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Health Service

Alcohol Policies and Legislation Review
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Submission to the Northern Territory Legislative Assembly Select Committee on Alcohol Policies and Legislation Review

Executive Summary

Danila Dilba Health Service welcomes the opportunity to make a submission to this important inquiry. While Danila Dilba Health Service (DDHS) acknowledges the importance of the full range of issues covered in the terms of reference for the Review, this submission will focus on our areas of expertise and will not cover the full range of "matters the review will report on". The submission will also cover some matters not listed specifically in the terms of references.

Therefore, this submission will cover:

- Harm Minimisation overall - A therapeutic framework to guide policy, regulation and legislation in relation to alcohol.
- Demand reduction – the social determinants of health that have an underlying impact on alcohol consumption and harm.
- Demand reduction – the availability of a range of rehabilitation services for and Aboriginal and Torres Strait Islander people (henceforth referred to as Aboriginal people) living with alcohol abuse.
- Harm reduction measures
- Supply issues.

While DDHS will not specifically address the technical aspects of supply reduction including density of licences, floor size, opening hours and pricing issues, we note that these issues are covered in detail in submissions by others including AMSANT, APONT and the Peoples Alcohol Action Coalition. DDHS supports the evidence based recommendations of those organisations.

Cultural, social and environmental factors are all complex contributors towards the consumption and misuse of alcohol in Aboriginal communities. The National Drug Strategy 2010-2015 states that harm minimisation strategies need to incorporate harm, supply and demand reduction. The Review Terms of Reference do not reflect

an appropriate balance across the three components and appear heavily focussed on supply issues.

DDHS Recommendations

Recommendation 1: That government place the reforms of alcohol policy, regulation and legislation within a therapeutic framework that recognises the complex nature of risky alcohol use, its causes and its consequences and ensures that policies address all aspects of the issue.

Recommendation 2: That government engage with service providers, the community and experts in designing a therapeutic framework taking the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 – 2019 as a starting point. (Intergovernmental Committee on Drugs, 2014)

Recommendation 3: The Government must immediately commence the development of strategy to improve the social determinants of health for all Territorians but with a particular focus on Aboriginal people as the most disadvantaged against most of the measures of the social determinants and should take account of the work of Osborne et al in relation to what works in addressing the social determinants (Osborne, 2013).

Recommendation 4: The Social Determinants of Health Strategy must be led by Government with a genuine commitment to implement the Strategy and it must be developed in genuine collaboration with Aboriginal people, communities and organisations along with an appropriate input from other groups who are disadvantaged across the determinants.

Recommendation 5: The government must ensure that any harm minimisation strategy and associated regulatory and policy framework includes an analysis of the range of treatment services, their appropriateness, gaps in the system and the adequacy of service availability. In this context, government must form partnerships with other key stakeholders and organisations to assess the current demand for service delivery in the community and develop cross-sector capacity to supply appropriate services based on the needs of individuals, families and communities.

Recommendation 6: It is recommended that governments increase number of rehabilitation beds available in the NT with Aboriginal community-controlled service the first preference for expansion of services for Aboriginal people.

Recommendation 7: All services providing rehabilitation, detoxification or other support must take a trauma informed approach and provide psychology and counselling for underlying issues.

Recommendation 8: The government must ensure a bigger range of treatment philosophies and approaches – non-residential, rehabilitation that accommodates families, age specific, gender specific, abstinence and other approaches.

Recommendation 9: The government must implement evidence based programs to support clients to maintain their rehabilitation outcome. For remote clients support

options should include transport options back to country or other arrangements if the client does not wish to return.

Recommendation 10: All service responses must be based on a detailed program-logic with rigorous planning and evaluations of treatment modalities to ensure that they are achieving their outcomes.

Recommendation 11: It is recommended that government takes immediate action to increase the operating hours of both community patrols and sobering up shelters.

Recommendation 12: It is recommended that government bring together organisations and community members to identify and develop services to support those engaging in risky drinking and improve safety while facilitating access to services including primary health care.

Recommendation 13: Increase the range and quantity of emergency and short term accommodation available to rough sleepers in Darwin and regional centres.

Recommendation 14: That the Review exercise great caution in considering the recommendations of the Bowchung report to reinstate access to alcohol in social clubs and in particular, ensure that any such decisions are made only with the input of all community members not just the most powerful voices, and that the capacity of communities to deal with any harms is assessed.

Recommendation 15: Increase access to women's shelters and safe houses across the Territory to address domestic violence (Brady, 2005).

About Danila Dilba

Danila Dilba Health Service was established in 1991 as an Aboriginal community-controlled organisation. Our aim is to improve the physical, mental, spiritual, cultural and social wellbeing of Biluru (and Torres Strait Islander) people in the Yilli Rreung (greater Darwin) region.

Danila Dilba is primarily funded by the Australian Government through the Department of Health. We employ some 130 people and provide services from five locations in Darwin and Palmerston, including five medical clinics, a mobile clinic. An additional three clinics will commence in 2017-18. We also have a Community Programs division that includes the Deadly Choices health promotion program, an Alcohol and Other Drugs program, Tackling Indigenous Smoking, and Social and Emotional Wellbeing.

Danila Dilba Health Service aims to provide culturally-appropriate primary health care services and all our activities are underpinned by core values of:

- providing and advocating for services that are equitable, accessible, professional, high quality and responsive to local needs.
- working with our community to ensure a culturally-appropriate environment that promotes safety, trust and respect.

- supporting a workplace culture based on honesty, integrity, fairness, transparency and accountability.

We provide services to more than 12,000 people – approx. 60% of the Aboriginal population residing in the Darwin - Palmerston region.

Danila Dilba response to the review

Alcohol consumption in the NT is amongst the world's highest and significantly contributes to a range of harms including premature death (Northern Territory Government, 2017).

Due to the nature of the work at DDHS, the submission will predominately be focussing on alcohol related harm relevant to Aboriginal Australians, however, it is noted that risky and dangerous alcohol consumption is not a problem exclusive to Aboriginal people in the Northern Territory but the population as a whole. A reduction in risky and dangerous alcohol consumption would result in a more sustainable living environment for all Territorians including Aboriginal communities, contributing to improved health, social and emotional wellbeing.

Key Indicators of Alcohol Related Harm in the Northern Territory

- Alcohol misuse was estimated to cost $36 billion annually to the Australian population as a result of loss in productivity, alcohol fuelled crime, health care and child protection costs and services (Laslett, et al., 2010).
- Aboriginal people are 1.6 times more likely to abstain from alcohol use compared to non-Aboriginal people. However, those who do drink are more likely to drink at dangerous and risky levels (Australian Government, 2017).
- The average number of drinks per day for people living in the Northern Territory is 3.2 which is almost 3 times higher than the global average. Alcohol consumption at a risky level was reported by 30.1% of adults who consumed alcohol in the NT (Northern Territory Government, 2017).
- The average amount of alcohol consumed amongst Aboriginal people was twice as high as their non-Aboriginal counterparts. Data shows that the average alcohol consumed amongst Aboriginal Australians was 1.5 bottles of wine compared to 5 glasses of wine amongst non- Aboriginal people (Australian Government, 2017).
- Increased drinking rates and hospitalisation as a result of alcohol consumption is evident in rural and remote communities.
    - Aboriginal people in rural and remote regions are 1.5 times more likely to drink at risky levels for both lifetime and single-occasion harm (National Rural Health Alliance, 2014).
    - A total of 9816 Aboriginal people were hospitalised related to alcohol during 2013-2015. This rate reflects 2% of total hospital admissions of Aboriginal Australians (Australian Government, 2017).
- The CEO of DDHS has been informed that emergency departments experience an influx of young men (Aboriginal and non-Aboriginal) with pancreatitis over weekends as a result of binge drinking.
- Crime statistics from the NT specifically show that 60% of assaults were associated with alcohol (Northern Territory Government, 2017).
- Roughly 40% of all NT road fatalities in 2015-2016 involved an illegal blood alcohol levels (Northern Territory Government, 2017).
- While there is a lack of reliable prevalence data on Foetal Alcohol Spectrum Disorder, due to the lack of a consistent diagnostic tool, feedback from health workers, educators and communities indicates a high incidence of FASD in the Territory. Internationally, studies have found prevalence rates of around 1 to 3 per 1,000 births in general populations and around 10 per 1,000 (or 1 percent) in high risk populations (Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, 2015).

1. ***Harm Minimisation overall - A therapeutic framework to guide policy, regulation and legislation in relation to alcohol.***

A true harm minimisation approach to alcohol policy and legislation must be situated within a therapeutic framework that:

- recognises both the strengths and disadvantages of the community in dealing with alcohol and its consequences;
- is based on evidence about the nature and causes of alcohol related harm;
- offers therapeutic pathways to those experiencing problematic alcohol use rather than punitive approaches that inappropriately criminalise the results of social disadvantage and trauma;
- offers a range of acceptable and effective treatments to those who wish to reduce alcohol use;
- incorporates primary health care into the process;
- improves the safety and well being of people currently involved in risky alcohol use; and
- regulates supply of alcohol in an evidence based way.

Further guidance on the elements of a therapeutic framework are offered by Gray and Wilkes who note that alcohol and drug related harm is a complex, multi-causal phenomenon and that addressing it requires a comprehensive approach, including:

- address the underlying social determinants
- prevent or minimise the uptake of harmful use
- provide safe acute care for those who are intoxicated
- provide treatment for those who are dependent
- support those whose harmful AOD use has left them disabled or cognitively impaired
- support those whose lives are affected by others' harmful AOD use (Gray, 2010).

A therapeutic framework will avoid the use of stigmatising language and the criminalisation of the simple fact of problematic alcohol use. It is concerning to note that the Terms of Reference and the discussion paper do not refer to or discuss issues related to addiction but does make frequent references to anti-social behaviour and to alcohol abuse. This language is unhelpful and stigmatises the very people who are in need of support, harm minimisation and treatment. For example, the Terms of Reference state at the outset that "However, alcohol abuse is a significant cause of violence, trauma and crime in our community." Taking a therapeutic perspective, it is arguable that problematic alcohol use is equally a result of high exposure to violence, trauma and crime.

A therapeutic framework that recognises the non-linear relationships between trauma, violence, crime and alcohol use will stand a better chance of addressing the challenges we face as a community.

Community wide approaches that seek to improve community functioning, community strength and community safety are a critical part of a therapeutic framework. There are a number of evidenced based approaches that the Review might consider. In particular, DDHS would recommend that the Review consider the RespectEd program developed by the Canadian Red Cross. More details can be found at http://www.redcross.ca/crc/documents/3-5-7-1_respected_2011_tensteps_english_c15_proof.pdf

Recommendations

Recommendation 1: That government place the reforms of alcohol policy, regulation and legislation within a therapeutic framework that recognises the complex nature of risky alcohol use, its causes and its consequences and ensures that policies address all aspects of the issue.

Recommendation 2: That government engage with service providers, the community and experts in designing a therapeutic framework taking the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 – 2019 as a starting point. (Intergovernmental Committee on Drugs, 2014)

2. Demand Reduction - The link between social determinants and alcohol

Any effort to reduce the harm to the community arising from the misuse of alcohol must give attention to the underlying reasons and causes for such misuse. As this submission is focused mainly on harms to Aboriginal people and harms associated with risky alcohol use by Aboriginal people, DDHS notes that there is an extensive body of work relevant to the role of the social determinants of health in the health disadvantage experienced by Aboriginal people. A continued focus on the downstream manifestations of these determinants will lead only to a continuing failure to fully address the harms. DDHS notes with concern that neither the terms of reference for this Review or the discussion paper mentions the social determinants of health. Addressing the upstream social determinants of health, including risky alcohol use, is a critical part of the demand reduction pillar of a harm minimisation strategy.

Alcohol can act as a mirage and escape mechanism from effects of trauma, daily stresses and disadvantages faced by Aboriginal people, this can lead to alcohol dependence, greater social upheaval and intergenerational patterns of disadvantage. If policies fail to deal with the underlying issues or the "causes of the causes", greater disadvantages are likely to be seen. The 'causes of the causes' are the foundational determinants that influence overall health (Australian Institute of Health and Welfare, 2016) . The intertwined nature of the social determinants and risky behaviours' grows or diminishes opportunities throughout a lifetime, with social and economic disadvantage linked to alcohol dependence (Australian Institute of Health and Welfare , 2017). A holistic approach to alcohol policy and regulation would recognise the causes of the most harmful uses of alcohol and would emphasise the importance of strengthening culture and creating more supportive environments (Dudgeon, 2014).

A more contextualised understanding of the link between social determinants is seen in the co-morbidity of mental health and alcohol consumption. An individual may live in a community with high levels of intergenerational trauma, resulting from colonisation, racism and marginalisation (Dudgeon, 2014). This trauma may led individuals towards unsafe drinking patterns (including dependence and addiction) resulting in social upheaval, housing complications and poverty.

Drawing on data analysed in the recent Health Performance Framework Report a typical Aboriginal Territorian family might experience:

- Overcrowded housing – 53.2% of Aboriginal households in the NT are overcrowded compared to 8.7% of non-Aboriginal households (Australian Institute of Health and Welfare, 2017).
- Low income – Aboriginal households in the NT have a median household income of $430 per week compared to $1,247 for non-Aboriginal households. The gap between Aboriginal and non-Aboriginal is significantly wider than any other state and Aboriginal households in the NT have the lowest median income compared to every other state (Australian Institute of Health and Welfare, 2017).
- Death and associated grief and loss – Aboriginal families are dealing with death in the family and the community at much higher rates than other Territorians. The all-cause mortality rate for Aboriginal Territorians (1,519 per 100,000) is almost three times the rate for non-Aboriginal Territorians (581 per 100,000) and significantly higher than for Aboriginal Australians nationally (991 per 100,000) (Australian Institute of Health and Welfare, 2017). In particular, suicide in Aboriginal communities accounts for 32% of all deaths with alcohol misuse being a significant contributing factor (Australian Government, 2017).

There is an array of social determinants that can influence the vulnerability of individuals and groups and hence impact on the extent of damaging alcohol consumption patterns. Key determinants are:

- Social norms
- Unemployment and low income
- Family and friends
- Homelessness and overcrowded housing
- Education
- Racism
- Intergenerational trauma.

The relationship between the social determinants of health and health outcomes for Aboriginal people is explored in considerable detail in publications under the Closing the Gap Clearinghouse. In particular, Osborne et al published a comprehensive paper exploring the evidence of what works in relation to the social determinants of health (Osborne, 2013)

Recommendations

Recommendation 3: The Government must immediately commence the development of strategy to improve the social determinants of health for all Territorians but with a particular focus on Aboriginal people as the most disadvantaged against most of the measures of the social determinants and should

take account of the work of Osborne et al in relation to what works in addressing the social determinants (Osborne, 2013).

Recommendation 4: The Social Determinants of Health Strategy must be led by Government with a genuine commitment to implement the Strategy and it must be developed in genuine collaboration with Aboriginal people, communities and organisations along with an appropriate input from other groups who are disadvantaged across the determinants.

3. Demand Reduction - rehabilitation and treatment services in the Northern Territory for alcohol misuse

The ready availability of a range of alcohol rehabilitation and treatment services for those individuals who recognise that their drinking is having a negative affect is an essential demand reduction measure as a component of a harm minimisation strategy. The existing service system in the NT includes services provided by government, services funded by the NT government and services funded by the Commonwealth Government. The range of services includes:

- Screening
- Brief interventions
- Detoxification and withdrawal services;
- Residential rehabilitation;
- Limited community based support;
- Limited relapse prevention.

The major concern from DDHS perspective in relation to treatment and rehabilitation is the undersupply of services and the limited range of options available particularly for Aboriginal people. Our experience as a provider of community based support service in the alcohol and other drug space is that rehabilitation services are in short supply and there are gaps in the continuum of service provision. Our workers report that it is not unusual for a client to wait 2 to 3 months to enter rehabilitation. This poses significant challenges for the client who may relapse or lose motivation to pursue treatment and imposes a large burden on health and other services attempting to support clients during the waiting period. DDHS staff work intensively with clients to support them during a waiting period but the results are mixed.

In relation to the range of available treatment and rehabilitation options in the NT, DDHS notes the analysis of Gray and Wilkes regarding what works in treatment services as part of a demand reductions strategy. The paper notes that treatment covers a broad range of interventions including screening, brief interventions, detoxification, various counselling approaches (including motivational interviewing and cognitive behavioural therapy), 12-steps programs, and the provision of social and vocational skills. Treatment services may include therapy to address underlying psychosocial trauma and can be carried out in both community and residential settings, may provide effective pharmacotherapies (Gray, 2010). The paper goes on to note that the literature shows that treatment (as per the definition above) is effective in reducing alcohol and drug related harm. And that generally residential treatment is not more effective than non-residential treatment.

Based on the evidence of what works, DDHS notes that while many aspects of an effective treatment sector exist in the NT, there are significant gaps and inadequate services to meet needs resulting in delays for clients progressing through various levels of treatment. Specific gaps and limitations in the treatment available for Aboriginal people in Darwin and Palmerston that DDHS has identified are:

- Screening and brief intervention in primary health care are carried out, although there is still room for improvement. However, the gap arises for the client who is ready to take action with a lack of immediate service responses.
    - Interim support and counselling can be provided by DDHS but the ultimate need for many clients is rehabilitation.
- Gaps and delays in the pathway into detoxification and subsequently into rehabilitation. Ideally a client who has undergone detoxification should have immediate access to rehabilitation.
- A narrow range of treatment services.
    - There is very little non-residential rehabilitation which can be difficult for clients who have work and family responsibilities.
    - Only one Aboriginal rehabilitation service can accommodate families.
    - Eligibility rules can preclude people who need rehabilitation, for example a criminal record or mental health comorbidity can exclude clients from some services.
    - Insufficient access to professional counselling and trauma informed approaches.
    - Limited range of ideological basis of service. For example, all services to our knowledge are abstinence based which may be the goal for many clients but for others, for example, binge drinkers, other approaches may be preferable.
    - Strict rules for referral, entry and completion of rehabilitation programs. For example, in most services, if a client leaves part way through a program they are not able to return and continue but must rejoin the queue and start again.
- Insufficient evidence based relapse prevention support post treatment.

Services that are more responsive, inclusive of different social circumstances and understand the complexity of issues that are associated with alcohol consumption are needed to support clients seeking rehabilitation (PricewaterhouseCoopers, 2015). Treatment services need to be culturally appropriate otherwise become punitive towards Aboriginal people as opposed to beneficial.

Rehabilitation methods need to recognise and address causal factors of alcohol consumption, including the social determinants of health (PricewaterhouseCoopers, 2015). Acknowledgement of the wide diversity among Aboriginal communities and comprehensive understanding of the services delivered in the community is essential.

The NT Government needs to ensure that rehabilitation services that are designed

with sufficient timeframes, sound program logic and adequately engage local communities, listening to their voices.

Recommendations

Recommendation 5: The government must ensure that any harm minimisation strategy and associated regulatory and policy framework includes an analysis of the range of treatment services, their appropriateness, gaps in the system and the adequacy of service availability. In this context, government must form partnerships with other key stakeholders and organisations to assess the current demand for service delivery in the community and develop cross-sector capacity to supply appropriate services based on the needs of individuals, families and communities.

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4. Harm Reduction and Supply Issues

In recent years, there has been an overall decline in alcohol consumption patterns in the NT. However, concern for the health of individuals with risky alcohol consumption patterns continues to be a problem with high levels of harm still evident (People's Alcohol Action Coalition, 2014). Alcohol associated harm can have acute and long term effects on both drinkers and non-drinkers across the community. Harms can arise from behaviours while intoxicated, the health impacts of risky drinking including impacts on children and pregnancy, and harm to the broader community. Harm reduction measures need to be implemented and work in conjunction with other legislations and policies to support individuals, families and communities.

Alcohol associated harm continues to present significant disparities in health and life expectancy between Aboriginal and non-Aboriginal Australians. A total of 22.4/1,000 Aboriginal deaths were related to alcohol use in comparison to 4.5/1,000 non-

Aboriginal deaths (Australian Institute of Health and Welfare , 2017) A critical health and social impact of risky alcohol consumption is Foetal Alcohol Spectrum Disorder. While there is not sufficient Australian-based evidence on the prevalence and social impacts of FASD, American studies demonstrated that there are high rates of individuals with FASD in the justice and child protection system (National Indigenous Drug and Alcohol Committee, 2012). Research released at the Australasian Fetal Alcohol Spectrum Disorders Conference in 2013 revealed that 40% of children on Protection Orders had experienced prenatal alcohol exposure (in some locations this exposure was up to 88%) and 86% of children on Protection Orders had been affected in various ways by parental alcohol use (Walker, 2013). It is pivotal that government harm reduction efforts address reducing FASD in the NT.

The major harm reduction activities in the NT at present are:

- Night patrols
- Sobering up shelters
- Emergency accommodation
- Restrictions on access to and use of alcohol including the soon to be reinstated Banned Drinkers Register, dry communities, limitations on alcohol strength in community social clubs, temporary beat locations
- Primary health care
- Health education, including brief interventions for pregnant women through primary health care and ante natal care providers.

While a range of measures are in place, there is continuing concern in the community in Darwin and Palmerston about alcohol related harm both to those engaging in risky drinking and the broader community. DDHS offers the following observations on harm reduction measures based on our experience as a primary health care provider to Aboriginal people:

- Night patrols and sobering up shelters are limited to night time operation but can be needed at any time of the day or night. There are limited options to seek support for individuals at risk during the day as a result of intoxication.
- Sobering up shelters and night patrols have the potential to serve as referral and engagement points to encourage clients as appropriate to engage in primary health care and in rehabilitation.
- The lack of flexible accommodation options for individuals living rough in Darwin and Palmerston means that the most vulnerable people – those who are engaged in risky drinking in public parks and other land – are without options for a safe place to sleep.
- Improvements are needed in the diagnosis and prevention of FASD.

DDHS notes that the Bowchung report has recommended the reinstatement of access to alcohol in social clubs as a harm reduction strategy (Shaw, Brady, & d'Abbs, 2015). While DDHS understands the basis for this recommendation, care should be taken in responding. In particular, it is essential that all voices in each community are heard, not just the voices of the most influential members. Government should also consider the risks of a blanket or widespread reinstatement

of alcohol to remote communities. Increasing access to alcohol in communities may have some limited impact on the challenges of problematic drinking in regional towns. However, without addressing the underlying causes of the problematic drinking, such a change carries a serious risk that under-resourced communities will be faced with an increase in harms.

On the supply reduction side, DDHS supports the evidence based recommendations of AMSANT, FARE and PAAC.

Recommendations:

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