Public Health Association
AUSTRALIA

Public Health Association of Australia submission on the Northern Territory alcohol policies and legislation review

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Introduction

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia. The PHAA works to ensure that the public's health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people's health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Preamble

PHAA welcomes the opportunity to provide input to the review of alcohol policies and legislation in the Northern Territory. The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on reducing health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Background

PHAA welcomes the NT Government's commitment to reducing harm from alcohol. Alcohol policies and regulations should be informed by the best available evidence about what will reduce or prevent harm from alcohol. While we recognise the importance of community consultation, we note that many of the questions presented in the Issues Paper require detailed and nuanced study in addition to community consultation. We strongly urge that any changes resulting from this review prioritise the health and safety of all Territorians and ensure that public health has clear priority over the commercial interests of the alcohol industry.

As discussed on page 5 of the Issues Paper, we recognise the positive economic impacts of the retail, tourism and hospitality industries in the NT, a proportion of which is associated with the supply of alcohol. However, consideration of the economic impacts of alcohol should include the costs of responding to health and social harms, including those associated with police, ambulances, hospitals and emergency departments, treatment and support services, and the justice system, as well as labour force costs such as those associated with absenteeism. There are also negative economic impacts on tourism and hospitality where the effects of alcohol abuse deter both locals and tourists from spending time (and money) in town centres at night. These costs are substantial and their consideration alongside the positive impacts of tourism and hospitality would provide a more complete picture of economic impacts associated with alcohol.

PHAA supports a comprehensive approach to prevention, treatment, support services and research to minimise alcohol harms, based on the best available evidence. We also strongly support the harm minimisation approach with the three pillars of supply reduction, demand reduction and harm reduction. Approaches to reducing alcohol-related harm must fit within a broader strategy to address the social determinants of health, including poverty, social exclusion and racism, early childhood development, housing, education and employment. PHAA does not support approaches which discriminate against or further marginalise Aboriginal people. Whatever strategies are implemented should be continued for long enough, and thoroughly evaluated and refined to maximise benefits. Politicisation and polarisation of approaches to alcohol are not helpful.

The evaluation of policies and approaches to reducing harm from alcohol is essential in planning changes to alcohol policies in NT. Appropriate funding and resources should be made available to support well-designed evaluation of strategies to monitor their impacts and further build the evidence base for approaches to addressing harms from alcohol.

All levels of government have important roles in preventing and reducing harms from alcohol, and comprehensive action at all levels is necessary to effectively address problems associated with alcohol. Through liquor licensing laws, state and territory governments have substantial ability to control availability and access to alcohol, including where, when and how alcohol may be sold and consumed. As we will cover in more detail below, appropriate controls on the availability of alcohol are an essential component of the comprehensive approach needed to effectively prevent and reduce harm from alcohol.

PHAA Response to the review Issues Paper

PHAA supports the submissions to the review made by Central Australian Aboriginal Congress and the People's Alcohol Action Coalition.

General issues

What do you think of the current approaches to reducing harms from alcohol, and what other strategies could be considered?

Harms associated with misuse of alcohol are many and varied, impacting on multiple areas of the lives of both the person misusing alcohol, and the people around them. These include parenting, relationships, employment, housing, risky sexual behaviour, interpersonal violence, injury and road trauma, as well as impacts on health.[1,2] Strategies to reduce harm from alcohol need to consider the variety of harms associated with alcohol misuse.

As PHAA noted in our submission to the Towards Zero Road Safety Action Plan Inquiry we believe NT should take a leadership role in reducing the blood alcohol limit, with a view to considering the merits of a zero blood alcohol limit for all drivers in the longer term to change the culture in NT by completely separating alcohol from driving. Greater use of random breath testing (RBT) could also reduce harms of alcohol through assisting in the enforcement of blood alcohol limits.

Efforts in the area of violence prevention require further research. Alcohol increases risks of being both victim and perpetrator of violence so there is much to be gained by reducing demand and supply rather than focusing on harms alone.

What do you think of the current approaches to reducing demand for alcohol, and what other strategies could be considered?

Underlying social determinants of health need to be considered, with harms of alcohol being compounded by other aspects of social disadvantage. For example, housing issues are significant in NT, with the highest rate of homelessness in Australia and problems associated with high levels of overcrowding.[3] Where underlying social disadvantage is not addressed, restrictions on the availability of alcohol may result in alcohol being substituted by another substance such as kava or another form of addictive behaviour such as gambling. Problematic use of alcohol is both a cause and a symptom of disadvantage. Managing alcohol related problems is an important step towards equity but only one among many. A comprehensive approach to addressing the social determinants of health can be expected to make significant progress to reducing demand for alcohol and alcohol-related harms.

PHAA supports the decision of the NT Government to repeal the Alcohol Mandatory Treatment (AMT) program and encourages the development of better pathways to treatment. While the AMT program may have provided opportunities for people previously unable to access health care services, significant concerns remained in regard to criminalising a medical problem, the lack of demonstrated long-term health benefits, and the cost of implementing AMT.[4]

Temporary Beat Locations (TBLs) are controversial because of the inherent racism of the strategy, and due to concerns about the lack of sustainability of this approach. However, they appear to have been successful and popular in their reduction in alcohol-related harm to Aboriginal people.[5] An authoritative non-police presence at alcohol-outlets, with ready access to police support could achieve many of the benefits of the TBLs. It is likely that TBLs had minimal effect on the alcohol-related harm to non-Aboriginal people because they were specifically targeted at Aboriginal people who may have no place where they can legally claim to be drinking alcohol. This racist impact both leaves non-Aboriginal people without the potential benefit of TBLs and also contributes to a stereotyped view of Aboriginal people as inherently problematic drinkers and trouble-makers. It would be highly beneficial to formally evaluate the TBL strategy so that the benefits can be maintained while the adverse impacts are minimised or until a more effective and non-discriminatory policy can replace the TBL.

PHAA welcomes the re-introduction of the Banned Drinker Register (BDR), linked to identification scanning at the point of sale, as a less-racially driven and much more whole-of-community approach to limiting opportunities for people with alcohol-related problems to access alcohol. We encourage the NT Government to provide appropriate resourcing for a comprehensive evaluation of the BDR.

Promoting cultural change to reduce risky drinking behaviours

A comprehensive, evidence-based approach to reducing demand, supply and harms associated with alcohol can be expected to influence community norms around drinking behaviours.

Well-developed public education campaigns could support positive changes in the drinking culture of NT to complement regulatory approaches. Adequately funded, sustained and research-based public education campaigns run independently of the alcohol industry are recommended as part of a comprehensive approach to reducing alcohol harms.[6] Health education campaigns have a role in building the community's knowledge about the health risks of alcohol, encouraging appropriate behaviour and preparing the ground for structural change including regulation.

There is a growing body of research which is available to inform and support the development of effective alcohol harm reduction education campaigns.[7,8] Recent research suggests that features of such campaigns include messages addressing the long-term harms of alcohol and information about low-risk drinking guidelines.[9]

A challenge for education campaigns is the ubiquity of alcohol marketing.[10] Alcohol promotion campaigns promote positive alcohol messages and are generally funded at much greater levels than health education campaigns could hope to be. It is therefore necessary to consider complementary policies which restrict exposure to alcohol marketing, particularly among young people.

Targeted versus whole-of-population approaches to reducing harm from alcohol

PHAA submits that whole-of-population approaches to preventing harm from alcohol should be a focus of the review of NT liquor policies and the resulting recommendations. Drinking at risky levels is not a minority problem in NT, or a problem that only affects specific communities or

population groups; rather, it is a whole-of-population issue which requires a comprehensive suite of population level approaches to effectively (and cost-effectively) prevent harm.

Certain groups espouse the benefits of 'targeted' approaches which do not impact the majority of drinkers who drink responsibly. Where 'targeted' approaches are advocated as an alternative to population-level approaches, they are often supported by those with vested interests in minimising regulation that would reduce alcohol sales and consumption.[11]

Targeted approaches alone are insufficient to reduce or prevent the majority of alcohol-related harm. Targeted approaches may be appropriate in certain circumstances, for example, tailored interventions for high-risk communities, but these must be considered in the context of a much broader, comprehensive approach to preventing harm from alcohol.[12, 13]

Data collection

We acknowledge the collection of alcohol sales data in the NT and strongly encourage that the collection of wholesale alcohol sales data is maintained in NT.[14] PHAA are supportive of alcohol sales data collection across all jurisdictions as an important measure of alcohol consumption. Robust measures of alcohol consumption are essential for the development of effective evidence-based policy responses to alcohol-related harm. Alcohol sales data are considered to be the best indicator of alcohol consumption at a population level as they are not susceptible to the errors inherent in self-report surveys,[15] and can be used to identify patterns of consumption of different beverage types.[16] Alcohol sales data are important for monitoring trends in per capita alcohol use, studying relationships between changes in per capita consumption and population health outcomes, providing a benchmark to assess the reliability of survey estimates of consumption[17] and evaluating interventions to reduce alcohol-related harm.[18]

Evidence based strategies to reducing harms from alcohol

A comprehensive approach is needed

A substantial literature of authoritative reports and reviews, including many from Australian public health and related research, provides clear direction for approaches to addressing alcohol related harms.[19,20,21] For example, drawing on key evidence and expert advice, the National Preventative Health Taskforce recommended a comprehensive approach to preventing harm from alcohol. Emphasising that there are no 'magic bullets', the Taskforce noted, 'there is an increasingly solid base of evidence upon which policy decisions can be made...it is clear which of the various policies and programs hold the most promise of being effective, and those which offer the least'.[22] The Taskforce produced a 'roadmap for action' on alcohol, with eight key action areas and a staged implementation plan, which offers a clear way forward to prevent harm from alcohol.[23]

Overall, the policy recommendations from health authorities are consistent: preventing harm from alcohol requires a comprehensive approach including controls on economic availability (including

taxation and pricing strategies) and physical availability (including licensing, days and hours of sale, and outlet density); curbs on alcohol promotion; sustained research-based public education; drink-driving policies; enforcement of relevant regulations; strengthened health services; appropriate local initiatives; and monitoring and surveillance that can inform the design of strategies and evaluation of their impact.

Many of these policy areas are relevant to the NT alcohol review and are discussed in more detail below.

Approaches to reducing drink-driving

The high levels of recidivism suggest that penalties in NT do not deter people from drink driving, relative to the strength of factors that lead to repetition of drink-driving behaviours. Furthermore, the high NT Indigenous imprisonment rates also point to a failure of incarceration to deter drink driving. It is likely that local research is needed to determine effective interventions in the NT.

Clamping and seizing vehicles and other strategies can be conceived as health interventions to protect the community from people who are at risk of driving while intoxicated, rather than as punitive measures. Other measures may include the use of interlock devices which do not allow the car to start if the person is intoxicated.[24]

Relative risks of crashing at different blood alcohol levels are known, with significant risks observed even at a level of 0.02%.[25] The risk increases at any level above zero, rising exponentially as the blood alcohol content rises, and is associated with other risky behaviour such as speeding and not wearing seatbelts.[26] Given the high levels of alcohol consumption in the NT, and the high road toll, NT should take a leadership role in reducing the blood alcohol limit, with a view to considering the merits of a zero blood alcohol limit for all drives in the longer term. This could be initiated for probationary drivers, as is the case in most other Australian jurisdictions.

Random breath testing (RBT) with adequate frequency and penalty can be an effective deterrent to drink driving. This requires both education of drivers about the effectiveness of RBT in increasing safety, and the perception that RBT is truly random and ubiquitous. People need to believe that all drivers are always at risk, with severe, certain and swift enough punishments to act as a deterrent.[27]

Liquor accords

The existing evidence base suggests that liquor accords are not a particularly effective approach in reducing harm from alcohol.[28] While it is possible that liquor accords may serve a useful purpose within a comprehensive approach to reducing harm from alcohol – e.g. to facilitate communication between stakeholders and supporting the coordination of local approaches - there is little evidence within the existing body of literature that they make a significant contribution to reducing harms in and of themselves. This is likely to be due to their voluntary nature and a reluctance for licensees to seek approaches which may affect their own profits. Liquor accords may give the appearance of action to reduce harms and may detract from support for strategies of proven effectiveness.[29] Given the absence of evidence regarding their effectiveness, liquor accords should not be a priority strategy for governments.

Collaborative approaches

PHAA supports a collaborative approach to policy making, with experts and community stakeholders fully consulted. Programs at community level are most successful when the community itself is invested in the program and takes ownership of it.[30]

However, we caution against the involvement of commercial interest groups in the development of alcohol policy. This position was encapsulated in a statement from the World Health Organization's former Director-General, Dr Margaret Chan, that 'In WHO's view, the alcohol industry has no role in formulating policies, which must be protected from distortion by commercial or vested interests'.[31]

Alcohol service provision and management in remote Aboriginal communities

General comments

Provision of affordable public transport to enable Aboriginal people to return home from towns can reduce the displacement that arises as a result of alcohol restrictions in remote communities. We note the demise of the return to country program run by Larrakia Nation, which was successful in assisting people return home.[32]This is a great loss, and efforts to re-establish the service will be beneficial for both Aboriginal people and the non-Aboriginal people of Darwin.

Has there been an increase in secondary supply of alcohol to remote communities, and is it possible to establish an evidence based link to what may have caused any identifiable increase?

Grog-running is a problem in some situations, with both non-Aboriginal people and Aboriginal people contributing.[33, 34]

Where communities themselves lead decision-making processes, enforcement is more feasible and is working with rather than imposing on communities.

Are the liquor licence restrictions imposed at venues that are in or close to remote communities sufficient in reducing alcohol related harms in communities?

Yes, dry communities are a highly successful element of self-determination for Aboriginal communities, particularly for women in situations of family violence. Even if people continue to drink alcohol at harmful levels, if they cannot do this in the community, then non-drinkers are protected from alcohol-related harm. This is particularly valued by women.[34]

Is there a continuing role for local and regional alcohol management plans?

Yes, locally driven plans achieve local engagement based on community concerns and strengths, and avoiding top-down pressures.[35] Community-driven restrictions provide an opportunity for Aboriginal people to exercise their own authority for themselves. However, government-driven restrictions further disempower Aboriginal communities. All communities include people with different opinions and views, and to facilitate the best outcomes, communities should be provided with quality information and a range of options.[36]

Alcohol Management Plans (AMPs) are voluntary and community driven; and comprehensive, including a range of activities and resources to support people and communities in managing alcohol and related harms.

What is the best way to foster community participation in regional planning to reduce alcohol-related harm?

With alcohol such a powerful force within the Territory community, people are interested in alcohol-related planning. Providing opportunities for participation through electronic, in person and organisational engagement will foster broad-based community participation.

Liquor licensing and the Liquor Act

Minimum pricing

Increasing the price of alcohol is one of the most effective approaches to reducing alcohol consumption and alcohol-related harms.[37, 38] PHAA supports the introduction of a minimum price per standard drink below which alcohol products cannot be sold. A minimum price increases the price of only the cheapest alcohol products and prevent liquor retailers from using excessive discounting to attract customers. Substantial research evidence is available which supports the effectiveness of minimum pricing in reducing alcohol consumption; evidence is available from international evaluations of the policy,[39, 40] international modelling[41, 42] and modelling using Australian data.[43, 44]

PHAA strongly supports the recommendation of the People's Alcohol Action Coalition for NT's Liquor Act to be amended to allow the price of alcohol to be set, and a minimum price to be set at approximately $1.50 per standard drink.

Reducing the number of liquor licences

There are 727 licensed premises in the Northern Territory, 514 of which are currently active.[45] Most are located in Darwin and the surrounding area, with the remainder generally clustered in towns such as Alice Springs, Tennant Creek and Katherine. These licences increase the accessibility and availability of alcohol in the Territory and contribute to the high levels of harm in the community.

The NT Government introduced a moratorium on new take away liquor licences (except for exceptional circumstances) in October 2016. This should be extended to include on-license premises, transfer of existing licences and reactivation of liquor licences.

Given the adverse effects of alcohol on the Territory community, governing buy-back of licenses and implementation of a moratorium on new licenses could be considered a cost effective way to reduce harms of alcohol. Furthermore, introduction of appropriate penalties for repeated breaches of licence conditions including forfeiture of licence could be used to manage licencees who are not upholding responsible practices.

Licence fees

The NT appears to be the only Australian jurisdiction that does not apply annual fees for liquor licences. This is a significant weakness of the current approach to liquor licensing in the NT.

Licencees in the Territory pay the lowest fees in the nation for liquor licences. Licencees pay a one-off application fee of $200 for a liquor licence that is granted in perpetuity. There are no annual fees payable and the same application fee applies to all venues, regardless of the location, type or size of the venue or its trading hours and revenue turnover. These fees have not changed for more than five years.[46]

Establishing an annual liquor licence fee, indexed annually, would be a significant improvement on the current system. The revenue from annual licence fees could fund administration of the licencing system, support monitoring and enforcement of liquor licencing, and contribute to approaches to preventing harm from alcohol.

Risk-based licensing

Risk-based licensing frameworks have been adopted in other states and territories to set licence fees commensurate with the risk of alcohol-related harm and help to recover costs of liquor regulation and policing. PHAA support a risk-based licensing (RBL) model for setting licence fees. Under an RBL system, fees are determined by the likely risk of harm of the venue. For example, on-premise licence fees may include a base fee that is common to all on-premise venues with a risk loading added according to factors such as trading hours, patron capacity, location, venue type, and compliance with licensing legislation. Licensed venues associated with higher risks would pay higher fees than venues with lower risks in a RBL system, creating an incentive to reduce the risk of harm associated with a venue. Fees for bottleshops are calculated in a number of different ways across jurisdictions, including using sales revenue (as in the ACT), the number of outlets held by the licensee (as in NSW) or other criteria.

The additional revenue accrued following the introduction of an RBL scheme would be available to recover the costs associated with managing the regulatory system, policing, and other services.

We have concerns about the current system of granting liquor licences in perpetuity. It would be appropriate for the NT Government to limit the period over which liquor licences are granted to support greater accountability for licensees.

Licence categories

Formalising licence categories would promote consistency in liquor licensing decisions and would allow for differentiated licence fees across the categories of liquor licences, according to the risk of alcohol-related harms under a RBL model.

Trading hours

Controlling trading hours is an important strategy for managing alcohol-related harms. Increased liquor trading hours has been shown to be associated with an increase in alcohol harms.[47, 48] Modest restrictions on late-night liquor trading hours have been successful in reducing alcohol-related harms, particularly assaults.[49] PHAA supports a review of liquor trading hours in NT with a view to establishing appropriate last drinks and closing times for all licensed premises.

In addition to reviewing the trading hours of licensed venues, particularly those that trade late, the government should consider nominating one day each week that would be free of take away alcohol sales by any type of outlet in a nominated area. This could be considered in locations where there is a particularly high risk of alcohol harm and may be timed to link with days on which Centrelink payments are made.

Community representation in liquor licensing processes

Community views should be appropriately represented in liquor licensing processes. Those applying for liquor licences are often vastly better resourced to have their interests represented than members of the public. There should be clear and simple process through which members of the public can participate, make their views and concerns known, and inform licensing decisions.

Of all substances, alcohol has the greatest harm to people other than the user.[50] Therefore liquor licences can affect the entire community, who all potentially have an interest in responding to liquor licence applications. Members of the public should be assumed to have standing in hearings, since all members of the community can be affected by the promotion and sale of alcohol. Current limitations to standing undermine the rights of community members to be involved in important decisions about alcohol licences.

Members of the public who wish to inform liquor licensing decisions through an objection or another process should not require or feel that they require formal legal representation. The costs and effort associated with seeking legal representation are likely to be prohibitive for the vast majority of the public.

The existing barriers to public consultation on liquor licensing issues must be comprehensively addressed to ensure proper community representation in decision-making. These include the length of time in which an objection may be made, the restrictions on the grounds for objection, the process by which applicants respond to objections, and the costs associated with appealing decisions.

PHAA understands that public engagement with liquor licensing processes in NT has reduced substantially since the NT Licensing Commission was abolished. PHAA supports the reinstatement

of the NT Licensing Commission and its full functions and powers as it operated under the *Northern Territory Licensing Commission Act*. We emphasise the importance of consultative and transparent processes in liquor licensing decision-making with appropriate support provided for community engagement.

Concerns about the big-box warehouse liquor retailing format

We support the recent NT Government action to prevent the liquor barn format with a very large floor size from operating in the NT. We believe this demonstrates important leadership in protecting the NT community from the likely problems associated with the increased availability of large volumes of low-price alcohol.

Monitoring and enforcement of the Liquor Act

Enforcement of liquor laws is a critical element in the success of their implementation. The threat of enforcement must be seen by the target group as a real possibility, therefore enforcement activity should be frequent, unpredictable, strongly publicised and ongoing.[51, 52] Agencies involved in the monitoring and enforcement of liquor laws must be adequately resourced and have appropriate powers to ensure that all provisions are effectively monitored and enforced, including obligations regarding the Responsible Service of Alcohol (RSA).

Licenses should be suspended and removed for breaches, to ensure that Liquor License holders demonstrate commitment to the purpose of the Liquor Act.

We note the review that suggested that alcohol outlets in remote communities selling low strength products under tightly controlled conditions could reduce harm of alcohol.[53]

Restrictions on the promotion of alcohol

There is compelling evidence that exposure to alcohol advertising influences young people's beliefs and attitudes about drinking, and increases the likelihood that adolescents will start to use alcohol and will drink more if they are already using alcohol.[54, 55] Alcohol is one of the most heavily marketed products in the world and young people are exposed to alcohol promotion in a wide range of forms including television, radio, online, sponsorship, print, outdoor and product placement.

Liquor promotions by retailers have increased substantially in recent years and often centre heavily on using price discounts as an enticement to purchase the product such as 2-for-1 offers, product bundling, buy-one-get-one-free promotions, happy hours, and free gifts.[56] Cheap liquor prices are a concern in light of the strong evidence on the inverse relationship between the price of alcohol and overall consumption.[57] Advertising by packaged liquor outlets associated with supermarket chains are particularly concerning since they have been found to use more point of sale promotions, have a greater focus on price based promotions and require more alcohol purchases to participate in a promotion than other off premise retailers.[58]

The Northern Territory has a *Responsible Promotion of Alcohol Code of Practice* designed to regulate some of these activities, especially at on-license premises.[59] Regulating and restricting the

promotion of alcohol through activities such as prohibiting shopper dockets, point of sale promotional materials, and catalogue promotions, are also needed to reduce exposure to these advertisements.

Alcohol industry self-regulation of advertising and promotion has been ineffective in ensuring alcohol marketing is socially responsible and in preventing young people's exposure. Self-regulatory processes should be replaced by independent regulation with a special focus on protecting young people from exposure and appropriate sanctions for non-compliance. While there is an important role for the federal government in improving the regulation of alcohol marketing, we strongly encourage state and territory governments to act to control alcohol promotions as a matter of priority.

Other issues

Foetal Alcohol Spectrum Disorder

The 2015 report of the NT's Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder (FASD) made 26 recommendations. PHAA strongly supports the implementation of these recommendations, with adequate funding to prevent, diagnose and manage FASD.

Increase treatment service capacity

Treatment is an important part of any response to alcohol and other drug harm in the community. It has been proven to be effective in reducing demand for alcohol and other drugs through decreasing consumption, improving health, reducing criminal behaviour, improving psychological wellbeing, and participation in the community. Alcohol and other drugs treatment has also been shown to be cost effective, providing a return of just over $7 for every $1 invested.[60]

Treatment should include a range of service delivery options to accommodate the diverse needs of clients and their families. In addition to primary prevention and residential rehabilitation programs, there is a need for more culturally sensitive, non-residential treatment for Aboriginal and Torres Strait Islander clients. More alcohol diversion programs are also needed to address the overrepresentation of Aboriginal and Torres Strait Islander peoples in the Northern Territory's criminal justice system.

Ban political donations from the alcohol industry

Political donations are one way in which the alcohol industry can influence decision-making by the government, including conditions of supply. The ability to influence ministerial or government decisions raises questions of fairness, independence and quality of decisions such as whether they are made in the public interest or some private or commercial interest.

Phase out alcohol as gifts

To support broader efforts to modify the drinking culture, it would be appropriate to ensure that NT government employees do not give alcohol as a gift. This includes both large scale entertainment in which people should cover the cost of their own alcoholic beverages, and also small scale awards, where it is mainly a symbolic measure.

Alcohol taxation reform

Ideally, a minimum price would be introduced in association with alcohol taxation reform at the federal level to provide a more equitable system of taxation that removes the incentive to produce large volumes of cheap alcohol. Currently, wine is taxed based on the wholesale value of the wine, which means that the cheaper the product, the less tax is paid by the producer to the government, even though the amount of alcohol in the product is the same. This encourages the production of large volumes of cheap wine. This is a concern because those that drink alcohol at the most harmful levels are more likely to consume cheap wine.

Beer and spirits, however, are taxed according to the volume of alcohol within the product. This is known as a volumetric tax and presents a more equitable way of taxing alcohol because it recognises that the potential for harm from a product is determined by the level of alcohol in the product, not by the price. Hence, public health advocates and others have called for reform of the alcohol taxation system so that all alcohol based beverages are taxed on a volumetric basis.

The introduction of a volumetric tax on wine would increase the price of the cheapest alcohol products and provide tax revenue that can be used for services that provide prevention, early intervention and treatment services.

Decisions about taxation are made at the federal level and at this stage, the Australian Government has not committed to changing the alcohol taxation system. Alcohol taxation reform should continue to be pursued however and the Northern Territory Government should be encouraged to advocate for this at the national level.

Conclusion

PHAA supports the broad directions of the Northern Territory Government in seeking to minimize the harms from alcohol. However, we are keen to ensure that alcohol issues are addressed across the entire community, rather than focusing only on a set of people who may be considered problem drinkers, and that people who are affected by alcohol are offered effective rehabilitation rather than punishment. We are particularly keen that the following points are highlighted:

- Community engagement and awareness of the significant harm to all members of the community from alcohol. Particular focus on non-Aboriginal people and harms to them from drink driving, difficulties at work, to heighten awareness that the entire NT community suffers from alcohol-related harm and this is not merely a problem for Aboriginal people.

- Commitment to research, monitoring and evaluation that provides local information to manage alcohol-related issues as they affect people in NT. Examples are evaluation of the BDR, better knowledge of FASD and effectiveness of alcohol-treatment programs as they are provided in NT.

The PHAA appreciates the opportunity to make this submission and would be available to provide further information on specific issues and further contribute our expertise on this issue.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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References

1. Gao, C, Ogeil, RP, & Lloyd, B. (2014). Alcohol's burden of disease in Australia. Canberra: FARE and VicHealth in collaboration with Turning Point.
2. Laslett, AM, Room, R, Ferris, J, Wilkinson, C, Livingston, M,& Mugavin, J. (2011). Surveying the range and magnitude of alcohol's harm to others in Australia. *Addiction*, 106, 1603–1611.
3. ABS Census of Population and Housing: Estimating Homelessness, 2011. Australian Bureau of Statistics Cat. number 2049.0 http://abs.gov.au/ausstats/abs@.nsf/Latestproducts/2049.0Main%20Features22011
4. PwC Indigenous Consulting with Menzies School of Health Research (2017). Evaluation of the Alcohol Mandatory Treatment Program. Darwin, Northern Territory Department of Health. Avaliable at http://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/1226/1/Alcohol%20Mandatory%20Treatment%20Evaluation%20Report.pdf
5. Rollins, A. "Rivers of Cheap Grog Blight Indigenous Communities." *Australian Medicine* 2014, 26 (22):25-6
6. Stafford, Allsop, Daube. From evidence to action: health promotion and alcohol. Health Promotion Journal of Australia, 2014, 25, 8–13
7. Wakefield MA, Loken B, Hornik RC. Use of mass media campaigns to change health behaviour. Lancet. 2010; 376(9748):1261–71..
8. Dunstone K, Brennan E, Durkin S, Dixon H, Pettigrew S, Slater M, Wakefield M. *Comparing alcohol harm reduction advertisements on their ability to motivate behaviour change among adult drinkers*. CBRC Research Paper Series No. 48. Melbourne, Australia: Centre for Behavioural Research in Cancer, Cancer Council Victoria, 2017.
9. Wakefield MA, Brennan E, Dunstone K, Durkin SJ, Dixon HG, Pettigrew S, et al. Features of alcohol harm reduction advertisements that most motivate reduced drinking among adults: an advertisement response study. BMJ .; 7(4):e014193.
10. Wakefield MA, Loken B, Hornik RC.(2010). Use of mass media campaigns to change health behaviour. Lancet. 376(9748):1261–71.
11. Pierce, H., Stafford, J. (2017). *A Guide to the Alcohol Industry. Peak Bodies and Representative Groups*. Perth: McCusker Centre for Action on Alcohol and Youth, Curtin University
12. Cobiac, L, Vos, T, Doran, C, Wallace, A.(2009).. Cost-effectiveness of interventions to prevent alcohol-related disease and injury in Australia. Addiction. 2009; 104(10):1646-1655
13. Rossow, I, & Romelsj, A.(2006). The extent of the 'prevention paradox' in alcohol problems as a function of population drinking patterns. Addiction. 101(1):84-90
14. Loxley W, Gilmore W, Catalano P, et al. National Alcohol Sales Data Project (NASDP) Stage 5 Report. Perth, Western Australia: National Drug Research Institute, Curtin University; 2016.
15. Stockwell T, Zhao J, Chikritzhs T, Greenfield T.(2009) What did you drink yesterday? Public health relevance of a recent recall method used in the 2004 Australian National Drug Strategy Household Survey. Addiction. 103:919-928.
16. World Health Organization. (2000). International guide for monitoring alcohol consumption and related harm. Geneva: WHO.
17. Stockwell T, Donath S, Cooper-Stanbury M, Chikritzhs T, Catalano P, Mateo C.(2004) Under-reporting of alcohol consumption in household surveys: a comparison of quantity-frequency, graduated-frequency and recent recall. Addiction. 99(8):1024-33.
18. National Preventative Health Taskforce.(2009). Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – the roadmap for action. Canberra: Commonwealth of Australia.
19. World Health Organization.(2010). Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization.
20. Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K,(2010). Alcohol: no ordinary commodity – research and public policy. Oxford: Oxford University Press; 2010.

21. Cobiac ,L, Vos, T, Doran, C, Wallace, A.(2009). Cost-effectiveness of interventions to prevent alcohol-related disease and injury in Australia. *Addiction.* **104**(10): 1646–55.
22. National Preventative Health Taskforce.(2008). Technical report no 3: preventing alcohol-related harm in Australia: a window of opportunity. Canberra: Commonwealth of Australia;.
23. National Preventative Health Taskforce. (2009). Australia: the healthiest country by 2020 – National Preventative Health Strategy – the roadmap for action. Canberra: Commonwealth of Australia;
24. Willis, C, Lybrand, S, & Bellamy, N.(2004). Alcohol ignition interlock programmes for reducing drink driving recidivism. The Cochrane database of systematic reviews. (4):Cd004168.
25. Martin TL, Solbeck PA, Mayers DJ, Langille RM, Buczek Y, & Pelletier MR.(2013). A review of alcohol-impaired driving: the role of blood alcohol concentration and complexity of the driving task. Journal of forensic sciences. 2013;58(5):1238-50
26. World Health Organization.(2012) Alcohol in the European Union: consumption, harm and policy approaches Copenhagen; 27 March 2012
27. Ferris J, Mazerolle L, King M, Bates L, Bennett S, Devaney M. (2013) Random breath testing in Queensland and Western Australia: examination of how the random breath testing rate influences alcohol related traffic crash rates. Accident; analysis and prevention.60:181-8.
28. Curtis, A, Coomber, K, Droste, N, Hyder, S, Palmer, D, Miller, PG.(2017). Effectiveness of community-based interventions for reducing alcohol-related harm in two metropolitan and two regional sites in Victoria, Australia. Drug and Alcohol Review. 2017; 36: 359–368.
29. Foster, J, Harrison, A, Brown, K, Manton, E, Wilkinson, C, & Ferguson, A. (2017). *Anytime, anyplace, anywhere? Addressing physical availability of alcohol in Australia and the UK.* London and Canberra: Institute of Alcohol Studies and the Foundation for Alcohol Research and Education.
30. Eversole, R. (2011). Community Agency and Community Engagement: Re-theorising Participation in Governance. *Journal of Public Policy, 31*(1), 51-71. DOI: https://doi.org/10.1017/S0143814X10000206
31. Chan, M. (2013). WHO's response to article on doctors and the alcohol industry. *BMJ* 2013;346: 2647.
32. Larrakia Nation. Outreach services. Accessed on 06/07/2017 at http://larrakia.com/services/outreach-services/#return
33. Senior, K, & Chenhall, R. (2008). "Lukumbat Marawana: A Changing Pattern of Drug Use by Youth in a Remote Aboriginal Community." *The Australian Journal of Rural Health.*, vol. 16 (2), 2008, pp. 75–79.
34. Brady, M.(2014). Lessons from a history of beer canteens and licensed clubs in Indigenous Australian communities'. Discussion Paper No. 290/2014. *Centre for Aboriginal Economic Policy Research ANU College of Arts & Social Sciences*.
35. Priday, E, Bygrave, L, Donnelly, H, Regester, J, Gargett, A, & Bedford, J. (2013). *Social justice and native title report 2013.* Canberra: Australian Human Rights Commission (p125)
36. Brady, M. Lessons from a history of beer canteens and licensed clubs in Indigenous Australian communities'. Discussion Paper No. 290/2014. Centre for Aboriginal Economic Policy Research ANU College of Arts & Social Sciences.
37. Wagenaar A, Salois M & Komro K.(2009). Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction, 2009; 104:179-90
38. Anderson P, Chisholm D & Fuhr DC.(2009). Alcohol and Global Health 2: Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. Lancet 2009; 373:2234-46
39. Stockwell, T, Zhao, H, Giesbrecht ,N, Tomas, G, & Wettlaufer, A.(2012). The raising of minimum alcohol prices in Saskatchewan, Canada: Impacts on consumption and implications for public health. American Journal of Public Health 2012; 102(12):e103-e110
40. Stockwell, T, Auld, M, Zhao, J, & Martin, G. Does minimum pricing reduce alcohol consumption? The experience of a Canadian province Addiction 2012; 107: 912-920
41. Meier, P, Holmes, J, Meng Y,& Brennan, A.(2014). Choosing between different alcohol pricing and taxation strategies: a comparative policy appraisal using the Sheffield Alcohol Policy Model. The Lancet. 384:Page S51.

42. Purshouse ,RC, Meier, PS, Brennan, A, Taylor KB, & Rafia R.(2010). Estimated effect of alcohol pricing policies on health and health economic outcomes in England: an epidemiological model. The Lancet. 375(9723):1355-1364.
43. Vandenberg, B, & Sharma, A.(2016). Are alcohol taxation and pricing policies regressive? Product-level effects of a specific tax and a minimum unit price for alcohol. Alcohol and Alcoholism. 51(4):493-502.
44. Sharma A, Vandenberg B, & Hollingsworth B.(2014). Minimum Pricing of Alcohol versus Volumetric Taxation: Which Policy Will Reduce Heavy Consumption without Adversely Affecting Light and Moderate Consumers? PLoS ONE. 9(1):e80936.
45. Northern Territory Department of the Attorney-General and Justice, Licencing, Regulation and Alcohol Strategy. http://notes.nt.gov.au/ntt/dibrglllr.nsf/WebByLicenceStatus?OpenView viewed 5/7/17
46. PAAC & FARE. (2016). Northern Territory 2016 Election Platform: Calling time on too much grog in the NT. People's Alcohol Action Coalition, Foundation for Alcohol Research & Education. http://paac.org.au/index.html.
47. Chikritzhs, TN, & Stockwell TR.(2002). The impact of later trading hours for Australian public houses (hotels) on levels of violence. J Stud Alcohol 2002; 63: 591–599.
48. Stockwell, T, & Chikritzhs, T.(2009). Do relaxed trading hours for bars and clubs mean more relaxed drinking? A review of international research on the impacts of changes to permitted hours of drinking. Crime Prev Community Saf . 11: 153–170.
49. Menéndez, P, Kypri, K, & Weatherburn, D. (2017). The effect of liquor licensing restrictions on assault: a quasi-experimental study in Sydney, Australia. Addiction, 112: 261–268. *doi:*10.1111/add.13621.
50. Nutt, DJ, King, LA, & Phillips, LD.(2010). Independent Scientific Committee on Drugs. Drug harms in the UK: a multicriteria decision analysis. Lancet 376: 1558–65
51. Auditor General Western Australia.(2011). Raising the Bar: Implementing key provisions of the Liquor Control Act in licensed premises,
52. National Drug Research Institute.(2007). Restrictions on the sale and supply of alcohol: Evidence and outcomes. Perth: National Drug Research Institute, Curtin University of Technology.
53. Shaw, G, Brady, M, & D'Abbs, P. (2015). Managing Alcohol Consumption: A review on licensed clubs in remote Indigenous communities in the NT. Bowching Ptd Ltd, Canberra
54. Anderson, P, De Bruijn, A, Angus, K, Gordon, R, & Hastings, G. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies. Alcohol and Alcoholism 44, pp. 229-43.
55. Jernigan, D, Noel, J, Landon, J, Thornton, N, & Lobstein,T.(2016). Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008. Addiction. 2016; 112(Suppl. 1):7-20.
56. Johnston, R, Stafford, J, Pierce, H, & Daube, M. (2016). Alcohol promotions in Australian supermarket catalogues. Drug and Alcohol Review. DOI: 10.1111/dar.12478
57. Wagenaar, AC, Salois, MJ, & Komro, KA. (2009). Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction 104: 179-190
58. Johnston, R, Stafford, J, Pierce, H, & Daube, M. (2016). Alcohol promotions in Australian supermarket catalogues. Drug and Alcohol Review. DOI: 10.1111/dar.12478
59. Department of Business and Industry (no date) Responsible promotion of alcohol code of practice. Accessed on 7 June 2017 at https://nt.gov.au/industry/hospitality/responsible-promotion-of-alcohol-code-of-practice
60. Ettner, S.L, Huang, D, Evans, E, Ash, DR, Jouravchi,M, & Hser,YI.(2006). Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? *Health Services Research* 2006; 41: 192-213