

Case study of a decolonising Aboriginal community controlled comprehensive primary health care response to alcohol-related harm

Toby Freeman,¹ Fran Baum,¹ Tamara Mackean,¹ Anna Ziersch,¹ Juanita Sherwood,² Tahniah Edwards,³ John Boffa³

Both Aboriginal and Torres Strait Islander peoples' use of alcohol and policy responses to address it are linked to Australia's history of colonisation.¹ While Brady has documented pre-colonisation Aboriginal and Torres Strait Islander use of fermented, intoxicating drinks including those made from pandanus plants, banksia cones, and coconut tree buds,² European settlers brought with them the practice of heavy drinking² and used alcohol as wages and to control and trade with Aboriginal and Torres Strait Islander people.³ When heavy drinking by Aboriginal and Torres Strait Islander people began to produce visible harms, the Europeans prohibited the supply of alcohol to Aboriginal and Torres Strait Islander people.² Langton⁴ recounts how the Europeans constructed the colonial stereotype of the "drunken Aborigine", and prohibited alcohol to Aboriginal and Torres Strait Islander people out of fear, exempting those who did not live in camps and mixed with "good" company.² This prohibition was repealed between 1957 and 1972 in different states and territories.² While, among Aboriginal and Torres Strait Islander people who drink, a higher proportion drink at risky levels than non-Indigenous people^{5,6} and disproportionately suffer from alcohol-related harms including violence, hospitalisations and death,^{6,7} the context around this disparity is vitally important.⁸ Colonisation is a root cause, or underpinning social determinant of health

Abstract

Objective: This paper provides a case study of the responses to alcohol of an Aboriginal Community Controlled Health Service (The Service), and investigates the implementation of comprehensive primary health care and how it challenges the logic of colonial approaches.

Methods: Data were drawn from a larger comprehensive primary health care study. Data on actions on alcohol were collected from: a) six-monthly service reports of activities; b) 29 interviews with staff and board members; c) six interviews with advocacy partners; and d) community assessment workshops with 13 service users.

Results: The Service engaged in rehabilitative, curative, preventive and promotive work targeting alcohol, including advocacy and collaborative action on social determinants of health. It challenged other government approaches by increasing Aboriginal people's control, providing culturally safe services, addressing racism, and advocating to government and industry.

Conclusions: This case study provides an example of implementation of the full continuum of comprehensive primary health care activities. It shows how community control can challenge colonialism and ongoing power imbalances to promote evidence-based policy and practice that support self-determination as a positive determinant for health.

Implications for public health: Aboriginal Community Controlled Health Services are a good model for comprehensive primary health care approaches to alcohol control.

Key words: alcohol drinking, primary health care, social determinants of health, colonisation, racism

for Indigenous peoples, providing the social and political context that drives inequities in the intermediate and proximal determinants of health such as education, health and other systems, employment, housing, interpersonal and institutional racism, discrimination and alcohol use.⁹⁻¹¹ There is a large shortfall in alcohol treatment services for Aboriginal and Torres Strait Islander people,¹² and extensive unmet needs for wider social and emotional wellbeing services.¹³

Alcohol-related harms among Aboriginal people are particularly prevalent in the Northern Territory (NT), where the alcohol-attributable death rates are considerably higher than the national average.¹⁴ Policy responses, particularly the Northern Territory Emergency Response (NTER, 2007–2008), have often continued the same logic and power relations of colonisation, problematising Aboriginal and Torres Strait Islander communities.¹⁵ Alcohol use was

1. Southgate Institute for Health, Society and Equity, Flinders University, South Australia

2. National Centre for Cultural Competency, University of Sydney, New South Wales

3. Central Australian Aboriginal Congress, Northern Territory

Correspondence to: Dr Toby Freeman, Southgate Institute for Health, Society and Equity, Flinders University, GPO Box 2100, Adelaide, SA 5001;

e-mail: toby.freeman@flinders.edu.au

Submitted: December 2018; Revision requested: June 2019; Accepted: August 2019

The authors have stated the following conflict of interest: Two co-authors are employees of the service where the project was conducted, as this was participatory research. This is an open access article under the terms of the Creative Commons Attribution License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

Aust NZ J Public Health. 2019; 43:532-7; doi: 10.1111/1753-6405.12938

a key NTER target, which included racial place-based alcohol restrictions, compulsory income management, increased policing and temporary acquisition of Aboriginal townships.¹⁶

Aboriginal Community Controlled Health Services (ACCHSs) have been established across Australia, often as a result of local, grassroots movements by Aboriginal and Torres Strait Islander peoples in response to poor access and discrimination in mainstream health care.¹⁷ Today, 150 ACCHSs serve one-third to one-half of the Aboriginal and Torres Strait Islander population.¹⁸ ACCHSs are an expression of self-determination that aim to improve health and wellbeing and mitigate the processes of ongoing colonisation.¹⁹ This is not to suggest a dichotomy between community controlled services versus government services, but to acknowledge that ongoing colonisation is a critical part of the context within which all efforts to improve Aboriginal and Torres Strait Islander health take place.¹¹ This paper seeks to investigate the extent to which a community controlled model of comprehensive primary health care has the potential to contest and provide an alternative to ongoing colonisation using alcohol as an example.

ACCHSs are a world-leading model of Primary Health Care⁴ – pre-dating but embodying the Alma Ata Declaration’s²⁰ vision of comprehensive primary health care. Key to the Alma Ata vision is that primary health care (PHC) ought to not only engage in treatment of diseases and rehabilitation, but also prevent diseases and promote health.²⁰ How this comprehensive PHC approach can be specifically applied to alcohol is illustrated in Table 1.

While ACCHSs often demonstrate these four pillars of PHC in action, we acknowledge that this Alma Ata terminology is Western and does not necessarily capture Aboriginal and Torres Strait Islander concepts of health and healing. This paper investigates the potential of an ACCHS approach to address alcohol-related harm among Aboriginal and Torres Strait Islander peoples in a way

that encourages self-determination rather than ongoing colonisation. It focuses on an example of one ACCHS’s actions on alcohol-related harm, Central Australian Aboriginal Congress Aboriginal Corporation (Congress), in a regional town in the Northern Territory (Alice Springs).

Two research questions guided the study:

1. How does the health service implement a community controlled comprehensive primary health care response to alcohol-related harm?
2. How does this comprehensive approach challenge the logic and processes of ongoing colonisation in responses to Aboriginal and Torres Strait Islander alcohol-related harm?

Methods

Data were drawn from a larger study on comprehensive PHC that partnered with five South Australian services and Congress.^{4,21-23} The six PHC services were selected to maximise diversity and because they had existing relationships with the research team that would make participation in a five-year research project (2009–2014) feasible. The research used participatory action methods²⁴ where participating services were partners in the research. Its aim was to understand how the principles of comprehensive PHC were implemented on the ground by these services. The South Australian services did not have a comprehensive approach to alcohol, but Congress’ activity stood out as a well-resourced, comprehensive response to alcohol-related harm in the community it serves.

Data on Congress’ response to alcohol-related harm were drawn from a) six-monthly service reports of activities; b) interviews with staff; c) interviews with partners in the People’s Alcohol Action Coalition; and d) community assessment workshops with service users:

a) *Service reports.* From 2009 to 2013, service data were collected from the services in a biannual audit that provided details

of budgets, types of services offered, organisational documents and staff numbers.

b) *Congress staff interviews.* There were two rounds of staff interviews, one in 2009–2010, including 14 interviews with Congress staff and board members²⁵ and one in 2013–2014, including 15 interviews with Congress staff and board members.²² The first round explored implementation of comprehensive PHC principles at the service, while the second round focused on how this had changed in the intervening four years.

c) *People’s Alcohol Action Coalition.* We interviewed two Congress staff, three staff from partner organisations and one community member who were all active in the alcohol action coalition.²⁶ We also collected reports and media releases from the coalition.

d) *Community assessment workshops.* Workshops were held at each service with community members,²⁷ including three workshops at Congress with a total of 13 community members, including some who had attended Congress’ alcohol treatment program. Community members were asked to rate services’ achievement of nine different comprehensive PHC service qualities and provide reasons for those ratings.

All interviews and workshops were audio recorded. Transcripts were imported into NVivo for analysis. *A priori* codes based on comprehensive PHC elements and context factors including colonisation and racism were developed and applied to the transcripts. Congress’ activities related to alcohol were categorised according to the PHC strategies of treatment, rehabilitation, prevention, and promotion based on the service reports and staff interviews and checked with the chief executive officer in a telephone interview.

The Congress board approved the service’s participation in the project, and the board’s senior executives were informed of each stage of research. Two Congress staff members were associate investigators on the grant and had input into the proposal. Ethical approval for each research stage was received from the relevant Flinders University and South Australian Health research ethics committees, and the Aboriginal Health Research Ethics Committee, South Australia. The alcohol-specific study was approved by Central Australian Human Research Ethics Committee and by the Congress research subcommittee. All participants provided informed consent.

Table 1: A comprehensive primary health care response to alcohol-related harms.	
Comprehensive primary health care element ²⁰	Application to alcohol-related harms
Rehabilitation	Rehabilitative support for people who have experienced alcohol-related harm, including addiction, injury, illness
Treatment	Treatment of alcohol-related harm, including addiction, injury, illness
Prevention	Prevention of alcohol-related harm, e.g. through screening, brief intervention, health education and early childhood programs
Health promotion	Promotion of health and wellbeing through addressing structures and environmental factors that contribute to alcohol-related harm, including addressing alcohol policies, alcohol availability, housing ³⁰

Results

Congress' history and context is presented, followed by the service's responses to alcohol-related harm. The extent to which these responses challenge colonial approaches to alcohol-related harm is then considered.

Context

Congress is situated in the remote township of Alice Springs in the Northern Territory with a population of approximately 28,000 people, 19% of whom are Aboriginal.²⁸ Congress was established in 1973 at a public meeting of Central Australian Aboriginal people and was initially formed as an advocacy organisation for Aboriginal people's rights. In 1975, after lobbying the Minister for Aboriginal Affairs and the Minister for Health, it came to provide a primary health care service that was "comprehensive, not selective", included treatment, prevention, and health promotion, and was controlled by the Aboriginal community.^{29(p126)} Congress grew throughout the 1980s, 1990s and 2000s. When this research commenced in 2009, the service employed approximately 300 people, serving Alice Springs and surrounding areas in a 100-km radius, as well as some remote Aboriginal communities in partnership with local health boards. The total annual budget was \$27 million⁴ and more than 90% of this funding came from the Commonwealth Department of Health. As of 2019, the service has a budget of more than \$50 million and employs more than 400 staff, of whom about half are Aboriginal people.

Policy context

Congress is addressing alcohol-related harm in a very challenging policy context. In 2007, the Federal Government instigated the NTER, which included alcohol restrictions ("near-blanket ban on possession and consumption of alcohol on all Aboriginal land"^{30(p462)}), increased policing, compulsory acquisition of some townships, suspension of the *Racial Discrimination Act* and a range of other interventionist measures.³¹ Importantly, nothing was done to reduce the supply of take-away alcohol; instead there was a punitive, place-based approach to the location where drinking could take place. Northern Territory Government approaches to alcohol are heavily politicised and are affected by vested interests relating to the tourist economy. The Australian Hotels Association is the single biggest funder of

both major political parties³⁰ and, in response to the advocacy on supply reduction, industry-sponsored groups emerged to protect the profits resulting from alcohol. Australian Government policies continue to focus on public drunkenness, rather than health and wellbeing,³⁰ reminiscent of Langton's account of the fears of the "drunken Aborigine".³ A range of punitive policies have been enacted in the NT, some with roots in the legacy of the NTER,³⁰ including the *Alcohol Mandatory Treatment Act*, which allows people to be held for up to four days without legal representation, the *Alcohol Protection Orders Act*, which allows for increased custodial sentences for individuals where alcohol is felt to be a factor in the crime, and Temporary Beat Locations, where police stand outside take-away alcohol outlets and can question patrons, ask for identification and confiscate alcohol.³⁰ An evaluation of the Alcohol Mandatory Treatment initiative found that it lacked a program logic and failed to impact on health, re-apprehension into custody or homelessness.³² The Temporary Beat Locations dramatically reduced the supply of alcohol, showing effectiveness in spite of their discriminatory nature.³³

Congress responses to alcohol-related harm

Congress has addressed alcohol-related harm since its inception, with methods that include addressing social determinants of alcohol-related harm and providing treatment services and strategies to minimise alcohol-related harm. Often these strategies have been driven by the Aboriginal community, not just the health professionals employed at Congress. Past examples include a night shelter and pick-up service to reduce the number of Aboriginal people being charged for public drunkenness, set up in 1975,²⁹ and an alcohol rehabilitation centre established in the 1980s. In 1990, Congress collaborated with other Aboriginal organisations to produce a comprehensive plan to address alcohol use, including supply reduction measures to reduce take-away trading hours, reduce outlets and remove cheap alcohol from the market, and approaches to rehabilitation, including the establishment of an alcohol programs unit.³⁴ Implementing this plan, Congress purchased an alcohol outlet in 1991, let the \$150,000 license lapse,³⁵ "ceremoniously poured all the grog down the drain" (Practitioner interview),

and converted it to a health service site. More recently, Congress set up an alcohol treatment program including intensive case management, with a medical/pharmacotherapy stream, psychological therapy stream, and a social and cultural support stream that addresses positive social and cultural determinants of health.³⁵

Table 2 presents the broad range of treatment, rehabilitation, prevention and health promotion activities Congress undertook to address alcohol-related harms at the time of this study.

As well as the medical, clinical and alcohol services, the Table indicates the activities in other sections of the service that contribute to addressing alcohol-related harm. For example, there is a strong link between healthy early childhood development and later alcohol consumption,³⁶ so Congress' activities in early childhood are likely to reduce future alcohol-related harm. Similarly, social determinants of Aboriginal health, including employment, education, housing, cultural determinants of health and self-determination, are all associated with increased health, and Congress' efforts in improving these determinants through collaborations with housing and other government sectors, and health promotion strategies, such as addressing job skills in the Men's health branch, are likely to reduce the burden of alcohol-related harm in the community.¹

One advocacy strategy was the People's Alcohol Action Coalition (PAAC), a community group formed in 1995 from a public meeting organised by the late, influential Arrernte leader, Charlie Perkins.³⁷ Congress is a leading partner in PAAC, along with other services, church groups, trade unions and Aboriginal organisations, with staff members active participants in the group. The coalition advocates for evidence-based alcohol supply measures, such as a minimum floor price and other sales restrictions.

The staff we spoke to overwhelmingly endorsed this comprehensive approach – "this idea of balancing the here and now with longer-term action to change the social determinants of health" (Practitioner interview). Even if staff did not participate in each aspect of the comprehensive approach, they saw how they fitted in with the larger picture:

We [treatment staff] are just one part of the wheel, a spoke in the wheel, but there needs to be a multi-pronged approach. Some of

the stuff [staff member] is doing with PAAC and that. ... None is greater than the other.
– Practitioner interview

Staff saw community participation in planning and service delivery as core business. The community board was seen as vital to self-determination and fully endorsed a comprehensive approach. The community control was reported to be vibrant and one community board member was reported as being able to debate with “our mob, our professionals and specialists” on approaches to alcohol-related harm. As well as the board, Congress engaged in community forums and men’s forums, and had a cultural advisory council for Alukura and an active complaints process. This community participation allowed a communal approach, where the board “themselves are a part of the community and they are in a position to change it within” (Practitioner interview). This communal approach was seen as critical to the success of alcohol services and other programs:

You can do all the work you like with a psychologist and psychology strategies on an individual level; if you send people back into an environment where there is no community engagement and no commitment on everyone’s part to say look, this is what we’re going to do as a group [it’s not going to work]. – Practitioner interview

Challenging colonial approaches

Institutional and interpersonal racism and colonialism were seen as key challenges surrounding approaches to alcohol-related harm. Interviewees viewed the NT Government as racist, either uncaring towards Aboriginal people (“I think there is

actually a level of apathy from governments ... because it is about the harm amongst blackfellas” [PAAC interview]), or desiring to get “Aboriginal people off the streets and locking them up, quite frankly” (Manager interview). The NTER was seen as ‘blaming the victim’ rather than addressing the determinants of alcohol-related harm, especially supply, a criticism that could be extended to most of the NT alcohol policy as d’Abbs has documented.³⁰

Congress’ approaches to alcohol-related harm challenge colonial approaches in a number of ways. Firstly, Congress’ model of care aims to respect and include Aboriginal knowledge and be culturally relevant and safe. This requires respecting Aboriginal ways of knowing, being and doing,³⁸ alongside Western medicine – an approach termed the ‘two-way model’.³⁹ This was seen as new and challenging ground by this alcohol program staff interviewee:

I think the problem is that there isn’t a model of care that has been developed as far as I know that legitimately marries two different worlds ... the white medical model is superimposed on communities who are not in the position to shape that as easily to their specific needs. So, you could call that medical colonialism. – Practitioner interview

Secondly, collaborative work with government sectors outside of health and other advocacy included anti-racism activism. Subsequent to a very public national incidence of racism (racial abuse of Aboriginal footballer Adam Goodes), Congress took out ads in the local *Advocate* newspaper to raise awareness of racism in the health system. Congress staff reported frustration that racism was often not named, for example:

We went to the Alice Springs transformation workshop a few weeks ago and there was different working groups on. There was early childhood, security and policing, family violence, family support. There was a couple of others, but there was nothing on racism.
– Manager interview

Thirdly, Congress’ approach is explicit about supporting people to regain control over their lives, a core determinant of health.⁴⁰ This was seen as vital by staff:

The ‘control factor’. People being able to make informed decisions that enables them to not be in a situation of ending up in gaol, unemployed ... so they maximise their full potential and they can take control of their own lives, which then allows them to be able to operate collectively later in life in running organisations like Congress, being on boards like Congress and working collectively. Get that collective control. – Manager interview

This quote shows the two-way relationship between the control Aboriginal and Torres Strait Islander peoples are able to exert over their lives and their collective self-determination. As a result, a practitioner reported a belief that community members were “not powerless here”. Empowerment was strongly evident in the community assessment workshops, where participants made comments such as “we as people in this community know, that if we have an issue with Congress, I think we feel like we could go and tell them”, and that staff were “supportive” and “good at explaining”. The aim of increasing power and control includes the community participation described above, Congress’ goals concerning Aboriginal leadership, its aim of creating culturally safe spaces and its employment of Aboriginal

Table 2: Rehabilitation, treatment, prevention, and promotion activities addressing alcohol-related harm.

Rehabilitation	Treatment	Prevention	Promotion
Alcohol treatment and rehabilitation program	Alcohol treatment and rehabilitation program	Social and emotional wellbeing services – counselling, youth outreach and drop in centre	People’s Alcohol Action Coalition
	Treatment of alcohol-related harms in medical clinic, plus physical and mental co-morbidities	Medical clinic – adult health checks	Women’s health branch - prenatal and antenatal care, Family Partnership Program
	Pharmacy – dispensing medications	Men’s health branch – Well men’s checks, violence intervention program, sexual offenders program	Early childhood and family support services, including childcare, Healthy Kids school outreach, community workers
	Social and emotional wellbeing services, inc. social and cultural support	Infant nurse home visiting program, Early Childhood Learning Centre, Pre-school readiness program	Youth Outreach team
			Social and emotional wellbeing services, including community wellbeing team
			Community Health Education
			Men’s health branch – job skills, health promotion and community development, anti-violence campaign
			Intersectoral collaboration on housing, and with Office of Families and Communities
			Supporting cultural determinants through community events eg NAIDOC week, bush trips, Women’s Health cultural advisory council
			Self-determination through community control, employment of Aboriginal staff, Aboriginal Health Practitioner training

Note:

NAIDOC = National Aboriginal and Islander Day Observance Committee

staff. One manager reported that “Aboriginal employment as a tool of empowerment within Congress is taken very seriously” (Manager interview).

Fourthly, through PAAC, Congress advocated to government on evidence-based alcohol policy, arguing that alcohol-related harm “needs a health response, not a criminal response” (Manager interview). This advocacy was conducted as core business, despite pressure from the government:

[PAAC] has been quite effective around some of the alcohol stuff, to the extent we had a specific visit by the Chief Minister asking what were we going to do about the noise that [staff and PAAC member] was making.
– Manager interview

Interviewees noted that Congress’ ability to advocate was in part due to being outside of government. While PAAC originally received a grant from the NT Government, “as we became more effective, the money dried up completely and we have never had a government grant since” (Practitioner interview).

PAAC was successful in lobbying a previous NT Government to introduce the Alice Springs Liquor Supply Plan in 2006 and supported the Banned Drinkers Register, which was then overturned by the next NT Government. The subsequent NT Government installed the Temporary Beat Locations policy, which was viewed as more discriminatory towards Aboriginal people (whereas the register covered everyone). The Banned Drinkers Register was associated with reducing alcohol-related presentations to the Alice Springs hospital.³³ As well as government, Congress and PAAC also found the need to advocate to and against private companies, particularly alcohol outlets. PAAC has had some success with many supermarkets agreeing to a minimum alcohol floor price at around \$1 per standard drink. A key success was the agreement by the current NT Government to undertake the Alcohol Policies and Legislative review,⁴¹ which has seen the Government agree to implement all but one recommendation, representing far-reaching alcohol policy reforms. This has included the successful implementation of a Territory-wide alcohol floor price of \$1.30 per standard drink.⁴²

Discussion

This case study illustrates how a comprehensive PHC service can provide care and rehabilitation for alcohol-related

harm and can reduce alcohol-related harm through individual prevention activities and addressing the social determinants of alcohol-related harm. This case provides an example of the full continuum of strategies in the Alma Ata Declaration for comprehensive PHC and concords with other literature indicating that ACCHSs are at the forefront of comprehensive PHC practice.⁴³ This is also supported by findings that when health services have been transferred to Aboriginal community control, more culturally respectful services and more focus on population health has followed.^{44,45} The ACCHS approach is also more in line with the United Nations Declaration on the Rights of Indigenous Peoples, which emphasises Indigenous peoples’ rights to “participate in decision-making”, “maintain and develop their own [I]ndigenous decision-making institutions”, “traditional medicines and to maintain their health practices”, and have “access, without any discrimination, to all social and health services”.⁴⁶

The findings highlight how community control can challenge colonialism, racism and power imbalances through incorporating Aboriginal and Torres Strait Islander knowledges, promoting cultural relevance and safety, empowering people to have more control in their lives, and encouraging Aboriginal and Torres Strait Islander-led advocacy. In so doing, community control promotes evidence-based policy and practice that supports self-determination. It also provides a somewhat protected space that enables political advocacy in ways that are difficult or impossible for government employees to undertake.^{21,47} This is especially important for alcohol, where ongoing colonisation and racism and support for industry frames so much of the public discussion and policy making. Increasing people’s control over their own lives is fundamental to reducing health inequities so they have the power to challenge these social determinants.^{40,48} The need to end the logic of paternalistic control evident in policies such as Stronger Futures,⁴⁹ and to instead increase self-determination, community and individual control, is clear in the writing of many Aboriginal and Torres Strait Islander researchers^{11,50} and statements such as the Uluru Statement from the Heart⁵¹ and the Redfern Statement.⁵² Data have been seen as an instrument of colonialism but control over data can instead make a tool of self-determination.⁵³ Congress uses data and evidence in all aspects of its

work, and community control means that community views can be brought together with professional knowledge and evidence to inform appropriate policy. All of these factors together are critical for effective public health advocacy, and community controlled health services create a unique environment to support this.

Only one ACCHS was included in this research. There are 150 ACCHSs around Australia that are tailored to their local communities. Further studies would yield additional approaches to address alcohol-related harm, and insights into how these solutions challenge colonialist approaches. Whatever research is conducted in the future should be designed to contribute to decolonisation. This will require incorporation of Indigenous knowledge to inform the epistemology and methods underpinning the research. Examples are that the research could incorporate yarning with people affected by alcohol-related harm and consideration of the extent to which alcohol policies are culturally safe.⁵⁴ The research focused on understanding local implementations of the principles of comprehensive PHC and did not seek to measure health outcomes. One study evaluated the alcohol program at Congress³⁵ and found 79% of clients stopped drinking or reduced their consumption, although 70% of the control group also stopped drinking or reduced their consumption, clouding the evidence for the program. In addition, PAAC have collaborated with research partners to provide data on reductions in alcohol consumption and harms in the community following increases in alcohol pricing, and after the introduction of the Banned Drinkers Register.³³ An evaluation of the alcohol supply measures undertaken in Alice Springs that PAAC advocated for found they were effective in reducing per capita consumption and rates of assaults and hospital admission for alcohol-attributable conditions.⁵⁵

Conclusion

This case study of a comprehensive, Aboriginal Community Controlled Health Service’s evidence-based responses to alcohol-related harm highlighted its strengths. In particular, the service employed a range of actions across the comprehensive spectrum of rehabilitation, treatment, disease prevention, and health promotion. ACCHSs have practiced such

comprehensive PHC approaches since before the Alma Ata Declaration, because that was the approach deemed suitable by the community grass roots movements that formed the first ACCHSs.²⁹ This pioneering of a comprehensive PHC approach further highlights the value of community control to develop locally responsive and appropriate solutions, and to address local determinants of health through advocacy.

Acknowledgements

This research was supported by the National Health and Medical Research Council (grant number 535041), and a Flinders University Faculty of Medicine, Nursing and Health Sciences Seeding Grant. We thank the Central Australian Aboriginal Congress staff and Board for their participation.

References

- Wilson M, Stearne A, Gray D, Siggers S. *The Harmful Use of Alcohol Amongst Indigenous Australians*. Australian Indigenous Health Reviews No. 4. Mount Lawley (AUST): Edith Cowan University Australian Education and Research Australian Indigenous HealthInfoNet; 2010.
- Brady M. *The Grog Book*. Revised ed. Canberra (AUST): Australian Department of Health and Ageing; 2005.
- Langton M. Rum, seduction and death: Aboriginality and alcohol. *Oceania*. 1993;63(3):195-206.
- Freeman T, Baum F, Lawless A, Labonte R, Sanders D, Boffa J, et al. Case Study of an Aboriginal Community-Controlled Health Service in Australia: Universal, Rights-Based, Publicly Funded Comprehensive Primary Health Care in Action. *Health Hum Rights*. 2016;18(2):93-108.
- Australian Health Ministers' Advisory Council. *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*. Canberra (AUST): AHMAC; 2017.
- Australian Indigenous HealthInfoNet. *Summary of Aboriginal and Torres Strait Islander Health 2017*. Mount Lawley (AUST): Edith Cowan University; 2017.
- Australian Institute of Health and Welfare. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2015*. Catalogue No. IHW 147. Canberra (AUST): AIHW; 2015.
- Vos T, Barker B, Stanley L, Lopez A. *The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples 2003*. Brisbane (AUST): The University of Queensland School of Population Health; 2007.
- Czyzewski K. Colonialism as a broader social determinant of health. *Int Indigenous Policy J*. 2011;2(1). DOI: 10.18584/iipj.2011.2.1.5.
- International Symposium on the Social Determinants of Indigenous Health. *Social Determinants and Indigenous Health: The International Experience and its Policy Implications*. Adelaide (AUST): Commission on Social Determinants of Health; 2007.
- Sherwood J. Colonisation - it's bad for your health: The context of Aboriginal health. *Contemp Nurse*. 2013;46:28-40.
- Brett J, Lee K, Gray D, Wilson S, Freeburn B, Harrison K, et al. Mind the gap: What is the difference between alcohol treatment need and access for Aboriginal and Torres Strait Islander Australians? *Drug Alcohol Rev*. 2016;35(4):456-60.
- Parker R, Milroy H. Aboriginal and Torres Strait Islander mental health: An overview. In: Purdie N, Dudgeon P, Walker R. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. 2nd ed. Nedlands (AUST): Telethon Kids Institute/Kulunga Aboriginal Research Development Unit; 2014.
- Chikritzhs T, Pascal R, Gray D, Stearne A, Siggers S, Jones P. *Trends in Alcohol-attributable Deaths among Indigenous Australians, 1998-2004*. National Alcohol Indicators, Bulletin No. 11. Perth (AUST): National Drug Research Institute, Curtin University of Technology; 2007.
- Moreton-Robinson A. The White Possessive: Property, Power, and Indigenous Sovereignty. In: *Indigenous Americas*. Volume 17. Minneapolis (MN): University of Minnesota Press; 2015.
- Evans BW. Northern Territory Emergency Response: Criticism, support and redesign. *Aust J Rural Health*. 2012;20(3):103-7.
- Torzillo P, Rainow S, Pholeros P, Tunkin W, Vartto K. Extending community health services. In: Baum F, Fry D, Lennie I, editors. *Community Health: Policy and Practice in Australia*. Leichhardt (AUST): Pluto Press; 1992.
- Dwyer J, Lavoie J, O'Donnell K, Marlina U, Sullivan P. Contracting for Indigenous health care: Towards mutual accountability. *Aust J Public Admin*. 2011;70(1):34-46.
- Fredericks BL, Legge D. *Revitalizing Health for All: International Indigenous Representative Group. Learning from the Experience of Comprehensive Primary Health Care in Aboriginal Australia—A Commentary on Three Projects*. Melbourne (AUST): The Lowitja Institute; 2011.
- World Health Organization. *Declaration of Alma-Ata, International Conference on Primary Health Care, USSR, 6-12 September*. Geneva (CHE): WHO; 1978.
- Baum F, Freeman T, Sanders D, Labonté R, Lawless A, Javanparast S. Comprehensive primary health care under neo-liberalism in Australia. *Soc Sci Med*. 2016;168:43-52.
- Freeman T, Baum F, Lawless A, Javanparast S, Jolley G, Labonté R, et al. Revisiting the ability of Australian primary health care services to respond to health inequity. *Aust J Prim Health*. 2015;22:332-8.
- Freeman T, Baum FE, Jolley GM, Lawless A, Edwards T, Javanparast S, et al. Service providers' views of community participation at six Australian primary healthcare services: scope for empowerment and challenges to implementation. *The International Journal of Health Planning and Management*. 2016;31:E1-E21.
- Baum F. Participatory action research. *J Epidemiol Community Health*. 2006;60(10):854-7.
- Baum F, Legge D, Freeman T, Lawless A, Labonté R, Jolley G. The potential for multi-disciplinary primary health care services to take action on the social determinants of health: actions and constraints. *BMC Public Health*. 2013;13(1):460.
- Anaf J, Baum F, Freeman T, Labonté R, Javanparast S, Jolley G, et al. Factors shaping intersectoral action in primary health care services. *Aust N Z J Public Health*. 2014;38(6):553-9.
- Freeman T, Jolley G, Baum F, Lawless A, Javanparast S, Labonté R. Community assessment workshops: a group method for gathering client experiences of health services. *Health Soc Care Comm*. 2014;22:47-56.
- Australian Bureau of Statistics. *Alice Springs Regional Summary*. Canberra (AUST): ABS; 2017.
- Rosewarne C, Vaarzon-Morel P, Bell S, Carter E, Liddle M, Liddle J. The historical context of developing an Aboriginal community controlled health service: A social history of the first ten years of the Central Australian Aboriginal Congress. *Health History*. 2007;9:114-43.
- d'Abbs P. Widening the gap: The gulf between policy rhetoric and implementation reality in addressing alcohol problems among Indigenous Australians. *Drug Alcohol Rev*. 2015;34:461-6.
- O'Mara P. Health impacts of the Northern Territory intervention. *Med J Aust*. 2010;192(10):546-8.
- PricewaterhouseCoopers Indigenous Consulting, Menzies School of Health Research. *Evaluation of the Alcohol Mandatory Treatment Program*. Darwin (AUST): Northern Territory Department of Health; 2017.
- People's Alcohol Action Coalition. *Submission to the Alcohol Policies and Legislation Review in the Northern Territory Alice Springs* (AUST): PAAC; 2017.
- Lyon P. *What Everybody Knows About Alice: A Report on the Impact of Alcohol Abuse on the Town of Alice Springs*. Alice Springs (AUST): Tangentyere Council; 1990.
- d'Abbs P, Togni S, Rosewarne C, Boffa J. The Grog Mob: Lessons from an evaluation of a multi-disciplinary alcohol intervention for Aboriginal clients. *Aust N Z J Public Health*. 2013;37(5):450-6.
- Roche A, Kostadinov V, Fischer J, Nicholas R, O'Rourke K, Pidd K, et al. Addressing inequities in alcohol consumption and related harms. *Health Promot Int*. 2015;30 Suppl 2:i20-35.
- Boffa J, Rosewarne C. Alcohol and Alice Springs: Meeting the needs and wishes of the community. *Indigenous Law Bull*. 2003;5(25):11.
- Martin K, Mirraboopa B. Ways of knowing, being and doing: A theoretical framework and methods for indigenous and indigenist re-search. *J Aust Stud*. 2003;27(76):203-14.
- McGuinness K, Leckning B. *Bicultural Practice in the Northern Territory Children and Families Sector: Practitioners' Reflections of Working Two-ways*. Casuarina (AUST): Menzies School of Health Research; 2013.
- Marmot M. Social determinants and the health of Indigenous Australians. *Med J Aust*. 2011;194(10):512-13.
- Department of the Chief Minister. *Alcohol Policies and Legislation Review: Final Report*. Darwin (AUST): Northern Territory Government; 2017.
- Boffa J. The NT is putting a minimum floor price on alcohol, because evidence shows this works to reduce harm. *The Conversation*. 2018 September 25.
- Dwyer J, Martini A, Brown C, Tilton E, Devitt J, Myott P, et al. *The Road is Made by Walking: Towards a Better Primary Health Care System for Australia's First Peoples*. Melbourne (AUST): The Lowitja Institute; 2015.
- Bailie R, Menzies School of Health Research Local Evaluation Team, Katherine West Health Board. *Jirntangu Miyrtja: Katherine West Coordinated Care Trial Local Evaluation Final Report*. Casuarina (AUST): Menzies School of Health Research; 2000.
- Department of Health and Ageing. *The National Evaluation of the Second Round of Coordinated Care Trials: Final Report* [Internet]. Canberra (AUST): Government of Australia; 2007 (cited 2016 Feb 22). Available from: http://apo.org.au/files/Resource/final_cct2.pdf.
- United Nations. *United Nations Declaration on the Rights of Indigenous Peoples*. New York (NY): UN; 2008.
- Boffa J, George C, Tsey K. Sex, alcohol and violence: A community collaborative action against striptease shows. *Aust J Public Health*. 1994;18(4):359-66.
- Devitt J, Hall G, Tsey K. *An Introduction to the Social Determinants of HEALTH in Relation to the Northern Territory Indigenous Population*. Darwin (AUST): Cooperative Research Centre for Aboriginal and Tropical Health; 2001.
- Bielefeld S. History wars and stronger futures laws: A stronger future or perpetuating past paternalism? *Altern Law J*. 2014;39(1):15-18.
- Anderson I. The end of Aboriginal self-determination? *Futures*. 2007;39(2):137-54.
- Referendum Council. *Uluru Statement from the Heart*. Uluru (AUST): National Constitutional Convention; 2017.
- National Congress of Australia's First Peoples et al. *Redfern Statement*. Redfern (AUST): ANTAr; 2016.
- Wilks J, Kennedy G, Drew N, Wilson K. Indigenous data sovereignty in higher education: Towards a decolonised data quality framework. *Aust Univ Rev*. 2018;60(2):4.
- Mackean T, Fisher M, Friel S, Baum F. A framework to assess cultural safety in Australian public policy. *Health Promot Int*. 2019. doi.org/10.1093/heapro/daz011.
- Symons M, Gray D, Chikritzhs T, Skov S, Siggers S, Boffa J, et al. *A Longitudinal Study of Influences on Alcohol Consumption and Related Harm in Central Australia: With a Particular Emphasis on the Role of Price*. Perth (AUST): Curtin University National Drug Research Institute; 2012.