Central Australian Aboriginal Congress Inc.

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October 2012

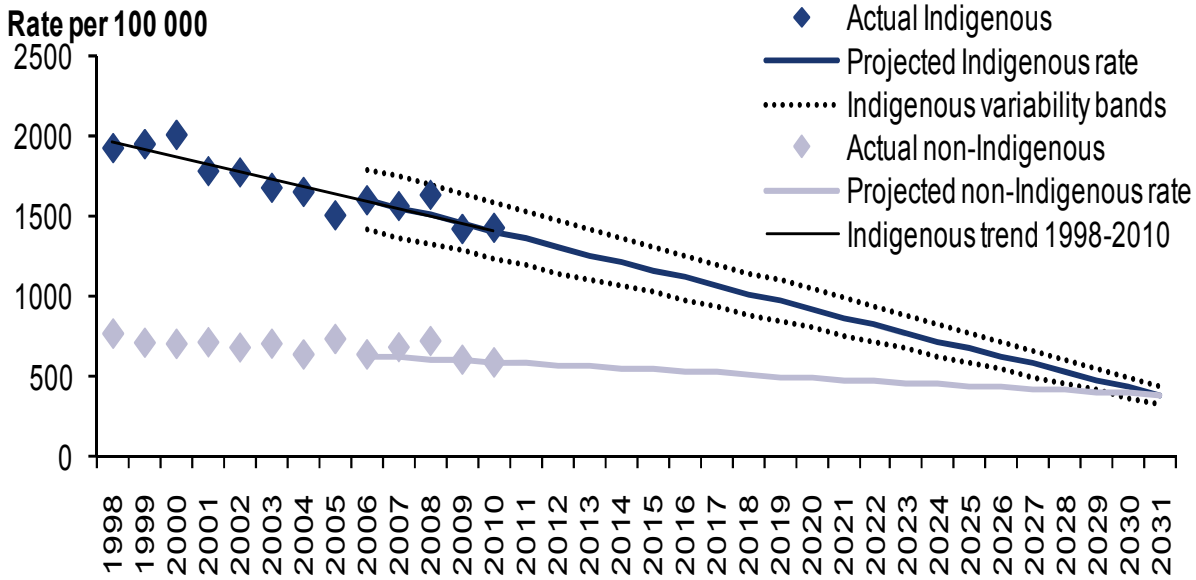
Submission to the Senate Community Affairs Reference Committee Inquiry: Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation".

Congress provides the Committee with a copy of the paper that was written in April 2011 "Rebuilding Family Life in Alice Springs and Central Australia: the social and community dimensions of change for our people"(see attached). This paper still largely reflects our current thinking on the Social Determinants of health for Aboriginal people and we commend the policy options in this paper to the committee.

However, since this paper was written there have been two key developments that warrant further description. The first is the Aboriginal health improvement that has occurred here in the NT that has been driven primarily by improved access to health care. This is strong evidence that the committee needs to ensure that access to health care is included as one of the key social determinants of health as far too often this has been excluded when it comes to any discussion about the social determinants of health.

Health Improvement in the NT

Figure 2.4 Age-standardised death rate per 100 000, actual and projected rates, by Indigenous status, Northern Territory, 1998–2031



It is vital that the story on this graph becomes widely known – the NT is the only jurisdiction on track to Close the Gap by 2031. There has been a 26% improvement in the age standardised death rate for Aboriginal people in the NT since 1998 and the improvement began in 2001. This is an average of 46 less premature deaths per year. This improvement is primarily due to the collaborative needs based planning process of the NT Aboriginal Health Forum that has overseen the improvement in the NT health system. This process has seen average per capita PHC expenditure increase from an average of $600 to more than $2500 per Aboriginal person. These resources are now equitably distributed on a population basis whereas in 2000 the worst funded area received only $330 and the best funded nearly $2000 per person. The Forum has also overseen the development of universal core primary health care services along with an NT wide system of core primary health care indicators to allow for continuous quality improvement and evaluation of the system.

In addition to the improved primary health care system the NT public hospital system began improving in 2001 with a large injection of new funds and improved management and performance monitoring systems. Hospital funding has more than trebled in this time as well. All this has meant many hundreds more doctors, nurses and other health professionals on the ground providing evidence based services and programs and this has happened in a planned and coordinated manner.

It is important for the Senate Committee to be aware of the struggle that took place to achieve this health system improvement.[1] We cannot afford to allow history to repeat itself and have senior policy makers, researchers and others argue that access to health care does not matter in terms of health improvement.

In October 1994 Congress convened a meeting in Alice Springs at the Desert Sands motel with other Aboriginal health services from across the NT and it agreed to establish a new peak body to advocate for the transfer of health funding from ATSIC to DoHA and to ensure that Aboriginal community controlled primary health care services were better funded and supported. This peak body was called the Aboriginal Medical Services Alliance NT or AMSANT.

In 1994 Congress in collaboration with the National Centre for Epidemiology and Population Health produced the manuscript "Beyond the Maze"[2] This identified a number of major barriers to Aboriginal health improvement including:

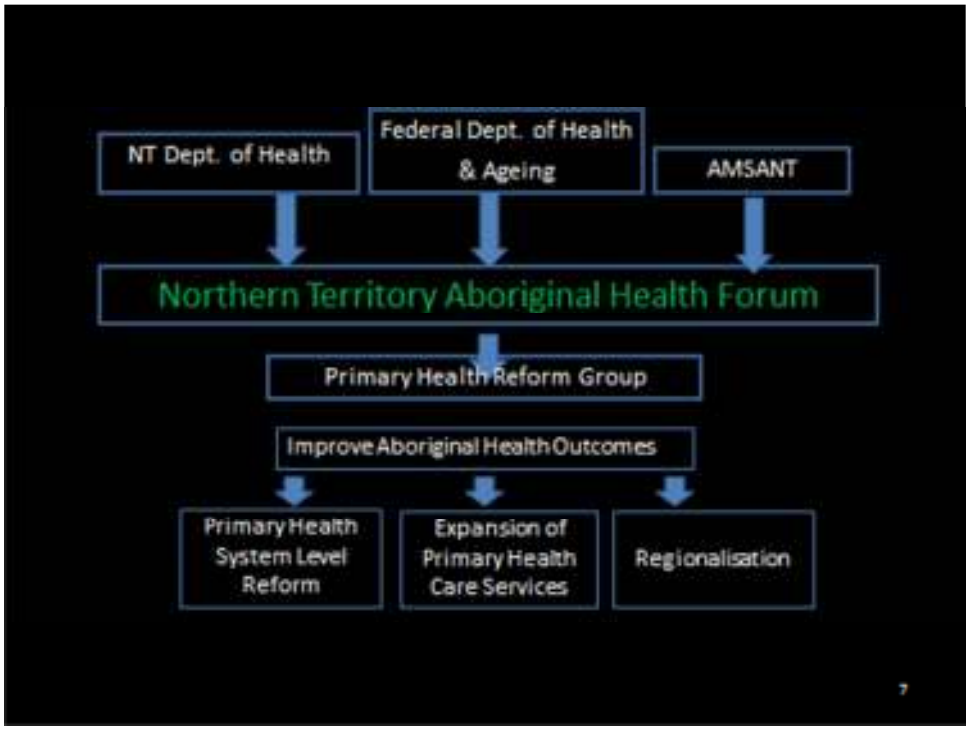
- Aboriginal community controlled health services were ignored in the ATSIC era on Aboriginal health policy. ATSIC, without health specific expertise, took over this role and had a very strong view that access to health care did not matter and other social determinants needed to be addressed only. This view was strongly led by the FAS of ATSIC at the time who later went on to become the head of Prime Minister and Cabinet in the Howard government.

[1] Bartlett, B & Boffa, J. 2005 The impact of Aboriginal community controlled health service advocacy on Aboriginal health policy*, Australian Journal of Primary Health — Vol. 11, No. 2.*

[2] Bartlett, B. and Legge, D. 1994, *Beyond the Maze: Proposals for more Effective Administration of Aboriginal Health Programs*, NCEPH Working Paper, no. 34, Central Australian Aboriginal Congress, Alice Springs and the National Centre for Epidemiology and Population Health, The Australian National University, Canberra.

- The NAHS funding from the Commonwealth did not combine with what the states and Territories were doing and ATSIC was doing something separate again – there was no common approach or coordination.
- There was also grossly inadequate expenditure on Indigenous health. ATSIC had only $52 million dollars for health services whereas in 1994/95 the Commonwealth DoH spent $18 billion and States and Territories spent $11 billion (1994/5). Aboriginal people were marginalised in a funding system that was called "welfare colonialism"
- Finally, there was a lack of comprehensive data on expenditure sources, patterns and service utilisation rates for Indigenous Australians.

Congress, AMSANT, the CLC, CYLC, the AMA and others campaigned for these reforms all of which were implemented although the pooled funding arrangements for primary health care only really happened in the NT. OATSIH health funding is now well over $1 billion recurrent and access to the MBS and PBS has been achieved. Planning Forums throughout Australia have been established although not all of them are working well and peak bodies such as AMSANT and NACCHO have been funded.



This is what the NT Aboriginal Health planning system looks like. There have been 3 iterations of the core functions of primary health care. The first in 2001 was used to drive the initial investment under the Primary Health Care Access Program[3] leading to a $30 million new investment over 5 years from 2001 to 2006 taking the system from $600 per capita to $1800 per capita. Version 2 of the core functions in 2007 was based on a large, successful remote Aboriginal community controlled PHC service at $2700 per person. This was used to lobby for the new investment as part of the Expanded Health Services Delivery

[3] Rosewarne, C & Boffa, J 2004 An analysis of the Primary Health Care Access Program in the Northern Territory: a major Aboriginal health policy reform *Australian Journal of Primary Health* — Vol. 10, No. 3.

Initiative (EHSDI) leading to a $50 million new investment in return for identified core services and corresponding core indicators. This took the system up to the current average of $2500 per capita. In 2011 Version 3 was developed with new focus areas to drive the next level of investment and integration mainly in early childhood, family support and alcohol and other drug services

There has been a lot of new funding coming into the NT in these areas in recent years from COAG, FaHCSIA, DoHA and other sources but it is not been allocated into these core services and programs in a planned manner. The investment is now largely being wasted

Why is it being wasted? Because competitive tendering of new funds on non-evidence based services and programs will not lead to further improvements. There needs to be further needs based investment in comprehensive primary health care especially in the 4 key focus areas. This will take the primary health care system to the next level and help to continue the current health improvement trend from a service and program perspective. The key new services and programs that will make a difference are those that have been shown to work against the social gradient and make a difference in spite of the

Haggerty et al[4] have demonstrated that the more employers there are for a multidisciplinary team the more likely it is that they will be working with different philosophies and different goals leading to poorer health care than a single provider. Creating multiple providers is not in the interests of Aboriginal health in the NT. Until the more recent COAG reforms this is not what was being done in the NT. Now that new resources that are coming into the NT are not being allocated according to need and against agreed evidence based services and programs this improvement is unlikely to continue. This is partly why the Productivity Commission has found a few weeks ago that for the rest of Australia there has been a $25 billion investment in Aboriginal people and little or no outcomes in return. What the Productivity Commission report failed to acknowledge that although the NT has had by far the highest per capita investment it has also had a big return in that investment up to the end of 2010. It may also be the case that there is more health gain to be made in the NT from health system improvements that in other jurisdictions where the baseline health system may have been better.

The key thing for the Senate committee to be aware of is that access to a quality health system is a key social determinant of health and it matters.

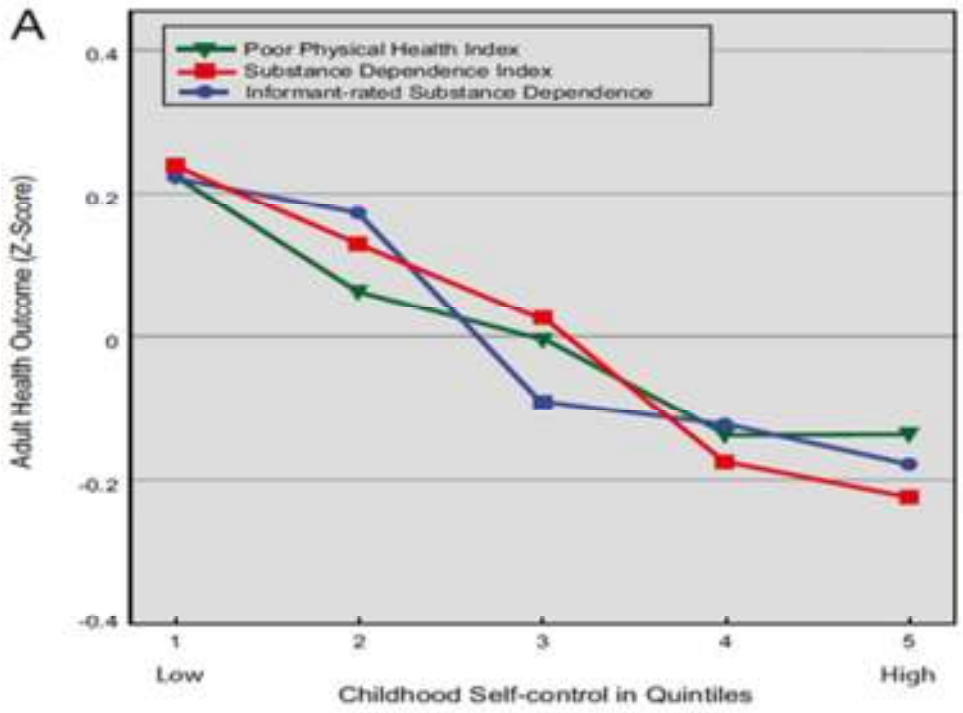
Early Childhood

In addition to the information on early childhood contained in the Rebuilding family Life paper there have been a few recent developments that it is important for the committee to be aware of. The first is the publication of a major longitudinal study in 2011[5] . This study

[4] Haggerty, J.L., et al., *Continuity of care: a multidisciplinary review.* British Medical Journal, 2003. 327(7425): p. 1219-21.

[5] www.pnas.org/cgi/doi/10.1073/pnas.1010076108 Moffitt, T. Arseneault, L. et al 2011 "A gradient of childhood self-control predicts health, wealth and public safety"

followed a cohort of 1000 children from birth to age 32 from Dunedin in New Zealand. The study achieved a 96% retention rate. The key finding is the relationship between the level of self-control in early childhood and the subsequent development of addictions and poor physical health as well as income, crime and other key determinants of well being in later life. This is the key graph from the study:



All children throughout Australia are now assessed in the first year of school at age 5 in these 5 key developmental domains and the following table reports on these findings for the Central Australian region:

Australian Early Development Index

Table 3.4 Summary AEDI Community results: Alice Springs Region, 2009

Region	Alice Springs	Hanson	Petermann-Simpson[1]	Sandover-Plenty[1]	Tanami[2]
No. of children	393	29	21	54	66
% of NT children	12.2	0.9	0.7	1.5	2.0
AEDI developmental vulnerability (DV)[3,4]					
% DV on Physical domain	12.6	40.9	30.0	43.2	75.5
% DV on Social domain	11.5	45.5	25.0	34.9	64.2
% DV on Emotional domain	13.5	36.4	16.7	38.1	45.3
% DV on Language/ Cognitive domain	15.7	63.6	30.0	72.7	71.7
% DV on Communication domain	11.0	59.1	35.0	50.0	83.3
% DV on 1 or more domain	29.2	81.8	50	79.5	94.4
% DV on 2 or more domains	16.0	72.7	40	56.8	79.6

This table tells us the extent of the challenge that is still in front of us in our region. The Australian Early Development Index has revealed the extent of the disadvantage that Aboriginal children have in the language and cognitive and other domains when they first enter school. The next generation of young people who are likely to be impulsive, have poor brain development leading to poor school performance, develop alcohol and other drug addictions, chronic diseases and be on the streets and incarcerated are already there. We must do better at preventing this from occurring and early childhood is key. The programs outlined in our Rebuilding Family Life paper are critical to addressing the social determinants of early childhood in addition to broader societal level change.

Education

The link between educational attainment and life long health and well being is growing in that having year 12 or greater is becoming more and more critical to achieving secure employment and living a long and healthy life in all countries across the world.

In this regard Michael Marmots 2010 study "Fair Society Healthy Lives"[6] reported that if everyone in Great Britain had a university degree then premature deaths would be reduced by nearly 50%. More recently, a report from Catholic Health and the National Centre for Economic Modelling at the University of Canberra "the Cost of Inaction on the Social Determinants of Health"(2012)[7] has revealed that tackling the social determinants of poor health could help 500,000 Australians avoid chronic illness and save $2.3bn a year in hospital costs. The study concludes that "helping the lowest 20 per cent of income earners finish school, gain secure employment and better take part in society could slash the chronic illness caused by lifestyle".

This is the first study of its kind in Australia that has quantified the impact that getting children to complete year 12 and gain secure employment would have on the prevention of the unhealthy lifestyles that have fuelled the chronic disease epidemic. Given that 80% of the Aboriginal Life Expectancy Gap is due to chronic disease better educational attainment has to be one of the main public health strategies going forward to Close the Gap. It is education itself which empowers individuals to be able to understand and shape the world in which they find themselves and so control their own lives and destiny. As society becomes more and more complex the impact that educational attainment has on secure employment, social participation and Life Expectancy and quality is increasing.

In this regard it is a concern that it appears that there is significant underfunding of remote Aboriginal schools in the NT. Wadeye community leaders lodged a racial discrimination action in the Human Rights and Equal Opportunity Commission (HREOC) in 2007, complaining that an agreement that set out funding arrangements for OLSH and several

[6] **Fair Society, Healthy Lives** The Marmot Review **www.ucl.ac.uk/marmotreview** Published by The Marmot Review February 2010© The Marmot Review ISBN 978–0–9564870–0–1

[7] THE COST OF INACTION ON THE SOCIAL DETERMINANTS OF HEALTH REPORT NO. 2/2012 CHA-NATSEM Second Report on Health Inequalities prepared by Laurie Brown, Linc Thurecht and Binod Nepal Catholic Health Australia National Centre for Social and Economic Modelling University of Canberra ACT 2601 Australia http://www.natsem.canberra.edu.au/storage/CHA-NATSEM%20Cost%20of%20Inaction.pdf

other ex-mission schools in the Territory guaranteed the schools were funded in "a different, and less favourable way" than mainstream schools. The claim followed initial findings from a landmark report by academic John Taylor from the Centre for Aboriginal Economic Policy and Research, which found that for every dollar spent on the average child attending school in the Territory, only 26c was spent on a child in Wadeye. The report was later amended based on extra data provided by the Territory, making the figure 47c. This occurred because the Wadeye school was funded assuming a much lower participation rate for students than mainstream schools. This was found by the HREOC to be racially discriminatory and as a result an additional $8 million has been given to fund the education system in Wadeye.

It is Congress' understanding that remote Aboriginal schools across the NT are funded at an Aboriginal participation rate similar to that which applied to the Port Keats schools and that this NT wide policy is exactly the same as the one that has been now found to be racially discriminatory and a breach of the Human Rights of Aboriginal people. It is therefore expected that there will be a flow on effect of the Port Keats decision providing a much needed increase in funding for Aboriginal education in the NT. Perhaps of the order of an additional $35 million across the NT.

It is very difficult to know what the real situation is in education funding for Aboriginal people in the NT as there have been no similar studies done such as the health planning studies and there is no structure like the NT Aboriginal Health Planning forum which might makes level of education funding more transparent. We are therefore forced to rely on sources that may be inaccurate but require a response in the light if the HREOC finding at Port Keats.

In a press release from Senator Nigel Scullion on Friday Sept 9 2011 (http://www.nigelscullion.com/media-hub/nt/nt-labor-attempt-deceive-territorians-over-education-policy-outcomes) he states that the NT Dept of Education and Training 2011-12 budget sets the following school attendance rates as the Key Deliverables for Aboriginal students across the NT:

Primary school – 34%
Middle school - 21%
Senior School – 31%

He claims that in the 2010 year the budgeted attendance rates for primary school, the most important years to engage students, was 33%. The actual achieved attendance rate was 32.1%. On this data the institutional racism that existed at Port Keats is generic across the system and must now be addressed.

Congress appreciates that the most of what makes a difference in educational attainment is what happens in the home and outside the education system however the education system itself accounts for about a third of educational attainment and its role can be enhanced with appropriate policies[8]

[8] Hattie, J. 2003 Teachers make a difference What is the Research Evidence? University of Auckland, Australian Council of Education, accessed at http://www.acer.edu.au/documents/Hattie_TeachersMakeADifference.pdf

In the article, “It’s never too early to start teaching our kids” (Weekend Australian August 13/14, 2011) comes a source of hope that it is possible to turn around some of the disadvantage that students enter primary school with as evidenced by the NT AEDI scores. This is consistent with the approach in Canadian Indigenous communities where they strive to ensure that all children are equal by the third year of primary school. This will require a much more resource intensive approach than has been applied up to now but if primary school were funded on a population basis rather than a very low projected participation rates the funds needed to make a difference would be there. But what could be done with the additional funds? Again the article points in a positive direction:

> At St Albans in Melbourne's north western suburbs, Dianne Blake, the principal of the Sacred Heart Primary School, oversees a school that acts as a community hub for its parents. The school co-ordinates a range of services: from an on-site psychologist to hospital care, from speech pathologists and occupational therapists to advice on renting a house.
> About 30 per cent of its students were assessed on the AEDI as being vulnerable in one developmental area and 40 per cent were at risk in two areas. About one-third of the school's students were born overseas and 90 per cent of parents are migrants or refugees, with one-third of students coming from Africa. More than four in five students speak English as a second language.
> But, by Year 3, students have caught up. In the national literacy and numeracy tests, the Sacred Heart students are above the national average in literacy and at the average in numeracy. By Year 5, they are further ahead.
> Blake attributes the school's success to its relationships with students and their families, learning about the students and the school's teaching practices.
> "The first time children put school bags on their backs to come to school, they come with different experiences and tools in their backpack. It's really important we understand what's in the child's school bag and their different experiences," she says.
> "Usually we've had parents who are literate in their own language but some of these families never had the opportunity to go to school themselves. That's new in Australia. We have to be conscious of what we expect of parents and that we work closely with parents to help them understand what we're trying to achieve."

The experience of this school should be translatable to Aboriginal communities where English is also often not a first language and parents need the same types of multidisciplinary, hub supports. This, however, will be resource intensive but the consequences of not investing will be severe.

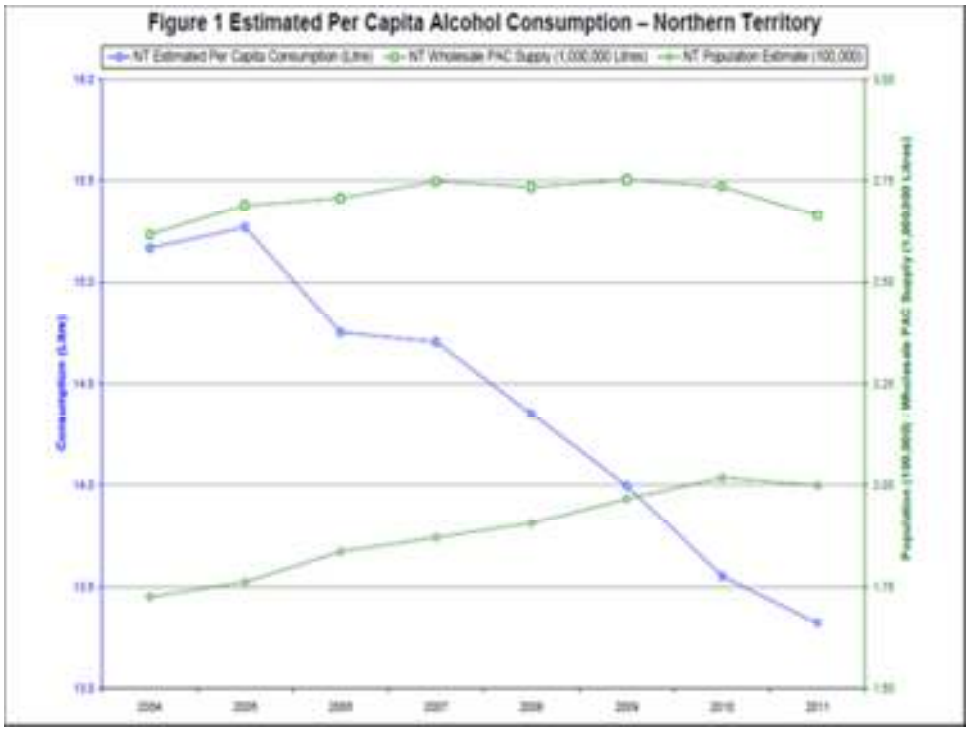
In Summary Congress believes in terms of education:

1. Improved Educational attainment is the key to Closing the Life Expectancy Gap for Aboriginal children in the NT
2. A greater investment in education, especially at the early primary level will make a difference
3. The policy of funding Aboriginal students on the basis of a very low participation rate compared with mainstream schools is racially discriminatory

4. The Port Keats decision creates a legal imperative for the chronic levels of underfunding to be addressed

Alcohol

Alcohol misuse is a key social determinant of health and further to the information in the Rebuilding Family Life paper recent data has demonstrated the success of one of the key recommendations – the need to increase the minimum price of alcohol.



The data published only a few months ago by the NT Department of Justice, reveals the success of price based supply reduction measures in Alice and then other parts of the NT. Beer, spirits and cider sales all increased in this period and the decline that is evident in per capita consumption is due to the decline in the sale of really cheap wine – 4 and 5 litre casks are now a thing of the past throughout the NT and this is helping to move us towards the national consumption average of just under 10 litres of pure alcohol per person per year.

A very recent study conducted by the National Drug Research Institute[9] examined what happened in Alice Springs over the ten years from 2000 to 2010 in relation to alcohol price, consumption and harms.

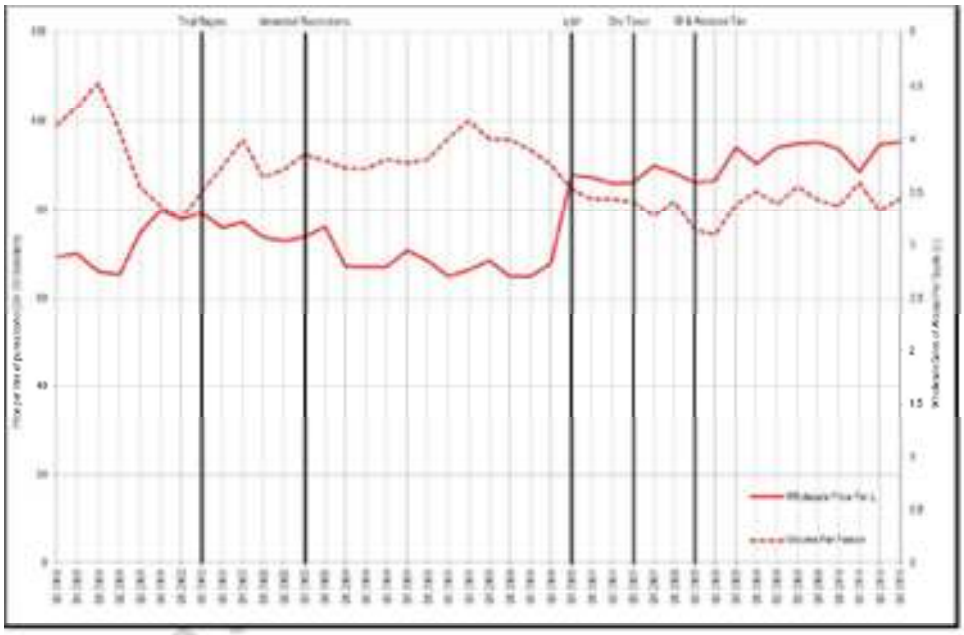


Figure 12: Average wholesale price (Q4 2010 dollars) per litre of pure alcohol and estimated per capita consumption of alcohol (persons aged ≥15 years), Central Australia, by quarter, July 2000 – December 2010

The graph shows a very strong correlation between price and consumption in Alice Springs. It confirms that when the restrictions were introduced on October 1 2006 (LSP) there was an effective increase in the minimum price of alcohol, and consumption declined by the 19% amount outlined in the Menzies evaluation. However, price again started to decrease as cheap bottled wine came on to the market in 2009 and as more people learned to wait for the cheap 2 litre casks after 6pm. The bottom line is that when price is low – the solid dark red line – consumption is high and then when the price is increased consumption declines. It is also clear that this effect is not due to Internet alcohol sales. The heaviest drinkers who were drinking the cheap cask wine switched to locally bought beer – there was a 70% shift to beer following the decline in cask wine sales. Whatever happened with the internet does not alter the fact that the drinkers who were previously buying cheap 4 and 5 litre casks primarily switched to locally bought beer. Internet sales are largely bottled wine and make up a very, very small proportion of total alcohol sales. So what then happened to alcohol cause harms as a result in the price based decline in consumption?

[9] Symons, M., Gray, D et al 2012, A longitudinal study of influences on alcohol consumption and related harm in Central Australia; with a particular emphasis on the role of price, National Drug Research Institute, Perth

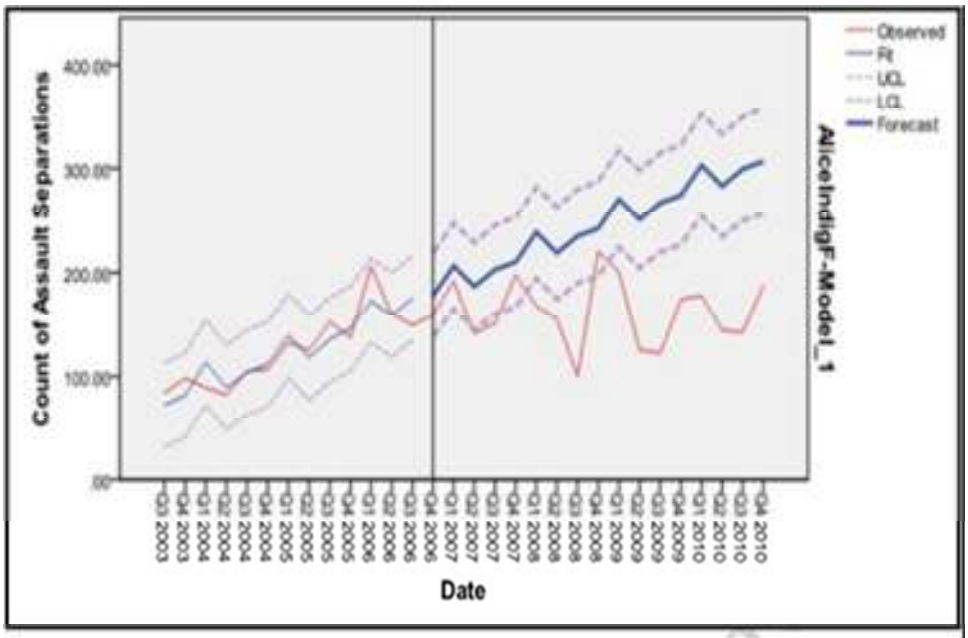


Figure 47: Number of hospital separations for assault for Indigenous females in Alice Springs, observed and forecast values based on a time-series model using data from Q3 2003 – Q3 2006

The graph shows that there is a correlation between the decline in alcohol consumption which came about with the introduction of the alcohol restrictions on October 1 2006 and hospital admission for Aboriginal women for assault. The blue line is the projected rate if the trend prior to the introduction of the restrictions had of continued and the red line is what actually happened after the restrictions were introduced a very significant change. This is a very objective indicator of a reduction of severe violence towards women as a result of the restrictions and the actual level of admission is around 120 per year less than the projected level.

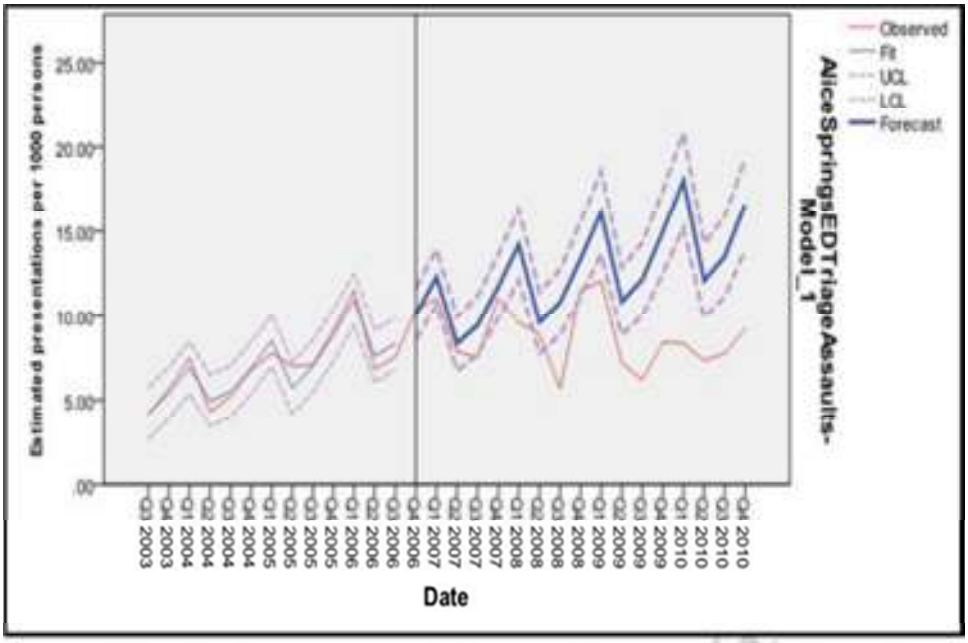


Figure 38: Observed vs. forecast time series for Emergency Department presentations for assault per 1000 persons based on triage data from Q3 2003 – Q3 2006, Alice Springs

The same trend is seen with the Emergency Department presentations for assault which has also declined. This data is consistent with the data in another recent independent study[10] "for the Alice Springs region. There is a reduction in harm due to assaults in Alice Springs hospital data in two independent studies and this is a significant step forward.

There is a still a large problem with alcohol that remains and the alcohol restrictions have not by any means solved the problem but they have moved Alice Springs in the right direction and they need to be strengthened and not weakened. There is a need to implement an alcohol floor price at the price of beer in order to address this key social determinant of Aboriginal health in the NT.

[10] Shu Qin Lee et al, 2012 Trends in alcohol-attributable hospitalisation in the Northern Territory,1998–99 to 2008–09", MJA 197 (6) · 17 September 2012

Rebuilding Family Life in Alice Springs and Central Australia: the social and community dimensions of change for our people

Rebuilding family life in Alice Springs and Central Australia: the social and community dimensions of change for our people

Foreword

This paper has been released by the Central Australian Aboriginal Congress as a constructive contribution to the debate on the social crisis facing Alice Springs and Central Australia. It presents powerful ideas as well as concrete strategies for change that we believe can make a real difference for our people.

Some clear points need to be made at the outset.

First, the crisis we face is not a new one, but a continuing one. It has been gathering for many years, and Aboriginal people and their organisations have been at the forefront of warning of the consequences of years of neglect and failure to act. These warnings have not been without self-criticism: we have also been aware of some failings within the Aboriginal community to show necessary leadership. Some in the Aboriginal community have failed in significant ways to respond to this continuing crisis.

Second, the heart of the crisis is reflected in the enormous disparity in what our sector calls the "social determinants of health". Put simply, the social gradient in terms of housing, education, employment, access to justice and empowerment are directly linked to the disastrous health outcomes we face. They are directly linked—also—to the ongoing effects of substance abuse, family violence and child neglect and abuse. The social gradient in Alice Springs and Central Australia is extreme.

Third, the response of the health sector has been to base its practice and actions on the strength of the best evidence available to tackle the problems we face. This means a commitment to gathering accurate data, and therefore basing our work on the best evidence-based practices available. This applies to preventative action, as well as to dealing with conditions as they arise. For the health sector this means:

> *… statistics are of profound concern: they are the surface gloss of so many of our lived experiences. As inadequate as they can sometimes be, they nonetheless hold a mirror up to our world—and the differences between our world and that of other Australians.*
>
> *For the Aboriginal health sector—and particular the Aboriginal leadership of the sector—statistics means much more. They do not just reflect life experiences and differences, they are the foundation of the work we do in operating from an evidence base. Good data can make the difference between life and death for our people.*[11]

But it's not just about the science, and this leads to the fourth point we make.

Having the evidence is not enough; knowing what "best practice" is not adequate. The best of ideas, the best of our knowledge, must come from a well-grounded base within our communities.

We must base our work on our social practice within our communities, and our social practice must reflect our "lived experiences" mentioned above, as well as a thorough going

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[11] Bell, Stephanie, "Lies, damned lies and statistics—or good data, damn good data, and improvements in Aboriginal health", *2nd Northern Territory Aboriginal Health KPIs collaborative workshop*, Alice Springs, 3 March 2011.

knowledge of where our people sit on the social gradient, and the cultural and other dimensions of those lived experiences.

Above all there must be a moral and ethical dimension to our work. Although we base our activities on the best evidence available, we don't do it from some sort of imaginary "value-free" science.

In this case, we do it to rebuild the lives of our families—and that is what motivates our social practice here in Alice Springs and Central Australia. That is our moral base. That is our ethical base.

As it turns out, the best evidence we have in comprehensive primary health care is that community control ***is*** best practice. Regional, national and international data has been building a strong evidence base to this effect.[12] Put simply, the evidence says that community control has superior outcomes in primary health care than solutions imposed from elsewhere.

That is why—whatever other solutions that might be considered and adopted to rebuild the lives of our families here in Alice Springs and Central Australia—our fundamental position is that Aboriginal peoples must own and operate those solutions.

Of course there will be partnerships involved: with government at all three levels, with industry, and with the non-Aboriginal community. There is no suggestion that we can or will do it in a vacuum. If nothing else, we will require cost effective resources to carry out our task.

This paper describes a number of approaches and programs that are already in place in a limited way here in Alice Springs. We say they should be expanded across the region. There are others that we believe we should be introduced here and across the region.

All the programs we propose, or are already putting into action in a limited way, are strongly evidence-based. They describe programs and activities with a strong preventative approach: building family life to avoid the damage so many currently experience. Others look to secondary responses to existing problems: reducing or eliminating existing damage. They look to the best learnings we can find internationally; they are refined through local experience and adaptation.

Of course, there will often be tensions between the evidence-based programs we describe and social reality. That's where the real art of community control comes into its own.

Helen Kantawarra — **Chairperson**

Stephanie Bell — **CEO**

[12] MJA 2010; 193: 602–607. For an expanded discussion, see 101125-JP-Speech-Shared Electronic Health Record Study Tour, an attachment to the "Speeches" section of the AMSANT Web Site, www.amsant.org.au.

1. Introduction

Our people established the Central Australian Aboriginal Congress nearly 40 years ago: as such, it has developed into an important institution in Alice Springs and Central Australia, with a skilled workforce. We are committed to the future of our region. Congress has a clear vision as to what needs to be done to ensure there is a better future for our children and our town through rebuilding family life in Alice Springs and Central Austrralia.

Congress is a large Aboriginal community controlled primary health care service in Alice Springs which employs more than 170 FTE staff including drivers, GPs, nurses, Aboriginal Health Workers [AHWs], psychologists, social workers, Aboriginal family support workers, pharmacists, a dentist, public health and other staff. There are five service delivery branches including the General Services branch, Alukura (women's heath and birthing), Ingkintja (male health), Social and Emotional Well Being and *headspace* (adolescent health). Congress provides more than 80 000 episodes of care each year to more than 6500 permanent residents and over 2000 visitors. We have attached a diagram outlining a summary of the program logic of Congress for further information.

In this response to the current spike in community and media interest on the ongoing social issues affecting our community, especially young people, we have outlined the key policy proposals that Congress has been advocating for the last few years. There is nothing new in these proposals, they have all been derived from existing submissions, position papers and other policy documents. The situation is far from hopeless and there are clear evidence based interventions that can and will make a big difference.

Congress does not want to see another crisis response to the current wave of concern with short term solutions only put in place – we must address the medium to long term issues with appropriate policies and programs.

The current media interest and even the concern of groups such as Alice Action may create an opportunity to have a renewed urgency and focus on the need to implement the policy agenda in this platform. The work that his begun in terms of the Alice Springs

Transformation Plan needs to be built on by implementing the policy platform set out in this document.

Recommendation 1

That the current social concern be used as an opportunity to:

a) explain to the Alice Springs community that the positive new programs, services and infrastructure which have been put in place as part of the Alice Springs Transformation Plan have not yet had time to have their full effect; and

b) to renew efforts to implement the types of evidence based-policy proposals that are going to further improve the social situation in Alice Springs in the short, medium and long term.

2. Income inequality, low social status and self esteem and the social problems in Alice Springs

Our people experience a vastly different set of outcomes to that of non-Aboriginal people in Central Australia. Although these circumstances are often brushed aside, they are an important factor in really understanding both the causes and symptoms of what we all witness — Aboriginal and non-Aboriginal residents — each day of the week.

What is less often understood, is that dramatically different "lived experiences" have deep effects — and the differences have been in existence for a very long time.

The relationship between income inequality, low social status, low self esteem and lack of control on the one hand and the types of social problems that Alice Springs is experiencing has been well described (WHO 2003, Marmot 2004, WHO 2008, Wilkinson 2009).

Alice Springs is one of the most unequal towns in Australia. Figures contained in the original Alice in Ten Report from the Alice Springs Town Council (1999) revealed that the average income difference between Aboriginal people and non Aboriginal people living in Alice Springs is nearly three fold and the absolute average for Aboriginal people is well below the poverty line. More recent data has shown that this has not changed.

There is a marked gap in employment rates and earnings between Aboriginal and non-Aboriginal people in both town and remote communities. In Alice Springs an Aboriginal person's weekly income in 2006 was $248, whereas a non-Aboriginal person averaged $725 a difference of $477. The gap in remote Central Australia was even larger with $721 for non-Aboriginal people compared with $207, a difference of $514 on average per week. The implications of this disparity on health outcomes are multiplied when average household size, unemployment rates and workforce participation rates are taken into account. According to the 2006 census, an average household in Alice Springs for an Aboriginal family was 3.4[13] residents and for a non-Aboriginal family 2.5, in remote communities the relative figures are 6 and 2 people.

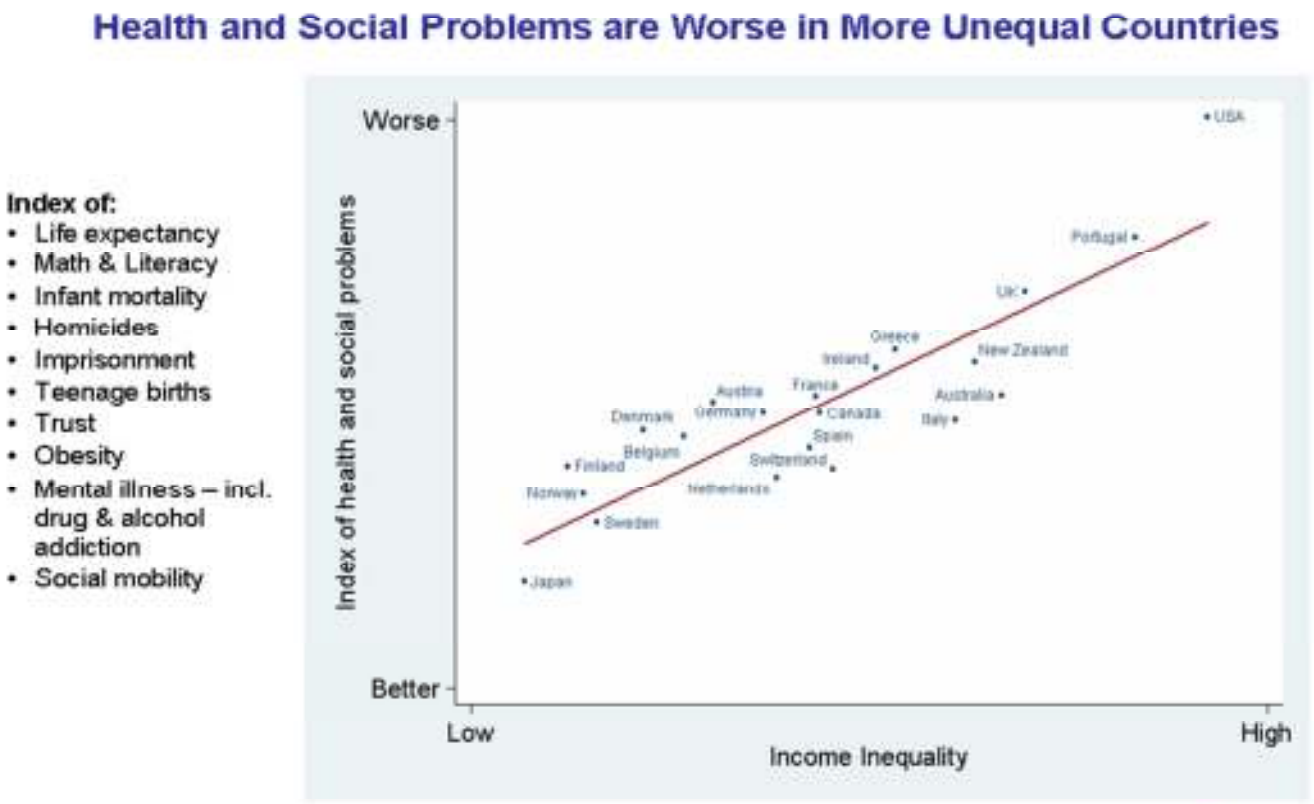
In Alice Springs unemployment, at the time of the 2006 census, was 10.1% for Aboriginal people, compared to 1.7% for non-Aboriginal people. In remote communities unemployment was 7.3% (Aboriginal) and 0.5% (non-Aboriginal). Labour force participation in Alice Springs for Aboriginal people was 41.2% and for non-Aboriginal people 82.2%, in remote communities, the Aboriginal labour force participation rate was just 30.2 % compared to 87.5% for non-Aboriginal people [NT Government Department of Business, Economic and Regional Development 2008].

Within the Aboriginal population of the region, there are marked disparities in social disadvantage between Aboriginal men and Aboriginal women. Utilising a Gender-Related Index for Indigenous Australians (GRIFIA) as a tool to create a ranking of relative disadvantage, Yap and Biddle have shown that Central Australian Aboriginal males are more socially disadvantaged than Aboriginal females and most other Aboriginal males [Yap and Biddle, 2009].

[13] This figure will vary depending on the type and location of housing, for example occupancy rates in Town camps is estimated to be significantly higher.

Richard Wilkinson in his recent book *The Spirit Level* (2009) has demonstrated the way that this income inequality actually causes many of the social problems that Alice Springs has long been experiencing. The following graph shows the relationship between income inequality and health between countries but this relationship holds within countries and within towns.

Growing up with very little alongside those who have plenty is bad for your health and is the root cause of many of the health and social problems in Alice Springs:



This applies especially to the well being of children and young people and the following graph from the same source shows the relationship between income inequality and child well being:

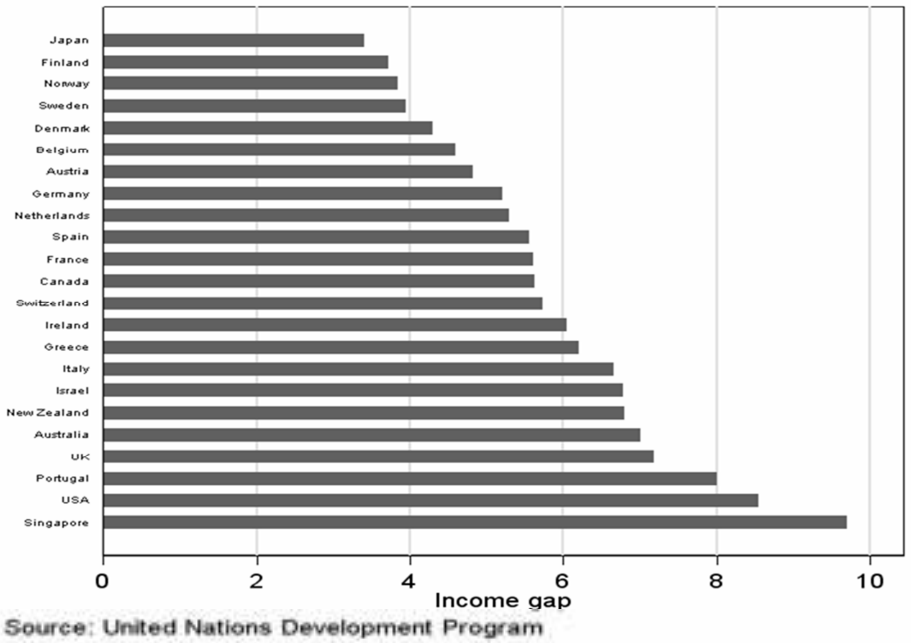
Child Well-being is Better in More Equal Rich Countries

Source: Wilkinson & Pickett, The Spirit Level (2009)

www.equalitytrust.org.uk

Given the level of income inequality in Alice Springs it should come as no surprise that young people in particular are experiencing significant social problems. However, Alice Springs is a very unequal town in a country that has very high levels of income inequality. As the next graph shows, Australia is one of the most unequal countries in the OECD and the inequality is growing. In the US in the last 15 years the top 1% have gone from owning 7% of the wealth to owning 23% of the wealth and a similar trend is occurring in Australia:

How much richer are the richest 20% than the poorest 20%?



Source: United Nations Development Program

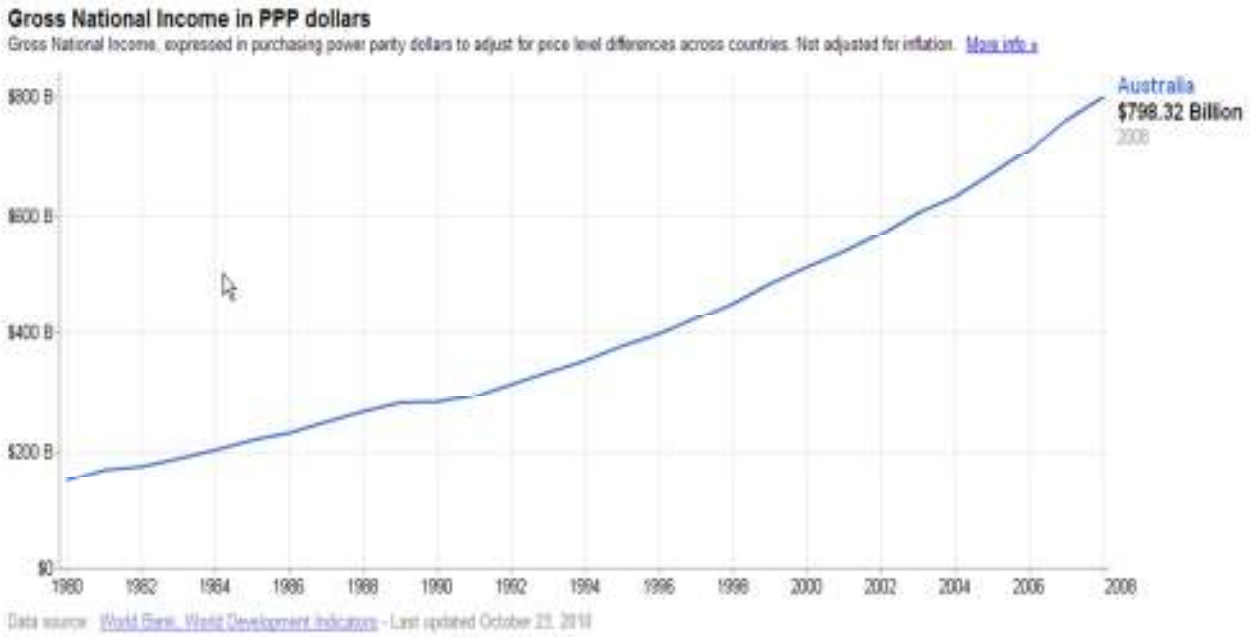
Source: Wilkinson & Pickett, The Spirit Level (2009)

www.equalitytrust.org.uk

What can be done about this? Is it all too hard to address? Congress believes the answer is no - and Wilkinson describes two clear pathways to address income inequality. The first is the Japanese pathway which is a "bottom up" focus on achieving very high levels of educational attainment leading to well paid, reliable work. Many of the policy proposals in this paper are aimed at improving the educational outcomes for Aboriginal people as a key pathway to achieving an improved income and reducing income inequality for our people. Congress believes that this approach has the support of the Australian public. However, a lot more needs to be done, especially in early childhood, to achieve this.

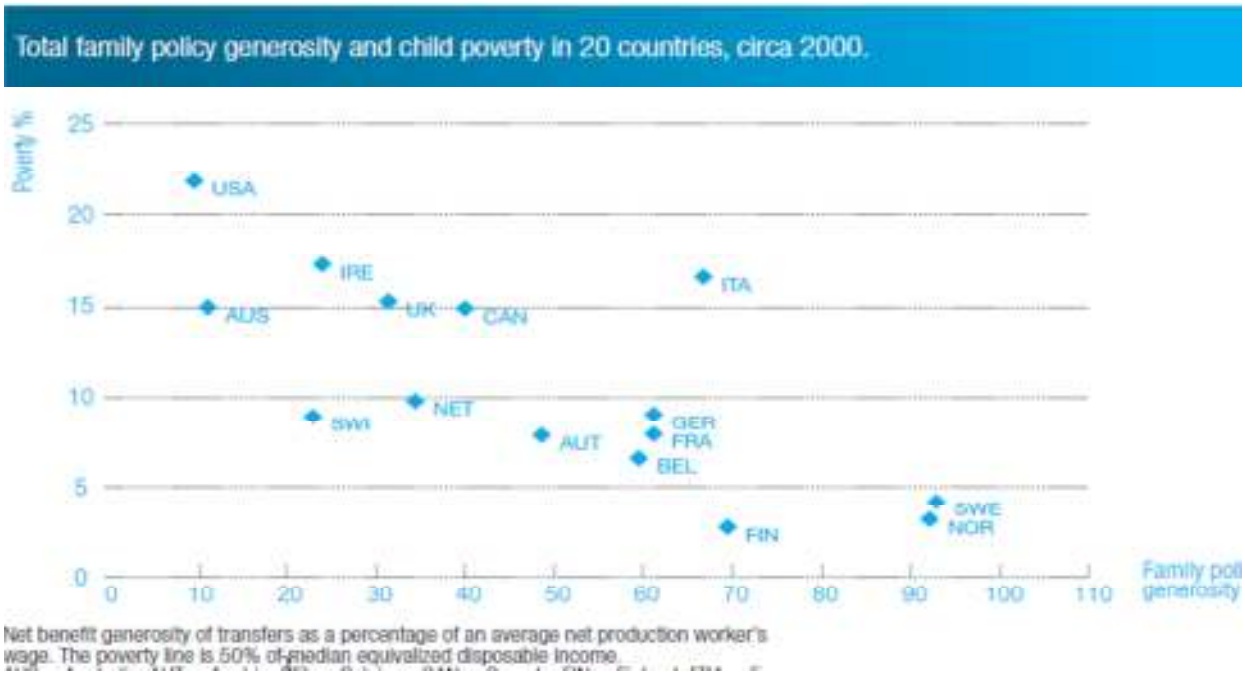
The second pathway in described in Wilkinson's book is that of the Northern European countries where there is a focus on redistributive government policies both through the provision of universal health, education and child care services as well as progressive taxation. Currently the debate on the super profits tax and the carbon tax demonstrates how difficult it is to achieve genuine redistributive taxation policies. It is worth noting that Norway, for example, does not have a child protection crisis and is a much more equal country than Australia – it has a super profit tax on mining of 78% and is investing a large part of this in a massive future fund for when the minerals run out.

There is no scarcity of resources in Australia - this is a myth that should not be used as an excuse of the failure to address Aboriginal disadvantage:



In global terms, Australia is very rich and getting richer and is in fact going through its biggest mining boom ever, but the wealth being generated is very unequally spread. The total taxation revenue of Australia is only 30% of GDP or about $300 billion on current figures - this is the third lowest in the OECD. The Northern European countries taxation revenue is 50% of GDP. If Australia was to match this then there would be an additional $200 billion dollars per year to spend on health, education, housing, childcare etc. Even with a much more modest approach, matching Canada at 34% for example, would mean an additional $4 billion annually. Progressive taxation can therefore be seen as a key public health issue since it both reduces income inequality per se and also provides the necessary government revenue to fund the programs and services that will further reduce inequality.

Australia is almost at the bottom of the ladder in terms of family policy generosity within the OECD as seen from the following graph again from *The Spirit Level*:



This unacceptable inequitable situation for the children and young people of this country is most acutely experienced by Aboriginal children across the nation, and within this, by Aboriginal children and young people in the most unequal towns, such as Alice Springs. This needs to be understood by any leaders or members of the community if they want to try to improve the situation of Aboriginal people. In the context of this overarching analysis we will now turn to some specific policy proposals to address the complex situation which exists in Alice Springs.

The policy proposals in this platform are not only about the social determinants of the problem but also include a very explicit recognition of the need for our people to take greater responsibility for solutions and to accept the need for social norms around acceptable standards of behaviour, especially in terms of parenting young children and violence.

Given that there is not much commitment in Australia at present for the types of redistributive policies that would promote greater equity through progressive taxation policies, such as the super profits tax, Congress has not focused on these types of policies. There is an assumption that, given Australia's wealth, it is up to government to ensure it has sufficient revenue to address Aboriginal disadvantage however it decides to obtain the necessary revenue. There are also some very effective policy proposals in this paper that cost taxpayers nothing.

3. Empowerment and greater control: a Central Australian Family Responsibility Commission

When this paper calls for the "rebuilding" of family life in Alice Springs and Central Australia, we do so in the knowledge that many of our families are severely damaged, and under considerable stress.

It is vitally important that the parents of all young people are engaged in a process where they are required to accept and act on their responsibilities towards their children. Families need to take responsibility for what is happening, and, if they are not willing or able to do so, then the development of a Central Australian Regional Family Responsibility Commission (FRC) will be a critical new institution that can assist and ensure that families do accept and act on their responsibilities.

Congress believes that an FRC will give greater control to elders in the community to be able to re-establish social norms *with the authority to assert consequences as they traditionally had.* This is an important strategy in terms of re-creating social cohesion and is very much supporting the traditional authority of elders who used to be able to assert authority with consequences if social norms were ignored. Traditionally, these consequences fell on the young people who were misbehaving *as well as* the parents of these young people as they were also held accountable for the behaviour of their children and punished if their children broke the law. The FRC proposal potentially empowers elders to be able to assert their authority with social consequences.

Currently the NT government, through the *Prevention of Alcohol-Related Crime & Substance Misuse Bill* is proposing that an Alcohol and other Drugs Tribunal be established. In this regard, Congress believes that the proposed Tribunal should be based on what now appears to be the successful Cape York Family Responsibilities Commission (FRC) model. ABC news (Binnie & Ryan Updated Fri Nov 26, 2010 10:37am AEDT) reported that a recently released KPMG audit has revealed that the trial is working. They reported that Commissioner Glasgow has been in Aurukun and says he has witnessed the changes himself:

> *The community is a much more united community, much more determined and have got great direction. You can actually see it in the community. I'm comfortable walking in this community at night time. I certainly wouldn't have been comfortable doing it two years ago.*

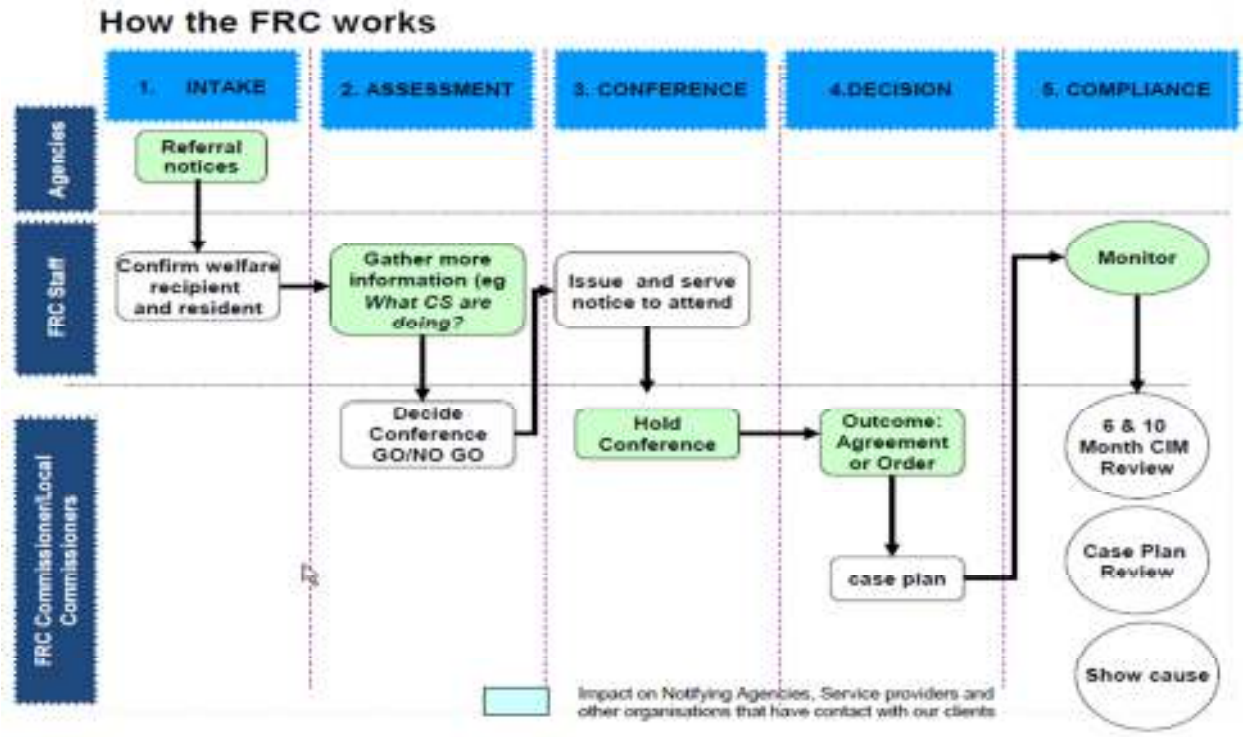
In addition to this, the KPMG audit reported that the Aurukun Mayor, Neville Pootchenumuka, says he is seeing a positive change in his community on Cape York's west coast. He says people who moved away from the community because of escalating violence are now coming back:

> *Things are actually improving; particularly the school attendances are improving each time - we do still have ups and downs. There are a lot of improvements through welfare reforms - people are coming back for employment. People are coming back to get their kids to be educated.* (Pootchenumuka in Binnie & Ryan Updated Fri Nov 26, 2010 10:37am AEDT)

Congress, in conjunction with the Central Land Council, convened a workshop late last year where Commissioner Glasgow presented the FRC model. Both he and Congress believe that the level of community ownership of the Commission is a critical part of its success. Each hearing is presided over by a Head Commissioner, David Glasgow, along with two local Aboriginal Commissioners. There are no doctors, lawyers or other professionals on the Commission itself – their views are sought as needed and reports are written to the Commission. This empowers respected local Aboriginal leaders to be part of re-establishing social norms and regain the respect that they need if they are going to be able to get young people to change their ways. This is a much better model than the professionally controlled model being proposed for the Alcohol and Other Drugs Tribunal. It is also more cost effective and leaves doctors and lawyers working within their own sectors and assessing people on referral from the Tribunal. The Tribunal itself should not be seen as a treatment service but as an institution that will assist in getting people to engage in treatment.

Commissioners should be chosen from appropriate elders from the Central Australian region including Alice Springs and remote communities. There are 18 Commissioners in the Cape York FRC for 4 Aboriginal communities and there would need to be many more than this to adequately cover all of the Aboriginal communities in Central Australia. The FRC would then convene in the community of origin of the family before it and draw upon the Commissioners from that same locality.

The role of the FRC would include all of the proposed roles for the Alcohol and Other Drugs Tribunal but, importantly, it would also be able to also consider referrals for child neglect where alcohol was not involved. The proposed powers for the AODT in terms of alcohol banning orders and income quarantining should be retained and used by the FRC.



Recommendation 2

That the proposed Alcohol and Other Drugs Tribunal be converted to a Family Responsibility Commission (FRC) modelled on that operating in Cape York, Queensland under the *Family Responsibilities Commission Act (2008)* and that the FRC operate in the following way:

a) an appropriately qualified commissioner be appointed to head up the FRC and two community leaders or respected elders as commissioners on each tribunal hearing;

b) the Commissioners would be the most appropriate ones for the family being considered chosen from the total pool of Commissioners from all over Central Australia;

c) eligibility for appointment of the head commissioner to be as defined by the *Family Responsibilities Commission Act (2008)* (section 17):

> *"(a) the person is lawyer if at least 5 years standing; and (b) the minister considers the person has an appropriate understanding of the history and culture of Aboriginal and Torres Strait Islanders; and (c) the minister considers the person has (i) appropriate experience in mediation or alternative dispute resolution; or (ii) other knowledge or experience making the person appropriate to be the commissioner or deputy commissioner."*

d) there be an equal partnership between all commissioners as there is in the FRC;

e) where an Aboriginal person is before the FRC the commissioners should be respected Aboriginal elders and where there is a non Aboriginal person they should be respected non Aboriginal elders; and

f) that the FRC be seen as a means of *empowering our community* and giving greater control to Aboriginal people through being active participants in re-establishing acceptable social norms.

Recommendation 3

That community members be able to make *anonymous referrals* to the FRC to diminish the negative consequences which may arise from a referral for the referring individual.

That referrals be able to be made before a crime is committed to encourage intervention at an earlier and more effective point.

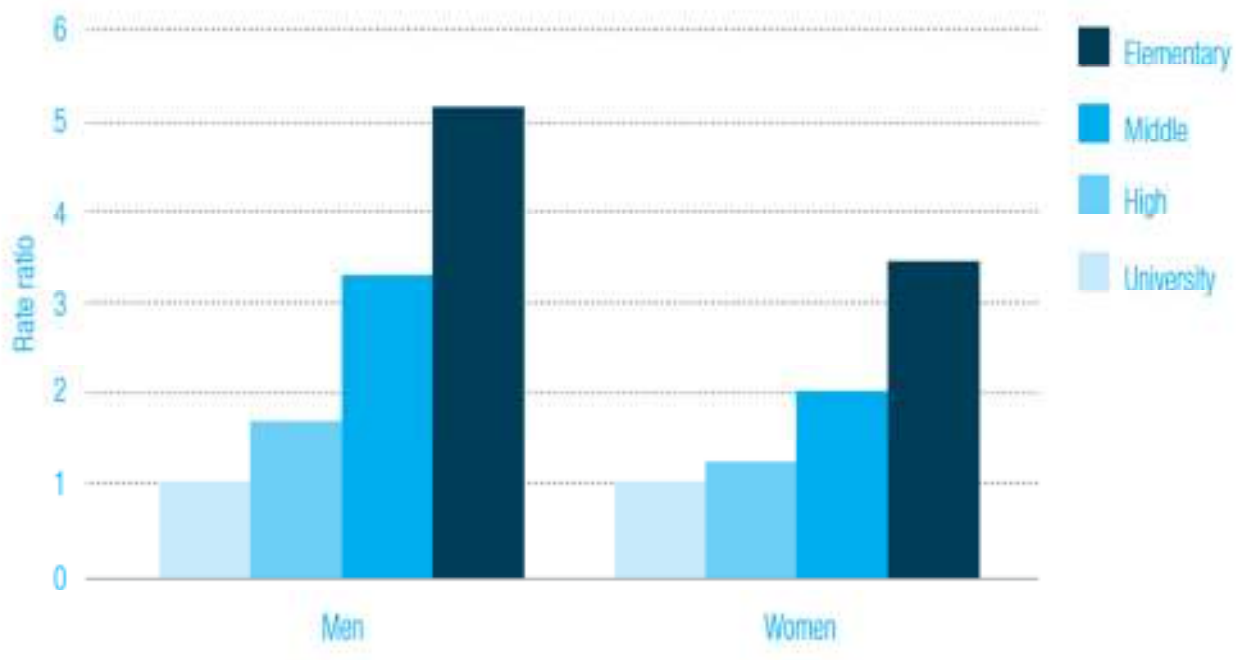
4. Early Childhood programs, educational attainment, employment and health

Rebuilding our families must start with our children, and this means providing opportunities from the first day of their lives, and building a strong family life to nurture and develop our kids. The community of Alice Springs and Central Australia will suffer if we cannot work to change this simple reality. It seems basic, but the evidence clearly shows that home life is the greatest determinant of future outcomes for our people.

As discussed earlier, education is a key pathway to achieve greater control, improved self esteem and employment with a reasonable and reliable income. As a result educational attainment is a critical determinant of life expectancy and the health of the population.

The importance of education in improving life expectancy was clearly documented in the health transitions work of the Caldwells who systematically studied more than 130 countries over many years (Caldwell 1986; 2005). The recent report from the World Health Organisation Commission on the Social Determinants of Health (2008) highlighted the strength of the relationship between education and health with data from many different countries:

Figure 14.2 Age-adjusted mortality among men and women of the Republic of Korea by educational attainment, 1993–1997.



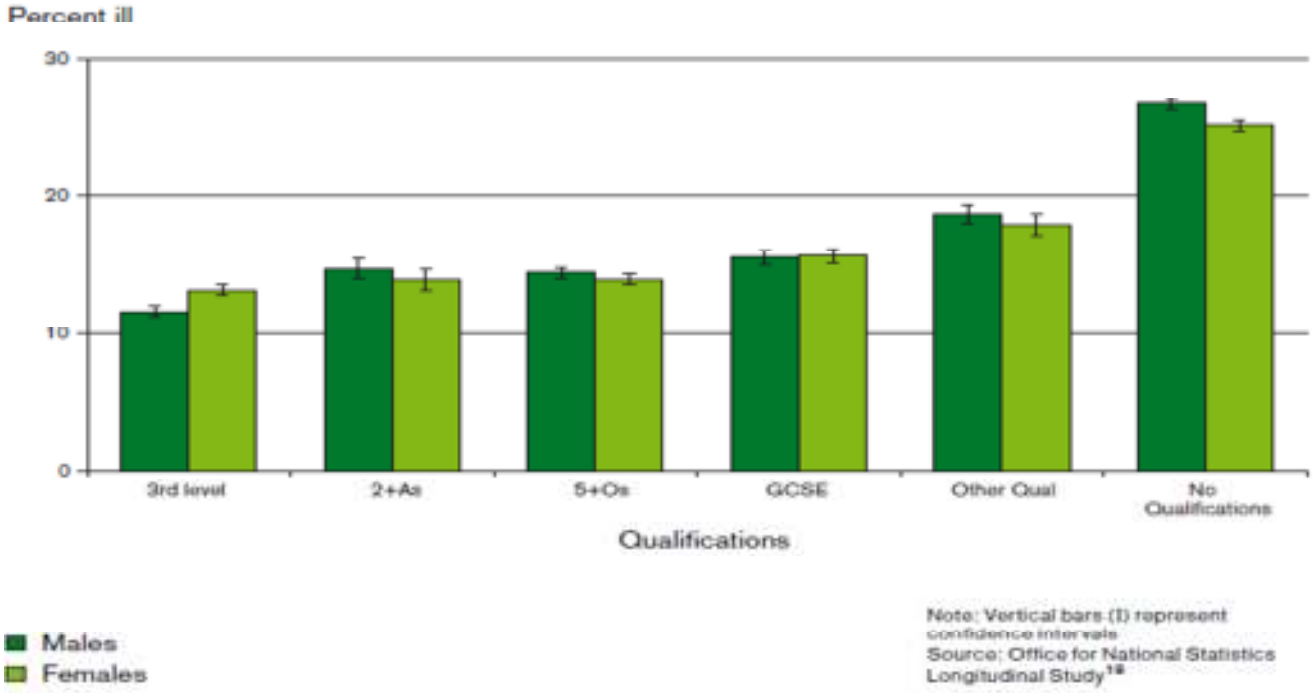
The data in the following graph from Russia shows that there is a trend for the gap to widen as higher paid jobs more and more require tertiary level qualifications:

Figure 2.5: Trends in male and female life expectancy at age 20, by educational attainment, Russian Federation.

Educational attainment: ○ elementary (open circles), ▽ intermediate (triangles), and ● university (filled circles).
Reprinted, with permission of the publisher, from Murphy et al. (2006).

Finally, recent data from England has also shown that premature death is greatly reduced as educational attainment rises. In fact, if everybody in England aged 30 and over had the mortality rate of graduates, there would be 202,000 fewer premature deaths each year, accounting for 40 per cent of all deaths (Marmot et al 2010).

Figure 7 Standardised limiting illness rates in 2001 at ages 16–74, by education level recorded in 2001



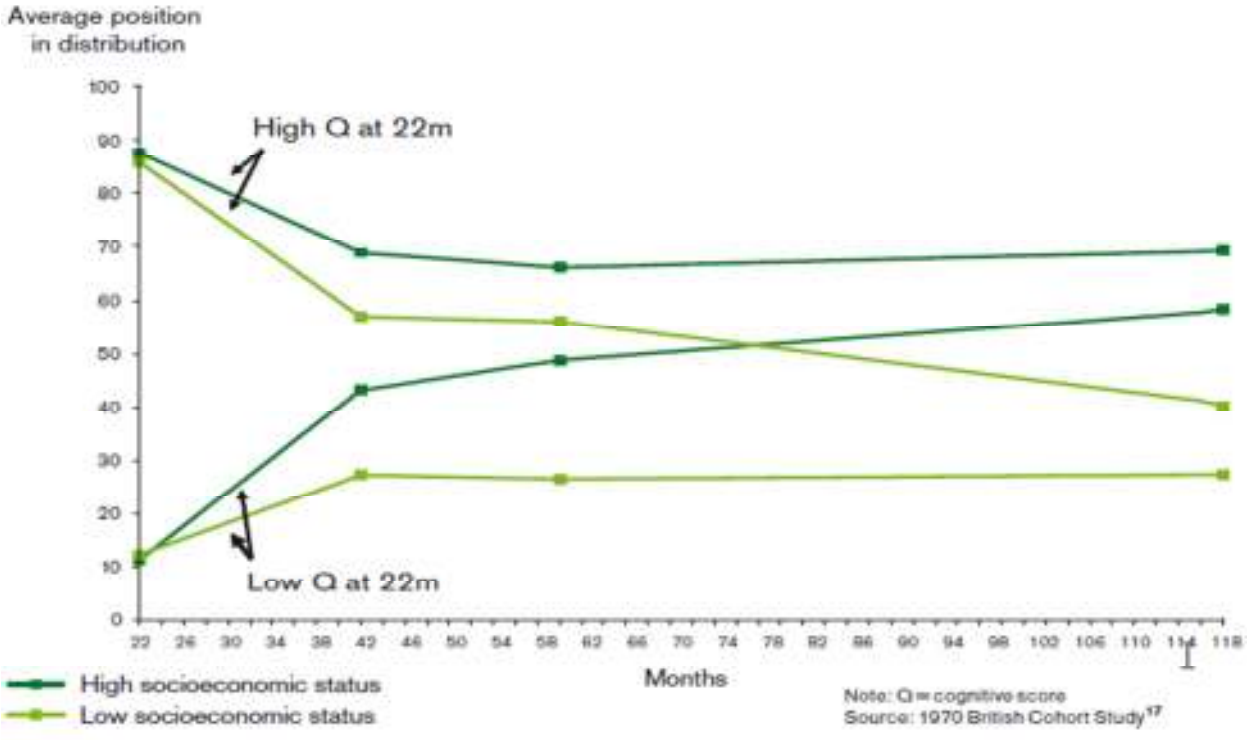
However, it is now clear that only about third of educational attainment is due to the quality of the school, principal and teachers and the rest is dependent on what happens at home and in the immediate social environment of the family (Hattie 2003).

There needs to be a continued focus on ensuring that there is adequate and equitable funding for pre-schools, primary and secondary education for Aboriginal people with highly qualified and experienced teachers. However, this by itself is not enough and for too long there has been a tendency to assume the education system alone will be able to overcome the disadvantage that many Aboriginal children experience in their home and family life. This will never be the case. Much greater focus needs to be given to the early childhood education that young children receive at home prior to age 3.

It is now clear that important and rapid cognitive and emotional growth happens very early in life. *If we wait until age 3 or 4 to enroll the most vulnerable children in education, they will enter far behind.*

Children who grow up in a disadvantaged early childhood environment do not develop the brain capacity to do well in education and, even though they attend primary school, will, on average, do badly and drop out as soon as they are old enough to vote with their feet. In addition, these same children develop character traits that greatly predispose them to the development of addictions in adolescence. Traits such as impulsivity, poor concentration, lack of self control and self discipline are more likely. The following graph from *Fair Society, Healthy Life* (Marmot 2010) shows how much the early childhood environment impacts on brain development for children born with both high IQ and low IQ:

Figure 6 Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years



Marmot concludes that most of the difference that is evident in this graph is due to children's experiences in the first three years of life in their homes. The things that make

the difference include daily one on one interactions and talking with young children, daily reading, going to bed at regular times, being physically active and having a good playgroup of children of similar age. What interventions can assist in these areas?

4.1 Universal Nurse-led Home Visitation

A key role of the primary health care system is to support children from disadvantaged backgrounds to be able to enrol in pre-school and school to support the optimal level of brain development. Nurse home visitation beginning prior to 28 weeks in pregnancy is synergistic with antenatal care in terms of addressing key preventable causes of low birth weight babies. It is synergistic with educational day care (discussed in the next section) in terms of promoting optimal brain development in disadvantaged children. All Aboriginal women need to access home visitation wherever they live in the NT.

The Old's Nurse Family partnership program of home visitation is now part of Congress and includes three key goals:

1. Improve pregnancy outcomes
2. Improve child health and development
3. Improve parents' economic self-sufficiency

There have been three randomised controlled trials of the effectiveness of this program, all done amongst low income socially disadvantaged families in rural and semi rural settings (Olds 1986, 1997, 1998). These studies were all done in high risk neighbourhoods and families where there was unemployment, no decent housing, violent crime, unsafe play areas and no sources of healthy food. Nurses have been shown to be the most effective home visitors and we have accepted this in the Congress program adapted to include Aboriginal community workers alongside the nurses.

There is very good evidence from randomised controlled trials of the effectiveness of nurse home visitation in preventing child abuse and neglect, again with increasing effect against the social gradient. No other program has such a strong evidence base and this evidence has been available for a long time. However, long term follow up with children who received the program to age 15 years has shown that this program can prevent a significant proportion of the problems that Alice Springs is experiencing with some young people. Outcomes from the trials included:

- Improvements in women's prenatal health and dramatic reduction in arrests, convictions and jail
- Reductions in child abuse, mortality and children's injuries
- Fewer subsequent pregnancies and greater intervals between births
- Increases in fathers' involvement
- Increases in employment and reductions in welfare dependency
- Improvements in school outcomes
- 50% less addictions, sexual partners and a healthier lifestyle at age 15

The results have been achieved in areas that are of major concern in Aboriginal communities throughout the Northern Territory, including Alice Springs. They are outcomes

that help to reverse the social gradient in a political climate where government policies for equity are few and far between. Although greater equity and more action by government to address the social determinants of health are urgently needed, the home visitation program can have an impact here and now in spite of an unequal social environment. The program will also have a significant impact on the primary prevention of the mid life chronic disease epidemic through the promotion of emotionally balanced young people, with fewer addictions and a healthier lifestyle. This is critical to our attempts to close the life expectancy gap for our people

The Washington State Institute for Public Policy Economic Analysis (Aos et al 2004) has shown the following:

1. Among all of the pre-kindergarten, child welfare, youth development, mentoring, youth substance abuse and teen pregnancy prevention programs examined, the Nurse-Family Partnership produced the largest per-family economic return.
2. In 2003 dollars, the program cost about $9,000, but returned $26,000 to government and society, leaving a $17,000 net economic benefit. These estimates are consistent with those produced by the most recent economic analyses produced by the Rand Corporation.

At present there is a significant number of young mothers who are enrolled in the program and are benefiting greatly from it but who then move back to live in remote communities where they cannot continue to access the program. This is a tragedy and needs to be addressed by rolling out the home visitation program across Central Australia

The Olds Nurse-Led Home Visitation program, currently available only in Alice Springs, needs to be rolled out across all communities in Central Australia. This needs to be complemented with the development of effective adult literacy programs so that more parents are better able to use more complex words in conversation at home, read to their children and, through their own experience of enhanced learning, become more committed to ensuring their children are well educated.

Recommendation 4

That the Olds “Nurse-Family Partnership” Program of home-visitation for new mothers be rolled out across all communities in Central Australia as an early intervention strategy to improve the health and social functioning of low-income mothers and their babies.

4.2 Educational Day Care for children aged 1 to 3 from disadvantaged households followed by two years of pre-school

Although, we can and should put in place programs to support parents to develop an optimal early childhood home environment, such as the nurse-led home visitation program, this is not sufficient by itself. Children from disadvantaged backgrounds need to be offered educational day care in accordance with the Abecedarian approach of Prof Joseph Sparling. *There is great cause for optimism*: those who need it most reap the greatest benefits from an early education program using the Abecedarian approach.

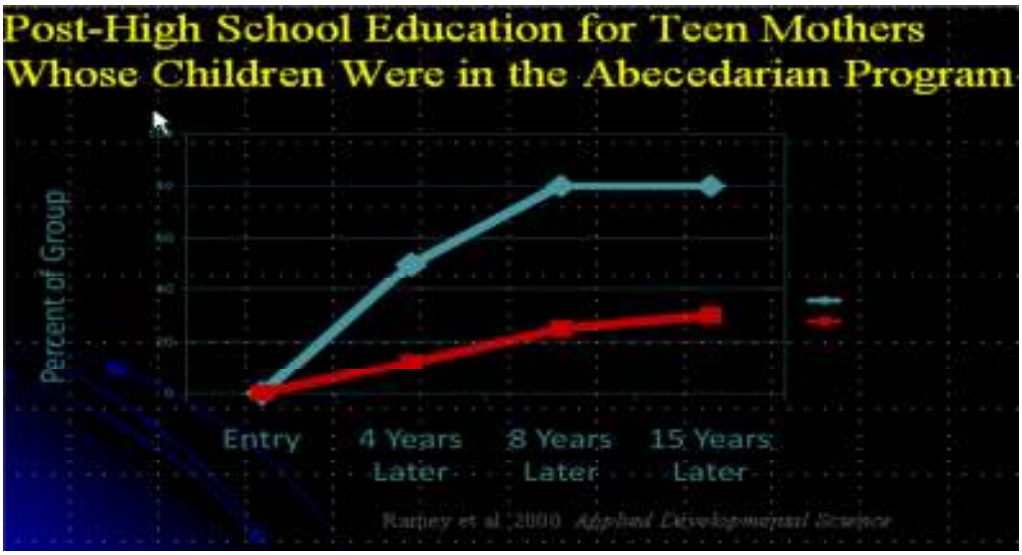
An Abecedarian program is beneficial across a wide range of socio-demographic groups. There are four key elements to the Abecedarian approach:

- Learning Games: Teachers daily engage in short interactive sessions (adult/child interaction games) with individual children or very small groups (e.g., 2 children).
- Conversational Reading: Teachers use a 3S strategy to read a book individually every day to every child.
- Language Priority: Teachers use a 3N strategy to surround spontaneous events with adult language.
- Enriched Caregiving: Teachers encourage children to practice skills (e.g., cooperating, listening, counting, colour recognition) during care routines.

The "teachers" referred to are not tertiary qualified people but are community people who are committed to working with children and have an acceptable level of literacy. They are then trained on the job to implement the four elements of the Abecedarian program. Thus, the program provides an opportunity to employ and train a significant number of local people as there is one "teacher" for every four children enrolled and in Alice Springs there would be about 250 children between one and three who would benefit from the program.

All four elements of the Abecedarian approach are shared with parents through home visits and through carers in day care centres for children from 1 to 3 years. In each day care centre there needs to be a ratio of one carer to four children. The carers do not need prior qualifications and can be local people trained on the job to implement the learning games. The children need to be in day care six hours a day four days per week. In each six hour session they need to be exposed to three one-on-one interactions with their care for the purpose of promoting cognitive development. This amounts to an out-of-the-home exposure of a total of 24 hours per week.

The following graph shows the outcome achieved in a 15 year follow up for teenage mothers who were on the program:



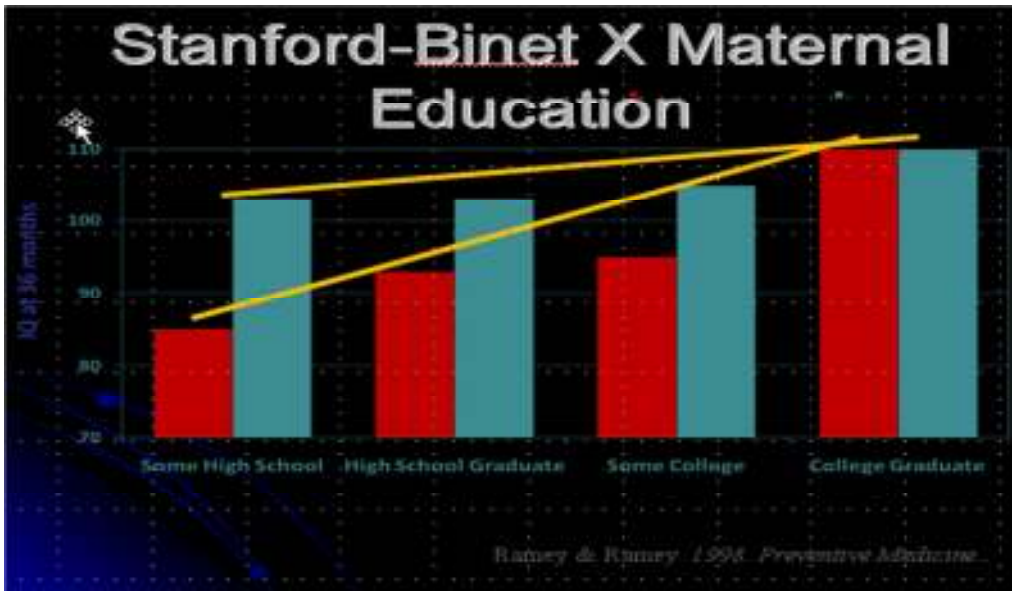
The long term results for the children in the program are also remarkable:

- Fewer risky behaviors at age 18 ($p<.05$)
- Fewer symptoms of depression ($p<.03$) at age 21

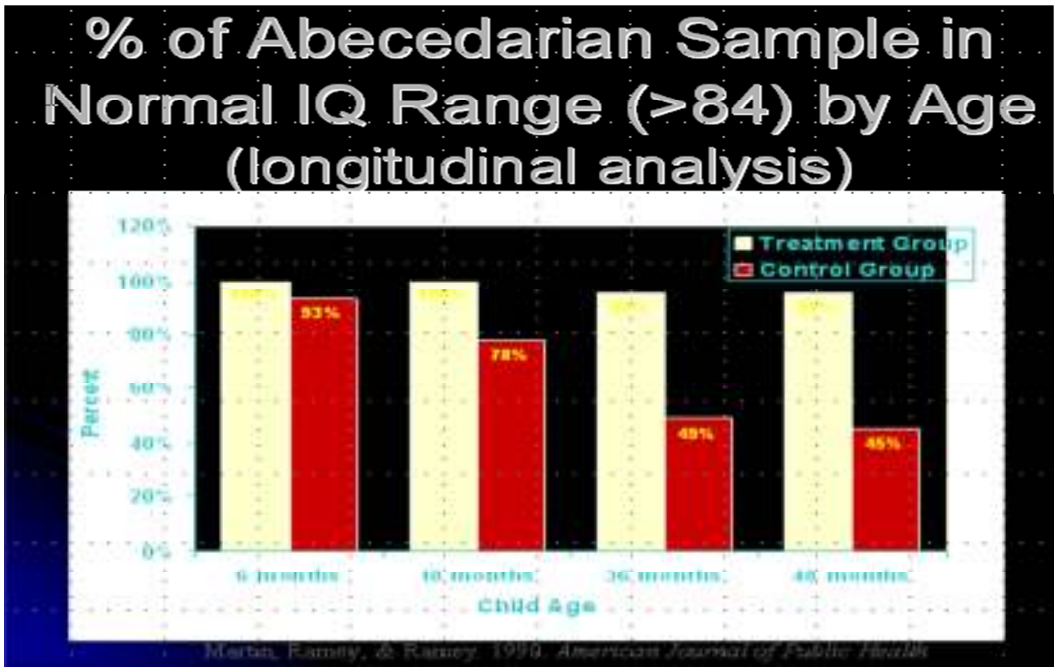
- Healthier life styles. The odds of reporting an active lifestyle in young adulthood were 3.92 times greater compared to the control group: *if there was a medicine that produced this odds ratio every child would be on it!*

(McCormick, et al. 2006. *Pediatrics.* McLaughlin. 2007. *Child Development,* Campbell et al., 2008. *Early Childhood Research Quarterly*).

Probably the most important outcome of all is the impact of the program on the cognitive development of the children. In the graph below you can see that if one parent has a university degree then the program has no benefit for their children. However, the benefit increases as the parents are more educationally disadvantaged. For example, if parents only have some high school education the program achieves a 20 point difference in the IQ level of their children compared to control children from equally disadvantaged backgrounds who did not receive the intervention. This could be the difference between a child attending primary school and doing badly compared with a child who has sufficient cognitive development to learn well and develop a love of learning and school:



Of great concern is the evidence on what happens to children from disadvantaged backgrounds who do not receive this intervention. The graph below shows that by 3 years of age 50% of the children who did not receive the Abecedarian program – the control group - had an IQ level below normal. In contrast to this, 95% of children from exactly the same disadvantaged backgrounds had an IQ in the normal range if they received the intervention:



This is a program that can help to reverse the social gradient and address income inequality later in life in a bottom up manner by giving children a greater chance to do well in education and achieve tertiary qualifications. The early assistance has a flow-on effect to the next generation of children and breaks the cycle of income inequality and disadvantage. In fact, at age 21, almost three times as many individuals in the treated group (**39.5%**) compared to the control group (**13.7%**) had attended, or were still attending, a 4-year university. (Campbell et al., 2002, *Applied Developmental Science*).

It is vital that this program is established with the same type of national support structure as the Australian Nurse Family Partnership Program, including training support, to ensure that all sites are able to maintain the required level of program fidelity to the Abecedarian approach. There is also the same need to ensure that quality data is collected from the outset so that the outcomes of the program can be adequately assessed in Aboriginal communities.

Recommendation 5

That high-quality child-care centres be established for all children aged 1 to 3 from disadvantaged households in Alice Springs and surrounding communities.

That these centres implement the Carolina Abecedarian early-intervention approach to build school readiness and maximise potential for positive educational and social outcomes in young adulthood.

That these children transition into 2 years of pre-school.

5. Supported accommodation services and public housing availability in the Alice Springs town area

There is universal acceptance that housing is a key to health, and in turn building strong families. For our people, the lived experience is that overcrowding is a key obstacle to building strong families. It is not just a matter of too many people living in a house: the reality is that any problem—particularly grog—becomes magnified and makes an already bad situation far, far worse.

Many families are desperately trying to care for children but struggle to do so because of accommodation issues such as overcrowded housing and inability to control visitors, including drinkers. Resulting chaos means no sleep, no food and exposure to violence, resulting in the caregiver becoming incredibly stressed and at risk of giving up. Such families, especially sole parent families and grandparents who are caring for children, want accommodation that has a capacity to *gatekeep* visitors and intoxicated family members.

Supported accommodation services need to be provided in both an alcohol-free and controlled drinking environments. The need is reflected in the current waiting list of 20-25 families at Ayeperenye hostel for the 12 family cabins there. Ayeperenye is not flash but it does provide safe accommodation, the gates are locked at night and drinkers are not allowed in.

Thus, common issues which impact negatively on parenting, including children exposed to an environment where there is excessive drinking, and carers who are constantly 'humbugged' for money and food by others, are mitigated. For these families, access to a secure supported accommodation setting would greatly improve their capacity to care for their children.

Supported accommodation should be provided to families in crisis for as long as it is needed depending on the parent's circumstances. In some cases this will be 12 months but in other cases this will be for a much longer time. Some supported accommodation facilities could be established with 24 hour support.

With community consent, supported accommodation facilities could be created within a town camp environment with a fence around a group of houses or an entire town camp could be set up in this way. The facility would need a manager or "gate keeper" who controls entry and exit to the accommodation and who is able to effectively support the residents. Also needed would be an agreed set of rules on dealing with disruptive people. The gate keeper would lock up at night and not let alcohol in. Such a facility could also be established outside of town camps. Similar models proven to be effective in this way are Aboriginal Hostels such as Ayeperenye Hostel in Alice Springs.

There are a number of immediate opportunities in Alice Springs to expand supported accommodation options, including hostels and other linked cottages. The St Mary's campus and associated underdeveloped land belonging to the Anglican Diocese are possible sites. The Catholic Church has an underutilised Irrkerlantye Unit that could be developed perhaps into a Hostel. Congress has land through the Gap which could also be used for this purpose. Batchelor College has its old residential and education block on Bloomfield St. These are all potential residential sites.

Other more exciting opportunities lie within existing town camp leases. For example, Old Timers camp is to be surrounded by supported accommodation, ie Old Timers Village, the

AHL visitors hostel, the St Mary's campus, Hetti Perkins, Alukura and the new housing estate. The existing senior people at Old Timers camp could be approached as to whether the site might be redeveloped as a gated hostel and housing community for vulnerable families. Priority could be given to applicants from their family and language groupings. Equally, Hidden Valley camp could develop hostel and mixed accommodation near where the current community facility is located. Hoppy's camp, Namatjira camp, White Gate camp and Warlpiri camp could be entirely reconstructed into gated and secure accommodation complexes targeting families with existing relationships to each area. Discussion could be held with these individual housing associations and relevant senior people from the associated language groups.

Areas also exist between Karnte and Anthepe camp for secure accommodation for vulnerable people. Large sections of Little Sisters camp and Abbotts camp would welcome respite from the marauding crowds of drinkers that access the camp to allow them to be close to nearby liquor outlets. Abbotts camp has previously requested dry camp status and has historically attempted to secure the camp from drinkers.

In addition there is some infrastructure, historical precedent and new opportunities at Jay Creek, around Harry Creek or surrounding outstations, Mt Undoolya, and possibly the Owen Springs area to develop treatment and long term rehabilitation initiatives for individuals and families who would prefer out-of-town accommodation. It may also suit many renal dialysis patients and their families.

An approach to the existing housing associations within the Tangentyere Council umbrella may see some associations agree to longer term leases [20-99 yr leases] to redevelop their existing housing infrastructure. Longer term leases would significantly address the current distress experienced by vulnerable families, usually long term residents of Alice Springs, who don't have any realistic public housing options because of historic debt to Territory Housing.

Another local discussion taking place includes the development of CBD-based sustainable and affordable housing initiatives which include building above existing community parking areas. One idea currently being floated is for a building between the Flynn Church and the Yipirinya Centre.

There is an urgent need for affordable public housing throughout Alice Springs and not only on town camps. There is not just a lack of supported accommodation. The availability of affordable public housing throughout the town has steadily declined as much of the public housing stock is progressively privatised. The effect has been to force people who need public housing on to the town camps rather than enabling them to find suitable accommodation throughout the town.

Recommendation 6

That supported accommodation services be established in different ways in different localities in and around Alice Springs.

That consideration be given to the creation of some town camps as gated communities as well as the establishment of more supported accommodation facilities throughout the town.

That supported accommodation be built to target the special needs of young people, the mentally ill and men who are violent separately.

6. Ensure that all primary health care services throughout Central Australia have a Social and Emotional Well-Being Program that includes a Targeted Family Support Service and an Alcohol and Other Drug Treatment Program

Our experience at Congress has taught us that our sector — the Comprehensive Primary Health Care sector — has a very important role to play in building strong families. We are at the front line — every day of the week—in treating the ill health of our people. This means we have a very strong motive to *prevent* ill health in the first place. Our experience has led us to establish Target Family Support Services. The sector often does this in conjunction with Alcohol and Other Drugs programs.

But Alice Springs does not exist in isolation: the problems of Alice Springs extend into the region and the problems of the region are visited upon Alice Springs. We believe policies of rebuilding our families should be extended to all primary health care services in Central Australia.

Every Aboriginal health service delivery area with a minimum population of 3,000 people needs a social and emotional health team with psychologists, social workers, Aboriginal family support workers, Aboriginal AOD workers and case workers. Such a team will deliver a range of services for depression, anxiety and other mental health conditions, alcohol and other addictions, family therapy and case management and parental education and support through programs such as positive parenting (Triple P) and Parents under Pressure or PuP. The team will also be able to work with the community to undertake community development activities in accordance with each community's identified needs.

6.1 The Parents Under Pressure Program (PuP)

The Parents Under Pressure (PuP) program (Dawe et al 2003; Harnett & Dawe 2008) combines psychological principles relating to parenting, child behaviour and parental emotion regulation within a case management framework. The program is home-based and designed for families in which there are many difficult life circumstances that impact on family functioning. Such problems may include depression and anxiety, substance misuse, family conflict and severe financial stress. The program is highly individualised to suit each family. Parents are given their own Parent Workbook. For many parents, this becomes a personal journal of their treatment experience.

The overarching aim of the PuP program is to help parents facing adversity develop positive and secure relationships with their children. Within this strength-based approach, the family environment becomes more nurturing and less conflictual and child behaviour problems can be managed in a calm non-punitive manner.

The PuP program is intended to be delivered on a one-to-one basis, preferably in the family's home. A Therapist Manual provides the theoretical overview behind the PuP program and the Parent Workbook is given to the family and forms the basis of the treatment program. Modules contain many different exercises that help the parent work towards their own parenting goals. The Parent Workbook is seen as a buffet of options from which to choose rather than a rigid recipe to follow. The art of PuP therapy is to use the program creatively, acknowledging the unique needs and resources of each family.

Module 1: Assessment

The first module of the Parents Under Pressure program aims to identify the diverse problems families may be facing and help parents understand how these may be impacting on their parenting. In doing this a shared understanding of the family's current concerns, strengths and areas of difficulty is developed. This information is used to decide on priority target areas for change.

Module 2: Checking Out Priorities and Setting Goals

Module 2 of the Parents Under Pressure program provides feedback on the assessment, arrives at shared goals to work towards, and develops a way of monitoring progress towards goals. This module also looks at the potential involvement of partners or other carers in the PUP program.

Module 3: View Of Self as a Parent

Module 3 of the Parents Under Pressure program aims to help parents reflect on their view of themselves as parents.

Module 4: Managing Emotions When Under Pressure

The aim of Module 4 of the Parents Under Pressure program is to teach and encourage the use of emotional regulation, positive thinking, and self-soothing skills. A fundamental assumption of the PuP program is that the pressures parents face in their day-to-day lives impact on their ability to be effective in the parenting role. An important first step in emotional regulation is to recognise one's emotional state. A negative emotional mood state should be a signal to take some active steps to alter one's current emotional state. It is not realistic to promote a positive mood state when a person is under considerable and real stress. When this is the case, it is necessary to consider techniques that might minimise the distress associated with that situation. Distress tolerance skills are an important skill for parents to use when under pressure.

Therefore the module starts with exercises on recognising emotional states.

This module provides information on a range of strategies that help parents cope more effectively under pressure. These strategies are aimed at helping a parent either shift their immediate mood state or to develop a tolerance for an aversive mood state. Whilst a Cognitive Behaviour Therapy (CBT) model influences the program to some extent (it includes techniques such as muscular relaxation training, use of imagery, and other self-soothing activities) there is an emphasis on mindfulness-based strategies.

Mindfulness skills aim to help parents let go of any preoccupation with the worries of everyday life, at least for short periods of time. The mindfulness skill of refocussing the mind on the present moment and letting go of negative thoughts can, at times, help a person to shift from a severely negative mood state or feeling of anxiety, to one that is less overwhelming.

Promoting a healthy diet and regular physical exercise is an important factor in enhancing emotional well-being more generally.

Recommendation 7

That additional resources be provided to Congress to expand the Parents under Pressure (PuP) program which focuses on parenting, child behaviour and parental emotional

regulation within a case management framework in order to reduce the current waiting list and manage projected expanding demand.

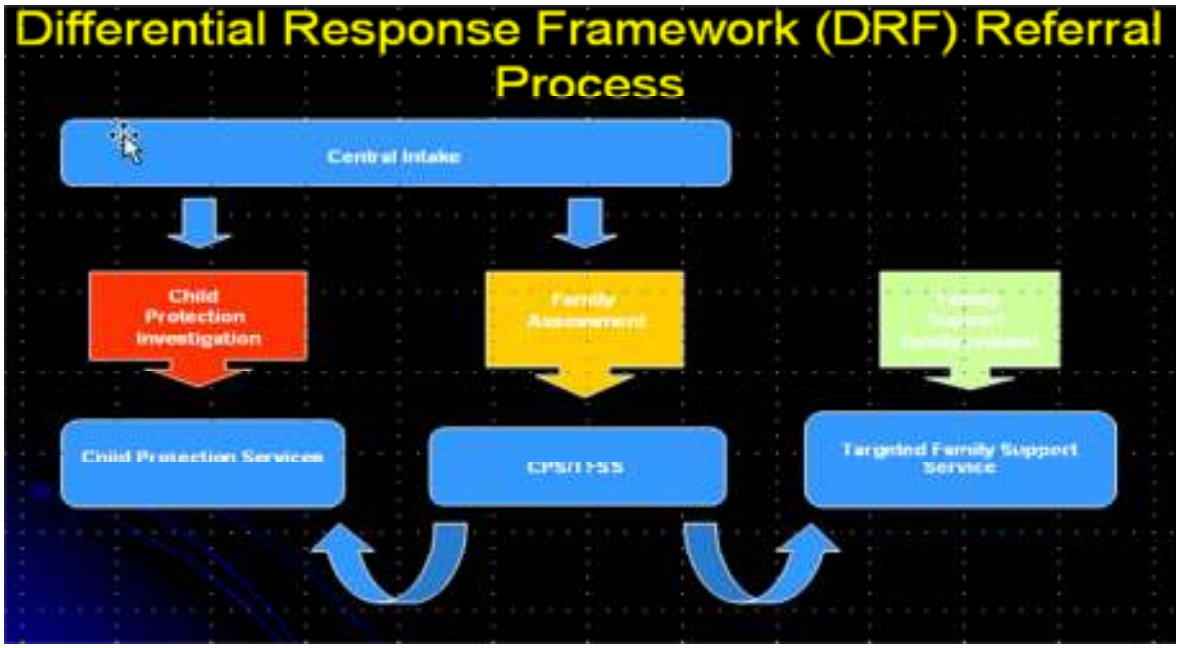
Recommendation 8

That all primary health care services throughout Central Australia be resourced to enable them to provide other Social and Emotional Well Being services including services for anxiety, depression, and other mental health conditions, alcohol and other addictions and family therapy.

That this be achieved by allocating current mental health funding according to need.

6.2 Targeted Family Support Service (TFSS)

Families with children not attending pre-school and school in spite of access to the two primary prevention programs we have just described (educational day care and nurse led home visitation) need access to an Targeted Family Support Service using a case management approach with social workers and Aboriginal case workers. Like home visitation, this is a core service that we think needs to become part of all Aboriginal community controlled health services. TFSS programs deal with medium to high risk clients in complex situations to help clients manage risks and keep them low.



A Differential Response Framework referral process is currently used by the NT government. Many clients are directed to a TFSS program through this process. The NT needs to adopt the Differential Response Framework [DRF] more broadly such as has been pioneered in Victoria and for which there is now evidence of its effectiveness.

Basically the DRF means that referrals made to NTCaF can lead to different responses based on the assessment at Central Intake. Some responses will require a formal Child Protection Investigation and possibly statutory intervention. Others require a family assessment conducted by the Child Protection Service itself. Still others can be referred from NTCaF to

an Aboriginal community controlled organisation. In our view this should always be an ACCHS, for an assessment within a Targeted Family Support Service. Clients would be high needs families whom NTCaF intake has decided do not need intervention from the Child Protection Service but need assessment from a community based provider without the stigma of the CPS getting in the way. Once these families are further assessed, they may then need to be referred back to the CPS but more often they can be well supported by the TFSS itself.

Finally, the TFSS can take referrals directly from the community. The community is the fastest growing referral source for the Congress TFSS which currently is case managing 52 families with a waiting list for others. Key aspects of the TFSS service at Congress are that it:

- is located in a Social and Emotional Well Being Service along with a community well being team, the Safe and Sober alcohol treatment program and the youth program;
- is co-ordinated by a highly skilled and very experienced child protection social worker; and
- employs 3 Social Workers and 3 Aboriginal case workers and a Community Based Child Protection Worker.

The Structured Decision Making assessment tool used by TFSS is a carefully validated tool that assesses families in 11 key areas and allows the service to prioritise client needs. Importantly, whichever tool is used, alcohol and other drug use has been shown to be the most important determinant of child neglect. Therefore, if there is a problem in this area, the AOD problems are addressed first.

A snapshot of closed cases from the TFSS show the following outcomes:

- Children exposed to DV, child neglect – assessment completed and goals identified but situation deteriorated further and children were placed in care;
- Child neglect, social failure to thrive – assessment completed and goals identified. Children placed in care for a period and returned after significant improvement in child health. Family self referred back to TFSS following closure with NTCaF;
- Child behavior issues – TFSS successfully engaged family and school in agreed plan to address issues. Suspensions ceased and child doing well at school; and
- Child medical neglect, school issues – medical issues addressed, TFSS successfully engaged family and school in agreed plan to address issues. Children doing well.

This is a service that is making real inroads into the very adolescent and family issues that are currently in the media spotlight. (Guenther et al 2009)

Recommendation 9

That all primary health care services in Central Australia be resourced to establish a Targeted Family Support Service (TFSS) to meet the need as part of a broader social and emotional well being service to families identified as high needs.

6.3 Alcohol and Other Drugs Treatment Program

Congress supports the Alcohol and Other Drugs/Mental Health AMSANT service model. This is an innovative ambulatory alcohol treatment model based in an existing primary health

care service. The minimum requirement in every primary health care service for such as service is for two additional positions: a therapist (psychologist or accredited social worker) and an AOD worker, to work alongside the existing GP service, remote area nurses and AHWs. Such staffing allows the essential three streams of care approach as outlined in the AMSANT service model: psychological therapy, social support and pharmacotherapies. The Safe and Sober Support Service currently run by Congress is based on this model.

Substantial new funding is needed for increased alcohol treatment and rehabilitation services in regional centres and in remote communities. We believe the cost would be in the vicinity of an additional $18 million per annum based on applying the Congress model (currently operating in Alice Springs) across the whole of the NT. The Congress program aims to intensively treat at least 320 people with a further 180 people engaged in less intensive treatment. The projections for this figure are based on the following assumptions:

- There are 5000 Aboriginal people age 15 yrs & over in Alice Springs and there are an additional 400 12-15yr olds
- 25% adults drink at unsafe levels based on health screening done through the Congress clinic on over 3000 Aboriginal people over the age of 15 in 2008 and 2009. This means 1250 of the original 5000 need alcohol treatment. We further assumed that 15% of 12-15yo, or 60 people, would need treatment
- Based on the rate of voluntary engagement with the "Grog Mob" treatment program over 18 months we then assumed that only 20% of these 1250 people over the age of 15 would intensively engage in treatment, 250 people and higher for 12-15yr olds.
- We then assumed 20% of these will stop drinking and 60% will reduce their drinking.
- We then added an estimate additional number of referrals from mandated treatment through the alcohol court as well as gaoled referrals
- Finally we included 10% of the 2000 Aboriginal visitors to Alice Springs
- The outcome projected is that at least 500 clients will engage in treatment each year.

Based on similar projections, including the additional treatment requirement from both the new Smart Court and the Alcohol and Other Drug Tribunal, a broader program will be needed to treat an additional 4500 people a year across the NT for a total of 5000 people in treatment each year. The cost is an additional $18 million for ambulatory treatment alone funded through all of the existing primary health care services.

Treatment services need to be located within and co-ordinated as part of the primary health care system in order to avoid confusion, waste and duplication. Co-location also allows relative ease of access, case management and follow up. Alcohol-dependent people need to engage with treatment for at least 1 year and in many cases 2 years. In the case of Aboriginal drinkers, the preferred model is to place treatment services within Aboriginal primary health care providers. The Department of Justice has been provided with details of the Safe and Sober Support Service model.

Recommendation 10

That the introduction of the Substance Misuse, Assessment and Referral for Treatment (SMART) Court and the Family Responsibilities Commission (FRC) only go ahead for remote

communities if adequate funding is secured for alcohol and other drug treatment services based on the Safe and Sober Support Service model located within all primary health care services and not only the 20 growth towns.

That the level of treatment services in Alice Springs which is sufficient at present for the FRC to go ahead, be reviewed once it is clear how much the FRC increases demand.

Youth Services

It *is* possible to turn around the lives of young people who have disengaged from school, are on the streets late at night and are involved in petty crimes. However, it is time consuming, resource intensive and not always successful. That is why we must also focus on the types of preventative programs already discussed. However, we also need to try to address the needs of the young people who have not had the benefit of these programs and services up to now.

There are currently a large number of youth services in Alice Springs. In spite of this, very few services provide the type of intensive case management of families needed to make a real difference in the lives of young people who are getting into trouble with the police, disengage from school and get into alcohol and other drugs. To make a real difference in the lives of these young people we need case management services, including Multisystemic Therapy, for those with the highest needs.

Multisystemic Therapy ("MST") (Henggeler et al 2009, Day et al 2010) is an intensive family- and community-based treatment program which focuses on the entire world of chronic and violent juvenile offenders: their homes and families, schools and teachers, neighbourhoods and friends. MST works with the toughest offenders. They are adolescents, male and female, between the ages of 12 and 17 who have long arrest histories. Key features of MST are as follows:

- MST clinicians go to where the young person is and are on call 24 hours a day, seven days a week
- They work intensively with parents and caregivers to put them in control
- The therapist works with the caregivers to keep the young person focused on school and gaining job skills
- The therapist and caregivers introduce the young person to sports and recreational activities as an alternative to hanging out

MST has been proven to work and produce positive results with the toughest kids. It blends the best clinical treatments—cognitive behavioural therapy, behaviour management training, family therapies and community psychology to reach this population.

After 30 years of research and 18 studies, MST repeatedly has been shown to:

- Keep kids in their home, reducing out-of-home placements up to 50 percent
- Keep kids in school
- Keep kids out of trouble, reducing re-arrest rates up to 70 percent
- Improve family relations and functioning
- Decrease adolescent psychiatric symptoms

- Decrease adolescent drug and alcohol use

Recommendation 11

That all youth services in Alice Springs be reviewed to ensure there is an appropriate mix of after-hours, early intervention and referral services as well as the necessary intensive case management service model (including Multisystemic Therapy – MST) for the most high needs young people and their families.

7. Alcohol Supply Reduction

The effect of grog on our people, our communities and our families is old news. It confronts us in our every waking hour. It is, unfortunately, also old news that solutions, especially in the area of supply reduction, have been around for many years. Governments have seemed unable to act. This must change. There are encouraging recent movements, with the NT Branch of the Australian Hotels Association, among others, now supporting reduction tools such as an alcohol floor price.

7.1 An Alcohol Floor Price at the Price of Beer

The evidence that price is the most important and effective determinant of population alcohol consumption is now beyond dispute (Barbor et al 2003, Coghlan 2008; WHO 2009; Lancet 2009; Purshouse et al 2010). This evidence has been confirmed in the NT with the 2002 Alice Springs alcohol restrictions (Hogan et al 2006). The recent report of the *National Preventative Health Taskforce* provides further support:

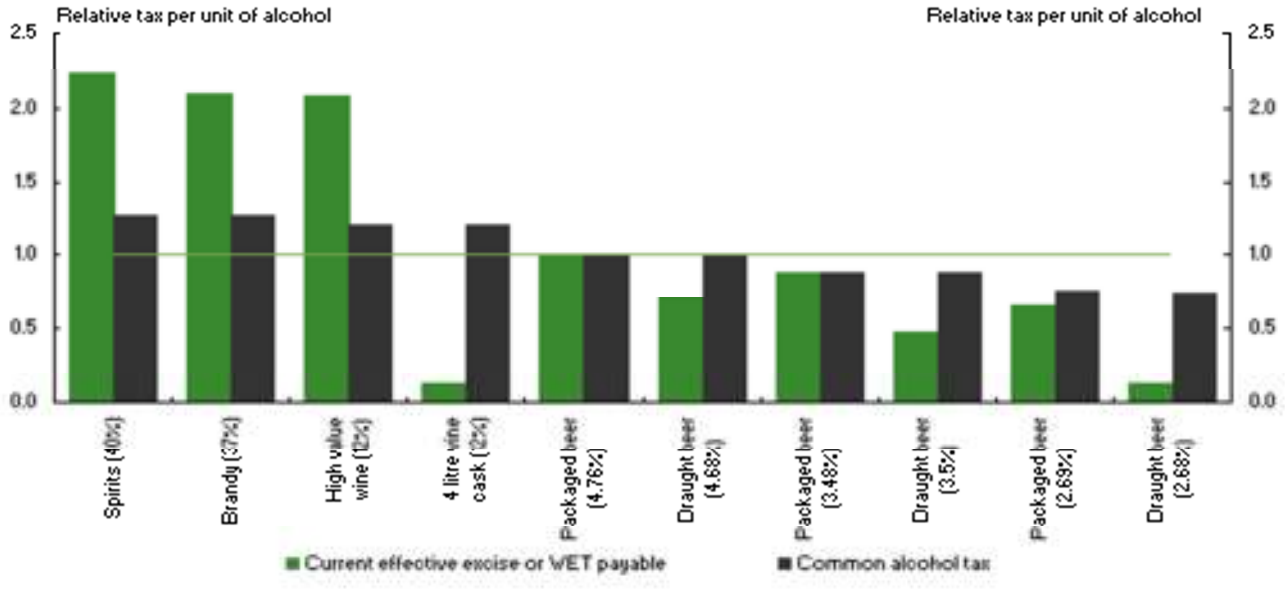
> *The price of alcohol clearly impacts on consumption patterns. Australian and international studies confirm that when alcohol increases in price, consumption is reduced… in other words, policies that raise the price of alcoholic beverages are an effective means of reducing alcohol consumption. In addition, studies have shown that price increases reduce problems due to alcohol, including binge drinking and a variety of alcohol-related harms (for example, motor vehicle accidents, cirrhosis mortality and violence).* (Australian Government 2010: 253)

It is also clear that increasing the price of alcohol specifically targets the two groups that most need greater protection – heavy drinkers and young people:

> *Heavy drinkers and young binge drinkers are least able to afford the increased costs, Anderson says, so making drink expensive has the strongest effect on the people whose drinking is most damaging.* (Coghlan: 2008)

Unfortunately, it has been assumed by many for many years that the only or best public policy to act on this evidence is a volumetric tax on alcohol. Volumetric tax has been proposed at the Commonwealth level since the development of the 1987 draft national policy on alcohol yet it has still not been implemented and can only be implemented by the Federal government.

It has been recommended on many people on many occasions through many national reports, most recently in the Henry Taxation Review (Australian Government 2009) and was supported by the report of the Preventative Health Task force last year. The main problem is that the current tax system makes cheap, lower quality alcohol such as cask wine and port relatively inexpensive. The table below from the Henry Tax Review reveals the tax levels for 4 litre cask wine:



As could be expected, there is extensive political opposition to the implementation of a volumetric tax, especially from the cheap wine industry lobby which has significant political power in marginal electorates. Opposition to volumetric taxation has meant that successive federal governments of both political persuasions have not implemented the tax over more than 20 years. However, it is also the case that a volumetric tax will increase the price of bottled wine at a level that affects many responsible drinkers – the $10 to $12 mark. Such a tax increase is thought to be electorally very unpopular and has thus contributed to federal inaction on the issue.

Congress supports the introduction of a volumetric tax on alcohol at the Federal level and deplores the lack of action. However, we do not think it is acceptable for the Northern Territory government to delay taking immediate action on price given there is an alternative which is at least as effective and is more tightly targeted at the heaviest drinkers. We refer here to a minimum price benchmark or floor price (Hogan et al 2006; Lancet editorial 2009; Pursehouse et al 2010; Australian Government 2009).

It is not necessary to look internationally to see how effective the floor price mechanism is – it was seen working to ill effect in the 2002 Alice Springs alcohol restrictions. On March 1, 2002 a trial of liquor restrictions was introduced in Alice Springs. Among other measures, restrictions included a ban on 4 and 5 litre cask wine - but importantly not on 2 litre port which sells at around the same price, that is, at 30 cents per standard drink.

Even though the alcohol industry claimed that people drink according to taste and not price and therefore they would not shift to port, the result of the restrictions was a 1000% shift to 2 litre port and no net change in consumption of pure alcohol. That is, t*he lowest price completely determined consumption.*

In addition, over this period, alcohol-caused hospital admissions increased especially for acute pancreatitis which was a direct result of the increased consumption of “monkey blood”. Access to cheap alcohol cannot be allowed to occur on an NT-wide basis. It would be irresponsible in the extreme and may well lead to successful court action against the NTG by a person who acquires pancreatitis from drinking 2 litre port.

Below is a table from the evaluation report on the 2002 Alice Springs alcohol restrictions done by Dr Ian Crundall and Chris Moon in 2003. It clearly shows the drop that occurred in the sale of cask wine and the corresponding increase that occurred in the sale of 2 litre port:

> *"….. that the most notable shifts in beverage preference were between cask wines that were restricted as part of the trial and fortified wines. While the market share of the former dropped over 20% [ie. From 24.6 to 4.0 per cent], the latter increased its share by 19.2% [ie.from 2.3 to 21.5 per cent]" (2003:3).*

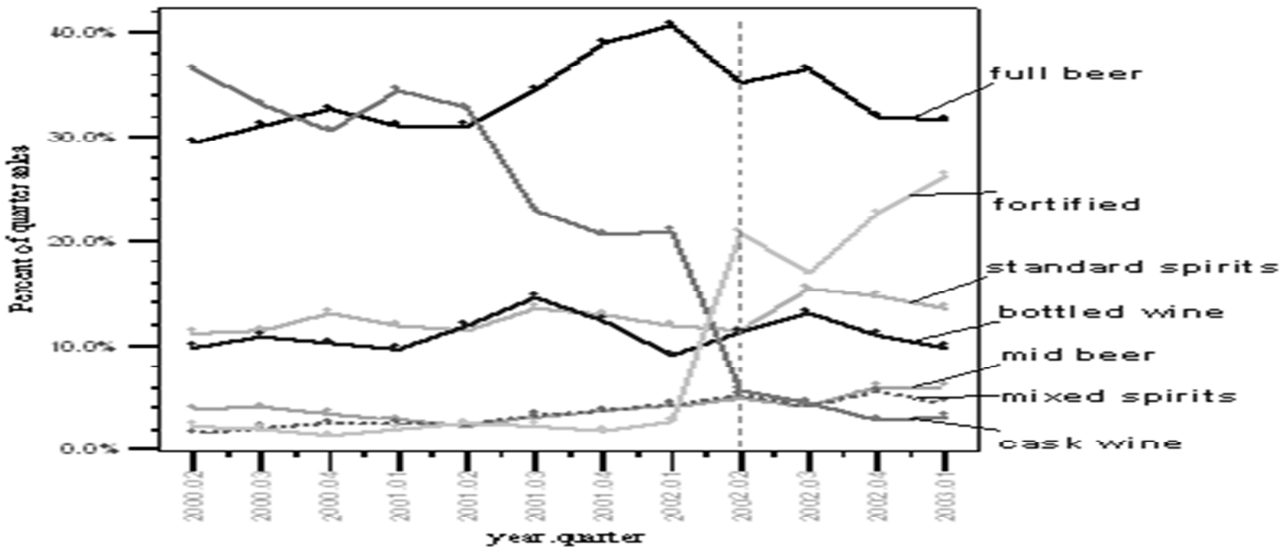


Figure 1: Market Share of Selected Beverage Types by Quarter

Table 2: Wholesale Sales and Market Share by Beverage Type
(litres of absolute alcohol)

Beverage	Pre-Trial		Trial	
	Litres	% of market	litres	% of market
Cask Wine	109,815	24.6	18,725	4.0
Bottled Wine	53,905	12.1	53,098	11.3
Fortified	10,351	2.3	101,209	21.5
Cider	5,853	1.3	5,169	1.1
Spirits (standard)	55,381	12.4	64,661	13.7
Spirits (mixed)	15,087	3.4	22,955	4.9
Full Strength Beer	160,373	36.0	159,285	33.9
Mid Strength Beer	14,679	3.3	24,832	5.3
Light Beer	20,645	4.6	20,491	4.4
Total	446,089	100.0	470,782	100.0

Table 2 shows the amount of absolute alcohol sold as various beverages for the trial and the twelve months before. The overall change in sales comprised increase and decreases across different beverages. Sales of cask wine decreased by 82.9%. Sales of fortified wine, on the other hand, multiplied by a factor of nearly ten. Mid-strength beer sales increased by 69.2% while mixed spirits

As a result of the ten fold increase in the sale of 2 litre port the graph below shows that there was no net change in the sale and consumption of pure alcohol, Harms were therefore not significantly reduced.

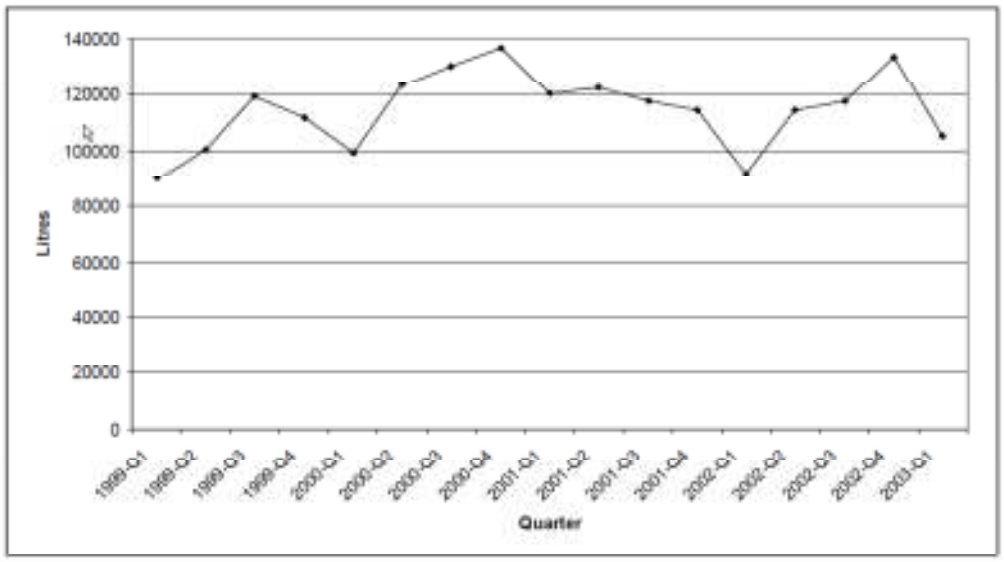


Figure 11: Quarterly wholesale sales of pure alcohol, Alice Springs, January 1999 – March 2003

Over the 2002 period, there was actually an increase in alcohol caused hospital admissions as shown in the table below:

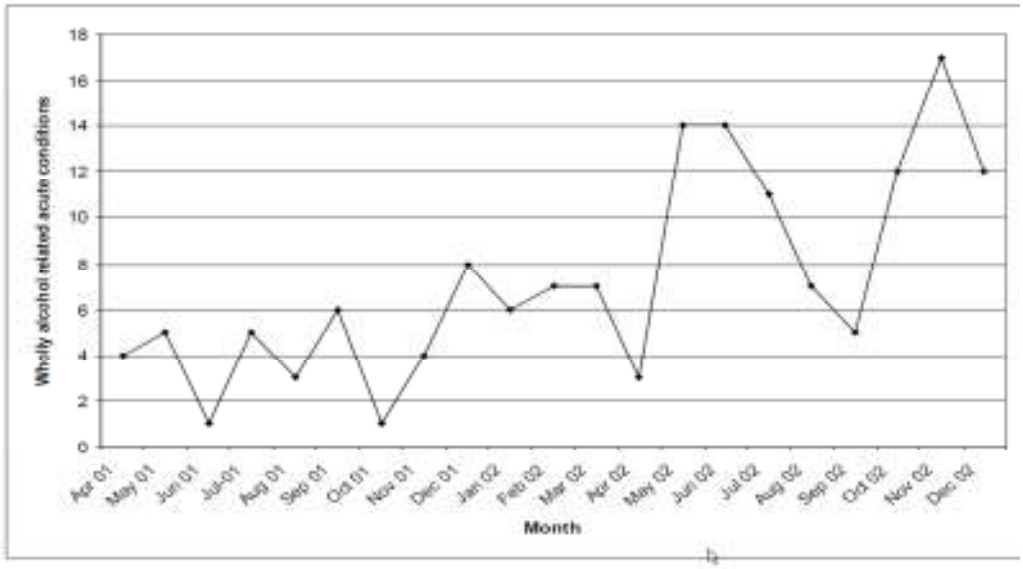


Figure 10: Wholly alcohol-related acute admissions to Alice Springs Hospital, April 2001 to December 2002

The Crundall report (2003) explained the increase:

> *There were more presentations with pancreatitis and various gut disturbances than previously, resulting in more in-patient admissions. These observations are consistent with the report data showing decreases in assault related presentations to ED and increases in acute separations. The Director attributed these changes to the restriction on container size and the increase in fortified wine consumption, speculating that consumption of a beverage with higher alcohol (possibly over shorter periods of time) allows less opportunity for assault but leads to the medical complications seen. (Crundall and Moon: 2003:24)*

In a paper published in the Drug and Alcohol review Hogan et al (2006) concluded:

The trials adds substantial new evidence to the strength of the relationship between alcohol price, consumption and harm as the restrictions led to a 1000% increase in the sale of the cheapest form of alcohol—2-litre port. Recent proposals for supply reduction strategies such as a tiered volumetric tax on alcohol and a trial of alcohol restrictions based on a minimum price benchmark demand further consideration by policy makers, especially in regions marked by a excessive alcohol consumption and a high burden of alcohol-related harms such as Alice Springs.

The 2006 Alice Springs restrictions were, as a result, carefully designed around the concept of a minimum price for alcohol of around $1 per standard drink between 2pm and 6 pm and 50 cents per standard drink after 6pm (due to the continued availability of 2 litre wine). The large shift to beer occurred because beer is the cheapest form of alcohol up to 6pm. As the minimum price increased 3 fold, there was a large reduction in the consumption of pure alcohol. The 2006 restrictions, at their peak, led to an 18% decline in the sale and consumption of pure alcohol as in the following:

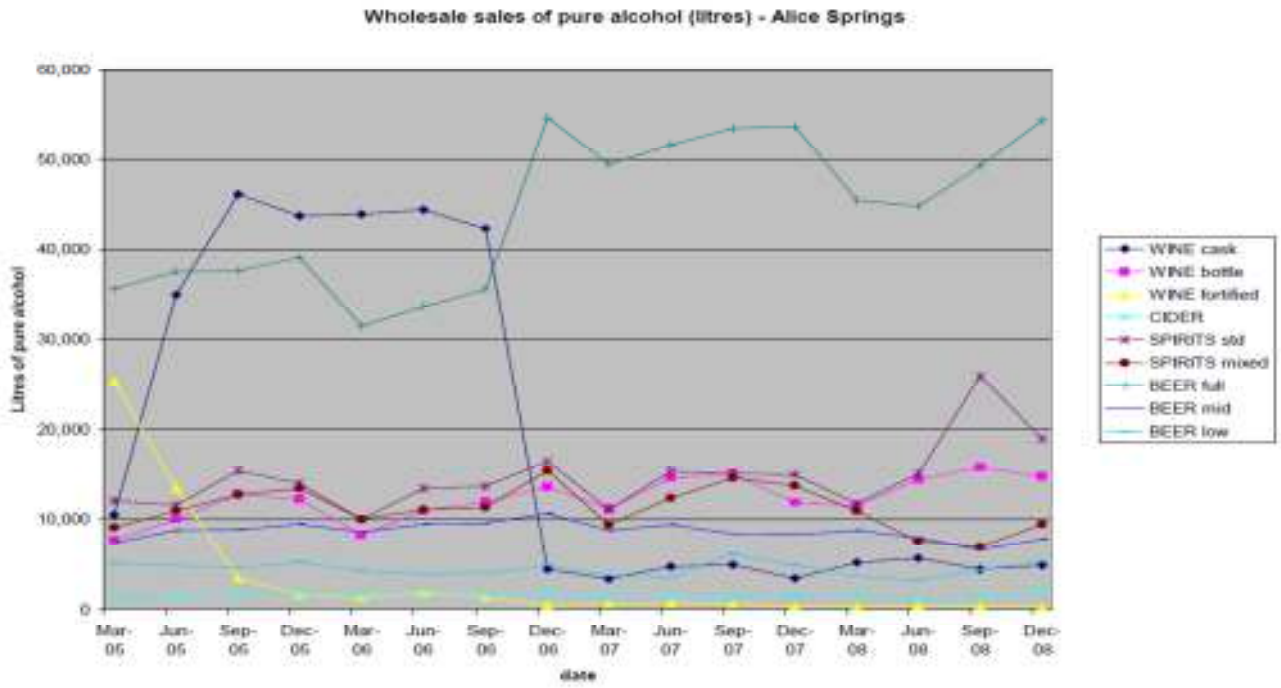


Figure 8.1: Wholesale sales of pure alcohol – Alice Springs

The above data provides further evidence of the paramount importance of price in determining consumption.

Regrettably, some heavy drinkers are now waiting until 6 pm to buy 2 litre wine – and this urgently needs to be addressed by the introduction of a floor price. Unfortunately, as there is not a legislated floor price, the alcohol industry continues to replace one form of cheap alcohol with another. The alcohol industry has had a sustained focus on cheap wine sold in casks in the NT but cheap alcohol in bottles in now available. For example, bottled red wine is being sold at times as cheaply as $1.99 a bottle – cheaper than a can of coke. At this price, the pure alcohol is as cheap as the alcohol in 4 and 5 litre casks and, unsurprisingly, there has been a significant shift to cheap bottled wine in the last 12 months in Alice Springs.

The cheapness of alcohol (both in bottles and casks) is seriously undermining the minimum price mechanism of the original restrictions and as a result alcohol consumption is on the rise again in Alice Springs (Department of Justice 2010). Consumption is now only about 15% lower than it was before the restrictions were introduced. A recent study has revealed the impact of removing cheap wine from the market in France where there has been a 10 fold reduction in alcohol-caused mortality from liver cirrhosis over the past 30 years (Sheron et al 2011).

There are proposals that the problem of cheap liquor availability be dealt with through the development of "voluntary accords" with the Liquor Industry. While this approach may once have had merit, it is taking far too long to implement and given the current social concerns there is a need for immediate action.

Congress believes that it is necessary to amend the NT Liquor Act to empower the Licensing Commission to impose a floor price set at the price of full strength beer. We cannot allow cheap alcohol to be sold anymore - it is doing too much harm.

Recommendation 12

That the *Liquor Act NT* be amended at s31(2) to empower the Licensing Commission to determine liquor licence conditions with respect to the charging of a particular price for liquor including a floor price.

That the Licensing Commission then be instructed to set a floor price at the price of full strength beer.

7.2 Alcohol take away free day linked to Centrelink payments

An alcohol take-away free day linked to Centrelink payments was implemented in Tennant Creek in 1995 and removed on July 1 2006. In the 1998 evaluation done by the NDRI it was found that the population consumption of pure alcohol had reduced by 20% although it was not possible to quantify the exact contribution of the ban on take-aways on Thursdays as other significant measures were also put in place.

At the time of its removal in 2006, it was widely accepted that the ban on take-away alcohol on Centrelink payment days was less effective than it had been initially. One of the principal reasons was that many people had moved their Centrelink payments away from Thursday to other days of the week. However, in spite of this, when the ban was removed in 2006, Tenant Creek saw a 7% increase in the sales and consumption of pure alcohol:

> *In 2006-07, following revocation of the Thirsty Thursday restrictions, total supplies of alcohol to outlets in Tennant Creek increased by 7.5% over the preceding year. The increase was accounted for entirely by supplies to the hotels and liquor merchant, which together increased their combined market share from 75.5% to 80.3%.*(D'Abbs et al 2010:8)

It can therefore be reasonably assumed that this one measure, if fully linked to Centrelink payments and on a day of very high take away alcohol sales such as Thursday, could reduce population alcohol consumption by about 10%. Such an initiative would make a very large contribution to harm reduction in the NT for only a small amount of pain for most people.

Recommendation 13

That there be one day per week on which take-away alcohol is banned and that day be linked to the day on which Centrelink payments are made.

That this day on which take-away alcohol is banned should be on a high volume alcohol consumption day such as Thursday.

8. The Stop the Violence Campaign

Stop The Violence - the march up Gap Road to the Council lawns
(http://media.crikey.com.au/wp-content/uploads/2010/09/stopviolence.jpg)

Much has been made of the violence that afflicts our communities, and this paper discusses at least one of the causes — grog — in some detail above.

However, violence as a community problem can only be solved by the community, and involves a major culture shift. At Congress, Ingkintja Men's Health continues to play a critical role in this important task — a task we firmly believe needs greater recognition and support.

Delegates from the 2010 STOP THE VIOLENCE workshop have said, "violence of any type is not acceptable. This is not our culture". They formed a committee to direct and drive a campaign forward to give people the skills and knowledge to bring about change.

Worla Nyintanti Atwerrentye Itja is a mix of Western Aranda, Central and Eastern Arrentre meaning “Live together stop the violence”. This logo is understood by Aboriginal people.

Explanation

> *The top group are our Elders, the middle our leaders, the bottom the parents. The row across the bottom are our children. The lines between groups are the lines of communication. Without that communication flowing backwards and forwards culture cannot be strong and deal with issues. As explained by the elders those lines of communication have been broken due to substance misuse, incarceration and violence. This campaign is about strengthening those lines of communication*

We need to develop a violence reduction, conflict resolution and cultural brokerage training program for Central Australia. We need a Central Australian-specific curriculum to be developed to provide training for males to equip them with the skills, knowledge attitudes and motivation to change their own behaviour if they are violent. They also need to be able to implement violence reduction, conflict resolution and cultural brokerage strategies in their home community, town camps and jails.

In addressing workshops, rallies and meetings over the past six months, it is the experience of Ingkintja staff that increasingly people want solution as to how they can make change. Through developing and workshopping a culturally appropriate training module that people can relate to with a sense of ownership, in their own community and providing a peer support program and through better usage of current service providers we believe we can make real advances in dealing with violence.

The overall aim of the program is to provide a safer, healthier environment for families and community members. We propose doing this through assisting people to develop the skills, knowledge, attitudes and motivation to make behavioural changes that reduce violence of any form, while providing support through service providers and a peer support group to encourage those behavioural changes.

The objectives of the proposed program include:

- Providing individuals with the knowledge of what is violence, nine types of violence were identified at the STOP THE VIOLENCE Workshop;

- Providing communities and individuals with skills, knowledge and support to make behavioural changes, through STOP THE VIOLENCE workshops in remote communities, town camps and Ingkintja;
- Facilitating an intergrated approach to provide additional help and support through identifing service providers working in communities and in town, and the development of a community peer support network' and
- Providing assesment, brief interventions and referral for ongoing counselling services for individuals, groups and families through Ingkintja psychologists and other agencies such as Relationships Australia.

Darren Hayes from Santa Teresa community at the front of the march (http://media.crikey.com.au/wp-content/uploads/2010/09/stopviolence2.jpg)

Recommendation 14

That the Stop the Violence Campaign undertaken by Ingkintja (Male Health Branch) at Congress is funded over 3 years to develop and implement a violence reduction, conflict resolution and cultural brokerage training program for Central Australia.

10. Adult Literacy Campaign

In addition to the focus on early childhood as a means to improve education, we need a focus on improving the literacy levels of adults. Societies which have seriously reduced levels of educational inequality have tended to be those where attention has also been paid to non-formal adult education, and particularly to achieving substantial reductions in adult illiteracy. Success in reducing adult literacy has been a feature of those societies said to have taken the 'low road' to health (e.g. Cuba, Costa Rica and the state of Kerala in India). More recently, successful mass literacy campaigns have significantly reduced educational inequality in Venezuela, Bolivia, India and Ecuador in the last ten years. It is worth noting that these countries all have large indigenous minority populations who benefited from these campaigns.

In 2009 the Cooperative Research Centre for Aboriginal Health (CRCAH), now the Lowitja Institute, sponsored a workshop in Alice Springs that examined the relationship between adult literacy and health. It looked at the international experience of the impact of Adult Literacy Campaigns, and the details of how they were conducted to optimise success. The workshop participants, who included a significant number of Aboriginal health and education leaders, were enthusiastic about exploring ways in which such Campaigns might be conducted in Aboriginal Australia. There was unanimous agreement on the need to research, deliver and evaluate a pilot Aboriginal Adult Literacy Campaign with Aboriginal communities in a small number of selected regions; while at the same time undertaking a parallel research project to measure the impact of the pilot Campaign on health development. This pilot project would establish whether or not government should be asked to undertake a national Aboriginal Adult Literacy Campaign.

The Workshop established an Aboriginal Adult Literacy Coalition Steering Committee and a Technical Group to further develop the project. It was agreed that the project would be conducted from Murrup Barak (Institute for Indigenous Partnerships) at Melbourne University headed by Prof Ian Anderson and be led by Professor Marcia Langton.

It should be noted that the term "Campaign" refers to an Adult Literacy Campaign. This is internationally recognised terminology referring to a fairly prescribed process of addressing adult illiteracy and involves three phases:

- Mobilisation – ensuring maximum involvement of targeted populations
- Literacy Classes – intensive over maximum of 15 weeks
- Post Literacy activity to consolidate literacy gains

Mass adult literacy campaigns are a necessary supplement to, not a replacement for, the drive to improve school retention and completion. Neither strategy of itself will significantly reduce educational inequality. At present however, the vast bulk of policy intervention and public investment is going to the formal education aspect of the problem.

Long term outcomes of a project to address adult literacy include improved health outcomes, especially for children. Parents would be better able to read to their children and converse at home using more complex language which better promotes brain development. In addition to this, they would be able to make better choices about when to utilise health and other services to maintain and promote the health and well being of their children. This includes a greater commitment to ensuring that their children attend school regularly from

pre-school onwards. Finally, improved literacy would enhance the leadership capacity in community organisations and in engagement with governments and other agencies

Recommendation 15

That an adult literacy campaign be established as a research project in Alice Springs and surrounding communities through the Murrup Barak Institute based on the 2009 proposal to the Lowitja Institute.

Summary of Recommendations:

Recommendation 1

That the current social concern be used as an opportunity to:

c) explain to the Alice Springs community that the positive new programs, services and infrastructure which have been put in place as part of the Alice Springs Transformation Plan have not yet had time to have their full effect; and

d) renew efforts to implement the types of evidence based-policy proposals that are going to further improve the social situation in Alice Springs in the short, medium and long term.

Recommendation 2

That the proposed Alcohol and Other Drugs Tribunal be converted to a Family Responsibility Commission (FRC) modelled on that operating in Cape York, Queensland under the *Family Responsibilities Commission Act (2008)* and that the FRC operate in the following way:

g) an appropriately qualified commissioner be appointed to head up the FRC and two community leaders or respected elders as commissioners on each tribunal hearing;

h) the Commissioners would be the most appropriate ones for the family being considered chosen from the total pool of Commissioners from all over Central Australia;

i) eligibility for appointment of the head commissioner to be as defined by the *Family Responsibilities Commission Act (2008)* (section 17):

"(a) the person is lawyer if at least 5 years standing; and (b) the minister considers the person has an appropriate understanding of the history and culture of Aboriginal and Torres Strait Islanders; and (c) the minister considers the person has (i) appropriate experience in mediation or alternative dispute resolution; or (ii) other knowledge or experience making the person appropriate to be the commissioner or deputy commissioner."

j) there be an equal partnership between all commissioners as there is in the FRC;

k) where an Aboriginal person is before the FRC the commissioners should be respected Aboriginal elders and where there is a non Aboriginal person they should be respected non Aboriginal elders; and

l) that the FRC be seen as a means of *empowering our community* and giving greater control to Aboriginal people through being active participants in re-establishing acceptable social norms.

Recommendation 3

That community members be able to make *anonymous referrals* to the FRC to diminish the negative consequences which may arise from a referral for the referring individual.

That referrals be able to be made before a crime is committed to encourage intervention at an earlier and more effective point.

Recommendation 4

That the Olds “Nurse-Family Partnership” Program of home-visitation for new mothers be rolled out across all communities in Central Australia as an early intervention strategy to improve the health and social functioning of low-income mothers and their babies.

Recommendation 5

That high-quality child-care centres be established for all children aged 1 to 3 from disadvantaged households in Alice Springs and surrounding communities.

That these centres implement the Carolina Abecedarian early-intervention approach to build school readiness and maximise potential for positive educational and social outcomes in young adulthood.

That these children transition into 2 years of pre-school.

Recommendation 6

That supported accommodation services be established in different ways in different localities in and around Alice Springs.

That consideration be given to the creation of some town camps as gated communities as well as the establishment of more supported accommodation facilities throughout the town.

That supported accommodation be built to target the special needs of young people, the mentally ill and men who are violent separately.

Recommendation 7

That additional resources be provided to Congress to expand the Parents under Pressure (PuP) program which focuses on parenting, child behaviour and parental emotional regulation within a case management model in order to reduce the current waiting list and manage projected expanding demand.

Recommendation 8

That all primary health care services throughout Central Australia be resourced to enable them to provide other Social and Emotional Well Being services including services for anxiety, depression, and other mental health conditions, alcohol and other addictions and family therapy.

That this be achieved by allocating current mental health funding according to need.

Recommendation 9

That all primary health care services in Central Australia be resourced to establish a Targeted Family Support Service (TFSS) to meet the need as part of a broader social and emotional well being service to families identified as high needs.

Recommendation 10

That the introduction of the Substance Misuse, Assessment and Referral for Treatment (SMART) Court and the Family Responsibilities Commission (FRC) only go ahead for remote communities if adequate funding is secured for alcohol and other drug treatment services based on the Safe and Sober Support Service model located within all primary health care services and not only the 20 growth towns.

That the level of treatment services in Alice Springs which is sufficient at present for the FRC to go ahead, be reviewed once it is clear how much the FRC increases demand.

Recommendation 11

That all youth services in Alice Springs be reviewed to ensure there is an appropriate mix of after-hours, early intervention and referral services as well as the necessary intensive case management service model (including Multisystemic Therapy – MST) for the most high needs young people and their families.

Recommendation 12

That the *Liquor Act NT* be amended at s31(2) to empower the Licensing Commission to determine liquor licence conditions with respect to the charging of a particular price for liquor including a floor price.

That the Licensing Commission then be instructed to set a floor price at the price of full strength beer.

Recommendation 13

That there be one day per week on which take-away alcohol is banned and that day be linked to the day on which Centrelink payments are made.

That this day on which take-away alcohol is banned should be on a high volume alcohol consumption day such as Thursday.

Recommendation 14

That the Stop the Violence Campaign undertaken by Ingkintja (Male Health Branch) at Congress be funded over 3 years to develop and implement a violence reduction, conflict resolution and cultural brokerage training program for Central Australia.

Recommendation 15

That an adult literacy campaign be established as a research project in Alice Springs and surrounding communities through the Murrup Barak Institute based on the 2009 proposal to the Lowitja Institute.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