

Submission to the Alcohol Policies and Legislation Review in the NT



July 2017

Contents

Recommendations	3
Context of this review	5
A social and cultural determinants of health perspective	5
Understanding the impact of trauma	6
Building culturally and socially resilient communities	7
Demand Reduction	9
Comprehensive primary health care	9
Addressing homelessness	10
School-based and community alcohol education	11
Youth services & programs	12
Advertising and promotions.....	12
Supply Reduction	13
Increasing the floor price of alcohol	13
Size and density of liquor outlets	14
Banned Drinkers' Register	14
Temporary Beat Locations	15
Licence conditions.....	16
Trading hours	16
Harm Reduction	17
FASD.....	17
Domestic and family violence.....	18
Social Clubs	18
AOD treatment services	20
Alcohol Mandatory Treatment.....	21
References	22

Recommendations

Recommendation 1: That reforms of alcohol policy and legislation recognise the complex nature of alcohol misuse, its causes and related harms, and ensure that policies are evidence-based and respond to the particular situation of disadvantage of Aboriginal people in the NT.

Recommendation 2: That harmful use of alcohol in the Northern Territory is addressed within a broader strategy to tackle the full range of the social determinants of health that impact on alcohol use, including poverty, racism and discrimination, access to health care, housing, education and employment.

Recommendation 3: That this review recommends that all alcohol policy and legislation adopts a therapeutic objective and framework that is informed by, and responsive to, the impact of trauma on alcohol misuse.

Recommendation 4: That the principles of community control and self-determination underpin the delivery of all services and programs related to alcohol to Aboriginal people in the Northern Territory.

Recommendation 5: That early intervention and prevention become a priority for alcohol policy and legislation in the Northern Territory. This includes through the adequate resourcing of Comprehensive Primary Health Care provided through Aboriginal community controlled health services (ACCHSs), which incorporates early childhood services, social and emotional wellbeing services that integrate mental health with alcohol and other drug services, as well as prevention and health promotion.

Recommendation 6: That the allocation of funds for health and wellbeing services to Aboriginal communities should explicitly recognise Aboriginal community controlled organisations as preferred providers.

Recommendation 7: That there is a coordinated response from departments within the Northern Territory Government that recognises the significant relationship between overcrowding, homelessness and alcohol misuse, and increases resourcing for housing and health and other outreach services to better respond to these issues.

Recommendation 8: That the recommendations of this review regarding school-based community education are supported by evidence.

Recommendation 9: That Aboriginal communities across the Northern Territory be engaged to co-design and deliver youth services and programs that can provide a meaningful and culturally responsive alternative to engagement in, or exposure to, substance misuse, with a particular focus on programs which run at night.

Recommendation 10: That the Northern Territory Government legislates to ban all forms of alcohol promotion and advertising.

Recommendation 11: That the Northern Territory Government recognises that price is the most cost effective way to reduce alcohol consumption and related harms by increasing the floor price of alcohol so that it is equivalent to the existing minimum price of takeaway full-strength beer, currently at approximately \$1.50 per standard drink.

Recommendation 12: That the current restriction on size of take away liquor outlets be maintained, and that further restrictions be considered in regards to the density of liquor outlets, including the consideration of licence buy-backs in areas with a high density of outlets.

Recommendation 13: That the Banned Drinkers' Register be reintroduced as it was previously implemented in 2011-12, with the consideration of appropriate resourcing of alcohol and other drug services for the proposed 'therapeutic pathway' as part of the scheme.

Recommendation 14: That Temporary Beat Locations be phased out after the reintroduction of the Banned Drinkers' Register, with the phase out of this measure to include consideration of issues arising during the roll-out of the BDR.

Recommendation 15: That a risk-based licencing scheme be introduced across the Northern Territory to incentivise licences to reduce the risk factors associated with the sale of alcohol on their premises.

Recommendation 16: That mechanisms be developed to increase community involvement in liquor licence regulation, with a particular focus on ensuring Aboriginal perspectives are heard.

Recommendation 17: That restrictions on trading hours, particular in regards to late-night trading, be considered in consultation with individual communities and centres.

Recommendation 18: That the recommendations of the NT Parliamentary Inquiry into Foetal Alcohol Spectrum Disorder (FASD) be implemented.

Recommendation 19: That the relationship between family violence, alcohol misuse and child protection be recognised by this review through the recommendation of a holistic suite of evidence-based measures which address key social and cultural determinants of health.

Recommendation 20: That Sobering up Shelters be further resourced to extend their hours of operation and ensure that demand is being met.

Recommendation 21: That the current Night Patrol services throughout the NT be further resourced to allow for the development of a complementary Day Patrol service.

Recommendation 22: That the review consider the findings of the recently published Bowchung Report in making any recommendations relating to licenced clubs in remote Indigenous communities.

Recommendation 23: That greater investments be made to ensure that the demand for alcohol and other drug treatment services is met, including a particular investment in residential rehabilitation facilities which accept families.

Recommendation 24: That the Alcohol Mandatory Treatment Bill be repealed and replaced with increased voluntary services that are responsive to the diverse needs of clients and their families.

Context of this review

In the Northern Territory, 38.6% of people aged 12 years and older consume alcohol at rates that place them at risk of short-term harm, and 28.8% consume alcohol at levels that place them at risk of long-term harm, including chronic disease and illness. This is significantly more than the reported national consumption rates of 25.7% and 17.6% respectively (AIHW 2014).

Alcohol is too readily available in the Territory with one licence for every 353 people aged 18 years and above¹. Too many people, including some of the most vulnerable and disadvantaged members of our society, are affected by alcohol-related harms. Alcohol was a contributing factor to more than 9,000 annual emergency department presentations in 2013 and 2014, with the number of presentations rising steadily over the last decade (Department of Health 2015). Alcohol has been associated with over 60% of all family and domestic violence cases where the alcohol status is known, and in some areas this figure is more than 80% (NT Police 2017).

Excessive consumption of alcohol in the Northern Territory is a whole of population issue, and therefore requires comprehensive and coordinated population-level interventions to reduce demand, supply and harm concurrently. It is also vital that policy reflects the reality that the Aboriginal population suffers disproportionate harms as a result of excessive consumption. Nationally, alcohol is estimated to contribute to 4% of the life expectancy gap between Indigenous and non-Indigenous Australians (Vos et al. 2007).

While most Aboriginal people in the NT experience positive wellbeing and engagement with their families, communities and culture, it is also the case that many people's lives are marked by profound disadvantage, including experience of intergenerational poverty and trauma, overcrowded housing, poor educational attainment and unemployment. It is within this context of disadvantage that the impacts of excessive alcohol consumption are most damaging, contributing to ill health and social and cultural breakdown within our communities.

Through this review, AMSANT calls for an honest recognition that this is a complex problem, and has reached its current crisis point through decades of neglecting to address the many factors that have driven its growth. Particularly, we note an ongoing failure to provide essential housing, services and infrastructure in communities, and a lack of proper education and employment opportunities. Without addressing the social determinants of health, policy makers are further entrenching the disadvantage of Aboriginal people and perpetuating the drivers of alcohol-related harm.

Reducing alcohol-related harms over time will require both short-term strategies to minimise immediate harm and long-term strategies to address the broader determinants of alcohol misuse and chronic addiction.

Recommendation 1: That reforms of alcohol policy and legislation recognise the complex nature of alcohol misuse, its causes and related harms and ensures that policies are evidence-based and respond to the particular situation of disadvantage of Aboriginal people in the NT.

¹ Based on the number of licensed premises as at 8 July 2016 and the Northern Territory population of 180,970 aged 18 and over at 30 June 2015 [Australian Bureau of Statistics (2016) 3101.0 - Australian demographic statistics, Dec 2015. Population by age and sex tables]

A social and cultural determinants of health perspective

Given recent policy interventions in the NT aimed at addressing alcohol-related harm, AMSANT feels it is necessary to emphasise that the harmful alcohol use must be understood and addressed as fundamentally a health concern, not a criminal one. Alcohol dependence is a relapsing chronic disorder which may be exacerbated by social conditions and circumstances.

The criminalisation of public drunkenness through recent policies such as alcohol mandatory treatment and alcohol protection orders indirectly discriminates against Aboriginal people in the NT, particularly those Aboriginal people living remotely who are often more likely to drink in public places when they visit service centres or towns.

Punitive policy responses that act to criminalise problem drinkers will increase contact and escalate tensions between Aboriginal people and police, and result in more Aboriginal people entering the criminal justice system. Furthermore, such responses are contrary to Recommendation 79 of the Royal Commission into Aboriginal Deaths in Custody which states that “governments should legislate to abolish the offence of public drunkenness” (Commonwealth 1991).

Instead, AMSANT calls for this review to recommend evidence-based, holistic and community-led solutions to alcohol problems in our communities. Research indicates the importance of key determinants for Indigenous peoples generally and Aboriginal peoples in Australia in particular. These include: the fundamental importance of control and empowerment; the debilitating impacts of social exclusion, racism and discrimination; and the protective role of culture, language and land (Cooper 2011).

The comorbidity of mental health and harmful substance use among Aboriginal people needs to be contextualised within the legacy of colonisation, racism and marginalisation from dominant social institutions. International and Australian research clearly demonstrates that health in general, as well as mental health and substance misuse are affected by social and structural factors such as housing, education, employment, income, and access to supportive social networks (Wilkes et al. 2010).

This evidence reflects the need to adopt a social and cultural determinants approach to understanding and addressing alcohol-related harm. Tackling the plight of our communities can only be achieved through coordinated, evidence-based action across a broad range of policy areas; but equally in ensuring that the right conditions are in place for creating strong, resilient communities.

Recommendation 2: That harmful use of alcohol in the Northern Territory is addressed within a broader strategy to tackle the full range of the social determinants of health including poverty, racism and discrimination, access to health care, housing, education and employment.

Understanding the impact of trauma

It is acknowledged that Aboriginal communities carry a high burden of intergenerational and ongoing trauma resulting from colonisation and historic and ongoing government policies, institutional racism, discrimination and the effects of entrenched disadvantage and disconnection from traditional lands, languages and cultural practices. Trauma has profound impacts on the physical and mental health and wellbeing of individuals as well as broader community wellbeing.

Alcohol and substance misuse has been associated with intergenerational and other types of trauma, including childhood trauma. Alcohol and other drugs are often used as a coping mechanism for dealing with unresolved trauma and its resulting psychological distress (Atkinson 2002). A 2012 study of alcohol and substance-addicted participants found over half were PTSD symptomatic and over 80% had experienced traumatic events (Dore et al. 2012).

Culture and spirituality have both been identified as important factors in addressing this trauma through supporting resilience, positive social and emotional wellbeing, and living a life free of addiction to alcohol and drugs (Dudgeon et al. 2014).

It is also important to understand the unique experience of social and emotional wellbeing (SEWB) for Aboriginal people. This concept encompasses domains of connection to culture, body, mind and emotions, land, family and kinship, spirituality and community (Gee et al. 2014). Understanding the implications of disruption and connection in relation to these domains is central to developing the capacity of staff, services and organisations involved in the housing, health, welfare and criminal justice systems to become trauma informed.

AMSANT supports Danila Dilba's submission to this review that "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."

The association of alcohol misuse and experiences of trauma and abuse suggests that harsh and inappropriate regimes that act to criminalise alcohol misuse may serve to exacerbate the underlying causes of substance abuse, and cause re-traumatisation. This further reinforces that such approaches will not be effective in changing the behaviours of those who misuse alcohol, nor are they cost effective in the long-term.

Recommendation 3: That this review recommends that all alcohol policy and legislation adopts a therapeutic objective and framework that is informed by and responsive to the impact of trauma on alcohol misuse.

Building culturally and socially resilient communities

Previous policy decisions reveal that systems developed for Aboriginal people, but not by Aboriginal people, have a long history of perpetuating and exacerbating disempowerment and trauma and therefore may further contribute to the very issues they have been funded to prevent or manage.

The task of improving health and social outcomes and reducing alcohol-related harm in our communities requires the development of self-esteem and strong cultural identity that can underpin educational achievement, enhance capacity to obtain and remain in employment, and assist in avoiding destructive behaviours including alcohol misuse that all too often lead to contact with the criminal justice system.

There is a growing body of evidence identifying resilience, self-determination, community control, and connection to language, culture and country as significant protective factors for Indigenous peoples in Australia and globally against emotional and mental ill-health, including suicide prevention (ATSISPEP 2016; Zubrick et al. 2014; Emerson et al. 2014; Chandler and LaLonde 1998).

The recommendations of this review must recognise the importance of individual- and community-control and empowerment and work to identify and develop the existing strengths and experience within Aboriginal communities and organisations, including ACCHSs, where many of these protective factors are already cultivated.

Social exclusion and discrimination

The direct relationship between racism, poor mental health and alcohol abuse must be acknowledged and addressed within this review. Aboriginal participants in a study examining the views and experiences of people living in the 'Long Grass'² in Darwin reported that Aboriginal people in public places were usually regarded with suspicion by mainstream society and perceived to be: irresponsible, choosing a morally corrupt lifestyle, a source of contagion, neglectful of their children, and engaging in unhealthy social behaviours including alcohol abuse (Holmes and McRae-Williams 2008).

More recent research has explored Aboriginal understandings and experiences of race and race relations through engagement with Aboriginal people living in, or regularly visiting Darwin. Respondents to this study reported feeling stereotyped, judged and patronised when engaging with non-Aboriginal people, and felt that this group displayed ignorance about Aboriginal culture as well as an active evasion and denial of the historic treatment of Aboriginal people (Habibis et al. 2016).

The sense of disempowerment and lack of control over one's life circumstances that come with such experiences of discrimination have a significant impact on ill-health, including misuse of alcohol. A study examining self-assessed mental and physical health among Aboriginal people with diabetes in Darwin found that stress, lack of control and feeling powerless were significant mediators of the relationship between racism and general mental health (Paradies and Cunningham 2012).

² 'Staying in the Long Grass' is a locally specific terminology used by Holmes and McRae-Williams 2008 in their study to describe people living rough in Darwin.

Programs and policies that act to empower community members by building on the existing strengths and capacity within Aboriginal communities and organisations are a fundamentally important part of combating the impacts of discrimination and lack of control.

Recommendation 4: That the principles of community control and self-determination underpin the delivery of all services and programs, including those related to alcohol, to Aboriginal people in the Northern Territory.

Demand Reduction

Comprehensive primary health care

The Aboriginal community controlled health sector is the largest provider of primary health care to Aboriginal people in the NT, providing over half of all the episodes of care (56%) and contacts (59%) (NTAHKPI Report 2015/16). ACCHSs bring with them strong relationships with communities, understanding of community needs, cultural competence, and a permanent presence in Aboriginal communities. This makes them well-placed to deliver primary prevention and early intervention services that are foundational in the reduction of alcohol-related harms in our communities.

The ACCHSs' model of care delivers Comprehensive Primary Health Care which includes early childhood programs, family support, mental health and alcohol and other drug (AOD) services, and prevention and health promotion programs. In order for the capacity of the sector to fully realise its potential to create more efficient and effective health outcomes additional funding is required.

Early Childhood

Evidence suggests that reducing parental alcohol misuse is likely to result in a significant improvement in the development of children. Parental alcohol misuse is frequently associated with lack of responsive care, stimulation and neglect of children during their critical early years, with profound and permanent effects on brain chemistry and development which continues into the school years (Mustard 2006).

The link between poor development in the early years and the subsequent development of addictions and other life-long problems is also well demonstrated (Moffitt et al. 2011). The evidence tells us that it is much more effective – and efficient in terms of resources – to invest in early childhood development programs which aim to offset developmental deficits already incurred and to prevent the development of this pattern of behaviours (Olds et al. 1997).

There are already a number of evidence-based programs that have been successfully applied in the NT context, including the Nurse Family Partnerships Program and Abecedarian program. When implemented in conjunction with community organisations and in a culturally responsive way, these programs can offset childhood adversity and offer an opportunity to break intergenerational cycles of disadvantage.

Social and emotional wellbeing (including mental health and alcohol and other drugs)

Social and emotional wellbeing (SEWB) programs that incorporate broad prevention and community development approaches, alongside clinical mental health and alcohol and other drug (AOD) programs should be fully resourced in regional and remote areas. In addition to being a major risk factor for alcohol misuse, SEWB issues contribute to compromised overall health, difficulties managing chronic diseases and high rates of chronic disease risk factors.

High rates of dual diagnosis - patients who have both a mental health and an AOD diagnosis - are common in mainstream service systems, although it is often under recognised (Senate Inquiry into Mental Health 2006). There is also evidence that dual diagnosis is equally, if not more common in the Aboriginal population, both nationally and in the NT. Mental health disorders due to substance misuse were the most common diagnosis in Aboriginal men attending specialist community mental health services and the second most common diagnosis in Aboriginal women (GPPHCNT 2007).

These two co-existing concerns have similar causes and usually require similar long-term treatments, namely evidence-based and culturally appropriate counselling along with rehabilitation. Consequently, a workforce that is skilled across these two areas is required to maximise effectiveness and efficiency. Funding which is currently being allocated via competitive tendering processes should be redirected to primary health care with preference for ACCHSs to provide an integrated service offering both prevention and treatment.

Prevention and health promotion

Given very high and rising rates of chronic disease in the Northern Territory, and the strong association between chronic disease and harmful alcohol use, prevention and health promotion are essential, not optional.

The evidence suggests that community-driven and based health promotion programs that involve Aboriginal people in the design and implementation are most likely to be successful (Tilton and Thomas 2011). These community driven programs should aim to support people across all age groups to retain healthy lifestyles. Support should be targeted across the community including those with and without chronic disease and across all age groups including young people.

The complex interplay of factors which contribute to chronic illness mean that lack of effective treatment of mental health and AOD problems also greatly hinders effective treatment of chronic physical disease in the high proportion of people where these conditions coexist (Brown 2012). This reinforces the need for a holistic approach to alcohol policy and legislation that recognises the causal factors that drive alcohol misuse and related harm.

Recommendation 5: That early intervention and prevention become a priority for alcohol policy and legislation in the Northern Territory. This includes through the adequate resourcing of Comprehensive Primary Health Care provided through Aboriginal community controlled health services (ACCHSs), which incorporates early childhood intervention, social and emotional

wellbeing services that integrate mental health with alcohol and other drug interventions, as well as prevention and health promotion for chronic illness.

Recommendation 6: That the allocation of funds for health and wellbeing services to Aboriginal communities should explicitly recognise Aboriginal community controlled organisations as preferred providers.

Addressing homelessness

Situations of overcrowding and unstable housing are far too common in many remote communities and these conditions contribute to stress, mental ill-health and substance misuse. Anecdotal evidence of clinicians within ACCHSs who operate in SEWB service delivery have found that provision of social and cultural supports that assist in accessing income and housing often have a major impact on AOD issues without the need for more formal treatment.

In addition, addiction and alcohol misuse are frequently seen in homeless and itinerant populations. The incentive to access alcohol has been identified as an important determinant for individuals who decide to leave their communities for main centres like Darwin, although family violence and the desire to be with family are also major factors (Holmes and McRae-Williams 2008). The reality of continuing numbers of homeless in our urban centres and those living rough or in the Long Grass requires a response by government to provide additional services to reduce avoidable harms and to provide basic facilities including health and other services.

These kinds of services include: night and day patrols and Sobering Up Shelters to provide safety to those in immediate harm from overconsumption of alcohol, short-term crisis accommodation especially for individuals and families escaping domestic violence, AOD treatment services integrated with mental health and counselling, and residential rehabilitation facilities incorporating aftercare to support clients with reintegration [refer to 'harm reduction' for more detail].

The factors discussed here suggest that ACCHSs in urban areas need to be better resourced to support homeless and itinerant people in coordination with other Aboriginal organisations providing outreach and welfare services.

Recommendation 7: That there is a coordinated response from departments within the Northern Territory Government that recognises the significant relationship between overcrowding, homelessness and alcohol misuse, and increases resourcing for housing and health and other outreach services to better respond to these issues.

School-based and community alcohol education

AMSANT notes that school-based alcohol education programs are listed as a demand reduction strategy in the issues paper for this review. While these programs can play a role in improving health literacy and understandings about the impact of alcohol misuse, we note that where these programs are undertaken it must be as part of broader community education and intervention strategies.

School-based and community health education programs, such as the Deadly Choices program, have been found to increase health knowledge, attitudes and self-efficacy of young people, however they report mostly low to modest improvements regarding changes to health behaviours (Malseed 2014).

Where school-based alcohol education is delivered, studies have shown that in order to be most effective it should be comprehensive, integrating alcohol and other drug education with education about; chronic disease, nutrition and physical activity and healthy relationships, and it must be informed by parents, community members and local health professionals (McCuaig and Nelson 2012).

Recommendation 8: That the recommendations of this review regarding school-based community education are supported by evidence.

Youth services & programs

The provision of recreation and drop in centres to young people that can provide a meaningful and culturally responsive alternative to engagement in, or exposure to, substance misuse should be included in a holistic approach to alcohol policy and legislation.

In a Social Return on Investment analysis of three youth programs in remote Central Australia the adjusted value of outcomes in relation to decrease in AOD misuse was calculated at between \$22,774 and \$51,759 over a three-year period (Nous Group 2017). Despite this strong evidence supporting the effectiveness of youth programs, there is currently no government policy or program that exists with the aim to ensure these programs are provided in every remote community. This results in patchy, inconsistent funding and unclear, competing priorities.

A report evaluating the support and delivery of youth programs by Central Australian Youth Link-up Service (CAYLUS) to young people aged 12-25 across 21 communities in Central Australia, found that 95% of respondents felt that youth programs help keep young people from drinking grog (Marel et al. 2016). This report also suggests that the best results have been achieved in programs which are offered consistently and reliably, especially at night.

Importantly, it has also been identified that the success of these activities is reliant on stable and skilled youth workers, regularity and consistency of activities and involvement of the community in the design and delivery of the program (Nous Group 2017).

Recommendation 9: That Aboriginal communities across the Northern Territory be engaged to co-design and deliver youth services and programs that can provide a meaningful and culturally responsive alternative to engagement in, or exposure to, substance misuse, with a particular focus on programs which run at night.

Advertising and promotions

The advertising and promotion of alcohol drives demand for consumption of alcohol, particularly among young people (Anderson et al 2009; Jones and Magee 2011). It is therefore important to ensure that appropriate restrictions are in place to monitor the way in which increased consumption of alcohol is promoted by the alcohol industry.

Alcohol promotions and marketing which lead people to buy more alcohol than they had originally intended to is concerning, with a report prepared for the NSW Office of Liquor, Gaming and Racing suggesting that these promotions are likely to increase consumption particularly for young people (Jones and Smith 2011). Given the context of alcohol misuse and related harm in the NT these additional incentives to purchase and consume more alcohol are not justifiable.

Point of sale (POS) marketing is also becoming more widespread (ANPHA 2014), which is likely to affect overall consumption by underage drinkers, as well as the consumption patterns of harmful drinkers, and regular drinkers (Meier et al 2008). It is important to note that these kinds of alcohol promotions and marketing strategies are most commonly undertaken by, 'big box' liquor outlets who dominate the market (Johnston et al 2016) [refer to 'Size and Density of Liquor outlets' below for more detail].

Recommendation 10: That the Northern Territory Government legislates to ban all forms of alcohol promotion and advertising.

Supply Reduction

Increasing the floor price of alcohol

The evidence is clear that increasing the price of alcohol, particularly in relation to cheap alcohol, leads to reduced consumption and alcohol-related harms, while remaining a highly cost effective interventions (Babor and Caetano 2010). Conversely, research shows that low alcohol prices result in higher levels of consumption, including heavier drinking, occasional drinking and underage drinking (FARE 2017).

A 2012 study examining the impact of alcohol control measures in Central Australia found that measures which increased the average price per litre of alcohol were the most effective in reducing consumption, and that the greatest discernible impact resulting from this reduction in consumption was a reduction in assault rates and hospital separations for alcohol-attributable conditions (Symons et al. 2012).

We would refer the panel to the submission made by the Central Australian Aboriginal Congress (CAAC) to this review for a more detailed discussion on reducing economic availability through a price mechanism. AMSANT endorses the findings and recommendations of this submission.

Recommendation 11: That the Northern Territory Government recognises that price is the most cost effective way to reduce alcohol consumption and related harms by increasing the floor price of alcohol so that it is equivalent to the existing minimum price of takeaway full-strength beer, currently at approximately \$1.50 per standard drink.

Size and density of liquor outlets

Research has consistently shown that the concentration of outlets in a particular area, referred to as outlet density, contributes to alcohol-related harm, including higher rates of intentional and unintentional injuries (Morrison et al 2015). Disadvantaged communities are particularly vulnerable to alcohol-related harm, so given that liquor outlets in disadvantaged areas often have cheaper alcohol, the harms related to cheap alcohol disproportionately affect those disadvantaged people (Morrison and Smith 2015).

Reducing and controlling the overall number and density of liquor outlets should be a priority for the NT Government and could be achieved with the buy-back of licenses from areas with a high density of outlets.

The issue of outlet density is also related to the size of the store, with research revealing that where there is high density of outlets *and* a presence of large chain outlets, able to sell alcohol at cheaper rates, there was a considerably greater contribution to injury risk (Morrison et al 2015).

Big Box liquor stores are able to maintain low prices through a high volume low profit margin business model (FARE 2017). As already stated, the relationship between low alcohol prices and higher consumption levels is well established. However, the relationship between supermarket giants and big box liquor outlets compounds these associated risks. Special offers and other promotions, including through supermarket catalogues and shopper docketts, are far more prolific and prevalent in larger stores. Furthermore, the positioning of alcohol promotions alongside everyday grocery items also gives the impression that alcohol is an everyday product, thereby normalising its consumption (Ibid).

In light of this evidence AMSANT supports the legislative restriction of take away alcohol venues to a maximum of 400m² which was introduced by the NT Government in December 2016.

Recommendation 12: That the current restriction on size of take away liquor outlets be maintained, and that further restrictions be considered in regards to the density of liquor outlets, including the consideration of licence buy-backs in areas with a high density of outlets.

Banned Drinkers' Register

AMSANT supports the NT Government's proposal to reintroduce the Banned Drinkers' Register and the use of identification (ID) scanners at takeaway outlets. The House of Representatives Standing Committee on Indigenous Affairs final report into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities noted that, "evidence shows... that the 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” (2015).

It is vitally important that supply reduction measures like the BDR are understood and implemented in conjunction with other measures like the use of point of sale interventions and the reintroduction of therapeutic specialist courts. It is important that there are multiple opportunities for diversion and treatment and that systems and services are properly resourced to manage an increased case load that may result. For example, in implementing a ‘therapeutic pathway’ as part of the BDR, as proposed in the issues paper for this review, it is imperative that there is sufficient resource allocation to support AOD rehabilitation and support services which already stretched [refer to AOD treatment services for more detail].

AMSANT would also like to note certain features of the BDR in its previous manifestation which we feel should be maintained in its reintroduction. Firstly, it is important that while it is considered an offence to sell alcohol to a person on the BDR, the person in breach should not be criminalised. Secondly, it is important that persons on the former BDR were encouraged to undertake treatment and were incentivised to do so through a reduction in the time they are banned, however this treatment was voluntary.

We also note that there was never a formal evaluation completed in relation to the impacts of the BDR, although there is a wealth of anecdotal evidence for its success. In order to ensure that the true impacts of this measure are understood we would suggest it is necessary to implement an independent evaluation of BDR after its introduction and for the results of this to be made publically available through an evaluation report.

Recommendation 13: That the Banned Drinkers’ Register be reintroduced as it was previously implemented in 2011-12, with the consideration of appropriate resourcing of alcohol and other drug services for the proposed ‘therapeutic pathway’ as part of the scheme.

Temporary Beat Locations

Temporary Beat Locations (TBLs), which were introduced in late 2012 before the elimination of the BDR, have been anecdotally supported as an effective measure in reducing alcohol consumption and related behaviour (Taffa 2015). However, this is another measure which is yet to undergo a complete evaluation and it is therefore difficult to comprehend its full impacts.

It is also important to note that concerns have been raised about the potentially discriminatory application of this measure, with Aboriginal people becoming particular targets for interrogation by the Police.

There have been some concerns raised about the intensive use of police resources to implement and maintain TBLs and AMSANT understands that there is an intention to phase out TBLs following the reintroduction of the BDR. AMSANT suggests that the phase out should take into consideration issues arising during the roll-out of the BDR.

Recommendation 14: That Temporary Beat Locations be phased out after the reintroduction of the Banned Drinkers' Register, with the phase out of this measure to include consideration of issues arising during the roll-out of the BDR.

Licence conditions

AMSANT supports the introduction of a risk-based licensing scheme which would see higher risk licensees required to pay proportionally greater amounts for their licensing fees. Such an approach was introduced in the ACT in 2010 and resulted in a decline in alcohol-related offences from 2010-2012 of 25%. This study also highlighted the importance of complementary policy reform in achieving best outcomes, listing a reduction in outlet density and a minimum price on alcohol to reduce 'preloading' as two key corresponding reforms which should be considered.

In an election platform document prepared by FARE and PAAC in 2016 it was noted that licensees in the NT pay the lowest fees in the nation for liquor licenses, with liquor licences granted in perpetuity (2016). This environment does not incentivise licensees to reduce the risk factors inherent to the selling of alcohol, nor does it allow for additional revenue that would be raised through a risk-based licensing system to be reinvested into primary prevention, demand and harm reduction measures.

As a consequence, we recommend to this review that liquor licences be granted on a 3-yearly basis, and the calculation of fees to be paid for a license should be commensurate with risk factors such as venue type, occupancy, trading hours and total volume of liquor sold (in the case of off-license premises).

In addition to the introduction of risk-based licensing, AMSANT would encourage this review to consider what mechanisms can be put in place to allow for increases community involvement in liquor licence regulation. Considering the disproportionate impact that alcohol-related harm has on the Aboriginal population of the NT it is vital that Aboriginal perspectives are engaged in the process of awarding liquor licenses.

Recommendation 15: That a risk-based licencing scheme be introduced across the Northern Territory to incentivise licences to reduce the risk factors associated with the sale of alcohol on their premises.

Recommendation 16: That mechanisms be developed to increase community involvement in liquor licence regulation, with a particular focus on ensuring Aboriginal perspectives are heard.

Trading hours

An increase in trading hours has been shown to be associated with an increase in alcohol-related harm (Babor and Caetano 2010). Within the remote context of the NT, this has been supported by a recent study examining licensed social clubs in remote Indigenous communities which listed reduced trading hours as one of the most important factors in managing excessive alcohol consumption and related harms (Shaw et al. 2015).

Importantly, this study also notes the need to understand the particular complexities of individual communities and provide scope for community members and local organisations to participate in the decision-making process around what restrictions and hours will work best in their context. There is also considerable evidence to suggest that extended late-night trading hours leads to increased consumption and related harms (Stockwell & Chikritzhs 2009). Restrictions on trading hours for a number of licensed premises in Newcastle in 2008 resulted in a “significant reduction in alcohol-related assaults” (Jones et al. 2009), and more recently these results have been replicated with the introduction of a ‘last drinks’ policy in Sydney’s Kings Cross and CBD coinciding with a 32% and 26% reduction in assaults for each respective area (Menendez et al. 2015).

Recommendation 17: That restrictions on trading hours, particular in regards to late-night trading, be considered in consultation with individual communities and centres.

Harm Reduction

FASD

As already noted in this submission, early childhood intervention is absolutely central to the prevention of intergenerational disadvantage and cycles of alcohol misuse. The excessive consumption of alcohol prior to, during and in the early years following pregnancy is resulting in an unacceptably high level of children born with Foetal Alcohol Spectrum Disorder (FASD) and is leading to a new generation of children who will not develop their potential. This is largely preventable.

In line with key studies (National Indigenous Drug and Alcohol Committee 2012), efforts to reduce the prevalence of FASD in the Northern Territory should focus on broad-based public health measures to reduce alcohol consumption amongst the whole population, including women and men of childbearing age. The fact that many women who drink at high levels before pregnancy have been found to continue to do so during pregnancy (Anderson et al. 2014), highlights the need for effective prevention strategies prior to pregnancy to reduce heavy drinking amongst the entire population.

The key approach therefore has to be on reducing heavy alcohol use for the entire population through primary prevention to reduce demand and key measures to reduce supply primarily, in conjunction with a more targeted approach that attempts to reduce alcohol consumption amongst pregnant women from about 8 weeks of pregnancy.

Although it is important to be able to diagnose FASD when it exists, population level interventions are for all disadvantaged children and this will include both diagnosed and undiagnosed children suffering from cognitive and behavioural issues.

There is also a suite of recommendations that emerged from the final report of the Select Committee on Action to Prevent FASD, released in Feb 2015, which remain to be implemented.

Recommendation 18: That the recommendations of the NT Parliamentary Inquiry into Foetal Alcohol Spectrum Disorder (FASD) be implemented.

Domestic and family violence

Across Australia it is estimated that alcohol is involved in up to 65% of family violence incidents reported to the police and up to 47% of child abuse cases each year (FARE 2015). Alcohol is also a major cause of child neglect both through increased exposure to domestic violence and lack of responsive care and stimulation from addicted parents.

Given that the NT has the highest rate of substantiated child neglect in Australia (AIHW 2017), it is vital that the recommendations of this review consider seriously the impact that alcohol policy and legislation reform could have on the lives of some of the most vulnerable children within our community, and their families.

This reality of family violence is particularly dire for the Indigenous members of our community whose women are 35 times more likely than their non-Indigenous counterparts to be hospitalised as a result of family violence, with data suggesting it is an increased likelihood of 21.4 times for Indigenous men (ANROWS).

A study of those staying in Darwin's Long Grass showed that the primary reason given for leaving home communities was family problems, mostly involving violence or other conflict (Holmes and McRae-Williams 2009). This emphasises the dialectic relationship between family violence and alcohol abuse where it may be both a driver of harmful alcohol use, and a consequence of it.

The complexity of this issues and the multifaceted nature of its causes and consequences once again point to the need for a holistic approach to alcohol policy and legislation that acknowledges the importance of addressing the social determinants of health, including improved housing, education and employment in order to close the gap on the higher prevalence of alcohol-related family violence.

Recommendation 19: That the relationship between family violence, alcohol misuse and child protection be recognised by this review through the recommendation of a holistic suite of evidence-based measures which address key social and cultural determinants of health.

Night Patrol and Sobering up Shelters

The current availability services like Night Patrol and the provision of Sobering up Shelters to people living rough and at risk of harm from alcohol misuse in main centres throughout the NT are absolutely vital.

Sobering up Shelters provide short-term, non-custodial shelter in a safe environment for intoxicated people over the age of 18, including overnight accommodation for some people. The

shelter helps relieve pressure on police and other community resources, and provides safe and secure accommodation to people from potential victimisation and violence. Importantly, these shelters also provide the opportunity for brief interventions and referrals to rehabilitation and medical services. The availability of space within the shelters is frequently surpassed by demand, and access is limited to certain hours. AMSANT recommends to this review that further resourcing be provided to extend the hours of operation of Sobering Up Shelters in the NT and ensure that all people who are in need of such a service are able to access it.

Night Patrol, as delivered by key Indigenous organisations like Larrakia Nation and Tangentyere Council, currently provides culturally safe interventions for people under the influence of alcohol by diffusing tense, potentially violent situations and taking people away from unsafe areas or behaviours. It is important to note, however, that harm from overconsumption of alcohol does not only occur at night, and the need has therefore been identified to extend these programs to include day patrols.

Recommendation 20: That Sobering up Shelters be further resourced to extend their hours of operation and ensure that demand is being met.

Recommendation 21: That the current Night Patrol services throughout the NT be further resourced to allow for the development of a complementary Day Patrol service.

Social Clubs

A recently released study reviewing the impact of licensed clubs in remote Indigenous communities has found a significant reduction in consumption of alcohol, and a reduction in alcohol-related assaults, where licensed social clubs were present (Shaw et al. 2015). A large part of this result was attributed to the restrictions introduced under the Northern Territory Emergency Response (NTER) in 2007, in particular a reduction in opening hours, the restriction to light and mid-strength beers only and abolition of take-away sales.

Interviews undertaken as part of this research revealed broad support among community members for the existence of the clubs and the restrictions placed on them, including among drinkers, non-drinkers and local service providers.

The impact of income management was also considered in this study, as a measure which was introduced at the same time under the NTER. Notably, one community was included within the study where income management was applied but restricted trading conditions were not, and in this case consumption of alcohol continued to increase after 2007. This would suggest that income management is not on its own a significant factor in reducing alcohol consumption.

This study provides us with some important lessons about how to better manage existing licenced clubs in communities, and what restrictions and standards should be in place should any new clubs be developed.

Recommendation 22: That the review consider the findings of the recently published Bowchung Report in making any recommendations relating to licenced clubs in remote Indigenous communities.

AOD treatment services

It has long been recognised that there is a shortage of appropriate alcohol treatment and rehabilitation services, particularly in regional and remote areas of the Territory. There is an urgent need for greater investment to ensure AOD and mental health integrated services are made available to all people, regardless of whether they live in an urban, regional or remote setting. It is AMSANT's position that AOD and mental health services should sit within a Comprehensive Primary Health Care framework, and that local community-controlled health services should be funded to provide these services wherever possible.

The recent expansion of the remote AOD workforce is welcome, however, in many communities there are no resident AOD workers and in others there is only a single worker. AOD treatment is frequently limited to residential rehabilitation in an urban centre. Residential rehabilitation (whether mandatory or voluntary) with no counselling/diversion support in communities has a high relapse rate and is not cost effective as a stand-alone treatment service (DoHA 2010, Taylor 2010, Gray et al. 2010).

A study conducted by the National Drug Law Enforcement Research Fund (NDLERF) in 2009, which examined the views and experiences of people living in the 'Long Grass', identified the need for respite care for individuals who have alcohol addiction as well as the need for safe places to detoxify, both in main centres and in home communities. It was also suggested that an increased availability of respite services would likely lead to an increasing number of clients who choose to enter more structured rehabilitation programs.

The high incidence of dual diagnosis and complexity of social problems that often present in individuals who seek treatment for AOD concerns emphasises the need for long-term treatment and support.

Residential Rehabilitation

A 2002 review of residential rehabilitation programs targeting Aboriginal people found that there was a lack of suitable post rehabilitation support and that this is a factor in poor outcomes (Brady 2002). Supported accommodation is needed for those exiting residential rehab so their complex issues, including those related to housing, finances and family problems can continue to be addressed and they can transition out of rehab and back into their community.

The kinds of intensive ongoing supports that are needed post rehab are best provided through the local PHC clinic, in conjunction with other local services where necessary. It is important that there are clear pathways for referral so that rehab centres can hand over to the local clinic in an individual's home community, and a concurrent need to ensure AOD teams are present in these communities and sufficiently resourced to continue support and treatment over the next 2 years.

More residential rehabilitation facilities are needed which can accommodate families. This is a particular concern in relation to Child Protection issues where parents may be disinclined to seek out or accept rehabilitation if there is a threat of their children being removed. There is a real need to provide spaces where parents can rehabilitate with their families and avoid further exacerbating existing trauma through the removal of children.

Recommendation 23: That greater investments be made to ensure that the demand for alcohol and other drug treatment services is met, including a particular investment in residential rehabilitation facilities which accept families.

Alcohol Mandatory Treatment

It is AMSANT's position that the policy of Alcohol Mandatory Treatment (AMT) is lacking in an evidence base, has been applied in a discriminatory manner to Aboriginal people, and has amounted to the de facto criminalisation of public drinking. Interventions to reduce alcohol-related harms should focus on health criteria for referrals to treatment, not criminal ones. On these grounds, we recommend that the NT Government repeal AMT Bill in favour of increased voluntary services that are responsive to the diverse needs of clients and their families.

The recently completed review of the AMT program has supported AMSANT's initial concerns about this Bill, finding that the program has been expensive, unable to provide effective interventions in the majority of cases and has not resulted in improved health and wellbeing for those individuals who were engaged in the program (PWC Indigenous Consulting and Menzies School of Health Research 2017).

We remind this review that rehabilitation programs are likely not to have long lasting positive effects if they do not address the underlying issues associated with histories of trauma and loss. The association of alcohol misuse and complex histories of trauma and abuse (Atkinson 2002) suggests that the harsh and inappropriate regime of mandatory treatment may serve to exacerbate the underlying causes of substance abuse, and cause re-traumatisation.

For these reasons, it is AMSANT's position that involuntary treatment regimes, by nature of the restrictions placed on an individual's rights and liberty, must be reserved for cases where individuals are putting themselves at very high risk and who lack the capacity to make informed decisions about their welfare.

Where individuals are at very high risk of harm and unable to manage their circumstances, there may be a limited a role for involuntary intervention if clinically effective and culturally appropriate methods of engaging the patient into treatment have been tried and failed. Any legislation that allows for this kind of involuntary systems requires strong safeguards and protections, including that it does not criminalise, either directly or indirectly, the behaviours it seeks to address.

Recommendation 24: That the Alcohol Mandatory Treatment Bill be repealed and replaced with increased voluntary services that are responsive to the diverse needs of clients and their families.

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