Hansard*, Sydney, 5 September 2015, p. 8.

45 Mr Jonathon Hunyor, Principal Legal Officer, NAAJA, *Committee Hansard*, Darwin, 3 April 2014, p. 13.

46 Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU), *Submission 73*, p. 2.

47 NT Government, *Submission 60*, pp. 9, 28.

- 5.52 Mr Stewart Naylor from the Tennant Creek Alcohol Reference Group spoke about humbugging:
- ‘You are my family member, so you have to come and drink.’ They want them to come and drink because that person has money and they do not. That person has saved their money to go to the football while the other one has chosen to go drinking. The person who is drinking knows who in their family group has money and there is an obligation within the family culture to provide it to each other. It is a very fine line for individuals to walk in that community.⁴⁹
- 5.53 Dr Shelley Bielefeld notes that income management was introduced in 2007 in the Northern Territory with the objective to minimise ‘humbugging’ and ensure funds intended for children’s welfare are used for that purpose.⁵⁰
- 5.54 At the public hearing in Ceduna Mayor Allan Suter commented that while the trial of income management had produced some positive results, he expressed concern that humbugging had arisen as a result of the implementation of income management.⁵¹
- 5.55 The Australian Crime Commission (ACC) states that:
- There is evidence to suggest that drinkers on income management are able to maintain high levels of consumption through the Indigenous domestic moral economy (demand sharing) and the substantial outflow and largesse from their drinking cohorts who are employed.⁵²

Creating ‘dry’ communities

- 5.56 One unintended consequence of alcohol restrictions has been the displacement of Aboriginal and Torres Strait Islander people from dry areas to areas without alcohol restrictions.⁵³
- 5.57 The Aboriginal Health Council of Western Australia (AHCWA) described consequences of displacement in the following terms:

48 Mr Stewart Naylor, Chief Executive Officer, Barkley Region Alcohol and Drug Abuse Advisory Group Inc, *Committee Hansard*, Tennant Creek, 1 April 2014, pp. 3-4; Councillor Allan Suter, Mayor, District Council of Ceduna, *Committee Hansard*, Ceduna, 5 May 2015, p. 1;

49 Mr Naylor, Tennant Creek Alcohol Reference Group, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 4.

50 Dr Shelley Bielefeld, *Submission 67*, p. 1.

51 Councillor Suter, District Council of Ceduna, *Committee Hansard*, Ceduna, 5 May 2015, p. 1.

52 Australian Crime Commission (ACC), *Submission 59*, p. 6.

53 Queensland Government, *Submission 98*, p. 7.

This not only impels excessive drinking outside of town but creates a social dichotomy between Aboriginal people who are campaigning for dry communities and those who force the old lifestyle of violence and alcohol dependence.⁵⁴

- 5.58 The Northern Territory (NT) Government is concerned about unmanaged drinking in unsafe public places.⁵⁵ It describes these drinking practices as including:
- ... on highways, close to rivers, or far away from communities hidden in the bush, where family members cannot watch over drinkers, where anti-social behaviour arises between clans and the mixing of communities, and where drinkers are at a long distance from Night Patrol or police officers.⁵⁶
- 5.59 The NT Government refers to research which found that the introduction of the Northern Territory Emergency Response resulted in drinking camps shifting further away from communities.⁵⁷ There was also an increased risk of car accidents from drinkers returning from camps.⁵⁸
- 5.60 This research found that drinking camps located close to the community but far enough away to not cause disruption, frequented predominantly by one clan or one community and run in accordance with community rules, generally had less alcohol-related incidents.⁵⁹
- 5.61 Professor Marcia Langton, Dr Richard Clenhall and Ms Kristen Smith assert that one of the negative consequences of widespread alcohol bans under Stronger Futures in the Northern Territory has been the establishment of informal drinking camps.⁶⁰
- 5.62 Evidence was given about a number of tragedies associated with informal drinking areas set up outside of the public restricted area at Mataranka in the Northern Territory. Langton, Clenhall and Smith report that eight deaths near Mataranka have involved intoxicated people walking into the path of fast-moving vehicles on the Stuart and Roper Highways.⁶¹
- 5.63 The Tangentyere Council expressed its concern about the issue of population and mobility/urban drift in Central Australia. They consider

54 Aboriginal Health Council of Western Australia (AHCWA), *Submission 69*, p. 30.

55 NT Government, *Submission 60*, p. 28.

56 NT Government, *Submission 60*, p. 28.

57 NT Government, *Submission 60*, p. 28.

58 NT Government, *Submission 60*, p. 28; M Langton, R Clenhall and K Smith, University of Melbourne, *Submission 44*, p. 7

59 NT Government, *Submission 60*, p. 28.

60 M Langton, R Clenhall and K Smith, University of Melbourne, *Submission 44*, p. 7

61 M Langton, R Clenhall and K Smith, University of Melbourne, *Submission 44*, p. 7.

that the issue is significant and represents a major factor in the determination of the level of disadvantage experienced by both residents and visitors. They also note that despite the significance of this issue there is little understood or done about it.⁶²

Trafficking alcohol or 'sly grogging'

- 5.64 The committee heard in evidence that alcohol is being trafficked illegally and sold to community members. This is often referred to as 'sly-grogging' although Commissioner O'Callaghan from the Western Australian Police does not favour this terminology:

I know this is a legal term, 'sly-grogging', but sly-grogging sounds a bit like something Jack the lad would do and is almost a bit mischievous. It is trafficking a restricted substance. That is what it is. We ought to start calling it 'trafficking a restricted substance' so that it has a level of gravitas that sly-grogging does not. It all sounds a bit mischievous to me, but it is a lot more serious than that.⁶³

- 5.65 Western Australian Police noted that the potential for profit from trafficking alcohol can be significant, citing a case from Fitzroy Crossing in late 2013 where the initial outlay of \$4,700 resulted in a profit of \$30,000.⁶⁴

- 5.66 Mr Peter Frewen from the Jungarni-Jutiya Indigenous Corporation in Halls Creek comments that:

... as soon as you get sly groggers coming to town you see all the broken bottles on the streets and stuff like that, and you hear the violence and you hear the parties. Then it ramps down for a couple of days until the next supply comes in. It is a real problem.⁶⁵

- 5.67 The Queensland Government reports that it is introducing measures to combat the prevalence of alcohol trafficking to communities that have alcohol restrictions. They have introduced bulk sales registers as a condition of a liquor licence in 63 licensed premises in Queensland. The

62 Tangentyere Council Inc, *Submission 95*, p. 13.

63 Commissioner Karl O'Callaghan, Commissioner for Police, Western Australian Police, *Committee Hansard*, Perth, 30 June 2014, p. 3.

64 Sergeant Shayne Knox, Liquor Enforcement Supervisor, Western Australian Police, *Committee Hansard*, Broome, 1 July 2014, p. 2.

65 Mr Peter Frewen, Executive Officer, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 2 July 2014, p. 14

registers record the purchaser's name and address, amount and type of alcohol sold and the intended place for consumption.⁶⁶

Illicit drug use and substitution

- 5.68 Concerns were raised that alcohol restrictions were likely to lead to people substituting illicit drugs for alcohol. For example, the Healing Foundation states that:

... many dry communities now face the scourge of drugs as a substitute for grog, causing many of the same social issues such as violence that alcohol did.⁶⁷

- 5.69 The 2013 *National Drug Strategy Household Survey* (Drug Survey) reports that apart from ecstasy and cocaine, Aboriginal and Torres Strait Islander people use illicit drugs at a higher rate than the general population. The NDSHS found that in 2013, Aboriginal and Torres Strait Islander people were:

- 1.6 times more likely to use any illicit drug in the last 12 months
- 1.9 times more likely to use cannabis
- 1.6 times more likely to use meth/amphetamines, and
- 1.5 times more likely to misuse pharmaceuticals than non-Indigenous people.⁶⁸

- 5.70 The Penington Institute reports that Aboriginal and Torres Strait Islander people who had used illicit drugs were more likely than those who had never used illicit drugs to consume alcohol at risky or high risk levels at a rate of 28 per cent compared with 13 per cent.⁶⁹

- 5.71 Mr Colin Goodsell from the Northern Territory Police Association (NTPA) observes that other drugs were being substituted for alcohol in Aboriginal and Torres Strait Islander communities that had supply restrictions:

From my understanding, alcohol related crime has dropped significantly. Unfortunately, it has been replaced to some extent by kava, cannabis and, increasingly, aerosol misuse. Whilst the

66 Queensland Government, *Submission 98*, p. 6.

67 Healing Foundation, *Submission 42*, p. 5.

68 Australian Institute of Health and Welfare (AIHW), 2014, *National Drug Strategy Household Survey (NDSHS) Detailed Report: 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra, AIHW, p. 95.

69 The Penington Institute, *Submission 80*, p. 3.

incidence of alcohol related crime might have dropped, that is rapidly being replaced by other factors.⁷⁰

- 5.72 The National Drug Research Institute (NDRI) disputes the notion that restrictions on the availability of alcohol will lead to an increase in cannabis use in Aboriginal and Torres Strait Islander communities, stating that international literature shows that ‘there is not a one-to-one substitution of one psychoactive substance for another’.⁷¹
- 5.73 Similarly, Inspector Raymond Briggs from the Western Australia Police said that there was no evidence to suggest that illicit drugs were being substituted for alcohol as a result of alcohol restrictions in Halls Creek.⁷²
- 5.74 Commissioner O’Callaghan from the Western Australian Police comments:

In regional locations, in the remote communities, an increase in drug use is starting to be seen. But whether you can relate it to alcohol restrictions or less availability of alcohol would be a long bow. It is just the fact that it is now more readily available than it historically was. Cannabis is very prevalent. I think poly-drug use is an issue in those communities. If they had access to alcohol and had a particular marijuana problem now, they just add that to the list. It would not be one or the other; it would just be all of it.⁷³

Contact with the criminal justice system

- 5.75 The criminalising of alcohol consumption can result in a higher than normal level of contact with the criminal justice system for Aboriginal and Torres Strait Islander people.⁷⁴
- 5.76 CAALAS asserts that the link between alcohol and contact with the criminal justice system is well-known and well documented. CAALAS further adds:

For many, alcohol is not only a factor in their offending, the harmful use of alcohol, personally or within family or community, also impacts on their ability to obtain stable accommodation, employment or training and access to health cares. This reduces

70 Mr Colin Goodsell, Senior Vice President, Northern Territory Police Association (NTPA), *Committee Hansard*, Canberra, 5 June 2014, p. 4.

71 National Drug Research Institute (NDRI), *Submission 47*, p. 25.

72 Inspector Raymond Briggs, Assistant District Officer, Kimberley District Police Office, Western Australia Police, *Committee Hansard*, Halls Creek, 2 July 2014, p. 9.

73 Commissioner O’Callaghan, Western Australia Police, *Committee Hansard*, Perth, 30 June 2014, p. 4.

74 CAALAS, *Submission 56*, p. 4.

their chances of obtaining bail or a non-custodial sentence, and impacts negatively on their rehabilitation prospects.⁷⁵

- 5.77 CAAPS notes that Aboriginal and Torres Strait Islander people make up approximately 30 per cent of the population of the Northern Territory but 80 per cent of the prison population.⁷⁶
- 5.78 Research from Dr Mandy Wilson and Ms Jocelyn Jones suggests the key issues that contribute to young Aboriginal and Torres Strait Islander people being involved in crime are:
- child abuse and neglect
 - parental psychiatric problems particularly maternal depression
 - family dissolution and violence
 - poor school performance
 - early school leaving
 - drug and alcohol abuse, and
 - youth unemployment.⁷⁷
- 5.79 The Australian Human Rights Commission (AHRC) notes that actions such as the imposition of complete bans of alcohol often in specific geographic areas without consultation or consent from a community can result in feelings of disempowerment and marginalisation.⁷⁸ They further state:
- Blanket bans also have the effect of criminalising behaviour that is not subject to criminalisation anywhere else.⁷⁹
- 5.80 Chief Superintendent Duval notes that if an offender was arrested for an offence where their alcohol consumption may impact their ability to be granted bail, they may voluntarily submit to a breath analysis test so that it may be used as a guide to when they might be granted bail.⁸⁰ However, blood alcohol reading cannot be used to delay bail if the given offence is not directly related to alcohol consumption, for example assault.⁸¹

75 CAALAS, *Submission 56*, p. 4.

76 Ms Jillian Smith, Chief Executive Officer, CAAPS, *Committee Hansard*, Darwin, 3 April 2014, p. 1.

77 Dr Mandy Wilson, Ms Jocelyn Jones, *Submission 118*, p. 8.

78 AHRC, *Submission 31*, p. 4.

79 AHRC, *Submission 31*, p. 4.

80 Chief Superintendent Duval, South Australia Police, *Committee Hansard*, Adelaide, 5 May 2015, p. 3.

81 Chief Superintendent Duval, South Australia Police, *Committee Hansard*, Adelaide, 5 May 2015, p. 3.

Conclusion

- 5.81 The committee is concerned that heavy or harmful drinking is being normalised in many communities with young Aboriginal and Torres Strait Islander people, girls as well as boys, starting to drink at a younger age.
- 5.82 The provision of alternatives to drinking through greater opportunities for recreation, education, work and recreation are important demand reduction strategies and need to be considered as part of any strategy to deal with alcohol-related harm.
- 5.83 The committee believes there needs to be more opportunities and activities for positive engagement of young people. The *Sport – More than just a game Contribution of Sport to Indigenous wellbeing and mentoring*, the report of the ATSIA committee noted the importance of sport in Closing the Gap.
- 5.84 There is also a great need for diversion programs which redirect individuals who come in contact with the criminal justice system. These programs should address learning deficits, prepare people for parenting and employment and address addiction and mental and physical health issues. The committee considers programs such as the Clontarf program need to be extended to be more widely available. An equivalent program needs to be developed, funded and supported for Aboriginal and Torres Strait Islander girls in similar locations across Australia.
- 5.85 There is a real need for role models and mentoring for both men and women as well as appropriate support for those with FAS and FASD.
- 5.86 Given the concerning numbers of Aboriginal and Torres Strait Islander people who are incarcerated as a result of alcohol-related offences and the significant social and financial costs associated with imprisonment, the committee favours the focus of justice reinvestment on prevention, early intervention and diversion over punitive approaches to crime reduction.
- 5.87 The principles of justice reinvestment are consistent with the committee's findings that measures to reduce harmful alcohol use and alcohol-related harm, including alcohol-related offending, in Aboriginal and Torres Strait Islander communities must address the social and economic determinants of why people drink to excess in the first place.
- 5.88 The committee supports the findings of the ATSIA committee that attention should be focussed on early intervention and diversionary programs, and recommends that the Commonwealth implement a justice reinvestment approach to reducing the number of Aboriginal and Torres Strait Islander people who are incarcerated as a result of their alcohol use.

Recommendation 14

- 5.89 **That Commonwealth, states and territories, through the COAG process implement justice reinvestment to reduce the number of Aboriginal and Torres Strait Islander people incarcerated as a result of harmful alcohol use.**
- 5.90 The committee is concerned by evidence that legal safeguards under the Northern Territory's AMT scheme are inadequate, that AMT does not represent evidence-based best practice, and that it is criminalising alcohol problems, which it views as a public health issue.
- 5.91 Although there is some evidence that mandatory treatment can help some individuals, the committee is concerned about mandatory treatment, especially when there is no community follow-up. Resources that could be used for more effective voluntary rehabilitation should not be redirected into mandatory treatment, without the necessary evidence-base of its effectiveness.

Recommendation 15

- 5.92 **That the Northern Territory Government prioritise the resourcing of voluntary alcohol treatment and rehabilitation programs in place of the Alcohol Mandatory Treatment program.**

FAS and FASD

Introduction

- 6.1 Fetal Alcohol Spectrum Disorder (FASD) and the more impacting fetal alcohol syndrome (FAS), is the clinical diagnoses of permanent damage to brain structure and function due to alcohol exposure in utero, i.e., when the pregnant mother drinks during pregnancy.¹
- 6.2 FASD is a 100 per cent preventable condition if there is no exposure to alcohol in utero. It is incurable and permanent. However, if children are assessed, diagnosed and treated early in life, therapeutic interventions may be helpful. If FASD is not diagnosed early it can have significant and profound impacts for a lifetime.²
- 6.3 FASD is not a problem only suffered by Aboriginal and Torres Strait Islander people; it affects all cultures where a woman might drink alcohol when pregnant.³
- 6.4 In Australia, there is low awareness of the effects of pre-natal exposure to alcohol. There are few places where FASD can be diagnosed and there is a general lack of awareness and misdiagnosis of the condition and how individuals are affected.
- 6.5 The National Indigenous Drug and Alcohol Committee (NIDAC) notes that both the frequency and intensity of alcohol consumption affect the risk of FASD. Risk to the fetus may occur from moderate levels of prenatal

1 Telethon Kids Institute, *Submission 74*, p. 3.

2 National Aboriginal and Torres Strait Islander Legal Services and the Human Rights Law Centre, *Submission 58*, p. 14.

3 Aboriginal Drug and Alcohol Council (SA) Inc. (ADAC), *Submission 40*, p. 5.

alcohol consumption, including occasional heavy episodic drinking. Lower levels of alcohol consumption can still result in permanent disability in the fetus.⁴

- 6.6 The Australian Guidelines to Reduce Health Risks from Drinking Alcohol (2009) advise in Guideline 4 that:
... maternal alcohol consumption can harm the developing foetus or breastfeeding baby and that for women who are pregnant or planning a pregnancy, not drinking is the safest option.⁵
- 6.7 The Northern Territory (NT) Government notes that due to lack of information or education there continues to be a lack of understanding about the harm that can be caused by alcohol consumption during pregnancy.⁶
- 6.8 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) express concern that one in five Australians continue to drink alcohol once their pregnancy is confirmed despite the fact that there is no known safe level of alcohol consumption in pregnancy.⁷
- 6.9 In this chapter, the reality of life with FASD in Australia is considered, with a focus on the difficulties with obtaining a diagnosis and the consequences of not recognising FASD as a disability.

Symptoms of FASD and FAS

- 6.10 FASD can be diagnosed with or without the recognisable characteristics of changed facial features, growth impairment and other defects. The children diagnosed with FAS and FASD have varying degrees of brain damage. The disabilities associated with FAS and FASD include behavioural disorders such as poor impulse control, developmental delay, impaired language and communication, and social and emotional development delays.⁸ The consistent feature of FAS and FASD is lifelong learning and behavioural impairment.⁹
- 6.11 Ninety per cent of adults with FAS demonstrate mental health problems, 60 per cent have trouble with the law and disrupted education, 40 per cent

4 National Indigenous Drug and Alcohol Committee (NIDAC), *Submission 94*, p. 6.

5 NIDAC, *Submission 94*, p. 6; ADAC, *Submission 40*, p. 6.

6 NT Government, *Submission 60*, p. 18.

7 Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Submission 66*, p. 2.

8 RANZCOG, *Submission 66*, p. 2.

9 Telethon Kids Institute, *Submission 74*, p. 3.

having substance abuse issues, and fewer than 10 per cent live or work independently by 21 years of age.¹⁰

- 6.12 The life of someone with FASD may also see them experiencing early life trauma and disadvantage in the early years, low socioeconomic status and welfare dependency, and exposure to household stressors including food insecurity, single parenthood, domestic violence, and mental health issues in a parent or carer.¹¹

Rates of FASD and FAS

- 6.13 FAS occurs across all cultures and socio-economic levels, and is not confined to Aboriginal and Torres Strait Islander people.¹² Aboriginal and Torres Strait Islander women are less likely to consume alcohol than non-Indigenous women but those who do are more likely to consume harmful amounts. The limited data suggests FAS is up to four times more prevalent in Aboriginal and Torres Strait Islander people at 2.767 to 4.75 per 1000 live births.¹³
- 6.14 NIDAC states that generally the expression of full FAS characteristics results from the consumption of large amounts of alcohol during pregnancy where there is a history of either chronic heavy alcohol use or frequent intermittent heavy alcohol use.¹⁴
- 6.15 The Lililwan Project Team reports that the main determinants of maternal alcohol consumption, are a lack of knowledge about harms to the fetus, stress, domestic violence, loss of land and culture, and unresolved historical trauma.¹⁵ Other determinants were identified as overcrowded living conditions, poor education and access to health care, unemployment, and exposure to violence and alcohol use in the home and community.¹⁶
- 6.16 Prevalence of FASD varies internationally. International data suggest that one to two per cent of the population in the US are affected by FASD. In Australia, it is most likely that FASD prevalence (0.68 per 1000 births) has been underestimated. Higher prevalence is observed in communities with high-risk drinking patterns.¹⁷

10 Telethon Kids Institute, *Submission 74*, p. 3.

11 Telethon Kids Institute, *Submission 74*, p. 3.

12 ADAC, *Submission 40*, p. 5.

13 RANZCOG, *Submission 66*, p. 2.

14 NIDAC, *Submission 94*, p. 6.

15 Lililwan Project Team, *Submission 90*, p. 3.

16 Lililwan Project Team, *Submission 90*, p. 3.

17 Telethon Kids Institute, *Submission 74*, p. 3.

- 6.17 The Foundation for Alcohol Research and Education (FARE) notes current Australian data that suggests prevalence rates for FAS, one of the conditions within the spectrum, in the Aboriginal and Torres Strait Islander population is between 2.8 and 4.7 per 1000 births.¹⁸
- 6.18 The Department of the Prime Minister and Cabinet (PM&C) notes that the community of Fitzroy Crossing Valley in WA was recently the focus of a prevalence study of FASD known as the Lililwan project, led by the George Institute for Global Health.¹⁹ The study looked at children living in the area born between 2002 and 2003, and the recently released data reported the rates of FAS (120 per 1000 children aged seven to nine) to be the highest in Australia and among the highest in the world.²⁰

Drinking alcohol when pregnant or breastfeeding

- 6.19 While Aboriginal and Torres Strait Islander women are less likely than men to consume alcohol at harmful levels, significant numbers of women continue to drink while they are pregnant or breastfeeding.
- 6.20 The Australian Institute of Health and Welfare (AIHW) notes that, in 2008, 3.3 per cent of mothers of Aboriginal and Torres Strait Islander children aged 0–3 years drank more or the same amount of alcohol during pregnancy, while 16.3 per cent drank less.²¹ There is no more recent data available.
- 6.21 It is likely that national statistics on maternal alcohol consumption mask more serious problems in certain communities, where harmful alcohol consumption is widespread. For example, it was reported that in Fitzroy Crossing, over 55 per cent of the mothers surveyed drank high levels of alcohol during their pregnancies.²²
- 6.22 Women who have an undiagnosed FASD may also be at significant risk of drinking when pregnant. Professor Elizabeth Elliot observes that, in some communities, there are generations of people with FASDs and that:

18 Foundation for Alcohol Research and Education (FARE), *Submission 83*, p. 25.

19 Department of Prime Minister and Cabinet (PM&C), *Submission 102*, p. 13.

20 PM&C, *Submission 102*, p. 13; Dale Owens, 'Nation's highest rate of fetal alcohol syndrome documented in WA's Fitzroy Valley', 19 January 2015, ABC News <http://www.abc.net.au/news/2015-01-16/fitzroy-valley-fetal-alcohol-research/6022430> viewed 10 June 2015; Telethon Kids Institute, 'Community is tackling FAS in the Fitzroy Valley', *Media Release*, 17 January 2015.

21 Australian Institute of Health and Welfare (AIHW), *Submission 19*, p. 5.

22 Professor Elizabeth Elliott, Paediatrician, Westmead Children's Hospital and the University of Sydney, *Committee Hansard*, Sydney, 5 September 2014, p. 2.

... some mothers who are giving birth to children with a foetal alcohol spectrum disorder may themselves have been damaged by alcohol in utero.²³

- 6.23 Education for women about the dangers of drinking when pregnant was emphasised during the inquiry.²⁴ FAS and FASD are 100 per cent preventable if the mother does not drink when pregnant. As well, it was found that there is little or no detox or support for pregnant women who try to reduce their alcohol consumption.

Conclusion

- 6.24 The committee is concerned that there continues to be such a low level of awareness of the harms caused by drinking when pregnant.
- 6.25 There has been little change in public awareness with the message from the National Health and Medical Research Council (NHMRC) Guidelines not being widely known or disseminated, especially by relevant health professionals.
- 6.26 The committee is concerned that popular magazines, such as the Women's Weekly²⁵, publish stories that give the impression that drinking during pregnancy is safe, even curative. The committee believes that promotion of such messages is irresponsible and misleading.
- 6.27 The committee is concerned that despite the several years since the release of the 2012 report *FASD: The Hidden Harm - Inquiry into the prevention, diagnosis and management of Fetal Alcohol Spectrum Disorders* by the House Standing Committee on Social Policy and Legal Affairs little has changed in relation to the promotion of the message that there is no safe level of alcohol consumption in pregnancy.
- 6.28 There needs to be a public awareness campaign, beyond the doctors surgery, that informs the wider community that women who are pregnant or planning to get pregnant or breastfeeding should not consume any alcohol for that time.

23 Professor Elliott, Westmead Children's Hospital and the University of Sydney, *Committee Hansard*, Sydney, 5 September 2014, p. 4.

24 See, for example: RANZCOG, *Submission 66*, p. 2; Lililwan Project Team, *Submission 90*, p. 7.

25 Australian Women's Weekly, February 2015.

Recommendation 16

- 6.29 That the Commonwealth, as a matter of urgency, increase its efforts to ensure that consistent messages:
- about the risks of consuming any alcohol during pregnancy, and
 - about the importance of supporting women to abstain from alcohol when planning pregnancy, when pregnant or breastfeeding
- to reduce the risk of Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorder are provided to the whole community.

FASD in Australia

- 6.30 Across Australia the awareness of FAS and FASD in the community and amongst health professionals continues to be low. Evidence received by the committee indicates that this lack of awareness has significant implications for those with FASD.²⁶
- 6.31 Lack of awareness extends from medical to educational, law and other professionals. The current prevalence rates are also thought to be greatly underestimated.²⁷
- 6.32 NIDAC highlight the lack of awareness and understanding of FASD within the Australian community. They state that there are many people still unaware of the risk to the fetus or baby if the mother consumes alcohol while pregnant or breastfeeding, particularly with low to medium levels of drinking or occasional or episodic use.²⁸
- 6.33 The Australian Human Rights Commission (AHRC) notes that many of the issues and difficulties that stand in the way of successful prevention and support programs stems from the lack of understanding of FASD.²⁹
- 6.34 FARE contends that there are significant gaps in awareness, knowledge, data, diagnosis and service delivery relating to FASD.³⁰

26 NIDAC, *Submission 94*, Attachment 2, p. 17.

27 NIDAC, *Submission 94*, Attachment 2, p. 9.

28 NIDAC, *Submission 94*, Attachment 2, p. 17.

29 Australian Human Rights Commission (AHRC), *Submission 31*, p. 7.

30 FARE, *Submission 83*, p. 30.

- 6.35 The Aboriginal Legal Rights Movement notes that information about the prevalence of FAS and FASD in Aboriginal and Torres Strait Islander communities may cause shame or distress to community members if the information from a particular community is made public.³¹ Other Aboriginal and Torres Strait Islander communities are making strenuous efforts, through music, art and dance, to highlight dangers to the unborn if drinking.
- 6.36 Research indicates that health professionals in particular do not have a high level of awareness of FASD. The most accurate data on awareness of the diagnostic criteria indicates that only 12 to 15 per cent of health professionals surveyed are aware of the four diagnostic features of FAS.³²
- 6.37 Ms Amanda Hand from the Gurriny Yealamucka Health Service explains that in Queensland, there has not been much training, nor is there a great understanding across the clinical population in both Aboriginal and Torres Strait Islander medical services and in the mainstream of the condition, the syndrome, the spectrum or of what therapies can be applied.³³
- 6.38 The Aboriginal Health Council of Western Australia (AHCWA) noted that as well as a lack of awareness of FASD, there is still reluctance from health professionals to address the issue of alcohol consumption:
- ... there are a number of practitioners who lack up to date information, who spread misinformation or who are reluctant to raise the topic of alcohol consumption with women who are pregnant or planning to become pregnant. This is a serious failing and is no doubt a major contributor to the lack of public awareness of the risks of FASD, and to the myths and the misinformation that currently exist across the wider community.³⁴
- 6.39 Mrs Catherine Crawford explains however that there is increasing awareness of FASD in practitioners in the Children's Court of Western Australia.³⁵ Broadly, however, she considers that there is awareness but no depth of knowledge.³⁶

31 Aboriginal Legal Rights Movement, *Submission 25*, p. 12.

32 Dr James Fitzpatrick, Paediatrician and Senior Clinical Research Fellow, Telethon Kids Institute, *Committee Hansard*, Perth, 30 June 2014, p. 40.

33 Ms Amanda Hand, Clinical Director, Gurriny Yealamucka Health Service, *Committee Hansard*, Cairns, 7 April 2015, p. 36.

34 Aboriginal Health Council of Western Australia (AHCWA), *Submission 69*, p. 39.

35 Ms Catherine Crawford, *Committee Hansard*, Perth, 30 June 2014, p. 55.

36 Ms Crawford, *Committee Hansard*, Perth, 30 June 2014, p. 55.

- 6.40 The Aboriginal Legal Service (NSW/ ACT) states that there is little awareness of FASD as well as other disabilities in the criminal justice system.³⁷
- 6.41 Anyinginyi Health Aboriginal Corporation in Tennant Creek ran a FASD awareness program in town which they consider was highly successful. They note, however, that there are no pathways for diagnosis or treatment in their health system if FAS or FASD is suspected.³⁸

Diagnosis of FASD

- 6.42 It is very difficult to obtain a diagnosis of FASD in Australia. There are very few appropriately trained professionals, very few clinics and overall a lack of awareness in the health sector and the general community.
- 6.43 Ideally a diagnosis of FASD requires a multidisciplinary team which ideally comprises a paediatrician, psychologist, occupational therapist, speech pathologist, physiotherapist and social worker.³⁹
- 6.44 A diagnosis of FASD usually requires that significant impairment of three or more neurocognitive domains or two domains plus structural central nervous system abnormality.⁴⁰ Neurocognitive domains include cognition, memory, and executive function in planning and language for example.⁴¹
- 6.45 There are very few clinics in Australia that have formal diagnostic capacity. The committee was made aware of one at the Sydney Children's Hospitals Network (Westmead) and one at the Gold Coast Hospital and Health Service.
- 6.46 FARE consider that Australia lags well behind the rest of the world in preventing, diagnosing and managing FASD.⁴²
- 6.47 Ms Prue Walker contends that children with FASD/FAS are rarely diagnosed in Australia.⁴³
- 6.48 NIDAC asserts that early diagnosis and intervention is crucial in reducing or preventing secondary disability from FASD.⁴⁴ Secondary disability can include mental health problems, trouble with the law, dropping out of

37 Ms Sarah Crellin, Deputy Principal Legal Officer, Aboriginal Legal Service (NSW/ ACT) Limited, *Committee Hansard*, Sydney, 5 September 2014, p. 23.

38 Mr Trevor Sanders, General Manager, Anyinginyi Health Aboriginal Corporation, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 16.

39 Telethon Kids Institute, *Submission 74*, p. 3.

40 Telethon Kids Institute, *Submission 74*, p. 3.

41 Dr Fitzpatrick, Telethon Kids Institute, *Committee Hansard*, Perth, 30 June 2014, p. 43.

42 FARE, *Submission 83*, p. 28.

43 Ms Prue Walker, *Submission 86*, p. 11.

44 NIDAC, *Submission 94*, Attachment 2, p. 11.

- school, becoming unemployed, homeless and having unwanted pregnancies or developing alcohol and drug problems.
- 6.49 The Commonwealth Government has funded a development of a FASD diagnostic tool for specialist clinicians and resources to support diagnosis and early management of FASD as part of the *Responding to the Impact of Fetal Alcohol Spectrum Disorders in Australia – A Commonwealth Action Plan*.⁴⁵
- 6.50 The diagnostic tool is currently being prepared for use, with training for health professionals and an implementation plan being developed.⁴⁶

Training clinicians

- 6.51 A critical factor in the diagnosis of FASD is access to trained clinicians who are able to perform a diagnosis.
- 6.52 Dr Doug Shelton contends that FASD training for clinicians in Australia is poor or non-existent.⁴⁷
- 6.53 Professor Elizabeth Elliott notes that as a professor of paediatrics she has been including FASD in the curriculum at Sydney Medical School. She adds that FASD teaching was being poorly addressed throughout the curricula and that she has been encouraging deans of medical schools to incorporate it into their curriculum.⁴⁸
- 6.54 The Royal Australasian College of Physicians (RACP) have been asked to include FASD as one of the continuing professional education modules. There is also an educational module available through the RACP website for paediatricians which includes sections on FASD.⁴⁹
- 6.55 Gurriny Yealamucka Health Service commends local paediatricians who work in their service but they assert that good training of clinicians is required to ensure that they are appropriately recognising the condition and diagnosing to enable support.⁵⁰
- 6.56 BushMob note that there is no relevant FASD training in the Northern Territory to help them manage the high percentage of their clients

45 Details of the plan can be found at www.health.gov.au

46 Ms Heather Jones, Manager, FASD Projects, Telethon Kids Institute, *Committee Hansard*, Perth, 30 June 2014, p. 40.

47 Dr Doug Shelton, *Submission 117*, p. 1.

48 Professor Elliott, Westmead Children's Hospital and the University of Sydney, *Committee Hansard*, Sydney, 5 September 2015, p. 1.

49 Professor Elliott, Westmead Children's Hospital and the University of Sydney, *Committee Hansard*, Sydney, 5 September 2015, p. 1.

50 Ms Hand, Gurriny Yealamucka Health Service, *Committee Hansard*, Cairns, 17 February 2015, p. 36.

suspected to have FASD, other than word of mouth and through the internet.⁵¹

- 6.57 Dr James Fitzpatrick recommends an approach which trains clinicians as well as approaching the major colleges and mandating that FAS and FASD training become part of their curriculum.⁵²

Conclusion

- 6.58 The committee is concerned that there is still a low level of awareness of FASD by health professionals and the wider community, despite a National Strategy now in its second year of implementation.
- 6.59 Despite the excellent work of several medical institutions who are committed to raising the profile of FASD in Australia, it is almost impossible for most parents and carers to obtain a diagnosis or support if FAS or FASD is present.
- 6.60 The fact that FASD is still being poorly addressed in medical school curriculums means that the issue is unlikely to be resolved soon. The committee believes that all medical students need to be aware of the impacts of alcohol exposure on the fetus and have an understanding of the condition to ensure that early diagnoses are made.
- 6.61 The committee considers it necessary for all health professionals to have an awareness of FAS and FASD.
- 6.62 Although there has been some progress with the Australian diagnostic tool, the committee is concerned that the rollout and evaluation has been subject to ongoing delays which has meant that it is still not available for health professionals to use.
- 6.63 The launch of the 2014 FASD Action Plan in July 2014 was a good first step but the committee is concerned that the Action Plan does not address all the key recommendations of the 2012 report *FASD: The Hidden Harm - Inquiry into the prevention, diagnosis and management of Fetal Alcohol Spectrum Disorders* by the House Standing Committee on Social Policy and Legal Affairs, in particular the need for prevention strategies that will provide information and education programs and support for pregnant women with drinking problems.

51 BushMob, *Submission 12*, p. 1.

52 Dr Fitzpatrick, Telethon Kids Institute, *Committee Hansard*, Perth, 30 June 2014, p. 40.

- 6.64 The committee sees that awareness of FASD must be raised, particularly with health professionals, the criminal justice system and in the wider community.
- 6.65 The committee believes that one of the best ways to ensure this is to release the diagnostic tool as soon as possible and ensure that its promotion and use is appropriately resourced.

Recommendation 17

That the Commonwealth, as a priority, ensure that the National FASD Diagnostic Tool and accompanying resource are released without any further delays.

Life for those with FASD

- 6.66 The physical and psychological wellbeing of individuals who have to live with FASD is made more difficult without early diagnosis and treatment. They will experience serious and life-long problems due to the complex behavioural, cognitive, physical and psychological impairments.⁵³
- 6.67 Individuals with FASD and FAS can have a range of needs and require a variety of intensive support throughout their life. The National Aboriginal and Torres Strait Islander Legal Services and the Human Rights Law Centre describe the all-encompassing role of caring for children and adults with FASD, as well as the significant financial cost of early intervention strategies.⁵⁴
- 6.68 National Congress of Australia's First Peoples note that FASD is a permanent, incurable, life-long condition which impacts on the individual's capacity to learn, justice and other services which in turn affects their carers in the community.⁵⁵

53 Synapse, *Submission 41*, p. 3.

54 National Aboriginal and Torres Strait Islander Legal Services and the Human Rights Law Centre, *Submission 58*, p. 15.

55 National Congress of Australia's First Peoples, *Submission 97*, p. 15.

- 6.69 AHCWA considers that FAS and FASD are now an intergenerational issue, which needs to be addressed using a whole of community approach.⁵⁶
- 6.70 As FAS and FASD are not officially recognised as a disability and are not easily diagnosed in Australia, there is no support specifically offered or designed to meet the needs of individuals with FAS or FASD.⁵⁷
- 6.71 Ms Walker notes that across the FASD spectrum there is a variety of presentations. She explains that some individuals may have an IQ over 70, while others have a significant intellectual disability. Additionally some individuals have clear neurological symptoms and delayed development, while others may only display difficulties when more advanced cognitive functions are required – such as making safe choices.⁵⁸
- 6.72 FARE highlight that difficulties in achieving a diagnosis mean it is a struggle to access disability support services and funding from social services, education and training systems, justice and health agencies.⁵⁹
- 6.73 BushMob, a group in Alice Springs who work with young people who are affected by alcohol and drugs note:
- All the young people who enter Bushmob are complex high needs clients with significant primary health care issues. We estimate that 30 per cent of our clients are affected by Fetal Alcohol Spectrum Disorder (FASD) issues.⁶⁰
- 6.74 The Aboriginal Drug and Alcohol Council (SA) Inc. (ADAC) are concerned that people affected by FASD, who do not have the appropriate support, are at a high risk of developing secondary disabilities. ADAC note that this can result in significant costs to society the individual. Victims of FAS and FASD are estimated to be significantly overrepresented in prison populations.⁶¹
- 6.75 Synapse are concerned that people with FASD remain undiagnosed despite 40 years of reliable evidence.⁶² Synapse states that people with FASD have been misunderstood and not well served by the disability, education and criminal justice sector.⁶³

56 AHCWA, *Submission 69*, p. 37.

57 Ms Prue Walker, *Submission 86*, p. 12.

58 Ms Prue Walker, *Submission 86*, p. 12.

59 FARE, *Submission 83*, p. 29.

60 BushMob, *Submission 12*, p. 1.

61 ADAC, *Submission 40*, Attachment 5, p. 1.

62 Synapse, *Submission 41*, p. 3.

63 Synapse, *Submission 41*, p. 3.

FASD as a recognised disability

- 6.76 The overwhelming evidence suggests that FASD needs to be an officially recognised disability. Access to better support and funding, carer support, recognition by education and criminal justice systems and the community would then follow.
- 6.77 Professor Conigrave, Dr Lee and Mr Jack believe the result of this recognition would be:
- ... greater support for carers of children with FAS and FASD, improved detection and early intervention for individuals suffering FASD, and encourage more compassionate handling of offenders with FASD by the justice system.⁶⁴
- 6.78 FARE considers that FASD needs greater recognition in the social security system. They propose that:
- FASD should be recognised as a cognitive impairment to allow access to support services⁶⁵
 - FASD should be included in the Impairment Tables for disability support pensions, acknowledged in the NDIS and included in the list of recognised disabilities for carer payments,⁶⁶ and
 - FASD should be included in the Better Start for Children with a Disability initiative.⁶⁷
- 6.79 FARE also explains that declaring FASD a disability will enable it to be included in disability policy and services development and reform in accordance with the Convention on the Rights of Persons with Disabilities.⁶⁸
- 6.80 AHCWA asserts that the government needs to recognise FASD as a disability to ensure that parents and carers are given the same support and recognition as others with children with disabilities.⁶⁹
- 6.81 CAALAS argue that best argument for declaring FAS and FASD as disabilities is that children with FAS or a FASD might be identified earlier

64 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, p. 6.

65 FARE, *Submission 83*, p. 9.

66 FARE, *Submission 83*, p. 9.

67 FARE, *Submission 83*, p. 28.

68 Synapse, *Submission 41*, p. 3.

69 AHCWA, *Submission 69*, p. 40.

and might be given the support they need to avoid contact with the criminal justice system.⁷⁰

6.82 The Lililwan Project consider the implications of declaring FASD as a disability would include:

- better support for families and caregivers
- better access to educational and health supports, and
- better understanding of the capabilities of individuals with FASD and their ability to function normally and negotiate the justice and education systems.⁷¹

6.83 St Vincent's Alcohol and Drug Service consider that declaring FAS and FASD as disabilities is one step towards ensuring people with these conditions get the adequate care and support necessary.⁷²

Accessing support

6.84 Although there is a list of recognised disabilities which provide fast-track qualification for the Carer Allowance for children, FAS or FASD are not included on this list.⁷³ Other spectrum disorders however such as Autism Spectrum Disorder and Autistic Disorder or Asperger's Disorder are included on this list.⁷⁴ There is evidence that children are given these diagnoses in order that some support is then forth coming.

6.85 The Law Society of the Northern Territory, in answer to the concern that FASD is difficult to define being a spectrum disorder, notes that Asperger's is also a spectrum disorder which is a recognised disability.⁷⁵

6.86 FARE is concerned that the use of the Impairment Tables for accessing the Disability Support Pension may mean that people with FASD who may have an IQ above 70, may not meet the criteria for Table 9 Intellectual function and could be assessed under Table 7 Brain Function.⁷⁶ The brain damage in FAS and FASD victims is cognitive rather than intellectual.

6.87 PM&C note that the Impairment Tables cover both intellectual and cognitive impairment.⁷⁷

6.88 In some cases the Impairment Tables also list examples of conditions that can be assessed with over 70 IQ, for example Table 7 Brain Function states:

70 Central Australian Aboriginal Legal Aid Services (CAALAS), *Submission 56*, p. 11.

71 Lililwan Project Team, *Submission 90*, p. 9.

72 The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 13.

73 See www.dss.gov.au Guide to the List of Recognised Disabilities viewed on 20 May 2015.

74 See www.dss.gov.au Guide to the List of Recognised Disabilities viewed on 20 May 2015.

75 Law Society of the Northern Territory, *Submission 89*, p. 11.

76 FARE, *Submission 83*, p. 29.

77 PM&C, *Submission 102.1*, Answer to Question on Notice, p. 3.

A person with Autism Spectrum Disorder who does not have a low IQ should be assessed under this Table.⁷⁸

- 6.89 Ms Cregan explains that a barrier to recognition of FASD is that much of the law and policy has developed around the needs of people with mental illness or intellectual disability but people with cognitive disorders such as FASD are at greater risk of not receiving help.⁷⁹
- 6.90 She notes that use of terms such as mental impairment, intellectual impairment, cognitive disorder or disorder of the mind in criteria to access services can be confusing.
- 6.91 Ms Cregan notes that there are no definitions for these terms in legislation or supporting documents. This may mean a decision on whether a person can receive funding for services is left to the interpretation of such terms by an official who is assessing a claim without the formality of a diagnosis.⁸⁰
- 6.92 Ms Laura Lombardo suggests that a model definition of cognitive impairment be developed which is inclusive of all forms of disability arising from impairment of the brain.⁸¹ This could serve all Commonwealth and state and territory law and policy.
- 6.93 Ms Lombardo proposes a review of Commonwealth law and policy to identify where eligibility criteria need to change to ensure that people with FASD and other cognitive impairment are included.⁸²

FASD support

- 6.94 NIDAC believes eligibility for government-funded support and services should include criteria that reflect the functional and behavioural deficits of developmental disorders like FASD.⁸³
- 6.95 Synapse identifies the support needed for those people with FASD:
- Interventions should be centred on a neurobehavioural accommodation model with a comprehensive, intrasectoral model of care and support. This will include well resourced, evidence based and culturally appropriate prevention and early intervention strategies as well ongoing, highly specialised co-

78 *Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011*

79 Ms Anne Cregan, *Committee Hansard*, Sydney, 5 September 2014, p. 56.

80 Ms Cregan, *Committee Hansard*, Sydney, 5 September 2014, p. 56.

81 Ms Laura Lombardo, Pro-bono coordinator and Senior Associate, Ashurst Australia, *Committee Hansard*, Sydney, 5 September 2014, p. 57.

82 Ms Lombardo, Ashurst Australia, *Committee Hansard*, Sydney, 5 September 2014, p. 57.

83 NIDAC, *Submission 94*, Attachment 2, p. 19.

ordinated support services in areas including health, housing, employment and justice.⁸⁴

- 6.96 The AHRC proposes that a ‘social model’ of disability be adopted as a response to FASD.⁸⁵ This recognises that disability is an evolving concept and requires early access to services as well as recognising the interactions between the impairment and the environment and attitudinal barriers that hinder full participation.⁸⁶
- 6.97 St Vincent’s Alcohol and Drug Service believes that prevention, screening and early detection, and access to appropriate intervention are crucial to responding to FAS and FASD and to minimising the complex problem behaviour, neurodevelopment and intergenerational impacts of FAS and FASD.⁸⁷
- 6.98 The New South Wales Government notes that there needs to be access to culturally appropriate support particularly for Aboriginal and Torres Strait Islander women and children with the condition.⁸⁸

Early intervention

- 6.99 There is evidence that screening and early intervention for children suspected of having FASD can make a significant difference to their life-long outcomes.⁸⁹
- 6.100 Dr Fitzpatrick made an important observation about the nature of conditions included on funding lists such as Better Start:
- The Better Start funding list includes cerebral palsy, because it has been shown that therapy for children with cerebral palsy improves their outcomes. But most children with cerebral palsy have an IQ above 70. The list also includes Fragile X syndrome, Rett syndrome and other syndromes that can be seen as quite obscure but have made their way onto the list because it has been showed that therapeutic intervention improves long-term outcomes.⁹⁰
- 6.101 Dr Fitzpatrick argues that FASD should also be included on the Better Start funding list since, similar to the conditions on the list, it has a

84 Synapse, *Submission 41*, p. [5].

85 AHRC, *Submission 31*, p. 8.

86 AHRC, *Submission 31*, p. 8.

87 The Alcohol & Drug Service, St Vincent’s Hospital, Sydney, *Submission 63*, p. 13.

88 NSW Government, *Submission 62*, p. 8.

89 Victorian Aboriginal Community Controlled Health Organisation (VACCHO), *Submission 33*, p. [5]

90 Dr Fitzpatrick, Telethon Kids Institute, *Committee Hansard*, Perth, 30 June 2014, p. 43.

- rigorous diagnostic process and therapeutic intervention will improve long-term outcomes.⁹¹
- 6.102 FARE support this, noting that there needs to be funding support for parents and foster carers to support those who care for people with FASD.⁹²
- 6.103 Ms Walker recommends that specific behavioural management services be provided for families and carers of children with FASD given traditional parenting interventions often do not work due to the specific nature of the brain injury.⁹³
- 6.104 Telethon Kids Institute notes that NDIS operational guidelines for therapy support estimate that \$12,000-\$16,000 in therapy per annum would be required to provide early intervention support for a child aged 0-6 years. With FASD diagnosis is often delayed, so it is important that any disability support funding should extend eligibility age to 8-10 years.⁹⁴
- 6.105 FAS is included in the Operational Guidelines for the National Disability Insurance Agency (NDIA), however, FASD is not.⁹⁵ PM&C note that further consideration to include FASD in the NDIA's Operational Guidelines should occur once the diagnostic tool and clinical guidelines have been finalised and approved and there is sufficient data about the needs of FASD participants and carers.⁹⁶
- 6.106 In Tennant Creek, the Anyinginyi Aboriginal Health Centre describe what happens when awareness of FASD is raised in the community:
- One of the good things, to us, is that we now get ladies coming into our health centre saying, 'I think my child has FASD,' which shows the awareness is there.⁹⁷
- 6.107 They note that diagnosis is not the only answer if there is no follow-up support:
- Then it leads us to, 'Where to from here?' What we need here is an early intervention service. We do not have a visiting paediatrician. We do not have visiting speech therapists, OTs, psychologists and all the rest. Asking 'where to from here?' is the next step.

91 Dr Fitzpatrick, Telethon Kids Institute, *Committee Hansard*, Perth, 30 June 2014, p. 43.

92 FARE, *Submission 83*, p. 9.

93 Ms Prue Walker, *Submission 86*, p. 35.

94 Telethon Kids Institute, *Submission 74*, p. 4.

95 PM&C, *Submission 102.1*, Answer to Question on Notice, p. 5.

96 PM&C, *Submission 102.1*, Answer to Question on Notice, p. 5.

97 Mr Sanders, Anyinginyi Health Aboriginal Corporation, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 16.

Someone – not us – needs to develop the clinical pathways and tell us what best practice is so that we can follow it.⁹⁸

6.108 CAAPU make the point that early diagnosis and intervention can also lead to better informed parents and may help prevent further alcohol affected children being born in the family.⁹⁹

6.109 Dr James Fitzpatrick described his experience in Western Australia:

The most powerful thing about diagnosis – and this has been the experience in North America – is that it drives prevention, because the people say, 'Ah, these problems are probably related to alcohol exposure in pregnancy, so we had better not do that next time.'¹⁰⁰

Education and FAS - FASD

6.110 Children and young people with FASD have specific educational requirements and behaviours which need to be taken into account in educational planning.

6.111 There is a call for the development and support of programs that address how best to educate children in the classroom with FASD, while minimising disruption to other students, including support for the training of special education teachers.¹⁰¹

6.112 Groups such as the Lililwan Project Team found that alternative pathways for children who have FASD should be considered. These pathways should focus on the children's capacities as well as their needs.¹⁰²

6.113 Professor Langton, Ms Smith and Dr Chenhall recommend that the number of special needs teachers should be assessed to meet the education requirements of children who have behavioural issues, including FASD-related conditions.¹⁰³

6.114 Aboriginal Peak Organisations of the Northern Territory (APO NT) note that there is little intensive school or learning support for children with FASD in remote communities.¹⁰⁴

98 Mr Sanders, Anyinginyi Health Aboriginal Corporation, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 16.

99 Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU), *Submission 73*, p. [11].

100 Dr Fitzpatrick, Telethon Kids Institute, *Committee Hansard*, Perth, 30 June 2014, p. 45.

101 Professor Langton, Dr Chenhall, Ms Smith, *Submission 44*, p. 6.

102 Lililwan Project Team, *Submission 90*, p. 8.

103 Professor Langton, Dr Chenhall, Ms Smith, *Submission 44*, p. 6.

104 Aboriginal Peak Organisations of the Northern Territory (APO NT), *Submission 72*, Attachment 4, p. 17.

Conclusion

- 6.115 The committee heard of the importance of schools and education systems being aware of FAS and FASD and having the appropriate level of training for staff. The specific requirements of children with FAS and FASD require a level of understanding from the education system about the best way forward.

Recommendation 18

- 6.116 **That states' and territories' teacher training, education and in-service systems provide:**
- **information and education on alcohol and drug exposed children's behaviour, and**
 - **details of the impact on the child's mental health and their achievement at school.**
- 6.117 The official recognition of FASD as a disability is not the only solution, however it would ensure that parents and carers of children who have FAS and FASD would more easily be able to access early intervention and support that is so necessary to reduce secondary disabilities.
- 6.118 Prevention of the condition is the key, however, screening and early detection, as well as access to appropriate interventions are critical for minimising the complex anti-social behaviour, neurodevelopment and intergenerational impacts of FAS/FASD.
- 6.119 The value of early intervention cannot be underestimated. The committee took evidence about how therapeutic intervention can make a significant difference in the life of a child with FASD.
- 6.120 The committee recommends parents and carers should easily be able to access the most appropriate early intervention for FASD. The committee is concerned about the experience of people in Tennant Creek who have awareness of FASD in their community but do not have the intervention services needed.
- 6.121 FASD is not included in the Operational Guidelines for the NDIA. The committee was told it may be included in the future, following the introduction of the diagnostic tool and collection of data on FASD participants. However, the committee believes there is sufficient data on FASD prevalence internationally and now in Fitzroy Crossing WA to

ensure that Australia does not need to further delay critical early intervention for individuals with FASD.

- 6.122 The committee argues that the Commonwealth should ensure that FASD is included in the Operational Guidelines for the NDIA as soon as possible.

Recommendation 19

6.123 That the Commonwealth:

- include FAS and FASD as recognised disabilities for Carer's allowance to allow fast-tracking of the application
- include FAS and FASD as a recognised disabilities in the Better Start for Children with a Disability initiative, and
- include FASD in the operational Guidelines for the National Disability Insurance Agency.

Out of home care

- 6.124 International data suggests that up to 25 per cent of children in foster care may have FASD.¹⁰⁵
- 6.125 Ms Catherine Crawford asserts that children with FASD are overrepresented in foster care and group care systems.¹⁰⁶ She adds that there may have been a number of placements of children with untrained caregivers.¹⁰⁷
- 6.126 Foster carers may not suspect FASD is affecting infants, as it may not be apparent for some time that a child is not meeting developmental milestones and the alcohol consumption of the mother when pregnant is not disclosed. This can impact on joining waiting lists and accessing services.¹⁰⁸
- 6.127 If a child is in kinship care, the carers may not be experienced in identifying development delays and FASD may be considered too stigmatising to suggest to other carers.¹⁰⁹

¹⁰⁵ Ms Jones, Telethon Kids Institute, *Committee Hansard*, Perth, 30 June 2014, p. 39.

¹⁰⁶ Ms Catherine Crawford, *Submission 103*, p. 3.

¹⁰⁷ Ms Catherine Crawford, *Submission 103*, p. 3.

¹⁰⁸ Ms Prue Walker, *Submission 86*, p. 16.

¹⁰⁹ Ms Prue Walker, *Submission 86*, p. 16.

- 6.128 Ms Walker notes that changes and transitions can be difficult for children with FASD. Each time there is a movement between the family of origin, kinship care and foster care, there may be a change in culture, language and location.¹¹⁰
- 6.129 Ms Walker described the dichotomy of home and foster care for Aboriginal and Torres Strait Islander children. The connection with family is critical but can have effects on overall behaviour. She explains:
- When a child with FASD goes into foster care, after a time they will settle down. Then they will have contact with their family and the carer will come back and say they are unmanageable – they have gone back six months in their behaviours. What do we do with that?¹¹¹
- 6.130 It is clear that the foster system and kinship caring is often reduced to crisis managing when trying to parent children with FAS and FASD, with little or no support.

FAS and FASD and the Criminal Justice system

- 6.131 It is widely recognised that FASD is a significant problem in the criminal justice system.
- 6.132 There is a strong link between FAS and FASD and contact with the criminal justice system.¹¹² This link is often not officially recognised, however, as CAALAS states:
- ... it is still quite rare for us to see a client with a formal diagnosis.¹¹³
- 6.133 Ms Catherine Crawford asserts that the failure to diagnose FASD in a young person involved in the criminal justice system has unintended and far-reaching consequences:
- ... causes injustice to the individual young person and exposes the family and community to a repetition of that unlawful behaviour and indeed, likely escalation of the offending, as the young person grows physically, suffers secondary disabilities and those dealing with the young person are unable to handle the behaviours.¹¹⁴
- 6.134 Synapse notes that FASD manifests in a range of difficulties, including:
- being able to link actions to consequences

110 Ms Prue Walker, *Submission 86*, p. 17.

111 Ms Prue Walker, *Committee Hansard*, Melbourne, 30 May 2014, p. 43.

112 CAALAS, *Submission 56*, p. 2.

113 CAALAS, *Submission 56*, p. 2.

114 Ms Catherine Crawford, *Submission 103*, p. 1.

- controlling impulses, and
 - being easily led.¹¹⁵
- 6.135 Synapse added that many become involved in the juvenile justice system and ultimately the adult criminal justice system. They are concerned that this is often a cyclical and transgenerational phenomenon which culminates in the onset of chronic disease and poor mental health including high incidence of self-harm and suicide.¹¹⁶
- 6.136 NIDAC states that people with FASD often have poor memory and can be highly suggestible. This suggestibility makes them an unreliable witness or mean they provide inaccurate information when being questioned by police.¹¹⁷
- 6.137 Ms Cregan notes that a person with an intellectual disability or mental illness is more likely to have their disability taken into account in determining their culpability or in sentencing, than a person with FASD who has cognitive impairment.¹¹⁸
- 6.138 FASD brain damage or impairment to cognitive function may be such that the person is not fit to plead. The general assumption, is that a person is fit to plead unless found otherwise by a court. Evidence needs to be provided by a suitably qualified expert based on set criteria.¹¹⁹ This is almost impossible to obtain for those suspected of having FASD in remote Australia.
- 6.139 Currently in Western Australia, there are no means for obtaining a diagnosis of FASD for a youth involved in the criminal justice system. A report from a psychiatrist or neuropsychologist may report that there are signs consistent with FASD but that does not constitute a diagnosis.¹²⁰
- 6.140 If an individual pleads guilty to one or more offences they must be sentenced and unless there is evidence, the court is unable to take into account that the individual has FASD when sentencing.¹²¹
- 6.141 Ms Crawford asserts:
- Diagnosis is the gateway for a court to consider FASD as a mitigating factor for sentencing purposes.¹²²

115 Synapse, *Submission 41*, p. [3].

116 Synapse, *Submission 41*, p. [3].

117 NIDAC, *Submission 94*, Attachment 2, p. 10.

118 Ms Cregan, *Committee Hansard*, Sydney, 5 September 2014, p. 56

119 Ms Catherine Crawford, *Submission 103*, p. 4.

120 Ms Catherine Crawford, *Submission 103*, pp. 4–5.

121 Ms Catherine Crawford, *Submission 103*, p. 4.

122 Ms Catherine Crawford, *Submission 103*, p. 5.

- 6.142 She notes that without a diagnosis, a youth affected with FASD will be treated as a fully-functional individual who has made choices about their behaviour, understands the consequences of their actions and can learn from their mistakes.¹²³ This is not the case with a victim of FAS or FASD.
- 6.143 Professor Douglas highlights that diagnoses costs and who pays for it as well as the lack of suitable diagnostic facilities for youths in juvenile detention or adults is a major problem.¹²⁴
- 6.144 Without the recognition of FASD as a disability Professor Douglas considers little will change:
- It is a bit of a double-edged sword: until you start recognising it in formal situations as a disability, things grow – it is part of a chicken-or-egg question really.¹²⁵
- 6.145 She added:
- ... the literature in Canada and the US tells us that the best way to help kids avoid criminal justice is through diagnosis and support.¹²⁶

Conclusion

- 6.146 There was significant evidence throughout the inquiry that making FASD a recognised disability is a necessary step in order that supports are provided, and unfair treatment of sufferers is avoided.
- 6.147 The committee heard how important it is that FASD is recognised as a disability in the social security system.
- 6.148 There was evidence that when the education and criminal justice systems cannot take FASD into account because there is no official diagnosis of a recognised disability, the individual is severely disadvantaged. The requirements for FASD to be considered in the courts are quite stringent and without a diagnosis, FASD cannot be seen to be a mitigating factor in the persons defence.
- 6.149 The benefits to be gained in recognising FASD as a disability are too great to continue to overlook. It is also a human rights issue.
- 6.150 The Commonwealth should include FASD as a recognised disability for Carer's allowance and Best Start as soon as possible.

123 Ms Catherine Crawford, *Submission 103*, p. 5.

124 Professor Heather Douglas, *Committee Hansard*, Brisbane, 20 June 2014, p. 22.

125 Professor Douglas, *Committee Hansard*, Brisbane, 20 June 2014, p. 22.

126 Professor Douglas, *Committee Hansard*, Brisbane, 20 June 2014, p. 23.

- 6.151 Including FASD as an example on the Impairment Tables for the Disability Support Pension would be a simple step in providing a guide for how the Impairment Tables could be best used to assess an individual who has the condition. This would streamline assistance for those with FASD and their carers.

Recommendation 20

- 6.152 That the Commonwealth, in consultation with the FASD Technical Network, include in the appropriate table in the Social Security Tables for the Assessment of Work-related Impairment for Disability Support Pension Determination 2011:
- A person with Fetal Alcohol Spectrum Disorder who does not have an IQ below 80 should be assessed under this Table.

Recommendation 21

- 6.153 That the Commonwealth, in consultation with the FASD Technical Network, and relevant organisations from the criminal justice system:
- develop a model definition for cognitive impairment, and
 - conduct a review of Commonwealth law and policy to identify where eligibility criteria need to change to ensure that people with FAS and FASD and other cognitive impairments can be included.

Determining patterns of supply and demand

Introduction

- 7.1 The committee examined the supply of and demand for alcohol in Aboriginal and Torres Strait Islander communities with a particular focus on how the consumption of alcohol varies within and across different communities.
- 7.2 Patterns of alcohol consumption in Aboriginal and Torres Strait Islander communities are shown to vary significantly by age, gender and location, and differ from those of non-Indigenous people.
- 7.3 A recurring theme in the evidence presented to the committee was that the lack of accurate and systematic estimates of alcohol consumption in Aboriginal and Torres Strait Islander communities, and more broadly across Australian society, makes it difficult to monitor trends and target strategies to reduce harmful alcohol use.
- 7.4 This chapter examines a range of methods currently used for estimating alcohol consumption, including wholesale alcohol sales data and national, population-based surveys.

Alcohol consumption

- 7.5 While the majority of Australians who drink alcohol do so moderately and responsibly, many people consume alcohol at levels that can either cause

them harm over the course of their lifetime, or can increase their risk of harm from a single drinking occasion.¹

- 7.6 Across the Australian population, on average one in five adults consumes more than two standard drinks per day on average. This level of consumption is associated with a lifetime risk of harm from alcohol-related disease or injury.² The harmful use of alcohol and other drugs is a significant public health problem for the Australian community as a whole and incurs significant economic costs.³
- 7.7 Aboriginal and Torres Strait Islander people are more likely to abstain from drinking alcohol than non-Indigenous people.⁴ The 2008 *National Aboriginal and Torres Strait Islander Social Survey* (Social Survey)⁵ found that more than one third of Aboriginal and Torres Strait Islander adults abstained from drinking alcohol compared with around one eighth of non-Indigenous adults.⁶
- 7.8 However, Aboriginal and Torres Strait Islander people who do consume alcohol are more likely to drink it at high-risk levels than non-Indigenous people. The 2008 Social Survey found that one in six Aboriginal and Torres Strait Islander adults were drinking at high-risk levels for a long time, referred to as chronic drinking. One third of Aboriginal and Torres Strait Islander adults had reported drinking at high-risk levels over a short time, referred to as binge drinking, in the two weeks before they were interviewed.⁷
- 7.9 The *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF) monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health. The Aboriginal and Torres Strait Islander health performance

1 According to current guidelines for minimising the risk of harm from drinking alcohol, harmful alcohol use is classified in two ways: lifetime risk, or drinking more than two standard drinks each day on average; and single occasion risk, or drinking more than four standard drinks on a single occasion. See: National Health and Medical Research Council (NHMRC), *Australian guidelines to reduce health risks from drinking alcohol*, 2009, Canberra, pp. 2-3.

2 NHMRC, *Australian guidelines to reduce health risks from drinking alcohol*, 2009, Canberra, pp. 2-3.

3 Aboriginal Drug and Alcohol Council (SA) Inc. (ADAC), *Submission 40*, Attachment 3, p. 2.

4 Australian Institute of Health and Welfare (AIHW), *2013 National Drug Strategy Household Survey (Drug Survey) Detailed Report*, 2014, Drug statistics series no. 28, Cat. no. PHE 183, Canberra, AIHW, p. 94.

5 The 2008 survey is the most recent National Aboriginal and Torres Strait Islander Social Survey (NATSISS) dataset, with the survey being conducted every six years.

6 Australian Bureau of Statistics (ABS), NATSISS: summary booklet, 2008, Canberra

7 ABS, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*, October 2010, Canberra.

framework: 2012 report provides the most recent report against the HPF, finding that:

- Aboriginal and Torres Strait Islander males and females were hospitalised at four and five times the rate, respectively, of their non-Indigenous counterparts for diagnoses related to alcohol use
- 86 per cent of all hospital episodes for Aboriginal and Torres Strait Islander people relating to alcohol use had a principle diagnosis of mental and behavioural disorders due to alcohol use (including acute intoxication, dependence syndrome and withdrawal)
- Aboriginal and Torres Strait Islander people were hospitalised at six times the rate of non-Indigenous people for alcoholic liver disease, and
- Aboriginal and Torres Strait Islander males and females died at five and eight times the rate, respectively, of their non-Indigenous counterparts from causes related to alcohol use. The greatest causes of death for Aboriginal and Torres Strait Islander people related to alcohol use were:
 - ⇒ mental and behavioural disorders (seven times the rate of non-Indigenous people)
 - ⇒ alcoholic liver disease (six times the rate of non-Indigenous people), and the greatest overall cause of death, and
 - ⇒ alcohol poisoning (five times the rate of non-Indigenous people).⁸

7.10 There is continuing concern in Aboriginal and Torres Strait Islander communities and in the wider community of the serious effect that alcohol is having on many Aboriginal and Torres Strait Islander individuals and communities.

7.11 In considering the evidence on alcohol consumption in Aboriginal and Torres Strait Islander communities, the committee was mindful that there is significant variation both within and between those communities. The committee was careful to ensure that it avoided assumptions about the uniformity of Aboriginal and Torres Strait Islander peoples.

Gender and alcohol consumption

7.12 The Royal Australian College of General Practitioners (RACGP) reports that, in 2012-13, Aboriginal and Torres Strait Islander men were more

8 Australian Health Ministers' Advisory Council (2012) Aboriginal and Torres Strait Islander health performance framework: 2012 report. Canberra: Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing, p.105.

likely than women to drink alcohol at levels that increased their risk of harm on a single occasion (64 per cent and 44 per cent respectively).⁹

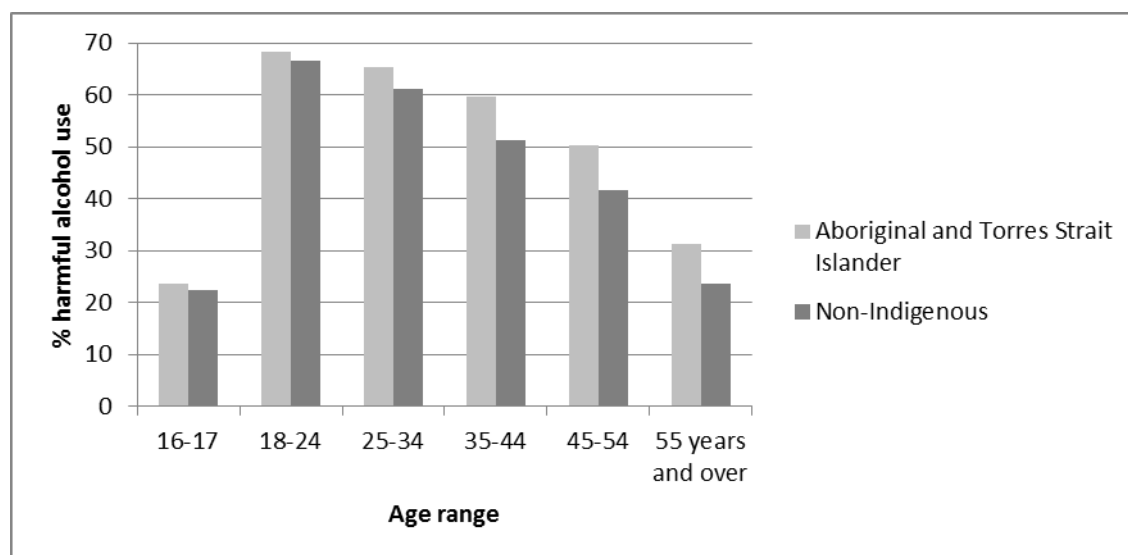
- 7.13 While national statistics suggest that in certain communities, the situation is particularly dire, Dr Patricia Miller from the Central Australian Aboriginal Legal Aid Service (CAALAS) comments that, as a consequence of harmful alcohol use:

... we have communities that are actually lacking that middle age group of young men because they are all incarcerated or in hospital, or they have been buried.¹⁰

Age

- 7.14 Figure 7.1 shows that across all age groups, Aboriginal and Torres Strait Islander people are more likely to consume alcohol at harmful levels than non-Indigenous people.
- 7.15 In particular, while young people are most likely to binge drink, more Aboriginal and Torres Strait Islander people continue to drink at harmful levels later in life than non-Indigenous people.

Figure 7.1 The prevalence of harmful alcohol use by age: Aboriginal and Torres Strait Islander and non-Indigenous people.



Source ABS, *National Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13, 2014*, cat. no. 4727.0.55.001.¹¹

9 Royal Australian College of General Practitioners (RACGP), *Submission 82*, p. 2.

10 Dr Patricia Miller, Chief Executive Officer, Central Australian Aboriginal Legal Aid Service (CAALAS), *Committee Hansard*, Alice Springs, 31 March 2014, p. 20.

11 Figures show the proportion of people who consumed alcohol at levels that placed them at risk of harm from a single drinking occasion.

- 7.16 High rates of binge drinking amongst young Aboriginal and Torres Strait Islander people was raised as a particular issue of concern in a variety of locations. In Sydney, the Aboriginal Medical Service reports that alcohol use among young people is increasing,¹² while at Halls Creek, concerns were raised that binge drinking amongst young Aboriginal and Torres Strait Islander people was being facilitated by alcohol trafficking.¹³
- 7.17 A Perth study found that while some young participants were able to buy alcohol directly from bottle shops while they were underage, the majority of alcohol the young people consumed was supplied by older relatives and friends, as well as asking strangers outside bottle shops to purchase alcohol on their behalf.¹⁴

Location

- 7.18 The most recent *National Aboriginal and Torres Strait Islander Social Survey* (Social Survey) reports that, in 2008, over two-thirds of Aboriginal and Torres Strait Islander people lived outside of major cities. It found that 44 per cent lived in regional areas and 24 per cent lived in remote or very remote areas.¹⁵
- 7.19 The Royal Australasian College of Physicians (RACP) notes the relationship between differences in rates of alcohol consumption in Aboriginal and Torres Strait Islander communities and remoteness. It states that while Aboriginal and Torres Strait Islander people in remote areas were more likely to have abstained from alcohol than those in non-remote areas, 38 per cent and 19 per cent respectively, more people in remote areas were likely to drink at levels that increased their risk of harm at least once a week, 23 per cent and 18 per cent respectively.¹⁶
- 7.20 The available data indicates that patterns of harmful alcohol use vary greatly both within and between Aboriginal and Torres Strait Islander communities. However, the RACP stressed that caution should be exercised in interpreting survey results because of concerns about the quality of statistical data they contain.¹⁷ The RACP suggests that this

12 Aboriginal Medical Service Redfern, *Submission 119*, p. 1.

13 Ms Alice Wason, *Committee Hansard*, Halls Creek, 2 July 2014, p. 25.

14 Dr Mandy Wilson and Ms Jocelyn Jones, National Drug Research Institute (NDRI), *Submission 118*, pp. 5–6.

15 ABS, *National Aboriginal and Torres Strait Islander Social Survey (Social Survey) 2008, 2009*, cat. no. 4714.0.

16 Royal Australasian College of Physicians (RACP), *Submission 28*, p. 9.

17 RACP, *Submission 28*, p. 8.

‘reinforces the need for higher quality, relevant and timely information to be made available to support informed policy decisions’.¹⁸

Measuring consumption

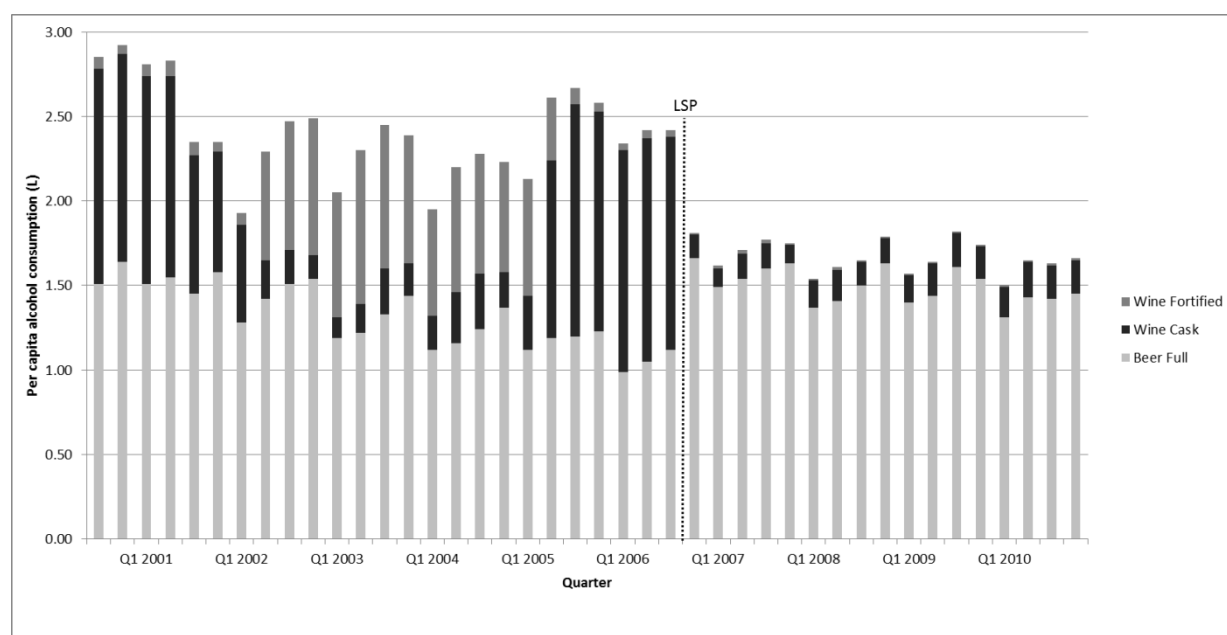
- 7.21 The committee heard that estimates of alcohol consumption are currently derived from:
- data collected for the purposes of levying alcohol excise
 - information collected from the wholesale sale of alcohol, and
 - national surveys.
- 7.22 Data on alcohol consumption can be an effective method of monitoring changes in drinking behaviour before and after interventions to minimise harmful alcohol use. For example, wholesale alcohol sales data from the Northern Territory demonstrates changes in alcohol consumption following the introduction of a Liquor Supply Plan in Alice Springs in 2006.¹⁹
- 7.23 The Alice Springs Liquor Supply Plan prohibited the sale of table wine in containers larger than two litres and fortified wine in containers larger than one litre. Wholesale sales data indicates that while the Liquor Supply Plan was in operation, there was a reduction in overall alcohol consumption and a significant reduction in consumption of cask table and fortified wine. There was a moderate increase in the consumption of beer.²⁰ Figure 7.2 illustrates these trends.

18 RACP, *Submission 28*, p. 8.

19 NDRI, *Submission 47*, p. 19. For original study, see: M Symons, D Gray, T Chikritzhs et al, *A longitudinal study of influences on alcohol consumption and related harm in Central Australia: with a particular emphasis on the role of price*, 2012, Perth, NDRI.

20 NDRI, *Submission 47*, p. 19. For original study, see: M Symons, D Gray, T Chikritzhs et al, *A longitudinal study of influences on alcohol consumption and related harm in Central Australia: with a particular emphasis on the role of price*, 2012, Perth, NDRI.

Figure 7.2 The impact of changes to supply on alcohol consumption: the Alice Springs Liquor Supply Plan (LSP)



Source *National Drug Research Institute, Submission 47, p. 19; M Symons, D Gray, T Chikritzhs et al, A Longitudinal Study of Influences on Alcohol Consumption and Related Harm in Central Australia: With a Particular Emphasis on the Role of Price, 2012, National Drug Research Institute, Perth, p. 35.*

7.24 Hospital admissions and police statistics also help to provide a more comprehensive picture of alcohol consumption, however such data is frequently not available.

Current methods

Estimates based on alcohol sales

7.25 In Australia, the total volume of alcohol available for sale to consumers is recorded nationally through the collection of alcohol excise. Excise is a commodity-based tax on alcohol, tobacco and petroleum products that is levied by the Commonwealth.²¹ Information collected as part of levying the alcohol excise form the basis of the national Apparent Consumption of Alcohol dataset, which is published by the Australian Bureau of Statistics (ABS).²²

7.26 The volume of alcohol available for sale by alcohol retailers is recorded in some states and territories in the form of wholesale alcohol sales data.

21 Australian Taxation Office (ATO), *Excise and excise equivalent goods*, 2014, <<https://www.ato.gov.au/Business/Excise-and-excise-equivalent-goods/>> viewed 3 November 2014.

22 ABS, *Apparent Consumption of Alcohol, Australia 2012-13, Explanatory Notes*, cat. no. 4307.0.55.001.

Both the National Drug Research Institute (NDRI) and the Foundation for Alcohol Research and Education (FARE) observe that alcohol wholesale sales data is an important source of information for monitoring alcohol consumption and the impact of public health measures to limit alcohol supply and associated harm.²³ The NDRI further highlights that wholesale sales data enables the identification of regional and local patterns of consumption.²⁴

- 7.27 Unfortunately, across Australia wholesale alcohol sales data is not uniformly collected.²⁵ The NDRI highlights that, prior to 1997, all state and territory jurisdictions recorded information on the wholesale sales of alcohol products as a basis for imposing liquor franchise (license) fees.²⁶ After a High Court of Australia ruling in 1997 several jurisdictions, including New South Wales, South Australia and Victoria, stopped collecting wholesale alcohol sales data.²⁷

Limitations of consumption data

- 7.28 A range of limitations were identified in the ways that alcohol consumption is currently estimated through the collection of information through excise and wholesale sales.
- 7.29 While the Apparent Consumption of Alcohol dataset may be a useful estimate of alcohol consumption on a national level, it is of limited use as a public health planning tool.²⁸ The People's Alcohol Action Coalition (PAAC) stresses the need for a combination of comprehensive wholesale alcohol sales data and data on alcohol-related harms to 'allow for targeting of effort at areas of most need as well as ongoing, routine monitoring of the effect of programs and policies aimed at reducing alcohol-related harm'.²⁹
- 7.30 Wholesale sales data is currently not collected in all jurisdictions. FARE asserts that the collection and publication of wholesale alcohol sales data should include postcode data and this information should be collected at

23 NDRI, *Submission 47*, p. 4; Foundation for Alcohol Research and Education (FARE), *Submission 83*, p. 8.

24 NDRI, *Submission 47*, p. 4.

25 Wholesale alcohol sales data is currently collected in Western Australia, Queensland, the Northern Territory and the Australian Capital Territory; it is not collected in New South Wales, Victoria, South Australia and Tasmania. NDRI, *Submission 47*, p. 4.

26 NDRI, *Submission 47*, p. 4.

27 NDRI, *Submission 47*, p. 4.

28 RACP, *Submission 28*, p. 31. The NDRI notes this is because the dataset cannot be broken down by location or by population characteristics. See: NDRI, *Submission 47*, p. 4.

29 People's Alcohol Action Coalition (PAAC), *Submission 7.1*, p. 3.

least annually, be publically available, and mandatory for all states and territories.³⁰

- 7.31 FARE calls for the alcohol industry to play a more proactive role in the provision of data about alcohol supply volumes and practices, particularly in relation to supply to 'Aboriginal and Torres Strait Islander communities and nearby regions given the disproportionate levels of harm evidenced'.³¹
- 7.32 The PAAC observes that other sources of data, such as alcohol-related hospitalisations and mortality rates, shows there is significant regional variation in alcohol consumption in Aboriginal and Torres Strait Islander communities that are not adequately captured using currently-available estimates.³²

National surveys

- 7.33 Currently, three national surveys collect information about alcohol consumption in Aboriginal and Torres Strait Islander communities:
- the *National Drug Strategy Household Survey* (Drug Survey)³³
 - the *National Aboriginal and Torres Strait Islander Social Survey* (Social Survey),³⁴ and
 - the *National Aboriginal and Torres Strait Islander Health Survey* (Health Survey).³⁵
- 7.34 While the Drug Survey, Social Survey and Health Survey complements sales data, these surveys have limitations.³⁶ The PAAC states that such surveys are infrequent, tend to underestimate consumption, and do not obtain adequate information from Aboriginal and Torres Strait Islander people about their drinking.³⁷
- 7.35 The Australian Institute of Health and Welfare (AIHW) reports that while the Drug Survey was designed to estimate drug and alcohol use nationally, it was not specifically designed to obtain reliable estimates for Aboriginal and Torres Strait Islander people's drug and alcohol use.³⁸ The AIHW therefore stresses the need for caution in interpreting estimates of

30 FARE, *Submission 83*, p. 8.

31 FARE, *Submission 83*, p. 19.

32 PAAC, *Submission 7.1*, p. 6.

33 AIHW, *2013 Drug Survey Detailed Report*, 2014, Drug statistics series no. 28, Canberra, AIHW.

34 ABS, *NATSISS 2008, 2009*, cat. no. 4714.0.

35 ABS, *NATSIHS 2012–13, 2014*, cat. no. 4727.0.55.001.

36 PAAC, *Submission 7.1*, p. 7; RACP, *Submission 28*, p. 31; NDRI, *Submission 47*, p. 7.

37 PAAC, *Submission 7.1*, p. 7.

38 AIHW, *Submission 19*, p. 3.

- alcohol consumption based on the Aboriginal and Torres Strait Islander population group in the Drug Survey.³⁹
- 7.36 The NDRI notes that neither the Social Survey nor the Health Survey conforms to recommendations made by the World Health Organisation (WHO) for eliciting responses about alcohol consumption.⁴⁰ The PAAC asserts that both the Social Survey and the Health Survey need to be upgraded to follow the methodology established by the WHO.⁴¹
- 7.37 The Department of the Prime Minister and Cabinet (PM&C) states:
- ... the main source of alcohol use prevalence estimates are from national surveys. It is well understood that these surveys tend to under report the prevalence of alcohol usage and they do not capture variations in consumption for specific communities.⁴²
- 7.38 A supplement to the 1994 Drug Survey was identified as an example of best practice in the conduct of surveys relating to alcohol consumption in Aboriginal and Torres Strait Islander communities.⁴³ The PAAC refers to the survey as the most comprehensive of its type conducted on Aboriginal and Torres Strait Islander alcohol and drug consumption.⁴⁴
- 7.39 Professor Dennis Gray from the NDRI observes that the 1994 survey was both unique and important because it distinguished between people who have never consumed alcohol and people who previously drank and no longer do. Professor Gray also notes that the 1994 survey had a large Aboriginal and Torres Strait Islander sample, in contrast to more recent Drug Survey.⁴⁵
- 7.40 The NDRI asserts that in order for alcohol trends to be better tracked and interventions targeted more effectively, similarly comprehensive data that was elicited by the 1994 survey needs to be collected on a regular basis.⁴⁶
- 7.41 Similarly, the PAAC recommends that either:
- the 1994 survey be replicated and conducted on a regular basis, or

39 AIHW, *Submission 19*, p. 3.

40 NDRI, *Submission 47*, p. 7; See: World Health Organization (WHO), *International Guide for Monitoring Alcohol Consumption and Related Harms*, 2000, pp. 56–8.

41 PAAC, *Submission 7.1*, p. 7.

42 Department of Prime Minister and Cabinet (PM&C), *Submission 102*, p. 11.

43 NDRI, *Submission 47*, p. 7; PAAC, *Submission 7.1*, p. 7; Professor Dennis Gray, Deputy Director, NDRI, *Committee Hansard*, Perth, 30 June 2014, p. 15; See: Department of Human Services and Health, *National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Supplement 1994*, 1996, Canberra, Australian Government Publishing Service.

44 PAAC, *Submission 7.1*, p. 7.

45 Professor Gray, NDRI, *Committee Hansard*, Perth, 30 June 2014, p. 15.

46 NDRI, *Submission 47*, p. 7.

- the relevant sections on alcohol consumption in the regular surveys be upgraded.⁴⁷

Conclusion

- 7.42 The committee observes that patterns of alcohol consumption in Aboriginal and Torres Strait Islander communities vary significantly according to location. The committee is aware that people living in very remote communities may be less likely to consume alcohol at harmful levels compared to those in regional and remote areas.⁴⁸ However, the committee also notes concerns about the quality of available data, and remains cautious about drawing conclusions about regional differences.
- 7.43 The committee sees benefit in further research being conducted to identify these regional differences and the reasons why patterns of alcohol consumption in Aboriginal and Torres Strait Islander communities vary considerably according to degrees of remoteness.
- 7.44 Issues of data quality and the need for caution in interpreting statistics about alcohol consumption in Aboriginal and Torres Strait Islander communities were reiterated throughout the inquiry.⁴⁹
- 7.45 With better data, Aboriginal and Torres Strait Islander communities can develop strategies that may be better targeted, monitored and evaluated.
- 7.46 The committee is concerned that despite there being three national surveys that collect information about alcohol use, the only example of a comprehensive survey of alcohol consumption amongst Aboriginal and Torres Strait Islander people was a one-off survey conducted in 1994, 21 years ago.
- 7.47 The Drug Survey was not designed to provide a reliable estimate of Aboriginal and Torres Strait Islander people's drug and alcohol use. The committee regards this as a serious oversight that should be corrected prior to the conduct of the 2017 Drug Survey.

47 PAAC, *Submission 7.1*, p. 7.

48 ABS, *Health Survey 2012–13*, 2014, cat. no. 4727.0.55.001.

49 AIHW, *Submission 19*, p. 3; PAAC, *Submission 7.1*, p. 7; RACP, *Submission 28*, p. 31; NDRI, *Submission 47*, p. 7.

Recommendation 22

- 7.48 **That the Australian Institute of Health and Welfare review and update the methodology and instrument of the National Drug Household Survey to obtain reliable estimates on Aboriginal and Torres Strait Islander and non-Indigenous illicit drug and alcohol use. These changes should be implemented for the conduct of the 2017 survey.**
- 7.49 Both the Social Survey and Health Survey should be comprehensively reviewed so there is improved data collection relating to alcohol consumption. This should be done in cooperation with Aboriginal and Torres Strait Islander stakeholders.

Recommendation 23

- 7.50 **That the Australian Bureau of Statistics conducts a review of the relevant sections of the National Aboriginal and Torres Strait Islander Social Survey and the National Aboriginal and Torres Strait Islander Health Survey to ensure international best practice is adopted in the instrument and conduct of surveys on alcohol consumption.**
- 7.51 The committee believes the scope of the work being done in the Aboriginal and Torres Strait Islander controlled health organisations needs to be recorded and be available to inform future decisions.
- 7.52 These organisations are often the organisations that can facilitate treatment for those who consume alcohol at harmful levels and their insight and information on the trends and harms of alcohol use are highly valuable and should be captured.
- 7.53 The committee is of the view that all medical services that provide treatment for Aboriginal and Torres Strait Islander people should collect data on trends and harms of alcohol use as a routine element of their work.

Demand – why do people drink to harmful levels?

- 7.54 As with other products that people consume, the demand for alcohol is related to a range of factors, including the price, desirability and access or

- availability of alcohol products. However, alcohol is unlike many other commodities because of its capacity to cause addiction and harm.⁵⁰
- 7.55 Evidence to this inquiry has shown that some individuals will continue to drink to excess regardless of changes to alcohol supply. For example, where alcohol restrictions are introduced, people who misuse alcohol may simply relocate to another location to continue drinking.⁵¹ Reducing the demand for alcohol therefore means addressing the reasons why some individuals consume alcohol at harmful levels.
- 7.56 The committee heard that for Aboriginal and Torres Strait Islander people who drink to excess, their demand for alcohol is a response to a range of social and economic determinants, including poor physical and mental health, a lack of educational and employment opportunities, boredom, experiences of racism and trauma, cultural acceptance of heavy drinking as a norm, a lack of connection to family, and a loss of community, culture and country.⁵² These determinants are examined in detail in Chapter 1.
- 7.57 The National Drug Strategy 2010 – 2015 has three pillars of the Australian Harm Minimisation approach: demand reduction, supply reduction and harm reduction. The National Drug Strategy considers four key elements for demand reduction are:
- prevent uptake and delay onset of drug use
 - reduce use of drugs in the community
 - support people to recover from dependence and reconnect with the community, and
 - support efforts to promote social inclusion and resilient individuals, families and communities.⁵³

50 Mr Michael Thorn, Chief Executive, FARE, *Committee Hansard*, Canberra, 28 August 2014, p. 3. See also: T. F. Babor, R. Caetano, S. Casswell, G. Edwards et. al., *Alcohol: No Ordinary Commodity. Research and Public Policy*, 2010, Oxford University Press, New York.

51 NIDAC, *Submission 94*, Attachment 6, p. 14; Professor Marcia Langton, Dr Richard Chenhall and Ms Kristen Smith, University of Melbourne, *Submission 44*, p. 7.

52 Nepean Community & Neighbourhood Services (NCNS), *Submission 122*, p. 1. See also: AIHW, *What works? A review of actions addressing the social and economic determinants of Indigenous Health*, 2013, pp. 4-9.

53 Ministerial Council on Drug Strategy, *National Drug Strategy 2010–2015*, February 2011, p. ii.

International Best Practice

Introduction

- 8.1 The Indigenous peoples of Canada, the United States and New Zealand have increasingly drawn on their unique cultural, spiritual and healing traditions to develop alcohol treatment and support programs alongside mainstream treatments.¹ These programs range from those based on mainstream treatment approaches, to programs that are based entirely on particular healing traditions and traditional knowledge.
- 8.2 While the international research on the effectiveness of culturally-informed treatment for alcohol problems is less extensive than for mainstream approaches to alcohol treatment, several reviews have been conducted that offer insight into the types of cultural interventions used, and have documented their efficacy in a broad range of treatment settings.²
- 8.3 The committee examined the evidence on best practice, culturally-informed treatment in Canada, the United States and New Zealand. Many of these approaches utilise holistic, Indigenous models of health, wellbeing and healing, emphasising the importance of connecting with

1 K Novins, A Aarons, S G Conti et al, 'Use of the evidence base in substance abuse treatment programs for American Indians and Alaska natives: pursuing quality in the crucible of practice and policy', *Implementation Science*, 2011, vol. 6, no. 63, p. 2.

2 For example, see: P J Abbott, 'Traditional and western healing practices for alcoholism in American Indians and Alaska Natives', *Substance Use and Misuse*, 1998, vol. 33, no. 13, pp. 2605-46; M Rowan, N Poole, B Shea et al, 'Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study', *Substance Abuse Treatment, Prevention, and Policy*, 2014, vol. 9, Article 34, pp. 1-34.

family, culture, traditions and spirituality, in addition to treating the psychological and physiological effects of alcohol misuse.

Evidence-based practices and culturally-informed treatments

- 8.4 A significant issue in the development of culturally-informed alcohol treatment services by Indigenous peoples has been the priority given to Evidence Based Practices (EBP) by health funding agencies, which has contributed to an ongoing debate concerning the best approach to improving the quality of treatment.³
- 8.5 EBP are considered, by some, to be the most effective treatment methods because they are based on the results of controlled scientific experiments to assess their efficacy. The movement towards EBP was an attempt to align professional practice more closely with scientific evidence.⁴ Cognitive behavioural therapy and motivational interviewing are two examples of commonly used EBP in the treatment of alcohol and substance abuse.⁵
- 8.6 While EBP are a response to the need to improve the quality of alcohol and substance abuse treatment services, their introduction within programs serving Indigenous communities has created divisions among key stakeholders.⁶ These divisions show that many Indigenous people remain uncomfortable or unresponsive to western approaches to alcohol treatment in their communities.⁷
- 8.7 A key problem relating to the emergence of EBP is that funding agencies have required behavioural health care providers to observe the same evidence-based practice standards that are expected in hospitals and other

3 K Novins, A Aarons, S G Conti et al, 'Use of the evidence base in substance abuse treatment programs for American Indians and Alaska natives: pursuing quality in the crucible of practice and policy', *Implementation Science*, 2011, vol. 6, no. 63, p. 2.

4 E Nebelkopf, J King, S Wright et al, 'Growing Roots: Native American Evidence-based Practices', *Journal of Psychoactive Drugs*, 2011, vol. 43, no. 4, p. 264.

5 E Nebelkopf, J King, S Wright et al, 'Growing Roots: Native American Evidence-based Practices', *Journal of Psychoactive Drugs*, 2011, vol. 43, no. 4, p. 264.

6 K Novins, A Aarons, S G Conti et al, 'Use of the evidence base in substance abuse treatment programs for American Indians and Alaska natives: pursuing quality in the crucible of practice and policy', *Implementation Science*, 2011, vol. 6, no. 63, p. 8.

7 K Novins, A Aarons, S G Conti et al, 'Use of the evidence base in substance abuse treatment programs for American Indians and Alaska natives: pursuing quality in the crucible of practice and policy', *Implementation Science*, 2011, vol. 6, no. 63, p. 2.

- primary health care settings. Under this system, funding is contingent on the provision of EBP.⁸
- 8.8 A comparative study on Indigenous culturally-informed treatments in the United States, Canada and Australia found that the provision of evidence supporting Indigenous cultural interventions is limited by a lack of good quality evaluations of these types of programs.⁹ This lack of evidence places many Indigenous service providers at a disadvantage in accessing program funding.
- 8.9 Other studies have suggested a range of reasons why culturally-informed treatments have limited available evaluation and outcome data:
- the lack of evidence can be partially attributed to the community-specific nature of Indigenous programs¹⁰
 - the broader objectives of these programs, such as enhancing community spirit, leadership, and improving self-esteem are difficult to measure,¹¹ and
 - it has been observed that many Indigenous communities are reluctant to participate in clinical trials, partially as a result of substantial research abuses in the past, as well as having serious concerns about the value of research for improving their circumstances.¹²
- 8.10 Another relevant concern is that Indigenous culturally-informed approaches to alcohol treatment are founded on holistic concepts of health, wellness and healing that may not be adequately addressed by EBP.
- 8.11 A recent review from Canada noted that while western biomedical approaches such as EBP focus on the absence of disease, and imply a mind/body separation in treating sickness, many Indigenous people have a more integrated and nuanced understanding of wellness. This concept of wellness is:

8 E Nebelkopf, J King, S Wright et al, 'Growing Roots: Native American Evidence-based Practices', *Journal of Psychoactive Drugs*, 2011, vol. 43, no. 4, p. 264.

9 M. Brady, 'Culture in Treatment, Culture as Treatment: a critical appraisal of developments in addictions programs for Indigenous North Americans and Australians', *Social Science and Medicine*, 1995, vol. 41, no. 11, pp. 1489.

10 A Jiwa, L Kelly and N Pierre-Hansen, 'Healing the community to heal the individual: Literature review of aboriginal community-based alcohol and substance abuse programs', *Canadian Family Physician*, 2008, vol. 54, no. 7, p. 1000.e6.

11 A Jiwa, L Kelly and N Pierre-Hansen, 'Healing the community to heal the individual: Literature review of aboriginal community-based alcohol and substance abuse programs', *Canadian Family Physician*, 2008, vol. 54, no. 7, p. 1000.e6.

12 K Novins, A Aarons, S G Conti et al, 'Use of the evidence base in substance abuse treatment programs for American Indians and Alaska natives: pursuing quality in the crucible of practice and policy', *Implementation Science*, 2011, vol. 6, no. 63, p. 2.

...understood as one of a harmonious relationship within the whole person, including mind, body, emotion, and spirit. Wellbeing and health emerge from a holistic worldview that emphasizes balance among one's tradition, culture, language, and community.¹³

- 8.12 A different review observed that, rather than having a one size fits all approach to treatment, Indigenous communities use a combination of culturally-informed practices and Western modes of treatment to respond to complex local needs. These needs may include the prevalence of co-occurring disorders, historical trauma, and poverty.¹⁴
- 8.13 There is often a poor alignment between so called EBP and Indigenous culturally-informed treatment programs. The reluctance of some Indigenous communities to engage with yet more research, means the efficacy of different alcohol treatments for Indigenous peoples is often not well understood.
- 8.14 Efforts are currently underway to develop reliable, culturally-informed measures of wellness and treatment efficacy. The development of alternative methods to evaluate the effectiveness of culturally-informed alcohol treatment practices may go some way in mediating the conflicting positions taken in the debate around what works.¹⁵

Canada

- 8.15 The Indigenous peoples of Canada have diverse cultural, spiritual and linguistic heritage and identify as being Aboriginal, First Nations or as one of three groups recognised in the Canadian Constitution: Indian, Métis

13 M Rowan, N Poole, B Shea et al, 'Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study', *Substance Abuse Treatment, Prevention, and Policy*, 2014, vol. 9, article 34, p. 2.

14 E Nebelkopf, J King, S Wright et al, 'Growing Roots: Native American Evidence-based Practices', *Journal of Psychoactive Drugs*, 2011, vol. 43, no. 4, p. 267.

15 See: M Rowan, N Poole, B Shea et al, 'Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study', *Substance Abuse Treatment, Prevention, and Policy*, 2014, vol. 9, article 34, p. 25.

- and Inuit.¹⁶ There are 617 Indigenous communities in Canada, comprising more than 50 distinct cultural groups and 50 languages.¹⁷
- 8.16 Many alcohol programs and services assisting Canadian Indigenous communities are informed by Indigenous values and traditional knowledge. The object of these is to provide communities with culturally-relevant treatment options and help to reduce the incidence of harmful alcohol use and alcohol related harm in those communities.
- 8.17 The primary network responding to Indigenous alcohol problems in Canada is the National Native Alcohol and Drug Abuse Program (NNADAP). The NNADAP is funded by the Canadian Government and includes 52 residential treatment centres and over 550 prevention programs.¹⁸ NNADAP treatment centres combine elements of mainstream and Indigenous models of treatment and support for alcohol-related problems.¹⁹
- 8.18 A review of the NNADAP found that a number of key characteristics were common to all NNADAP treatment centres. These features were:
- one-to-one counselling
 - large group experiences
 - small group sessions
 - native spirituality
 - heavy reliance on the use of abstinence models and Alcoholics Anonymous (AA) philosophy
 - heavy educational emphasis, and
 - counselling staff who are in recovery themselves.²⁰
- 8.19 The review also found that clients were more responsive to the cultural elements of treatment at NNADAP treatment centres, and viewed

16 For further information on terminology, see: Department of Aboriginal Affairs and Northern Development Canada, *Terminology*, 2013, <<http://www.aadnc-aandc.gc.ca/eng/1100100014642/1100100014643>> viewed 8 September 2014.

17 Department of Aboriginal Affairs and Northern Development Canada, *First Nations*, 2013, <<http://www.aadnc-aandc.gc.ca/eng/1100100013791/1100100013795>> viewed 8 September 2014.

18 Health Canada, *The National Native Alcohol and Drug Abuse Program*, 2013, <<http://www.hc-sc.gc.ca/fniah-spnia/substan/ads/nnadap-pnlaada-eng.php>> viewed 10 April 2014.

19 S Saggars and D Gray, *Dealing with Alcohol: Indigenous Usage in Australia, New Zealand and Canada*, 1998, Cambridge University Press, Cambridge, United Kingdom, p. 151.

20 NNADAP, *National Native Alcohol and Drug Abuse Program General Review*, 1998, <http://www.hc-sc.gc.ca/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/ads/1998_rpt-nnadap-pnlaada-eng.pdf> viewed 15 August 2014, p. 42.

traditional approaches to treatment as offering a better prospect of success.²¹

- 8.20 Indigenous culture is incorporated into alcohol treatment and support programs in Canada in a variety of ways. These range from programs that incorporate Indigenous concepts of health and healing into western paradigms of treatment such as the 12 steps of AA, to those that utilise multiple forms of cultural interventions.
- 8.21 An example of a commonly-used Indigenous concept of health and healing in Canada is the medicine wheel model, which takes a holistic approach to the understanding of alcohol-related problems. According to a treatment centre in Alberta, the medicine wheel teaches that:
- ... in order to live a healthy life we must have balance in the four dimensions of ourselves: the mental, the physical, the emotional and the spiritual. It is our belief that addiction destroys these dimensions and the only effective method of recovery is a holistic approach.²²
- 8.22 In addition to holistic approaches to the wellbeing of Indigenous Canadians experiencing alcohol problems, a range of cultural healing interventions are used in treatment, including sweat lodges, various ceremonial practices including smudges with sage, cedar or sweet grass, and a variety of cultural activities and teachings.²³

Box 8.1 Traditional healing in North America: the sweat lodge

One of the more common cultural interventions used in the treatment of alcohol problems among Indigenous people in Canada and the United States is the use of the sweat lodge. Traditionally, the sweat lodge ceremony was broadly distributed across North America, rather than being specific to particular regions or tribal groups.

The sweat lodge is typically a dome-shaped structure made from natural materials, within which water is poured on heated stones to make steam. Participants sit around the stones in complete darkness, while herbs and tobacco

21 NNADAP, *National Native Alcohol and Drug Abuse Program General Review*, 1998, <http://www.hc-sc.gc.ca/fniah-spnia/alt_formats/fnihb-dgspni/pdf/pubs/ads/1998_rpt-nnadap-pnlaada-eng.pdf> viewed 15 August 2014, p. 23.

22 Poundmaker's Lodge Treatment Centre, *Medicine Ways: Traditional Healers and Healing*, 2014, <<http://www.nlm.nih.gov/nativevoices/exhibition/healing-ways/medicine-ways/medicine-wheel.html>> viewed 15 August 2014.

23 M Rowan, N Poole, B Shea et al, 'Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study', *Substance Abuse Treatment, Prevention, and Policy*, 2014, vol. 9, article 34, p. 11.

may be used along with various ritual practices to 'purify, cleanse, and heal the body, mind, emotions, and spirit'.

Participation in the ceremony may reaffirm an individual's sense of who they are, and may also serve as a rite of passage, providing an opportunity for an individual to ritually demarcate their decision to change their drinking behaviour.

Furthermore, the physical sensation of sweating is detoxifying and cleansing, lending itself to psychological and spiritual associations with purification and renewal.

Source: JW Schiff and K Moore, 'The impact of the Sweat Lodge Ceremony on dimensions of well-being', *American Indian and Alaska Native Mental Health Research*, 2006, vol. 13, no. 3, p.49.

- 8.23 One of the more detailed studies of culturally-informed treatment for alcohol problems amongst Indigenous people in Canada examined the Kakawis Family Development Centre in a remote region of British Columbia. The study reported that over half of those people treated at the Centre remained sober for a least a year after leaving the program.²⁴
- 8.24 The Centre provides a combination of western psychotherapeutic treatment methods, aspects of the AA 12 step program, and cultural activities and traditionally-based therapy.²⁵ The program includes treatment and support for whole families over a six week period, involving group sessions, periods of family counselling, AA meetings, and some individual sessions.²⁶
- 8.25 Another detailed study examined how cultural practices were incorporated into the therapeutic activities of a Healing Lodge situated on a northern Algonquian reserve in Canada. The Healing Lodge offers residential, outpatient, and referral services for the treatment of alcohol and other substance abuse issues, and a range of additional problems associated with the legacy of the residential school experience.²⁷
- 8.26 The study found that a core element of the program was the integration of conceptual elements of the medicine wheel into the provision of treatment.

24 E N Anderson, 'A Healing Place: Ethnographic notes on a treatment centre', *Alcoholism Treatment Quarterly*, 1993, vol. 9, no.3/4, p. 4.

25 E N Anderson, 'A Healing Place: Ethnographic notes on a treatment centre', *Alcoholism Treatment Quarterly*, 1993, vol. 9, no.3/4, pp. 1-21. The Centre has subsequently been renamed the Kackaamin Family Development Centre. See: Kackaamin Family Development Centre, About us, 2014, < <http://www.kackaamin.org/> > viewed 25 September 2014.

26 E N Anderson, 'A Healing Place: Ethnographic notes on a treatment centre', *Alcoholism Treatment Quarterly*, 1993, vol. 9, no.3/4, pp. 8-9.

27 J P Gone, 'The Red Road to Wellness: Cultural Reclamation in a Native First Nations Community Treatment Center', *American Journal of Community Psychology*, 2011, vol. 43, no. 1-2, p. 189.

This approach promoted client awareness of all four aspects of the self, including the mental, physical, emotional and spiritual, and facilitated the pursuit of balance among these aspects through healthier lifestyle choices.²⁸

- 8.27 A number of studies have examined the Community Mobile Treatment model, which was developed in 1984 to address substance misuse in Canadian Indigenous communities. The goal of Community Mobile Treatment is to mobilise a community in order to heal the group as a whole.²⁹
- 8.28 The model requires that a community must first identify the need for intervention and accept that change is possible. This process may take between one and two years, during which time community mobilisation work is undertaken to promote a culture of sobriety and mutual support. Following this process, the community receives three to four weeks of Community Mobile Treatment and aftercare programming.³⁰
- 8.29 A review of the literature on Community Mobile Treatment reported that, for one Indigenous community in British Columbia, abstinence rates six months after treatment were 75 per cent.³¹

First Nations Addictions Advisory Panel

- 8.30 In 2011, the First Nations Addictions Advisory Panel (the Panel) released *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada*.³² The framework was developed between 2007 and 2011 as part of an evidence-based, comprehensive, community-driven review of substance use-related supports and services for Canada's Indigenous peoples.

28 J P Gone, 'The Red Road to Wellness: Cultural Reclamation in a Native First Nations Community Treatment Center', *American Journal of Community Psychology*, 2011, vol. 43, no. 1-2, p. 194.

29 A Jiwa, L Kelly and N Pierre-Hansen, 'Healing the community to heal the individual: Literature review of aboriginal community-based alcohol and substance abuse programs', *Canadian Family Physician*, 2008, vol. 54, no. 7, p. 1000.e4.

30 A Jiwa, L Kelly and N Pierre-Hansen, 'Healing the community to heal the individual: Literature review of aboriginal community-based alcohol and substance abuse programs', *Canadian Family Physician*, 2008, vol. 54, no. 7, p. 1000.e4.

31 A Jiwa, L Kelly and N Pierre-Hansen, 'Healing the community to heal the individual: Literature review of aboriginal community-based alcohol and substance abuse programs', *Canadian Family Physician*, 2008, vol. 54, no. 7, p. 1000.e4.

32 The First Nations Addictions Advisory Panel (FNAAP), *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*, 2011, Health Canada, Ottawa, Ontario, Canada.

- 8.31 As a product of the review process, the framework outlines a range of best practice, culturally-informed Indigenous substance use treatment and support services, along a continuum of care including early identification, brief intervention and aftercare, with the aim of intervening before substance abuse becomes a major problem.³³
- 8.32 One of the programs highlighted by the Panel was the Sakwatamo Lodge in Saskatchewan, which provides an Elder aftercare network to support the continuum of care for clients that complete their program, in addition to support provided by NNADAP aftercare workers. The Elder network provides guidance for clients in cultural knowledge, traditional ceremonies and in the transition to a healthier lifestyle in order to decrease the likelihood of recidivism. The Elders are trained and work with Sakwatamo staff prior to becoming part of the aftercare network.³⁴
- 8.33 The Panel also drew attention to the work of the Shamattawa First Nation in Manitoba, which hosts regular AA meetings via video conference. These meetings provide ongoing support to a number of rural communities that do not have access to local support groups.³⁵
- 8.34 The Panel noted that while there has been limited research on alcohol and substance abuse prevention in First Nations communities, community forums have indicated that there is a high level of interest in research on the role of culture in healing and on ways to integrate Indigenous and mainstream therapeutic approaches.³⁶ In response, the Panel is developing a range of culturally-based instruments to measure the effect of participation in cultural interventions on wellness in alcohol and substance treatment settings.³⁷

33 The First Nations Addictions Advisory Panel (FNAAP), *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*, 2011, Health Canada, Ottawa, Ontario, Canada, pp. 2-3.

34 The First Nations Addictions Advisory Panel (FNAAP), *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*, 2011, Health Canada, Ottawa, Ontario, Canada, p. 62.

35 The First Nations Addictions Advisory Panel (FNAAP), *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*, 2011, Health Canada, Ottawa, Ontario, Canada, p. 34.

36 The First Nations Addictions Advisory Panel (FNAAP), *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*, 2011, Health Canada, Ottawa, Ontario, Canada, p. 84.

37 M Rowan, N Poole, B Shea et al, 'Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study', *Substance Abuse Treatment, Prevention, and Policy*, 2014, vol. 9, article 34, p. 24.

United States

- 8.35 The Indigenous people of the United States commonly identify as Native American, American Indian, and Alaskan Natives. There are 566 federally-recognized American Indian and Alaskan Native tribes and villages in the United States, which have government-to-government relationships with the United States for the provision of certain benefits, services, and protections.³⁸
- 8.36 The United States Department of Health and Human Services provides federal health services to American Indians and Alaska Natives through the Indian Health Service (IHS). The IHS provides comprehensive health service delivery, including the Alcohol and Substance Abuse Program, which supports the continuum of alcohol and substance use disorders, from awareness and identification to recovery. The Alcohol and Substance Abuse Program includes alcohol and substance abuse prevention, education services, and treatment in rural and urban community settings.³⁹
- 8.37 The IHS has undergone a transition from a direct service provision role to supporting communities to plan, develop, and implement their own culturally-informed programs. Changes to legislation from 1975 allowed the US Government to enter into contracts with Indian tribal organisations to transfer the responsibility for the administration and provision of services to tribal leadership.⁴⁰ By 2010, the majority of alcohol and substance abuse programs in the IHS were community controlled.⁴¹ This transition has occurred as part of a broader movement towards self-determination and tribal self-governance in the United States.⁴²
- 8.38 In the United States, the provision of treatment and support services to Indigenous peoples experiencing problems with alcohol are, like Canada, founded on holistic, culturally-informed concepts of health and healing including the medicine wheel model. One study found that, when

38 US Department of the Interior, Indian Affairs, *What is a federally recognised Tribe?*, <<http://www.bia.gov/FAQs/index.htm>> viewed 8 September 2014.

39 US Indian Health Service (IHS), Alcohol and Substance Abuse Program (ASAP), 2014, <<http://www.ihs.gov/dbh/programs/asap/>> viewed 11 April 2014.

40 US IHS, Office of Tribal Self-Governance, *History of the Tribal Self-Governance Program*, 2014, <http://www.ihs.gov/selfgovernance/index.cfm?module=dsp_otsg_about> viewed 28 October 2014.

41 US IHS, ASAP, 2014, <<http://www.ihs.gov/dbh/programs/asap/>>, accessed 11/4/2014

42 US IHS, Office of Tribal Self-Governance, *History of the Tribal Self-Governance Program*, 2014, <http://www.ihs.gov/selfgovernance/index.cfm?module=dsp_otsg_about> viewed 28 October 2014.

incorporated into treatment, the medicine wheel can assist in identifying areas of a person's life that need support:

... in the spiritual direction, for example, the individual may gauge their spiritual life in regard to their participation in activities that feed their spirit such as art, music, drumming, singing, prayer, humor, and gratitude. In the direction of the physical, one might illustrate the extent to which they are clean & sober, engage in preventive medical care, exercise, rest, sleep, and maintain a healthy diet.⁴³

- 8.39 A similar concept of wellness utilised in Indigenous alcohol treatment in the United States is the Red Road, which symbolises the healing of the body and soul.⁴⁴ The Red Road is a holistic approach to recovery that can assist Indigenous people to rediscover their cultural traditions whilst maintaining sobriety.⁴⁵

Box 8.2 The Medicine Wheel and the 12 Steps: combining Indigenous and Western healing traditions

The Indigenous peoples of North America draw on their rich cultural traditions to conceptualise health and healing. One of these cultural traditions is the Medicine Wheel, which is used in the treatment of alcoholism and other alcohol-related problems in Indigenous communities. The Medicine Wheel teaches that all living beings are integrated into an interconnected and balanced system of cycles that, when expressed visually, intersect with the cardinal points of east, south, west and north. These cycles provide a different way of thinking about a person's life than from a Western point of view.

Many older Indigenous people in North America have achieved sobriety through the assistance of Alcoholics Anonymous (AA), and culturally-specific elements were gradually incorporated into AA meetings that had Indigenous people in attendance. Today, the philosophy of AA and its 12 step methodology have been blended with the teachings of the Medicine Wheel.

The Medicine Wheel and the 12 Steps program makes substantial changes to the wording of each step, while retaining their original meaning, and reconfigures the 12 steps as a circle to emphasise the interconnectedness of each element of

43 N Gray and P Nye, 'American Indian and Alaska Native substance abuse: co-morbidity and cultural issues', *American Indian and Alaskan Native Mental Health Research*, 2001, vol. 10, no. 2, p. 78.

44 G Thin Elk, 'Walking in Balance on the Red Road', *Journal of Emotional and Behavioral Problems*, 1993, vol. 2, no. 3, p. 54.

45 G Thin Elk, 'Walking in Balance on the Red Road', *Journal of Emotional and Behavioral Problems*, 1993, vol. 2, no. 3, p. 55.

recovery. Along with the integration of Indigenous stories into program material, these changes make the philosophy of AA more culturally accessible, and more closely aligned with traditional teachings.

Source: D Coyhis and R Simonelli, *The Native American Healing Experience, Substance Use and Misuse*, 2008, vol. 4, no. 2, pp. 1932-4.

- 8.40 Studies of the use of Indigenous culture in alcohol treatment in the United States have, like Canada, found evidence that it can have a positive effect on treatment outcomes.
- 8.41 One study investigated the influence of enculturation on traditional practices, traditional spirituality, and cultural identity to evaluate the specific mechanisms through which traditional culture affects alcohol cessation among Native American adults.⁴⁶ The study found that enculturation, or learning about culture, was a significant predictor of alcohol cessation and that participation in traditional activities and traditional spirituality had significant positive effects on alcohol cessation.⁴⁷
- 8.42 Another study examined the effectiveness of the Holistic System of Care model amongst urban Indigenous people in San Francisco over a ten year period. This model integrates western scientific methods of treatment with the Red Road concept of wellness and Indigenous cultural activities including talking circles, and seasonal and sweat lodge ceremonies.⁴⁸
- 8.43 In the Holistic System of Care model, alcohol and substance abuse, mental and physical illness, poverty, homelessness, crime, and violence are viewed as symptoms of historical trauma, family dysfunction, and spiritual imbalance.⁴⁹ The study found that the Holistic System of Care model produced positive results in terms of decreasing alcohol and substance use, and criminal activity, improving mental health, and increasing employment, education and training.⁵⁰

46 R Torres Stone, L Whitebeck, Z Chen et al, 'Traditional Practices, Traditional Spirituality, and Alcohol Cessation Among American Indians', *Journal of Studies on Alcohol*, 2006, vol. 67, no. 2, p. 236.

47 R Torres Stone, L Whitebeck, Z Chen et al, 'Traditional Practices, Traditional Spirituality, and Alcohol Cessation Among American Indians', *Journal of Studies on Alcohol*, 2006, vol. 67, no. 2, p. 242.

48 E Nebelkopf and N Wright, 'Holistic System of Care: A Ten-Year Perspective', *Journal of Psychoactive Drugs*, 2011, vol. 43, no. 4, p. 303.

49 E Nebelkopf and N Wright, 'Holistic System of Care: A Ten-Year Perspective', *Journal of Psychoactive Drugs*, 2011, vol. 43, no. 4, p. 302.

50 E Nebelkopf and N Wright, 'Holistic System of Care: A Ten-Year Perspective', *Journal of Psychoactive Drugs*, 2011, vol. 43, no. 4, p. 305.

- 8.44 Another study examined the Women's Circle Project, which offered holistic health care and psychotherapy to Indigenous women alongside a range of cultural practices and ceremonies.⁵¹ The study reported that, after six months, alcohol use amongst participants decreased by 13 per cent and drinking alcohol to intoxication was reduced by 19 per cent.⁵²
- 8.45 The Women's Circle Project provided a nonthreatening entry point for women to address some of the issues that may be compounding their alcohol and substance abuse. It focussed on mental health issues, domestic violence, positive parenting skills, and included community-oriented, participatory activities such as beading classes and art therapy.⁵³
- 8.46 Another program in San Francisco, Friendship House, operates a variety of programs for Indigenous people seeking help with alcohol and other substances. Friendship House integrates Indigenous traditions with western models of treatment, including 12-step methods, in order to 'address the many issues that trap American Indian men and women in addictive lifestyles'.⁵⁴
- 8.47 The study of the treatment provided by Friendship House found that the key elements of the program were:
- An enculturation process involving education about Indigenous values and traditions, participation in talking circles and sweat lodge ceremonies, and interaction with staff and visiting elders counselling, education and group work to address trauma, and the adaptation of AA philosophy into a Native American perspective.⁵⁵
- 8.48 The study reported that participants had a range of transformational experiences as a result of their treatment, including gaining insight into their relapse triggers, making a commitment to recovery and sobriety, reconnecting with traditional values, and healing in relation to childhood trauma.⁵⁶

51 K Sayers, 'The women's circle comes full circle', *Journal of Psychoactive Drugs*, 2003, vol. 35, no. 1, pp. 59-71.

52 K Sayers, 'The women's circle comes full circle', *Journal of Psychoactive Drugs*, 2003, vol. 35, no. 1, p. 61.

53 K Sayers, 'The women's circle comes full circle', *Journal of Psychoactive Drugs*, 2003, vol. 35, no. 1, p. 61.

54 Friendship House, *Recovery*, 2014, <<http://www.friendshiphousesf.org/what-we-do/recovery>> viewed 19 September 2014.

55 Y Edwards, 'Cultural connection and transformation: Substance abuse treatment at Friendship House', *Journal of Psychoactive Drugs*, 2003, vol. 35, no. 1, p. 57.

56 Y Edwards, 'Cultural connection and transformation: Substance abuse treatment at Friendship House', *Journal of Psychoactive Drugs*, 2003, vol. 35, no. 1, pp. 55-6.

- 8.49 Research has shown that one of the biggest issues in the treatment of alcohol problems amongst Native Americans is high rates of relapse. To minimise the likelihood of relapse, aftercare involves continued contact and service provision to clients following the conclusion of a formal treatment program. During aftercare clients are trained to anticipate and cope with high risk events and triggers so that they do not revert to pre-treatment drinking behaviours.⁵⁷
- 8.50 One study examined the effectiveness of the Telephone Aftercare Project that was facilitated by Native American Connections in Phoenix. Native American Connections is a substance abuse treatment agency providing culturally-informed treatment for Native Americans. Participants in the project had successfully completed the residential substance abuse treatment program and were provided aftercare over the telephone. The study found that after six months, fewer clients reported alcohol use and, amongst those who did drink, the number of drinking days and the proportion of days drinking to intoxication were significantly reduced.⁵⁸

New Zealand

- 8.51 In New Zealand, the principles of the Treaty of Waitangi have been increasingly interpreted by Māori as providing the right to develop and deliver their own health initiatives, including culturally-informed alcohol treatment services.⁵⁹
- 8.52 In a similar way that the Indigenous peoples of Canada and the United States use Indigenous concepts of health and wellbeing to frame alcohol treatment programs, many *Kaupapa Māori*⁶⁰ services draw on a model of holistic health called *Te Whare Tapa Wha* (holistic health/wellness). This model views health as a four-sided concept representing four, interconnected areas of life:
- *Taha Tinana* (physical health)

57 J Chong and M Herman-Stahl, 'Substance abuse treatment outcomes among American Indians in the Telephone Aftercare Project', *Journal of Psychoactive Drugs*, 2003, vol. 35, no. 1, p.72.

58 J Chong and M Herman-Stahl, 'Substance abuse treatment outcomes among American Indians in the Telephone Aftercare Project', *Journal of Psychoactive Drugs*, 2003, vol. 35, no. 1, p.75.

59 See: T Huriwai, P Robinson, T Armstrong et al, 'Whanaungatanga – a process in the treatment of Māori with alcohol and drug-use related problems', *Substance Use and Misuse*, 2001, vol. 36, no. 8, p. 1034, pp. 1044-5.

60 *Kaupapa Māori* is a complex idiom referring to Māori knowledge and philosophy. See: Rangahau, *Principles of Kaupapa Māori*, 2013, <<http://www.rangahau.co.nz/research-idea/27/>> viewed 20 August 2014.

- *Taha Wairua* (spiritual health)
 - *Taha Whānau* (family health), and
 - *Taha Hinengaro* (mental/emotional health).⁶¹
- 8.53 Research suggests that Māori are more likely to access culturally-informed treatment services for their alcohol problems than mainstream services. A study of clients attending dedicated alcohol and other drug treatment services in New Zealand found that while services were less able to retain Māori clients, there was an improved ratio between assessment and follow-up for Kaupapa Māori services that treat a primarily Māori population, compared to the overall ratio for Māori clients.⁶²
- 8.54 Another study examined the importance of culture amongst Māori in alcohol and drug treatment. The study reported a strong endorsement of cultural factors and cultural identity in their recovery, and found that a significant number of participants believed that a sense of belonging to an *Iwi* (tribe), identifying as a Māori and having pride in being Māori were important in the recovery process.⁶³
- 8.55 Other researchers have found that learning about and connecting with Māori culture can be an essential element of treatment. One study reported that, for many Māori presenting at dedicated Māori treatment services, clients reconnected with their Māori identity, and learned about cultural values and practices, which increased their ability to access and participate in their Māori communities. The study further found that the inclusion of a Māori perspective on health during the treatment process provided clients with holistic values and principles for living a healthy and balanced lifestyle.⁶⁴
- 8.56 While these studies show the potential of improved treatment outcomes through the incorporation of Māori culture into alcohol treatment, research on the effectiveness of specific Māori cultural interventions in treatment programs is very limited.

61 Drug Help New Zealand, Kaupapa Maori, 2013, < <http://www.drughelp.org.nz/drug-treatment/kaupapa-maori> > viewed 17 April 2014.

62 S Adamson, D Sellman, D Deering et al, 'Alcohol and drug treatment population profile: a comparison of 1998 and 2004 data in New Zealand', *The New Zealand Medical Journal*, 2006, vol. 119, no. 1244, p. 7.

63 T Huriwai, J D Sellman, P Sullivan et al, 'Optimal treatment for Māori with alcohol and drug-use-related problems: an investigation of cultural factors in treatment', *Substance Use and Misuse*, 2000, vol. 35, no. 3, p. 281.

64 T Huriwai, 'Re-Enculturation: culturally congruent interventions for Māori with alcohol-and-drug-use-associated problems in New Zealand', *Substance Use and Misuse*, vol. 37, no. 8–10, p. 1263.

- 8.57 One study examined the impact of participation in the Moana House therapeutic community program on the functioning of, and changes in its residents. Based in Dunedin, Moana House caters for adult male offenders who may have a history of alcohol and substance abuse and includes a strong cultural component throughout the program.⁶⁵
- 8.58 The study found that a key indicator of the success of Moana House was that the program achieved high retention rates among participants, which was considered particularly noteworthy given that participants had extensive criminal offending, and alcohol and substance abuse histories.⁶⁶
- 8.59 The study was distinctive because it utilised measures based on the *Hua Oranga* (the fruits of health) model of Māori wellbeing to determine improvements across physical, mental, spiritual and family domains. The study found that there was a strong endorsement amongst participants that the program had a positive impact on all four aspects of health as expressed by *Hua Oranga*.⁶⁷

Australia

- 8.60 The People's Alcohol Action Coalition (PAAC) states in its submission that rigorous evaluations of interventions in the Australian context for Aboriginal and Torres Strait Islander people are still relatively rare.⁶⁸ PAAC comments however that there is strong evidence from overseas on effective ways to reduce alcohol-related harm and that this should be the starting point to any domestic approaches to this issue among Aboriginal and Torres Strait Islander communities.⁶⁹
- 8.61 Professor Conigrave, Dr Lee and Mr Jack submit that there is a considerable international literature on best-practice treatments for alcohol-related harm and a small but growing domestic body of work on prevention among Aboriginal and Torres Strait Islander communities.⁷⁰

65 Moana House, Our Program, 2014, <<http://www.moanahouse.net/programme/>> viewed 26 September 2014.

66 S Adamson, D Deering, M Hinerangi et al, *An Evaluation of the Moana House Residential Therapeutic Community*, 2010, Alcohol Advisory Council of New Zealand, Wellington, p. 93.

67 S Adamson, D Deering, M Hinerangi et al, *An Evaluation of the Moana House Residential Therapeutic Community*, 2010, Alcohol Advisory Council of New Zealand, Wellington, p. x.

68 People's Alcohol Action Coalition (PAAC), *Submission 7.1*, p. 28.

69 PAAC, *Submission 7.1*, p. 28.

70 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, p. 12.

They emphasise however that the willingness to do further research in Australia on this issue is being stymied by a lack of funding:

Recent research has shown the willingness of Indigenous communities, and Indigenous community controlled organisations and academic organisations to work in partnership to perform quality research. However in the past funding for such evaluations has been inadequate, not available at the start of initiatives, or the research or evaluation has had to be done in an unrealistic time frame. Hence the literature has been slow to develop. Further funding is needed to perform systematic and quality research.⁷¹

- 8.62 The Alcohol and Drug Service at St Vincent's Hospital, Sydney also takes the view that the domestic evidence-base for best practice interventions is currently insufficient.⁷² It submits also however that 'evaluating interventions and strategies for minimising alcohol misuse and alcohol-related harm in Aboriginal and Torres Strait Islander communities is no easy task'.⁷³
- 8.63 The Royal Australasian College of Physicians (RACP) also states that further research and evaluation of initiatives to prevent and treat alcohol use disorders in Aboriginal and Torres Strait Islander people is needed and that there has been little investment in determining the effectiveness of specific interventions.⁷⁴
- 8.64 The National Aboriginal Community Controlled Health Organisation (NACCHO) cites a recent domestic review that lists effective and ineffective practices in interventions for alcohol harm in Aboriginal and Torres Strait Islander communities.⁷⁵ The effective practices highlighted in that report include:
- a range of primary health care services in one place
 - holistic approaches that take into account the full cultural, social, emotional and economic context of Aboriginal and Torres Strait Islander people
 - community based public health and population health activities

71 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, p. 12.

72 The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 12.

73 The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 12.

74 Royal Australasian College of Physicians (RACP), *Submission 28*, p. 31.

75 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 52*, p. 9; the cited review is Alford, K (2014) Economic Value of Aboriginal Community Controlled Health Services. This report is accessible at <<http://www.naccho.org.au/resources-downloads>> viewed 22 May 2015.

- collective community governed control of health services, and
- partnerships with Aboriginal and Torres Strait Islander organisations within a framework of Aboriginal and Torres Strait Islander self-determination, control and Aboriginal and Torres Strait Islander driven priorities.

The ineffective practices encompass:

- short-term funding and not continuing to fund programs that have demonstrated success
- staff operating on assumptions about the Aboriginal and Torres Strait Islander community and failing to recognise language difference and diversity within Aboriginal and Torres Strait Islander communities
- not training and employing Aboriginal and Torres Strait Islander staff to contribute towards program implementation and delivery
- governments failing to address power inequalities, expecting Aboriginal and Torres Strait Islander people to function in western bureaucratic forms and style and favouring western over Aboriginal and Torres Strait Islander knowledge, and
- racism embedded in organisations, institutions and in individual attitudes and practices.⁷⁶

- 8.65 The Royal Australian College of General Practitioners (RACGP) cautions that not all best practice approaches in other settings will be appropriate or readily applicable to the Australian Aboriginal and Torres Strait Islander context:

However the complex historical, cultural and socioeconomic context means that it is essential that individual local communities should lead in the planning, delivery and evaluation of strategies.⁷⁷

- 8.66 The Foundation for Alcohol Research and Education (FARE) cites examples of domestic and international policies and programs that have been effective against alcohol-related harm. These include a program in the Northern Territory (*Living with Alcohol Program*) that seeks to foster behavioural change, implement legislative restrictions on the sale of alcohol and provide care and intervention strategies for affected individuals and their families.⁷⁸

⁷⁶ NACCHO, *Submission 52*, p. 10.

⁷⁷ Royal Australian College of General Practitioners (RACGP), *Submission 82*, p. [6].

⁷⁸ Foundation for Alcohol Research and Education (FARE), *Submission 83*, pp. 38-39.

8.67 FARE contends that the *Living with Alcohol Program* should be more widely implemented in Australia.⁷⁹

8.68 Ms Hand cited an example of an effective collaborative research project *Beat Da Binge* which involved James Cook University and incorporated an evaluation process:

... there was a program run in Yarrabah a couple of years ago. It was funded on \$20,000. It was then done as a collaborative research project with JCU called Beat da Binge. It was incredibly well supported by the community, but, because of the fact that we had an action research practice within the program, when there was a barrier it was reviewed and the program modified in line with what community required. That is the strength of community control, and that is the strength of organisations which are built from what community wants. That particular program was focused on youth binge drinking, which continues to be a high-risk area in Yarrabah, in addition to ice.⁸⁰

8.69 Mr Gillie Freeman commented that narrative therapy has been very beneficial for the programs that his organisation has been involved with:

The narrative therapy gives the clients the opportunity to tell their story either through music, through writing or through poetry; we have also had a few doing drama through our programs. We find that helps. It helps within the area of alcohol and domestic violence because the men and the women from both centres worked together on a domestic violence program. So that let the men see the women's point of view and it made the men step back and look at how they have treated women over time with their drinking and abuse. That worked really well.⁸¹

Conclusion

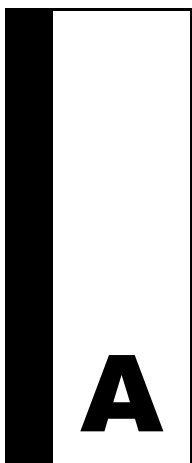
8.70 The committee notes that progress is being made by the Indigenous peoples of Canada, the United States and New Zealand to incorporate their culture and healing traditions into alcohol treatment and support programs alongside mainstream treatment approaches.

79 FARE, *Submission 83*, p. 40.

80 Ms Amanda Hand, Clinical Director, Gurriny Yealamucka Health Service, *Committee Hansard*, Cairns, 17 February 2015, p. 37.

81 Mr Gillie Freeman, Counsellor/ Assistant Manager, Galiamble Men's Recovery Centre, Ngwala Willumbong Co-operative, *Committee Hansard*, Melbourne, 30 May 2014, p. 10.

- 8.71 A common theme across the three countries is that Indigenous models of health, wellbeing and healing are holistic, and stress the importance of cultural and family connections, in addition to the psychological and physiological aspects of harmful alcohol use and alcohol-related harm.
- 8.72 The committee finds a number of Indigenous culturally-informed, community-based programs have great potential to be effective in addressing the alcohol problems of both the individual and the community.
- 8.73 Other similarities between efforts to provide treatment and support for Indigenous people with alcohol problems in Canada, the United States and New Zealand is the degree to which programs are developed and instituted by Indigenous people for their communities, and the assertion of Indigenous cultural knowledge and traditions through various programs.
- 8.74 The committee notes that these similarities exist despite each of the three countries having their own distinct historical and contemporary circumstances, as well as markedly different health care systems and arrangements regarding the governance and funding of Indigenous-run services.
- 8.75 The committee recognises that there is limited research evidence on the efficacy of culturally-informed alcohol treatment for Indigenous peoples.
- 8.76 The debate around EBP highlights a range of factors that have contributed to this evidence gap, including the reluctance of some Indigenous communities to engage with researchers, and difficulties in evaluating cultural interventions using conventional approaches such as randomised, controlled trials.
- 8.77 However, the committee is optimistic that the development and utilisation of culturally-informed measures of treatment effectiveness such as *Hua Oranga* by Māori in New Zealand, is likely to contribute to improving the evidence base on best practice in alcohol treatment amongst Aboriginal and Torres Strait Islander people.



Appendix A – List of Submissions

Submissions

No.

- | | |
|------|--|
| 2 | Kimberley Aboriginal Law and Culture Centre |
| 3 | Professor James Franklin |
| 4 | Russell Family Fetal Alcohol Disorders Association |
| 5 | Ms Adele Gibson |
| 6 | Unique Global Possibilities Medical Pty Ltd |
| 7 | People's Alcohol Action Coalition |
| 7.1 | People's Alcohol Action Coalition
Supplementary Submission |
| 8 | Drug and Alcohol Services Association |
| 9 | Anyinginyi Health Aboriginal Corporation |
| 10 | Northern Territory Children's Commissioner |
| 10.1 | Northern Territory Children's Commissioner
Supplementary Submission |
| 11 | Association of Alcohol and Other Drugs Agencies Northern Territory |
| 12 | BushMob Incorporated |
| 13 | Mr Ted Egan AO |
| 14 | The District Council of Ceduna |

- 14.1 The District Council of Ceduna
Supplementary Submission
- 15 Confidential
- 16 The Lyndon Community
- 17 Wirrpanda Foundation
- 18 Leedal Pty Ltd
- 19 Australian Institute of Health and Welfare
- 20 Queensland Aboriginal and Islander Health Council
- 21 McCusker Centre for Action on Alcohol and Youth
- 21.1 McCusker Centre for Action on Alcohol and Youth
Supplementary Submission
- 22 Professor Heather Douglas
- 23 Police Federation of Australia
- 24 Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- 25 Aboriginal Legal Rights Movement
- 26 Confidential
- 27 Northern Territory Police Association
- 28 Royal Australasian College of Physicians
- 29 Victorian Alcohol and Drug Association
- 30 City of Yarra
- 31 Australian Human Rights Commission
- 32 Confidential
- 33 Victorian Aboriginal Community Controlled Health Organisation
- 34 National Centre for Education and Training on Addiction
- 35 Australian Indigenous HealthInfoNet
- 36 Confidential

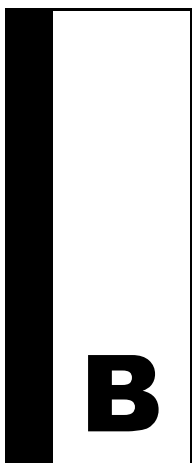
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- 37 Katherine West Health Board Aboriginal Corporation
- 38 Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine
- 39 Dr Stephanie Jarrett
- 40 Aboriginal Drug and Alcohol Council (SA) Inc.
- 40.1 Aboriginal Drug and Alcohol Council (SA) Inc.
Supplementary Submission
- 41 Synapse
- 42 Healing Foundation
- 43 Queensland Network of Alcohol and other Drug Agencies
- 44 Professor Marcia Langton, Dr Richard Chenhall and Ms Kristen Smith
- 44.1 Professor Marcia Langton, Dr Richard Chenhall and Ms Kristen Smith
Supplementary Submission
- 45 Australian Hotels Association, Northern Territory Branch
- 46 Lord Mayor Katrina Fong Lim, City of Darwin
- 47 National Drug Research Institute
- 48 Commissioner for Children and Young People, Western Australia
- 49 Victorian Health Promotion Foundation (VicHealth)
- 50 Northern Territory Legal Aid Commission
- 51 Perinatal Society of Australia and New Zealand
- 52 National Aboriginal Community Controlled Health Organisation
- 53 Australian College of Children and Young People's Nurses
- 54 National Alliance for Action on Alcohol
- 55 Reverend Basil Schild, Nightcliff Uniting Church Darwin
- 56 Central Australian Aboriginal Legal Aid Service
- 57 Intervention Rollback Action Group

- 58 National Aboriginal and Torres Strait Islander Legal Services and the Human Rights Law Centre
- 59 Australian Crime Commission
- 60 Northern Territory Government
- 61 Brewers Association of Australia and New Zealand
- 62 New South Wales Government
- 63 Alcohol and Drug Service, St Vincent's Hospital
- 63.1 Alcohol and Drug Service, St Vincent's Hospital
Supplementary Submission
- 64 The General Service Board of Alcoholics Anonymous Australia
- 65 Dr Vanda Rounsefell
- 66 Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- 67 Dr Shelley Bielefeld
- 67.1 Dr Shelley Bielefeld
Supplementary Submission
- 68 Central Land Council
- 69 Aboriginal Health Council of Western Australia
- 70 Aboriginal Health and Medical Research Council of New South Wales
- 71 Aboriginal Drug and Alcohol Network of New South Wales
- 72 Aboriginal Peak Organisations of the Northern Territory
- 73 Central Australian Aboriginal Alcohol Programmes Unit
- 74 Telethon Kids Institute
- 75 Australian Society for Medical Research
- 76 Criminal Lawyers Association of the Northern Territory
- 77 National Organisation for Fetal Alcohol Spectrum Disorders
- 78 Indigenous Health Unit, University of Wollongong

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- 79 Central Australian Youth Link-Up Service
 - 80 Penington Institute
 - 81 Shire of Halls Creek
 - 82 Royal Australian College of General Practitioners
 - 83 Foundation for Alcohol Research and Education
 - 84 Central Australian Aboriginal Congress Aboriginal Corporation
 - 85 Aboriginal Child, Family and Community Care State Secretariat, New South Wales
 - 86 Ms Prue Walker
 - 87 Western Australian Network of Alcohol and other Drug Agencies
 - 88 Faculty of Law, University of Wollongong
 - 89 Law Society Northern Territory
 - 90 Lililwan Project Team
 - 91 Public Health Association of Australia, Northern Territory Branch
 - 92 Australian Drug Foundation
 - 93 Confidential
 - 94 National Indigenous Drug and Alcohol Committee
 - 95 Tangentyere Council
 - 96 Top End Women's Legal Service
 - 97 National Congress of Australia's First Peoples
 - 98 Queensland Government
 - 99 Professor Peter d'Abbs, Menzies School of Health Research
 - 100 Tasmanian Government
 - 101 Aboriginal and Islander Community Resource Agency
 - 102 Department of the Prime Minister and Cabinet
 - 102.1 Department of the Prime Minister and Cabinet
Supplementary Submission

- 103 Magistrate Catherine Crawford
- 104 Mr Stephen Barnes
- 105 Halls Creek Hospital
- 106 Marninwarntikura Fitzroy Women's Resource Centre
- 110 Queensland Aboriginal and Torres Strait Islanders Corporation for Alcohol and Drug Dependence Services
- 111 Name Withheld
- 112 Ms Siobhan Casson
- 113 Mr Trevor Bedford
- 114 Milliya Rumurra Aboriginal Corporation
- 115 Dr Barrie Pittock
- 116 Department of Corrective Services, Western Australia
- 117 Dr Doug Shelton
- 118 Dr Mandy Wilson and Ms Jocelyn Jones
- 119 Aboriginal Medical Service, Redfern
- 120 Mr Harold Hunt OAM
- 121 Dr Tom Gavranic
- 122 Nepean Community and Neighbourhood Services
- 123 Confidential
- 124 Confidential
- 125 Coles Liquor
- 126 Associate Professor Alan Clough
- 126.1 Associate Professor Alan Clough
Supplementary Submission
- 126.2 Associate Professor Alan Clough
Supplementary Submission
- 127 Mr John Hansen

-
- 128 Confidential
 - 129 Cape York Partnership
 - 130 Ceduna Aboriginal Corporation
 - 131 Coober Pedy Hospital and Health Services
 - 132 Aboriginal Health Council of South Australia
 - 133 Australasian College of Emergency Medicine
 - 134 Ceduna District Health Services



Appendix B – Hearings and Witnesses

Monday, 31 March 2014 – Alice Springs

People's Alcohol Action Coalition

Dr John Boffa, Spokesperson

Mr Bob Durnan, Member

Ms Vicki Gillick, Policy Coordinator

Mr David Hewitt, Member

Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council

Ms Andrea Mason, Coordinator

Mrs Margaret Smith, Director

Central Australian Aboriginal Congress

Ms Donna Ah Chee, Chief Executive Officer

Central Australian Aboriginal Legal Aid Service (CAALAS)

Mr Noel Hayes, Chairperson

Dr Patricia Miller, Chief Executive Officer

Central Australian Aboriginal Programmes Unit (CAAAPU)

Mr Philip Allnutt, Chief Executive Officer

Ms Eileen Hoosan, Chairperson

Ms Christobel Swan, Director

Ms Merle Thomas, Director

Ms Sabine Wedemeyer, Alcohol Mandatory Treatment Manager

Drug and Alcohol Services Association (DASA)

Ms Kathryn Broadbent, Program Manager

Ms Margo MacGregor, Chief Executive Officer

Tangentyere Council

Mrs Shirleen Campbell, Secretary

Mr Allan Dempsey, 4 Corners Community Engagement

Ms Shaye Jordan, Human Resources Officer

Mr Michael Klerck, Policy Officer,

Ms Barbara Shaw, Women's Council

Mr Geoff Shaw, OAM, 4 Corners Council

Mr Timothy Shaw, Coordinator, 4 Corners

Mr Walter Shaw, Chief Executive Officer

Mr Baydon Williams, Inarlange Executive Delegate

Tuesday, 1 April 2014 – Tennant Creek

Barkly Region Alcohol and Drug Abuse Advisory Group Inc.

Mr Stewart Naylor, Chief Executive Officer

Mr Andrew Scholz, Operations Manager

Licensees Alcohol Accord Tennant Creek

Mr Jordan Jenkins

Anyinginyi Health Aboriginal Corporation

LT, Chairperson

Mr Trevor Sanders, General Manager

Tennant Creek Women's Refuge

Ms Georgina Bracken, Manger

Julalikari Council Aboriginal Corporation

Mrs Patricia Brahim, Chief Executive Officer

Ms Shirley Lewis, Chairperson

Tennant Creek Alcohol Reference Group

Ms Georgina Bracken, Member

Mr Stewart Naylor, Member

Wednesday, 2 April 2014 – Darwin**Association of Alcohol and Other Drug Agencies NT**

Ms Michelle Kudell, Executive Officer

NT Shelter Inc.

Ms Toni Vine Bromley, Executive Officer

Northern Territory Children's Commissioner

Dr Howard Bath

Mr Adam Harwood

Thursday, 3 April 2015 – Darwin**Council for Aboriginal Alcohol Program Services**

Ms Jillian Smith, Chief Executive Officer

Ms Elizabeth Stubbs, Clinical Supervisor

Northern Territory Council of Social Service

Ms Wendy Morton, Executive Director

Ms Nicola Coulter, Board Member

North Australian Aboriginal Justice Agency

Ms Priscilla Collins, Chief Executive Officer

Mr Jonathon Hunyor, Principal Legal Officer

Darwin Shire Council

Alderman Robin Knox, Acting Lord Mayor

Mr Mark Blackburn, Acting Chief Executive Officer

Aboriginal Medical Services Alliance Northern Territory

Mr John Paterson, Executive Officer

Dr David Cooper, Manager

Aboriginal Peak Organisations Northern Territory

Ms Priscilla Collins

Dr David Cooper

Mr John Paterson

Larrakia Nation Aboriginal Corporation

Ms Ilana Eldridge, Chief Executive Officer

Thursday, 15 May 2014 – Canberra**National Indigenous Drug and Alcohol Committee**

Professor Dennis Gray, Member

Mr Scott Wilson, Deputy Chair

Thursday, 29 May 2014 – Canberra**National Aboriginal Community Controlled Health Organisation**

Mr Roy Monaghan, Workforce Manager

Friday, 30 May 2014 – Melbourne**Australian Drug Foundation**

Mr Geoffrey Munro, National Policy Manager

Ms Julie Rae, Head of Information and Research

Ngwala Willumbong Co-operative

Mr Gillie Freeman, Counsellor/ Assistant Manager, Galiamble Men's Recovery Centre

Mr De Joel Upkett, Telkaya Co-ordinator

National Faculty for Aboriginal and Torres Strait Islander Health, Royal Australian College of General Practitioners

Dr Tim Senior, Medical Advisor

Dr Mark Wenitong, Committee Member

Prue Walker Consulting

Ms Prue Walker, Foetal Alcohol Spectrum Disorder Consultant

Victorian Alcohol and Drug Association

Mr Sam Biondo, Executive Officer

Mr Brad Pearce, Program Manager

Private capacity

Professor Marcia Langton

Mr Peter Russ

Ms Kristen Smith

Thursday, 5 June 2015 – Canberra**Northern Territory Police Association**

Mr Vince Kelly, President

Mr Colin Goodsell, Senior Vice President

Friday, 20 June 2014 – Brisbane**Department of Aboriginal and Torres Strait Islander and Multicultural Affairs**

Ms Robyn Kerr, Director

Mrs Denise Andrews, Manager

Queensland Treasury and Trade

Ms Sandra Van Roo, Principal Statistician

Menzies School of Health Research

Professor Peter D'Abbs, Substance Misuse Studies

Queensland Aboriginal and Islander Health Council

Mr Selwyn Button, Chief Executive Officer

Queensland Aboriginal and Torres Strait Islander Corporation for Alcohol and Drug Dependence Services

Mr Yigezu Ergetu, Chief Executive Officer

Synapse

Dr Janet Hammill, Research Fellow

Dr Clare Townsend, Manager, Research and Development

Dr Paul White, Specialist Physician in Psychiatry

Queensland Network of Alcohol and Other Drugs Agencies Ltd

Mrs Rebecca MacBean, Chief Executive Officer

National Aboriginal and Torres Strait Islander Legal Services

Mr Shane Duffy, Chairperson

Private capacity

Professor Heather Douglas

Thursday, 26 June 2014 – Canberra**Healing Foundation**

Mr Richard Weston, Chief Executive Officer

Monday, 30 June 2014 – Perth**Western Australia Police**

Mr Gary Dreibergs, Deputy Commissioner

Dr Karl O’Callaghan, Commissioner of Police

Detective Superintendent James Migro, Licensing Enforcement Division

National Drug Research Institute, Curtin University

Professor Dennis Gray, Professor and Deputy Director

Associate Professor Edward Wilkes

McCusker Centre for Action on Alcohol and Youth

Professor Mike Daube, Director

Ms Julia Stafford, Executive Officer

Aboriginal Alcohol and Drug Service Inc.

Mr Daniel Morrison, Chief Executive Officer

Western Australian Network of Alcohol and Other Drugs Agencies

Ms Jill Rundle, Chief Executive Officer

Ord Valley Aboriginal Health Service

Mr Graeme Cooper, Chief Executive Officer

Aboriginal Health Council of Western Australia

Mr Des Martin, Chief Executive Officer

Ms Nadia Currie, Principal Policy Officer

Telethon Kids Institute

Dr James Fitzpatrick, Paediatrician and Senior Clinical Research Fellow

Ms Heather Jones, Manager, FASD Projects

Save the Children

Mr Juan Larranaga, State Manager, Programs

Private capacity

Ms Catherine Crawford

Tuesday, 1 July 2014 – Broome**Western Australia Police**

Sergeant Shayne Knox, Liquor Enforcement Supervisor

Detective Superintendent James Migro

Superintendent Michael Sutherland

WA Country Health Service

Ms Hayley Diver, Coordinator, Kimberley Mental Health and Drug Service

Mr Bob Goodie, Regional Manager, Kimberley Mental Health and Drug Service

Milliya Rumurra Aboriginal Corporation

Mr Andrew Amor, Chief Executive Officer

Mr Christopher Bin Kali, Chairperson

Ms Helena Cox, Director

Miss Mary Martin, Director

Mr Errol Buddy Morrison, Director

Ms Kathleen Watson, Director

Ngnowar Aerwah Aboriginal Corporation

Mr Ken Riddiford, Chief Executive Officer

Wednesday, 2 July 2014 – Halls Creek**Shire of Halls Creek**

Councillor Malcolm Edwards, President

Mr Rodger Kerr-Newell, Chief Executive Officer

Western Australia Police Service

Police Inspector Raymond Briggs

Senior Sergeant Mark Harring

Children and Families Centre, Halls Creek

Ms Maria Lovison, Manager

Department of Child Protection and Family Support

Ms Fiona Fischer, District Director

Halls Creek District High School

Mr Clifton Fong, Principal

Halls Creek Healing Taskforce

Ms Rosemary Yaloot, Director

Halls Creek Hospital

Ms Robyn Cotterill, Acting Director of Nursing

Kimberley Community Drug Service

Ms Cheryl Durrans, Team Leader

Legislative Assembly of Western Australia

Ms Josephine Farrer, Member for Kimberley

Yura Yungi Medical Service

Mr Ian Benjamin, Chief Executive Officer

Ms Donna Smith, Chair

Jungarni-Jutiya Indigenous Corporation

Mr Peter Frewen, Executive Officer

Yardgee Community

Ms Rose Stretch, Chair

Private capacity

Ms Robyn Long

Mr Paddy McGinty

Mrs Dale Reichel

Thursday, 17 July 2014 – Canberra**Department of the Prime Minister and Cabinet**

Ms Caroline Edwards, Acting Deputy Secretary

Ms Bronwyn Field, Acting Assistant Secretary

Mr John Shelvin, Assistant Secretary

Thursday, 28 August 2014 – Canberra**Foundation for Alcohol Research and Education**

Ms Meredythe Crane, Senior Policy Officer

Ms Caterina Giorgi, Director, Policy and Research

Mr Michael Thorn, Chief Executive Officer

Friday, 5 September 2014 – Sydney**Westmead Children's Hospital and the University of Sydney**

Professor Elizabeth Elliott, Paediatrician

National Congress of Australia's First Peoples

Ms Kirstie Parker, Co-Chair

Mr Geoff Scott, Chief Executive Officer

Aboriginal Health and Medical Research Council of New South Wales

Miss Lucy Abbott, Manager

Ms Sandra Bailey, Chief Executive Officer

Miss Kristie Harrison, Senior ADAN Project Officer

Aboriginal Legal Service (NSW/ACT) Limited

Ms Sarah Crellin, Deputy Principal Legal Officer

School of Law, University of Wollongong

Ms Vanessa Cavanagh, Research Assistant

Professor Elena Marchetti, Professor of Law

Dr Barbara Nicholson, Honorary Senior Fellow

St Vincent's Hospital

Associate Professor Nadine Ezard, Clinical Director

Aboriginal Medical Service Redfern

Ms LaVerne Belleair, Acting Chief Executive Officer

University of Sydney

Professor Katherine Conigrave, Conjoint Professor

Mr Peter Jack, Associate Lecturer

Ashurst Australia

Ms Laura Lombardo

Private capacity

Professor John Boulton

Ms Anne Cregan

Thursday, 23 October 2014 – Canberra**Private capacity**

Dr Maggie Brady

Thursday, 30 October 2014 – Canberra**Australian Human Rights Commission**

Mr Michael Gooda, Aboriginal and Torres Strait Islander Social Justice
Commissioner

Thursday, 27 November 2014 – Canberra**Private capacity**

Professor Jon Altman
Dr Shelly Bielefeld

Thursday, 4 December 2014 – Canberra**Woolworths Limited**

Mr Andrew Thomas, Head of Government Relations and Industry
Mr Andrew Wilshire, Manager, Public Affairs

Winemakers' Federation of Australia

Mr Paul Evans, Chief Executive

Brewers Association of Australia and New Zealand Incorporated

Mrs Denita Wawn, Chief Executive Officer

Distilled Spirits Industry Council of Australia

Mr Gordon Broderick, Executive Director

Coles Liquor

Mr Thinus Kieve, General Manager Operations
Ms Cecelia Burgman, National Safety and Regulatory Manager

Tuesday, 17 February 2015 – Cairns**James Cook University**

Associate Professor Alan Clough, Principal Research Fellow

Apunipima Cape York Health Council

Dr Alan Ruben, Paediatrician

Dr Mark Wenitong, Public Health Medical Advisor

Cape York Partnership

Mr James Fa’Aoso, Head of Leadership

Ms Doreen Hart, Regional Coordinator

Mr Brian Stacey, Head of Policy

Local Government Association of Queensland

Mr Anthony Goode, Workforce Strategy Executive

Gurriny Yealamucka Health Service

Ms Amanda Hand, Clinical Director

Youth Empowered Towards Independence

Ms Melanie Spencer, Team Leader

Family Fetal Alcohol Disorders Association/My Pathway

Mrs Elizabeth Russell, Executive Officer/Facilitator

Gindija Treatment and Healing Indigenous Corporation

Mr Ian Patterson, Client Support Officer

Ms Lyndel Thomas, Coordinator

Dr Timothy White, Psychologist

Mrs Thelma Yeatman, Treatment Program Manager

Wuchopperen Health Service Limited

Mr Robert Wallace, Coordinator, Substance Misuse Program

Private capacity

Ms Susie Barstow

Dr Ernest Hunter

Mrs Jeannie Little

Wednesday, 8 April 2015 – Groote Eylandt

Anindilyakwa Land Council

Mr Jabani Lalara

Aminjarrinja Enterprises

Mr Keith Hansen, Chief Executive Officer

Private capacity

Mr Nesman Bara

Mr Keith Hansen

Mr Joaz Wurramara

Monday, 4 May 2015 – Coober Pedy

District Council of Coober Pedy

Mr Damien Clark, Acting Chief Executive Officer

Councillor Stephen Staines, Mayor

Coober Pedy Alcohol Management Plan Working Party

Mr John Bacon, Program Facilitator

Mrs Rose-Marie Berry, Chairperson

Aboriginal Family Support Services

Mrs Susie Crisa, Regional Manager

Umoona Community Council

Ms Ethel Cherrington, Chief Executive Officer

Mr George Cooley, Former Chair

Mr Ian Crombie, Board member

Ms Rose Temple, Service Manager

Umoona Tjutagku Health Service

Mr George Laslett, Drug and Alcohol Services Manager

South Australia Police

Superintendent Peter Anderson

Community Health

Ms Shaun Byrne, Drug and Alcohol Worker

Coober Pedy Hospital, Country Health SA

Mr Christopher Crismani, Acting Executive Officer and Director of Nursing

Private capacity

Ms Lynn Gordon

Ms Samantha Hayes

Ms Francine Hoani

Ms Pauline Lewis

Tuesday, 5 May 2014 – Ceduna**District Council of Ceduna**

Councillor Allan Suter, Mayor

Ceduna Aboriginal Corporation

Mr Michael Haynes, Chief Executive Officer

Mr Peter Miller, Chairperson

Mr Wayne Miller, Indigenous Community Engagement and Governance Officer

Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation

Mrs Debra Miller, Chairperson

Miss Jessie Sleep, Social Health Manager

Ceduna District Health Service

Mr Andrew Lane, Executive Officer

Ceduna Police Station

Senior Sergeant Matthew Steinbeck

Tuesday, 5 May 2014 – Adelaide**South Australia Police**

Chief Superintendent Scott Duval

Aboriginal Drug and Alcohol Council (SA) Inc.

Mr Scott Wilson, Director

Drug and Alcohol Services South Australia

Associate Professor Robert Ali, Director

Ms Marina Bowshall, Deputy State Director

Ms Simone Cormack, State Director

Aboriginal Legal Rights Movement Inc.

Mr Christopher Charles, Director of Legal Services

Aboriginal Health Council of South Australia

Dr Jessica Leonard, Public Health Medical Registrar

Dr David Scrimgeour, Public Health Medical Officer

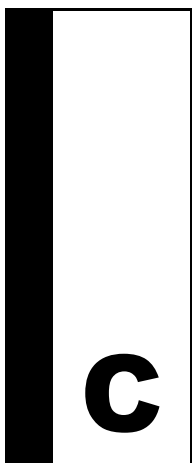
Department for Communities and Social Inclusion

Ms Jacqueline Costanzo, Manager Aboriginal Policies and Projects

Thursday, 14 May 2015 – Canberra

National Organisation for Fetal Alcohol Spectrum Disorders Australia

Mrs Vicki Russell, Chief Executive Officer



Appendix C – List of exhibits

- 1 *IPA Report into behavioural taxation*
forwarded to the committee by Senator the Hon Nigel Scullion, Minister for
Indigenous Affairs