



# Central Australian Aboriginal Congress

Submission to the  
**Northern Territory Alcohol Policies  
and Legislation Review**

**28 June 2017**

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## Executive Summary

Central Australian Aboriginal Congress (Congress) is a large Aboriginal community controlled primary health care service based in Alice Springs. We have been active for many years in both the treatment of alcohol-related problems amongst the communities we serve, and in advocating for evidence-based policy to prevent alcohol-related harm.

The levels of alcohol-related harm in the Northern Territory are so great that the Northern Territory Government has both the opportunity and the responsibility to lead community opinion and forcefully advocate for an evidence-based approach that will save many lives and contribute to the development of a safe, productive Territory.

### Demand Reduction

- The harmful use of alcohol cannot be completely addressed in isolation from broader efforts to tackle disadvantage across the whole range of the social determinants of health, particularly in Aboriginal communities.
- Early childhood is a key intervention point for the primary prevention of alcohol related harm through sustained investment in evidence-based early childhood programs.
- Poor housing contributes to alcohol-related consumption and harms through children's poorer socio-emotional outcomes and decreased school attendance and through contributing to a range of social and emotional wellbeing issues such as stress, depression, anxiety and suicide which are also associated with alcohol consumption.
- Overcrowded, poor quality, poorly maintained and insecure housing is another social determinant of problems with alcohol.
- There is a strong association between the experience of racism and poor mental health and alcohol misuse, pointing to the need for any policy approaches to address alcohol-related harm to be non-rationally discriminatory and to support Aboriginal control of services to the Aboriginal population.
- Primary health care interventions are known to be effective in managing alcohol consumption and harm in individuals.
- Residential and community treatment options are important in decreasing consumption, improving health, reducing criminal behaviour, improving psychological wellbeing, and improving community participation. Treatment in all settings should be provided for both alcohol and other drugs, and needs to include the three streams of care approach: medical care including pharmacotherapies and co-morbid chronic disease management; psychological therapy; and social and cultural support with intensive case management for those who need it.
- Advertising and marketing leads to young people beginning to drink earlier in their lives, and to drinkers consuming more alcohol.
- In the Northern Territory, alcohol industry representatives continue to be amongst the highest spenders when it comes to donations to political parties and candidates.

Such political donations have a potentially unhealthy influence on policy making processes.

### **Supply Reduction**

- Increasing the price of alcohol reduces consumption and hence alcohol related harm; it is a highly cost effective intervention that saves lives and prevents harm.
- There is substantial support for the introduction of a minimum unit price (MUP) in the Northern Territory, from health and community organisations; parliamentary inquiries; Northern Territory businesses; and the Australian Hotels Association (NT Branch).
- In relation to setting a MUP for alcohol, it should be noted that:
  - there is no evidence that price control measures are ineffective in reducing consumption in Aboriginal communities;
  - drinkers of lower socioeconomic status have the most to gain from increases in price, with gains in health more than offsetting increases in the cost of alcohol;
  - a MUP should be accompanied by restrictions on alcohol advertising and promotion to prevent non-price competition.
- After price (economic availability), the most important determinant of alcohol consumption is its physical availability, and in particular trading hours and license density, so policies that reduce hours of trade including take away and late-night trading, and the number of liquor licences are highly likely to be effective in reducing alcohol-related harm.
- Congress welcomes the Northern Territory Government's reintroduction of a Banned Drinkers register in conjunction with scanning of photo identification at point-of-sale. High quality expert evaluation of this and other alcohol measures in the Northern Territory are needed.

### **Harm Reduction**

- Sobering Up Shelters and Night Patrols provide opportunities for other treatment (e.g. brief interventions) and may encourage further community-based action to tackle alcohol abuse.
- Licensed clubs on remote Aboriginal communities have long been associated with high levels of alcohol-related harm. However, restrictions on their operation from 2007 show that if well-managed there is no evidence to suggest that communities with clubs experience higher rates of alcohol-related harms than other communities. It is strongly suggested that Income Management in such communities was not significant in reducing consumption by itself.

### **Monitoring and evaluation**

- Reliable, long-term datasets that can monitor patterns of alcohol consumption and harm in the community at a regional level are an essential tool for targeting effort and monitoring the effect of programs and policies.

## Recommendations

1. *Addressing the harmful use of alcohol in the Northern Territory must be situated as part of a broader strategy to tackle the full range of the social determinants of ill-health including poverty, social exclusion and racism, unhealthy early childhood development, housing, education and employment.*
2. *Access to evidence-based early childhood development programs is a key strategy for the primary prevention of alcohol-related harms in the future and for breaking the intergenerational cycle of the harmful use of alcohol. Sustained investment in such programs should be a foundation for addressing alcohol related harm in the Northern Territory.*
3. *Given the association of the experience of racism with increased alcohol consumption:*
  - a. *no program or policy designed to address the harmful use of alcohol in Aboriginal communities should be founded upon discrimination on the basis of race; and*
  - b. *commissioning for health and wellbeing services to Aboriginal populations should explicitly recognise Aboriginal community controlled organisations as preferred providers, due to a range of inter-linked structural advantages they have in delivering services and hence improved health and wellbeing outcomes compared to non-Indigenous services (government or private).*
4. *There are a number of treatment and support options which have evidence of effectiveness. These should be the starting point for any public policy aimed at demand reduction and harm reduction in relation to alcohol consumption in Australia, including in the Aboriginal context. They include:*
  - a. *well-resourced interventions from the primary health care setting, delivered by trained staff, including brief interventions and community based treatment that includes medical treatment, evidence-based psychological care, and social and cultural support;*
  - b. *residential and community-based treatment programs which include social and cultural support for clients during and after treatment and adequate investment in infrastructure and training; and*
  - c. *Sobering Up Shelters and Night Patrols.*
5. *Ensuring the maximum effectiveness of treatment and support options for Aboriginal communities requires at least:*
  - a. *addressing cultural safety and supporting community control;*

- b. providing a full range of treatment and support options;*
  - c. investing in a Continuous Quality Improvement (CQI) approach; and*
  - d. providing adequate and secure resourcing (five-year block funding) to support maximum service effectiveness.*
- 6. That the Northern Territory Government enact legislation to:*
  - a. ban all forms of alcohol promotion and advertising in the Northern Territory; and*
  - b. ban political donations in the Northern Territory from the alcohol industry and its representatives.*
- 7. That the Northern Territory Government, recognising that raising the price of alcohol is the most cost-effective way to reduce alcohol-related harm in the Northern Territory including in the Aboriginal community:*
  - a. amend the Liquor Act to allow Licensing NT to set the price of alcohol;*
  - b. introduces a minimum unit price (MUP) for takeaway alcohol products equivalent to the existing minimum price of takeaway full-strength beer, currently at approximately \$1.50 per standard drink; and*
  - c. advocate to the Australian Government for a volumetric tax to create a national fund for the reduction of alcohol related harm, with access to this fund by jurisdictions to be determined on the basis of their actions to reduce alcohol-related harm across the whole population, including for the Aboriginal and Torres Strait Islander community.*
- 8. That the Northern Territory Government takes action on reducing the availability of alcohol as a key measure to reduce alcohol related harm, including at a minimum:*
  - a. one take-away free day per week in locations where a need is identified as a way to reduce total take away trading hours;*
  - b. reduced and modified late night trading in accordance with the successful Newcastle and Sydney CBD trials; and*
  - c. additional measures, with community support, implemented through local Alcohol Management Plans for specific communities or living areas.*
- 9. That in relation to the number of licensed outlets in the Northern Territory:*
  - a. the Northern Territory Government should introduce a moratorium on new, transferred, and reactivated take-away liquor licences for all licensed premises, with no exemptions;*



# 1 Background

## 1.1 About us

Central Australian Aboriginal Congress (Congress) is a large Aboriginal community controlled health service based in Alice Springs. Since the 1970s, we have developed a comprehensive model of primary health care delivering quality, evidence-based services on a foundation of cultural appropriateness. Today, we are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care, and a strong advocate for the health of our people.

Congress has been active for many years in both the treatment of alcohol-related problems amongst the communities it serves, and in advocating for evidence-based policy to prevent alcohol-related harm.

## 1.2 About this submission

This submission is structured around the three pillars of harm minimisation that are the basis of national approaches to reducing alcohol-related harm in Australia [1]:

- *Demand Reduction*: strategies to prevent the uptake of alcohol use, delay the first use of alcohol, and reduce the harmful use of alcohol in the community. It includes supporting people to recover from dependence and re-integration with the community.
- *Supply Reduction*: strategies to control, manage or regulate the supply of alcohol.
- *Harm Reduction*: strategies that aim to reduce the negative outcomes from alcohol use when it is occurring by encouraging safer behaviours, creating supportive environments and reducing preventable risk factors.

While this submission places a strong emphasis on an evidence-based approach, we acknowledge that there is some truth in the old cliché that, in relation to addressing the harm caused by alcohol, "what works is not popular, and what is popular does not work".

However, we believe that the levels of harm in the Northern Territory are so great that the Northern Territory Government has both the opportunity and the responsibility to lead community opinion and forcefully advocate for an evidence-based approach that will save many lives and contribute to the development of a safe, productive Territory.

This submission is based upon Congress' many years of advocacy in this area. We also draw on work by the Peoples Alcohol Action Coalition (PAAC), an Alice Springs-based community alcohol reform group of which Congress is an organisational member and that of the Foundation for Alcohol Research and Education (FARE), an independent, not-for-profit organisation working to stop the harm caused by alcohol. We acknowledge in particular the joint FARE-PAAC publication *Calling time on too much grog in the Northern Territory* [2] and the PAAC *Submission to the House of Representatives Standing Committee on Indigenous Affairs Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities*. We have drawn on these documents in the preparation of this submission.



## 2 Alcohol consumption and related harms

The Review's Discussion Paper [3] summarises some of the key data about consumption and alcohol-related harm in the Northern Territory, and it is not the purpose of this submission to re-state the well-known facts about the very high levels of alcohol consumption and harm in the Territory. There are however, a few key points we would like to emphasise:

- *Alcohol is a very significant net cost to the Northern Territory.* The Review's Discussion Paper claims that the 'supply, purchase and consumption of alcohol makes a significant contribution to many sectors of the Territory economy through employment, new and existing business growth and consumption expenditure' (page 5). However, this claim is specifically rebutted by a major study estimating the burden on the Northern Territory economy from alcohol [4], which states (page iv) that:

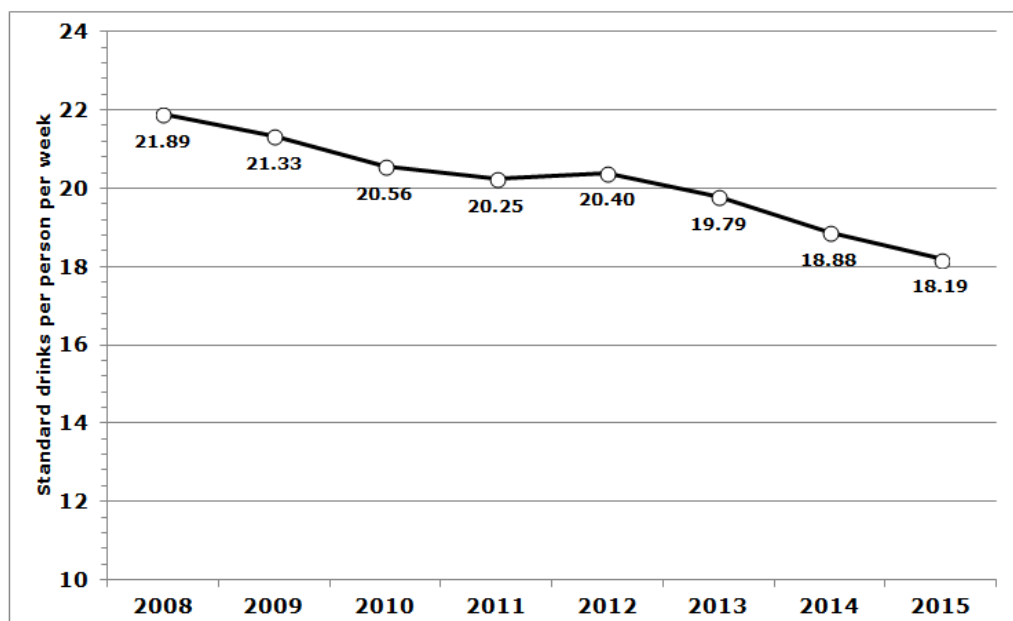
*It is sometimes claimed that economic activity from consumer expenditure on alcohol (and associated employment, wages, and profits) represents a social benefit which at least partially offsets social costs arising from alcohol consumption ... However, as expenditure on alcohol would have been spent on some other good or service if not spent on alcohol, the economic activity related to alcohol does not represent a net social benefit to the Northern Territory.*

This same study (quoted in the Discussion Paper) estimated the costs of alcohol in 2004/05 to be \$642M or over \$4,000 per person, more than four times the national average, with the bulk of those costs falling upon Territory households. Of course the costs today to Territorians, twelve years later, would be very significantly higher.

- *There is strong community support for government action to address alcohol-related harm.* A recent national survey shows that four out of five Australians (81%) believe that more needs to be done to reduce the harm caused by alcohol, and six in ten (61%) believe that governments are not doing enough [5]. While recent figures are not available, even during a divisive public debate about alcohol in Alice Springs in 2002, over half of Alice Springs residents (54%) and two thirds of Aboriginal town camp residents (67%) wanted restrictions on the supply of alcohol maintained or strengthened [6, 7].
- *Alcohol is an issue for the whole Northern Territory community.* Territorians as a whole experience high levels of alcohol-related harm, including both men and women, and Aboriginal and non-Aboriginal people. The Territory has the highest per capita consumption in Australia (over 18 standard drinks per week per person over the age of 15) [8] and one in three (30%) drinkers consumes alcohol at a level that puts them at risk of long term harm [9].
- *Nevertheless, alcohol disproportionately harms Aboriginal Territorians.* In 2012-13, alcohol-related hospitalisations were nine times higher for Aboriginal people than for other Territorians [10]. Excessive alcohol consumption – especially binge drinking – also leads to increased levels of violence, with women often the victims: in 2011/12 Aboriginal women in the NT were 80 times more likely to be hospitalised as a result of assault than non-Indigenous women [11].

- *Alcohol is a major cause of child neglect* both through increased exposure to domestic violence and lack of responsive care and stimulation from addicted parents. The NT has the highest rate of substantiated child neglect in Australia [12]. Consequences of neglect include increased risk of developmental delay (intellectual, physical and emotional), poor educational outcomes, compromised physical and mental health, drug use and incarceration and premature death [13, 14] (see also 3.1.2 *Early childhood development* below).
- *The NT has been making progress in reducing consumption based on effective evidence based measures (Figure 1).*

**Figure 1: estimated per capita consumption of alcohol in the Northern Territory (people aged 15 years and above), standard drinks per week, 2008-2015 [8]**

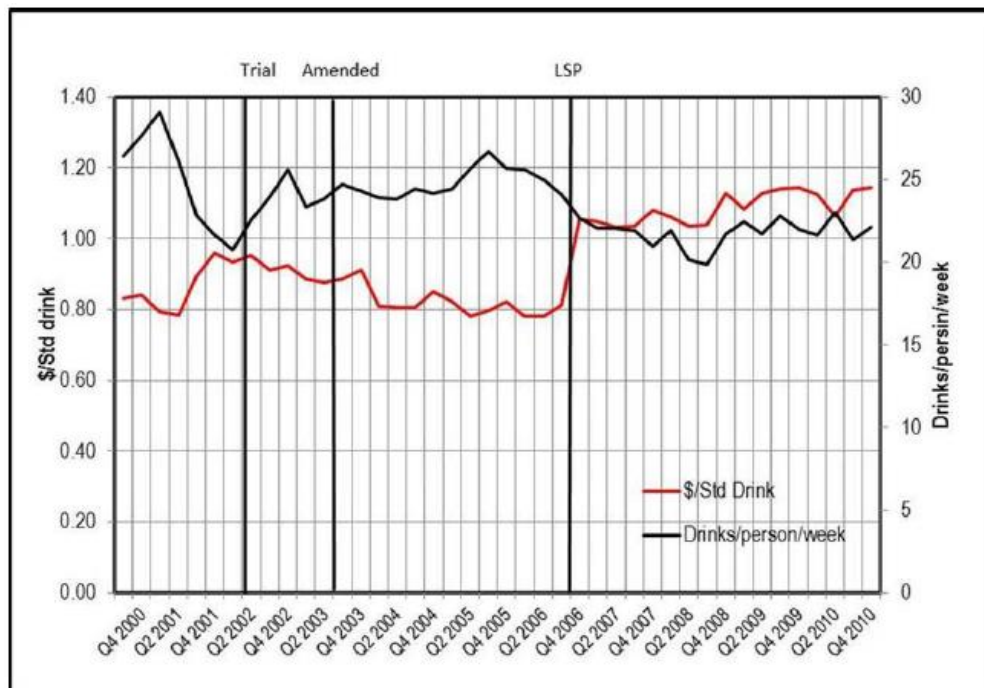


While there is still an unacceptable level of preventable harm from alcohol, a number of measures have contributed to the decline in consumption, including:

- the ban on the sale of 4 and 5 litre wine casks which began in Alice Springs in 2006 and became Territory wide in 2010;
  - an effective floor price introduced into Alice Springs in 2011 at about 75 cents per standard drink (pubs continued to sell cheap 2 litre cask at this price even though all the supermarkets had implemented a voluntary MUP of \$1 per standard drink or more); and
  - in 2011/ 12 the Banned Drinkers Register (BDR) was complemented by episodic Temporary Beat Locations (TBLs), followed from 2013 by the full implementation of Temporary Beat Locations (TBLs) despite the removal of the BDR.
- *There is strong evidence from Alice Springs that measures increase the effective price of alcohol lead to decreased consumption and to reduced harms, especially for alcohol-fuelled violence.* Unfortunately, statistics on the Northern Territory as a whole are not readily available – pointing to the need for regular, public reporting on consumption and harms across the Territory (see *Monitoring and evaluation* on page

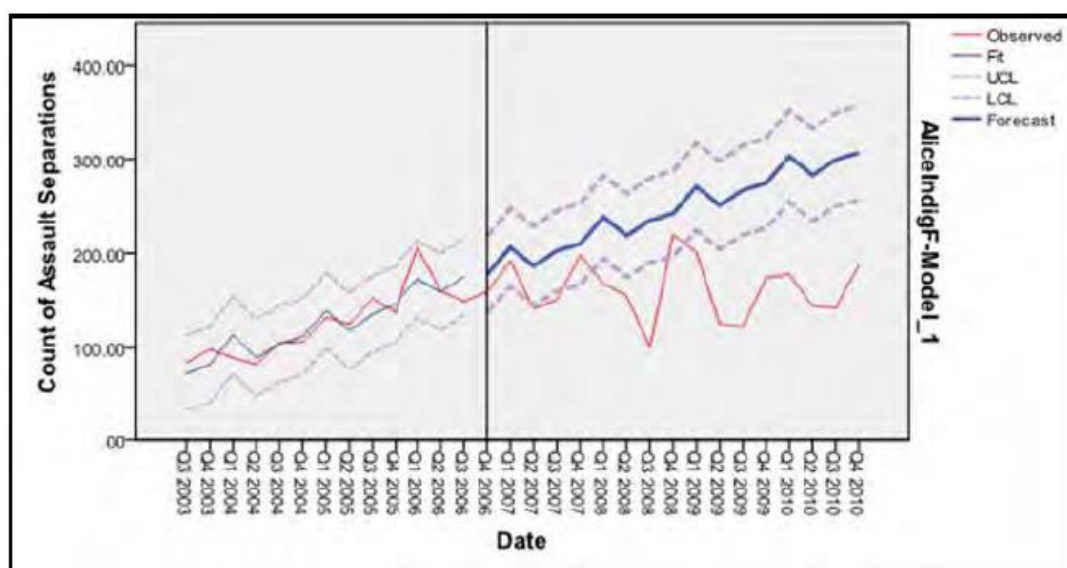
27). Nevertheless, the 2006 Liquor Supply Plan in Alice Springs provides important evidence whereby the removal of the cheapest alcohol from the market led to an increase in the average price per drink and a fall in consumption (Figure 2).

**Figure 2: Mean wholesale price per standard drink (2010 dollars) and mean weekly consumption of alcohol (standard drinks) per person ≥15 years by quarter, Central Australia, 2000 – 2010**



This in turn was associated with significant reductions in a range of alcohol-related harms, but in particular of the alcohol related assault of Aboriginal women as measured by comparing the predicted numbers of such assaults on the basis of the rates before the LSP, to the observed rates after the restrictions were introduced (Figure 7; see also section 4.1.1 and Attachment A).

**Figure 3: Alice Springs Hospital admissions for assault for Aboriginal women observed and forecast values 2003 – 2010**



## 3 Demand Reduction

### 3.1 The social and economic determinants of harmful alcohol use

Explanations of illness based on exposure to individual risk-factors such as smoking, alcohol misuse, or being overweight have been the basis for many improvements in the health of populations, especially when it comes to chronic disease. However, these risk factors are not evenly distributed in society: beneath these individual risk factors lie deeper causative factors known as the social determinants of health. A person's social and economic position in society, their early life, exposure to stress, educational attainment, access or lack of it to employment, access to health services, their exclusion from participation in society, and their access to food and transport: all exert a powerful influence on a person's health and their exposure to risk.

A number of the social determinants of health are of particular relevance to alcohol use in the Northern Territory.

#### 3.1.1 Poverty

It has been extensively documented across the world that alcohol dependence is closely related to social and economic disadvantage [15, 16].

It is in this context that Aboriginal alcohol consumption in particular must be placed. Aboriginal people are not inherently susceptible to alcohol or dangerous levels of drinking: higher levels of alcohol consumption and thus higher levels of alcohol-related harm is not a problem unique to Australia's First Peoples, but a pattern observed globally amongst poor and socially marginalised populations.

Given that the median total personal income of Aboriginal Territorians is only \$269, less than a third (29%) of that for non-Indigenous Territorians [17], the harmful use of alcohol cannot be completely addressed in isolation from broader efforts to tackle disadvantage across the whole range of the social determinants of health, particularly in Aboriginal communities.

#### 3.1.2 Early childhood development

Early childhood is a key intervention point for the primary prevention of alcohol related harm. The experience of the child, including in the months before birth, is critical for building a platform for a healthy life and deficits at this time are powerfully linked to disadvantage and ill health later in life including to an increased risk of unhealthy levels of alcohol consumption [18, 19].

This suggests the existence of a dangerous 'feed-back loop' relating to harmful alcohol consumption amongst disadvantaged populations. Harmful alcohol use by parents and carers is known to be associated with a lack of responsive care and stimulation in early childhood. Children brought up in these environments often lack the necessary skills for effective emotional regulation and self-control and other executive brain functions that have been shown in longitudinal studies to lead to addictions including alcohol [20]. More susceptible to addictions, including to alcohol, as they grow to adulthood they will be, in turn, less likely to provide their own children with the care and nurture they need. This cycle is reinforced by emerging evidence that every generation born to parents with an alcohol addiction is more genetically predisposed to an addiction [21].

Such an intergenerational feedback loop – mirroring and adding to the intergenerational trauma and disadvantage suffered by many Aboriginal families resulting from the process of colonisation – is consistent with the evidence and supported by the experience of many Aboriginal community members and organisations.

Fortunately, we know how to break such intergenerational cycles of disadvantage through sustained investment in evidence-based early childhood programs including parenting programs. If properly designed, these can offset early childhood disadvantage, and are widely acknowledged as a ‘best buy’ in terms of breaking the long-term cycle of harmful alcohol use [22]. Congress has been able to successfully adapt evidence-based programs such as Nurse Home visiting to ensure they are appropriate for the cross-cultural environment of central Australia.

Such evidence-based investments in early childhood development are not just beneficial for the children themselves as they grow into adulthood; they are a corner-stone of economic development and productivity and have been identified by the Organisation for Economic Co-operation and Development (OECD) as the single most important thing Australia can do to grow its economy and be competitive in the future [23].

### 3.1.3 Housing and overcrowding

Overcrowded, poor quality, poorly maintained and insecure housing is another social determinant of problems with alcohol. First, children growing up in overcrowded and poor living conditions have poorer socio-emotional outcomes and decreased school attendance [24, 25], which are associated with higher rates of alcohol use later in life. Second, insecure or overcrowded housing is associated with a range of social and emotional wellbeing issues such as stress, depression, anxiety and suicide [26] which again are associated with increased risk of dangerous levels of alcohol consumption.

### 3.1.4 Racism and the ‘control factor’

There is a strong association between the experience of racism and poor mental health and alcohol misuse [27]. Aboriginal and Torres Strait Islander Australians commonly experience high levels of racism, from relatively minor incidents such as being called racist names, through verbal abuse, to serious assault and systemic barriers to services, including health services [28, 29]. Tackling racism is therefore part of the suite of policies needed to tackle alcohol abuse in the Aboriginal community. This also points strongly to the need for interventions to be non-rationally discriminatory.

Lack of control over one’s life is an important driver of ill-health and is associated with higher consumption of alcohol. There is good evidence based on biomedicine that the consistent exposure to stress associated with lack of ability to exercise control in life can profoundly undermine physical and mental health [30, 31]. Policy makers will thus need to be alert to the importance of empowerment approaches in addressing alcohol in the Aboriginal community. In these circumstances, Aboriginal community controlled organisations should be the preferred service provider in all cases.

**1 Addressing the harmful use of alcohol in the Northern Territory must be situated as part of a broader strategy to tackle the full range of the social determinants of ill-health including poverty, social exclusion and racism, unhealthy early childhood development, housing, education and employment.**

- 2 Access to evidence-based early childhood development programs is a key strategy for the primary prevention of alcohol-related harms in the future and for breaking the intergenerational cycle of the harmful use of alcohol. Sustained investment in such programs should be a foundation for addressing alcohol related harm in the Northern Territory.**
- 3 Given the association of the experience of racism with increased alcohol consumption:**
  - a. no program or policy designed to address the harmful use of alcohol in Aboriginal communities should be founded upon discrimination on the basis of race; and**
  - b. commissioning for health and wellbeing services to Aboriginal populations should explicitly recognise Aboriginal community controlled organisations as preferred providers, due to a range of inter-linked structural advantages they have in delivering services and hence improved health and wellbeing outcomes compared to non-Indigenous services (government or private).**

### 3.2 Primary health care interventions

Interventions from the primary health care setting are known to be effective in other populations [32], and there is evidence of their effectiveness in the Aboriginal context [33]. Congress has developed – and is in the process of documenting for the Australian National Advisory Council on Alcohol and Drugs (ANACAD) – a set of well-structured interventions for Aboriginal clients based on three inter-related streams of care:

- *the medical stream* uses medicines like Acamprosate, Naltrexone and other pharmacotherapies to address the balance of chemicals in the brain and increase the effectiveness of treatment;
- *the psychological stream* includes structured therapies such as Cognitive Behaviour Therapy (CBT) and other approaches that require the development of an ongoing relationship with psychologist or skilled therapist over many sessions; and
- *the social and cultural support stream* helps the client change the social context which is part of the reason that addiction occurs and is maintained, including assistance with education and training, finding employment, accommodation, Centrelink, strengthening relationships with kin and country, enhanced cultural identity, group work and many other services.

To be effective in the face of the high acute care demand primary health care services face, the successful and sustainable delivery of such interventions requires specific resourcing which goes beyond the provision of materials (e.g. to support brief interventions) to include training for staff and the provision of in-house public health expertise to maintain a focus on non-acute services such as those related to reduction in alcohol related harm.

### 3.3 Residential and community-based treatment programs

Treatment is an important response to alcohol-related harm in the community, and is effective in decreasing consumption, improving health, reducing criminal behaviour, improving psychological wellbeing, and improving community participation [34]. In the



Northern Territory, the number of publicly funded AOD treatment services in the Northern Territory has been falling and the sector struggles to keep up with the demand from the community (80 per cent of services report that they are unable to meet demand) [2]. Adequate and sustained funding, that includes provision of evidence-based treatment models; social and cultural support for clients during and after treatment (such as assistance with accommodation, education, training and employment); and integration with other health and community services is required.

The situation of the treatment sector has been further undermined in recent years by the former NT Government's mandatory approach to alcohol treatment. Introduced in 2013, this program refers adults who are taken into police protective custody three or more times within a two-month period for being intoxicated in public to a tribunal which may impose either mandatory residential or community treatment, or another form of community management for up to three months. Initially, those under order from the tribunal could be imprisoned for up to three months if they absconded from treatment, though this provision was removed in 2014.

Numerous health and community services – including Congress – opposed the introduction of Alcohol Mandatory Treatment (AMT) on the basis that it adds to the disadvantage experienced by marginalised groups, may displace voluntary clients from limited treatment spaces, and is likely to be ineffective.

A review of the AMT program has now been completed which bears out those warnings: it found the program was poorly designed and monitored; expensive (in 2015/16 it cost \$18 million to deliver mandatory treatment to 190 people at an average cost per person of well over \$50,000 each); and had no long-term health benefits with numerous people cycling in and out of the AMT system with no effective intervention [35].

Congress therefore welcomes the decision of the Northern Territory Government to repeal the AMT Act and create better pathways to treatment.

### 3.4 Conditions for success

There are a number of conditions for successful implementation of treatment and support measures to reduce alcohol-related harm in Aboriginal communities. These include:

- *Addressing issues of cultural safety.* Interventions that are adapted to the particular cultural needs of the community they serve are significantly more effective than those which are not [36]. Developing genuine partnerships with Aboriginal communities to deliver treatment and support services, and support for community controlled services are essential pathways to developing culturally safe services [37].
- *Integration of primary health care and community / residential treatment services.* Poor integration is a major barrier of effective service delivery for clients with complex needs; it is a priority to ensure that clients of treatment services have access to all three streams of care (see above) including medical services and socio-cultural support. This integration supports effective care and also continuing care (after care) for clients once they complete a session of treatment and return to the community.

- *Providing a full range of treatment and support options.* Just as in any community, not all interventions are appropriate or relevant for all those whose use of alcohol puts them and those around them at risk of harm. While some may benefit from pharmacotherapy to address dependency, for others brief interventions or motivational interviewing may be required, and for others again residential treatment. The Aboriginal community in a particular region needs access to the full range of services. The development of a set of 'core services' for alcohol treatment, followed by a region-by-region needs-analysis to document key gaps, and a resource and investment program to meet those needs should be priority.
- *Investing in a Continuous Quality Improvement (CQI) approach.* Many Aboriginal alcohol treatment services (especially those outside the primary health care sector) face continual activity or outcome evaluation demands from funding organisations. In many cases client numbers are too small to provide statistically significant results, and the services (many of which are substantially and historically underfunded) face a large reporting 'overburden'. The focus should move towards a CQI approach based on appropriate indicators and IT systems which seeks to identify areas for improvement (e.g. staff training, infrastructure [38]) and invests in addressing such barriers to effective service provision. An effective CQI approach should also include resources for monitoring and reporting on key performance indicators such as the level of alcohol consumption 12 months after treatment.
- *Providing adequate and secure resourcing to allow for actions to be refined and developed over time.* Developing effective programs and partnerships in complex cross-cultural environments often marked by significant under-resourcing and fragile physical and organisational infrastructure takes time. Short-term funding can undermine community commitment, weaken consistent implementation of quality treatment, and destabilise services through loss of experienced staff and continual diversion of resources into cycles of recruitment and training [39]. Congress welcomes the decision by the Northern Territory Government to offer five-year funding blocks for all services that it funds; this should be the standard for all government to support effective implementation.

- 4 There are a number of treatment and support options which have evidence of effectiveness. These should be the starting point for any public policy aimed at demand reduction and harm reduction in relation to alcohol consumption in Australia, including in the Aboriginal context. They include:**
- a. well-resourced interventions from the primary health care setting, delivered by trained staff, including brief interventions and community based treatment that includes medical treatment, evidence-based psychological care, and social and cultural support.**
  - b. residential and community-based treatment programs which include social and cultural support for clients during and after treatment and adequate investment in infrastructure and training;**
  - c. Sobering Up Shelters and Night Patrols.**



- 5 Ensuring the maximum effectiveness of treatment and support options for Aboriginal communities requires at least:**
- a. addressing cultural safety and supporting community control;**
  - b. providing a full range of treatment and support options;**
  - c. investing in a Continuous Quality Improvement (CQI) approach; and**
  - d. providing adequate and secure resourcing (five-year block funding) to support maximum service effectiveness.**

### **3.5 Bans on alcohol advertising, promotion and political donations**

The effect of advertising and marketing on young people's drinking patterns in particular is well-established: it leads to young people beginning to drink earlier in their lives, and to drinkers consuming more alcohol [40]. While incomplete bans on alcohol advertising and promotion maybe ineffective as the industry shifts its effort to non-restricted forms of promotion, a major international study reviewing the evidence concludes that 'extensive restriction of marketing would have an impact' [32].

In the Northern Territory, alcohol industry representatives continue to be amongst the highest spenders when it comes to donations to political parties and candidates [41]. While those both making and receiving the donations deny that these have any influence on policy, independent studies have repeatedly shown that political donations *do* have an undue influence on political and policy making processes [42]. This raises questions as to whether policy decisions are being made in the public interest. The World Health Organization (WHO) Director-General Dr Margaret Chan has stated that, '*In the view of WHO, the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests*' [43].

Most Australians (57%) believe that the alcohol industry has too much influence with governments and over half (55%) believe that it makes political donations to influence policy; three quarters (72%) believe that political parties should not be able to receive donations from the alcohol industry [5].

- 6 That the Northern Territory Government enact legislation to**
- a. ban all forms of alcohol promotion and advertising in the Northern Territory; and**
  - b. ban political donations in the Northern Territory from the alcohol industry and its representatives.**

## **4 Supply Reduction**

### **4.1 Reducing economic availability: a minimum unit price for alcohol**

There is incontrovertible evidence that increasing the price of alcohol reduces consumption and hence alcohol related harm; it is also a highly cost effective

intervention [32]. There are several commonly used approaches to increasing the price of alcohol:

- a *volumetric tax* has the advantage of generating tax income, a proportion of which could be set aside for treatment programs or other approaches to reduce alcohol-related harms;
- a *minimum unit price* (MUP or floor price) approach sets a price per standard drink (or unit of pure alcohol) below which alcoholic beverages cannot be sold. This increases the price of the cheapest alcohol products, and is particularly effective in reducing alcohol consumption and related harms amongst heavy drinkers and young people, while not significantly affecting the price of relatively more expensive products that the majority of responsible drinkers purchase; and
- *local level agreements* have been successful in the Aboriginal context but have often proved difficult to enforce and to sustain [44, 45].

Note that volumetric and floor price approaches can be combined to utilise the advantages of each [46].

The increasing availability of cheap alcohol in the Northern Territory over the past 20 years warrants considered action by government. For example, in relation to wine, the same proportion of a Darwin person's wage in 2016 could purchase 1.7 times as much wine as was possible in 1997. A floor price is the most effective policy intervention available to any government [47].

#### **4.1.1 Effectiveness of a MUP, especially in preventing community violence**

There is strong evidence for the effectiveness of a minimum unit price from Canada, where a 10% increase in the minimum price of alcohol reduced its consumption by 16% [48].

There is also very good de-facto evidence for setting a minimum price for take-away alcohol from the introduction of the Alice Springs Liquor Supply Plan (LSP) in 2006 (see [Attachment A](#) for details). By banning the sale of wine and fortified wine in large containers, the LSP in effect increased the average price of a standard drink from 80 cents to \$1.10 and doubled the minimum price per standard drink from 25 cents to 50 cents.

A substantial study by the National Drug Research Institute [49] found that this led to a significant decrease alcohol consumption in Central Australia from around 25 to about 20 standard drinks per person per week. This fall in consumption led to significantly lower levels of alcohol-related harm, as measured by hospital admissions and Emergency Department presentations (particularly for assaults), as well as alcohol-related anti-social behaviour. The effect of the LSP on halting the alarming rate of increase in assaults suffered by Aboriginal women was particularly noteworthy.

#### **4.1.2 Support for a MUP**

There is substantial support for the introduction of a MUP in the Northern Territory:

- it has been a key policy proposal by health and community organisations concerned about the harm alcohol is doing to Territorians for many years [2, 50];

- it has been a central recommendation of recent parliamentary inquiries, including the House of Representatives *Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities* [51] and the *Northern Territory Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorders* [52];
- Northern Territory businesses have already voluntarily entered into retailers' accords that set a floor price on the cheapest take away alcohol in recognition of the social problems these products cause [53]; and
- the Australian Hotels Association (NT Branch) has expressed support for the introduction of a floor price as one way to address alcohol-related harm [41, 54].

#### 4.1.3 Issues to consider in introducing a MUP

There are a number of issues to consider in introducing a minimum price for alcohol, as follows:

- *Price elasticity in the Aboriginal context.* There have been arguments that for Aboriginal drinkers the demand for alcohol is inelastic (that is, not responsive to price) and that increased prices will simply lead to drinkers spending more on alcohol and less on necessities such as food [6]. However, the data of a commonly cited study [55] to support this view has recently been re-examined and it is now clear that *'the study does not support the assertion ... that population-based price control measures are likely to be ineffective in reducing consumption in Indigenous communities'* [56]. The effectiveness of the LSP in Alice Springs in reducing violence against Aboriginal women is further compelling if indirect evidence that removing the cheapest alcohol from the market reduces consumption amongst Aboriginal drinkers (see [Attachment A](#)).
- *Disadvantage to low-income drinkers.* The introduction of a floor-price can be considered regressive, in that it will result in poor drinkers paying a larger proportion of their income for alcohol compared to better-off drinkers who consume less of the cheapest alcohol on the market. However, this regressive effect will be substantially outweighed at a population level by the reduction in harm to the least well-off. A recent substantial study of alcohol consumption and socioeconomic class showed that the risk of harm from high levels of alcohol use was much greater for drinkers living in socially deprived areas, and that:

*drinkers of lower socioeconomic status have even more to gain than do those of higher socioeconomic status from the most effective public health alcohol policies –namely, increasing alcohol taxation, setting a minimum unit alcohol price, and reducing alcohol availability. This inference should undermine any opposition to raising alcohol taxes because of the notion that this policy would have socially inequitable effects on drinkers of lower socioeconomic status* [57].

Note also that any comprehensive effort to address alcohol-related harm must include broad measures to reduce poverty and inequality (refer 3.1.1 Poverty above).

- *Increased non-price competition.* It has been suggested that a MUP may encourage alcohol producers and retailers to compete with each other through increasing their advertising and promotion activities, as competition through lower pricing will be restricted by the floor price [46]. This could encourage higher rates of consumption and undermine the reduced consumption achieved through a MUP, and points to the

need for an MUP to be accompanied by restrictions on alcohol advertising and promotion (see 3.5 above).

- *Windfall profits for the alcohol industry.* There are also concerns that an MUP will lead to greater profits for alcohol supplies and retailers. There is obviously a complex relationship between consumption levels, prices and costs that underlie alcohol industry profits. A couple of points may be relevant:
  - while increased taxation to offset the potential effect of an MUP to increase industry profit is constitutionally not an option, it is open to the Northern Territory Government to substantially increase licence fees (for example, with a new much higher scale of fees on a risk-based system) to ensure that the introduction of an MUP did not simply lead to windfall profits; and
  - the windfall for the alcohol industry may not eventuate. For example, in Alice Springs where there has been an effective MUP of about \$1 per standard drink for some time, it appears anecdotally that the poorest quality alcohol products are no longer sold as there is no demand for these products at higher prices when other better quality alcohol sells at the same price.
- *The Northern Territory Legislative Assembly has the authority to introduce a minimum price for alcohol* through amending the *Liquor Act* to control liquor pricing; the provisions of Part XA of the *Liquor Act* authorises restrictive trade practices by licensees (section 120C) [2].

All the points above, point to the need for an ongoing commitment to monitoring and evaluation of an MUP (see 6 *Monitoring and evaluation* below).

**7 That the Northern Territory Government, recognising that raising the price of alcohol is the most cost-effective way to reduce alcohol-related harm in the Northern Territory including in the Aboriginal community:**

- a. amend the *Liquor Act* to allow Licensing NT to set the price of alcohol
- b. introduces a minimum unit price (MUP) for takeaway alcohol products equivalent to the existing minimum price of takeaway full-strength beer, currently at approximately \$1.50 per standard drink
- c. advocate to the Australian Government for a volumetric tax to create a national fund for the reduction of alcohol related harm, with access to this fund by jurisdictions to be determined on the basis of their actions to reduce alcohol-related harm across the whole population, including for the Aboriginal and Torres Strait Islander community.

## 4.2 Reducing physical alcohol availability

After price, the most important determinant of alcohol consumption is its physical availability, and in particular trading hours and license density [32, 58].

### 4.2.1 Reduced hours for take-away and on-license trading

Restrictions on trading hours have intermittently been applied in a number of places in the Northern Territory over the last twenty years, the most sustained and effective example being the ban on take-away sales on Thursdays in Tennant Creek which were in

effect from 1996 to 2006 [59]. Although the effectiveness of the restrictions diminished over time because new Centrelink provisions meant that from recipients of benefits would no longer automatically receive their payments on Thursdays, they were associated a 20% reduction in the consumption of pure alcohol, and significant declines in alcohol-related harm and alcohol-related offences [44].

The restrictions introduced in 2007 on remote Aboriginal community licensed clubs also provide good evidence that restrictions on trading hours (along with bans on certain types of alcohol and take-away, but *not* Income Management) can significantly reduce consumption (see 5.2 *Licensed clubs in remote Aboriginal communities* below).

There is also good evidence that restrictions on late-night on-premises trading reduces the amount of alcohol related harm, particularly assaults. For example, in Newcastle (NSW), restricting pub closing times to 3 am in reduced assaults by 37% [60]. Similarly, the 2014 Kings Cross and Sydney CBD entertainment precincts restrictions (1:30 ban on entry to licensed premises, 3am last drinks) reduced assaults by up to 70%, with a similar reduction in serious (77%) and less serious (73%) antisocial behaviour [61].

#### **4.2.2 Reducing the number and types of liquor outlets**

The other major availability factor with a strong correlation to alcohol-related harm is the number and type of liquor outlets.

Generally the more licensed premises there are in a given area, the greater the harms through assaults, domestic violence, drink driving, homicide, suicide, child maltreatment, adolescent drinking, and alcohol-related chronic disease [62]. The Territory has very high rates of alcohol availability as measured by the number of outlets, with one licence for every 353 people aged 18 years and above in 2016 [2]. Congress has argued for many years that the Northern Territory Government needs to address this preventable driver of alcohol-related harm through the buy-back of licences, particularly from corner stores and petrol stations.

Within this overall picture, it is important to note that some types of liquor outlet are more harmful than others. In particular, take-away chain stores (so-called 'big box liquor stores') characterised by large warehouse-style outlets with large floor-spaces are particularly associated with harms such as domestic violence, with a recent study showing that each additional chain outlet was associated with a 35% increase in intentional injuries and a 22% increase in unintentional injuries [63]. Recent moves by a chain store to open a very large take-away outlet in Darwin have the capacity to disproportionately cause harm given the large increase in availability and ability to market cheap alcohol. To this end, the Northern Territory Government's December 2016 legislation to restrict take away alcohol venues to a maximum of 400m<sup>2</sup> is sound public health policy and to be supported.

- 8 That the Northern Territory Government takes action on reducing the availability of alcohol as a key measure to reduce alcohol related harm, including at a minimum:**
  - a. one take-away free day per week in locations where a need is identified as a way to reduce total take away trading hours;**
  - b. reduced and modified late night trading in accordance with the successful Newcastle and Sydney CBD trials; and**
  - c. additional measures, with community support, implemented through local Alcohol Management Plans for specific communities or living areas.**
- 9 That in relation to the number of licensed outlets in the Northern Territory:**
  - a. the Northern Territory Government should introduce a moratorium on new, transferred, and reactivated liquor take-away licences for all licensed premises, with no exemptions;**
  - b. introduce a buy-back scheme for certain types of liquor licences especially those in “corner stores” where food sales are not the major focus of a stores turnover (for example where alcohol sales are greater than 20% of total turnover)**
  - c. the December 2016 legislation restricting take away licences to a floor area of 400m<sup>2</sup> should be supported and continued as an important measure to reduce harm.**

### 4.3 Reintroduction of a Banned Drinkers register

Congress welcomes the Northern Territory Government's reintroduction of a Banned Drinkers register in conjunction with scanning of photo identification at point-of-sale.

The previous version of the BDR in operation from July 2011 to August 2012 has never been formally evaluated. However, the National Drug Research Institute (NDRI) carried out an analysis of the Alice Springs Hospital's Emergency Department presentations and hospital admissions for alcohol-related conditions and for assaults for the period 2005 to 2013 [64]. This analysis concludes that *'taken together, these indicators strongly suggest that the BDR was effective in reducing alcohol-related harms to health in Alice Springs'*. In particular, the figures show that the *removal* of the BDR led to a significant increase in harms:

- Alcohol-caused hospital admissions doubled from around 40 to about 80 per month which equates to nearly 500 additional alcohol-caused hospital admissions per year.
- Alcohol-related presentations to the Emergency Department also doubled from about 140 per month to about 280 per month.

Given this, it is clear that photo-licensing at the point of sale coupled with a BDR is an important and effective part of an overall, comprehensive approach to address the harm caused by alcohol misuse. It is a population-wide approach that effectively targets the heaviest drinker and applied more widely it is likely to make a major contribution to reducing alcohol caused harms in both the Aboriginal and non-Aboriginal communities.



#### 4.4 Temporary Beat Locations

It is important to note that in the last few months of 2012, the Northern Territory Police began complementing the operation of the BDR with the introduction of what became known as Temporary Beat Locations or TBLs whereby police were stationed outside take-away liquor outlets, asking customers to show ID as a way of establishing where they plan to consume take-away alcohol that they have bought or which they intend to purchase. Police could seize liquor if they form a reasonable belief that an offence was being, or was likely to be, committed – for example, that alcohol was to be consumed in a 'dry' area (which, for example, applies to most of Alice Springs).

Following the overturning of the effective BDR and photo-licensing at point of sale, the previous CLP government was faced with a major increase in consumption and harms but was not prepared to re-introduce the BDR. We understand that they then asked the police to make the TBLs permanent which the police agreed to do for an initial trial period of 3 months. Following the trial period the reduction in consumption and harm was so great it was decided by government to make these permanent.

A number of questions have been raised about the operations of TBLs, including:

- their effectiveness –figures from the NT Government's Department of Business show a significant decline in per capita alcohol consumption since their introduction in Alice Springs, Tennant Creek and Katherine following the introduction of TBLs. There is also much anecdotal evidence from Alice Springs Hospital, the town council and others about the reduction in harm and the improvement in public amenity that they have achieved, however no formal evaluation of the measure has been carried out;
- whether they are a sustainable, long-term solution given the opposition to the measure from the police union on the grounds that it is not the tole of the police to do this type of work and it diverts police resources away from other police work;
- their apparently discriminatory application, as in practice they are largely applied to Aboriginal people, thus adding to community tension [65]; and
- their legality, for example whether people are obliged to tell police where they reside in these circumstances.

Overall, the TBLs appear to have been effective but potentially unsustainable and in practice discriminatory in the way they operate. Faced with this situation, Congress has adopted a view that they need to continue until such time as they can be replaced by a range of effective, non-discriminatory evidence-based strategies.

**10 That the Northern Territory Government, with the support of the Australian Government and other stakeholders as necessary, commission a high quality expert longitudinal evaluation of alcohol measures in the Northern Territory including:**

- a. the Banned Drinkers Register as it operated in the Northern Territory between 2011 and 2012;**
- b. Temporary Beat Locations from 2012 to the present;**
- c. the current iteration of the BDR expected to commence on 1 September 2017.**

## 5 Harm Reduction

**Harm reduction strategies aim to reduce the negative outcomes from alcohol, tobacco and other drug use when it is occurring by encouraging safer behaviours, creating supportive environments and reducing preventable risk factors.**

### 5.1 Sobering Up Shelters and Night Patrols

Sobering Up Shelters and Night Patrols aim to prevent harm to people who have been drinking (including the risk of arrest and incarceration) and those around them (including through violence and accidents). While there are few evaluations of such programs, they provide opportunities for other treatment (e.g. brief interventions) and may encourage further community-based action to tackle alcohol abuse [66].

### 5.2 Licensed clubs in remote Aboriginal communities

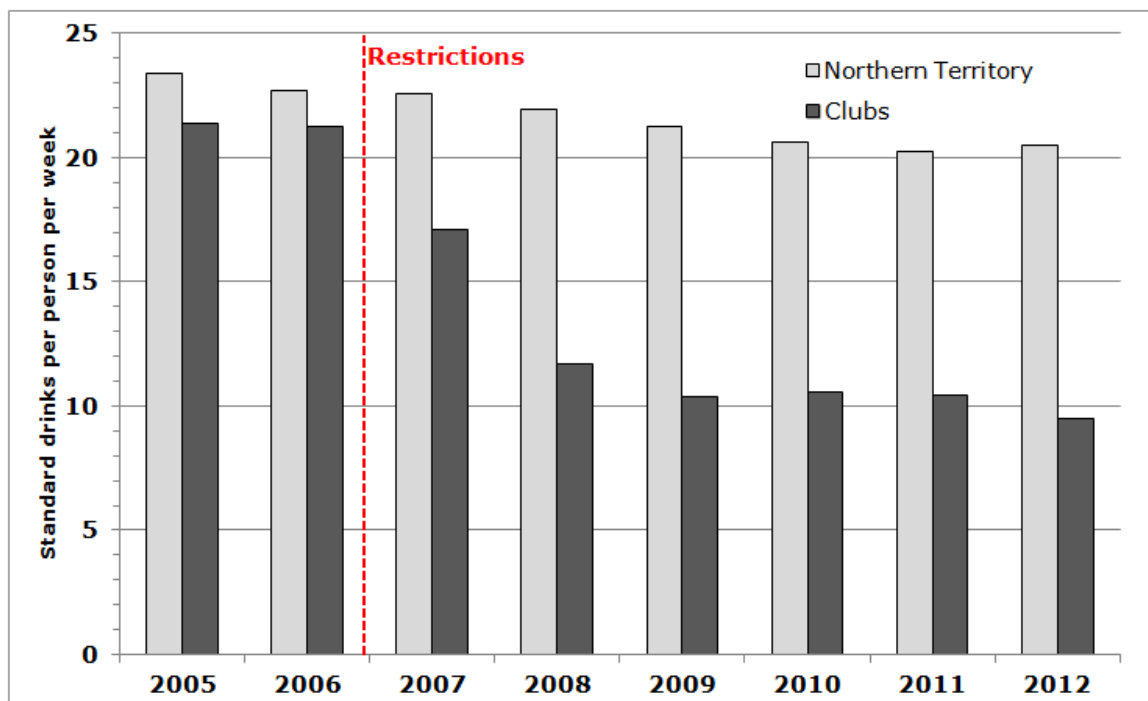
Beginning in the 1970s, many remote Aboriginal communities have established licensed clubs with the aim of providing their residents with a safe place to drink alcohol without having to leave the community, of encouraging safe drinking, and of generating profits for re-investment in community activities. Despite the sometimes enthusiastic backing of government agencies, these clubs were largely unregulated (except to the extent that they were expected to operate within the particular conditions of their license) and operated without practical support, guidance or review. As a result, they were frequently associated with high levels of drinking and negative social consequences; became the centre of much community conflict especially between 'drinkers' and 'non-drinkers'; and the subject of considerable public and policy controversy [67].

However, in 2007 as part of the Northern Territory Emergency Response (NTER) the Commonwealth Government imposed uniform restrictions on (most) of the licensed clubs operating in remote communities at that time. These included restrictions on opening hours (a maximum of 12 hours per week); restrictions on the type of alcohol available (low- and mid-strength beer only); and the abolition of take away sales. In addition, all these communities were, as part of other changes introduced by the NTER, subjected to income management under which half of residents' Centrelink income is quarantined from spending on alcohol or tobacco.

A review of the effect of these changes was completed in 2014, and has now been released [68]. It shows *a significant reduction in consumption of alcohol through the clubs*, from around 20 to around 10 standard drinks per person per week (see Figure 4).



**Figure 4: Apparent per capita consumption of alcohol by persons aged 15 and over, NT and remote community social clubs, 2005-12 (standard drinks / week)**



Note that of course these figures do not include alcohol consumed in the community obtained from other sources e.g. sly grog.

Importantly, in the one community where the restrictions on trading conditions were *not* imposed, but Income Management *was*, the consumption of alcohol per person continued to rise steeply after 2007, strongly suggesting that Income Management was not significant in reducing consumption by itself.

The restrictions did not see a reduction in the overall number of assaults in the communities with clubs, although the proportion of assaults which were alcohol-related declined. Once again the exception was the community that did not have availability restrictions imposed where alcohol-related assaults continued to increase sharply after the introduction of restrictions in 2007, again demonstrating the ineffectiveness of Income Management in the absence of other supply and harm reduction measures.

The qualitative research which was part of the Review also revealed high-levels of support for the clubs and the restrictions they operate under, from both drinkers and non-drinkers, and from other service providers.

Overall, the Review concluded that, contrary to the situation before the introduction of the restrictions, when the operation of these licenses is appropriately tightly controlled:

*...there is no evidence to suggest that communities with clubs experience higher rates of alcohol-related harms than other communities (page 102).*

Critically however, the Review recommended:

- the restrictions on trading hours and on selling full-strength beer should be maintained at existing clubs and be required of any proposed new clubs;

- strengthened governance arrangements for all clubs, including incorporation under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006*;
- the establishment of a unit within the Northern Territory government focused exclusively on licensed clubs in Aboriginal communities and working proactively with those communities to ensure the clubs function responsibly; and
- a range of standards for clubs, including provision of hot meals, appropriate layout and design, high standards of governance, working with local health services on alcohol-related health issues, transparency of decision-making and re-investment of profits, and regular review and evaluation.

The findings of the Review and its recommendations are similar to the Congress Position Paper on Aboriginal Social Clubs (2009) – [Attachment B](#).

**11 That licensed clubs in remote communities should only be established in accordance with the criteria outlined in recently released *Managing Alcohol Consumption – a review on licensed clubs in remote Indigenous communities in the NT and the Congress Position Paper on Aboriginal Social Clubs*, and always include an evaluated trial to ascertain that they are acting as an effective harm minimisation strategy.**

### 5.3 Harm reduction approaches with little evidence of success

The best practice treatments and supports listed above, combined with the conditions for success, provide an evidence-based pathway to effectively reducing the harm done by alcohol in Northern Territory Aboriginal communities. Notwithstanding the need for well-structured, rigorously evaluated innovation under some circumstances, there are some approaches which have little evidence of success. These include:

- *mandatory treatment linked to criminal sanctions has very little evidence of success.* It appears to work least well for young people, can add to the disadvantage experienced by marginalised groups, and may displace voluntary clients from limited treatment spaces [69]. Note that this does not include short-term mandatory commitment of people who may be at risk of harming themselves or others for the purpose of assessment and care; and
- *education and persuasion strategies, including school-based education and media campaigns, have at best a minimal, short-term effect* and as a substantial review of the international literature note, 'cannot be relied upon as an effective approach' [32].

**12 The Northern Territory Government should avoid investment in approaches for which there is no reasonable prospect of effectiveness or which discriminate against or further marginalise Aboriginal people. This includes:**

- a. **mandatory treatment linked to criminal sanctions; and**
- b. **education and persuasion strategies, including school-based education and media campaigns.**

## 6 Monitoring and evaluation

Healthy public policy needs to be backed by evidence of the scale of the problem and what is working to address that problem. Accordingly, reliable, long-term datasets that can monitor patterns of alcohol consumption and harm in the community at a regional level are an essential tool for targeting effort and monitoring the effect of programs and policies. Unfortunately, routine, consistent reporting on alcohol consumption patterns have not been the rule in Australia.

Sales data – which provide a proxy measure of consumption – are collected in the Northern Territory and despite their inherent limitation in not being able to be disaggregated to provide data on consumption by population sub-groups, for example Aboriginal Australians. Such data – including historical data – needs to be made publically available on a regular basis.

In addition, regular reporting of alcohol related harms on a regional basis is a key tool for targeting programs and policies to areas of need and evaluating their effect. Unfortunately, as with consumption data, this information is not consistently available for governments, researchers, health services and policy makers. Key data to be collected on harms is detailed in [Attachment C](#).

**13 That the Northern Territory Government implement within the Territory and advocate at the national level for the establishment of an alcohol data infrastructure that would allow for targeting of effort at areas of most need as well as ongoing, routine monitoring of the effect of programs and policies aimed at reducing alcohol-related harm. This should include appropriate longitudinal datasets able to be analysed at a regional level containing agreed minimum datasets on sales / consumption and alcohol-related harms, with appropriate identification of Aboriginality.**

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**Attachment A:**

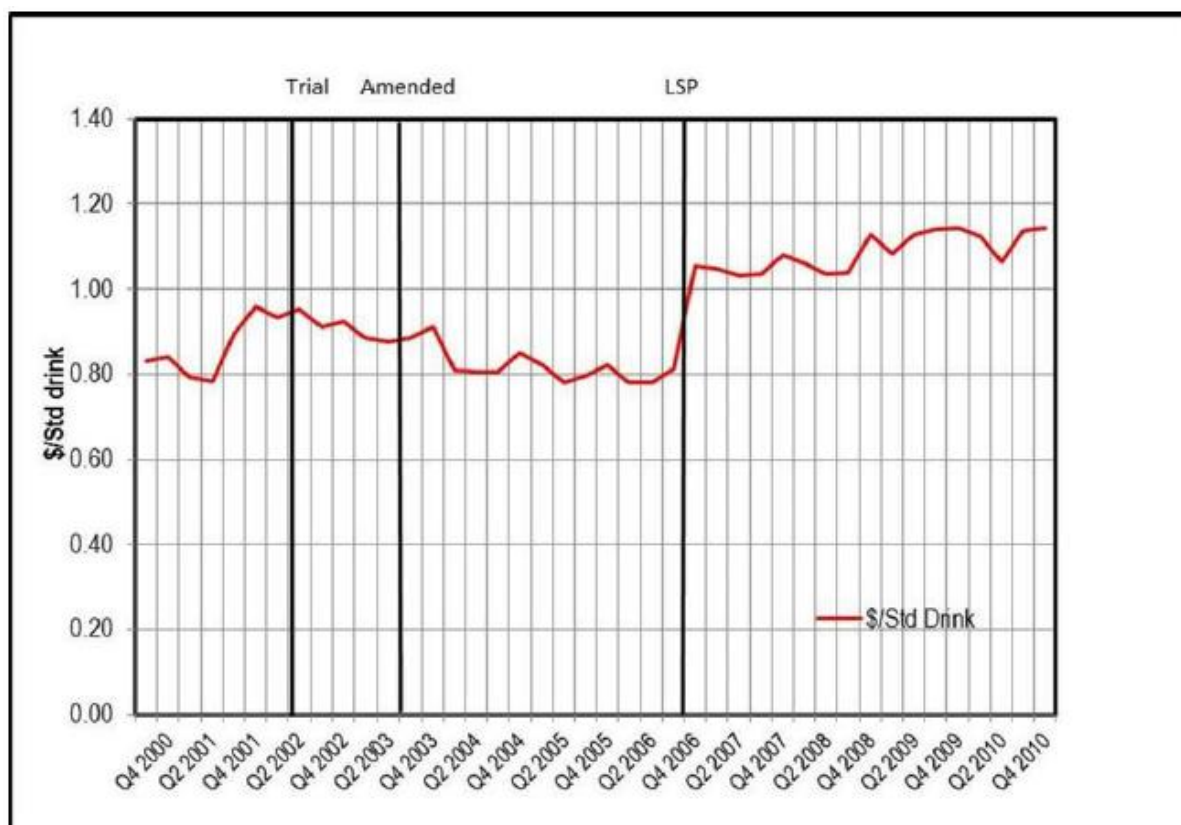
**Setting a minimum price for alcohol – a de-facto case study from Central Australia**

In the Northern Territory, an important de-facto case-study has shown the benefits of increasing the minimum price at which cheap alcohol is available. This was the Alice Springs Liquor Supply Plan (LSP) of 2006.

**Effect on price of alcohol**

While regulatory price controls were not introduced, the LSP banned the sale of cheap alcohol (wine and fortified wine in large containers). A substantial study of alcohol price, consumption and harms in Central Australia for the period 2000 to 2010 carried out by the National Drug Research Institute [49] found that by banning the sale of cheap take away alcohol, the LSP in effect increased the average price of a standard drink from 80 cents to \$1.10 and the minimum price per standard drink from 25 cents to 50 cents [70] (see Figure 5).

**Figure 5: Mean wholesale price per standard drink by quarter, Central Australia, 2000 – 2010 (2010 dollars)**

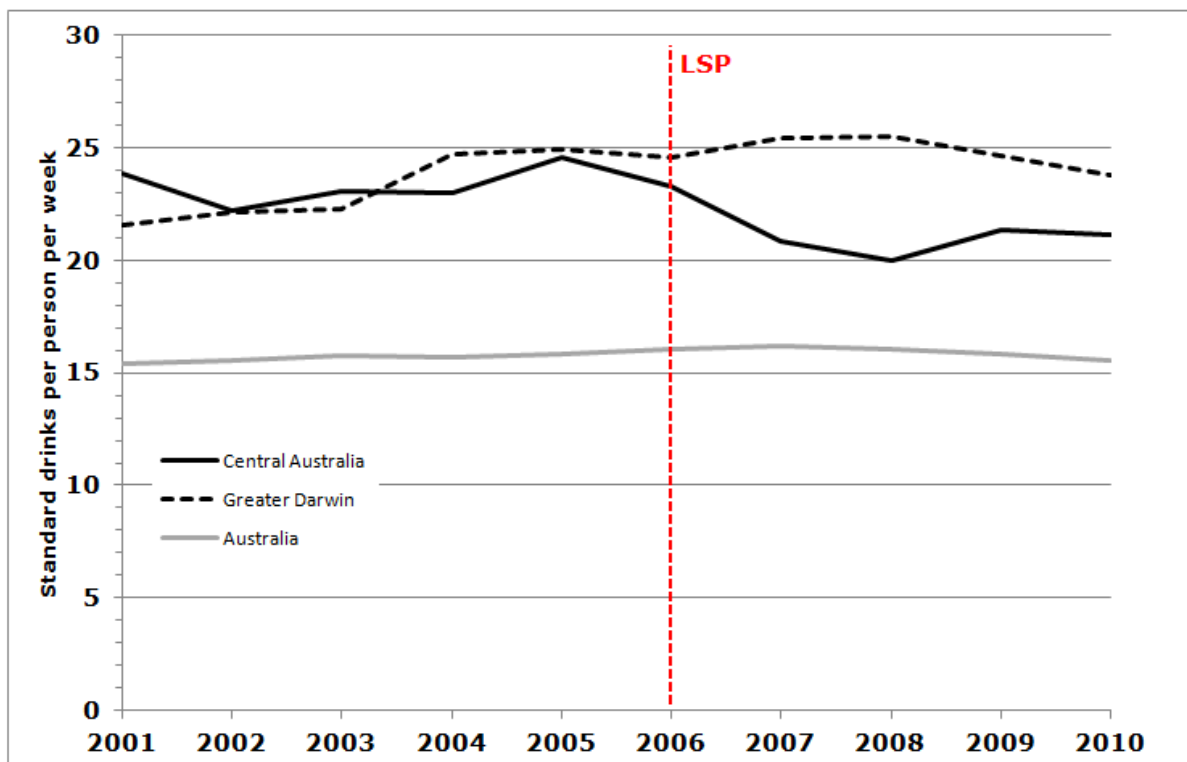


**Effect on consumption of alcohol**

The introduction of the LSP was accompanied by a significant decrease in per capita alcohol consumption in Central Australia. Consumption in the control area of Greater Darwin did not show significant reductions in this period.



**Figure 6: Estimated of per capita consumption (standard drinks per week) of alcohol (persons ≥15), 2001 to 2010, Central Australia, Greater Darwin, and Australia**



### Effect on levels of alcohol-related harm

The reductions in the level of consumption resulting from the introduction of the LSP were accompanied by significant reductions in health and social harms. This included [49]:

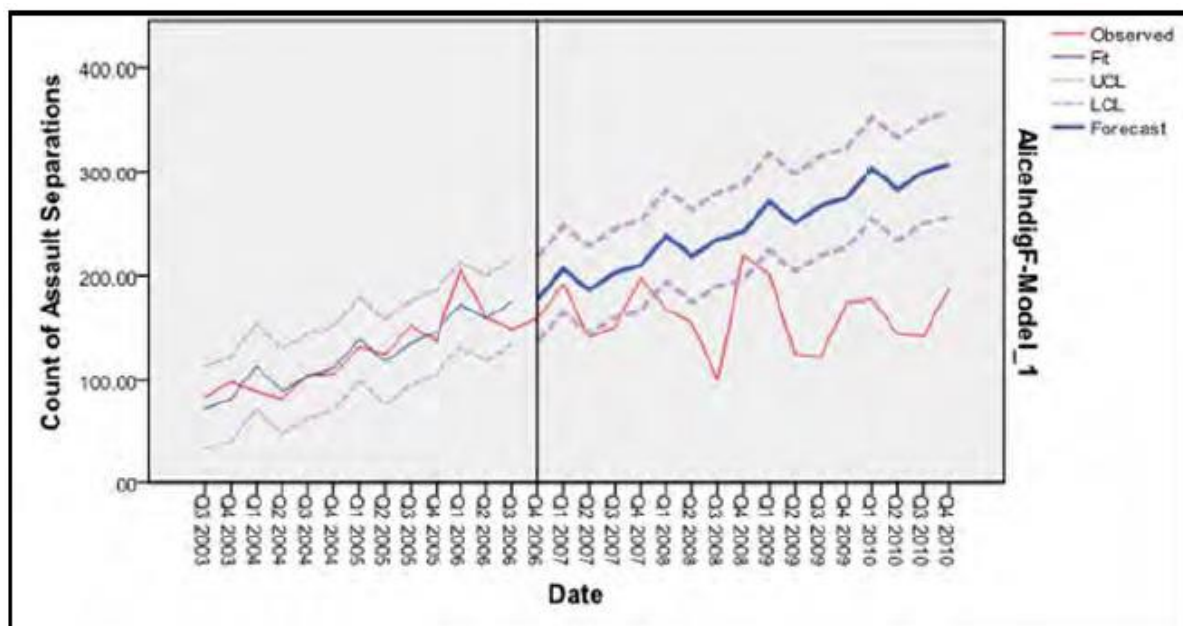
- significantly lower rates of hospital admissions for alcohol-attributable conditions compared to those forecast, due to declines in acute cases and particularly alcohol-related assaults;
- a significant decrease in Emergency Department presentations triaged as assaults; and
- significant reductions in the percentage of anti-social behaviour incidents that were alcohol-related.

### Prevention of community violence

While there is a complex causality for community violence, the LSP's restrictions on the availability of cheap alcohol were shown to be effective in contributing to community safety, in particular through reducing the number of Aboriginal women who were subjected to assault.

Between 2003 and 2006, the rate of hospitalisation of Aboriginal women for assault was growing rapidly. After the introduction of the LSP, although there were wide fluctuations this trend stabilised at around 175 separations per quarter. This was confirmed by modelling which showed significant differences between observed and expected numbers of hospital admissions for assault amongst Aboriginal women (Figure 7).

Figure 7: Alice Springs Hospital admissions for assault for Aboriginal women, observed and forecast values 2003 – 2010



**Price elasticity amongst Aboriginal drinkers**

Some researchers (and some community members) have posited that demand for alcohol amongst Indigenous drinkers is price inelastic: in effect, that Indigenous heavy drinkers will respond to increases in the price of alcohol by increasing their expenditure on alcohol and maintaining their consumption [6]. The NDRI study provides indirect evidence that this is incorrect: not only did increases in price correlate strongly with reduced consumption across Central Australia as a whole, but the significant reductions in the rate of hospital admissions for Aboriginal women for assault strongly suggests that the increases in price were accompanied by a reduction in consumption amongst Aboriginal drinkers in Central Australia.

## Attachment B:

### Congress Position Paper: Aboriginal Social Clubs (2009)

An Aboriginal Community Social Clubs is a social club, generally on a remote Aboriginal community, with a license to sell alcohol. The purpose is often to provide a place where alcohol can be consumed safely by community residents.

Congress is aware of the published evidence to date which suggests that Aboriginal community social clubs lead to an increase in alcohol caused harms in the communities in which they are present and do not lead to a decrease in community members travelling to regional centres to drink alcohol. There was therefore a net increase in harms without evidence that they led to responsible drinking. This led Prof Peter D'Abbs to draw this conclusion:

"It is concluded that, while the rights of Aboriginal communities to establish community controlled clubs should be respected, the notion that they are under some sort of obligation to do so should be exposed as a measure likely to add to the health burdens of people already inadequately serviced by health, education and other services" (*Aust NZ J Public Health* 1998;22:679-84)

At present there appears to be at least one Aboriginal social club that is operating well and achieving the key objectives of providing a place where people can socialise together and drink responsibly with food without causing an increase in harm. Congress believes that a further independent evaluation of existing Aboriginal social clubs is required to assess whether the clubs running under more stringent rules than those evaluated previously by Prof D'Abbs are operating well and not leading to increased harm.

Until there is further evidence from such an evaluation, Congress remains concerned that any increase access to alcohol may have a negative impact on the community and its residents and that any Aboriginal social clubs agreed to by communities need to be evaluated to assess their impact in an ongoing way.

Congress supports the establishment of licensed clubs in communities on a trial basis under the following conditions:

**All decision-making processes about the introduction of licensed clubs or canteens must satisfy the NT Liquor Licensing Commission that:**

- The proposed license application has involved the local population and obtained their consent.
- Proposals for community approval for a social club are voted on in secret ballot.
- That the presence of the club will not lead to an increase to the total quantum of harms accruing to the members of the community, including to non-drinkers, and the wider public.
- That the operation of the license is transparent and accountable and will be conducted independently of all community and liquor retailers.

- If a local ownership model is proposed, provisions for addressing conflict of interest issues are clearly defined.

**Any licensed clubs must be:**

- Governed by Rules and Directors committed to the principles of community well-being and public health.
- Governed by a Management Committees where none of the committee members have an alcohol problem.
- Governed and managed by people who have a range of expertise, including public health, public safety and financial planning.
- Governed and managed according to protocols which ensure minimal conflicts of interest – with all applications for a liquor license demonstrating how they will address these issues.
- Accompanied by a Local Alcohol Management Plan - with details of how Management will address individual behavioural issues (e.g. local rules for addressing issues where people are not attending work).
- Managed on a not-for-profit basis with all profits going back into the community for a public good.
- Supported by the existence of a permanent and adequate police presence, a functional women's safe house and a fully operational night patrol on the community.

**License Applications must also observe the following criteria:**

- No takeaway alcohol to be served.
- Food must be available for patrons during all opening hours.
- Processes must be in place for ensuring no patron is served to intoxication including limiting the number of standard drinks that can be served to a person.
- Processes to ensure that people prohibited from consuming alcohol are not served alcohol (e.g. consider the use of the IdEye system for selling alcohol over the counter).
- Established Rules on patrons making purchases on behalf of other customer(s) with penalties for supplying alcohol to someone who is prohibited from drinking (i.e. if on an alcohol court order).
- Intoxicated persons must be evicted from the licensed premises.
- Low alcohol products must be available at all times.
- All purchases should be opened prior to being taken away from the bar.
- Alcohol should not be served to people at high risk including pregnant woman and people with severe chronic diseases.
- No credit or book up to be given for any purchases under any circumstances.

- Management must be capable of understanding and enforcing the licensed club's rules at all times, or else the licensed club must remain closed until it has the capability to do so.
- Community must have access to transparent and responsive complaints process.
- After 3 years there should be a review of the license including a further assessment as to whether the community wants the license to continue.

Congress also believes that some of these criteria should be applied to all licensed on site premises in urban, rural and remote areas to limit the harmful effects of alcohol.

#### Footnote

The Liquor Licensing Commission has advised that the *licensee* can be an individual, incorporated body or any other legal entity. The *nominee* is the manager of the service and this is always a designated individual. Normally if the Licensing Commission has an issue with an outlet they will approach the nominee first depending on the seriousness and only go to the licensee as a second step.

**Attachment C:****Suggested minimum dataset on alcohol consumption and alcohol-related harm****Main indicators**

- Apparent per capita consumption
- Hospital separations for selected acute and chronic alcohol-related conditions
- Alcohol-related deaths
- Confirmed assaults
- Serious road injuries (fatalities or injuries requiring hospitalisation)
- Proportion of alcohol consumed at risky and high-risk levels
- Proportion of the population drinking at risky and high-risk levels
- Estimated acute and chronic hospital separations attributed to risky and high-risk drinking

**Additional Measures**

- Alcohol-related admissions to treatment agencies
- Ambulance callouts
- Admissions to sobering up shelters
- Apprehensions without arrest/ protective custodies
- Night patrol encounters
- Confirmed public order incidents
- Alcohol-related prison reception