ENDEAVOUR
DRINKS GROUP

24 March 2017

**By email: AODD.DOH@nt.gov.au**

To Whom It May Concern

**RE: ALCOHOL POLICIES AND LEGISLATION REVIEW IN THE NORTHERN TERRITORY**

Endeavour Drinks Group (EDG) welcomes the opportunity to provide this submission on the Draft Terms of Reference for the above forthcoming review.

EDG operates 12 liquor outlets across the Northern Territory trading under the BWS brand. These operate under several classes of licences and include Supermarket-attached, stand-alone as well as hotel drive-through formats.

EDG is further committed to bringing Dan Murphy's, Australia's most successful retail drinks business, to the Darwin market and we are presently seeking the opportunity to transfer the BWS Stuart Park licence to a brand new Dan Murphy's at the Darwin Airport.

In operating these outlets, EDG fully acknowledges that it has a responsibility to work with the Governments as well as the community to minimise harm to individuals and local communities. It is for this reason that we continue to operate our liquor business over and above the required standards of legal compliance and have implemented a wide range of voluntary product and service control initiatives across our stores that are focussed on responsible supply and promotion of alcohol.

We thank the Northern Territory Government for the opportunity to make this submission. EDG has a long record of cooperation with NT regulators in the development of policy to reduce the negative impact of alcohol on some sections of the NT community.

**Context of alcohol-related harm and the need for a more holistic terms-of-reference**

With infectious and communicable disease largely contained, chronic diseases are now Australia's greatest burden of disease. The largest disease groups contributing to the Australasian burden of disease in 2010 were cancer, musculoskeletal disorders, cardiovascular diseases, and mental and behavioural disorders.

Alcohol consumption and its contribution to the burden of disease is calculated by the NHMRC[1] as accounting for 3.3 per cent of the total burden of disease and injury in Australia in 2003; 4.9 per cent in males and 1.6 per cent in females. This compared with a contribution of 7.8 per cent for tobacco smoking, 7.5 per cent for high body mass, 7.6 per cent for hypertension and 6.6 per cent for physical inactivity[2] .

The relative weight of alcohol as a contributor to the burden of disease is important as it sets the context from which Governments and policy-makers seek to allocate a finite amount of taxpayers dollars in order to achieve returns on the health of all Australians from that investment.

In the NT Government seeking to establish an integrated Alcohol Harm Reduction Strategy, care must be taken not to separate alcohol from a range of action and activities that can holistically lead to large health gains across the population.

The ability to successful modify preventable shared risk factors can reduce illness and rates of death. This is because the likelihood of developing certain chronic diseases increases proportionally to an individuals number of risk factors.

According to the AIHW, chronic diseases are closely associated with modifiable risk factors[3] such as smoking, physical inactivity, poor nutrition and the harmful use of alcohol. These behaviours contribute to the development of biomedical risk factors[4], including overweight and obesity, high blood pressure, and high cholesterol levels, which in turn lead to chronic disease.

Two risk factors that commonly occur together are risky alcohol drinking and smoking. In 2010, 38% of current smokers also consumed alcohol at risky levels, compared with only 12% of people who had never smoked[5]. Daily smoking is also more commonly reported by people with low levels of physical activity. People who are obese often also have high blood pressure[6].

The risk in developing a stand-alone review looking narrowly at 'Alcohol Policy' and 'Alcohol Legislation' is the decoupling of alcohol from other modifiable risk behaviours.

A holistic policy approach to improving health outcomes for all Northern Territorians would be a combined strategy that involves better delivery and coordination across the health-care continuum, from health promotion and prevention, to early detection where appropriate, and to primary, secondary and tertiary care. There would clearly be a need for General Practioners and the medical profession to perform a key role in screening, advice and prevention and for referral to further professional services and support networks.

[1] https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf
[2] Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD 2007. The burden of disease and injury in Australia 2003. Cat. no. PHE 82. Canberra: AIHW.
[3] http://www.aihw.gov.au/australias-health/2014/health-behaviours/#t2
[4] http://www.aihw.gov.au/australias-health/2014/health-behaviours/#t1
[5] AIHW, forthcoming 2014a. Head and neck cancers in Australia. Canberra: AIHW
[6] AIHW 2012b. Risk factors contributing to chronic disease. Cat. no. PHE 157. Canberra: AIHW

Commonwealth and State Health Ministers have previously recognised that such an approach can strengthen and transform health-care systems, resulting in more effective, efficient, and timely care[7].

EDG submits that the Terms of Reference should be significantly broadened to review the wider multi-faceted elements which contribute to the Territory having higher rates of harm in a number of health outcomes, rather than just on alcohol alone.

Focussing specifically on alcohol runs the risk of the review dividing down the lines of special vested interest groups and the efficacy of their well held policy positions.

EDG further submits that the proposed "Expert Advisory Panel" should draw most heavily from experts who carry a multi-disciplined approach to achieving health outcomes, rather than from specialised alcohol researchers/anti-alcohol advocates.

Clearly, there should be a role for industry participants, as changes to alcohol policy can have a significant impact on the jobs and economic activity that flow from the Northern Territory's important hospitality and tourism industries.

The Panel would also be significantly strengthened through the chairing of an eminent person who is clear of conflicts and takes a strong methodological and evidence-based approach.

If the Government chooses to discount the clear benefits in a broadly holistic approach and instead solely focus on the alcohol, then the Terms of Reference should clearly specific that the Review encompasses the entire Liquor Act, rather than its present weighting in both ministerial statement and media interview towards off-premise matters.

In doing so, attention is warranted in framing the Terms of Reference to the specific Objectives of the Act, or at least to test why the Objectives may or may not be relevant any longer.

For example, it is unclear why 400 sq m was imposed as the maximum floor limit for off-premise. The terms of reference should review the evidence base for this number as well as its applicability for bars, restaurants, sporting clubs, social venues, and the licensed areas of casino's and accommodation hotels. Several leading hotel presently serve alcoholic beverages to customers in 1,000 sq m plus sized function rooms, and the Northern Territory Government itself is a owner of the Convention centre boasting over 22,900 square metres of space.

Equally in light of the claimed success of lockouts in Sydney, Newcastle and Adelaide; the Terms of Reference should specifically review this particular policy.

As the Northern Territory Government is also a respondent to the Harper Review into competition reform, the Terms of Reference provide the perfect opportunity to review the alcohol related recommendations of that review, particularly scrutinising the closure of liquor stores on a Sunday in order to protect the trade of hotel bottle-shop and drive throughs.

[7] Standing Council on Health 2013. National Primary Care Strategic Framework. Canberra: Commonwealth of Australia.

The Terms of Reference should:

- Take a holistic approach to alcohol harms and its contribution to the wider disease burden.
- If a holistic approach is not taken, then the Terms of Reference should test why the Objectives may or may not be relevant any longer, and in doing so clearly encompass the entire Liquor Act in the Review, while specifically looking at:
  - extending the 400 sq m. rule to other liquor outlets if the Review finds it to be an effective policy mechanism
  - lockouts and late night closing hours which has been recognised as one of the reportedly more successful strategies used to minimise alcohol-related harms in other jurisdictions
  - Harper Review recommendation on alcohol with particular scrutiny on the closure of liquor stores on a Sunday to protect the trade of hotel bottle-shops and drive-throughs
- The "Expert Panel" to be chaired by an eminent person and comprised from industry and people of a multi-discipline background rather than vested interests in alcohol research and anti-alcohol advocacy

<u>Social Determinants are important when looking at Northern Territory rates of alcohol-related harm</u>

Furthering the case for a holistic approach is a recognition that improving health outcomes is contingent on social determinants of health – namely the conditions into which people are born, grow, live, work and age – and redressing health disadvantage across the social gradient.

Low socioeconomic groups generally have a higher prevalence of risk factors and greater health needs, and can benefit from targeted prevention activities. Hard-to-reach population groups, whether through distance or other access barriers such as language or culture, present additional challenges which can benefit from community-level action.

The following AIHW table demonstrates the dichotomy of the Territory against relevant peer sets. Firstly comparing against other capital cities, Darwin rates of harm are similar to other capital cities. Secondly comparing against other 'Outback' regions, the Territory rates of harm are similar to other Outback areas. What is clearly highlighted when comparing the two is that rates of harm are significantly higher in Outback areas than in metropolitan.

The present Terms of Reference fail to adequately acknowledge the Territory has distinctly different levels of harms arising in both geographic and population sub-groups. This challenges the assumption that creating a single set of alcohol-policies is the only path to be explored.

**Table S7.19: Tobacco use, alcohol risk and recent[a] illicit drug use, people aged 14 years or older, by Statistical Area Level 4 (SA4), 2013 (per cent)**

| | Smoking status | | | Alcohol risk | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| SA4 | Daily | Ex-smoker[c] | Never smoked[d] | Abstainers/ ex-drinkers[e] | Lifetime risk: Low risk[f] | Lifetime risk: Risky[g] | Single occasion: Low risk[h] | Single occasion: yearly but not monthly[i] | Single occasion: At least monthly[j] | Recent any illicit[k] |
| Sydney - City and Inner South(117) | 9.8 | 28.4 | 56.2 | 18.3 | 54.9 | 26.9 | 35.9 | 10.8 | 35.0 | 29.0 |
| Melbourne - Inner(206) | 9.5 | 23.4 | 59.5 | 17.4 | 57.5 | 25.0 | 35.9 | 12.7 | 33.9 | 25.9 |
| Brisbane Inner City(305) | 10.3 | 21.6 | 65.9 | 15.0 | 62.7 | 22.3 | 32.8 | 18.3 | 33.9 | 22.6 |
| Perth - Inner(503) | 7.0 | 22.7 | 68.1 | 16.2 | 62.9 | 20.9 | 39.1 | 13.1 | 31.6 | 18.9 |
| Adelaide - Central and Hills(401) | 13.0 | 22.2 | 61.2 | 14.4 | 70.6 | 15.0 | 46.5 | 15.9 | 23.2 | 15.9 |
| Darwin(701) | 20.8 | 24.0 | 52.3 | 19.0 | 53.3 | 27.8 | 30.0 | 13.4 | 37.6 | 21.1 |
| Average | 11.7 | 23.7 | 60.5 # | 16.7 | 60.3 | 23.0 | 36.7 | 14.0 | 32.6 | 22.2 |
| Far West and Orana(105) | 22.9 | 17.8 | 59.3 | 26.5 | 55.9 | 17.6 | 26.7 | 13.0 | 33.8 | *17.7 |
| Queensland - Outback(315) | 15.4 | 32.9 | 51.7 | 16.3 | 47.9 | 35.7 | 32.3 | 10.1 | 41.3 | 4.0 |
| Western Australia - Outback(508) | 19.1 | 29.2 | 48.7 | 17.3 | 43.7 | 39.0 | 24.8 | 12.0 | 46.0 | 24.2 |
| Western Australia - Wheat Belt(509) | 23.6 | 28.8 | 45.7 | 14.4 | 53.5 | 32.1 | 44.6 | 4.3 | 36.8 | 7.1 |
| South Australia - Outback(406) | 11.3 | 31.2 | 57.5 | 18.8 | 46.8 | 34.4 | 38.8 | 7.4 | 35.0 | 15.3 |
| Northern Territory - Outback(702) | 22.0 | 28.0 | 47.2 | 13.6 | 54.1 | 32.4 | 33.3 | 10.4 | 42.7 | 23.4 |
| Average | 19.0 | 28.0 | 51.7 # | 17.8 | 50.3 | 31.9 | 33.4 | 9.5 | 39.3 | 14.8 |

(a) Used in previous 12 months.
(b) Includes people who smoke weekly or less than weekly.
(c) Smoked at least 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco in their life, and reported no longer smoking.
(d) Never smoked 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco.
(e) Not consumed alcohol in the previous 12 months.
(f) On average, had no more than 2 standard drinks per day.
(g) On average, had more than 2 standard drinks per day.
(h) Never had more than 4 standard drinks on any occasion.
(i) At least once in the previous year but not as often as monthly.
(j) Had more than 4 standard drinks on one occasion at least once a month.
(k) Illict use of at least 1 of 17 drugs in the previous 12 months in 2013.

The Terms of Reference should:

- Recognise improving health outcomes is contingent on social determinants of health - namely the conditions into which people are born, grow, live, work and age – and redressing health disadvantage across the social gradient.

**Alcohol can be both a harm and a benefit to chronic health problems**

Northern Territorians are probably one of the most social people in the world. It is a part of Australia that celebrates friendship, honesty, generosity and hospitality. Coupled with that is the associated consumption of alcohol which entwines with many social and cultural activities.

The draft Terms of Reference are correct to focus on excessive consumption of alcohol as it is widely acknowledged as a major cause of road and other accidents, domestic and public violence, crime, liver disease and brain damage, and contributes to family breakdown and broader social dysfunction.

In moderation, however, it is evident that it has a beneficial effect on Australia's largest disease burden – cardiovascular disease – even when accounting for the so-called "sick quitters". And for the majority of Territorians, alcohol is associated with an improvement in their overall wellbeing.

As such, the Terms of Reference should also recognise that there is both a carrot and a stick to helping achieve health outcomes. As such, they would significantly benefit in a consideration of strategies and policies which can provide "a carrot" to better encourage and explicitly recognise that

alcohol can be largely enjoyed in moderation by the vast majority of Territorians. The present focus too narrowly casts any form of alcohol consumption as being harmful.

| |
|---|
| The Terms of Reference should:<br><br>• consider strategies and policies which can provide "a carrot" to better encourage and explicitly recognise that alcohol can be largely enjoyed in moderation by the vast majority of Territorians |

**A focus on prevention can help solve chronic health problems**

The development of an Alcohol Harm Reduction Strategy should recognise and frame the role that Prevention plays in reducing the harmful use of alcohol and other risk factors to chronic disease.

Casting the Strategy in this light creates a decision matrix upon which specific alcohol policies can be assessed[8]:

- primary prevention, which reduces the likelihood of developing a disease or disorder
- secondary prevention, which interrupts, prevents or minimises the progress of a disease or disorder at an early stage
- tertiary prevention, which halts the progression of damage already done.

How to then determine the best avenue for directing that policy depends on the population groups you are trying to influence[9]:

- Universal prevention is desirable for the entire population, or particular age groups such as early childhood, adolescence or the elderly.
- Selective prevention is for people with a greater than average risk of developing a disease, such as Aboriginal and Torres Strait Islander people, people from low socioeconomic status groups and refugees.
- Indicated prevention is for people at high risk, such as injecting drug users or prisoners

Clearly each of these prevention activities requires a range of stakeholders who will have varying levels of engagement, expertise and capability to influence and assist people in making healthy choices and leading healthier lives.

Who needs to act depends largely on which area of prevention is a focus: whether it is modifying health risk factors, or preventing the progression, complications and recurrence of disease. For example in the alcohol space, the work that DrinkWise conducts around health promotion through public awareness campaigns and community-based programs largely target risk factor prevention, while general Practitioners, specialists and allied health professionals often provide health counselling and the effective management of disease[10].

[8] WHO (World Health Organization) 2004. Global forum on chronic disease prevention and control (4th, Ottawa, Canada). Geneva: WHO.
[9] http://www.aihw.gov.au/australias-health/2014/preventing-ill-health/#t1
[10] RACGP (Royal Australian College of General Practitioners) 2012. Guidelines for preventive activities in general practice, 8th edn. East Melbourne: RACGP

Decisions by policy makers and Governments on where and how to invest in prevention are often multifaceted and take regard of the efficacy of the measure, whether it is costly or adds value, whether its targets the few or many, and how widespread the benefits and return is likely to be.

The Terms of Reference would, therefore, benefit from better defining which of these three areas are more worthy of exploring. EDG submits that the universal prevention has largely been exhausted and should be specifically removed as an area of focus in the review.

Northern Territory has already pulled the 'universal prevention' lever

As previously outlined, universal prevention is a prevention activity aimed at the entire population, and is also commonly referred to as "whole-of-population" measures.

While highly contested over their effectiveness at targeting harmful consumption, the World Health Organization (WHO) has suggested that there are three universal prevention measures that countries can use to produce results in terms of lives saved, diseases prevented and large costs avoided[11] which include:

- restricting or enforcing bans on tobacco and alcohol advertising, promotion and sponsorship
- excise tax increases on tobacco and alcohol
- restricting access to retailed alcohol

As an advanced economy with a strong history in leading with public health universal population measures, Australia and the Northern Territory in particular, has already pulled these levers.

Australians are subject to robust and enforceable drink-driving laws; our alcohol taxes are the second highest in the OECD; we have significant restriction on when, where, and how we can purchase alcohol; and we prohibit many forms of alcohol advertising, promotion, marketing, and sponsorships that are acceptable in many other advanced economies.

Recent comments and continual reviews by the Productivity Commission would suggest that this has been to the detriment of customers and consumers[12].

EDG questions the value of a term-of-reference which involves reviewing further restrictions and further tightening of alcohol control policies. With the exception of Nordic countries who maintain Government-owned and controlled alcohol stores, Australia has one of the strongest set of universal Alcohol Control Policies in the world[13] and the strictest in our region[14]. In turn, the Northern Territory Government, through COAG and the National Alcohol Strategy, would be aware it has Australia's most restrictive alcohol-control polices over that of other States and Territories.

[11] WHO 2013. Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva: WHO.
[12] http://www.pc.gov.au/news-media/speeches/making-a-difference
[13] Brand DA, Saisana M, Rynn LA, Pennoni F, Lowenfels AB (2007) Comparative analysis of alcohol control policies in 30 countries. PLoS Med 4(4): e151. doi:10.1371/journal. pmed.0040151
[14] Developing an alcohol policy assessment toolkit: application in the western Pacific Natacha Carragher, Joshua Byrnes, Christopher M Doran & Anthony Shakeshaft

For example, no other jurisdictions maintain quasi-minimum-price policies in three major regional areas. No other jurisdiction has a moratorium on new packaged liquor licences. No other jurisdiction has applied an arbitrary 400 sq m. maximum trading floor. No other jurisdiction has decided its Supermarket shoppers should be denied the convenience of purchasing alcohol on a Sunday.

As such, in reviewing other regimes, it is important not to jump to conclusions about other more restrictive regimes and instead think laterally about available options.

| Country | Ranks | | | Scores | | |
|---|---|---|---|---|---|---|
| | Baseline | Median | Range | Baseline | Median | Range |
| Norway | 1 | 1 | 1–2 | 67.3 | 71.1 | 63–77 |
| Poland | 2 | 2 | 1–4 | 67.0 | 70.6 | 67–76 |
| Iceland | 3 | 4 | 2–6 | 64.5 | 63.4 | 56–74 |
| Sweden | 4 | 4 | 2–5 | 63.8 | 64.3 | 60–73 |
| Australia | 5 | 5 | 3–7 | 62.8 | 62.9 | 56–65 |
| Hungary | 6 | 8.5 | 6–12 | 57.5 | 51.4 | 46–62 |
| Slovakia | 7 | 7.5 | 6–12 | 57.0 | 54.9 | 46–63 |
| Finland | 8 | 7 | 4–10 | 54.2 | 57.3 | 50–65 |
| Japan | 9 | 10.5 | 6–17 | 52.4 | 50.1 | 38–55 |
| Canada | 10 | 10 | 7–14 | 50.1 | 50.1 | 46–52 |
| New Zealand | 11 | 10 | 6–12 | 49.9 | 50.1 | 47–59 |
| Turkey | 12 | 12 | 6–16 | 48.7 | 48.8 | 41–57 |
| Mexico | 13 | 13 | 11–17 | 45.1 | 43.8 | 39–49 |
| Korea | 14 | 13 | 8–18 | 43.3 | 47.0 | 39–53 |
| United States | 15 | 16.5 | 13–27 | 43.1 | 40.2 | 19–47 |
| Belgium | 16 | 16 | 14–20 | 41.7 | 39.8 | 36–43 |
| Spain | 17 | 18 | 14–21 | 40.9 | 38.4 | 32–47 |
| Ireland | 18 | 17.5 | 15–19 | 40.8 | 38.7 | 36–45 |
| Greece | 19 | 18.5 | 15–23 | 36.2 | 37.6 | 32–42 |
| United Kingdom | 20 | 21.5 | 20–23 | 35.5 | 33.9 | 28–36 |
| Czech Republic | 21 | 23 | 19–26 | 35.4 | 31.8 | 25–36 |
| Netherlands | 22 | 21 | 17–24 | 34.4 | 35.0 | 29–40 |
| Italy | 23 | 22 | 16–24 | 34.2 | 33.6 | 30–39 |
| Denmark | 24 | 22 | 18–24 | 33.2 | 32.1 | 28–37 |
| Portugal | 25 | 25.5 | 23–27 | 27.2 | 25.1 | 21–28 |
| France | 26 | 26 | 24–27 | 26.9 | 24.3 | 20–28 |
| Austria | 27 | 27.5 | 27–28 | 23.0 | 19.4 | 15–23 |
| Germany | 28 | 29 | 28–29 | 22.4 | 17.3 | 11–22 |
| Switzerland | 29 | 27 | 24–29 | 22.4 | 21.7 | 14–30 |
| Luxembourg | 30 | 30 | 30–30 | 14.5 | 12.1 | 6–16 |

Table 2. **TEASE-16 alcohol policy scores for nine study areas in the western Pacific, 2011**

| Study area | Rank | Points scored | | | | | |
|---|---|---|---|---|---|---|---|
| | | Physical availability | Drinking context | Alcohol prices | Alcohol advertising | Motor vehicle regulations | Total |
| Australia | 1 | 11.2 | 5.3 | 18.4 | 0.4 | 32.2 | 67.5 |
| Singapore | 2 | 14.5 | 5.3 | 23.7 | 0.4 | 20.5 | 64.4 |
| New Zealand | 3 | 3.9 | 3.9 | 23.7 | 0.4 | 30.3 | 62.3 |
| Hong Kong SAR | 4 | 10.5 | 5.3 | 17.8 | 1.5 | 23.0 | 58.1 |
| Japan | 5 | 5.9 | 3.9 | 21.1 | 0.4 | 25.0 | 56.4 |
| Malaysia | 6 | 9.6 | 3.9 | 23.7 | 2.0 | 16.6 | 55.8 |
| China[a] | 7 | 5.9 | 0.0 | 17.8 | 0.0 | 26.4 | 50.1 |
| Viet Nam | 8 | 5.9 | 7.9 | 11.8 | 2.6 | 13.6 | 41.8 |
| Philippines | 9 | 5.9 | 0.0 | 17.8 | 0.4 | 0.0 | 24.1 |
| **Median** | | **5.9** | **3.9** | **18.4** | **0.4** | **23.0** | **56.4** |
| **Maximum points available** | | **28.9** | **10.5** | **23.7** | **2.6** | **34.2** | **100** |

The recent commentary and public feedback to the 400 sq m. imposition on bottleshop trading areas would suggest that the Northern Territory Government has actually gone too far in its levels of alcohol control policies and that Territorians are seeking a Government to enact a more liberal "population-level" licensing regime.

The AIHW National Drug Strategy Survey results for the Northern Territory also provide empirical evidence to support this view:

> The Northern Territory has the least support for the following three policies which are all population-level controls:
>
> 1. increasing the price of alcohol
> 2. reducing the number of outlets that sell alcohol
> 3. increasing tax on alcohol to pay for health, education, and the cost of treating alcohol related problems

The Northern Territory has the most support for the following three policies which are targeted policies:

1. more severe penalties for drink driving
2. stricter enforcement of the law against serving customers who are drunk
3. stricter enforcement of law against supplying minors

The Northern Territory has graduated to a jurisdiction in which alcohol harms are largely contained to targeted population subgroups highlighting Selective and Indicated Prevention strategies will deliver superior results.

Focusing solely on universal settings – such as licence density and size of outlet - show the draft Terms of Reference to be severely limited. In addition they are actively looking at further restrictive policies that are not supported by the vast majority of Territorians. As presently drafted, the expectation is that by controlling "alcohol supply" variables, it will magically solve a range of health problems caused largely by "alcohol-demand" causes.

The most telling example of this is the consistent focus on supply restriction measures to solve concerns around the impact of alcohol on the indigenous community in the Northern Territory. It is well acknowledged that Indigenous Australians have higher levels of abstinence than the general population, but some of those that do drink tend to have higher levels of harmful drinking than the general population.

As the Closing the Gap[15] report makes clear, there are a multiplicity of complex causes of Indigenous disadvantage, which often externalises in alcohol abuse and manifests in areas such as children's welfare and domestic violence. Restrictions on the supply of alcohol are sometimes seen as a panacea to solve these challenges, and in some remote areas when implemented with broad levels of community support have had some success. However supply restrictions alone are ineffective unless demand reduction strategies, rehabilitation resources, and measures that address the root causes of the disadvantage that drives abusive consumption accompany them.

In this light, it is clear the Draft Terms of Reference are overly concentrated on universal "alcohol-supply" strategies, when the emphasis should be targeted strategies aimed at reducing the harmful use of alcohol.

Our earlier submissions highlight that Governments are best to consider alcohol holistically as part of wider health actions to curb a range of risk factors association with chronic disease.

Despite this, we pragmatically recognise the desire for the Territory political leadership to have a specific Alcohol Harm Reduction Strategy.

To that end, we encourage decision makers who are framing the Terms of Reference to consider policies and actions that prioritise against where the most harm from alcohol is taking place.

[15] http://closingthegap.pmc.gov.au/

As previously outlined, this would be a combination of Selective prevention (for people with a greater than average risk of developing a disease) and Indicated prevention (for people at high risk) against those groups and subgroups of the population that need targeting with actions to minimise or reduce the causes of harm.

We, therefore, turn to the NHMRC who has invested over $85 million into research (not counting the development of the Drinking Guidelines) related to alcohol and alcoholism from 2000 to 2015.

The NHMRC assessed the main risk factors involved to determine levels of harmful consumption when they most recently reviewed the drinking guidelines in 2011.

The main cause of alcohol-related deaths that they identified remains road trauma[16].

For Australian men, about one-third (33 per cent) of motor vehicle deaths and one-quarter (25 per cent) of motor vehicle injuries have been attributed to alcohol consumption; for women the figures are 11 per cent in each case. For pedestrians, alcohol accounted for 40 per cent of male and 17 per cent of female deaths; and 37 per cent of male and 6 per cent of female hospitalisations[17].

Emergency department studies show that most injuries involve men rather than women, and approximately two-thirds of all patients with an alcohol-related injury are men. The NHMRC observes that men's behaviour when drinking is, on average, more risky than women's at a given level of drinking.

In addition to road trauma, the other NHMRC areas that should guide any Terms of Reference for an Alcohol Harm Reduction Strategy are a focus on:

- People with a family history of alcohol-related problems, including alcohol dependence. They are more at risk than the general population of being unable to control their level of drinking. Anyone with first or second-degree relatives with alcohol dependence should be targeted for alcohol intervention.

- Social and environmental factors, such as being exposed to a family culture that accepts heavy drinking. These may contribute to development of dependence in the children of heavy drinkers (Hingson et al 2003). Social environments and routines, such as tobacco smoking, can contribute to increased drinking frequency and hence lead to dependence (Barrett et al 2006; Grucza & Bierut 2006).

- Drugs such as cannabis, methamphetamines, ecstasy, cocaine and heroin are increasingly used with alcohol, placing users at greater risk of harm. Many studies have reported that any level of alcohol consumption is a significant predictor of non-fatal and fatal drug overdose (eg Kaye & Darke 2004; Coffin et al 2007). However, people who use drugs illicitly are typically unaware of the potentiating effects of alcohol and illicit drugs (Dietze et al 2005; Neira-León et al 2006). There are no recommended safe levels of illicit drug use when combined with alcohol as dosage levels for illicit drugs are unpredictable.

[16] https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf citing: (Loxley et al 2004).
[17] https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf citing (Ridolfo & Stevenson 2001).

- A range of people that may need to seek professional advice about drinking, because of the possibility of interactions and harmful effects. This includes:
    - anyone taking medication, either over-the-counter or prescription
    - people with alcohol-related or other physical conditions that can be made worse or affected by alcohol
    - people with mental health conditions.

The Terms of Reference should:

- Reject the need to review universal control measures such as price, availability and marketing as the Northern Territory already has one of the world's most restrictive liquor licensing regimes

- Utilise NHMRC insights into the main risk factors related to alcohol related harms and focus on Selective prevention (for people with a greater than average risk of developing a disease) and Indicated prevention (for people at high risk) against those groups and subgroups of the population that need targeting with actions to minimise or reduce the causes of harm.

**Industry-led initiatives**

EDG strongly believes industry has a role to lead responsible drinking initiatives in the community. In recent years, we have partnered with DrinksWise, a fact-based not-for-profit organisation that dedicates resources to educating the public on the impacts of consumption of alcohol by minors and adults through television and print media. DrinkWise is responsible for the very successful "Kids absorb your drinking", "Alcohol and Pregnancy", and the award-winning "Drinking: Do it properly" campaigns whose communications materials are displayed and available throughout EDG-owned liquor stores and ALH pubs.

EDG submits that the Terms of Reference should seek to review successful industry led schemes for ways of Government to partner in expanding their reach to affect generational change in the way all Australians consume alcohol.

The Terms of Reference should:

- seek to review successful industry led schemes for ways of Government to partner in expanding their reach to affect generational change in the way all Australians consume alcohol

**Conclusion**

EDG welcomes the opportunity to comment on the Draft Terms of Reference. Our key points are:

- Alcohol should not be viewed discreetly as it is one component to chronic disease. It needs to be holistically reviewed including addressing many of social determinants which lead to alcohol abuse
- The Northern Territory has one of the world's most restrictive liquor regulatory environments. Further "population-level" controls are not supported by Territorians when the modern Australia lifestyle is demanding a more relaxed and liberal licensing regime with targeted measures to address key risk areas and groups.

- Selective and Indicated prevention (targeted) strategies should be prioritised
- Expert review should focus on address the largest contributors to alcohol-related mortality and at-risk population subgroups

If you require further information, please do not hesitate to contact me at andrew.wilsmore@edg.com.au.

Yours sincerely

Andrew Wilsmore
Head of Risk & Reputation